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. 2012-16348 CMH
Case No. 1057062515

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] 2012. Appellant's mother, [redacted], appeared and testified on behalf of the Appellant. [redacted] Appellant's Case Manager with Wayne Center also testified on behalf of the Appellant.

[redacted], Fair Hearing Officer, appeared and testified for the Department's agent, [redacted] County Community Mental Health (CMH). [redacted], Director of Utilization Management for [redacted] Partners, appeared as a witness for [redacted] County Community Mental Health Agency.

ISSUE

Did the CMH properly deny the Appellant's request for additional speech therapy 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. Appellant is a [redacted] year-old male Medicaid beneficiary [redacted]. Appellant is receiving services for the developmentally disabled at [redacted] Center and his assigned MCPN is [redacted]. The Appellant has been diagnosed with Autism and Asthma. (Exhibits 1, 2 & 4).

2. [redacted] County Community Mental Health Agency is a Community Mental Health Services Program (CMH).

3. Appellant lives in an apartment with his mother and younger brother. (Exhibit 4).

4. On [redacted], Appellant's Individual Person Centered Plan of Support (IPCPOS) provided for a speech therapy evaluation to address Appellant's overall communication deficits. (Exhibit 4).

5. On [redacted], a Speech-Language Pathology report by [redacted] ([redacted]) recommended that Appellant receive "speech and language services once a week to improve his receptive language skills, expressive language skills, and his pragmatic language skills." (Exhibit 5).

6. On [redacted], an IPCPOS Review authorized Appellant to receive 1 session per week of speech therapy at [redacted]. (Exhibit 4).

7. Appellant attends [redacted] School in the [redacted] school district and currently receives speech therapy two times each week for 30 minutes each time at school per his IEP. (Exhibits 1, 2, 9).

8. On [redacted], [redacted] sent an adequate action notice to the Appellant's mother stating that effective [redacted] the Appellant's request for one time per week of speech therapy through CMH was being denied because Appellant was receiving speech therapy one to two times per week at school per his IEP, and based on the recommendation in his speech evaluation dated [redacted], he is receiving the appropriate level through his school. CMH agreed with the action taken by [redacted]. (Exhibits 1 & 3).

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

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.

Medicaid Provider Manual, Mental Health and Substance Abuse, January 1, 2012, p. 8

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, January 1, 2012, p. 13.

The CMH/Department's witnesses [redacted] and [redacted] testified Appellant was denied speech therapy once per week through CMH because he was receiving speech therapy through his school one to two times per week. Appellant was authorized to receive speech therapy once per week following an evaluation by [redacted], but [redacted] denied the speech therapy through CMH due to the fact that he was receiving the appropriate level of speech therapy at his school.

[redacted] stated speech therapy was approved as part of Appellant's IEP with the [redacted] Schools. Appellant's mother had expressed concern that Appellant wasn't getting individual therapy, and she was advised to seek an amendment to his IEP to specify individual therapy. [redacted] stated the evaluation by [redacted] did not specify individual therapy. [redacted] further stated that Medicaid was a payer of last resort and since Appellant was receiving the appropriate level of therapy through his school, Medicaid could not pay for additional therapy outside of the school setting.

According to policy contained in the Medicaid provider Manual in order to authorize a 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. However, 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.

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, January 1, 2012, page 15

The following section covers Speech, Hearing and Language services:

3.22 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, January 1, 2012, pp. 21-22

[redacted], Appellant's Case Manager, testified Appellant had obtained a letter from a speech therapist at Appellant's school [redacted] Elementary. (Exhibit 9). The letter states Appellant is getting group speech therapy 2 times each week for 30 minutes each time, and that Appellant is getting the appropriate amount of service to meet his needs in the academic setting. [redacted] stated she believed Appellant needed additional therapy to deal with his ability to function within the community.

Appellant's mother testified she received the letter from the school and it was dated on the date of the hearing. [redacted] did not think Appellant's group therapy at school was helping him and she wanted to receive additional therapy outside of the school setting. She stated Appellant was currently receiving the therapy in a group of 15 to 16 students. [redacted] acknowledged that the letter from the school did not specify the need for additional therapy for the Appellant.

The Appellant bears the burden of proving by a preponderance of the evidence that medical necessity exists for additional speech and language services beyond what is being provided through the Appellant's school in accordance with the Code of Federal Regulations (CFR). The Appellant did not meet the burden of establishing medical necessity for the additional therapy. This Administrative Law Judge is limited to the evidence the CMH had at the time it made its decision to deny the speech therapy through the CMH. The information reviewed by CMH at that time does not establish medical necessity for additional speech therapy.

Appellant has been receiving the appropriate level of speech services through his school and according to Medicaid policy additional therapy can not be covered by Medicaid. The recommendation by [redacted] and Appellant's IPCPOS review called for 1 session per week of speech therapy. As indicated by the adequate action notice, the CMH properly denied additional speech therapy through the CMH, because Appellant is receiving speech therapy one to two times per week at school per his IEP, and based on the recommendation in his speech evaluation dated [redacted], he is receiving the appropriate level of therapy through his school.

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. The Appellant is receiving the appropriate level of speech therapy at his school, and the fact that it is being provided in a group academic setting does not establish an entitlement to additional therapy services outside of the appellant's school. To the contrary, policy contained in the Medicaid Provider manual states that it is expected that such therapy interventions will be provided in an individual's school, and when they are additional services cannot be covered by

Medicaid. Accordingly, the decision by the CMH to deny additional individual speech therapy 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: 1/27/2012

***** 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.