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

Docket No. 2010-18999 QHP
Case No. [redacted]

[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 the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared on behalf of the Appellant. Her witness was [redacted], [redacted], [redacted], represented the Medicaid Health Plan (MHP). Her witnesses [redacted] Also in attendance: [redacted]

ISSUE

Did the Medicaid Health Plan (MHP) properly deny Appellant's request for Occupation Therapy (OT)?

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] (Appellant's Exhibit #1)

2. The Appellant is a [redacted] girl afflicted with developmental delay, difficulty swallowing/dysphagia and a reported "walking problem." (Respondent's Exhibit A, p. 1 and *See* Testimony)

3. On [redacted] the Appellant sought authorization for occupational therapy and other services through [redacted]. (Respondent's Exhibit A, p. 8)

4. The MHP reviewed the request and denied it as not a covered benefit under Michigan Health Plan coverage guidelines.

5. In a letter dated [redacted] the MHP advised the Appellant of the denial effective [redacted] (Respondent's Exhibit A, p. 11)

6. The Appellant was advised that PT services related to the Appellant's diagnosis of torticollis were authorized – and after acquired information obtained during testimony today established that the MHP authorized a swallow study on [redacted] (Respondent's Exhibit A, p. 11 and *See* Testimony[1])

7. The Appellant was further advised that the remaining services could be obtained through the Appellant's school system. (Respondent's Exhibit A, p. 11 and *See* Testimony)

8. The Appellant was advised of her further appeal rights in that written notice. (Respondent's Exhibit A, pp. 11-13)

9. The Appellant's request for hearing was received by the State Office of Administrative Hearings and Rules (SOAHR) on [redacted] (Appellant's Exhibit #1)

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. 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

[1] The Appellant's petition was received by SOAHR on [redacted]

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 I-Z.

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 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 EPSDT policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services for individuals under age 21
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and supplies
- Emergency services
- End Stage Renal Disease services
- Family Planning Services
- Health education
- Hearing & speech services,
- Hearing aids for individuals under age 21
- 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)
- Maternal and Infant Support Services (MSS/ISS)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per Contract 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 for individuals under age 21
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics & orthotics
- Therapies, (speech, language, physical, occupational)
- Transplant services
- Transportation
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under 21.

Article II-G. Scope of Comprehensive Benefit Package, contract with qualified managed health care plans November 6, 2007, p. 32.

As it recites in the MDCH-MHP contract language, a health plan such as [redacted] may limit services to those that are medically necessary and consistent with Medicaid policy.

The Medicaid Provider Manual places limitations on criteria for speech therapy, outlined below:

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 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.

MPM, Outpatient Therapy, §5.3 Speech Therapy, April 1, 2010, p. 20 [2]

Finally, the Contract also requires that:

> All policies, procedures, and clinical guidelines that the Contractor follows must be in writing and available upon request to DCH and/or CMS. All medical records, reporting formats, information systems, liability policies, provider network information and other detail specific to performing the contracted services must be available on request to DCH and/or CMS. Contract §II-L (3) p. 51

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The MHP witness testified that the request for occupational therapy was denied as a developmental issue as opposed to a medical issue and because the requested service is the responsibility of her school district.

The Appellant's representative testified that her daughter needs more services because that which the school system supplies is inadequate. In her petition, the Appellant's representative alleged that the school system only provided therapy once a week for less than an hour. In her testimony the Appellant's representative said that the school system provides therapy twice a week for one (1) hour.

The Appellant's representative said that not all of the Appellant's issues were related to developmental delay and that she needed services related to feeding problems and her leg braces. The MHP medical director testified that there was no link between the Appellant's diagnosis of torticollis and problems encountered in walking.

There was no testimony about whether services continue during the summer months.

The essence of the MHP decision to deny was reached owing to their justifiable conclusion that the Appellant's request is an excluded service under the MHP Contract and Medicaid policy[3].

The Appellant did not provide persuasive documentation establishing the goals of therapy or its medical basis. She has failed to preponderate her burden of proof that the MHP decision was in error.

[2] This edition of the MPM is identical to the version in place at the time of the Appellant's appeal.
[3] *See generally*, MPM, §5.3, e*t seq.* [Outpatient Therapy], [redacted]

On review, absent information relating to the Appellant's medical necessity, the MHP decision to deny OT was appropriate when made.

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 Appellant's request for Occupational Therapy.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 04/27/2010

***** 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.