

**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:

██████████

Appellant

Docket No. 2013-57810 PA

██████████

**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 begun on ██████████ and was adjourned to attempt to obtain more legible copies of some of the Department's proposed exhibits. The hearing was completed on ██████████. The Appellant was represented by ██████████ mother. ██████████ Appeals Review Officer, represented the Department. ██████████ Consultant Reviewer, appeared as a witness for the Department.

**ISSUE**

Did the Department properly deny the 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. The Appellant is a ██████ year-old Medicaid beneficiary. (Exhibit 1, page 16)
2. On ██████████ the Department received a request for continuing occupational therapy services for the Appellant from the therapy provider for the months of ██████████ and J ██████████ (Exhibit 1, pages 14-16)
3. On ██████████ the Department sent a request for additional information to the therapy provider. This letter requested the prior authorization request be re-submitted with a physiatrist evaluation. A copy was also sent to the parent or Guardian of the Appellant. (Exhibit 1, pages 18-22)

4. On ██████████ the Department received a request for occupational therapy services for the Appellant from the therapy provider. This request was marked as initial treatment and the requested months were ██████████ and ██████████ (Exhibit 1, pages 23-37)
5. The Appellant's prior authorization request was reviewed by the Department's team, including a physician and an occupational therapist. The Department determined the prior authorization request should be denied because the stated goals are not medical, the stated goals do not meet policy guidelines, the long term goals are for a home exercise program, and no treatment goals were included. (Exhibit 1, pages 43-44)
6. On ██████████ the Department sent the Appellant notice that the ██████████ request for occupational therapy services was denied because the stated goals do not meet policy guidelines and are not medical. A copy of the notice was also sent to the therapy provider. (Exhibit 1, pages 39-42)
7. On ██████████ the Michigan Administrative Hearing System received the Request for Hearing submitted on the Appellant's behalf. (Exhibit 1, page 11)

## **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 Department policy regarding outpatient occupational therapy can be found in the Outpatient Therapy section of the Medicaid Provider Manual:

### **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 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 OTs and OTAs 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 [PT], 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 to provide Medicare-covered therapy and bill Medicaid only for Medicare coinsurance and/or deductible.

#### **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.

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### **Treatment Plan**

The OT treatment plan that results from the evaluation must consist of the following:

- Time-related short-term goals that are measurable, functional, and significant to the beneficiary's life goals;
- Long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from therapy;
- Anticipated frequency and duration of treatment required to meet short- and long term goals;
- Plan for discharge from service, including the development of follow-up activities/maintenance programs;

- A statement detailing coordination of services with other therapies (e.g., medical and educational); and
- Physician signature verifying acceptance of the treatment plan.

CSHCS beneficiaries must have a treatment plan signed by the referring specialty physician.

### **Initiation of Services**

OT may be initiated without PA upon completion of the assessment and development of a treatment plan that is reasonable and medically necessary as documented in the patient record. The outpatient setting allows up to 144 units of OT services provided in the initial 12-month treatment period. If therapy is not initiated within 30 days of the prescription date, a new prescription is required.

PA is not required for the initial period of skilled therapy for the first 12 consecutive calendar months in the outpatient setting for a new treatment diagnosis or new medical diagnosis if:

- The beneficiary remains Medicaid-eligible during the period therapy is provided.
- A copy of the physician's signed and dated (within 30 days of initiation of services) prescription for OT is on file in the beneficiary's medical record.

Providers may initiate services without PA when there is a change in the treatment diagnosis and/or medical diagnosis resulting in decreased functional ability.

OT must be provided by the evaluating discipline. (Example: A speech-language pathologist cannot provide treatment under an occupational therapist's evaluation.) Cosigning of evaluations and sharing treatments require PA.

MDCH does not cover the service when Medicare determines that the service is not medically necessary.

### **Requirements of Continued Therapy**

The OT must request PA to continue therapy beyond the initial 12 months. When requesting PA, providers must complete the MSA-115. MDCH returns a copy of the PA to the provider, and it must be retained in the beneficiary's medical record.

Requests to continue active therapy must be supported by the following:

- Treatment summary of previous OT period, including measurable progress on each short- and long-term goal. This must include the treating OT's analysis of the therapy provided during the previous month, rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes.
- Progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy.
- Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested.
- Statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
- Statement detailing coordination of services with other therapies (e.g., medical and educational) if appropriate.
- A copy of the prescription must be provided with each request. The prescription must be hand-signed by the referring physician and dated within 30 days prior to initiation of the continued service.
- A discharge plan.

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When a beneficiary completes 144 units of initial therapy and then chooses to change providers for continued therapy, prior authorization for the continued therapy is required.

*Department of Community Health,  
Medicaid Provider Manual, Outpatient Therapy Section  
Version Date: April 1, 2013, Pages 7-12.*

In response to the [REDACTED] prior authorization request for continuing occupational therapy services for the Appellant, the Department sent a request for additional information to the therapy provider on [REDACTED]. This letter requested the prior authorization request be re-submitted with a physiatrist evaluation. A copy was also sent to the parent or Guardian of the Appellant. (Exhibit 1, pages 18-22) The Department did not receive any further prior authorization requests for occupational therapy for the Appellant until the [REDACTED] prior authorization for initial treatment for the months of [REDACTED] and [REDACTED] (Exhibit 1, pages 25-37; Consultant Reviewer Testimony)

The Appellant's [REDACTED] prior authorization request was reviewed by the Department's team, which included a physician and an occupational therapist. The Department determined the prior authorization request should be denied because the stated goals are not medical, the stated goals do not meet policy guidelines, the long term goals are for a home exercise program, and no treatment goals were included. (Exhibit 1, pages 43-44) The Consultant Reviewer explained that the Medicaid Provider Manual Policy requires treatment goals that are medical in nature for covered occupational therapy services. The listed goals were not medically oriented and do not allow for coverage of the requested occupational therapy services. For example, the occupational therapy for goals that could be treated by a teacher or school therapist would be not be covered and would be the responsibility of another public agency to provide for school age beneficiaries. Further, some objective measures, such as grip strength and several of the range of motion areas, were not tested according to the information provided with this prior authorization request. Accordingly, they could not be utilized as a baseline and re-tested to determine an objective measureable outcome. The Consultant Reviewer described covered occupational therapy as being short term burst therapy. Services may be covered for [REDACTED] to [REDACTED] months then the individual would be discharged when those goals are met. There may be another need for services for that individual again in the future, which could be covered if the policy criteria are met at that time. The covered occupational therapy services are not ongoing for [REDACTED] to [REDACTED] years at a time. For the [REDACTED] prior authorization request, the listed goals did not appear to be medically related or have an objective measurable baseline and outcome. The Consultant Reviewer did not dispute that the Appellant has needs for occupational therapy. Rather, the Department asserts the based on the goals provided with the [REDACTED] prior authorization request, the Appellant did not qualify for the occupational therapy to be covered under the Medicaid Provider Manual policy. (Consultant Reviewer Testimony; Exhibit 1, pages 23-28)

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The Appellant's mother disagrees with the denial and testified that the goals were not really written differently than they had been in the past. The Appellant has worked on goals in the past and demonstrated progress. The Appellant's mother was understandably upset that the Appellant, who has chronic issues, has not been getting therapy she needs since ██████████. The Appellant went to a physiatrist in ██████████ who also indicated the Appellant needs occupational therapy. The Appellant's mother has found other therapy services for the Appellant that she is paying for, despite being unemployed. The Appellant's mother testified the occupational therapy services are medically necessary for the Appellant, and this should have been reviewed and remedied a long time ago. (Mother Testimony)

This hearing process cannot address the reason for the delay between the ██████████ request for additional information and the next prior authorization request that was submitted on ██████████. During that time period there was no pending prior authorization request for the Department to consider. Accordingly, the denial of occupational therapy services at issue for the ██████████ hearing request is the ██████████ notice denying the Appellant's ██████████ prior authorization request for initial occupational therapy treatment for the months of ██████████ and ██████████.

While this ALJ sympathizes with the Appellant's circumstances, the information provided for the ██████████ prior authorization request does not support coverage of the requested speech therapy services. The above cited Medicaid policy states that occupational therapy is not covered in several circumstances, including: if services are required to be provided by another public agency (e.g. community mental health services provider, school-based services); for educational, vocational, or recreational purposes; and continuation of therapy that is maintenance in nature. The stated goals did not meet policy criteria and were not clearly medical goals. Example include the second listed goal related to preparing to play t-ball during the summer and several of the goals relating to increasing upper extremity range of motion when many aspects of upper extremity range of motion were not tested. (Exhibit 1, pages 23 and 26) The Department's denial of this prior authorization request was consistent with the Medicaid policy and must be upheld.

If she has not already done so, the Appellant may wish to have a new prior authorization request and supporting documentation submitted for occupational therapy services.

**DECISION AND ORDER**

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

  
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**IT IS THEREFORE ORDERED** that:

The Department's decision is **AFFIRMED**.

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

Date Signed: 

Date Mailed: 

CL/db

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.