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]

Docket No. 2013-58945 QHP
Case No. [redacted]

Appellant
_____/

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 Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant was represented by her mother, [redacted]. [redacted], Inquiry Dispute Appeals Resolution Coordinator, represented [redacted], the Medicaid Health Plan ("MHP"). Dr. [redacted], Medical Director, appeared as a witness for the MHP.

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for psychological 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. Appellant is a [redacted] year-old Medicaid beneficiary, born [redacted], enrolled in Respondent MHP. (Exhibit A, p 8)

2. On or about [redacted], the MHP received a request for coverage for psychological testing for Appellant. Appellant's diagnoses were listed as learning disorder NOS with a GAF of 60. (Exhibit A, pp 8-21)

3. On [redacted], the MHP sent Appellant notice that the request for psychological testing was denied because it is not a covered benefit under the [redacted] Healthcare Evidence of Coverage Guidelines. The notice stated that eligible members 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 A, pp 22-25)

4. 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.

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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 July 1, 2013
(Underline added by ALJ)

The MHP Medical Director testified that Appellant was denied psychological testing because the requested service is not a covered benefit under the MHP. The MHP Medical Director testified that psychological testing is not a covered benefit because the services are to be provided by the intermediate school district.

Appellant's mother testified that Appellant needs the testing because she has had difficulty in school for many years, even though she has been held back one year and has failed one year. Appellant's mother indicated that she has been going back and forth with the school and the intermediate school district (ISD) for many years, all to no avail. Appellant's mother indicated that Appellant needs to be evaluated so that the school knows where to begin with her. Appellant's mother indicated that Appellant's difficulties have been going on for many years, but have intensified the last 4-5 years. Appellant's mother said she is at a loss and wants someone to recognize that her daughter has a problem.

The MHP Medical Director recommended that Petitioner take the medical documentation that was submitted with her daughter's prior authorization request to the school principal and demand that the school complete an individualized education program (IEP) for Appellant, as required by law. The MHP Medical Director suggested that Appellant present the documentation to the school with a cover letter demanding the IEP. The MHP Medical Director indicated that the school district is required by law to complete an IEP for Appellant because she has a documented learning disability, as evidenced by the documents submitted with the prior authorization request.

School-based services are excluded from coverage both under the MHP certificate of coverage and through the Medicaid Provider Manual. The psychological testing was requested for a diagnoses of learning disorder NOS. The MHP Medical Director correctly stated that this is a service expected to be provided by the school system. Accordingly, the MHP denial of coverage for psychological testing for Appellant was consistent with the Department's Medicaid policy and must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that that the MHP properly denied the Appellant's request for psychological testing.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[redacted]

cc: [redacted]

Date Signed: 9/19/2013

Date Mailed: 9/19/2013

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.