

**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

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Docket No. 2014-24003 PA

██████████

██████████

**DECISION AND ORDER**

This matter is before the undersigned Administrative Law Judge (ALJ) 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 held on ██████████. Attorney ██████████ represented the Appellant. (██████████) Appellant's husband was present for the hearing but did not testify. ██████████, Appeals Review Officer, represented the Department. ██████████ Occupational Therapist and Medicaid Utilization Analyst appeared as a witness for the Department.

**ISSUE**

Did the Department properly deny Appellant's request for Prior Authorization (PA) of a continuation of occupational and speech therapies?

**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, born ██████████. (Exhibit A, pp. 25, 26).
2. The Appellant's nursing facility (████████████████████) sought prior approval requests for a continuation of occupational and speech therapies on ██████████. (Exhibit A, pp. 61-64, 82-84, 86-88).
3. On ██████████, the Department sent written notices to Appellant and the provider stating that Appellant's Prior Authorization requests for a continuation of occupational and speech therapies was being denied for lack of progress and noting therapy was initiated on ██████████. A previous Notice of Denial was sent concerning Appellant's speech

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therapies on [REDACTED] stating that the request was denied as significant progress had not been documented and noting therapy was initiated on [REDACTED]. Appellant was advised of her appeal rights. (Exhibit A, pp. 25, 26, 78-79, 80-81, 85).

4. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received the Appellant's request for hearing (Exhibit 1).

**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 providers and beneficiaries in the Medicaid Provider Manual (MPM). With respect to the responsibilities of a nursing facility to provide nursing care as part of the patient's per diem, the MPM provides in part:

**10.21 NURSING CARE**

Nursing facilities must have nursing staff sufficient to provide nursing and other related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Nursing care includes the responsibility for development, implementation and oversight of a plan of care that remains consistent with on-going observation, assessment and intervention by licensed nurses. The following are examples of custodial and rehabilitative nursing care that may be performed by, or under the supervision of, licensed nurses and are included in the per diem rate. Nursing services include, but are not limited to:

\* \* \*

- Proper positioning in bed, wheelchair, or other accommodation to prevent deformity and pressure sores;

\* \* \*

- Training and assistance in transfer techniques (bed to wheelchair, wheelchair to commode, etc.);

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- Training, assistance, and encouragement of self-care as required for feeding, grooming, toileting activities (including toilet routine to encourage continence), and other activities of daily living;
- Normal range-of-motion exercises as part of routine maintenance nursing care; and . . . [*Medicaid Provider Manual, Nursing Facility Coverages*, January 1, 2014, pp. 48-49, emphasis added].

With respect to the provision of skilled therapies by nursing facilities and related prior authorization requests, the MPM states:

**10.36 THERAPIES**

Nursing facilities must provide or obtain specialized rehabilitative services if required by the beneficiary's plan of care.

Routine maintenance therapy consists of the repetitive services required to maintain function. The development of the therapy and treatment are included in the per diem rate. Such therapy does not require the therapist to perform the service, nor does it require complex and sophisticated procedures.

Non-routine occupational therapy (OT), physical therapy (PT) and speech/language/pathology (ST) are ancillary services that are covered if prior authorization is obtained and the following conditions are met:

- The therapy must be billed by the facility;
- There must be a written order by the attending physician/licensed physician's assistant for each calendar month of therapy; and
- The written orders must be signed by the attending physician/licensed physician's assistant and retained in the beneficiary's medical record.

Non-routine ancillary therapy is therapy that requires the skills of qualified technical or professional health personnel such as physical therapists, occupational therapists, speech pathologists or audiologists, and is directly provided by or under the general supervision of these skilled personnel to assure the safety of the beneficiary and achieve the medically desired results as ordered by the beneficiary's physician.

Federal regulations require the facility to have a valid contract with the OT, PT, or ST provider. A valid contract allows the facility to retain professional and administrative control over the services provided. Therefore, an

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agreement that stipulates only the use of facility space does not constitute a valid contract.

If Medicaid funds have inappropriately been paid to a facility for OT, PT, or ST services when a facility did not possess a valid contract, the funds may be recovered by gross adjustment or at the time of cost settlement, as appropriate.

The following clarifies the professional responsibilities of the nursing facility, the physician, and the therapist in the provision of OT, PT or ST services for Medicaid beneficiaries.

- The facility has administrative and professional responsibility for the management of the total health care needs of the beneficiary as outlined in the plan of care. The facility must assure that appropriate OT, PT, or ST services are available to the beneficiary as needed. In situations where the therapist is not an employee of the facility, the facility must establish a valid contract with a therapist/speech pathologist who meets applicable licensure/certification/accreditation requirements.
- The attending physician is responsible for determining the medical necessity and appropriateness for services and preparing the written orders for OT, PT or ST evaluation and treatment. These are reviewed and approved/disapproved by the MDCH Program Review Division.
- The therapists are responsible for evaluating the beneficiary's needs; developing a written plan of treatment, including goals and objectives; and providing or overseeing the appropriate services. A copy of the treatment plan must be retained in the beneficiary's medical record.

The facility's responsibilities, as described above, are not meant to conflict in any way with the professional responsibilities of OTs, PTs or STs in the evaluation and treatment of the beneficiary.

The cost of supplies and equipment (e.g., plate guards) used as part of the therapy program is included in the reimbursement for the therapy/speech pathology.

Therapies provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

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Therapies provided to county medical care facility, hospital long term care unit or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital. ST may also be provided by a hearing center. Prior authorization must be obtained by the facility regardless of where the service is to be provided.

**Note:** Therapy provided by a physician (MD or DO) is not a covered benefit for beneficiaries in a nursing facility.

**10.36.A. OCCUPATIONAL THERAPY (OT)**

Occupational therapy (OT) must be active and restorative. A licensed occupational therapist or a licensed occupational therapy assistant must render the services. If the assistant renders the service, the assistant must be under the supervision of the therapist.

The following are examples of occupational therapy services that may be covered by Medicaid:

- Training in activities of daily living;
- Fabrication of adaptive equipment;
- Perceptual motor training;
- Splinting;
- Testing;
- Therapeutic exercises; and
- Prosthetic and orthotic training.

OT services that are provided and billed simultaneous with PT are not covered. Also, diversional OT, reality orientation, and restorative nursing functions are considered part of the per diem rate, and are not separately reimbursable.

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**10.36.C. SPEECH PATHOLOGY/THERAPY (ST)**

The services must be for active, restorative treatment and must be rendered by a licensed speech pathologist. For speech pathology

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evaluations, a copy of the speech pathologist's license must accompany the first prior authorization request for that pathologist.

The following are examples of conditions that may warrant speech pathology services:

- Cerebral vascular accident (CVA) or trauma;
- Neurological disease, such as Parkinsonism or multiple sclerosis;
- Laryngectomy;
- Voice disorders caused by conditions such as nodules, polyps, papilloma, ulcers, cysts, or cord damage (the exact diagnosis must be included in the physician's order); or
- Maxillofacial abnormalities with traumatic or surgical excision of the tongue, lips, or hard or soft palate.

When properly documented, other diagnoses and conditions may be covered if they meet the above requirements and are prior authorized. Since the purpose of speech pathology services is restorative rather than habilitative, these services are not covered for:

- Speech problems due to symptoms of organic brain syndrome or chronic brain syndrome; or
- Speech problems due to mental retardation.

Medicaid does not cover ST when another public agency (e.g., local or intermediate school district special education program) can assume the responsibility of services for the beneficiary.

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**10.36.D. PRIOR APPROVAL FOR THERAPIES**

The Occupational Therapy - Physical Therapy – Speech Pathology Prior Approval Request/Authorization (MSA-115) is used to request prior authorization. The MSA-115 must be reviewed and signed by the attending physician. Refer to the Forms Appendix or MDCH website for a copy of, and instructions for, the MSA-115.

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The initial evaluation does not require prior authorization and cannot be provided more often than twice in a 12-month period (and at least six months apart).

**Exception:** Evaluation of oral pharyngeal swallowing cannot be provided more than four times in a 12-month period.

Prior authorization may be requested for up to two calendar months per request.

The therapist or speech pathologist must keep appropriate notes that include the date of treatment, the name of the therapist, the type and length of treatment, and the resident's response to treatment. These notes must be maintained in the beneficiary's medical record.

Prior authorization requests for group therapy require documentation that group therapy is in the best interest of the beneficiary's treatment.

\* \* \*

#### **10.36.D.2. CONTINUED REQUEST**

Authorization of the initial service does not guarantee authorization of continued service. The therapist must submit the MSA-115 for continued therapy with documentation of the most recent progress. The progress summary must be concise and refer to the baseline established in the initial evaluation. Progress must be objective and measurable.

#### **10.36.D.3. PROCESS**

The MDCH consultant will make a determination and return to the provider a letter indicating approved, denied, insufficient data, no action, or approved as amended. [Medicaid Provider Manual, Nursing Facility Coverages, January 1, 2014, pp. 58-62, emphasis added].

In this case, the Department's witness ██████████ an experienced Occupational Therapist and Medicaid Utilization Analyst identified the reason why Appellant's requests for speech and occupational therapies were denied. For the reasons discussed below, this Administrative Law Judge finds that the Department's decision should be sustained.

The Department's witness ██████████ stated Appellant's Prior Authorization requests for continued occupational therapy and speech therapy, that had been initiated on ██████████, were denied. The Analyst noted that according to the policy in the Medicaid Provider Manual occupational therapy and speech therapy must be active and

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restorative. The denial letters noted that the documentation submitted with the request for a continuation of these therapies did not demonstrate that any significant progress had been made as a result of the therapies, and they had been on-going for almost a

specifically addressed the occupational therapy noting it had been initiated on , and was first approved on pointed out that on Appellant was given the final approval for occupational therapy, and the therapist was advised to develop a restorative program and turn the matter over to the nursing facility staff. She noted the final denial letter was then sent out on

stated the occupational therapy had been ongoing for almost a and hours of occupational therapy had been approved by the Department. stated the Department's expectation after that period of time would be that the Appellant would be able to complete her activities of daily living under the supervision of the nursing staff, and have a restorative program in place to maintain her skills. Thereafter, further repetitive or routine activities (non-skilled therapies) would be carried out by the nursing facility staff as part of the Medicaid covered services included in the per diem paid to the nursing facility for the Appellant's care. stated the reports submitted with the PA request did not provide documentation that skilled therapy was still needed in this case, i.e., that the therapy was active and restorative as required by the policy in the Medicaid Provider Manual quoted above.

also addressed the speech therapy that had been initiated on , and first approved on stated the speech therapy was on-going for almost a and there had been visits by the speech pathologist. noted the denial of speech therapy was made on and the denial letter was sent on The denial letter noted significant progress was not documented. A subsequent denial letter was sent on indicating that the current submission did not permit a reconsideration of the denial.

stated at the end of the visits by the speech pathologist, the Appellant should be able to consistently and accurately express her wants and needs verbally or by alternative means, and have a restorative program in place. noted the report submitted with the PA request did not document active and restorative treatment required by the Medicaid policy quoted above. stated after almost a of treatment Appellant would be past the acute stages of recovery that would normally be covered as part of skilled speech therapy. Thereafter, the Appellant should have been turned over to the nursing facility staff for routine non-skilled therapy as part of the treatment provided under the nursing facility's per diem being paid for the Appellant's care.

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Appellant declined to present any testimony, but did submit [REDACTED] exhibits, the Request for Hearing filed on [REDACTED], and an Affidavit of [REDACTED] Occupational Therapist, dated [REDACTED]. The affidavit of [REDACTED] documented events subsequent to the Department's denials in this case. Accordingly, they have no bearing on the question of whether the Department's denials of occupational therapy and speech therapy were proper based on the information submitted along with the PA requests.

Appellant bears the burden of proving by a preponderance of the evidence that the Department erred in denying her Prior Authorization requests. Here, Appellant has failed to meet that burden. As described above, the Department's representative properly identified the reason why Appellant's requests were denied and this reason establishes a sufficient basis for the denial in this case. Accordingly, the Department's decision must be affirmed.

On review, the Department's decision to deny the request for a continuation of occupational and speech therapies was reached within policy.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's PA request for a continuation of occupational and speech therapies.

**IT IS THEREFORE ORDERED** that:

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

*William D Bond*

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William D. Bond  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

WDB/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 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.