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) 373-4147

IN THE MATTER OF:

Docket No. 2012-74023 QHP
Case No. [redacted]

[redacted]

Appellant

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared on behalf of the Appellant. She had no witnesses. [redacted] attorney, represented Meridian Health Plan. His witnesses were; [redacted] of [redacted] and [redacted], [redacted].

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for occupational 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. Appellant is a [redacted] Medicaid beneficiary who is enrolled in the Meridian Health Plan.

2. The Appellant is afflicted with "limited attention span, anger outbursts and limited food range." (Appellant's Exhibit #1 - throughout)

3. On [redacted] the MHP received Appellant's request for occupational therapy as submitted by the Detroit Institute for Children (DIC). (Respondent's Exhibit A, pp. 17 through 25)

4. On or about [redacted], the MHP advised the Appellant [in writing] that his request for occupational therapy services was reviewed and denied because it is not a covered benefit under Meridian's criteria for coverage

as the occupational services requested are related to the treatment of a developmental delay. (Respondent's Exhibit A, pp. 16, 27 – 30)

5. The Appellant was further advised that such service was available [and the responsibility] of the Appellant's Intermediate School District. The Appellant was provided with the telephone number to arrange such therapy through the Oakland County ISD. The Appellant's further appeal rights were contained therein.(Respondent's Exhibit A, page 27 – 30)

6. There were some areas of "concern" proposed by the DIC evaluators; however habilitative therapy, as explained by [redacted] is not a covered benefit under the MHP standards of coverage. (*See also,* Respondent's Exhibit A, pp. 36-36)

7. On [redacted], the instant request for hearing was received by the Michigan Administrative Hearing System (MAHS) for the Department of Community Health. (Appellant's Exhibit #1)

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.

On May 30, 1997, the Department received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified Medicaid Health Plans.

The Respondent Health Plan of Michigan is one of those Medicaid Health Plans.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below. The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Contractor must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 2.024.

Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)

- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21

Article 1.020 Scope of [Services],
at §1.022 E (1) contract, 2010, p. 22.

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Utilization Management

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

- Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- An annual review and reporting of utilization review activities and outcomes/interventions from the review.
- The UM activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure
The Contractor must establish and use a written prior approval policy and procedure for UM purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must

> ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review. Contract, *Supra,* at page 49.
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> ***

The MHP denied the Appellant's request for occupational therapy because the service requested is the responsibility of his ISD.

The Appellant's representative explained that the school is not involved and that she has been working with her son all summer. She said that he has extreme sensory issues via touch and smell in addition to outbursts of anger.

It was not clear whether the Appellant had pressed his appeal against the ISD and why they are "not involved."

The Department's medical witness [redacted] said that following her review of the PA there was neither indication of failure to thrive nor any "acute perceptions that would contributed to any of his issues."

On review the MHP witnesses were correct when they said that the requested services are the responsibility of the school system.

The Appellant's mother testified that her son needs occupational therapy. She was given instructions on how to pursue that service through the ISD. Under the MHP plan of coverage, its contract with the State of Michigan and the MPM habilitative therapy is not a covered service. The Appellant's representative did not provide any persuasive documentation establishing a clinical basis for MHP involvement beyond school-based services.

Accordingly, the decision to deny occupational therapy was clearly supportable and within the MHP's reasonably drawn utilization guidelines.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the Appellant's request for occupational therapy.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

/s/
Dale Malewska
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 03/18/13

***** 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.