

**STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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IN THE MATTER OF:

██████████

Appellant

_____ /

Docket No. 2011-22364 QHP
Case No. 34354478

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 ██████████. The Appellant was represented by his ██████████.

██████████ represented ██████████, a Michigan Department of Community Health contracted Medicaid provider (hereinafter MHP). ██████████ ██████████, was present and testified on behalf of the MHP.

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for speech and occupational therapies?

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 ██████████ and Medicaid beneficiary.
2. On ██████████, the MHP received a request for coverage for outpatient speech and occupational therapies.
3. On ██████████, the MHP sent the Appellant notice that the request for speech, and occupational therapy coverage was denied because these services are not covered to treat developmental delays. The notice also indicated that the requested services could be obtained through the local school system or early on.

4. On ██████████, the Department received the 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 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 (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.*

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.

SECTION 5 – STANDARDS OF COVERAGE AND SERVICE LIMITATIONS

5.1 OCCUPATIONAL THERAPY

MDCH uses the terms Occupational Therapy, OT, and therapy interchangeably. OT is covered when furnished by a Medicaid-enrolled outpatient therapy provider when performed by:

- An occupational therapist currently registered in Michigan (OTR);
- A certified occupational therapy assistant (COTA) under the supervision of an OTR (i.e., the COTA's services must follow the evaluation and treatment plan developed by the OTR, and the OTR must supervise and monitor the COTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the appropriate supervising OTR; or
- A student completing his clinical affiliation under the direct supervision of (i.e., in the presence of) an OTR. All documentation must be reviewed and signed by the appropriate supervising OTR.

OT is considered an all-inclusive charge and MDCH does not reimburse for a clinic room charge in addition to OT services unless it is unrelated. MDCH expects OTR's and COTA's to utilize the most ethically appropriate therapy within their scope of practice as defined by state law and/or the appropriate national professional association. OT must be medically necessary, reasonable and required to:

- Return the beneficiary to the functional level prior to illness or disability;
- Return the beneficiary to a functional level that is appropriate to a stable medical status; or
- Prevent a reduction in medical or functional status had the therapy not been provided.

For CSHCS beneficiaries

OT must be directly related to the CSHCS-eligible diagnosis(es) and prescribed by the specialty physician who is overseeing care.

For beneficiaries 21 years of age and older

OT is only covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant in the beneficiary's life roles despite impairments, activity limitations or participation restrictions.

MDCH anticipates OT will result in a functional improvement that is significant to the beneficiary's ability to perform appropriate daily living tasks (per beneficiary's chronological, developmental, or functional status). Functional improvements must be achieved in a reasonable amount of time and must be maintainable. MDCH does not cover therapy that does not have an impact on the beneficiary's ability to perform age-appropriate tasks.

OT must be skilled (i.e., require the skills, knowledge and education of an OTR). MDCH does not cover interventions provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [LPT], family member, or caregiver).

MDCH anticipates OT will result in a functional improvement that is significant to the beneficiary's ability to perform appropriate daily living tasks (per beneficiary's chronological, developmental, or functional status). Functional improvements must be achieved in a reasonable amount of time and must be maintainable. MDCH does not cover therapy that does not have an impact on the beneficiary's ability to perform age-appropriate tasks.

OT must be skilled (i.e., require the skills, knowledge and education of an OTR). MDCH does not cover interventions provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [LPT], family member, or caregiver).

OT may be covered for one or more of the following:

- Therapeutic use of occupations*.
- Adaptation of environments and processes to enhance functional performance in occupations*.

- Graded tasks (performance components) in activities as prerequisites to an engagement in occupations*.
- Design, fabrication, application, or training in the use of assistive technology or orthotic devices.
- Skilled services that are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers.

Routine provision of the maintenance/prevention program is not a covered OT service.

* Occupations are goal-directed activities that extend over time (i.e., performed repeatedly), are meaningful to the performer, and involve multiple steps or tasks. For example, doing dishes is a repeated task. Buying dishes happens once; therefore, does not extend over time and is not a repeated task.

OT is not covered for the following:

- When provided by an independent OTR**.
- For educational, vocational, or recreational purposes.
- If services are required to be provided by another public agency (e.g., community mental health services provider, school-based services).
- If therapy requires PA and service is rendered before PA is approved.
- If therapy is habilitative. Habilitative treatment includes teaching someone how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. This may include teaching a child normal dressing techniques or cooking skills to an adult who has not performed meal preparation tasks in the past.
- If therapy is designed to facilitate the normal progression of development without compensatory techniques or processes.
- For development of perceptual motor skills and sensory integrative functions to follow a normal sequence. If the beneficiary exhibits severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function, OT may be covered.
- Continuation of therapy that is maintenance in nature.

** An independent OTR may enroll in Medicaid if he provides Medicare-covered therapy and intends to bill Medicaid for Medicare coinsurance and/or deductible only.

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The evidence of record submitted by the MHP establishes the Appellant has had speech and language evaluations resulting in a finding of a mild speech delay in articulation/development. His occupational therapy assessment indicates he has a primary diagnosis of sensory deregulation's fine motor delay. For purposes of therapy treatment, the diagnosis is identified as oral-motor hypersensitivity and fine motor coordination impairment. The evaluation further indicates the Appellant did not qualify for school based services. ██████████, for the MHP, testified that the Appellant is not qualified for the therapies sought under the contract guidelines with the Department of Community Health and the Medicaid Provider Manual criteria for school aged children. The MHP noted that the denial notice also explained that the requested services could be obtained through the local school system or the early on program.

The Appellant's ██████████ stated she wants the best for her child and the schools have stated he does not qualify for assistance through them but she can clearly see that he needs the help. She does not address the evidence contained in the speech therapy evaluation indicating her child's level of language functioning is within age expectation. Nor did she directly address the finding that "the Appellant's speech/articulation skills were judged to be mildly below that of age-matched peers." The oral mechanism exam was unremarkable.

The Medicaid policy clearly states the therapies are not provided in the specific circumstance the Appellant is in. He is experiencing some mild developmental delay according to the uncontested evidence of record. He has not "lost" his abilities and in need of the therapies to help him recover skills he once had. Accordingly, the therapies sought are all habilitative, not rehabilitative. Beneficiaries in the Appellant's circumstances are expected to obtain the needed therapies through the local school systems.

The documentation submitted indicated the speech and occupational therapy services were requested because the Appellant was not meeting developmental milestones. Accordingly, the MHP denial, based upon the documentation submitted, was consistent with the Department's Medicaid policy.

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 the Appellant's request for physical, speech and occupational therapy.

[REDACTED]
Docket No. 2011-22364 QHP
Decision and Order

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: 4/12/2011

***** 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.