STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Appellant

_____/

Docket No. 2013-21293 QHP
Case No. [redacted]

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]. The Appellant was represented by [redacted]. [redacted] represented [redacted], appeared as a witness for the MHP.

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for neuropsychological testing?

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 a [redacted] Medicaid beneficiary.

2. The [redacted] approved request for coverage for office visits at the [redacted] for the Appellant. The approval was valid form [redacted] through [redacted]. (Exhibit 1, page 19)

3. The Appellant was unable to get an appointment with the [redacted] before the authorization expired. [redacted] Testimony)

4. On of about [redacted], the [redacted] received a request for coverage for [redacted] for the Appellant for a [redacted] with a date of service of [redacted]. The Appellant's

diagnoses were listed as global developmental delay and sensory processing disorder. (Exhibit 1, page 5)

5. Additional documentation was faxed to the [redacted] to support the prior authorization request. (Exhibit 1, pages 6-18)

6. On [redacted], the [redacted] sent the Appellant notice that the request for [redacted] was denied because it is not a covered benefit under the [redacted] Evidence of Coverage Guidelines. The notice stated that members eligible are referred to receive the requested behavioral health service through the intermediate school district for their coordination of care and that services provided by a school district and billed through the intermediate school district are not a covered [redacted] benefit. (Exhibit 1, pages 20-23)

7. On [redacted], the Michigan Administrative Hearing System received the Request for Hearing submitted on the Appellant's behalf with attached documentation.

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 Health Plan of Michigan 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.

....

Utilization Management

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

- Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- An annual review and reporting of utilization review activities and outcomes/interventions from the review.
- 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. Contract, *Supra,* at page 49.
>
> ***

As stated in the Department-MHP contract language above, a MHP, "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The pertinent sections of the Michigan Medicaid Provider Manual (MPM) are as follows:

> **9.7 EXCLUDED HEALTH PLAN SERVICES**
>
> Services are either included or excluded from the health plan's monthly capitation rate. The following services are not included in the monthly capitation rate and may be provided by an enrolled provider who would be directly reimbursed by Medicaid.
>
> - Dental services. (Oral-maxillofacial surgeons providing medical services are included in the health plan's capitation rate and should follow health plan authorization rules.)
> - Nursing facility (NF) services. The health plan is responsible for restorative or rehabilitative care in a nursing facility up to 45 days in a rolling 12-month period. If nursing facility services will exceed this coverage, the health plan may initiate the disenrollment process by submitting the Request for Disenrollment Long Term Care form (MSA-2007). The provider may bill Medicaid after the disenrollment is processed.
>
>   Beneficiaries who reside in a nursing facility are excluded from subsequent enrollment in a MHP. However, a beneficiary may occasionally be enrolled in a MHP due to administrative error. When this happens, disenrollment may be requested by either the nursing facility or MHP. For a nursing facility to request disenrollment, the facility must submit a Nursing Facility Request to Disenroll from Medicaid Health Plan form (DCH-1185) along with a copy of the Facility Admission Notice form (MSA-2565-C). The completed forms must be mailed or faxed to the MDCH Enrollment Services Section as indicated on

> the DCH-1185. A MHP uses the Request for Administrative Disenrollment form (MSA-2008) for disenrollment.
>
> The nursing facility or MHP must submit a disenrollment to MDCH within six months of the administrative error occurrence. Disenrollment requests that exceed six months from the date of occurrence will be retroactive to six months from receipt of the request.
>
> - Mental health services in excess of 20 outpatient mental health visits each contract year. (Refer to the Medicaid Health Plans and the Mental Health/Substance Abuse chapters for additional information.)
> - Services provided to persons with developmental disabilities and billed through the Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP).
> - Substance abuse treatment services.
> - Inpatient hospital psychiatric services and outpatient partial hospitalization psychiatric services.
> - Personal care authorized through DHS.
> - School-based services.
> - Pharmacy and related services prescribed by providers under the State's contract for specialty behavior services.
> - Private Duty Nursing (PDN) services, for beneficiaries under 21 years. (Beneficiaries over 21 may receive PDN services through the Habilitation/Supports or MIChoice waiver programs.)
> - Maternal Infant Health Program services as defined in the Maternal Infant Health Program chapter of this manual.
>
> Medicaid Provider Manual
> Beneficiary Eligibility, Version Date October 1, 2012
> (Underline added by ALJ)

The [redacted] denied the Appellant's request for [redacted] because the service requested is the responsibility of the intermediate school district. (Exhibit 1, pages 20-23)

The Appellant's [redacted] asserted that the [redacted] previously authorized the requested testing, but they could not get the Appellant in before the authorization expires. ([redacted] Testimony) However, a close review of the two prior authorization request forms

reveals that "office visits only" was specified on earlier prior authorization request form, and the present prior authorization request was for '[redacted]' (Exhibit 1, pages 5 and 19) The [redacted] testified that the earlier approval may have been in error. Further, the [redacted] noted that the time limited approval was during the summer time and the Medicaid Provider Manual policy does allow for an [redacted] to cover services normally considered the responsibility of the intermediate school district over a school summer break. This would include therapy services and is intended to prevent a gap in services when they are not available though the schools. ([redacted] Testimony) For example, the Medicaid Provider Manual policy regarding outpatient occupational therapy states:

> **5.1.B. SERVICES TO SCHOOL-AGED BENEFICIARIES [CHANGE MADE 4/1/12]**
>
> School-aged beneficiaries may be eligible to receive OT through multiple sources. MDCH expects educational OT to be provided by the school system, and it is not covered by MDCH or CSHCS. (Example: OT coordination for handwriting, increasing attention span, identifying colors and numbers.)
>
> MDCH only covers medically necessary OT when provided in the outpatient setting. Coordination between all OT providers must be continuous to ensure a smooth transition between sources.
>
> <u>Outpatient therapy provided to school-aged children during the summer months in order to maintain the therapy services provided in the school is considered a continuation of therapy services when there is no change in beneficiary diagnosis or function. Prior authorization is required before initiating a continuation of therapy.</u>
>
> If a school-aged beneficiary receives medically necessary therapy services in both a school setting (as part of an Individualized Education Plan [IEP]) and in an outpatient setting, coordination of therapy between the providers is required. Providers are to maintain documentation of coordination in the beneficiary's file. **(text added per bulletin MSA 12-02)**.
>
> Medicaid Provider Manual
> Outpatient Therapy, Version Date October 1, 2012
> (Underline added by ALJ)

Beyond this exception allowing for a continuation in services during the school break over the summer months, school-based services are excluded from coverage both under the [redacted] certificate of coverage and through the Medicaid Provider Manual. The neuropsychological testing was requested for diagnoses of global developmental delay and sensory processing disorder. (Exhibit 1, page 5) The [redacted] correctly stated that this is a service expected to be provided by the school system. ([redacted] Testimony) Accordingly, the [redacted] denial of coverage for neuropsychological testing for the Appellant was consistent with the Department's Medicaid policy and must be upheld.

As noted during the hearing proceedings, the Appellant also has appeal rights regarding services provided thought the school district.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that that the [redacted] properly denied the Appellant's request for [redacted]

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

/S/
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 03/19/13

***** 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.