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) 334-4147

IN THE MATTER OF

Docket No. 2012-40880 CMH

[redacted]
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 [redacted]. [redacted], Appellant's mother/guardian appeared and testified, on behalf of the Appellant. [redacted] Appellant's Supports Coordinator with [redacted], was present for the hearing but did not testify.

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

ISSUE

Did the CMH properly deny the Appellant's request for occupational therapy and additional community living supports hours?

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 [redacted]r-old male ([redacted]) who is enrolled in Medicaid, but not in any of the specialty Waivers administered by CMH. Appellant has been receiving services from CMH through a self-determination arrangement since [redacted]. (Exhibit 1, Attachments C-E and testimony).

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. Appellant has been diagnosed with autistic disorder, and attention deficit hyperactivity disorder. (Exhibit 1 and Attachment D).

4. The Appellant lives in a private [redacted] bedroom home with his mother and his mother's girlfriend. Appellant's mother is his primary caregiver. (Exhibit 1 and Attachment D).

5. Appellant currently attends school full-time at Elmwood Elementary in [redacted] Appellant is in the [redacted] grade, and has been mainstreamed at the request of his mother. (Exhibit 1 and Attachment D).

6. On [redacted], an adequate action notice was sent to Appellant's mother indicating that [redacted] of the [redacted] CLS hours per week requested had been authorized and the occupational therapy requested was denied as not being medically necessary. The notice provided Appellant with his rights to a fair hearing. (Exhibit 1 and Attachment A).

7. The Appellant's request for a hearing signed by the Appellant's mother was received by MAHS on [redacted]. The Appellant's mother requested a hearing only in regards to the denial of occupational therapy for the Appellant. (Exhibit 1 and 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.
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> *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.

The evidence of record shows that the Appellant was previously receiving occupational therapy through CMH. On February 16, 2012, however, CMH sent the Appellant's mother notice that her request for occupational therapy was denied effective February 15, 2012. On March 16, 2012, the Appellant's mother and guardian appealed, the denial of occupational therapy for the Appellant.

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 *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Its states the following with regard to occupational therapy:

3.18 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, April 1, 2012, pp. 19-20

The *Medicaid Provider Manual* states the following with regard to community living supports:

> **17.3.B. COMMUNITY LIVING SUPPORTS**
>
> Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).
>
> Coverage includes:
>
> - Assisting (that exceeds state plan for adults), prompting, reminding, cueing, (revised 7/1/11) observing, guiding and/or training in the following activities:
> - meal preparation
> - laundry
> - routine, seasonal, and heavy household care and maintenance
> - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
> - shopping for food and other necessities of daily living
>
> CLS services may not supplant state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and

duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the DHS assessment.

- Staff assistance, support and/or training with activities such as:

  - money management
  - non-medical care (not requiring nurse or physician intervention)
  - socialization and relationship building
  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
  - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
  - attendance at medical appointments
  - acquiring or procuring goods, other than those listed under shopping, and non-medical services
  - Reminding, observing and/or monitoring of medication administration
  - Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

    CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through DHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.

    CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from

> a Fair Hearing of the appeal of a DHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.
>
> Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensorymotor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings or to be provided when the child would typically be in school but for the parent's choice to home-school the child. (added 7/1/11)
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> *Medicaid Provider Manual, Mental Health and Substance Abuse, April 1, 2012, pages 108-109.*

The *Medicaid Provider Manual, Mental Health/Substance Abuse* section states the following with regard to determining medical necessity:

> **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.

Medicaid Provider Manual, Mental Health and Substance Abuse, April 1, 2012, pages 12-14.

The CMH witness [redacted] a fully licensed psychologist with CMH testified the Appellant was a [redacted] year old diagnosed with autistic disorder and ADHD. Appellant is attending [redacted] Elementary School full-time. [redacted] stated Appellant had been receiving Medicaid services from CMH since [redacted], which included assessments, treatment planning, supports coordination, community living supports, behavioral services, occupational therapy, and respite care.

[redacted] referenced the requirements for occupational therapy under the Medicaid Provider Manual. [redacted] stated therapy must 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. She stated any therapy that does not have an impact on the beneficiary's ability to perform age appropriate tasks is not covered. (See Attachment L).

[redacted] stated there must be coordination between therapies provided by CMH and other agencies such as the Appellant's school. [redacted] could find no evidence of coordination with the school, and further that it was unclear whether the school was still providing occupational therapy to the Appellant.

[redacted] stated the Appellant's records did not contain any measurable objectives for Appellant's occupational therapy. She stated there was no clear statement in the records as to the Appellant's progress other than he was showing improvement, but no specifics as to measurable goals or improvements. [redacted] stated the records must document measurable goals and improvements to show the progress the Appellant is making towards performing skills appropriate to the daily living skills for his chronological age. She stated without written objectives or documentation of progress the occupational therapy could not be demonstrated as being medically necessary. (See Attachment K).

[redacted] stated the Appellant had been approved for [redacted] CLS hours per week and there was a request to increase it to [redacted] hours per week. She could find no changes in the Appellant's records to justify an increase in the CLS hours to be approved. She stated if additional hours were needed for the Appellant to attend a summer program, additional CLS hours could be approved at that time.

The Appellant's mother [redacted] testified the documents submitted by CMH did pertain to her son the Appellant. Ms. Sawgle stated, however, that there have been some changes since these documents were submitted to CMH. For example, Appellant's new IEP does not call for an in-school aide. She also stated the school is no longer providing occupational therapy. The school believes he has attained the skills

necessary to function at school.

[redacted] stated she agrees there has to be a statement showing the Appellant's improvement from the occupational therapy. She stated the Appellant is a [redacted] year old with the social skills of a [redacted] year old. She stated he is severely ADHD and his medications only take the edge off. [redacted] stated the Appellant should not be in special education as he needs to learn how to be normal and function in society. [redacted] believes Appellant needs occupational therapy to help him learn social skills and how to engage in self calming behaviors.

[redacted] also stated the Appellant needs an aide during the day. She thinks the school should take up some of the slack, but wants additional CLS hours to provide an aide for the Appellant during the day when he is not in school. Ms. Sawgle stated additional CLS is needed to allow the Appellant to attend Cub Scouts and to attend day camp in the summer.

The Appellant bears the burden of proving by a preponderance of the evidence that the requested occupational therapy was in accordance with the requirements of the Medicaid Provider Manual and that the services are medically necessary. The Appellant's mother was given the opportunity to prove why her request for occupational therapy met the requirements under the Medicaid Provider Manual. The testimony of the Appellant's mother did not support a reversal of CMH's decision.

The CMH must authorize CLS services in accordance to the CFR and state policy. The CMH provided sufficient evidence that it adhered to the CFR and state policy when denied occupational therapy for the Appellant. The information contained in the Appellant's records that was reviewed by CMH before it made the decision to deny occupational therapy supports the CMH's decision to deny occupational therapy at this time.

As CMH argued at the hearing, this was essentially a records problem. The Appellant failed to prove by a preponderance of the evidence that the requested occupational therapy met the requirements of the policy contained in the Medicaid Provider manual or that it was medically necessary. Without a statement of measurable goals or a demonstration of actual progress towards such goals in the Appellant's records, CMH cannot justify the authorization of such occupational therapies.

The undersigned administrative law judge also notes that the Appellant's request for a hearing did not challenge the number of CLS hours approved. Furthermore, the evidence presented at the hearing would support the decision not to increase the CLS hours at this time. CMH acknowledged that CLS could be increased in the event that additional time is needed in order for the Appellant to attend a summer day camp program with an aide.

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 request for occupational therapy and for an increase in CLS for the Appellant.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 5-4-12

***** 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.