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. 2011-52597 CMH
Case No. 37471174

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 Wednesday, [redacted]. Appellant's mother and guardian, [redacted], appeared and testified on behalf of the Appellant. [redacted], Appellant's Supports Coordinator also appeared as a witness for the Appellant.

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

ISSUE

Did the CMH properly deny the Appellant's request for speech and language services?

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 has received services through the CMH since [redacted]. Services have included assessments, supports coordination, planning, community living supports, speech-language services, and occupational therapy services. His family has received respite services. Appellant also receives home help services through DHS. (Exhibit 1, p. 1 and Attachments C&D).

2. 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.

3. The Appellant is a [redacted]-year-old male Medicaid beneficiary (DOB [redacted]). The Appellant has been identified as a person with Autism since age four, severe cognitive impairment asthma, GERD, hypertension, and hypokalemia. Appellant also has a developmental disability with substantial limitations in self-care, receptive/expressive language, learning, self-direction, capacity for independent living and economic self-sufficiency. (Exhibit 1, p. 1, and Attachment D).

4. The Appellant lives with his parents in a private residence. (Exhibit 1, Attachment D, p. 24).

5. The Appellant attends a special education program at [redacted] School and receives group speech and language services and occupational therapy at his school. (Exhibit 1, p. 1 and Attachment D).

6. On [redacted], the CMH sent an adequate action notice to the Appellant stating that effective [redacted] the Appellant's speech and language services were terminated as the documentation submitted did not justify the requested service. (Exhibit 1, p.1, and Attachment A).

7. The Michigan Administrative Hearing System received Appellant's request for hearing on [redacted], along with [redacted]'s guardianship papers. (Exhibit 1, p. 1, Attachment B, and Exhibit 2).

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 his 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 [redacted], Ph.D., a fully licensed psychologist, testified she had reviewed the clinical records of the Appellant and the prehearing summary submitted in this case. [redacted] stated Appellant was [redacted] years old and is diagnosed with autism, severe cognitive impairment asthma, GERD, hypertension, hypokalemia, and a developmental disability. [redacted] testified Appellant attends [redacted] School and receives group speech services at the school.

[redacted] stated Appellant has received speech services provided by the CMH on a twice weekly basis from [redacted] up until their decision to deny the services in [redacted]. Appellant received the speech services for 3½ to 4 years. [redacted] stated that according to the policy contained in the Medicaid Provider Manual, in order to authorize a continuation of speech and language services, there must be evidence in Appellant's clinical records that the therapy is reasonable, medically necessary, and anticipated to result in an improvement and/or elimination of the stated problem within a reasonable amount of time.

[redacted] referenced the recent evaluation contained in the clinical records and stated that the evaluation did not demonstrate a significant improvement or elimination of the stated problem within a reasonable amount of time. [redacted] stated that you would expect to see an improvement considering the fact that the services had been provided since [redacted]. [redacted] stated there was not sufficient progress shown to justify continuation of the services.

[redacted] stated the clinical records contained no evidence of coordination of the services being provided by the school with the services provided by the CMH, which is required by the policy in the Medicaid Provider Manual. Such coordination is required to insure that the strategies used are similar and not contradictory in type.

[redacted] concluded by saying that the Appellant's clinical records did not show appreciable improvement or elimination of the problem within a reasonable length of time as required by the policy contained in the Medicaid Provider Manual for continuation of those services.

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 section covers Speech, Hearing and Language services:

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

Appellant's mother [redacted] questioned what [redacted] meant by her statement that Appellant had not shown a significant improvement from the speech services that had been provided by the CMH. [redacted] then asserted that apparently she had to try another solution with her son. [redacted] offered no further testimony.

Appellant's Supports Coordinator [redacted] testified the Appellant has shown some change in his communication skills since she first met him. She stated she has seen the Appellant learning more words to communicate his wants and needs. [redacted] stated she has seen some progress over the past couple of years, but not the amount of change or improvement indicated by [redacted] as being required by the Medicaid Provider Manual. Appellant will greet her now, when a couple of years ago he would not do so. [redacted] stated she had been working with the Appellant for two out of the four years he has been going to therapy.

The Appellant bears the burden of proving by a preponderance of the evidence that the information contained in his clinical records that was reviewed by the CMH establishes the medical necessity for speech and language services in accordance with the Code of Federal Regulations (CFR). The Appellant did not meet the burden of establishing medical necessity. This Administrative Law Judge is limited to the evidence the CMH had at the time it made its decision. The information reviewed by CMH at the time it made the decision to terminate the speech and language services did not show medical necessity. Appellant has been receiving these services since [redacted] and there has not been sufficient improvement to justify a continuation of the services.

Furthermore, Appellant is receiving group speech services at his school. There has been no showing that these services were coordinated with the CMH services as required by the policy in the Medicaid Provider Manual.

The CMH and this Administrative Law Judge are bound by the policy contained in the Medicaid Provider Manual for authorization of speech and language services. In addition, this Administrative Law Judge possesses no equitable jurisdiction to grant exceptions to Medicaid, Department and the other relevant policies contained in the Medicaid Provider Manual. As established by [redacted], the clinical psychologist who testified for the CMH, there simply was not sufficient progress demonstrated in Appellant's clinical records to meet the policy requirements that the requested therapy be "reasonable, medically necessary and anticipated to result in an improvement and/or

elimination of the stated problem within a reasonable amount of time". Furthermore, it was not shown that the services provided through the CMH were coordinated with the similar services being provided at the Appellant's school as required by policy. Accordingly, the decision by the CMH was proper and should be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied Appellant's request for speech and language 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: 10/31/2011

***** 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.