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:

[redacted]

Docket No. 2013-23283 QHP
Case No. [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]. The Appellant was represented by [redacted], mother. [redacted] of Michigan, appeared as a witness for the Appellant. [redacted], represented [redacted] of Michigan, the Medicaid Health Plan ("MHP"). [redacted] appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for 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. The Appellant is a [redacted] year-old Medicaid beneficiary.

2. On or about [redacted], the MHP received a request for continuing coverage for speech therapy services for the Appellant. The Appellant's diagnoses are apraxia and expressive language disorder. (Exhibit 1, pages 4-14)

3. On [redacted], the MHP sent the Appellant, [redacted] doctor and the requesting speech therapy provider notice that the request for outpatient speech therapy services was denied because speech therapy is not covered to treat delays in development. The notice indicated that these services may be provided through another public agency via the intermediate school district. The notice also stated that under the Michigan Department of Community Health Medicaid Provider Manual policy, speech therapy is not covered when required to be provided by

school based services or when provided to meet developmental milestones. (Exhibit 1, pages 15-18)

4. On [redacted], the Michigan Administrative Hearing System received the Request for Hearing submitted on the Appellant's behalf.

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.

The Respondent is one of those MHPs.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). 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.
>
> *Section 1.022(E)(1), Covered Services.*
> *MDCH contract (Contract) with the Medicaid Health Plans,*
> *October 1, 2009.*

> (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.

Section 1.022(AA), Utilization Management,
MDCH contract (Contract) with the Medicaid Health Plans*,*
October 1, 2009.

As stated in the Department-MHP contract language above, a MHP, "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The pertinent sections of the Michigan Medicaid Provider Manual are as follows:

5.3 SPEECH THERAPY

The terms speech therapy, speech-language pathology, speech-language therapy, and therapy are used to mean speech and language rehabilitation services and speech-language therapy.

MDCH covers speech-language therapy provided in the outpatient setting. MDCH only reimburses services for speech-language therapy when provided by:

- A speech-language pathologist (SLP) with a current Certificate of Clinical Competence (CCC).

- An appropriately supervised SLP candidate (i.e., in their clinical fellowship year [CFY]) or having completed all requirements but has not obtained a CCC. All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.

- A student completing his clinical affiliation under direct supervision of (i.e., in the presence of) an SLP having a current CCC. All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.

MDCH expects that all SLPs will utilize the most ethically appropriate therapy within their scope of practice as defined by Michigan law and/or the appropriate national professional association.

For all beneficiaries of all ages, speech therapy must relate to a medical diagnosis, and is limited to services for:

- Articulation
- Language
- Rhythm
- Swallowing
- Training in the use of an speech-generating device
- Training in the use of an oral-pharyngeal prosthesis
- Voice

For CSHCS beneficiaries (i.e., those not enrolled in Medicaid; only enrolled with CSHCS), therapy must be directly related to the CSHCS-eligible diagnosis(es) and prescribed by the specialty physician who is overseeing the care of the beneficiary.

Therapy must be reasonable, medically necessary and expected to result in an improvement and/or elimination of the stated problem within a reasonable amount of time (i.e., when treatment is due to a recent change in medical or functional status affecting speech, and the beneficiary would experience a reduction in medical or functional status without therapy).

Speech therapy services must be skilled (i.e., require the skills, knowledge and education of a certified SLP to assess the beneficiary for deficits, develop a treatment program and provide therapy). Interventions that could be provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [LPT], registered occupational therapist [OTR], family member, or caregiver) would not be reimbursed as speech therapy by MDCH.

For beneficiaries of all ages, therapy is **not** covered:

- When provided by an independent SLP.
- For educational, vocational, social/emotional, or recreational purposes.
- If services are required to be provided by another public agency (e.g., PIHP/CMHSP provider, SBS).
- When intended to improve communication skills beyond premorbid levels (e.g., beyond the functional communication status prior to the onset of a new diagnosis or change in medical status).
- If it requires PA but is rendered before PA is approved.
- If it is habilitative. Habilitative treatment includes teaching someone communication skills for the first time without compensatory techniques or processes. This may include syntax or semantics (which are developmental) or articulation errors that are within the normal developmental process.
- If it is designed to facilitate the normal progression of development without compensatory techniques or processes.
- If continuation is maintenance in nature.
- If provided to meet developmental milestones.
- If Medicare does not consider the service medically necessary.

5.3.A. DUPLICATION OF SERVICES

Some areas (e.g., dysphagia, assistive technology) may appropriately be addressed by more than one discipline (e.g., OT, PT, speech therapy) in more than one setting. MDCH does not cover duplication of services, i.e., where two disciplines are working on similar areas/goals. It is the treating therapist's responsibility to communicate with other practitioners, coordinate services, and document this in his reports.

5.3.B. SERVICES TO SCHOOL-AGED BENEFICIARIES

School-aged beneficiaries may be eligible to receive speech-language therapy through multiple sources. Educational speech is expected to be provided by the school system and is not covered by MDCH or CSHCS. Examples of educational speech include enhancing vocabulary, improving sentence structure, improving reading, increasing attention span, and identifying colors and numbers. Only medically necessary therapy may be provided in the outpatient setting. Coordination between all speech therapy providers should be continuous to ensure a smooth transition between sources.

> Outpatient therapy provided to school-aged children during the summer months in order to maintain the therapy services provided in the school are considered a continuation of therapy services when there is no change in beneficiary diagnosis or function. Prior authorization is required before initiating a continuation of therapy.
>
> If a school-aged beneficiary receives medically necessary therapy services in both a school setting (as part of an Individualized Education Plan [IEP]) and in an outpatient setting, coordination of therapy between the providers is required. Providers are to maintain documentation of coordination in the beneficiary's file. **(text added per bulletin MSA 12-02)**
>
> *Department of Community Health,*
> *Medicaid Provider Manual, Outpatient Therapy Section*
> *Version Date: October 1, 2012, Pages 19-21.*

The MHP explained that the requested speech therapy services were denied based upon the Medicaid Provider Manual policy, which does not allow for coverage to treat delays in development, habilitative treatment, or when required to be provided by school based services. Developmental delays in this context only means not developing at the age appropriate levels they should be. Rather, covered therapy services are for rehabilitative treatment. Rehabilitative treatment would be when the individual had a skill that has been lost and the therapy services are trying to restore or improve that skill. (Inquiry [redacted] and [redacted] Testimony)

The Appellant's mother testified that the Appellant has a hard time expressing [redacted] through words. The Appellant's tongue and lips move the wrong way and needs skilled therapy. The Appellant's mother believes this is not a developmental delay. The Appellant did receive some school based services through the TOTE program, but it was more like play. A teacher consultant would come to the home and play with the Appellant, but no skilled therapy services were provided. There is a speech lady at the school, but again this was more like a play date once per week. (Mother Testimony)

The Speech Language Pathologist testified that the Appellant has apraxia and the deficiencies are not strictly developmental. Rather, the Appellant has a medical condition, which would not be covered by school based services. The Appellant is also receiving some occupational therapy services in which feeding issues are being worked on. This goes along with the speech issues and the apraxia. The Appellant has to work on moving [redacted] tongue for both eating food and making speech sounds. The Appellant has shown much success since the initial visit. Given the Appellant's age, it is difficult to tell if the Appellant has lost any skills or if these are skills [redacted] is learning for the first time. It may be easier to tell when [redacted] is [redacted] years old. The Appellant is not yet showing signs of frustration with not being able to express [redacted]. It is expected that

[redacted] would show these signs if there is a wait to determine if this is developmental and would be covered by school based services. When there has not been an event like a stroke or trauma to the brain it is not always clear what is causing the neurological pathways to be messed up. With structured therapy, it has been shown that they can correct and retrain the pathways to lessen the apraxia that is preventing the child from speaking functionally and clearly. ([redacted] Testimony)

While this ALJ sympathizes with the Appellant's circumstances, the above cited Medicaid policy states that speech therapy is not covered in several circumstances, including: if services are required to be provided by another public agency; when intended to improve communication skills beyond premorbid levels; for educational, vocational, social/emotional, or recreational purposes; if it is habilitative; designed to facilitate the normal progression of development without compensatory techniques or processes; or to meet developmental milestones. Speech therapy services would also not be covered if another discipline, such as occupational therapy, is working on similar areas/goals. The Appellant received some school based services through the TOTE program. Given the Appellant's age, it is understandably difficult to establish the requested speech therapy services are addressing skills [redacted] has lost rather than skills [redacted] is learning for the first time. The Appellant's overall development was reported to be slightly delayed. The reason for the referral for speech therapy was the Appellant not talking as much as can be expected for [redacted] age and poor oral structure movements. The Appellant is receiving some occupational therapy services for feeding and oral motor movement. The expected functional outcome includes the Appellant increasing prelinguistic skills and developing more age appropriate play skills. (Exhibit 1, pages 5-14, Mother Testimony, [redacted] Testimony) The MHP's denial of this prior authorization request for speech therapy services was consistent with the Medicaid policy and must be upheld.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

/S/
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 03/22/13

***** 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.