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. 2009-16455 QHP
Case No. [redacted]
Load 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 [redacted]. [redacted], the Appellant's mother, appeared on behalf of the Appellant. [redacted], [redacted], a Medicaid Health plan, appeared. [redacted] appeared and provided testimony on behalf of the health plan.

ISSUE

Did [redacted]. properly deny Appellant's request for speech therapy?

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 Medicaid beneficiary, enrolled in [redacted] (herein after the MHP).

2. The Appellant is a [redacted] year old boy with speech and fine motor delays, diagnosed as speech and fine motor apraxia.

3. The Appellant has been evaluated at the [redacted] and speech and occupational therapies have been requested on his behalf.

4. The MHP denied the request for speech and occupational therapies on [redacted].

5. The Department received the Appellant's request for hearing before the State Office of Administrative Hearings and Rules for the Department of Community Health on or about [redacted].

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 (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. Contractors 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 1-Z. (Bold emphasis added).
>
> *Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans, September 30, 2004, Page 30.*

As it says in the above Department - MHP contract language, a MHP such as [redacted] may limit services to those that are medically necessary and that are consistent with applicable Medicaid Provider Manuals. The Medicaid Provider Manual places limitations on criteria for speech therapy, outlined below. The MHP representative stated that its limitations were consistent with Medicaid policy.

5.3. SPEECH THERAPY

For all beneficiaries of all ages, speech therapy must relate to a medical diagnosis and is limited (to) sic services for:

- Articulation
- Language
- Rhythm
- Swallowing
- Training in the use of an augmentative communication device
- Training in the use of an oral-pharyngeal prosthesis
- Voice

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Therapy must be reasonable, medically necessary, and expected to result in improvement and/or elimination of the stated problem within a reasonable amount of time.

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For beneficiaries of all ages, therapy is <u>not</u> covered:

- When provided by an independent SLP.
- *For educational, vocational, social/emotional, or recreational purposes.*
- *If services are required to be provided by another public agency (e.g., PIHP/CMHSP provider, SBS).*
- When intended to improve communication skills beyond premorbid levels (e.g., beyond the functional communication status prior to the onset of a new diagnosis or change in medical status).
- If it requires PA but is rendered before PA is approved.
- *If it is habilitative. Habilitative treatment includes teaching someone communication skills for the first time without compensatory techniques or processes. This may include syntax or semantics (which are developmental) or articulation errors that are within the normal developmental process.*
- *If it is designed to facilitate the normal progression of development without compensatory techniques or processes.*
- If continuation is maintenance in nature.
- *If provided to meet developmental milestones.*
- Medicare does not consider the service medically necessary.

<u>Occupational Therapy</u>

OT is not covered for the following:

- When provided by an independent OTR**.
- For educational, vocational, or recreational purposes.
- If services are required to be provided by another public agency (e.g., community mental health services provider, school-based services).
- If therapy requires PA and service is rendered before PA is approved.
- If therapy is habilitative. Habilitative treatment includes teaching someone how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. This may include teaching a child normal dressing techniques or cooking skills to an adult who has not performed meal preparation tasks in the past.
- If therapy is designed to facilitate the normal progression of development without compensatory techniques or processes.
- For development of perceptual motor skills and sensory integrative functions to follow a normal sequence. If the beneficiary exhibits severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function, OT may be covered.
- Continuation of therapy that is maintenance in nature.

** An independent OTR may enroll in Medicaid if he provides Medicare-covered therapy and intends to bill Medicaid for Medicare coinsurance and/or deductible only.

5.1.A. DUPLICATION OF SERVICES

Some therapy areas (e.g., dysphagia, assistive technology, hand therapy) may be appropriately addressed by more than one discipline (e.g., OT, PT, speech therapy) in more than one setting. MDCH does not cover duplication of service (i.e., where two disciplines are working on similar goals/areas). The OTR is responsible to communicate with other therapists and coordinate services. MDCH requires any related documentation to include coordination of services.

5.1.B. SERVICES TO SCHOOL-AGED BENEFICIARIES

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.
>
> Outpatient therapy provided to school-aged children during the summer months in order to maintain the therapy services provided in the school are 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.
>
> *MPM, Outpatient Therapy Section, January 1, 2006, Pages 8 and 9*

The uncontested material facts are that Appellant has developmental speech and fine motor delays. The purpose of speech therapy to address developmental delays is habilitative rather than rehabilitative, thus is expressly excluded from coverage under the Medicaid Provider Manual, the controlling authority. An additional basis for denial of the requested coverage is that the Appellant is receiving both therapies through the school system and that it is not for the purpose of restoring function once held by him. This ALJ understands why the Appellant's mother would have confusion and/or dissatisfaction with the denial of what is appropriate for her son, however, coverage for these therapies is specifically excluded under the circumstances in this case. While this ALJ is sympathetic to the Appellant's needs, the limited authority given this ALJ does not allow for exceptions to the policy. If the Appellant believes the amount of service provided by the public school system is inadequate, she has a right to request a hearing from the school system regarding the level of services. She does not have to agree with or sign off on the IEP.

[redacted] has provided sufficient evidence that the Appellant's request for speech therapy did not meet coverage guidelines, thus it properly denied the request.

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 Appellant's request for speech therapy.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5/4/2009

***** 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.