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. 2013-8015 QHP
Case No.

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 . The Appellant was represented by , foster mother and prospective adoptive mother. was represented by , Director of Customer Service. is a Department of Community Health contracted Medicaid Health Plan (MHP). , Director of Health Services, and , Denial Appeals Assistant appeared as witnesses for the MHP. , Denial Appeals Coordinator and , Manager , both with the MHP, were also present.

ISSUE

Did the MHP properly deny the Appellant's request for speech and occupational 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 year-old Medicaid beneficiary.

2. On or about , the MHP received a request for coverage for speech therapy and occupational therapy services for the Appellant. (Exhibit 1, pages 8-10)

3. The Appellant has been diagnosed with articulation and phonological impairment. (Exhibit 1, page 8-9)

4. On and , the MHP sent the Appellant notices that the request for speech and occupational therapy services was denied because the speech and occupational therapy is

considered habilitative. The notices indicated that these services are not covered when required to be provided by another public agency such as school based services or Early On Program, if therapy is habilitative, is continuation of therapy that is maintenance in nature or if provided to meet developmental milestones. (Exhibit 1, pages 4-7)

5. On [redacted], the Michigan Administrative Hearing System received the Request for Hearing submitted on the Appellant's behalf with attached documentation. (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.

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:

SECTION 5 – STANDARDS OF COVERAGE AND SERVICE LIMITATIONS

5.1 OCCUPATIONAL THERAPY
MDCH uses the terms Occupational Therapy, OT, and therapy interchangeably. OT is covered when furnished by a Medicaid-enrolled outpatient therapy provider when performed by:

- A licensed occupational therapist (OT);
- A licensed occupational therapy assistant (OTA) under the supervision of an OT (i.e., the OTA's services must follow the evaluation and treatment plan developed by the OT, and the OT must supervise and monitor the

OTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the appropriate supervising OT; or
- A student completing his clinical affiliation under the direct supervision of (i.e., in the presence of) an OT. All documentation must be reviewed and signed by the appropriate supervising OT.

OT is considered an all-inclusive charge and MDCH does not reimburse for a clinic room charge in addition to OT services unless it is unrelated. MDCH expects OT's and OTA's to utilize the most ethically appropriate therapy within their scope of practice as defined by state law and/or the appropriate national professional association. OT must be medically necessary, reasonable and required to:

- Return the beneficiary to the functional level prior to illness or disability;
- Return the beneficiary to a functional level that is appropriate to a stable medical status; or
- Prevent a reduction in medical or functional status had the therapy not been provided.

For CSHCS beneficiaries
OT must be directly related to the CSHCS-eligible diagnosis(es) and prescribed by the specialty physician who is overseeing care.

For beneficiaries 21 years of age and older
OT is only covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant in the beneficiary's life roles despite impairments, activity limitations or participation restrictions.

MDCH anticipates OT will result in a functional improvement that is significant to the beneficiary's ability to perform appropriate daily living tasks (per beneficiary's chronological, developmental, or functional status). Functional improvements must be achieved in a reasonable amount of time and must be maintainable. MDCH does not cover therapy that does not have an impact on the beneficiary's ability to perform age-appropriate tasks.

OT must be skilled (i.e., require the skills, knowledge and education of an OT). MDCH does not cover interventions

provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [LPT], family member, or caregiver).

OT may be covered for one or more of the following:

- Therapeutic use of occupations*.
- Adaptation of environments and processes to enhance functional performance in occupations*.
- Graded tasks (performance components) in activities as prerequisites to an engagement in occupations*.
- Design, fabrication, application, or training in the use of assistive technology or orthotic devices.
- Skilled services that are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers. Routine provision of the maintenance/prevention program is not a covered OT service.

* Occupations are goal-directed activities that extend over time (i.e., performed repeatedly), are meaningful to the performer, and involve multiple steps or tasks. For example, doing dishes is a repeated task. Buying dishes happens once; therefore, does not extend over time and is not a repeated task.

OT is not covered for the following:

- When provided by an independent OT**.
- For educational, vocational, or recreational purposes.
- If services are required to be provided by another public agency (e.g., community mental health services provider, school-based services).
- If therapy requires PA and service is rendered before PA is approved.
- If therapy is habilitative. Habilitative treatment includes teaching someone how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. This may include teaching a child normal dressing techniques or cooking skills to an adult who has not performed meal preparation tasks in the past.
- If therapy is designed to facilitate the normal progression of development without compensatory techniques or processes.

- For development of perceptual motor skills and sensory integrative functions to follow a normal sequence. If the beneficiary exhibits severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function, OT may be covered.
- Continuation of therapy that is maintenance in nature.

** An independent OT may enroll in Medicaid if he provides Medicare-covered therapy and intends to bill Medicaid for Medicare coinsurance and/or deductible only.

5.1.A. DUPLICATION OF SERVICES

Some therapy areas (e.g., dysphagia, assistive technology, hand therapy) may be appropriately addressed by more than one discipline (e.g., OT, PT, speech therapy) in more than one setting. MDCH does not cover duplication of service (i.e., where two disciplines are working on similar goals/areas). The OT is responsible to communicate with other therapists and coordinate services. MDCH requires any related documentation to include coordination of services.

5.1.B. SERVICES TO SCHOOL-AGED BENEFICIARIES

School-aged beneficiaries may be eligible to receive OT through multiple sources. MDCH expects educational OT to be provided by the school system, and it is not covered by MDCH or CSHCS. (Example: OT coordination for handwriting, increasing attention span, identifying colors and numbers.)

MDCH only covers medically necessary OT when provided in the outpatient setting. Coordination between all OT providers must 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 is 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: July 1, 2012, Pages 7-9

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: July 1, 2012, Pages 19-21.

The MHP testified that the requested speech and occupational therapy services were denied because the requested services were habilitative. The MHP also explained that the requested services would not be covered to treat delays in development or when required to be provided by school based services. (Director of Customer Service and Director of Health Services Testimony)

The Appellant's foster mother disagrees with the denial testified that the Appellant is not receiving any of the requested therapy services. The Appellant was a crack baby, has many issues, and is a state foster child. Therefore, therapy services should not be denied services. The Appellant was not able to be diagnosed until age , but now that she is years old she is no longer eligible for the Early On Program. The Appellant's foster mother has requested an IEP from the school district, but it has not been done. The only response has been from the Appellant's teacher, who said the Appellant does not qualify. (Foster Mother Testimony)

The Appellant is years old. The prior authorization request indicates that the speech and occupational therapy services are being requested to treat the diagnosis of articulation and phonological impairment. (Exhibit 1, pages 8-10)

Additional documentation was submitted with the Request for Hearing, including several letters from the Director of Pediatric Neurology. The letter indicates the Appellant has a "neurologic residua consist of delay of language skills, together with elements of a significant speech dyspraxia" as well as features of an attention deficit hyperactivity disorder of moderate to severe degree. The neurologic disorder compounds the Appellant's ability to make developmental, educational and social gains as well as increases frustration and anxiety. (Exhibit 2, page 2) The consult letter sets out the Appellant's background history. In part, the letter indicates "a history of borderline to mild degree of delay of language skills. There are elements of speech dyspraxia." Features of an attention deficit hyperactivity disorder of moderate to severe degree were also noted. The Appellant received in-home teaching from the school district, 2 hours per week, and will enroll in preschool next academic year. "There is a borderline to mild degree of delay of language skills." Significant speech dyspraxia was noted. Fine and gross motor skills were within the broad range of normal, but it was noted the Appellant trips and falls excessively. Later in the letter, possible delay with fine motor manipulation is noted. Early motor milestones were within the broad range of normal. The listed impressions include "developmental dyspraxia affecting speech patterns and possible also fine motor abilities." The letter indicates concepts of developmental dyspraxia or developmental coordination were discussed with the Appellant's foster mother. Attention deficit hyperactivity disorder was also discussed and a letter of support for remediation services in the school district was also provided. (Exhibit 2, pages 9-12) non-patient letters include diagnoses of mild language delay, speech dyspraxia, borderline to mild language delay, developmental dyspraxia affecting speech patterns and possible fine motor abilities. Recommendations included speech pathology evaluation and treatment, occupational

therapy, social work intervention, as well as an IEP evaluation and 504 plan. (Exhibit 2, page 13-15)

While this ALJ sympathizes with the Appellant's circumstances, Medicaid policy clearly states that speech and occupational therapy that is habilitative, developmental, or required to be provided by another public agency is not covered. Based upon available evidence, the requested therapy services are habilitative and developmental. It further appears that some services may be being provided through the school district and there is a recommendation supporting remediation services through the school district. Accordingly, the MHP denial was consistent with the Medicaid policy and must be upheld.

As noted during the telephone hearing proceedings, the Appellant also has appeal rights regarding services thought the school district, which the Appellant's foster mother may wish to pursue.

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 and occupational 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:

Date Mailed: 1/4/2013

*** 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.