STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF:

[redacted],

Docket No. 2011-49531 CMH
Case No. 82757242

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, a hearing was held on Tuesday, [redacted]. Appellant's mother, [redacted], appeared and testified on behalf of the Appellant.

Ms. [redacted], Assistant Corporation Counsel, [redacted] County Community Mental Health Authority (CMH), represented the Department. Dr. [redacted], CMH Clinical Services Manager, appeared as a witness for the Department.

ISSUE

Did the CMH properly deny the Appellant evaluations for occupational and 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 a Medicaid beneficiary receiving services through [redacted] County Community Mental Health (CMH). The Appellant is enrolled in Medicaid, but not in any of the Specialty Waivers administered by the CMH. Appellant was served by the CMH from [redacted] to [redacted] and again continuously since [redacted]. Services have included assessments, treatment planning, supports coordination, speech services, occupational therapy, and community living supports. Her family has received respite services. Services are now delivered through a self-determination arrangement. (Exhibit 1, p. 2, and Attachment C).

2. Appellant receives Supplemental Security Income from Social Security. Appellant also receives about 53 hours per month of Adult Home Help through DHS. (Exhibit 1, p. 1).

3. CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.

4. The Appellant is a [redacted]-year-old Medicaid beneficiary. The Appellant is a person with a severe cognitive impairment. She is diagnosed with Down's syndrome, Lennox Gestalt Syndrome, and a history of seizure disorder. Appellant is considered to be a person with a developmental disability. (Exhibit 1, p.1 and Attachment D, pp. 20 & 23).

5. The Appellant lives with her parents and younger sister. (Exhibit 1, p. 2).

6. The Appellant attends a special education program at [redacted] School administered by the [redacted] ISD five days per week. (Exhibit 1, p. 2).

7. On [redacted], the CMH sent an adequate action notice to the Appellant stating that effective [redacted] Appellant was being denied evaluations for occupational and speech therapy services as occupational therapy had not resulted in improvement or elimination of the problem in a reasonable length of time and speech therapy was not medically necessary. (Exhibit 1, Attachment A).

8. The Michigan Administrative Hearing System received Appellant's request for hearing on [redacted]. (Exhibit 1, Attachment B).

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 of Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.*

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Section 2 – Program Requirements* provides:

SECTION 2 – PROGRAM REQUIREMENTS

2.1 MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICES

Mental health and developmental disabilities services (state plan, HSW, and additional/B3) must be:

- Provided under the supervision of a physician, or other licensed health professional whose profession is relevant to the services being provided. This includes professionals who are licensed or certified in Michigan in a human services field typically associated with mental health or developmental disabilities services. (Refer to Staff Provider Qualifications later in this section.)
- Provided to the beneficiary as part of a comprehensive array of specialized mental health or developmental disabilities services.
- Coordinated with other community agencies (including, but not limited to, Medicaid Health Plans [MHPs], family courts, local health departments [LHDs], MIChoice waiver providers, school-based services providers, and the county Department of Human Services [DHS] offices).
- Provided according to an individual written plan of service that has been developed using a person-centered planning process and that meets the requirements of Section 712 of the Michigan Mental Health Code. A preliminary plan must be developed within seven days of the commencement of services or, if a beneficiary is hospitalized, before discharge or release. Pursuant to state law and in conjunction with the Balanced Budget Act of 1997, Section 438.10(f)(6)(v), each beneficiary must be made aware of the amount, duration, and scope of the services to which he is entitled. Therefore, each plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service. The beneficiary must receive a copy of his plan of services within 15 business days of completion of the plan.
- The individual plan of service shall be kept current and modified when needed (reflecting changes in the intensity of the beneficiary's health and welfare needs or changes in the beneficiary's preferences for

support). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan with the beneficiary and his/her guardian or authorized representative shall occur not less than annually to review progress toward goals and objectives and to assess beneficiary satisfaction. The review may occur during person-centered planning.

- Provided without the use of aversive, intrusive, or restrictive techniques unless identified in the individual plan of service and individually approved and monitored by a behavior treatment plan review committee.

The CMH is mandated by federal regulation to perform an assessment for the Appellant to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services that are needed to reasonably achieve her goals. The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria, Section 2.5* lists the criteria the CMH must apply before Medicaid can pay for outpatient mental health benefits. The Medicaid Provider Manual sets out the eligibility requirements as:

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.

Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Section, July 1, 2011, p. 13.

The CMH/Department's witness Dr. [redacted], Ph.D.; a fully licensed psychologist testified she had reviewed the prehearing summary and clinical records of the Appellant. Dr. [redacted] stated Appellant was [redacted] years old and is diagnosed with a severe cognitive impairment; Down's syndrome, Lennox Gestalt Syndrome, (a form of Epilepsy); and, a seizure disorder. Dr. [redacted] testified Appellant attends [redacted] School. Dr. [redacted] stated [redacted] was the provider of occupational and speech therapy services for the Appellant.

Dr. [redacted] stated Attachments D-O (including documents received after the adequate action notice was sent out) were utilized by the CMH to make their determination that the requested services were not medically necessary. (Exhibit 1, Attachments D-O, pp. 19-115). Dr. [redacted] stated there was no evidence in Appellant's clinical records that the occupational therapy or the speech therapy had resulted in or would result in a significant functional improvement necessary for the Appellant to perform daily living tasks, which is a requirement for continuation of such services. There also was no evidence that such improvements could be achieved in a reasonable length of time.

Dr. [redacted] stated there were doctor's prescriptions for the occupational and speech therapy services which are necessary according to the Medicaid Provider Manual, but by themselves the prescriptions are not sufficient to make the authorization for the requested services. (Exhibit 1, Attachment H, pp. 93-95). Dr. [redacted] noted the PCP dated [redacted] does not even mention occupational therapy. (Exhibit 1, Attachment G, pp. 83-92). Dr. [redacted] also pointed out there was no evidence contained in the records that there was any attempt to coordinate the occupational and speech services being provided by the school with those being provided by the CMH as required by policy. (See Exhibit 1, Attachment Q, p. 119). Dr. [redacted] concluded by saying that progress towards Appellant's goals was not sufficient to justify continuation of either therapy.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Covered Services, Section 3* sets forth the following concerning Medicaid covered services:

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.

Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, July 1, 2011, page 15

The following sections cover Occupational Therapy and Speech, Hearing and Language services:

3.17 OCCUPATIONAL THERAPY

Evaluation
Physician-prescribed activities provided by an occupational therapist currently registered by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment. An occupational therapy assistant may not complete evaluations.

Therapy
It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to his chronological developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy to make changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered.

Therapy must be skilled (requiring the skills, knowledge, and education of a registered occupational therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage.

Services must be prescribed by a physician and may be provided on an individual or group basis by an occupational therapist or occupational therapy assistant, currently registered by the State of Michigan or by an occupational therapy aide who has received on-the-job training. The occupational therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress, but on-site supervision of an assistant is not required. An aide performing an occupational therapy service must be directly supervised by

a qualified occupational therapist who is on site. All documentation by an occupational therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising occupational therapist.

Medicaid Provider Manual, Mental Health and Substance Abuse, Occupational Therapy Section, July 1, 2011, p. 19

3.20 SPEECH, HEARING, AND LANGUAGE

Evaluation
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. A speech-language pathology assistant may not complete evaluations.

Therapy
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.
>
> *Medicaid Provider Manual, Mental Health and Substance Abuse, Speech, Hearing, and Language Section*, July 1, 2011, p. 21

Ms. [redacted] Appellant's mother testified that as a mother and guardian Appellant's progress has been slow, but even small things in Appellant's life are a big deal. For example Appellant previously had a great deal of difficulty sitting through getting her hair cut, but after receiving therapy, Appellant was recently able to sit through a haircut with Ms. [redacted] simply rubbing the Appellant's hands.

Ms. [redacted] believes the occupational therapy and speech therapy services Appellant received through [redacted] have helped the Appellant. Appellant has just started working with an I Pad to assist her in communication. Appellant is non-verbal and gets frustrated when she can't communicate what she wants. Ms. [redacted] acknowledged that the school was providing occupational and speech therapy, but it was not being provided that often, maybe on a weekly or a monthly basis.

The Appellant bears the burden of proving by a preponderance of the evidence that she provided supportive documentation establishing medical necessity for occupational and speech therapy in accordance with the Code of Federal Regulations (CFR). The Appellant did not meet the burden to establish medical necessity. The information reviewed by CMH at the time it made the decision to deny the Appellant evaluations for occupational and speech therapy services did not show medical necessity. Furthermore, the information received shortly after the adequate action notice was sent out did not change the determination by the CMH that occupational and speech therapy were not shown to be medically necessary for the Appellant.

There is no evidence in Appellant's clinical records that either the occupational therapy or the speech therapy had resulted in or would result in a significant functional improvement for the Appellant within a reasonable amount of time. Furthermore, there was no evidence contained in the records that there was any attempt to coordinate the occupational and speech services being provided by the school with those being provided by the CMH as required by policy. As stated by Dr. [redacted] progress towards Appellant's goals was not sufficient to justify continuation of either therapy.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied the Appellant evaluations for occupational and speech therapy services.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

William D Bond

William D. Bond
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/03/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.