

**STATE OF MICHIGAN  
MICHIGAN ADMINISTRATIVE HEARING SYSTEM  
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

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**IN THE MATTER OF:**

Docket No. 15-005844 MHP

██████████,

██████████

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.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. The Appellant's mother ██████████ appeared on the Appellant's behalf. ██████████ represented the Medicaid Health Plan (MHP), ██████████. ██████████, Member Grievance and Appeal Coordinator, and ██████████ Senior Plan Medical Director testified on behalf of ██████████.

**ISSUE**

Did the MHP properly deny the Appellant's request for Occupational Therapy (OT) and Speech Therapy (ST)?

**FINDINGS OF FACT**

Based on the competent, material, and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. Appellant is a ██████-year-old (DOB 1 ██████████) Medicaid beneficiary. (Exhibit E, p. 3 and testimony).
2. On ██████████, the MHP received a Prior Authorization Request from ██████████ on behalf of the Appellant for OT and ST. (Exhibit B, p. and testimony).
3. On ██████████, denial letters were sent to the Appellant, the Appellant's doctor, and the Appellant's provider. The reason for the denial was that the request for OT and ST did not meet the criteria under the *Medicaid Provider Manual, Medical Supplier, §2.26 - Orthotics (Lower Extremity)*, pp. 52-54, October 1, 2014. (Exhibits B-D and testimony).

4. On ██████████, the Appellant filed a Request for Hearing with the Michigan Administrative Hearing System (MAHS). (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.

On May 30, 1997, the 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 MHPs.

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. 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. In general, the Contractor is responsible for covered services related to the following:

- The prevention, diagnosis, and treatment of health impairments
- The ability to achieve age-appropriate growth and development
- The ability to attain, maintain, or regain functional capacity

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:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids (only for enrollees under 21 years of age)
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year in accordance with Medicaid policy as stated in the Medicaid Provider Manual, Mental Health/Substance Abuse Chapter, Beneficiary Eligibility Section
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics

- Tobacco cessation treatment including pharmaceutical and behavioral support
- 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.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSTD for persons under age 21 [Article 1.020 Scope of Work and Deliverables, at §1.022 E (1), contract, 10/13/2014, pp. 22-23, emphasis added].

\* \* \*

#### AA. Utilization Management

(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. [Contract, *supra*, pp. 59-60].

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 *Medicaid Provider Manual, Outpatient Therapy, §5.1 – Occupational Therapy and §5.3 Speech Therapy*, pp. 7-8 and 18-20, January 1, 2015 state in part:

### **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.

\* \* \*

### 5.3 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 license.
- An appropriately supervised SLP candidate (i.e., in their clinical fellowship year [CFY]) or having completed all requirements but has not obtained a license. 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 license. 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 licensed 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 [PT], licensed occupational therapist [OT], 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.

Respondent's documentary evidence established that on ██████████, the MHP received a Prior Authorization Request from ██████████ on behalf of the Appellant for OT and ST. Thereafter, on ██████████, denial letters were sent to the Appellant, the Appellant's doctor, and the Appellant's provider. The reason for the denial was that the request for OT and ST did not meet the criteria under the *Medicaid Provider Manual*.

██████████ Member Grievance and Appeal Coordinator, and ██████████ Senior Plan Medical Director testified on behalf of the MHP. They established that the MHP received a referral from ██████████ on the Appellant's behalf for physical therapy, speech therapy, and occupational therapy. The MHP approved the physical therapy because the clinical documentation submitted with the doctor's request supported an authorization for physical therapy for the Appellant.

██████████ and ██████████ both stated that the request for speech therapy and occupational therapy could not be approved because there was no clinical documentation submitted along with the request for the speech and occupational therapy to support the doctor's request and to establish medical necessity for the requested therapies. ██████████ established that according to the policy contained in the Medicaid Provider Manual quoted above, there needs to be clinical documentation to establish medical necessity for the requested speech and occupational therapies. The witnesses for ██████████ stated no additional clinical documentation has been received to support the request for speech and occupational therapy following the on ██████████. Accordingly, the request for the OT and ST for the Appellant had to be denied based on the above quoted policy contained in the Medicaid Provider Manual.

Appellant's mother testified that her daughter is ██████ years old and has therapy on her legs on ██████ and ██████. She said her doctor asked her how many words her daughter can say and she told him ██████ words. The doctor replied that the Appellant should be able to say ██████ words by now. Appellant's mother says she wants to get the speech therapy approved for her daughter. She said her doctor ██████ is the one requesting the speech therapy

The Appellant failed to satisfy her burden of proving by a preponderance of the evidence that the MHP improperly denied her request for OT and ST. The MHP and the undersigned administrative law judge are bound by the policy contained in the Medicaid Provider Manual that was cited by the Respondent MHP and must uphold the denial of the Appellant's request for Medicaid coverage for the OT and ST.

[REDACTED]  
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**DECISION AND ORDER**

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP's denial of the Appellant's request for OT and ST from [REDACTED]. [REDACTED] was proper.

**IT IS THEREFORE ORDERED** that:

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

*William D Bond*

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William D. Bond  
Administrative Law Judge  
for Nick Lyon, Director  
Michigan Department of Health and Human  
Services

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

WDB/db

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.