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. 2011-975 QHP
Case No. 3043217

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 on [redacted]. [redacted] appeared on behalf of the Appellant, who was present and testified. [redacted] represented the Medicaid Health Plan (MHP).

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for additional counseling sessions?

FINDINGS OF FACT

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

1. At the time of hearing the Appellant is [redacted] Medicaid beneficiary. Appellant's Exhibit #1.

2. The Appellant has been a member of the MHP since [redacted]. See Testimony.

3. The Appellant has an assortment of mild to moderate mental health issues including: major depressive disorder – moderate – recurrent, adjustment disorder and other limitations in his daily activities. See Testimony and Exhibit A, p. 16.

4. On or about [redacted], the Appellant was notified by the MHP on the denial of continued outpatient mental health visits. Exhibit A, p. 9.

5. The Appellant appealed the MHP decision internally and then for fair hearing, received [redacted]. Exhibit A – throughout.

6. The Appellant exhausted his 20-visit mental health outpatient benefit as of [redacted]. Exhibit A, p. 9.

7. The Appellant's therapist contacted the MHP and stated her intention to treat the Appellant free of charge and/or until his new benefit year became active. See Testimony and Appellant's Exhibit #1.

8. The Appellant's predicament was aggravated by his inability to read or write. See Testimony.

9. The instant request for hearing was received by the State Office of Administrative Hearings and Rules [redacted]. Appellant's Exhibit #1.

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 Medicaid Health Plans.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below. 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.

Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.

- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21

Article 1.020 Scope of [Services], at §1.022 E (1) contract, 2010, p. 22.

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The MHP witness testified that the Appellant became active with their plan in [redacted]. The member was sent all necessary enrollment materials including the plan handbook and certificate of coverage. Included therein was information on accessing mental health services. However the Appellant disputed receipt of those materials.

The Appellant's representative explained that as he left prison he felt the need to talk - to enable him to cope with present day society. He found his therapist to be a good fit.

The Appellant said he did not want to start and stop his counseling sessions and was unaware on the visit limitation. At hearing the Appellant admitted that he was unaware that his therapist had contacted the MHP and volunteered to treat him for free – or until his next benefit year began.

However, he did not withdraw his appeal.

On review while there were apparent communication difficulties between the parties and the therapist – the Appellant failed to preponderate his burden of proof that the MHP improperly denied counseling sessions beyond his allocated [and used] maximum 20 outpatient visits per calendar year.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied Appellants request for additional counseling sessions.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

_____

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

[redacted]
Docket No. 2011-975 QHP
Decision and Order

cc: [redacted]

Date Mailed: 1/4/2011

***** 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.