STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-34027 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.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted] appeared on behalf of her daughter, [redacted]).

[redacted], Lead Appeals Coordinator, appeared on behalf of [redacted] of Michigan, a Medicaid Health Plan (MHP). Also appearing on behalf of the MHP was [redacted].

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for speech therapy?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. At the time of hearing, the Appellant is a [redacted] old Medicaid beneficiary, who is enrolled with [redacted], a Medicaid Health Plan.

2. On [redacted], the Appellant's request for outpatient speech therapy was denied by the MHP. The reason for the denial is that the diagnosis code submitted (307.0-stuttering) is classified as a mental health diagnosis code, and not a medical diagnosis code. The request was also denied, because, per

Medicaid policy, speech therapy is not covered when required to be provided through school-based services or for educational, vocational, social/emotional, or recreational purposes.

3. The Appellant's [redacted] Speech Therapy Initial Evaluation reveals, in pertinent part, as follows:

> *"This young middle school pre-adolescent girl was referred to the [redacted] Center by her PCP, [redacted] and her pediatric pulmonologist, [redacted] for persistent severe secondary stuttering impairment. [redacted] will enter the [redacted] in the fall o [redacted] and has worsening secondary stuttering that will impact her psychosocial development and classroom performance. She has had school treatment with minimal success. [redacted] reports that [redacted] was born several months premature and spent six months in the hospital after birth with respiratory assistance. In [redacted] she was hospitalized with pneumonia and continues to utilize Flovent and an Albuterol Inhaler to maintain normal respiratory functioning. She is seeing [redacted] for this respiratory management. Her mother reports that she has had treatment at [redacted] with some improvement."*
>
> *"SPEECH FLUENCY ASSESSMENT*
>
> *[redacted] was administered the Riley Stuttering Severity Instrument-II in both reading, and imitative speech tasks. She demonstrated significant vocal hard onsets, syllable repetitions vowel prolongations and a number of facial myospasms accompanying the stuttering symptoms. Her stuttering blocks amounted to 30% or more the syllables uttered and lasted on average duration for 3-5 seconds. She had poor fluency controls and considerable eye aversion, head and body turns, facial tremors and vocal hard and silent onsets. Her Riley score was 33 or well above the 90% percentile (severe).*
>
> *[redacted] was able to imitate easy onset word and phrase controls with good success. She could demonstrate phoneme prolongation and inhibition of some secondary physical struggling behavior. [redacted] verbal communication was compromised substantially by her stuttering behavior, which I estimated at 40-50% intelligibility when classroom requirement*

> *would be 97 to 100%. She has a very positive personality and a willingness to verbally communicate even though it is a physical struggle."*
>
> *" . . ."*
>
> *(Exhibit 1; pp. 10-11)*

4. On [redacted], the Appellant filed her Request for Hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health.

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. (Emphasis supplied by ALJ) 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.
>
> ***Article II-G, Scope of Comprehensive Benefit Package. MDCH contract Contract) with the Medicaid Health Plans, September 30, 2004.***

> 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 coverage(s) established under the Contract. (Emphasis supplied by ALJ) 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.
>
> ***Article II-P, Utilization Management, Contract, September 30, 2004.***

Fee-for-service Medicaid beneficiaries are subject to the prior approval process found in the Medicaid Provider Manual. MHP beneficiaries are entitled to the same benefits as fee-for-service Medicaid beneficiaries.

Coverage for Speech Therapy is addressed in the Medicaid Provider Manual. The Medicaid Provider Manual covers speech therapy under the following conditions:

> **5.3 SPEECH THERAPY**
>
> The terms speech therapy, speech-language pathology, speech-language therapy, and therapy are used to mean speech and language rehabilitation services and speech-language therapy. MDCH covers speech-language

therapy provided in the outpatient setting. MDCH only reimburses services for speech-language therapy when provided by:

- A speech-language pathologist (SLP) with a current Certificate of Clinical Competence (CCC).
- An appropriately supervised SLP candidate (i.e., in their clinical fellowship year [CFY]) or having completed all requirements but has not obtained a CCC. All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.
- A student completing his clinical affiliation under direct supervision of (i.e., in the presence of) an SLP having a current CCC. All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.

MDCH expects that all SLPs will utilize the most ethically appropriate therapy within their scope of practice as defined by Michigan law and/or the appropriate national professional association.

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

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

For CSHCS beneficiaries (i.e., those not enrolled in Medicaid; only enrolled with CSHCS), therapy must be directly related to the CSHCS-eligible diagnosis(es) and prescribed by the specialty physician who is overseeing the care of the beneficiary.
Therapy must be reasonable, medically necessary and expected to result in an improvement and/or elimination of the stated problem within a reasonable amount of time (i.e., when treatment is due to a recent change in medical or functional status affecting speech, and the beneficiary would experience a reduction in medical or functional status without therapy).

Speech therapy services must be skilled (i.e., require the skills, knowledge and education of a certified SLP to assess the beneficiary for deficits, develop a treatment program and provide therapy).

Interventions that could be provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [LPT], registered occupational therapist [OTR], family member, or caregiver) would not be reimbursed as speech therapy by MDCH.

For beneficiaries of all ages, therapy is **not** 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 pre-morbid 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.
- If Medicare does not consider the service medically necessary.

5.3.A. DUPLICATION OF SERVICES

Some areas (e.g., dysphagia, assistive technology) may appropriately be addressed by more than one discipline (e.g., OT, PT, speech therapy) in more than one setting. MDCH does not cover duplication of services, i.e., where two disciplines are working on similar areas/goals. It is the treating therapist's responsibility to communicate with other practitioners, coordinate services, and document this in his reports.

5.3.B. SERVICES TO SCHOOL-AGED BENEFICIARIES

School-aged beneficiaries may be eligible to receive speech-language therapy through multiple sources. Educational speech is expected to be provided by the school system and is not covered by MDCH or CSHCS. Examples of educational speech include enhancing vocabulary, improving sentence structure, improving reading, increasing attention span, and identifying colors and numbers. Only medically necessary therapy may be provided in the outpatient setting.

Coordination between all speech therapy providers should 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.

5.3.C. PHYSICIAN REFERRAL FOR SPEECH THERAPY

A physician referral is required for Medicaid coverage of speech therapy. A physician referral for speech therapy must be documented in the beneficiary's medical record and must include the following:

- Beneficiary name;
- Beneficiary date of birth;
- Diagnosis for referral (for CSHCS beneficiaries, this must be the CSHCS-qualifying diagnosis); and
- A statement indicating that the beneficiary is being referred for speech therapy.

If therapy is not initiated within 30 days of the referral date, a new referral is required. A new physician referral must be made at least annually for continuing treatment lasting longer than 12 months. Whenever a beneficiary is discharged from speech therapy treatment, a new referral must be made and an evaluation and treatment plan must be completed before therapy may resume.

A copy of the physician referral must be attached to all PA requests for speech therapy.

Evaluation Does not require PA. This is formalized testing in early stages of a beneficiary's treatment program followed by periodic testing and reports to indicate measurable functional change resulting from the beneficiary's treatment. These may be provided for the same diagnosis without PA twice in a 365-day period with a physician's referral.

If an evaluation is needed more frequently, PA is required.

Evaluations must include standardized tests and/or measurable functional baselines. The speech-language evaluation must be completed by an SLP and include:

- The disorder and the medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with dysphasia as the speech disorder being treated).
- Speech therapy provided previously, including facility/site, dates, duration and summary of measurable change.
- Current rehabilitation services being provided to the beneficiary in this or other settings.
- Medical history as it relates to the current course of therapy.
- Beneficiary's current functional communication status (functional baseline).
- Standardized and other evaluation tools used to establish the baseline and to document progress.
- Assessment of the beneficiary's functional communication skill level, which must be measurable.
- Medical, physical, intellectual deficits that could interfere with the beneficiary's improvement in therapy.

Evaluations must include, but are not limited to:

- Articulation – standardized tests that measure receptive and expressive language, mental age, oral motor skills, articulation skills, current diet level (including difficulties with any food consistencies), current means of communication and a medical diagnosis.
- Language – standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es).
- Rhythm – standardized tests that measure receptive and expressive language, mental age, oral motor skills, measurable assessment of dysfluency, current means of communication and a medical diagnosis.
- Swallowing – copy of a video fluoroscopy or documentation that objectively addresses the laryngeal and pharyngeal stages, oral motor assessment that measures consistencies that have been attempted and the results, voice quality (i.e., pre- and post-feeding and natural voice), articulation assessment and a standardized cognitive assessment.
- Voice – copy of the physician's medical assessment of the beneficiary's voice mechanism and medical diagnosis.

Treatment Plan: Is the immediate result of the evaluation and consists of:

- Time-related short-term goals that are measurable, functional and significant to the beneficiary's communication needs.
- Long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from speech-language therapy services.

- Anticipated frequency and duration of treatment required to meet short-term and long-term goals.
- Plan for discharge from service, including the development of follow-up activities/maintenance programs.
- Statement detailing coordination of services with other therapies (e.g., medical and educational).
- Documentation of physician acceptance of stated treatment plan. The treatment plan must be accepted by the referring specialty physician for CSHCS beneficiaries.

Physician acceptance of the speech therapy treatment plan must be documented by one of the following processes:

- Phone call to the referring physician (document date and time)
- Copy of the plan to the referring physician (document date sent and method sent)
- Referring physician sign-off on the treatment plan

Documentation of the physician acceptance of the speech therapy treatment plan must be placed in the beneficiary's medical record.

Initiation of Services Therapy may only be initiated upon completion of an evaluation and development of a treatment plan that supports the reasonableness and medical necessity of therapy without PA.

For the initial period, speech may be provided up to a maximum of 36 times during the 90 consecutive calendar days in the outpatient setting. If therapy is not initiated within 30 days of the referral, a new referral is required.

No more than one encounter for individual speech therapy and one encounter for
group speech therapy may be billed on the same date of service. Each encounter must represent a minimum of 25 minutes of therapy provided on the date of service.

Therapy must be provided by the evaluating discipline. (An OTR cannot provide treatment under a SLP's evaluation.) Co-signing of evaluations and sharing treatments require PA.

PA is not required for the initial period of skilled therapy for the first 90 consecutive calendar days in the outpatient setting for a new treatment diagnosis or new medical diagnosis if:

- The beneficiary remains Medicaid-eligible and enrolled during the period services are provided; and

- A copy of the physician's signed and dated (within 30 days of initiation of services) referral for speech-language therapy is on file in the beneficiary's medical record.

Providers may also initiate services without PA when there is a change in the treatment diagnosis and/or medical diagnosis resulting in decreased functional ability.

Continued Active Treatment

MDCH requires providers to request PA for therapy beyond the initial 90 days. The SLP must complete the MSA-115. MDCH returns a copy of the PA to the provider after processing the request. The PA must be retained in the beneficiary's medical record.

The SLP may request up to 90 consecutive calendar days of continued active therapy in the OPH setting.

Requests to continue active treatment must be accompanied by:

- Treatment summary of the previous service period, including measurable progress on each short-term and long-term goal. This must include the treating SLP's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes.
- A progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy.
- Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested.
- A statement of the beneficiary's treatment response, including factors that have affected progress during this interim.
- A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.
- Anticipated frequency and duration of maintenance/monitoring.
- A discharge plan.
- A copy of the referral, hand-signed by the referring physician and dated within 30 days prior to initiation of continued service, must be provided with each request.

Maintenance/Monitoring Services

A beneficiary may not require active treatment, but the skills of an SLP are required for training or monitoring of maintenance programs that are being carried out by a family member and/or caregiver. In the outpatient setting, these types of service may be provided without PA up to four times per 90-day period.

If continued maintenance therapy is needed after the initial period specified in the paragraph above, PA is required. The SLP must complete the MSA-115 and include:

- A service summary, including a description of the skilled services being provided.

  This should include the treating SLP's analysis of the rate of progress and justification for any change in treatment plan. Documentation must relate to the period immediately prior to that time period for which PA is requested and can cover up to three months.

- A comprehensive description or copy of the maintenance/activity plan.
- A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
- A statement detailing coordination of service with other therapies (e.g., medical and educational) if appropriate.
- The anticipated frequency and duration of continued maintenance/monitoring.
- A discharge plan.

5.3.D. DISCHARGE SUMMARY

When the beneficiary is discharged from therapy services, the SLP must maintain a discharge summary on file as a mechanism for identifying completion of services and beneficiary status at discharge. The discharge summary should include:

- Dates of service (initial and discharge);
- Description of services provided;
- Functional status related to treatment areas/goals at discharge;
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status;
- Description or copy of follow-up or maintenance program put into place, if appropriate;
- Identification of adaptive equipment provided and its current utilization, if appropriate; and
- Recommendations/referral to other services, if appropriate.

Michigan Department of Community Health
Medicaid Provider Manual
Outpatient Therapy
Version Date: July 1, 2009
Pages 86-91
(PREVIOUS VERSIONS SUBSTANTIVELY UNCHANGED)

A Medicaid beneficiary bears the burden of proving he or she was denied a medically necessary and appropriate service. See, e.g., *J.K By and Through R.K. v Dillenberg*, 836 F Supp 694, 700 (Ariz, 1993). Whether the Appellant satisfied her burden here must be determined in accord with the preponderance of the evidence standard. See, e.g., *Aquilina v General Motors Corp*, 403 Mich 206, 210; 267 NW2d 923 (1978).

Regarding an appeal filed with the State Office of Administrative Hearing and Rules for the Department of Community Health, the Administrative Law Judge is given ultimate discretion to determine the weight and credibility of the evidence presented. *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 491; 668 NW2d 402 (2003); *Zeeland Farm Services, Inc v JBL Enterprises, Inc*, 219 Mich App 190, 195; 555 NW2d 733 (1996) (the fact finder is provided with the unique opportunity to observe or listen to witnesses; and, it is the fact finder's responsibility to determine the credibility and weight of the testimony and other evidence provided).

Does the Appellant meet Medicaid Provider Manual criteria for coverage of speech therapy?

A review of Medicaid policy leads me to conclude the MHP has erred in two distinct respects, in concluding that speech therapy is not a medically necessary covered service.

First and foremost, the MPM controls when coverage of speech therapy services are considered medically necessary. The MHP's coverage policies may be different, but must be consistent with MPM coverage of otherwise medically necessary services. In other words, the MHP's coverage guidelines may not deny medically necessary goods, services or equipment to its members, when fee-for-service or non-MHP beneficiaries would otherwise qualify for such goods, services or equipment.

Based on the evidence presented, the MHP has overlooked a crucial component in concluding the Appellant's request for speech therapy is neither a covered service, nor medically necessary. The MHP asserts that stuttering is a mental health diagnosis, and therefore not a covered service. I disagree.

> **Stuttering** (*alalia syllabaris*), also known as **stammering** (*alalia literalis* or *anarthria literalis*), is a speech disorder in which the flow of speech is disrupted by involuntary repetitions and prolongations of sounds, syllables, words or phrases, and involuntary silent pauses or blocks in which the stutterer is unable to produce sounds. Stuttering is generally not a problem

> with the physical production of speech sounds or putting thoughts into words. Apart from their speech impediment, people who stutter may well be 'normal' in the clinical sense of the term. Anxiety, low self-esteem, nervousness, and stress therefore do not cause stuttering *per se*, although they are very often the result of living with a highly stigmatized disability and, in turn, exacerbate the problem in the manner of a positive feedback system. ***http://en.wikipedia.org/wiki/Stuttering***
>
> The disorder is also *variable*, which means that in certain situations, such as talking on the telephone, the stuttering might be more severe or less, depending on the anxiety level connected with that activity. Although the exact etiology of stuttering is unknown, both genetics and neurophysiology are thought to contribute. There are many treatments and speech therapy techniques available that may help increase fluency in some stutterers to the point where an untrained ear can not identify a problem; however, there is essentially no "cure" for the disorder at present. ***http://en.wikipedia.org/wiki/Stuttering*.**

The above-referenced information supports a conclusion that, although stuttering is included in the DSM-IV as a mental illness diagnosis, it also contains a medical component. Thus, it is not entirely a mental health diagnosis, but rather, a combination of a mental health and medical diagnosis. It is therefore a covered service.

The MPM specifically covers a beneficiary's initial request for speech therapy without prior authorization. The evidence presented appears to support a conclusion that this is the Appellant's first request for coverage of speech therapy. On this basis alone, the MHP's denial is inappropriate, as prior authorization is not required. Under the MPM, speech therapy must be covered, if medically necessary. Exhibit 1 contains substantial evidence in support of the Appellant's request for speech therapy. Her evaluation specifically identifies worsening, not improving symptoms, as she enters her [redacted]. Exhibit 1 also identifies medical, not mental health, symptomatology associated with this disorder.

Here, the MHP has denied the Appellant's request for speech therapy, on the basis that it is not a covered service, asserting that stuttering is, by virtue of its inclusion as a mental health diagnosis in the DSM-IV, a mental health, and not a medical diagnosis. This position completely ignores the medical component of stuttering as a speech language disorder.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide that the MHP has inappropriately denied the Appellant's request for speech therapy services.

IT IS THEREFORE ORDERED that:

> The Medicaid Health Plan's decision is REVERSED.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 11/18/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 for the Department of Community Health 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.