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. 2011-12439 PA
Case No. 39574607

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 as the Appellant's representative. [redacted] represented the Department. [redacted] appeared as a witness for the Department.

ISSUE

Did the Department properly deny the Appellant's prior authorization 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. The Appellant is [redacted] Medicaid beneficiary who has been diagnosed with neonatal abstinence syndrome, prematurity, low birth weight, thrombocytopenia, necrotizing enterocolitis, perforated small intestine and autism. (Exhibit 1, page 9)

2. On [redacted], the Department received a prior approval-request for initial speech therapy for the months of [redacted] from the [redacted]. (Exhibit 1, page 6)

3. On [redacted], the Department sent a Request for Additional Information to [redacted] requesting a total of four items. The fourth item was a current evaluation and treatment plan in accordance with the MDCH Outpatient Speech published policy guidelines. (Exhibit 2)

4. On [redacted], the Appellant's [redacted] sent the Department a letter in response to the request for additional information and attached an outpatient progress summary to satisfy the fourth requested item. (Exhibit 1, pages 7-14)

5. Department policy outlines the specific criteria for evaluations and treatment plans. *Medicaid Provider Manual, Outpatient Therapy, 5.3.C Physician Referral for Speech Therapy, October 1, 2010, Pages 21-22.*

6. On [redacted], the Department denied the prior authorization requests because the documentation submitted did not constitute an evaluation. (Exhibit 1, pages 4-5)

7. On [redacted], the State Office of Administrative Hearings and Rules received the hearing request filed on the Appellant's behalf. (Department Exhibit 1, page 3)

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.

The Department policy regarding outpatient speech therapy can be found in the Outpatient Therapy section of the Medicaid Provider Manual:

> **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.

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.

5.3.C. PHYSICIAN REFERRAL FOR SPEECH THERAPY

A physician referral is required for Medicaid coverage of speech therapy. A physician referral for speech therapy must be documented in the beneficiary's medical record and must include the following:

- Beneficiary name;
- Beneficiary date of birth;
- Diagnosis for referral (for CSHCS beneficiaries, this must be the CSHCS-qualifying diagnosis); and
- A statement indicating that the beneficiary is being referred for speech therapy.

If therapy is not initiated within 30 days of the referral date, a new referral is required. A new physician referral must be made at least annually for continuing treatment lasting longer than 12 months. Whenever a beneficiary is discharged from speech therapy treatment, a new referral must be made and an evaluation and treatment plan must be completed before therapy may resume.

A copy of the physician referral must be attached to all PA requests for speech therapy.

Evaluation
Does not require PA. This is formalized testing in early stages of a beneficiary's treatment program followed by periodic testing and reports to indicate measurable functional change resulting from the beneficiary's treatment. These may be provided for the same diagnosis without PA twice in a 365-day period with a physician's referral. If an evaluation is needed more frequently, PA is required.

Evaluations must include standardized tests and/or measurable functional baselines.

The speech-language evaluation must be completed by an SLP and include:

- The disorder and the medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with dysphasia as the speech disorder being treated).
- Speech therapy provided previously, including facility/site, dates, duration and summary of measurable change.
- Current rehabilitation services being provided to the beneficiary in this or other settings.
- Medical history as it relates to the current course of therapy.
- Beneficiary's current functional communication status (functional baseline).
- Standardized and other evaluation tools used to establish the baseline and to document progress.
- Assessment of the beneficiary's functional communication skill level, which must be measurable.
- Medical, physical, intellectual deficits that could interfere with the beneficiary's improvement in therapy.

Evaluations must include, but are not limited to:

- Articulation – standardized tests that measure receptive and expressive language, mental age, oral motor skills, articulation skills, current diet level (including difficulties with any food consistencies), current means of communication and a medical diagnosis.

- Language – standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es).
- Rhythm – standardized tests that measure receptive and expressive language, mental age, oral motor skills, measurable assessment of dysfluency, current means of communication and a medical diagnosis.
- Swallowing – copy of a video fluoroscopy or documentation that objectively addresses the laryngeal and pharyngeal stages, oral motor assessment that measures consistencies that have been attempted and the results, voice quality (i.e., pre- and post-feeding and natural voice), articulation assessment and a standardized cognitive assessment.
- Voice – copy of the physician's medical assessment of the beneficiary's voice mechanism and medical diagnosis.

Treatment Plan
Is the immediate result of the evaluation and consists of:

- Time-related short-term goals that are measurable, functional and significant to the beneficiary's communication needs.
- Long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from speech-language therapy services.
- Anticipated frequency and duration of treatment required to meet short-term and long-term goals.
- Plan for discharge from service, including the development of follow-up activities/maintenance programs.
- Statement detailing coordination of services with other therapies (e.g., medical and educational).
- Documentation of physician acceptance of stated treatment plan. The treatment plan must be accepted by the referring specialty physician for CSHCS beneficiaries.

Physician acceptance of the speech therapy treatment plan must be documented by one of the following processes:

- Phone call to the referring physician (document date and time)
- Copy of the plan to the referring physician (document date sent and method sent)
- Referring physician sign-off on the treatment plan

Documentation of the physician acceptance of the speech therapy treatment plan must be placed in the beneficiary's medical record.

Initiation of Services

Therapy may only be initiated upon completion of an evaluation and development of a treatment plan that supports the reasonableness and medical necessity of therapy without PA.

For the initial period, speech may be provided up to a maximum of 36 times during the 90 consecutive calendar days in the outpatient setting. If therapy is not initiated within 30 days of the referral, a new referral is required.

No more than one encounter for individual speech therapy and one encounter for group speech therapy may be billed on the same date of service. Each encounter must represent a minimum of 25 minutes of therapy provided on the date of service.

Therapy must be provided by the evaluating discipline. (An OTR cannot provide treatment under a SLP's evaluation.) Co-signing of evaluations and sharing treatments require PA.

PA is not required for the initial period of skilled therapy for the first 90 consecutive calendar days in the outpatient setting for a new treatment diagnosis or new medical diagnosis if:

- The beneficiary remains Medicaid-eligible and enrolled during the period services are provided; and
- A copy of the physician's signed and dated (within 30 days of initiation of services) referral for speech-language therapy is on file in the beneficiary's medical record.

Providers may also initiate services without PA when there is a change in the treatment diagnosis and/or medical diagnosis resulting in decreased functional ability.

Continued Active Treatment
MDCH requires providers to request PA for therapy beyond the initial 90 days. The SLP must complete the MSA-115. MDCH returns a copy of the PA to the provider after processing the request. The PA must be retained in the beneficiary's medical record.

The SLP may request up to 90 consecutive calendar days of continued active therapy in the OPH setting.

Requests to continue active treatment must be accompanied by:

- Treatment summary of the previous service period, including measurable progress on each short-term and long-term goal. This must include the treating SLP's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes.
- A progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy.
- Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested.
- A statement of the beneficiary's treatment response, including factors that have affected progress during this interim.
- A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.
- Anticipated frequency and duration of maintenance/monitoring.
- A discharge plan.
- A copy of the referral, hand-signed by the referring physician and dated within 30 days prior to initiation of continued service, must be provided with each request.

MDCH Medicaid Provider Manual,
Outpatient Therapy Section,
October 1, 2010, pages 19-24.
(Exhibit 1, pages 19-24)

In the present case, the [redacted] prior authorization request is marked as an initial treatment authorization request for the months of [redacted]. (Exhibit 1, page 6) The above cited Medicaid policy requires completion of an evaluation and development of a treatment plan supporting the reasonableness and medical necessity prior to the initiation of therapy. On [redacted], the Department sent the Appellant's provider a request for additional information, including a current evaluation and treatment plan in accordance with MDCH Outpatient Speech published policy guidelines. (Exhibit 2) The Appellant's provider submitted a letter addressing each of the four items requested by the Department and attached an Outpatient Progress Summary in response to the request for a current evaluation and treatment plan. (Exhibit 1, pages 7-14) The Department's [redacted] explained that the Outpatient Progress Summary did not meet the criteria for an evaluation outlined in the above cited policy, therefore, the prior authorization request was denied.

The Appellant's [redacted] disagrees with the denial and testified that the Appellant did have an evaluation in [redacted] at [redacted]. She explained that the [redacted] evaluation included the required standardized testing and she can submit a copy to the Department. The Department's [redacted] indicated that the Appellant's provider may need to add an addendum to update this evaluation if there have been any changes, and discussed concerns regarding the submitted goals meeting the criteria.

It appears that the Appellant's provider submitted the progress summary in accordance with the Medicaid policy for Continued Active Treatment. However, the prior authorization request was marked for an initial treatment authorization. Accordingly, documentation of completion of an evaluation was required. The Outpatient Progress Summary does not meet the criteria for an evaluation. Based on the information provided on the [redacted] prior authorization request, and additional information submitted, the Department's denial must be upheld.

If the Appellant's [redacted] has not already done so, a new prior authorization request and supporting documentation can be submitted at any time.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's prior authorization requests for speech therapy services based upon the submitted information.

[redacted]
Docket No. 2011-12439 PA
Decision and Order

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/2/2011

***** 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.