

**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. 2013-56127 CMH
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.* and upon a request for a hearing filed on behalf of the Appellant/Petitioner.

After due notice, a hearing was held on _____, Appellant's adoptive mother and legal guardian, appeared and testified on Appellant's behalf. _____, a representative from _____; _____, a representative from _____, LLC; and _____, Appellant's Occupational Therapist; also testified as witnesses for Appellant. _____, Fair Hearings Officer, appeared and testified on behalf of _____ Community Mental Health ("_____ " or "CMH"). _____, a registered nurse/unit manager at _____, also testified as a witness for the CMH.

ISSUE

Did _____ properly deny Appellant's request for 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. Appellant is a _____ year-old Medicaid beneficiary who has been diagnosed with cerebral palsy, scoliosis, seizures, and osteoporosis. (Respondent's Exhibit 1, pages 1, 3).
2. _____ is under contract with the Michigan Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in its service area.
3. Appellant has been receiving services through _____, including two (2) hours a day of Community Living Supports (CLS). (Testimony of _____).

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4. Those two hours of CLS each day includes thirty (30) minutes of assistance with range of motion (ROM) exercises. (Testimony of Smith).
5. Through _____, Appellant was also approved for occupational therapy (OT) services for thirty (30) minutes each month. Appellant's occupational therapist would come to Appellant's home once a month. (Testimony of _____; Testimony of F _____).
6. The therapist was responsible for developing a treatment plan, teaching the CLS workers any necessary techniques, and reviewing Appellant's progress. If necessary, the therapist would change the treatment plan. (Respondent's Exhibit A, pages 17-21).
7. The therapist did not provide any direct or hands-on OT. Instead, she merely oversaw the ROM exercises performed by the CLS staff. (Testimony of _____; Testimony of _____).
8. Between _____ and _____, the progress notes entered by Appellant's occupational therapist all indicated that Appellant had met her specific objectives and should continue on the plan as written. (Respondent's Exhibit A, pages 17-28).
9. Appellant's guardian subsequently requested that OT services be continued after _____. (Testimony of Appellant's representative).
10. On _____, _____ sent Appellant written notice that the request for OT was denied. The notice also provided that the documentation submitted did not establish medical necessity and that the goals and objectives of Appellant's Individual Plan of Service (IPOS) had been met. (Respondent's Exhibit A, pages 7-9).
11. On _____, the Michigan Administrative Hearing System (MAHS) received a Request for Hearing filed on behalf of Appellant. (Respondent's Exhibit A, page 11).
12. The hearing in Appellant's case was held on _____.
13. During that hearing, the representative for _____ stated that Appellant's OT services would be reinstated while the appeal was pending. (Testimony of _____).

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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.

42 CFR 430.10

Moreover, 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...

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42 U.S.C. § 1396n(b)

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.

contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department. Among the services that may provide is occupational therapy (OT).

With respect to OT, the applicable version of the Medicaid Provider Manual (MPM) states:

3.18 OCCUPATIONAL THERAPY

Evaluation

Physician-prescribed activities provided by an occupational therapist licensed 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 licensed 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

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therapist or occupational therapy assistant, licensed 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.

*MPM, April 1, 2013 version
Mental Health/Substance Abuse Chapter, pages 19-20*

However, Medicaid beneficiaries are only entitled to medically necessary 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. The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. See 42 CFR 440.230. With respect to medical necessity, the MPM provides:

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

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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;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;

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- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- 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;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- 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.

*MPM, April 1, 2013 version
Mental Health/Substance Abuse Chapter, pages 12-13*

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Here, Respondent denied Appellant's request for OT on the basis that the documentation submitted did not establish medical necessity and that the goals and objectives of Appellant's Individual Plan of Service (IPOS) had been met.

Appellant bears the burden of proving by a preponderance of the evidence that Respondent erred in denying her request. Given the evidence in this case, Appellant has failed to meet that burden of proof and the denial must be affirmed.

As discussed above, Appellant was initially approved for OT for thirty minutes a month through [redacted]. However, that limited OT was only for planning and supervision. The therapist was responsible for developing a treatment plan, teaching the CLS workers any necessary techniques, and reviewing Appellant's progress. The therapist did not provide any hands-on OT and, instead, merely oversaw the ROM exercises performed by the CLS staff in the time allocated for such exercises as part of Appellant's CLS.

If necessary, the therapist was to change the treatment plan. However, that was not necessary in this case and the progress notes entered by Appellant's occupational therapist all indicate that Appellant has met her specific objectives and should continue with the same exercises. Moreover, pursuant to the plan, Appellant's CLS workers and family have been trained to provide the necessary ROM exercises. Assistance with those exercises continues to be approved by [redacted]. Given the success of the plan, both in meeting goals and training staff and family to provide assistance with exercises, [redacted] found that the limited OT was no longer necessary and denied Appellant's request for more OT.

In response, Appellant's guardian and witnesses testified that the agency hired to provide Appellant with CLS is unwilling to continue to assist her with ROM exercises without the supervision of the occupational therapist. However, they failed to explain why the CLS cannot to provide the same assistance or why the limited supervision by the therapist is necessary. The assistance being provided is not skilled OT and the CLS workers have already been trained in how to assist in the exercises. Moreover, given that the therapist was only present for thirty minutes a month, it is undisputed that the CLS workers were already providing the assistance almost every single day without supervision.

Appellant's occupational therapist also testified that she had intended to change Appellant's treatment plan and that her skills and supervision are still necessary. However, the progress notes that she entered and that were relied upon by Respondent failed to indicate any forthcoming changes or need for supervision by a skilled therapist.

Given the above evidence and policies, Appellant has failed to meet her burden of proving by a preponderance of the evidence that Respondent erred in denying her request for OT. Accordingly, that decision must be sustained.

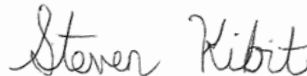
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DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

Respondent's decision is **AFFIRMED**.



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

Date Signed: 9/11/2013

Date Mailed: 9/11/2013

cc:

***** 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.