

**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. 2013-56632 QHP

██████████,

██████████ ██████████

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 ██████████ Appellant's mother, appeared and testified on Appellant's behalf. ██████████ represented ██████████, the Respondent Medicaid Health Plan ("MHP"). ██████████, the MHP's Medical Director, testified as a witness on behalf of the 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 is a ██████-year-old Medicaid beneficiary whose date of birth is ██████████. (Respondent's Exhibit C).
2. Appellant has been diagnosed with "Other Symbolic Dysfunction Other", Other Speech Disturbance, and Congenital Hemiplegia. (Respondent's Exhibit C).
3. On or about ██████████ the MHP received a request made on behalf of Appellant for ██████ speech therapy visits through the MHP for the period of ██████████ through ██████████ and some of Appellant's medical records were included. (Respondent's Exhibit C).

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4. On [REDACTED], the MHP sent Appellant written notice that the request for speech therapy services was denied for the following pertinent reasons:

Speech therapy related to a developmental delay is covered by the state (School Based Services). It is not covered by the Health plan. We did not see that your speech problems resulted from recent trauma. We did not see that your speech problems resulted from an accident. We did not see that your speech problems resulted from a stroke. Your problem is considered a developmental delay.

United Healthcare Community Plan uses MCG 17th Edition, which is nationally recognized criteria, as well as Michigan Association of Health Plans Bariatric Guidelines, Michigan Medicaid coverage guidelines, and/or benefit interpretation criteria that are internally developed...

You may request an expedited appeal if you believe that the denied care or services could cause potential harm to the member's life or health...

Respondent's Exhibit A

5. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed on 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.

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.

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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

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- 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/EPSTD 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

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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

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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

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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.*

In this case, the MHP's representative provided evidence to establish that Appellant did not meet the MHP's guidelines for the ■ sessions of speech therapy requested. The MHP's Medical Director testified that speech therapy is not covered for developmental delays. The MHP's evidence of coverage guidelines state that "covered outpatient services include dialysis, chemotherapy, outpatient surgery and associated anesthesia services, diagnostic laboratory, diagnostic and therapeutic radiological services, short-term rehabilitative therapy, and other services delivered by Health Professionals." Short-term rehabilitative therapy limited to physical therapy for speech may be covered under certain conditions. "Short-term" is defined as a condition which is subject to a significant improvement in a relatively limited and predictable period.

As it says in the above Department-MHP contract language, an MHP may limit services as long as the limitations are consistent with applicable Medicaid provider manuals. The MHP's Medical Director 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. Speech therapy for such purposes is required to be provided by the school.

Appellant bears the burden of proving by a preponderance of the evidence that the MHP erred in denying her request. Appellant's mother/representative testified that

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Appellant has a speech delay, and she wants her daughter to catch up. In the hearing request, Appellant's mother stated that Appellant's difficulties are not just developmental in nature, Appellant has medical problems, congenital hemiplegia, which affects the right side of Appellant's brain, and although it is not a result of a trauma, it is a disorder.

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 pre-morbid 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 and developmental purposes. The evidence provided on Appellant's behalf fails to establish that the requested speech therapy services are to address skills Appellant has lost rather than skills she is learning for the first time.

In conclusion, the MHP's denial was proper. The MHP established that the speech therapy services request submitted on behalf of Appellant is not a covered benefit under the MHP's Evidence of Coverage Guidelines, which is consistent with Medicaid policy.

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**.

/s/

Marya A. Nelson-Davis
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

MAND/db

cc: [REDACTED]

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***** 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.