STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRAVE 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. 2009-34014 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], Appellant's mother/guardian, appeared and testified on behalf of Appellant. [redacted] and Denial Coordinator, [redacted], represented the Medicaid Health Plan (MHP). [redacted], appeared and testified as a witness for the MHP.

ISSUE

Did the Department properly deny Appellant's request for occupational 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 whose date of birth is [redacted].

2. Appellant was diagnosed with developmental delay. (Exhibit 1)

3. On [redacted], the MHP received a referral request from [redacted] Pediatric Rehabilitation, requesting that Appellant receive occupational therapy for developmental delay. (Exhibit 1, p. 5)

4. On [redacted], the MHP sent Appellant notice that the request for him to receive occupational therapy was denied on the basis that it is not covered to "help the normal progress of development", and "it may be provided through another public agency via the intermediate school district." (Exhibit 1, p. 2)

5. On [redacted], the State Office of Administrative Hearings and Rules received a hearing request, from Appellant's legal guardian, protesting the denial of occupational therapy for Appellant.

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 coverage's 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,*

> The major components of the Contractor's utilization management plan 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 Contractor must establish and use a written prior approval policy and procedure for utilization management 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 utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

The MHP testified that its evidence of coverage guidelines state that occupational therapy is not covered for the treatment of delays in development. In addition, this service may be provided through another public agency via the intermediate school district.

The Medicaid Provider Manual addresses occupational therapy. The policy, states in pertinent part that:

> SECTION 5 – STANDARDS OF COVERAGE AND SERVICE LIMITATIONS
> 5.1 OCCUPATIONAL THERAPY
>
> OT must be medically necessary, reasonable and required to:

- Return the beneficiary to the functional level prior to illness or disability;
- Return the beneficiary to a functional level that is appropriate to a stable medical status; or
- Prevent a reduction in medical or functional status had the therapy not been provided.

OT may be covered for one or more of the following:

- Therapeutic use of occupations*.
- Adaptation of environments and processes to enhance functional performance in occupations*.
- Graded tasks (performance components) in activities as prerequisites to an engagement in occupations*.
- Design, fabrication, application, or training in the use of assistive technology or orthotic devices.
- Skilled services that are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers.
- Routine provision of the maintenance/prevention program is not a covered OT service.

* Occupations are goal-directed activities that extend over time (i.e., performed repeatedly), are meaningful to the performer, and involve multiple steps or tasks. For example, doing dishes is a repeated task. Buying dishes happens once; therefore, does not extend over time and is not a repeated task.

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.

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 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.

5.1.F. PRESCRIPTION REQUIREMENTS

MDCH requires a physician's prescription for an OT evaluation and preparation of the treatment plan. The prescription must include beneficiary name, prescribed therapy, and diagnosis(es) or medical conditions(s). MDCH requires a new prescription if OT is not initiated within 30 days of the prescription date. An evaluation may be provided for the same medical diagnosis without PA twice in a 365-day period with a physician's prescription. PA is required if an evaluation is needed more frequently. Evaluations must include standardized tests and/or measurable functional baselines.

OT evaluations must be completed by an OTR and include the following:

- Treatment diagnosis and medical diagnosis, if different from the treatment diagnosis(es) (e.g., medical diagnosis of cerebral palsy with contractures being treated);
- OT provided previously, including facility/site, dates, duration, and summary of change;
- Current therapy being provided to the beneficiary in this or other settings;
- Medical history as it relates to the current course of therapy;

- The beneficiary's current functional status (functional baseline);
- Standardized and other evaluation tools used to establish the baseline and to document progress;
- Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; and
- Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension).
- Treatment Plan The OT treatment plan that results from the evaluation must consist of the following:
- Time-related short-term goals that are measurable, functional, and significant to the beneficiary's life goals;
- Long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from therapy;
- Anticipated frequency and duration of treatment required to meet short- and long term goals

Version Outpatient Therapy
Date: April 1, 2009
Medicaid Provider Manual

As it says in the above Department-MHP contract language, an MHP may limit services as long as the limitations are consistent with the applicable Medicaid Provider Manual. Based on Appellant's documentary evidence, the occupational therapy was recommended only for the purposes of treating his developmental delay. Occupational therapy is not a covered benefit for the treatment of developmental delay under the MHP's Evidence of Coverage Guidelines, which is consistent with Medicaid policy. The documentary evidence fails to establish that the occupational therapy requested is medically necessary to: return Appellant to a functional level prior to an illness or injury; or return Appellant to a functional level that is appropriate to a stable medical status; or prevent a reduction in medical or functional status had the therapy not been provided. The occupational therapy was requested for habilitative purposes or treatment that includes teaching someone how to perform a task (i.e., daily living skills) for the first time without compensatory techniques or processes; and it is designed to facilitate the normal progression of development without compensatory techniques or processes. Accordingly, the MHP properly denied the request for occupational therapy.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the request for Appellant to receive occupational therapy.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Marya Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 11/5/2009

***** 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.