

**STATE OF MICHIGAN  
MICHIGAN ADMINISTRATIVE HEARING SYSTEM  
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

P.O. Box 30763, Lansing, MI 48909  
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IN THE MATTER OF:

██████████,

Appellant

Docket No. 2014-32294 QHP

Case No. ██████████

**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 held on ██████████. The Appellant was represented by ██████████, grandmother.

Respondent ██████████, subcontractor for the Medicaid Health Plan with Michigan Department of Community Health, was represented by ██████████, Attorney at Law, ██████████, Member Satisfaction Coordinator, and ██████████, Medical Director. ██████████ is a Department of Community Health contracted Medicaid Health Plan.

**ISSUE**

Did the Medicaid Health Plan properly deny the Appellant's 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 whose diagnoses are sensory disturbance, visual tracking and visual perceptual skills. (Exhibit B)
2. On ██████████, the MHP received Appellant's request from Appellant's primary care physician for 1 evaluation and 12 occupational therapy (OT) sessions. (Respondent's Attachment to the Hearing Summary)
3. The MHP failed to submit as evidence the ██████████ request submitted by Appellant's physician.

4. On ██████████ the MHP issued a denial letter stating that the request was denied for the following reasons in part: that the OT is not medically necessary; is not needed to return Appellant to a pre-existing state prior to an illness or disability; it is not needed to return Appellant to the level that is normal for his medical condition(s); is not needed to stop a drop in medical or functional status had the therapy not been given. The denial also indicated that the request is for teaching something for the first time (habilitative). (Exhibit D)
5. After an internal appeal review, on ██████████ the MHP issued a confirming denial stating that the denial was being upheld in part due to there being no medical records of illness or disability, and that OT is not a benefit for treatment or benefit for learning or sensory disturbances, and is not a benefit for the treatment of developmental milestones. (Exhibit F)
6. The Appellant does not receive OT from the school district.
7. A ██████████ Hurley Children's Rehabilitation Center assessment indicates that Appellant has been assessed as "...exhibiting significant sensory processing disorder which affects his ability to interact with his environment appropriately; smells everything routinely, and demonstrates auditory hypersensitivity." (Exhibit C)
8. On ██████████, a Request for Hearing was submitted on the Appellant's behalf.

### **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.

On May 30, 1997, the Michigan Department of Community Health (Department or MDCH) 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.

The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to

professionally accepted standards of care. 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.

*Section 1.022(E)(1), Covered Services.  
MDCH contract (Contract) with the Medicaid Health Plans,*

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

- (a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- (b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- (c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- (d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
- (e) The UM activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure

The Contractor must establish and use a written prior approval policy and procedure for UM purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

*Section 1.022(AA)(1) and (2),  
Utilization Management, Contract.*

As stated in the Department-MHP contract language above, a MHP, “must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations.” The pertinent sections of the Michigan Medicaid Provider Manual are as follows:

## **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 (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 appropriate 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 OT’s and OTA’s 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.

**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 OTR may enroll in Medicaid if he provides Medicare-covered therapy and intends to bill Medicaid for Medicare coinsurance and/or deductible only.

**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 OTR 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.

*Department of Community Health,  
Medicaid Provider Manual, Outpatient Therapy Section  
Version Date: April 1, 2011, Pages 7-9*

### **5.2 PHYSICAL THERAPY**

MDCH uses the terms physical therapy, PT and therapy interchangeably. PT is covered when furnished by a Medicaid-enrolled outpatient therapy provider and performed by a Michigan-licensed Physical Therapist (LPT) or an appropriately supervised Certified Physical Therapy Assistant (CPTA).

The LPT must supervise and monitor the CPTA's performance with continuous assessment of the beneficiary's progress. All documentation must be reviewed and signed by the licensed supervising LPT.

PT must be medically necessary and reasonable for the maximum reduction of physical disability and restoration of a beneficiary to his/her best possible functional level.

#### **For CSHCS beneficiaries**

PT must be directly related to the CSHCS-eligible diagnosis(es) and prescribed by the specialty physician who is overseeing the beneficiary's care. Functional progress must be demonstrated and documented.

**For beneficiaries 21 years of age and older**

PT is 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 to the beneficiary's life roles despite impairments, activity limitations or participation restrictions.

MDCH anticipates PT will result in significant functional improvement in the beneficiary's ability to perform mobility skills appropriate to his chronological, developmental, or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). PT making changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered.

PT must be skilled (i.e., require the skills, knowledge and education of a LPT). MDCH does not cover interventions provided by another practitioner (e.g., teacher, RN, OTR, family member, or caregiver).

MDCH covers the physical therapist's initial evaluation of the beneficiary's needs and design of the PT program. The program must be appropriate to the beneficiary's capacity, tolerance, treatment objectives, and include the instructions to the beneficiary and support personnel (e.g., aides or nursing personnel) for delivery of the individualized treatment plan. MDCH covers infrequent reevaluations, if appropriate.

The cost of supplies and equipment used as part of the therapy program is included in the reimbursement for the therapy. MDCH only covers a clinic room charge in addition to PT if it is unrelated.

PT services may be covered for one or more of the following reasons:

- PT is expected to result in the restoration or amelioration of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills;
- PT service is diagnostic;
- PT is for a temporary condition that creates decreased mobility and/or function; or

- Skilled PT services are designed to set up, train, monitor, and modify a maintenance or prevention program to be performed by family or caregivers. MDCH does not reimburse for routine provision of the maintenance/prevention program.

PT may include:

- Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility);
- Stretching for improved flexibility;
- Instruction of family or caregivers;
- Modalities to allow gains of function, strength, or mobility; and/or
- Training in the use of orthotic/prosthetic devices.

MDCH requires a new prescription if PT is not initiated within 30 days of the prescription date.

PT is not covered for beneficiaries of all ages for the following:

- When PT is provided by an independent LPT. (An independent LPT may enroll in Medicaid if they provide Medicare-covered therapy and intend to bill Medicaid for Medicare coinsurance and/or deductible only.)
- When PT is for educational, vocational, or recreational purposes.
- If PT services are required to be provided by another public agency (e.g., CMHSP services, school-based services [SBS]).
- If PT requires PA and services are rendered prior to approval.
- If PT is habilitative therapy. Habilitative treatment includes teaching a beneficiary how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. For example, teaching a child normal dressing techniques or teaching cooking skills to an adult who has not performed meal preparation tasks previously.
- If PT is designed to facilitate the normal progression of development without compensatory techniques or processes.
- If PT is a continuation of PT that is maintenance in nature.
- If PT services are provided to meet developmental milestones.
- If PT services are not covered by Medicare as medically necessary.

Only medically necessary PT may be provided in the outpatient setting. Coordination between all PT providers must be continuous to ensure a smooth transition between sources.

### **5.2.A. DUPLICATION OF SERVICES**

MDCH recognizes some areas of therapy (e.g., dysphagia, assistive technology, and hand therapy) may also be addressed appropriately by multiple disciplines (e.g., OT, PT, speech therapy) in more than one setting. MDCH does not cover two disciplines working on similar areas/goals. The LPT is responsible for coordinating/communicating with other therapists and providing documentation in the medical record.

### **5.2.B. SERVICES TO SCHOOL-AGED BENEFICIARIES**

MDCH recognizes school-aged beneficiaries may be eligible to receive PT through multiple sources. MDCH expects educational PT (e.g., strengthening to play school sports) to be provided by the school system and is not covered by MDCH or CSHCS.

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.

*Department of Community Health,  
Medicaid Provider Manual, Outpatient Therapy Section  
Version Date: April 1, 2011, Pages 13-15.*

### **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.

*Department of Community Health,  
Medicaid Provider Manual, Outpatient Therapy Section*

The purview of an administrative law judge (ALJ) is to review the Department's action and to make a determination if those actions are in compliance with Department policy, and not contrary to law. The ALJ must base the hearing decision on the preponderance of the evidence offered at the hearing or otherwise included in the record.

As noted in the Findings of Fact, the MHP received Appellant's primary care physician's request on ██████████. However, the MHP failed to submit Appellant the application in the evidentiary packet. As discussed above, the MPM and the Respondent's contract with the state discusses eligibility in large part based on the applicant's diagnosis. However, this ALJ was not provided with Appellant's physician's diagnosis. However, the MHP did submit in its evidentiary packet the ██████████ ██████████ assessment (Exhibit C). Appellant also attached a copy with her hearing request another narrative of the ██████████ evaluation. This evaluation clearly states that Appellant has "...diagnosis of sensory disturbance, visual tracking and visual perceptual skills." (Exhibit C and Appellant's attachment to hearing request) At the same time, Respondent's Exhibit F states that the evidence did not contain a "medical diagnosis" of "illness or disability." (Exhibit F) Under the general and prudent rules of evidence that this ALJ is required to follow at an administrative, this ALJ finds that the Appellant has a medical diagnosis of 'significant sensory processing disorder affecting his ability to interact with his environment appropriately.' (Exhibit C)

Relevant to the case herein, the applicable portion of the MPM states that one of the criteria for OT is to "prevent a reduction in medical or functional status had the therapy not been provided." MPM, Occupational Therapy, January 1, 2014, Page 7. More specifically, under this section the MPM states:

...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. MPP, Outpatient Therapy, January 1, 2014, Page 7.

After a careful review of the credible and substantial evidence of record, this ALJ finds that the evidence that Appellant has **significant sensory processing disorder which affects his ability to interact with his environment** meet the 'severe pathology in the

perception of, or response to sensory input that significantly limits the Appellant's ability to function' pursuant to the eligibility criteria identified in the Medicaid Provider Manual cited above. The MHP's denial is reversed.

It is noted that the MHP presented no evidence that the OT habilitative; there is no evidence that this is a developmental and/or behavioral issue. Moreover, it is noted that the MHP presented no evidence that this service is available through the school district. Evidence does indicate that Appellant is not receiving such services. While it is a well-known fact that the State of Michigan schools offer speech therapy, no evidence was submitted that the type of OT Appellant needs is a service that is offered by the school system.

The evidence supports finding that under the MPM Occupational Therapy Section 5, Appellant meets the criteria.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that that the Medicaid Health Plan incorrectly denied the Appellant's request for, occupational therapy.

**IT IS THEREFORE ORDERED** that:

The Medicaid Health Plan's decision is REVERSED.

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Janice Spodarek  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

JS/ [REDACTED]

cc: [REDACTED]

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

**Docket No. 2014-32294 QHP**  
**Decision and Order**

**\*\*\* 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.