[redacted]
MI [redacted]

Date Mailed:
MOAHR Docket No.: 20-007091
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on January 27, 2021.[1] [redacted] Petitioner's mother, appeared and testified on Petitioner's behalf. [redacted] Petitioner's father, and Lisa Frentz, Supports Coordinator, also testified as witnesses for Petitioner. Stacy Coleman, Chief Privacy and Compliance Officer, appeared and testified on behalf of Respondent Macomb County Community Mental Health (MCCMH).

During the hearing, Petitioner's Request for Hearing was entered into the record as Exhibit #1, pages 1-13. Respondent also submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-15.

ISSUE

Did Respondent properly deny Petitioner's request for the reauthorization of 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. Petitioner is a Medicaid beneficiary who has been diagnosed with autism spectrum disorder and expressive and receptive language disorders. (Testimony of Supports Coordinator).

2. Since 2009, Petitioner has been approved for speech therapy services through Respondent. (Exhibit #1, page 5; Exhibit A, page 9).

[1] For purposes of hearing, this matter was consolidated with two other matters involving the same parties.

3. On August 27, 2020, Petitioner requested reauthorization of his speech therapy services. (Exhibit #1, page 5; Exhibit A, page 9).

4. On September 9, 2020, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that Respondent was denying Petitioner's request for speech therapy services. (Exhibit #1, pages 5-11; Exhibit A, pages 9-15).

5. With respect to the reason for the denial, the notice stated:

> Based on the review of the available documentation in the electronic medial record (EMR) it appears that the beneficiary has been receiving SLP therapy services from MCCMH since 2009. Recent and prior treatment plans and progress notes indicate the beneficiary has attained effective communication skills. According to the Medicaid Provider Manual, Speech therapy services must be reasonable, medically necessary and anticipated to result in an improvement and/or elimination of the stated problem within a reasonable amount of time.

Exhibit #1, page 5

6. On September 11, 2020, Petitioner requested an Internal Appeal with Respondent regarding that decision. (Exhibit A, page 2).

7. On October 9, 2020, Respondent sent Petitioner a Notice of Appeal Denial stating that the Internal Appeal had been denied. (Exhibit A, pages 2-7).

8. With respect to the reason for the denial, the notice stated in part:

> We **denied** your internal appeal for the service/item listed above because you have been actively receiving this service twice weekly since 2009. This service is again being requested for two sessions per week. This service has been provided in excess of 11 years and there has not been an improvement and/or elimination of the stated problem within a reasonable amount of time.

Exhibit A, page 2

9. On November 16, 2020, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter regarding Respondent's decision. (Exhibit #1, pages 1-13).

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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:

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> *42 CFR 430.10*

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other

> than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…
>
> *42 USC 1396n(b)*

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915 (c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, Petitioner has been receiving speech therapy services through Respondent. With respect to services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **3.23 SPEECH, HEARING, AND LANGUAGE**
>
> | Evaluation | Therapy |
> |---|---|
> | Activities provided by a licensed speech-language pathologist or licensed audiologist to determine the beneficiary's need for services and to recommend a course of treatment. A speech-language pathology assistant may not complete evaluations. | Diagnostic, screening, preventive, or corrective services provided on an individual or group basis, as appropriate, when referred by a physician (MD, DO).

Therapy must be reasonable, medically necessary and anticipated to result in an improvement and/or elimination of the stated problem within a reasonable amount of time. An example of medically necessary therapy is when the treatment is required due to a recent change in the beneficiary's medical or functional status affecting speech, and the beneficiary would experience a reduction in medical or functional status were the |

	therapy not provided. Speech therapy must be skilled (i.e., requires the skills, knowledge, and education of a licensed speech-language pathologist) to assess the beneficiary's speech/language function, develop a treatment program, and provide therapy. Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, licensed occupational therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage. Services may be provided by a licensed speech-language pathologist or licensed audiologist or by a speech pathology or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a license). All documentation by the candidate must be reviewed and signed by the appropriately licensed supervising speech-language pathologist or audiologist.

Moreover, with respect to the medical necessity referenced in the above policy, the MPM also provides:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
>
> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
> - Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
> - Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
> - Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
> - Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.
>
> **2.5.B. DETERMINATION CRITERIA**
>
> The determination of a medically necessary support, service or treatment must be:
>
> - Based on information provided by the beneficiary, beneficiary's family, and/or other

individuals (e.g., friends, personal assistants/aides) who know the beneficiary;

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;

- Made within federal and state standards for timeliness;

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and

- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:

  - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

  - that are experimental or investigational in nature; or

  - for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or

- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

MPM, July 1, 2020 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
Pages 14-15

Here, as discussed above, Respondent decided to deny Petitioner's request for the reauthorization of speech therapy services and Petitioner then requested the administrative hearing in this matter with respect to that decision.

In support of Respondent's action, its representative testified that, to be approved, speech therapy must be reasonable, medically necessary and anticipated to result in an improvement and/or elimination of the stated problem within a reasonable amount of time, which is no longer the case for Petitioner as he has been receiving speech therapy two times a week for eleven years without any improvement or elimination of the stated problems. Respondent's representative did agree that the notices of adverse benefit determination and appeal denial gave different reasons for the action, but denied that the reasons conflicted. She also agreed that Respondent did not provide any records or medical documentation as part of its exhibit in support of its action, and that she does not know who made any findings that Respondent relied upon.[2]

In response, Petitioner's Supports Coordinator testified that Petitioner was again prescribed speech therapy in June of 2020 by his neurologist and that Petitioner continues to have active speech therapy goals, with the goals updated annually as necessary. She also testified that Petitioner has been diagnosed with expressive and receptive language disorders in addition to his autism spectrum disorder, and that his improvement with speech has been on-and-off, with the recent COVID-19 virus epidemic and a lack of services as a result negatively affecting him. She further testified that Petitioner has recently had his previously approved iPad taken away as well, which has also negatively affected him.

Petitioner's representative testified that she was not allowed to participate in the Internal Appeal and that Respondent's representative just completed a records review.

Petitioner's father testified that Respondent's reasons for denying the request do not make sense and that Petitioner needed the therapy to maintain his skills and avoid regression.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned Administrative Law Judge is limited to

[2] Respondent's representative further testified that, after the decision to deny the request was made, Respondent learned that speech therapy was also covered through Petitioner's private insurance, which would be another basis for the denial. However, as that information was not the basis for the decision at issue in this case, the undersigned Administrative Law Judge declined to consider it. Testimony from Petitioner's witnesses regarding private insurance was likewise disregarded.

reviewing the Respondent's decision in light of the information it had at the time it made the decision.

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that, while it is unclear if Petitioner continues to meet the criteria for speech therapy services, Petitioner has met his burden of proving that Respondent erred and that Respondent's decision must therefore be reversed.

The record is minimal in this case, with neither side submitting any records or medical documentation in support of or opposition to the denial, but it is undisputed that Petitioner had a medical necessity for speech therapy services in the past; nothing suggests that there has been any significant change in his needs; the Supports Coordinator credibly testified that Petitioner had a prescription for continuing speech therapy; and, even if Petitioner has been receiving speech therapy for an extensive period of time, there is no specific time limitation in policy with respect to such services.

Moreover, in addition to being unsupported, Respondent's stated reasons for the denial appear to conflict with each other and suggest that Respondent erred, with one notice stating that Petitioner "has attained effective communication skills", to the point where he does not need speech therapy services, while the other stated that Petitioner no longer qualifies because "there has not been an improvement and/or elimination of the stated problem within a reasonable amount of time".

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent erred in denying Petitioner's request for the reauthorization of speech therapy services.

IT IS THEREFORE ORDERED that

> The Respondent's decision is **REVERSED,** and it must initiate a reassessment of Petitioner's request.

Steven Kibit

SK/sb

Steven Kibit
Administrative Law Judge
for Elizabeth Hertel, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact

Belinda Hawks
320 S. Walnut St.
5th Floor
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48913
MDHHS-BHDDA-Hearing-Notices@michigan.gov

Authorized Hearing Rep.

[redacted]
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DHHS-Location Contact

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