STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2010-55809 QHP
Case No. 4642777

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.* upon the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. [redacted] appeared on her own behalf. [redacted], represented the Medicaid Health Plan (MHP). [redacted] appeared as a witness for the MHP. Also present was [redacted], for Health Plan of Michigan.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for additional outpatient mental health visits?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. The Appellant is [redacted] Medicaid beneficiary who was enrolled in Health Plan of Michigan MHP at all times relevant to this matter.

2. The Appellant requires mental health treatment.

3. The Appellant has participated in mental health treatment during the [redacted] calendar year. She had 20 outpatient mental health visits covered by the Respondent health plan between [redacted], and [redacted].

(Director of Utilization Management Testimony)

4. After 10 visits, the Appellant's provider completed a Continued Outpatient Treatment Notification Form indicating the plan for the Appellant once her benefits are exhausted would be a referral to Community Mental Health (CMH). (Exhibit 2)

5. The Appellant is seeking authorization for continued mental health treatment services through her provider.

6. The Appellant was notified by the MHP on [redacted], that coverage for continuing mental health treatment services would not be authorized due to coverage limitations of 20 visits per calendar year. (Exhibit 1, page 9)

7. On [redacted], the State Office of Administrative Hearings and Rules received Appellant's request for an Administrative Hearing. (Exhibit 1, pages 7-8)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

On May 30, 1997, the Department received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified Medicaid Health Plans.

The Respondent is one of those MHPs.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Contractor must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the

provisions of Contract Section 2.024.

Section 1.022(E)(1), Covered Services.
MDCH contract (Contract) with the Medicaid Health Plans,
October 1, 2009.

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

(a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.

(b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.

(c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.

(d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.

(e) The Um activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure
The Contractor must establish and use a written prior approval policy and procedure for UM purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

Section 1.022(AA), Utilization Management, Contract,
October 1, 2009.

According to the MHP's member handbook, Health Plan of Michigan covers up to 20 outpatient mental health visits per year. (Exhibit 1, page 13) The MHP's policy on outpatient mental health visits is consistent with the Medicaid policy. Medicaid policy does not provide coverage for mental health services in excess of 20 outpatient mental health visits each contract year. (*DCH Medicaid Provider Manual, Medicaid Health Plans, section 1.1, July 1, 2010)* Should the Appellant require treatment in excess of 20 visits per year, she can contact Community Mental Health for assistance in getting the additional mental health treatment she may need.

In this case, the Appellant is protesting the MHP's denial of her request for continued coverage of outpatient mental health treatment. The Appellant testified that she has a big problem leaving home and it takes a lot for her to get out and feel comfortable with someone. The Appellant explained that she is comfortable with her current therapist at [redacted], but needs more than the allowed 20 outpatient visits. She stated she has been with [redacted] for two years. The Appellant explained that she can not leave home to go to the store, let alone to start with a new therapist somewhere else.

The MHP established that Appellant had already received coverage for 20 outpatient mental health visits in [redacted], and she had reached her outpatient visit limit. The Medicaid policy does not require the MHP's to provide coverage for more than 20 outpatient mental health visits per calendar year. Accordingly, the MHP's denial must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Medicaid Health Plan properly denied the Appellant's request for additional outpatient mental health visits.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/16/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.