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. 2010-43991 CMH
Case No. 1011018364

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9, following the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. The Appellant was represented by [redacted].

[redacted], appeared on behalf of the [redacted]), an agency contracted with the [redacted] to provide Medicaid-funded community mental health supports and services (hereafter, 'Department'). Also appearing on behalf of the Department was [redacted].

ISSUE

Has the Department appropriately denied the Appellant's request for Medicaid-funded occupational therapy services?

FINDINGS OF FACT

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

1. The Appellant is [redacted] who resides with his family in [redacted]

2. The Appellant resides in the [redacted] geographical service area.

3. The Appellant has been involved with the [redacted] since [redacted]. He is developmentally

disabled.

4. The Appellant's diagnoses include autism spectrum disorder, severe mental retardation and obesity. He is also indicated to be excitable.

5. The Appellant does exhibit symptoms of Prader-Willi syndrome. The CMH is recommending he be tested for the aforementioned diagnosis.

6. The Appellant is enrolled in special education services through the [redacted] School system. He receives therapy services, including occupational therapy services, through the school system.

7. The Appellant receives Community Living Supports, supports coordination and planning services through CMH. The family has received respite services in the past.

8. The Appellant's school based services are provided in a group setting.

9. The Appellant's [redacted] is requesting occupational therapy services be provided to [redacted] by the CMH to supplement those received through the school system.

10. The Appellant's physician prescribed occupational therapy sessions 2-3 times per week for 1 hour for a 1 year period.

11. The Appellant has had a recent occupational therapy evaluation. The evaluation specifies short term goals that include: improve endurance so he can exercise on treadmill; improve self care skills to brush teeth independently; improve visual-motor/perceptual skills to assemble a 24 piece puzzle.

12. Long term goals identified on the aforementioned occupational therapy assessment include: improve ADL's e.g. hand washing, toileting, hygiene, dressing and brushing teeth; improve sensory processing to help reduce self-stimulating behaviors; improve life skills to perform household chores; improve safety awareness by written and/or reciting personal information.

13. Interventions listed on the occupational therapy evaluation included: ADL's (esp. self care); sensory integration; visual-motor and visual-perceptual skills, life skills, strengthening for low tone; parent/caregiver weekly updates/education.

14. Deficits found as a result of the occupational therapy evaluation include: self regulation, ADL's, activity tolerance and endurance, fine and gross motor skills, dynamic movements, sensory processing, muscle tone and social skills.

15. The Appellant's initial intake assessment states he is receiving occupational therapy through his school and that he had received occupational therapy "through [redacted]" in 1999 1x per week for 3 months.

16. The Appellant cannot use a knife or fork. He is unable to button his clothing. He can pull a zipper that is started for him.

17. The Appellant's initial intake assessment indicates if given a toothbrush he will place it in his mouth and leave it there.

18. The Appellant's Person Centered Plan (PCP) recommends occupational therapy to address his fine motor deficits and skills used for daily living.

19. The Appellant's [redacted] requested individual occupational therapy be provided. He submitted a physician's prescription for occupational therapy to the CMH.

20. [redacted] denied the request for occupational therapy services, asserting it is not medically necessary, on or about [redacted].

21. The Appellant's [redacted] requested a formal, administrative hearing [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.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be

> administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
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> *42 CFR 430.10*

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS), the Department operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) HSW. [redacted] contracts with the Michigan Department of Community Health to provide Medicaid State Plan Specialty Supports and Services.

The Code of Federal Regulations at *42 CFR 440.230* states that Medicaid beneficiaries are only entitled to medically necessary **Medicaid-covered** services, provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. The Manual states:

> **2.5 MEDICAL NECESSITY CRITERIA**
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
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> **2.5.A. MEDICAL NECESSITY CRITERIA**
> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or

- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services that are:
  - deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
  - experimental or investigational in nature; or
  - for which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

The Medicaid Provider Manual, Mental Health/Substance Abuse chapter provides a listing of the Medicaid covered services [redacted] may provide. With regard to "covered services," Section 3 states, in pertinent part, as follows:

> **SECTION 3 – COVERED SERVICES**
> The Mental Health Specialty Services and Supports program is limited to the state plan services listed in this section, the services described in the Habilitation/Supports Waiver for Persons with Developmental Disabilities Section of this chapter, and the additional/B3 services described in the Additional Mental Health Services (B3s) section of this chapter. The PIHP is not responsible for providing state plan covered services that MDCH has designated another agency to provide (refer to other chapters in this manual for additional information, including the Chapters on Medicaid Health Plans, Home Health, Hospice, Pharmacy and Ambulance), nor is the PIHP responsible for providing the Children's Waiver Services described in this chapter. However, it is expected that the PIHP will assist beneficiaries in accessing these other Medicaid services. (Refer to the Substance Abuse Section of this chapter for the specific program requirements for substance abuse services.) It is expected that PIHPs will offer evidence based and promising practices as part of the Medicaid covered specialty services where applicable. PIHPs shall assure that these practices are provided by staff who have been appropriately trained in the model(s) and are provided to the population for which the model was intended.
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> **3.17 OCCUPATIONAL THERAPY**
> **Evaluation Therapy**
> Physician-prescribed activities provided by an occupational therapist currently registered by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment. An occupational therapy assistant may not complete evaluations.
>
> It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to his chronological developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy to make changes in components of function that do

> not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered.
>
> Therapy must be skilled (requiring the skills, knowledge, and education of a registered occupational therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage.
>
> Services must be prescribed by a physician and may be provided on an individual or group basis by an occupational therapist or occupational therapy assistant, currently registered by the State of Michigan or by an occupational therapy aide who has received on-the-job training. The occupational therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress, but on-site supervision of an assistant is not required. An aide performing an occupational therapy service must be directly supervised by a qualified occupational therapist who is on site. All documentation by an occupational therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising occupational therapist.
>
> Mental Health/Substance Abuse
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In this case, the Appellant is seeking authorization of occupational therapy services to address deficits identified in his occupational therapy evaluation. Among the deficits identified at the evaluation were: activity tolerance and endurance, fine motor skills, gross motor skills, dynamic movements, sensory processing, muscle tone, social skills and ADL's (activities of daily living). The Appellant's Person Centered Plan lists occupational therapy as a recommendation. A separate recommendation is made for Community Living Supports. The Appellant's physician has written a prescription for occupational therapy for the Appellant 2-3 times per week for 1 hour. The prescription further states the service should continue for 1 year. At hearing, the Appellant's [redacted] testified [redacted] is over-weight, requires more exercise and believes the occupational therapy will help him in this regard. Although this ALJ cannot find this testimony satisfies the requirement that the service sought is medically necessary, the testimony of the Appellant's [redacted] alone is not the only evidence being considered. The entirety of the record is being considered. The PCP, the OT evaluation and all additional documentation in the record was reviewed prior to making the material findings of fact and decision.

The CMH denied the requested service, asserting it is not medically necessary. It is asserted "current documentation does not establish medical necessity for the occupational therapy requested from [redacted]." Further, in contesting the medical necessity for the

requested service, the CMH states "the results of the OT evaluation do not link well with the goals in the PCP" and finally, "The Person-Centered Plan does not document how the services requested through [redacted] are to be coordinated with the services provided through the school." The main thrust of the CMH appeared to be at hearing, that the Appellant does not have a medical need for OT and his need for assistance with ADL's is addressed by authorization of CLS. Furthermore, the written documentation is focused on an assertion that because some of the goals of the two services are the same, OT is not medically necessary.

This ALJ reviewed the documentation submitted by [redacted] at the hearing. The OT evaluation identifies several deficits the Appellant suffers that are not addressed by Community Living Supports services. Specifically, sensory and perceptual deficits, muscle tone, motor planning and fine and gross motor skills. Furthermore, the intervention identified on the occupational therapy evaluation include: sensory integration, visual motor and visual perceptual skills, strengthening for low tone, life skills, ADL's and parent/caregiver weekly updates, education. While some of the goals and deficits are overlapping, that does not evidence the means by which the goals are addressed are the same. Or more simply stated, occupational therapy services and Community Living Support services are not the same. Furthermore, occupational therapy is identified and recommended in the Appellant's Person Centered Plan. While the CMH offers that the PCP fails to state exactly how occupational therapy services provided through CMH would be coordinated with the ISD, that does not evidence the occupational therapy is not medically necessary. Nor does it evidence that the coordination would not in fact, happen. It is merely a criticism of the PCP document itself. The assertion from the CMH that the results of the OT evaluation do not link well with the goals of the PCP is not sufficiently specific to persuade this ALJ the OT recommended in the PCP itself is not medically necessary. It is not really understood what is meant by this statement. The CMH does not address how the perceptual and sensory deficits identified are otherwise addressed with services being provided. Perceptual integration, visual motor and visual perceptual skills are identified as specific OT interventions that are not otherwise addressed by the services authorization in place for the Appellant. CLS training for ADL's and community outings are not substitute for OT services designed to address these types of deficits. While both services seek to address the deficits the Appellant has with respect to performing his own ADL's as well as other life skills, they are addressed by different interventions. Community Living Supports services provides assistance with and training for completion of ADL's. Community Living Supports does not specifically intervene to address visual motor, sensory integration and perceptual motor deficits. The result of having those deficits may be addressed by CLS where it provides assistance in performing ADL's, however, the Appellant may be able to achieve an increase in functional ability as a result of having occupational therapy.

The Medicaid Provider Manual authorizes the type of services sought where "it is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to his chronological developmental or functional status." These are exactly the outcomes identified in the OT

evaluation where both short and long term goals are identified. The manual further requires the functional improvements should be able to be achieved in a reasonable amount of time and should be durable. There is no evidence indicating the therapy sought is for an unreasonable amount of time or that it would not be durable. The therapy sought is skilled therapy, thus comporting with that requirement of the manual criteria. The services are prescribed by the Appellant's physician, thus satisfying another of the criteria. This ALJ finds the documentation submitted does establish the medical necessity for the occupational therapy sought. Occupational therapy outside of the ISD has only been provided for 1 hour per week for a 3 month time period, over 10 years ago, according to the only documentation in the record. This is insufficient to find an unreasonable amount of therapy has already been provided. This ALJ finds the evidence of records supports a determination that occupational therapy is medically necessary for the Appellant.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I find that, the evidentiary record is sufficient to support a finding the occupational therapy sought is medically necessary. The decision of the [redacted] is hereby REVERSED. [redacted] is hereby ordered to authorize the occupation therapy services identified in the occupational therapy evaluation, recommended in the Appellant's Person Centered Plan and prescribed by the Appellant's physician.

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

cc: [redacted]

Date Mailed: 10/25/2010

***** 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 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.