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. 14-012442 QHP
Case No. [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]. [redacted], Appellant's mother, appeared on behalf of Appellant.

Attorney [redacted], Senior Staff Attorney, represented [redacted], the Respondent Medicaid Health Plan ("MHP"). [redacted], Member Satisfaction Coordinator, appeared as a witness for 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 [redacted] year-old beneficiary of Medicaid whose date of birth is [redacted].

2. Appellant is a member of the MHP.

3. On [redacted] Appellant's primary care physician requested 1 evaluation and 12 speech therapy sessions.

4. On [redacted], the MHP sent Appellant's mother and Appellant's physician written notice that the request for speech therapy services was denied on the grounds that the member did not meet medical necessity criteria for coverage of ST, as the medical documentation did not support the medical necessity to treat an illness, injury, or birth defect affecting the muscles of the throat or mouth, that the

requested services appears habilitative in nature. Exhibit C

5. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed on behalf of Appellant in this case stating that her son is only [redacted] years old and the school system is years away. (Exhibit A)

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 Michigan Department of Community Health ("MDCH" or "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 one of those MHPs and, as provided in the Medicaid Provider Manual (MPM), is responsible for providing covered services pursuant to its contract with the Department:

> The Michigan Department of Community Health (MDCH) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDCH website. (Refer to the Directory Appendix for website information.) MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The

> following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.
>
> *MPM, October 1, 2013 version*
> *Medicaid Health Plan Chapter, page 1*
> *(Underline added by ALJ)*

Here, the MHP did not submit its contract with the Department. However, the DCH standard contract language applicable to subcontracting MHPs' as laid out on the State of Michigan MDCH website states in part:

> 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, but may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of an enrollee.
>
> * * *
>
> 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:
>
> * * *
>
> - 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.
>
> *Section 1.022(E)(1), Covered Services.*
> *MDCH contract (Contract) with the Medicaid Health Plans, FY 2013*

Moreover, as it was allowed to by MPM policy and its contract, the MHP has developed management and review criteria for prior authorization requests. With respect to Speech-language pathology services, that utilization management criteria follows the above contractual language and states that the services must be related to member's condition and that the services are not covered for educational, vocational, recreational, or habilitative purposes. The criteria also provides that services are non-covered where they are required to be provided by another public agency, such as a community mental health services provider or a school district.

A MHP must operate consistent with all applicable MPM and publications for coverages and, in this case, the utilization management criteria also tracks the limitations found in the MPM itself:

> **1.2 SERVICES EXCLUDED FROM MHP COVERAGE BUT COVERED BY MEDICAID**
>
> * * *
>
> ▪Services provided to persons with developmental disabilities and billed through the Community Mental Health Services Program (CMHSP)
>
> ▪Services provided by a school district and billed through the Intermediate School District
>
> *MPM, October 1, 2013 version*
> *Medicaid Health Plans Chapter, pages 2-3*:
>
> **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.
>
> *MPM, October 1, 2013 version,*
> *Outpatient Therapy Chapter, pages 18-20.*

Here, the MHP's witness explained that the requested speech therapy services were denied based upon the above policy, which 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.

The MHP's witness also testified that covered therapy services through the MHP are only 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.

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.

Here the Appellant stated that she is not aware that her child has any birth defect, but rather, was concerned that her child had not developed a sufficient vocabulary. The facts in this case do not support finding that the criteria and policy established the MDCH fall under the MPM requirements for speech therapy found at Section 5.3. Thus, the Department must be upheld

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 services.

IT IS THEREFORE ORDERED that:

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

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

JS/[redacted]

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.