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Date Mailed: February 4, 2025
MOAHR Docket No.: 24-013514
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

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 30, 2025. [redacted] Petitioner's mother and guardian, appeared on Petitioner's behalf. Eric Miller, Case Manager, appeared as a witness for Petitioner.

Stacy Coleman, Fair Hearing Officer, appeared on behalf of Respondent, [redacted] County Community Mental Health (Department).

ISSUE

Did the Department properly deny Petitioner's request for continued 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. Petitioner is a Medicaid beneficiary who has been receiving services through Department. (Exhibit A; Testimony.)

2. Petitioner is diagnosed with I/DD severe and autism spectrum disorder. (Exhibit A; Testimony.)

3. As of July 24, 2024, Petitioner had been receiving OT for 7 years. (Exhibit A; Testimony.)

4. As of July 24, 2024, Petitioner was approved for 21 hours per week of Community Living Supports (CLS). (Exhibit A; Testimony.)

5. July 24, 2024, OT goals for Petitioner state, Petitioner will be able to eat a sandwich, taking average-size bites and chewing bites completely. This is to help improve the safety by swallowing and chewing food. Petitioner will also practice pouring water from a milk jug. (Exhibit A; Testimony.)

6. On August 1, 2024, the Department sent Petitioner a Notice of Adverse Benefit Determination. The notice provided the following:

> Your case manager requested occupational therapy services for the date range of 8/10/24-8/31/24. 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 of 08/10/24 to 08/24/24. This will allow for you to transition out of services with the provider.[1]

7. On August 23, 2024, the Department sent Petitioner a Notice of Appeal Denial. The notice provided the following:

> You are appealing the denial for 8 units per week from 09/01/2024-02/07/2025 of Occupational Therapy. [redacted] has been in occupational therapy for 7 years and has gotten a lot better at using his hands. There are no new issues. [redacted] lives with his parents, who can help him keep practicing these skills. His community living supports staff can also help with these goals. The Medicaid Provider Manual says therapy should help someone improve quickly and keep those improvements. [redacted] has made as much progress as he can with this therapy. Medical necessity is not met for these services as requested and the denial is upheld.[2]

8. On December 16, 2024, Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules.

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.

[1] Exhibit A, p 8.
[2] Exhibit A, p 2.

> 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.[3]
>
> 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.[4]

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.[5] Medical necessity is defined by the Medicaid Provider Manual as follows:

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[3] 42 CFR 430.0.
[4] 42 CFR 430.10.
[5] See 42 CFR 440.230.

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.[6]

Occupational 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 Michigan to determine the beneficiary's need for services and to recommend a course of treatment. An occupational therapy assistant may not complete evaluations.	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 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

[6] MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, July 1, 2024, pp 12-14.

	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.[7]

The Department's representative argued that the denial of continued OT was proper because Petitioner had been receiving OT for 7 years and has likely reached his potential in functional improvement.

Petitioner's mother/guardian testified that Petitioner needed the additional services but failed to produce any arguments to support the statement. Petitioner's case manager, however, did offer up some arguments and focused on Petitioners regression since the OT had stopped and the need for OT to assist Petitioner in listening and following directions. These arguments, however, suggest that OT and any progress made are not durable in nature as required by policy. Additionally, the skills mentioned are of the type that CLS services could be provided for.

Based on the evidence presented, Department properly denied Petitioner's request for continued OT 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>." Here, Petitioner has been receiving OT for 7

[7] *Ibid*, at pp 21-22.

years and has likely reached his potential in functional improvement. As such, Petitioner does not meet the above medical necessity criteria for OT.

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 request for continued Occupational Therapy services.

IT IS THEREFORE, ORDERED that:

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

CA/pe

Corey Arendt
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

Via Electronic Mail:

DHHS Department Contacts
Belinda Hawks
MDHHS - BPHASA
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