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. 2009-36854 QHP
Case No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) 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]. The Appellant was represented by [redacted].

[redacted], represented the Medicaid Health Plan (hereinafter MHP or [redacted]). [redacted], was present and testified on behalf of the MHP.

ISSUE

Did the Medicaid Health Plan 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. Appellant is a [redacted] boy and Medicaid beneficiary at the time of his therapy evaluations.

2. The Appellant is diagnosed with pervasive developmental disorder/Aspergers syndrome.

3. The Appellant did not meet his developmental milestones at a typical pace. (uncontested)

4. The Appellant has participated in occupational therapy for sensory integration sessions in the past.

5. The Appellant is not currently enrolled in special education through his local school

system. He is not currently authorized for occupational therapy at his school.

6. His most recent evaluation for occupational therapy was at [redacted] in [redacted].

7. The problem areas identified for the Appellant, at his evaluation are: sensory modulation, self care skills, fine motor skills and muscle tone.

8. The goals stated on the most recent evaluation include a sensory home program to help with behaviors and fine motor challenges. The goals specified in the evaluation include: 1) accept unexpected light touch without behavioral overreactions, 75% of the time 2) child will follow picture schedule of activities during OT session with 2 cues 3) Participate in a vestibular/proprioceptive activity for 5 minutes to increase attention span for self care task and 4) complete fastening activity with fading hand over hand assist.

9. The occupational therapy plan of treatment states: sensory integration, graded fine motor and self care activities.

10. A request for prior authorization for therapy 1 time per week for 8 weeks was submitted to [redacted] on or about [redacted].

11. On [redacted], [redacted] sent the Appellant a denial notice indicating occupational therapy had been denied. The Notice specifically stated: therapy to treat delays in development (progress) is not covered. This service may be provided through another pubic agency via the intermediate school district (example: early on or project find). Additionally, per the Michigan Department of Community Health Medicaid Provider Manual, occupational therapy is not covered when required to be provided by school-based services.

12. On [redacted], the Department received Appellant's Request for Hearing.

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 Michigan Department of Community Health (Department or MDCH) 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. As such, the MHP contracts with the Department to provide medically necessary Medicaid covered services to eligible Medicaid beneficiaries:

> 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. (Italics added by ALJ).
>
> *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 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.
>
> *Article II-P, Utilization Management, Contract, September 30, 2004.*

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:

SECTION 5 – STANDARDS OF COVERAGE AND SERVICE LIMITATIONS

5.1 OCCUPATIONAL THERAPY

MDCH uses the terms Occupational Therapy, OT, and therapy interchangeably. OT is covered when furnished by a Medicaid-enrolled outpatient therapy provider when performed by:

- An occupational therapist currently registered in Michigan (OTR);
- A certified occupational therapy assistant (COTA) under the supervision of an OTR (i.e., the COTA's services must follow the evaluation and treatment plan developed by the OTR, and the OTR must supervise and monitor the COTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the appropriate supervising OTR; or
- A student completing his clinical affiliation under the direct supervision of (i.e., in the presence of) an OTR. All documentation must be reviewed and signed by the appropriate supervising OTR.

OT is considered an all-inclusive charge and MDCH does not reimburse for a clinic room charge in addition to OT services unless it is unrelated. MDCH expects OTR's and COTA's to utilize the most ethically appropriate therapy within their scope of practice as defined by state law and/or the appropriate national professional association. 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.

For CSHCS beneficiaries

OT must be directly related to the CSHCS-eligible diagnosis(es) and prescribed by the specialty physician who is overseeing care.

For beneficiaries 21 years of age and older

OT is only covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant in the beneficiary's

life roles despite impairments, activity limitations or participation restrictions.

MDCH anticipates OT will result in a functional improvement that is significant to the beneficiary's ability to perform appropriate daily living tasks (per beneficiary's chronological, developmental, or functional status). Functional improvements must be achieved in a reasonable amount of time and must be maintainable. MDCH does not cover therapy that does not have an impact on the beneficiary's ability to perform age-appropriate tasks.

OT must be skilled (i.e., require the skills, knowledge and education of an OTR). MDCH does not cover interventions provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [LPT], family member, or caregiver).

MDCH anticipates OT will result in a functional improvement that is significant to the beneficiary's ability to perform appropriate daily living tasks (per beneficiary's chronological, developmental, or functional status). Functional improvements must be achieved in a reasonable amount of time and must be maintainable. MDCH does not cover therapy that does not have an impact on the beneficiary's ability to perform age-appropriate tasks.

OT must be skilled (i.e., require the skills, knowledge and education of an OTR). MDCH does not cover interventions provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [LPT], family member, or caregiver).

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.

** 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.

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The MHP witness, [redacted], testified he reviewed the requests sent on behalf of the Appellant. He stated the Appellant is suffering developmental delays and the MHP does not cover any of the sought therapies needed to address these. He said coverage for this reason is explicitly excluded, in part because the services are offered through the school systems.

The Appellant's mother asserted her son is not in special education, does not qualify for it and is not receiving occupational therapy through the school. She stated she used to get it through [redacted] and had no problem getting it approved when she lived up north. The physical/cognitive abilities of the Appellant are not at issue or contested. She asserted the policy cited by [redacted] states explicitly that 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. She asserts this policy statement should be interpreted to require the health plan to approve the occupational therapy.

This ALJ did review the occupational therapy evaluation for evidence of the severity of the Appellant's sensory functioning. There is no use of the word severe in the evaluation, nor is there other language from which it could be interpreted that the Appellant is severely impacted by his sensory integration issues. He does have behavioral outbursts in response to light touches, however, his functioning is not described as being severely limited anywhere in the evaluation. It seems inconsistent to this ALJ to assert both that the Appellant's condition is so severe as to qualify for the therapy and that the Appellant does not require special education services.

Review of the Medicaid Policy leaves this ALJ in the in-enviable position of finding the MHP has not wrongfully denied the therapy sought. Not because the Appellant would not benefit from the therapy. Certainly not because he is not deserving of it, but solely because the Medicaid Policy does not require the health plan to provide it in these circumstances. The Medicaid policy clearly states the therapy is not provided in the specific circumstance the Appellant is in. He requires the therapy to address ongoing developmental delays. This is specifically excluded as a basis for coverage. He has not met and is not meeting his developmental milestones. He has not "lost" his abilities and in need of the therapy to help him recover skills he once had; rather, the therapies sought are all habilitative, not rehabilitative. The fact that the therapy needed is habilitative rather than rehabilitative renders the therapy sought specifically excluded from coverage not only for the MHP, but for so called "straight" Medicaid recipients.

Medicaid policy is clear that it does not cover occupational therapy for the purpose of meeting developmental milestones. The MHP therapy limitation policy is consistent with the Department's Medicaid policy. This ALJ is left no choice but to uphold the denial of services to the Appellant in this circumstance.

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 occupational 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]