STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 14-012350 PAC

[redacted] [redacted] [redacted]

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 Appellant's behalf. [redacted] Appeals Review Officer, represented the Department of Community Health. [redacted], Manager of the Department's Program Review Division, testified as a witness for the Department.

ISSUE

Did the Department properly deny Appellant's requests for in-home speech therapy (ST), occupational therapy (OT), and physical therapy (PT)?

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 two year-old Medicaid beneficiary. (Respondent's Exhibit A, page 9; Testimony of [redacted].

2. On or about [redacted], the Department received prior authorization requests submitted on Appellant's behalf and requesting ST, OT and PT in Appellant's home. (Respondent's Exhibit A, pages 9-25; Testimony of Appellant's representative; Testimony of [redacted]

3. Those requests indicated that Appellant was born premature and has been diagnosed with dysphagia, tracheostomy, and chronic respiratory disease. (Respondent's Exhibit A, page 9; Testimony of [redacted]

4. They also indicated that Appellant is on a ventilator while sleeping and has received in-home ST, OT and PT in the past. (Respondent's Exhibit A, page 10; Testimony of [redacted].

5. The requests further stated that Appellant is homebound and should continue with home care therapy, as opposed to outpatient therapy, due to his weakened immune system and the fact that going out of the home would introduce him to more germs and viruses, as well as Appellant's decreased endurance. (Respondent's Exhibit A, page 10; Testimony of [redacted]

6. On [redacted], the Department sent written notices that the prior authorization requests had been denied. (Respondent's Exhibit A, pages 6-7; Respondent's Exhibit B, page 1).

7. The Department was willing to approve outpatient ST, OT and PT (Testimony of [redacted]), but it denied the request for in-home therapies on the basis that the "documentation submitted does not support the medical need for therapy in the home versus in an outpatient setting." (Respondent's Exhibit A, pages 6-7; Respondent's Exhibit B, page 1).

8. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed on Appellant's behalf in this matter. (Respondent's Exhibit A, pages 4-5).

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.

Medicaid covered benefits are addressed for the practitioners and beneficiaries in the Medicaid Provider Manual (MPM) and, with respect to Home Health benefits, the applicable version of the MPM states in part:

SECTION 1 – GENERAL INFORMATION

This chapter applies to Home Health providers.

Home health is a covered Medicaid benefit for beneficiaries whose conditions do not require continuous medical/nursing and related care, but do require health services on an intermittent basis in the home setting for the treatment of an injury, illness, or disability. Medicaid covered services may

be provided in the home only if circumstances, conditions, or situations exist which prevent the beneficiary from being served in a physician's office or other outpatient setting. Except as detailed in this chapter, the beneficiary's primary need must be for nursing care and/or physical therapy, rather than personal care or physician's care.

A Home Health Agency (HHA) is an organization that provides home care services, such as skilled nursing care, physical therapy (PT), occupational therapy (OT), speech therapy (ST) and care by home health aides. The HHA must be Medicare certified to enroll as a Medicaid provider and must comply with the Medicare/Medicaid Conditions of Participation (42 CFR § 484) and the policies outlined in this manual.

Services solely to prevent an illness, injury or disability are only covered for women/newborns following delivery. For postpartum/newborn follow-up nurse visits, a nursing diagnosis can be used to establish medical necessity. Otherwise, a medical diagnosis is required to establish medical necessity. Medicaid beneficiaries are expected to be an active participant in the planning for their home health care. For beneficiaries enrolled in a Medicaid Health Plan (MHP), the HHA must contact that health plan for authorization to provide services to their members.

Medicaid home health services must be ordered, in writing, by the beneficiary's attending physician (MD, DO) as part of a written plan of care (POC) and reviewed by this physician every 60 days. The physician's order and POC must be only for functions that are within the scope of his current medical practice and Medicaid guidelines.

This chapter includes information about services covered for Medicaid and Children's Special Health Care Services (CSHCS) beneficiaries unless otherwise noted.

* * *

SECTION 2 – HOME SETTING [CHANGE MADE 7/1/14]

Home health services are intended for beneficiaries who are unable to access services (nursing, OT, PT, speech and language pathology therapy [ST]) in an outpatient setting. However, it is not required that beneficiaries be totally

restricted to their home. A determination and documentation is required by the HHA that the home is the most appropriate setting in which to provide the service(s). Home health services are **not** provided solely on the basis of convenience.

All covered home health services must be rendered in a beneficiary's home, except for those services listed below. Home may be the beneficiary's owned/rented home, an apartment, Assisted Living Facility, Adult Foster Care (AFC) facility, or home of another family member (secondary residence of the beneficiary, i.e., joint custody situation for a minor child).

- Home Health aide services are not a covered benefit for beneficiaries who reside in a Home for the Aged (HFA) or Adult Foster Care (AFC) facility as this would be duplication of personal care services already provided by staff of these facilities.

- MDCH does not cover any Home Health services rendered to a beneficiary in a hospital, nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), **(revised 7/1/14)** Intermediate Care Facility for the Mentally Ill (ICF/MI), school or adult day care.

To determine if services in the home, rather than in an outpatient setting, are most appropriate, consider the following:

- Is in-home care necessary for the adaptation, training or teaching of nursing or treatment procedures, plans, equipment, appliances or prosthetics in the home setting?

- Is in-home care necessary to prevent undue exposure to infection and/or stress for the beneficiary as identified and documented by a health care professional?

- Is leaving the home medically contraindicated, as identified and documented by a health care professional?

- Is in-home care necessary to prevent a documented problem with access to services, continuity of care or provider, or coordination of services, as documented by a health care professional?

- Is in-home care the most cost-effective method to provide care?

Services must be appropriate and necessary for the treatment of an identified illness, injury or disability. The services provided must be consistent with the nature and severity of the beneficiary's illness, injury or disability, his particular medical needs and accepted standards of medical practice. Beneficiaries with established frail conditions may need assessments by skilled nurses to prevent further decline of the frail condition.

MPM, July 1, 2014 version
Home Health Chapter, pages 1, 4

As testified by the Department's witness, the Department denied the prior authorization requests for in-home ST, OT and PT in this case pursuant to the above policies. Specifically, the Department's witness testified that, while the therapies themselves are medically necessary and would be approved in an outpatient setting, the documentation received by the Department does not demonstrate a medical need for therapy in the home as opposed to in an outpatient setting.

Appellant's representative bears the burden of proving by a preponderance of the evidence that the Department erred in denying the prior authorization requests. Moreover, in reviewing the Department's decisions, the undersigned Administrative Law Judge is limited to reviewing the decisions in light of the information available at the time they were made.

Here, given the contents of the prior authorization requests and the attached documentation, Appellant's representative has failed to meet her burden of proving that the Department erred. While the requests and documentation all broadly state that Appellant is homebound, has a weakened immune system, and should receive home therapies in order to avoid exposing him to germs and viruses, there is no specific evidence supporting those broad statements. Nor is a diagnosis of chronic respiratory disease sufficient on its own to demonstrate a need for home therapies.

The above policy does not require that a beneficiary be totally restricted to his home to receive in-home services, but it does require specific evidence and documentation regarding the circumstances, conditions, or situations which prevent the beneficiary from being served in a physician's office or other outpatient setting. No such specific

evidence was submitted to the Department in this case and it therefore properly denied Appellant's requests.

To the extent Appellant's representative has additional or updated information regarding Appellant's medical conditions or the need in-home therapies, she and the service provider are free to resubmit the prior authorization requests, along with all the relevant documents and information. With respect to the decisions at issue in this case, however, the Department's actions must be affirmed given the available information.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Appellant's requests for in-home speech therapy (ST), occupational therapy (OT), and physical therapy (PT).

IT IS THEREFORE ORDERED THAT:

The Department's decisions are **AFFIRMED**.

Steven Kibit

Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

SJK/db

cc: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System for the Department of Community Health 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 for the Department of Community Health 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.