
In the Matter of the Appeal of
[REDACTED]

from a determination by the New York City
Department of Social Services

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**DECISION
AFTER
FAIR
HEARING**

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on September 9, 2015, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[REDACTED]

For the Managed Care Organization (MCO)

Appearance waived by the Office of Administrative Hearings

ISSUE

Was the Agency's determination to limit speech therapy through the Appellant's managed care plan to 20 visits per calendar year correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 52, resides in a ¾ house. The Appellant has been in receipt of Medicaid for himself only and receives care and services through the Managed Care Organization [REDACTED].
2. The Appellant suffered a stroke and had been receiving speech therapy services. The Appellant requested 10 additional speech therapy visits.

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3. On May 19, 2015 the Agency determined to partially approve the Appellant's request for additional speech therapy visits. The Agency approved 5 additional speech therapy visits and denied 5 speech therapy visits because the Appellant was limited to 20 visits each per calendar year and had already had 15 for the calendar year.

4. The Appellant is not a Medicaid Managed Care recipient under age 21, nor does he have a traumatic brain injury, nor is he developmentally disabled.

5. On June 29, 2015, the Appellant requested this fair hearing.

APPLICABLE LAW

Section 358-5.9 of the Regulations provides in part:

(a) At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services, the appellant must establish that the agency's denial of assistance or benefits was not correct or that the appellant is eligible for a greater amount of assistance or benefits.

Section 365-a of the Social Services Law provides in part:

2. "Medical Assistance" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized by this title or the regulations..., which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations...

Section 364.2 of the Social Services Law provides in part, as follows:

The Department of Health shall be responsible for . . .

(b) establishing and maintaining standards for all non-institutional health care and services rendered pursuant to this title, . . .

* * *

Pursuant to regulations at 18 NYCRR 513.0, where prior approval of medical, dental and remedial care, services or supplies is required under the MA program, such prior approval will be granted when the medical, dental and remedial care, services or supplies are shown to be medically necessary to prevent, diagnose, correct or cure a condition of the recipient which: (1) causes acute suffering; (2) endangers life; (3) results in illness or infirmity; (4) interferes with the capacity for normal activity; or (5) threatens to cause a significant handicap. Pursuant to 18

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NYCRR 513.6, the determination to grant, modify or deny a request initially must be made by qualified Department of Health professional staff exercising professional judgment based upon objective criteria and the written guidelines of the Department of Health and regulations, and commonly accepted medical practice.

Pursuant to Chapter 59 L. 2011, Part H, Section 27, Social Services Law Section 365-a(2)(h) was amended, effective October 1, 2011, to provide that speech therapy, physical therapy, and occupational therapy, each shall be limited to coverage of twenty visits per year; such limitations shall not apply to persons with developmental disabilities or, notwithstanding any other provision of law to the contrary, to persons with traumatic brain injury. Additionally, this limit will not apply to Medicaid Managed Care recipients younger than twenty-one years of age.

DISCUSSION

The evidence establishes that the Appellant, age 52, resides in a $\frac{3}{4}$ house. The Appellant has been in receipt of Medicaid for himself only and receives care and services through the Managed Care Organization [REDACTED]. The Appellant suffered a stroke and had been receiving speech therapy services. The Appellant requested 10 additional speech therapy visits. On May 19, 2015 the Agency determined to partially approve the Appellant's request for additional speech therapy visits. The Agency approved 5 additional speech therapy visits and denied 5 speech therapy visits because the Appellant was limited to 20 visits per calendar year and had already had 15 for the calendar year. The Appellant is not a Medicaid Managed Care recipient under age 21, nor does he have a traumatic brain injury, nor is he developmentally disabled.

Pursuant to the above law, the Appellant is limited to twenty speech therapy visits for the same diagnosis in a calendar year. The Appellant has had 15 such visits and seeks 10 additional visits. The Appellant has been approved for 5 additional visits, but denied for more than 20 in the calendar year. The Appellant is not under age 21 years and does not suffer from a traumatic brain injury nor is the Appellant developmentally disabled. The Appellant does not meet any of the criteria for additional speech therapy visits.

At the hearing, the Appellant testified that he needs more speech therapy to recover from the [REDACTED]. The Appellant's brother also testified that the Appellant needs additional speech therapy visits to get better. At the hearing, the Appellant submitted into evidence medical records from the Brooklyn Hospital regarding the Appellant's lumbar spine MRI (Appellant's Exhibit A) and Progress Notes made by the Appellant's speech therapist (Appellant's Exhibit B). The medical records and progress notes fail to establish that the Appellant meets any exceptions to the rule of 20 therapy visits per year. The Appellant's testimony and evidence has been considered but is not enough to overcome the Agency's evidence.

The Agency's determination must be sustained.

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DECISION

The Agency determination to limit speech therapy through the Appellant's managed care plan to 20 visits per calendar year is correct.

DATED: Albany, New York
09/18/2015

NEW YORK STATE
DEPARTMENT OF HEALTH

By

C. C. Olesca.

Commissioner's Designee