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. 14-005412 PA
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 minor Appellant.

After due notice, a hearing was held on . , Appellant's mother, appeared and testified on Appellant's behalf. , Appellant's father, also testified as a witness for Appellant. , Appeals Review Officer, represented the Department of Community Health. , Consultant Reviewer, testified as a witness for the Department.

ISSUE

Did the Department properly deny Appellant's prior authorization request for occupational therapy (OT)?

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. (Respondent's Exhibit A, page 9).

2. On or about , the Department received a prior authorization request and supporting documentation filed on Appellant's behalf and requesting a continuation of OT for Appellant. (Respondent's Exhibit A, pages 9-15).

3. Specifically, the request asked for neuromuscular reeducation; therapeutic exercises; self-care management training; and therapeutic activities. (Respondent's Exhibit A, page 9).

4. The request also noted that Appellant had been diagnosed with a muscle/ligament disorder, not otherwise specified, and that he had received 56 sessions of OT since [redacted]. (Respondent's Exhibit A, page 9).

5. Regarding Appellant's progress, the request stated:

> Patient has made steady gains in goal areas with increased participation and endurance in age appropriate motor skill tasks. Good carry over of home program assists with his progress. He is cooperative and has consistent attendance at scheduled sessions. He demonstrates Good [sic] potential to make functional gains.

Respondent's Exhibit A, page 9

6. Additionally, the request identified various short term goals relating to the completion of certain exercises and tasks and long term goals relating to improvement in the areas of motor proficiency, visual motor skills, processing inputs and coordination. (Respondent's Exhibit A, page 9).

7. On [redacted], the Department sent Appellant's parents written notice that the request for OT was denied. (Respondent's Exhibit A, pages 7-8).

8. Specifically, that notice of denial stated:

> The policy this denial is based on is Sections 5.1, 5.1.A, 5.1.B and 5.1.F of the Outpatient Therapy chapter of the Medicaid Provider Manual, which indicates:
>
> - Goals are beyond the scope of published policy.
> - Goals must be skilled/medical.
> - Goals can be implemented by an individual not specific to an outpatient medical facility.

Respondent's Exhibit A, page 7

9. On [redacted], the Michigan Administrative Hearing System received the request for hearing filed on Appellant's behalf in this case. (Respondent's Exhibit A, page 4).

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:

> **SECTION 5 – STANDARDS OF COVERAGE AND SERVICE LIMITATIONS**
>
> **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.

5.1.C. AQUATIC THERAPY

Medicaid does not cover aquatic therapy as a separately reimbursable treatment or modality. A covered therapeutic procedure performed in a pool would be reimbursed when billed using the HCPCS code describing the covered procedure as long as the service met all Medicaid coverage requirements.

5.1.D. GROUP THERAPY

OT is not covered by Medicaid when provided concurrently to a group of two or more individuals by the same therapist. Covered therapeutic procedures require direct (one - to-one) patient contact by the therapist.

5.1.E. SERIAL CASTING

Serial casting is a process in which a joint(s) which normally lacks full range of motion, is immobilized with a rigid cast. During this procedure, the affected joint(s) is gradually and repeatedly set in more anatomically correct alignment to improve joint alignment and/or to achieve a decrease in abnormal tone and increased muscle length, resulting in an increase in the range of motion.

Casts are applied and removed in succession, usually every week, over a specified period of time. Upon removal of each cast, the limb is stretched and a new cast is applied immediately to hold the limb in place.

Serial casting is a covered Medicaid/CSHCS benefit when performed by or under the direct supervision of a qualified therapist and defined in a treatment plan as medically necessary rehabilitation services for improving range of motion and/or reducing abnormal tone. Either the physician referral for therapy services must specifically indicate that the beneficiary is being referred for serial casting, or the referring physician must provide written concurrence of any treatment plan, including serial casting. For CSHCS beneficiaries without dual Medicaid eligibility, the service must be directly related to the CSHCS-eligible diagnosis and must be referred by the beneficiary's assigned pediatric subspecialist.

5.1.F. PRESCRIPTION REQUIREMENTS

MDCH requires a physician's prescription for an OT evaluation and preparation of the treatment plan. The prescription must include beneficiary name, prescribed therapy, and diagnosis(es) or medical conditions(s). MDCH requires a new prescription if OT is not initiated within 30 days of the prescription date. An evaluation may be provided for the same medical diagnosis without PA twice in a 365-day period with a physician's prescription. PA is required if an evaluation is needed more frequently.

Evaluations	Evaluations must include standardized tests and/or measurable functional baselines. OT evaluations must be completed by an OT and include the following: ▪ Treatment diagnosis and medical diagnosis, if different from the treatment diagnosis(es) (e.g., medical diagnosis of cerebral palsy with contractures being treated);

	▪ OT provided previously, including facility/site, dates, duration, and summary of change; ▪ Current therapy being provided to the beneficiary in this or other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ Standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; and ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension).
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. 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.
Maintenance/Monitoring Services	In some cases, the beneficiary does not require active treatment, but the skills of an OT are required for training or monitoring of maintenance programs being carried out by family and/or caregivers, or continued follow-up for the fit and function of orthotic or prosthetic devices. PA is not required for these types of service for up to four times per 90-day period in the outpatient setting. If continued maintenance therapy is needed after the initial period specified in the paragraph above, PA is required. The OT must complete an MSA-115 and include the following: ▪ Service summary, including a description of the skilled services being provided (to include the treating OT'S

	analysis of the rate of progress, and justification for any change in the treatment plan). Documentation must relate to the period immediately prior to that time period for which PA is being requested. ▪ A comprehensive description of the maintenance/activity plan. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (medical and educational) if appropriate. ▪ The anticipated discharge plan. ▪ The anticipated frequency and duration of continued maintenance/monitoring.

MPM, April 1, 2014 version
Outpatient Therapy Chapter, pages 7-12

Here, the Department denied a request made on Appellant's behalf for the continuation of OT for Appellant. As provided in the written notice of denial and the Department's witness' testimony during the hearing, that decision was based on the fact that the goals identified in the prior authorization request were insufficient under the applicable policy to justify an authorization of OT. In particular, the Department's witness testified that the goals are educational, developmental or habilitative in nature, and therefore non-covered, and that none of the goals reflected a need for a skilled occupational therapist or a medical basis for the requested OT.

Appellant's representatives bear the burden of proving by a preponderance of the evidence that the Department erred in deciding to deny the prior authorization request for OT. Moreover, this Administrative Law Judge is limited to reviewing the Department's decision in light of the information it had at the time it made that decision.

In this case, given the information submitted along with the prior authorization request and available to the Department at the time of the decision, Appellant's representatives have failed to meet their burden of proof and the Department's decision must be affirmed. Appellant's representatives appear to concede the Department's position that the prior authorization request and supporting documentation fail to reflect a need for skilled OT, *i.e.* therapy that requires the skills, knowledge and education of an occupational therapist; fail to identify the specific medical basis for the OT; and only identify non-covered educational, developmental, or habilitative goals. Instead, Appellant's representatives argue and testify that the goals in the prior authorization request do not fully describe the need and purpose of the OT and that they relied on their provider to submit the request on Appellant's behalf. However, as discussed above, this Administrative Law Judge is limited to reviewing the Department's decision in light of the information it had at the time it made that decision and the information submitted in this case does not support Appellant's representatives' testimony.

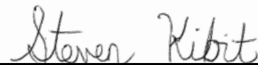
To the extent Appellant's representatives have additional or updated information to provide regarding the request for OT, they are free to have that information submitted to the Department as part of a new prior authorization request. With respect to the denial at issue in this case, however, the MHP's decision must be affirmed given the information available at the time.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED THAT:

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



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

Date Signed:

Date Mailed:

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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 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.