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

[redacted]/

Docket No. 2010-45602 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]. [redacted], appeared on behalf of the Appellant.

[redacted], represented the Medicaid Health Plan (MHP).

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for speech 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] man and Medicaid beneficiary.

2. The Appellant has been enrolled in the MHP since [redacted].

3. The Appellant has a diagnosis of mental retardation, a developmental disability. (Exhibit 1, page 6). The Appellant's developmental disability results in speech delay. (Exhibit 1, page 9).

4. Appellant's representative at hearing is his father.

5. Appellant lives with his father and mother in [redacted].

6. The Appellant attends a day program/work program. (Father's testimony).

7. The Appellant was home-schooled for his high-school years and did not receive speech therapy through the school system those years. (Father's testimony).

8. In or around [redacted] the Appellant received a speech language pathology evaluation at [redacted] and a report was generated listing speech therapy goals. (Exhibit 1, Page 9).

9. On or around [redacted], the Appellant's physician sent a request to the MHP for speech therapy evaluation and treatment to be provided through the MHP. (Exhibit 1, Page 6).

10. On [redacted], the MHP sent a letter to the Appellant and to his physician denying authorization for speech therapy. The reason given was "Your Certificate of Coverage... specifically excludes coverage for all therapies for developmental delays." (Exhibit 1, Page 7).

11. On [redacted], the Department received Appellant's Request for Hearing. (Exhibit 1, page 5).

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. The Contractor 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 2.024.

Section 1.022(E)(1), Covered Services.
MDCH contract (Contract) with the Medicaid Health Plans,
October 1, 2009.

(1) The major components of the Contractor's utilization management (UM) program 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 Um activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure
The Contractor must establish and use a written prior approval policy and procedure for UM 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 UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

Section 1.022(AA), Utilization Management, Contract,
October 1, 2009.

The Michigan Medicaid program covers speech therapy if specified criteria are met. 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 MHP representative testified that its policies regarding limitations on speech therapy were consistent with Medicaid policy. The MHP representative noted that the MHP policy it used for the speech therapy denial is consistent with the Department policy, and the MHP introduced evidence supporting its position. (Exhibit one, Pages 14-34).

The pertinent sections of the Michigan Medicaid Provider Manual (MPM) are as follows:

> **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 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.
- If Medicare does not consider the service medically necessary. (Underline added).

Michigan Medicaid Provider Manual, Outpatient Therapy, July 1, 2010, pages 19-20.

The MHP witness testified that policy does not cover speech therapy if it is provided to improve communication skills beyond the level prior to mental retardation. The MHP witness explained that the Appellant's diagnosis indicated his speech condition was due to a developmental disability instead of due to an illness, injury, or birth defect affecting the throat, mouth, or hearing. The MHP witness elaborated that because in Appellant's case speech therapy was for his developmental delay and not due to an injury or change in medical condition after he was born with mental retardation, speech therapy was not a covered service under Medicaid and, likewise, not a covered service under the MHP.

The MHP witness also testified that Medicaid policy does not cover speech therapy if it is provided to meet developmental milestones. The MHP witness explained that a person with speech delay due to developmental disability is frequently trying to catch up to developmental milestones, and speech therapy is not covered under Medicaid or the MHP for that purpose.

The Appellant's father testified that the MHP started to cover speech therapy for the Appellant, but the speech therapist informed him that the therapy had to stop because the MHP would not pay. The MHP clarified that the speech therapy provider did not need a prior authorization for the speech evaluation and therefore the MHP paid for the speech evaluation, but did not prior authorize speech therapy treatment because it was not a covered service for a person with developmental delay.

The Appellant's father repeatedly asked if the health plan could at least provide some speech therapy to see whether there was an improvement in the Appellant's speech and if there was an improvement in the Appellant's speech, to continue the speech therapy. The MHP is legally bound to follow the laws and Medicaid policy. The laws and Medicaid policy do not allow the use of Medicaid funds to provide speech therapy to persons with speech delays due to a developmental disability such as mental retardation. Therefore the MHP, even if it wanted to try speech therapy on a trial basis, is prohibited from using Medicaid funds for speech therapy in Appellant's case. The MHPs written reason for denial, that it does not cover speech therapy for developmental delay, is consistent with Medicaid policy. Similarly, this administrative law judge does not have any equitable jurisdiction, and is also bound by the laws and Medicaid policy.

The Appellant failed to prove by a preponderance of evidence that the MHP was obligated to provide speech therapy and the MHP properly denied speech therapy services at this time.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Medicaid Health Plan properly denied Appellant's request for speech therapy.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/28/2010

***** 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.