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. 2011-2486 CMH
Case No. 308086053

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 his [redacted], [redacted] provided translation services from [redacted] to English and English to [redacted]. The Appellant's [redacted], [redacted] was present. The Appellant's [redacted], [redacted] was present. [redacted], was present on behalf of the Appellant.

[redacted], appeared on behalf of the [redacted], an agency contracted with the Michigan Department of Community Health 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 [redacted] in [redacted] where the primary spoken language is [redacted].

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

area.

3. The Appellant has received services which included supports coordination and some speech therapy from the [redacted] since [redacted]. He has been provided services as a developmentally disabled person.

4. The Appellant's diagnoses are in dispute. He may have Asperger's syndrome. It is stipulated he has ADHD. There is evidence of a medical opinion in the record he has a learning disability.

5. It is undisputed the Appellant has some speech impediment and delay.

6. The Appellant attends school and receives speech therapy services in school.

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

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

9. The Appellant's physician provided correspondence indicating the Appellant has a diagnosis of cognitive impairment and developmental delay related to it. It further states he is behind in his speech and language skills for his age and would benefit from continuation of current special speech therapy classes that he is taking.

10. The Appellant's [redacted] speech therapy evaluation noted no deficits in articulation, his vocabulary was fairly in tact. It was recommended he participate in speech therapy to improve syntax, pragmatics and vocabulary. The evaluation further states the Appellant's [redacted] "jumped in to answer questions posed" to her [redacted] and that she complained he did not respond to requests he perform housework and his own ADL's.

11. The Appellant's most recent speech therapy progress notes in the record dates between [redacted] and [redacted] of [redacted]. They state his volume has improved, his volitional speech is increasing and he is making better effort. He is improving his attention to task and his reading comprehension. The interventions recommended were expressive language intervention and Higher Level language intervention.

12. The Appellant's [redacted] Person Centered Plan (PCP) recommends speech and language therapy to address the Appellant's behavioral and speech deficits. Behavioral modifications sought include reacting to his family in a calm appropriate tone, decreasing offensive/defensive language with family, reacting to his family the same way he knows how to

appropriately respond to other people in the society. Other revised goals identified in the PCP include supplying 3 attributes of an item with written cues for 80% of the time, state object similarity and differences with written cues for 80% of the time and participate in reasoning tasks for exclusion with verbal cues 80% of the time and answer "wh" questions regarding verbally presented material with verbal cues 80% of the time. The PCP was updated in [redacted] of [redacted] and a request for speech therapy services to continue made.

13. [redacted] CMH denied the request for speech therapy services, asserting it is not medically necessary, on or about [redacted]. It was suggested the services of a behaviorist (provided by CMH) were appropriate to address the Appellant's needs. The fact that the Appellant receives speech therapy in school was cited.

14. 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.
>
> *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.
>
> **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.
>
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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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> **3.20 SPEECH, HEARING, AND LANGUAGE**
> Evaluation Therapy Activities provided by a speech-language pathologist or licensed audiologist to determine the beneficiary's need for services and to recommend a course of treatment.
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> A speech-language pathology assistant may not complete evaluations.
>
> Diagnostic, screening, preventive, or corrective services provided on an individual or group basis, as appropriate, when referred by a physician (MD, DO).

> Therapy must be reasonable, medically necessary and anticipated to result in an improvement and/or elimination of the stated problem within a reasonable amount of time. An example of medically necessary therapy is when the treatment is required due to a recent change in the beneficiary's medical or functional status affecting speech, and the beneficiary would experience a reduction in medical or functional status were the therapy not provided.
>
> Speech therapy must be skilled (i.e., requires the skills, knowledge, and education of a certified speech language pathologist) to assess the beneficiary's speech/language function, develop a treatment program, and provide therapy. Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, registered occupational therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage.
>
> Services may be provided by a speech-language pathologist or licensed audiologist or by a speech pathology or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a license). All documentation by the candidate must be reviewed and signed by the appropriately credentialed supervising speech-language pathologist or audiologist.
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In this case the PIHP is asserting that the Appellant is participating in speech and language therapy at school, thus the policy does not support authorization of additional Medicaid funds be used to duplicate the same service. Furthermore, at least some of the goals and concerns identified in the speech and language evaluation and the PCP are better addressed by services provided by a behaviorist. This ALJ concurs. The evidence presented does not establish a medical need for speech and language therapy beyond what the Appellant does receive in school. He is not deprived of the service. It is not appropriate to use Medicaid funding to provide additional services of the same type and for the same purpose as those already being provided by another source in this instance.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I find that, the evidentiary record is insufficient to support a finding the speech therapy sought is medically necessary.

[redacted]
Docket No. 2011-2486 CMH
Decision and Order

IT IS THEREFORE ORDERED that:

The decision of the [redacted] is hereby AFFIRMED.

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

cc: [redacted]

Date Mailed: 1/5/2011

***** 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.