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. 2013-50516 QHP
Case No. 38221335

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.*, and upon a request for a hearing filed on behalf of the minor Appellant.

After due notice, a hearing was held on [redacted], Appellant's mother, appeared and testified on his behalf. [redacted], Director of Medicaid, appeared on behalf of [redacted], the Respondent Medicaid Health Plan ("MHP).

ISSUE

Did the MHP properly deny 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. Appellant was born on [redacted] and was [redacted] years-old at the time of the hearing. (Respondent's Exhibit A, page 4).

2. Appellant has been diagnosed with Apraxia, NOS; a peanut allergy; Developmental Disorder, NOS; Attention Deficit Disorder with Hyperactivity; and weight loss. (Respondent's Exhibit A, pages 4, 6, 9, 11).

3. Appellant has been receiving speech therapy services through his school. (Testimony of Appellant's representative).

4. On or about [redacted], the MHP received a request made on behalf of Appellant for speech therapy services through the MHP. The request also included copies of some of Appellant's medical records. (Respondent's Exhibit A, pages 3-21).

5. On [redacted], the MHP sent Appellant written notice that the request for speech therapy services was denied. (Respondent's Exhibit A, pages 22-23).

6. Regarding the denial, the notice provided:

> Based on the information provided, we are unable to approve the request.
>
> This decision is based on Medical Director review of available information, Priority Health's Medical Policy No. 91336-RS Speech Therapy and your Certificate of Coverage, Section 5, Schedule of Covered Services, 35, Short Term Rehabilitative Therapy, letter d. This policy and certificate state speech therapy is not covered if the services can be provided by any federal or state agency or by any local political subdivision, including school districts, when a member is not liable for costs in the absence of insurance.
>
> Information reviewed shows speech therapy is available in the school district. Therefore, Priority Health is unable to approve your request. Our coverage criterion has been shared with your primary care physician.
>
> An internal rule, guideline, protocol or other similar criterion was relied upon in making this adverse determination. A copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request.
>
> This adverse determination was based on a medical necessity determination, experimental treatment or similar exclusion or limit. An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, will be provided to you free of charge upon request.

Respondent's Exhibit A, page 22

7. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed on behalf of Appellant in this case. (Petitioner's Exhibit 1, page 1; Respondent's Exhibit A, page 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.

In 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 is in one of those Medicaid Health Plans.

The Respondent is one of those MHPs. With respect to such MHPs, their contract with the Michigan Department of Community Health ("MDCH" or "Department") provides:

> 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

Section 1.022(E)(1), Covered Services.
MDCH contract (Contract) with the Medicaid Health Plans,
October 1, 2009.

The applicable contract also provides:

(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,* p. 49

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 section of the Michigan Medicaid Provider Manual (MPM) states:

> **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.

Department of Community Health,
Medicaid Provider Manual, Outpatient Therapy Section
Version Date: April 1, 2013, pages 18-20.

Here, the MHP's witness first noted that speech therapy for the condition of apraxia is expressly excluded under the MHP's policy. However, as that policy must be consistent with the MPM, she also addressed the policy of the MPM. The MHP's witness explained that the requested speech therapy services were denied based upon the Medicaid Provider Manual policy that does not allow for coverage to treat delays in development, habilitative treatment, or educational purposes. Developmental delays in this context only means not developing at the age appropriate levels they should be. Similarly, habilitative speech therapy involves learning a skill for the first time. Speech therapy for such purposes, among others, is required to be provided by the school, or due to developmental delay. (Testimony of [redacted]).

The MHP's witness also testified that, 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. Under the Medicaid subscriber contract, covered speech therapy is a short-term rehabilitation benefit. Rehabilitation means restoring a skill level back to the original state prior to the injury or illness. (Testimony of [redacted]).

Appellant bears the burden of proving by a preponderance of the evidence that the MHP erred in denying that request. Here, Appellant has failed to meet that burden.

Appellant's mother/representative testified that Appellant's problems with speech are related to his apraxia, which she asserts is a neurological disorder, and not to any developmental delay. She also testified that the school's speech therapist is not trained to treat apraxia and that Appellant needs someone trained in that area. She further notes that Appellant has trouble communicating and is incoherent because of his disorder, but that, with the proper therapy, Appellant's speech issues may be improved or resolved. (Testimony of Appellant's representative).

However, 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.

Based upon available evidence, the requested therapy services are for habilitative, developmental and educational purposes. Given the Appellant's age, it is understandably difficult to establish the requested speech therapy services are addressing skills he has lost rather than skills he is learning for the first time, but Appellant's medical records simply fail to reflect Appellant's representative's testimony or justify an approval of speech therapy services by the MHP.

The medical records in this case relate speech therapy specifically to Appellant's apraxia rather than his developmental disorder, NOS, but fail to fully describe Appellant's issues with speech or the reasons for the speech therapy. At most, they provide that his school speech therapist, who has seen Appellant since at least [redacted], is worried about Appellant's palate and tonsils. It is also noted that Appellant has made progress with his speech therapy, but is not up to the level of his peers. (Respondent's Exhibit A, page 21).

Those records fail to suggest any rehabilitative goals of speech therapy or that the speech therapy is, as required by the MPM, even expected to result in an improvement and/or elimination of the stated problem within a reasonable amount of time. Instead, to the extent the records demonstrate anything at all, it is that Appellant has long-term problems with speech and is not developing at the age appropriate levels he should be.

Moreover, it further appears that the Appellant is receiving some speech therapy services through his school district and, to the extent such services are inadequate, Appellant's representative must address that issue with the school.

With respect to the issue before this Administrative Law Judge, Appellant has failed to meet his burden of proving that the MHP erred in denying the request for speech therapy. The MHP's denial of this prior authorization request for speech therapy services was consistent with the Medicaid policy and proper in this case.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is **AFFIRMED**.

Steven Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[redacted]

Date Signed: 8/9/2013

Date Mailed: 8/9/2013

cc: [redacted]

***** 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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.