[redacted]
[redacted] MI [redacted]

Date Mailed: October 6, 2023
MOAHR Docket No.: 23-005028
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 42 CFR 431.200 *et seq.,* and upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on October 4, 2023. [redacted] [redacted] Petitioner's mother, appeared and testified on the minor Petitioner's behalf. Allison Pool, Appeals Review Officer, represented the Respondent Department of Health and Human Services (DHHS or Department). Jan White, Consultant Reviewer, testified as a witness for the Department.

During the hearing, the Department offered a hearing summary and hearing summary addendum that were admitted into the record as Exhibit A and Exhibit B respectively. No other proposed exhibits were submitted.

ISSUE

Did the Department properly deny Petitioner's prior authorization request for occupational therapy?[1]

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 [redacted] year-old Medicaid beneficiary who has been diagnosed with autistic disorder and other disorders of psychological development. (Exhibit A, page 15).

2. In the past, he has received occupational therapy (OT) at Ivy Rehab in [redacted] Michigan. (Exhibit A, page 15; Testimony of Petitioner's

[1] Petitioner was also denied speech therapy, but his representative stated on the record that Petitioner was not requesting a hearing with respect to any such denial.

representative).

3. On June 2, 2023, Ivy Rehab submitted a prior authorization request for therapy services for Petitioner starting on May 18, 2023. (Exhibit A, pages 29-32).

4. However, in that request, it used an obsolete, outdated version of the MSA-115 form required by the Department for the prior authorization request. (Exhibit A, page 32; Testimony of Consultant Reviewer).

5. That same day, the Department sent Ivy Rehab written notice that no action had been taken on the request because the prior authorization request form submitted was obsolete. (Exhibit A, page 32).

6. The Department's notice also advised the provider where the updated forms could be located and asked it to resubmit the request. (Exhibit A, page 32).

7. On July 24, 2023, and July 26, 2023, Ivy Rehab submitted new prior authorization requests for therapy services for Petitioner starting on July 17, 2023. (Exhibit A, pages 35-49, 52-57).

8. However, in both requests, it again used the obsolete, outdated version of the MSA-115 form required by the Department for the prior authorization request. (Exhibit A, pages 38, 57; Testimony of Consultant Reviewer).

9. In response to each request, the Department sent Ivy Rehab written notice that no action had been taken because the prior authorization request form submitted was obsolete. (Exhibit A, pages 50-51, 58-59).

10. On July 31, 2023, Ivy Rehab submitted another prior authorization request for therapy services for Petitioner starting on July 17, 2023. (Exhibit A, pages 60-62).

11. In response, the Department sent a Request for Additional Information. (Exhibit A, pages 63-64).

12. The Consultant Reviewer also spoke with someone from Ivy Rehab regarding what documentation needed to be submitted. (Testimony of Consultant Reviewer).

13. On August 8, 2023, Ivy Rehab submitted another prior authorization request for therapy services for Petitioner starting on July 17, 2023. (Exhibit A, pages 14-25).

14. In that request, it included both an obsolete MSA-115 form and the new, applicable version of the form. (Exhibit A, pages 23-25).

15. However, the new MSA-115 form was incomplete. (Exhibit A, page 24; Testimony of Petitioner's representative; Testimony of Consultant Reviewer).

16. On August 28, 2023, the Department sent Petitioner written notice that the request for occupational therapy had been denied. (Exhibit A, pages 8-9).

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

> The policy this denial is based on is Sections 3, 3.2 and 4.1 of the Therapy Services Chapter and section 1.6 of the Medical Supplier chapter of the Medicaid Provider Manual. Specifically:
>
> - Refer to tracking numbers 1001001659, 1001009127, 1001010188, 100101132, and this request, Reference our no action and return letters dates 6/2/2023, 7/25/2023, 7/26/2023, 8/02/2023 and denial letter of 8/15/203.
> - It is the providers [sic] responsibility to submit all prior authorization documentation as required by current published Medicaid policies. The required and requested published policy documentation was not received.
> - Your standard of care and coverage conditions have not been met. The published Medicaid policies this denial is based on is the The [sic] Therapy Services Chapter, Section 3.3.2, 4.1, and the Medical Supplier Chapter, Section 1.6 of the Medicaid Provider Manual.
> - The PA request form submitted is obsolete, this request has not been reviewed and must be resubmitted on the correct, current form. Updated forms are posted at . . . This has been submitted incorrectly. The provider has also submitted a copy of our return letter dated 8/02/2023, but still not included all required policy information, times. Additionally, the address and NPI# do not match.
> - Unable to accept an incomplete, unsigned, current MSA-115 form without goals and a signed, completed, obsolete form.

* * *

- Your MSA is not legible. Please refer to the Therapy Services Chapter, Section 3, prior authorization requests.
- It is the responsibility of the provider to submit all prior authorization documentation in accordance with current Medicaid published policies.
- Please not for all future submissions . . .
- The beneficiary may resubmit with all required and requested policy documentation for consideration of future services,

Exhibit A, pages 8-9

18. On August 29, 2023, the Michigan Office of Administrative Hearings and Rules received the request for hearing filed with respect to that denial. (Exhibit A, page 7).

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 statutes, 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 practitioners and beneficiaries in the Medicaid Provider Manual (MPM) and, with respect to occupational therapy, the applicable version of the MPM states in part:

SECTION 4 – STANDARDS OF COVERAGE AND SERVICE LIMITATIONS

4.1 OCCUPATIONAL THERAPY

MDHHS uses the terms Occupational Therapy, OT, and therapy interchangeably. OT is covered when furnished by a Medicaid-enrolled therapy provider and the documentation is signed by the treating therapist. Medicaid reimburses for occupational therapy services when provided by any of the following:

- A licensed occupational therapist.
- A licensed occupational therapy assistant under the supervision of an occupational therapist (i.e., the occupational therapy assistant services must follow

the evaluation and treatment plan developed by the occupational therapist, and the occupational therapist must supervise and monitor the occupational therapy assistant's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and co-signed by the supervising occupational therapist.

- A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) an occupational therapist. All documentation must be reviewed and co-signed by the supervising occupational therapist.

OT is considered an all-inclusive charge. Medicaid does not reimburse for a clinic room charge in addition to therapy services unless the room charges are unrelated. MDHHS expects occupational therapists and occupational therapy assistants to utilize the most ethically appropriate therapy within their scope of practice as defined by state law or the appropriate national professional association. OT must be medically necessary, reasonable and required to achieve one or more of the following:

- 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;

- Prevent a reduction in medical or functional status had the therapy not been provided.

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.

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.

Medicaid standard coverage allows the following:

Outpatient/Private Practice Occupational Therapy
• Up to 144 units of OT per calendar year period. • Prior authorization is required for treatment that exceeds this unit limitation.

MPM, July 1, 2023 version
Therapy Services Chapter, page 9

Moreover, regarding prior authorization for therapy services, including requests for treatment exceeding 144 units of OT per calendar year, the MPM also states in part:

SECTION 3 – PRIOR AUTHORIZATION REQUESTS

Prior authorization is required for certain therapy services before the services are rendered. To determine which therapy services require prior authorization, refer to the Standards of Coverage and Service Limitations Section of this chapter, the Medicaid Code and Rate Reference tool in CHAMPS, or the MDHHS Therapies Database on the MDHHS website. (Refer to the Directory Appendix for website
information.)

Prior authorization (PA) is not required for the initiation of home health therapy services for up to a maximum of 24 visits within the first 60 consecutive days if:

- the beneficiary has not received home health therapy services within the calendar year, and
- services do not exceed the maximum.

If a beneficiary has previously received home health therapy services at the maximum 24 visits within the first 60 consecutive days of service for each calendar year, PA is needed.

PA is needed when therapy limits are exceeded regardless of diagnosis.

PA may be authorized for a period not to exceed six months for outpatient and private practice therapy providers and outpatient hospitals, or two months for home health agencies and nursing facilities.

Nursing facilities participating in Medicare are not required to obtain prior authorization for the deductible and/or coinsurance amounts when Medicare approves the services.

If a beneficiary is approved for ventilator care and requires therapy, prior authorization for the therapy must be obtained under the Ventilator Dependent Care Unit (VDCU) National Provider Identification (NPI).

Prior authorization requests must be submitted on the Occupational Therapy-Physical Therapy-Speech Therapy Prior Approval Request/Authorization form (MSA-115). (Refer to the Forms Appendix or the MDHHS website for a copy of the form.) Required medical documentation must accompany the form.

The information on the MSA-115 must be:

- Typed – All information must be clearly typed in the designated boxes of the form.

- Thorough – Complete information, including the appropriate HCPCS procedure codes, must be provided on the form. The form and all documentation must include the beneficiary's name and **mihealth** card ID number, provider name and address, and the provider's NPI number.

Whenever a beneficiary is admitted to a nursing facility directly from a general hospital or from another nursing facility where the beneficiary was receiving reimbursable therapy services, the name of that facility and the date of discharge from that facility should be included on the prior authorization request.

Prior authorization requests should be submitted with the appropriate therapy modifier to distinguish the discipline under which the service is being requested. When the therapy is habilitative, a modifier that represents the nature of the therapy being requested must also be reported.

> Requests for maintenance therapy services should also contain the appropriate maintenance modifier. Refer to the Billing & Reimbursement Chapters for additional modifier information.
>
> For all Medicaid Fee-for-Service (FFS) beneficiaries, the MSA-115 must be mailed or faxed to the MDHHS Program Review Division. Providers can check the status of a prior authorization request in CHAMPS or by contacting the MDHHS Program Review Division via telephone. (Refer to the Directory Appendix for website and contact information.)
>
> Prior authorization requests may also be submitted electronically via FFS Direct Data Entry (DDE) in CHAMPS. (Refer to the General Information for Providers chapter of this manual for additional information.) A copy of the MSA-115 must be attached to each electronic prior authorization request.
>
> A copy of the prior authorization determination letter must be retained in the beneficiary's medical record.
>
> *MPM, July 1, 2023 version*
> *Therapy Services Chapter, pages 6-7*

Here, as discussed above, Respondent denied Petitioner's request for OT services pursuant to the above policies and the basis that the prior authorization request did not contain all the required documentation or information.

In appealing the denial, Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Department's decision in light of the information available at the time the decision was made.

Given the record and applicable policy in this case, Petitioner has failed to meet that burden of proof and the Department's decision must be affirmed.

As provided in the above policies, prior authorization requests must be submitted on the Occupational Therapy-Physical Therapy-Speech Therapy Prior Approval Request/Authorization form (MSA-115), with the information on the MSA-115 typed and complete, and the form signed by the prescribing practitioner and therapist.

Here, despite multiple notices regarding what was required, it is undisputed that no current, completed, and signed MSA-115 form was provided as part of the prior authorization request. At best, as conceded by Petitioner's representative, the provider

submitted an incomplete new form hoping that it, combined with information provided on the obsolete form, would be sufficient; and that does not comply with policy.

Accordingly, the request was properly denied.

The parties did discuss Petitioner's representative having a new request including all the necessary information submitted, and, while recognizing that Petitioner's representative must rely on the provider to submit the new request properly, the undersigned Administrative Law Judge would encourage her to do so.

With respect to the decision at issue in this case however, the Department's decision must be affirmed given the available information and applicable policies.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department properly denied Petitioner's prior authorization request.

IT IS THEREFORE ORDERED that:

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

Steven Kibit

SK/sj

Steven Kibit
Administrative Law Judge

NOTICE OF APPEAL: Petitioner 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

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 6th day of October 2023.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

Via Electronic Mail:

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