STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

MARLON BROWN
DIRECTOR

[redacted]
[redacted] MI [redacted]

Date Mailed: January 21, 2025
MOAHR Docket No.: 24-013171
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's request for a hearing.

After due notice, a hearing was held on January 16, 2025. [redacted] Petitioner's mother and guardian, appeared on Petitioner's behalf.

Stacy Coleman, Fair Hearing Officer, appeared on behalf of Respondent, Macomb County Community Mental Health (CMH).

ISSUE

Did Respondent properly deny Petitioner's request for continued Occupational and Speech Therapy (OT & ST)?

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 receiving services through Respondent. (Exhibit A; Testimony.)

2. Petitioner is diagnosed with hypotonic cerebral palsy, focal epilepsy, chronic static encephalopathy, OCD, and autism. (Exhibits A, 1; Testimony.)

3. Petitioner lives with his mother. (Exhibit A, p 16; Testimony.)

4. Petitioner is in a special education program through the [redacted] Intermediate School District and Petitioner receives group OT and ST through the school. (Exhibit 1, pp 32-68.)

5. In July 2024, Petitioner submitted a request for continued OT & ST and, after review, Respondent concluded that Petitioner no longer met the medical necessity criteria for continued OT & ST because Petitioner had been receiving OT & ST for 11 years, with little to no progress in the last few years. (Exhibit A, pp 1; 9-15; Testimony.)

6. During the last authorization period, Petitioner only utilized 21 out of 52 authorized ST services. (Testimony.)

7. Respondent did approve OT & ST through September 30, 2024,[1] to allow Petitioner to transition out of the services with his provider. (*Id*.)

8. On August 6, 2024, Respondent sent Petitioner a Notice of Adverse Benefit Determination (NABD) informing Petitioner that the request for continued OT & ST was denied. (Exhibit A, pp 9-15; Testimony) Specifically, the NABD indicated:

> Your case manager requested occupational and speech therapy services for the date range of 8/1/24-1/10/25. Based on a review of the documentation in the record, in conjunction with the Medicaid Provider Manual, the medical necessity of this service was not supported. Authorization approved for a reduced date range from 9/1/24-9/30/24. This will allow time for you to transition out of services with the provider. (Exhibit A, p 9; Testimony.)

9. Petitioner then requested an Internal Appeal. (Exhibit A, p 3; Testimony)

10. On August 23, 2024, after reviewing Petitioner's appeal, Respondent sent Petitioner a Notice of Appeal Denial, which upheld the original findings. (Exhibit A, pp 3-8; Testimony). Specifically, the Notice indicated:

> Your Internal Appeal was denied for the service/item listed above because:
>
> You are appealing the denial of 2 units of speech therapy and 2 units of occupational therapy from 08/01/24 through 01/10/25. J[redacted]hasn't made progress in the last 3 years with Occupational or Speech Therapy. He has reached the maximum potential for improvement with these treatments. Medical necessity is not met for these services as requested and the denial is upheld. Occupational and Speech Therapy services will continue from 8/1/24 to 8/31/24, giving the family time to close out services with the provider, as

[1] According to Petitioner's mother and guardian, services were cut off effective August 31, 2024. (Testimony.)

recommended in the original denial. (Exhibit A, p 3; Testimony.)

11. On December 2, 2024, Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules. (Exhibit 1.)

12. With the request for hearing, Petitioner submitted letters from two of his medical providers who supported the continuation of OT & ST. (Exhibit 1.) The language in the body of the two letters is identical. (*Id*.)

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.

> 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…

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 Michigan Department of Health and Human Services (MDHHS) operates a section 1915(b) Medicaid Managed Specialty Services waiver. Respondent contracts with MDHHS to provide specialty mental health services. Services are provided by Respondent pursuant to its contract obligations with the Department and in accordance with the federal waiver.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.* Medical necessity is defined by the Medicaid Provider Manual as follows:

> **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; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
- 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; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- 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;
    - 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.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
July 1, 2024, pp 12-14

Occupational and Speech Therapy services are also defined in the Medicaid Provider Manual:

3.19 OCCUPATIONAL THERAPY

Evaluation	Therapy
Physician/ licensed physician assistant /family nurse practitioner /clinical nurse specialist prescribed activities provided by an occupational therapist licensed by the State of	It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to their chronological

Michigan to determine the beneficiary's need for services and to recommend a course of treatment. An occupational therapy assistant may not complete evaluations.	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). Therapy to make changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered. Therapy must be skilled (requiring the skills, knowledge, and education of a licensed occupational therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage. Services must be prescribed by a physician/ licensed physician assistant/ family nurse practitioner/ clinical nurse specialist and may be provided on an individual or group basis by an occupational therapist or occupational therapy assistant, licensed by the State of Michigan or by an occupational therapy aide who has received on-the-job training. The occupational therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress, but on-site supervision of an assistant is not required. An aide performing an occupational therapy service must be directly supervised by a qualified occupational therapist who is on site. All documentation by an occupational therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising occupational therapist.

3.25 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 their 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.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
July 1, 2024, pp 21-22, 33
Emphasis added

Respondent's representative argued that the denial of continued OT & ST was proper because Petitioner had been receiving OT & ST for 11 years, with little to no progress in the last few years. Respondent's representative indicated that lengthy OT & ST without progress or improvement was not supported by medical necessity under Medicaid policy.

Petitioner's mother/guardian testified that Petitioner did not receive services from September 1, 2024, through September 30, 2024, as promised as the provider informed her that services were terminated effective August 31, 2024. Petitioner's mother/guardian argued that two of Petitioner's medical providers support Petitioner continuing with OT & ST. Petitioner's mother/guardian testified that Petitioner could communicate but he can barely be understood. Petitioner's mother/guardian noted that Petitioner has epilepsy, cerebral palsy, OCD and autism. Petitioner's mother/guardian indicated that while Petitioner does receive OT & ST in school, those services are not one on one; they are in a group setting. Petitioner's mother/guardian indicated that while Petitioner has been receiving OT & ST for many years, there was a gap during COVID and there was a delay in starting the services after COVID. Petitioner's mother/guardian testified that CMH is using evaluations from 2022 and they should use more updated information. Petitioner's mother/guardian indicated that Petitioner has made some progress in the past few years and the services are also important to Petitioner because they keep up his routine, which helps with his autism and OCD.

Based on the evidence presented, Respondent properly denied Petitioner's request for continued OT & ST services. As indicated above, to be medically necessary OT "<u>. . . will result in a functional improvement that is significant</u>, and <u>. . . should be able to be achieved in a reasonable amount of time</u>." For ST to be deemed medically necessary, it must be "<u>anticipated to result in an improvement and/or elimination of the stated problem within a reasonable amount of time</u>". Here, Petitioner has been receiving OT & ST for 11 years but has shown little to no progress within the past few years. As such, Petitioner does not meet the above medical necessity criteria for OT & ST because he

has not continued to show a significant functional improvement over a reasonable amount of time.

Petitioner's arguments to the contrary are not persuasive. First, the fact that Petitioner's medical providers believe he should continue OT & ST is not controlling because those doctors do not determine what is medically necessary under Medicaid. In other words, just because Petitioner's medical providers believe he should continue to receive OT & ST, that does not mean Medicaid should continue to pay for those services. Second, the fact that the PT & ST Petitioner receives in school is in a group setting does not mean that Petitioner meets the medical necessity criteria for those services under Medicaid. Third, the fact that going to OT & ST might help Petitioner maintain a routine, and therefore help with his autism and OCD, does not mean Medicaid can continue to fund the services without a showing of continued improvement within a reasonable amount of time. Medicaid can only pay for services that are medically necessary and here, as indicated above, the services are no longer medically necessary. Should Petitioner's condition deteriorate, he can always request the services again.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Respondent properly denied Petitioner's request for continued Occupational and Speech Therapy services.

IT IS THEREFORE ORDERED that:

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

RM/sj

Robert J. Meade
Administrative Law Judge

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

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 21st day of January 2025.

S. James
Michigan Office of Administrative Hearings and Rules

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