Michigan Office of Administrative Hearings and Rules
P.O. BOX 30763
LANSING, MI 48909

Date Mailed: June 11, 2025
Docket No.: 25-015271
Case No.: [redacted]
Petitioner: [redacted]

[redacted]
MI [redacted]

This is an important legal document. Please have someone translate the document.

هذه وثيقة قانونية مهمة. يرجى أن يكون هناك شخص ما يترجم المستند.

এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।

Este es un documento legal importante. Por favor, que alguien traduzca el documento.

这是一份重要的法律文件。请让别人翻译文件。

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Docket No.: 25-015271
Case No.: [redacted]
Petitioner: [redacted]

DECISION AND ORDER

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

After due notice, a hearing was held on June 5, 2025. [redacted] Petitioner's mother, appeared and testified on Petitioner's behalf. John Lambert, Appeals Review Officer, appeared on behalf of Respondent, Michigan Department of Health and Human Services (Respondent, MDHHS or Department). Jan White, Contract Reviewer, appeared as a witness for the Department.

ISSUE

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

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. (Exhibit A, p 15; Testimony).

2. On April 10, 2025, the Department received a prior authorization request for occupational therapy for Petitioner. (Exhibit A, pp 14-63; Testimony).

3. On April 10, 2025, the Department sent Petitioner a Notification of Denial indicating that the request for occupation therapy was denied. Specifically, the notice indicated:

    - This request is denied due to lack of medically based Occupational Therapy goals/goal attainment as defined in the Therapy Services chapter of the Medicaid Provider Manual MedicaidProviderManual.pdf (state.mi.us) section 5 (all portions) for rehabilitation/habilitation.

- Occupational therapy may, however, be covered under the beneficiary's Prepaid Inpatient Health Plan (PIHP) specialty service benefit for beneficiaries diagnosed with autism spectrum disorder (ASD), therefore the beneficiary's PIHP CEO and PIHP Autism Lead/Coordinator will be sent a copy of this letter for follow-up with either the provider or the beneficiary (or their parents/caregiver as appropriate). The PIHP provider, Region 5 Midstate Health Network, can be reached at 517-253-7525. See Numbered-Letter-L-24-23.pdf (michigan.gov) or available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Numbered Letters >> 2024.

- This submission was received on 4/10/2025. Unable to backdate for the dates of 4/02/2025 through 4/09/2025. Therapy Services Chapter, Section 3.3, Retroactive Prior Authorization of the Medicaid Provider Manual. The treatment plan/goals submitted do not qualify in accordance with published Medicaid policies. The clinical documentation is discrepant from the beneficiary's IEP.

- Your standard of care and coverage conditions have not been met. The published Medicaid policies this denial is based on the Therapy Services Chapter, Sections 3 (all portions) 5 (all portions) of the Medicaid Provider Manual and Numbered Letter-L24-23.

(Exhibit A, pp 11-13; Testimony).

4. On April 28, 2025, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's request for hearing. (Exhibit A, pp 7-9).

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). Regarding the specific request in this case, the applicable version of the MPM states in part:

SECTION 3 – PRIOR AUTHORIZATION REQUESTS [CHANGE MADE 4/1/25]

Prior authorization is required for certain therapy services before the services are rendered, dependent upon the Standards of Coverage for each provider type. To determine which therapy services require prior authorization, and when, refer to the Standards of Coverage and Service Limitations Section of this chapter, the Medicaid Code and Rate Reference tool in CHAMPS, and/or (revised 4/1/25) the MDHHS Therapies Database on the MDHHS website. (Refer to the Directory Appendix for website information.)

Home Health Therapy

Prior authorization (PA) is not required for the initiation of home health physical and occupational therapy services for up to a maximum of 24 visits within one 60 consecutive-day period per calendar year. The first date of therapy service during the calendar year starts the 60-day period. PA is required if therapy is needed beyond the 24 visits within the 60-day period, or if the beneficiary has previously received home health therapy within the calendar year. PA is needed when therapy limits are exceeded regardless of diagnosis. Continued therapy may be authorized for periods not to exceed 60-days.

Home Health speech therapy is only covered for CSHCS beneficiaries and requires PA for visits beyond initial evaluation.

Nursing Facility Therapy

Providers must obtain PA for therapy services that are provided after the initial 60-day post-admission period. This includes new episodes of therapy or continuations of therapy already in progress and is not dependent on the amount of therapy performed during the admission period. Continued therapy may be authorized for periods not to exceed 60-days.

Subsequent emergency or planned hospitalizations do not impact the requirements for PA. A copy of the physician prescription or documented medical clearance to resume therapy must be retained in the beneficiary's medical record.

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

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

Outpatient/ Private Practice Therapy

PA is needed when therapy limits are exceeded regardless of diagnosis. Continued therapy may be authorized for periods not to exceed six months.

3.1 FORM AND COMPLETION INSTRUCTIONS [CHANGES MADE 4/1/25]

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 required signatures and appropriate 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 facility address, and the provider's billing NPI number. (revised 4/1/2025)

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 must 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, prior authorization requests should 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 PA request. Prior authorization requests (MSA-115) may also be faxed or mailed to the MDHHS Program Review Division.

Providers can check the status of a PA request in CHAMPS or by contacting the MDHHS Program Review Division via telephone. (Refer to the Directory Appendix for website and contact information.) (text revised 4/1/2025)

A copy of the prior authorization determination letter must be retained in the beneficiary's medical record.

3.2 EMERGENCY/VERBAL PRIOR AUTHORIZATION [CHANGES MADE 4/1/25]

A provider may contact MDHHS to obtain a verbal prior authorization when the prescribing practitioner (practicing within their scope of practice as defined by state law) has indicated that it is medically necessary to provide therapy services without delay. If the initiation of a therapy service is required during MDHHS nonworking hours, providers may perform the service and call the Program Review Division by the end of the next working day.

To obtain verbal prior authorization, providers may call the Program Review Division. (Refer to the Directory Appendix for contact information. Refer to the Forms Appendix for a copy of form MSA-115 and completion instructions.) (revised 4/1/2025)

The following steps must be completed before a prior authorization number is issued for billing purposes:

- The verbal authorization date must be entered on the MSA-115 or electronically in CHAMPS via FFS DDE.

- The MSA-115 or FFS DDE prior authorization request must be submitted to the Program Review Division within 30 days of the verbal authorization.

- Supporting documentation must be submitted with the prior authorization request.

The verbal authorization does not guarantee reimbursement for the services if:

- The beneficiary was not eligible for Medicaid when the therapy service was provided.
- The Program Review Division does not receive the completed MSA-115 and documentation within 30 days of the verbal authorization.
- The prescription is dated after the date the verbal authorization was requested.

3.3 RETROACTIVE PRIOR AUTHORIZATION

Therapy services provided before prior authorization is requested will not be covered unless the beneficiary was not eligible on the date of service and a subsequent eligibility determination was made retroactive to the date of service. If the MDHHS eligibility file does not show that retroactive eligibility was approved, then the request for retroactive prior authorization will be denied.

3.4 BENEFICIARY ELIGIBILITY

Approval of a therapy service on the prior authorization request confirms that the service is authorized for the beneficiary. Approval of a prior authorization request does not guarantee beneficiary eligibility or payment. It is the provider's responsibility to verify the beneficiary's eligibility prior to rendering the service.

3.5 BILLING AUTHORIZED SERVICES

After prior authorization is issued, the information (e.g., prior authorization number, HCPCS/ CPT procedure code, modifier, and quantity) that was approved on the prior authorization must match the information on the claim form.

Therapy rendered to a nursing facility beneficiary must be billed by the nursing facility.

Refer to the Billing & Reimbursement Chapters of this manual for complete billing instructions.

SECTION 5 – OCCUPATIONAL THERAPY [SECTION RE-FORMATTED/ADDED 4/1/25]

5.1 STANDARDS OF COVERAGE AND SERVICE LIMITATIONS [RE-NUMBERED, RE-TITLED AND CHANGES MADE 4/1/25]

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.

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.

Rehabilitative 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.

Habilitative OT must be medically necessary, reasonable and required to develop a reasonable functional status that was not previously learned/achieved at a typically expected age or without compensatory techniques or processes.

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 Provider Manual
Therapy Services Chapter
April 1, 2025, pp 6-8;13
Emphasis added

With regard to occupational therapy for beneficiaries diagnosed with autism, the Department issued a letter to all Medicaid providers on May 14, 2024, which provides:

Dear Prepaid Inpatient Health Plan Chief Executive Officers (CEOs) and Therapy Providers:

RE: Physical, Occupational, and Speech-Language Therapy for Beneficiaries Diagnosed with Autism Spectrum Disorder

The purpose of this letter is to remind therapy providers that Medicaid covers occupational therapy (OT), physical therapy (PT), and speech-language (ST) therapy services for beneficiaries diagnosed with autism spectrum disorder (ASD) under the beneficiary's Prepaid Inpatient Health Plan (PIHP) specialty service benefit. An ASD beneficiary who has been determined eligible by the PIHP for specialty Behavioral Health Treatment (BHT) services will also have any related OT/PT/ST services covered through the PIHP when the 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). Refer to the Covered Services section (individual subsections for Occupational Therapy, for Physical Therapy, and for Speech, Hearing and Language) in the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of the MDHHS Medicaid Provider Manual for additional information. The MDHHS Medicaid Provider Manual is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters and Forms.

Medicaid does not require beneficiaries to be referred to or access OT/ PT/ST services through the Medicaid Health Plan (MHP) or Medicaid Fee-for-Service (FFS) program prior to, or in lieu of, accessing therapy through the PIHP when the therapy is related to the beneficiary's ASD diagnosis.

Therapy services covered by the PIHP must meet the criteria outlined within the Program Requirements section (Medical Necessity Criteria subsection) of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter in the MDHHS Medicaid Provider Manual.

Effective June 1, 2024, therapy prior authorization (PA) denial letters for Medicaid FFS beneficiaries with ASD diagnoses will include the beneficiary's PIHP contact information when the PA request is denied due to the lack of medically based therapy goals or goal attainment. PIHPs will be sent a copy of this therapy denial letter which will include the requesting therapist's contact information. The PIHP Autism Lead will review the beneficiary for current BHT eligibility in the PIHP system. If the beneficiary has had a comprehensive ASD evaluation and been determined eligible for services, the PIHP Autism Lead will contact the therapy provider listed in the denial letter to arrange OT/PT/ST services and provide information regarding the PIHP's provider enrollment, PA, and, claim submission processes as necessary. Therapists not currently contracted with the PIHP will need to become enrolled with the PIHP prior to rendering services. If the beneficiary has not received a PIHP ASD evaluation, the Autism Lead will contact the beneficiary (or their parents/caregiver as appropriate) to set up an evaluation or behavior assessment appointment.

A copy of the PA denial letter will also be sent to the requesting therapist and the beneficiary. These individuals have the option to also contact the PIHP directly to arrange services. The beneficiary must have been

determined eligible for BHT by the PIHP before the related OT/PT/ST service will be approved.

An electronic version of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Exhibit A, pp 75-76
Emphasis added

Here, the Department's witness testified that autism is considered a behavioral health diagnosis, not a medical based diagnosis so occupational therapy would be provided by Petitioner's PIHP, not Medicaid Fee for Service. The Department's witness noted that when this occurs, the autism coordinator at the PIHP is notified by the Department and they should reach out to Petitioner regarding services.

The Department's witness recommended that Petitioner's mother reach out to the PIHP for occupational therapy services at the number found in the Notice of Denial. The Department's witness also indicated that the request for occupational therapy could not be approved because part of the request was retroactive in nature, which is contrary to policy found above.

Petitioner's mother testified that she had not heard from the PIHP but would reach out to them after the hearing.

Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred in denying the prior authorization request in this case. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Department's decision in light of the information that was available at the time the decision was made.

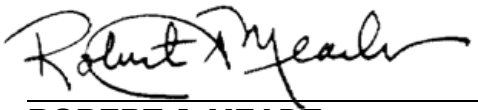
Given the record and available information in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet this burden of proof and that the Department's decision must therefore be affirmed. Policy clearly states that beneficiaries who are diagnosed with autism alone must receive their occupational therapy from the local PIHP. Petitioner's mother indicated that she had not heard from the PIHP but would reach out to them following the hearing. Also, part of the request for occupational therapy was retroactive in nature, which would also be contrary to policy. Therefore, based on the information provided, the denial was proper and must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly denied Petitioner's prior authorization request for occupational therapy.

IT IS THEREFORE ORDERED THAT:

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



ROBERT J. MEADE
ADMINISTRATIVE LAW JUDGE

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to LARA-MOAHR-DCH@michigan.gov , **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

Via Electronic Mail:

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