

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. 2010-26929 QHP
Case No. 23629025

Boggon, Anthony,

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 [REDACTED]. The Appellant was represented by his mother, [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 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] boy and Medicaid beneficiary at the time of his therapy evaluation.
2. The Appellant seeks coverage for speech therapy. He is diagnosed with moderate dysfluency (stuttering). (Respondent exhibit A, page 9)
3. The Appellant does not have any eating or swallowing difficulties. (Respondent exhibit A)
4. The Appellant attends public schools in his city of residence. He has not participated in speech therapy through the school system.

5. The Appellant's mother has sought school based therapy. He is being scheduled for evaluation through the school based system as of the date of [REDACTED]
6. The MHP reviewed the request for coverage for speech therapy. The request was denied on or about [REDACTED]. The denial cites the mental health diagnosis and coverage guidelines.
7. 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:

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 a 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.

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.

Medicaid Provider Manual
Outpatient Therapy
Version Date: July 1, 2009, Pages 19-20

The MHP witness, ██████████, testified he reviewed the request sent on behalf of the Appellant. He stated the Appellant is diagnosed with a mental health diagnosis, stuttering or moderate dysfluency. He has moderate secondary motor behaviors accompanying the stuttering. He stated speech therapy for this reason is not a covered benefit. Further evidenced establishes that mental health treatments are covered benefits, they do not require a referral from the PCP and are covered for up to 20 visits per year. Finally, it was stated school aged beneficiaries are expected to have coverage for speech therapy through the school based systems.

The Appellant's mother asserts he does not have a mental health issue, he has a speech issue. Furthermore, the speech therapy he may be able to get through the school system is inadequate to address his needs. She testified there is ██████████ pathologist for ██████████ schools and ██████████ in each school. She further testified he will be ██████████ years old in ██████████ t and his speech is getting worse.

Review of the Medicaid Policy leaves this ALJ in the inenviable position of finding the MHP has not wrongfully denied the therapy sought. Not because the Appellant is not in need of speech therapy, nor because he is not deserving of it. The Medicaid policy clearly states the therapy is not provided in the specific circumstance the Appellant is in. He is eligible for school based therapy. Beneficiaries in the Appellant's circumstances are expected to obtain the needed therapies through the school based system in place. This ALJ agrees the school based system offers insufficient help for the Appellant. However, this ALJ is powerless to ignore or change 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 speech therapy.

[REDACTED]
Docket No. 2010-26929 QHP
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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]

Date Mailed: 05/27/2010

***** 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 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.