STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
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MEMORANDUM

DATE: September 29, 2015

TO: Ms. Sharon L. Summers, DMMA
Planning & Policy Development Unit

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: 19 DE Reg. 164 (DMMA Proposed Hippotherapy Regulation)

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMAs) proposal to adopt a Medicaid State Plan amendment to add therapeutic horseback-riding (hippotherapy) as a form of approved physical, occupational, or speech therapy. The proposed regulation was published as 19 DE Reg. 164 in the September 1, 2015 issue of the Register of Regulations. Background on hippotherapy is contained in the attached Wikipedia article. More information is available through the website of the American Hippotherapy Association, Inc.: http://www.americanhippotherapyassociation.org/. SCPD endorses this initiative subject to consideration of a few amendments.

First, §1.1.6 requires therapists to have a "HCPS" certification:

> 1.1.6. Therapists that provide Hippotherapy must be certified by the American Hippotherapy Certification Board as a Hippotherapy Professional Clinical Specialist (HCPS).

The Board's website indicates that there is only one therapist in Delaware with the certification, a single upstate OT. See http://www.americanhippotherapyassociation.org/find-a-therapist-2/. The Board also maintains a list of approval "member therapists" who have completed at least some coursework. There is one ST in Delaware who has "member therapist" status. Id. Given that there is only 1 therapist in the entire State with the required certification, the Division may wish to consider expanding the scope of therapists eligible to provide Hippotherapy under the Medicaid program on a provisional basis. For example, DMMA could adopt a transitional standard in which "member therapists" could also provide Hippotherapy under the Medicaid program with a defined expiration date. This would provide some time to achieve full HCPS certification. Consider the following amendment:

> 1.1.6. Therapists that provide Hippotherapy must be certified by the American Hippotherapy

Certification Board as a Hippotherapy Professional Clinical Specialist (HCPS). **[Given the low number of Delaware therapists with HCPS certification, a therapist enrolled as an American Hippotherapy Association "member therapist" may bill the DMAP for Hippotherapy provided through December 31, 2016.]**

Second, the Medicaid Plan excerpt included in the proposed regulation contains the following provision which is not earmarked for revision:

> 3.3 Services Not Covered
>
> 3.3.1 Occupational therapy services that are not covered include but are not limited to OT services which are not intended to improve functions. is not covered by DMAP.

At 169.

Apart from the obvious grammatical problems with this subsection, its substance is inconsistent with federal regulation and the DMMA medical necessity regulation. It literally limits OT to "medical improvement". In contrast, 42 C.F.R. 440.110(b) (reproduced on p. 165) authorizes OT for both "medical improvement" AND restoration of function. The DMMA "medical necessity" regulation does not require services to result in medical improvement, i.e. services can "restore" or "prevent worsening" of function. See attached regulatory definition [2 DE Reg. 1249 (1/1/99)]. See also attached correspondence from Delaware Medicaid Director disapproving an MCO denial notice based on a "chronic" condition which would "not significantly improve ... with occupational therapy". Section 3.3.1 literally bars coverage of OT which would restore or prevent the worsening of effects of a condition. The entire subsection could be deleted since it is grammatically infirm, substantively incorrect, and superfluous (other sections define the scope of covered OT). The Division is authorized to informally correct this section pursuant to Title 29 Del.C. §10113(b)(4)(5).

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our position or recommendations on the proposed regulation.

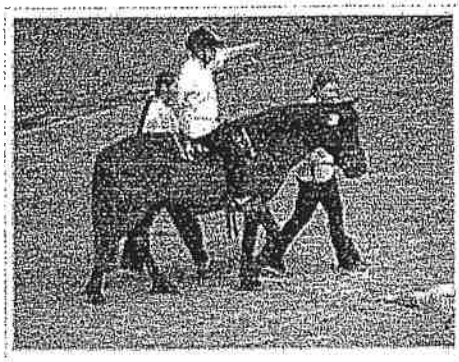
cc: Mr. Stephen Groff
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

19reg164 dmma-hippotherapy 9-28-15

Hippotherapy

From Wikipedia, the free encyclopedia

Hippotherapy is a form of physical, occupational and speech therapy in which a therapist uses the characteristic movements of a horse to provide carefully graded motor and sensory input. A foundation is established to improve neurological function and sensory processing, which can be generalized to a wide range of daily activities. Unlike therapeutic horseback riding (where specific riding skills are taught), the movement of the horse is a means to a treatment goal when utilizing hippotherapy as a treatment strategy.



Hippotherapy has been used to treat people with physical or mental challenges.

Contents

History

Derived from the Greek *hippos* (horse), "hippotherapy" literally refers to treatment or therapy aided by a horse. The concept of hippotherapy finds its earliest recorded mention in the ancient Greek writings of Hippocrates. However, hippotherapy as a formalized discipline was not developed until the 1960s, when it began to be used in Germany, Austria, and Switzerland as an adjunct to traditional physical therapy.[1] In Germany hippotherapy was treatment by a physiotherapist, a specially trained horse, and a horse handler. The theories of physiotherapy practice were applied; the physiotherapist gave directives to the horse handler as to the gait, tempo, cadence, and direction for the horse to perform. The movement of the horse was carefully modulated to influence neuromuscular changes in the patient. The first standardized hippotherapy curriculum would be formulated in the late 1980s by a group of Canadian and American therapists who traveled to Germany to learn about hippotherapy and would bring the new discipline back to North America upon their return.[1] The discipline was formalized in the United States

in 1992 with the formation of the American Hippotherapy Association (AHA). Since its inception, the AHA has established official standards of practice and formalized therapist educational curriculum processes for occupational, physical and speech therapists in the United States.[1]

Modern hippotherapy

See also: Animal-assisted therapy

Equine-assisted therapy is an umbrella term for therapy incorporating the equine environment into a treatment session within the scope of a therapist's practice and professional designation.Physical and occupational therapists, physical and occupational therapy assistants, and speech and language pathologists practicing hippotherapy incorporate the horse's movement into the total care plan for their patients.

In the mental-health field, social workers, psychologists and mental-health providers may incorporate equine-assisted psychotherapy into their treatment sessions. This is different from hippotherapy, where the movement of the horse influences or facilitates an adaptive response in the patient. Forms of equine assisted psychotherapy may have the patient on or off the horse, and the treatment is not focused on a set of specific movements for the horse to produce an adaptive response in the patient.

In the United States, the American Hippotherapy Association (AHA) offers education to therapists, promotes research in equine assisted therapy and provides continuing education courses.

The role of the horse

The horse's pelvis has a similar three-dimensional movement to the human's pelvis at the walk. The horse's movement is carefully graded at the walk in each treatment for the patient. This movement provides physical and sensory input which is variable, rhythmic and repetitive. The variability of the horse's gait enables the therapist to grade the degree of input to the patient and use this movement in combination with other treatment strategies to achieve desired therapy goals or functional outcomes. In addition, the three-dimensional movement of the horse's pelvis leads to a movement response in the patient's pelvis which is similar to the movement patterns of human walking. A foundation is established to improve neurological function and sensory processing, which can be generalized to a wide range of daily activities and address functional outcomes and therapy goals.

Indications

Hippotherapy has been used to treat patients with neurological or other disabilities, such as autism, cerebral palsy, arthritis, multiple sclerosis, head injury, stroke, spinal cord injury, behavioral disorders and psychiatric disorders. The effectiveness of hippotherapy for many of these indications is unclear, and more research has been recommended. There is a lack of scientific evidence regarding the effectiveness of hippotherapy in the treatment of autism.[2] The Argentine Institute for Clinical Effectiveness and Health Policy concluded, in a study of the evidence for the efficacy of hippotherapy, that there were generally significant problems in terms of study design and/or methodology. "The

efficacy of this therapy does not seem to have been sufficiently proven for any specific indication. Its recreational role and impact on the quality of life of these patients have not been sufficiently analyzed."[3]

Use in physical, occupational, speech and language therapies

Physical therapists who have had training in hippotherapy may incorporate the multi-dimensional movement of the horse to achieve gait training, balance, postural/core control, strengthening and range of motion goals. Improvement in gross motor skills and functional activities for developing children with disabilities has been reported. Impairments are addressed through the variability of the horse's movement by modifying the rhythm, tempo and cadence of the horses movement.

Occupational therapists providing hippotherapy utilize the movement of the horse to improve motor control, coordination, balance, attention, sensory processing and performance in daily tasks. The reciprocal multi-dimensional movement of the horse helps with the development of fine motor skills, visual motor skills, bilateral control and cognition as well. Sensory processing via hippotherapy simultaneously addresses the vestibular, proprioceptive, tactile, visual and auditory systems. The occupational therapist incorporates the movement of the horse, hippotherapy, to modulate the sensory system in preparation for a therapy or treatment goal that leads to a functional activity.

Hippotherapy has also seen use in speech and language pathology. Hippotherapy uses a horse to accomplish traditional speech, language, cognitive, and swallowing goals. Using hippotherapy, appropriate sensory processing strategies have been integrated into the treatment to facilitate successful communication.[4]

Certification

The American Hippotherapy Association offers certification qualifications for working as a hippotherapist. Hippotherapy Clinical Specialty (HPCS) Certification is a designation indicating board certification for therapists who have advanced knowledge and experience in hippotherapy. Physical therapists, occupational therapists, and speech-language pathologists in practice for at least three years (6,000 hours) and have 100 hours of hippotherapy practice within the prior three years are permitted to take the Hippotherapy Clinical Specialty Certification Examination through the American Hippotherapy Certification Board. Those who pass are board-certified in hippotherapy, and entitled to use the HPCS designation after their name. HPCS certification is for five years. After five years the therapist can either retake the exam or show written evidence of 120 hours of continuing education distributed over the five years. Continuing education must include 50% (60 hours) in education related to equine subject matter: psychology, training, riding skills and so on; 25% (30 hours) in education related to direct service in the professional discipline and 25% (30 hours) in any other subject related to hippotherapy. An alternative is to provide written evidence of scholarly activity appropriate to the field of hippotherapy. Acceptable scholarly activity may include graduate education in hippotherapy, publication of articles on hippotherapy in juried publications, scientific research related to hippotherapy, the teaching or development of hippotherapy, or acting as AHA-approved course faculty. AHA, Inc now recognizes two different AHCB credentials: AHCB Certified Therapist and AHCB Certified Hippotherapy Clinical Specialist. [5]

Professional Association of Therapeutic Horsemanship (PATH) International, offers similar licensing and certification processes, for the center hosting hippotherapeutic activities. Accreditation is a voluntary process that recognizes PATH Intl. Centers that have met established industry standards. The accreditation process is a peer review system in which trained volunteers visit and review centers in accordance with PATH Intl. standards. A center that meets the accreditation requirements based on the administrative, facility, program and applicable special interest standards becomes a PATH Intl. Premier Accredited Center for a period of five years. There are more than 850 Professional Association of Therapeutic Horsemanship International (PATH Intl.) Centers in the United States and around the world providing equine-assisted activities and therapies. These member centers range from small, one-person programs to large operations with several certified instructors and licensed therapists. In addition to therapeutic equitation, a center may offer any number of equine-assisted activities and therapies, including Hippotherapy, equine facilitated mental health, driving, vaulting, trail riding, competition, ground work or stable management. [6]

See also

- Occupational therapy
- Physiotherapy

References

1. "The History of Hippotherapy" (http://www.americanhippotherapyassociation.org/aha_hpot_a_history.htm). "American Hippotherapy Association"
2. "Clinical Policy Bulletin: Hippotherapy (151)" (http://www.aetna.com/cpb/medical/data/100_199/0151.html). *Aetna Clinical Policy Bulletins*. Aetna. 2010-04-23. Retrieved 17 August 2010.
3. Pichon Riviere, Andres; Augustovski, Federico; Colantonio, Lisandro (July 2006). "Utilidad de la equinoterapia" [Usefulness of hippotherapy] (http://www.iecs.org.ar/iecs-visor-publicacion.php?cod_publicacion=387) (in Spanish). Institute for Clinical Effectiveness and Health Policy. Retrieved 18 November 2010.
4. Borton, Bettie B., Au.D. and Ogburn, Amy C., Ph.D., CCC-SLP, "Therapeutic Riding and Hippotherapy: What Is It and How Does It Work?" (http://www.speechpathology.com/articles/article_detail.asp?article_id=367) Retrieved February 17, 2011.
5. "AHCB – How to become certified – HPCS / AHCB Certified Therapist" (http://www.americanhippotherapyassociation.org/education/aha-how-to-become-certified-hpcs/).
6. "PATH International" (http://www.pathintl.org/).

External links

- American Hippotherapy Association (AHA) (http://www.americanhippotherapyassociation.org/)
- Federation of Riding for the Disabled International (http://www.frdi.net/)
- North American Riding for the Handicapped Association (NARHA) (http://www.narha.org/)

Categories: Equine therapies | Human–animal interaction | Physical therapy | Occupational therapy

at a minimum, include the following:

1.2.1 Students in grades 1-8 must receive instruction in English Language Arts or its equivalent, mathematics, social studies and science each year as defined in the Delaware Content Standards.

1.2.2 Students in grades 1-8 must pass 50% of their instructional program each year (excluding physical education) to be promoted to the next grade level. One of the subject areas that must be passed is English Language Arts or its equivalent. English Language Arts or its equivalent includes English as a Second Language (ESL), and bilingual classes that are designed to develop the English language proficiency of students who have been identified as LEP. Classes in English Language Arts, mathematics, science and social studies include those which employ alternative instructional methodologies designed to meet the needs of LEP students in the content areas.]

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF SOCIAL SERVICES

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** 512)

IN THE MATTER OF:

REVISION OF THE CHILD CARE AND THE FIRST STEP REGULATIONS NATURE OF THE PROCEEDINGS:

The Delaware Health and Social Services, Division of Social Services, initiated proceedings to change policy governing the Child Care and First Step programs to the Division of Social Services' Manual Sections 11000 and 12000, pursuant to the Administrative Procedures Act. The policy changes arose from the Personal Responsibility and Work Opportunity Act, the new Child Care and Development Block Grant and *A Better Chance* provisions.

On September 9, 1998, the DHSS published in the Delaware Register of Regulations (pages 466-485) its notice of proposed regulation changes, pursuant to 29 Delaware Code Section 10115. It requested that written materials and suggestions from the public concerning the proposed be delivered by October 31, 1998, at which time the Department would review information, factual evidence and public comment to the said proposed changes to the regulations.

It was determined that no written materials or suggestions had been received from any individual or the public.

FINDINGS OF FACT:

The Department finds that the proposed changes, as set forth in the attached copy should be made in the best interest of the general public of the State of Delaware.

THEREFORE, IT IS ORDERED that the proposed regulations of the Child Care Manual and the elimination of the First Step Manual are adopted and shall become effective ten days after publication of the final regulation in the Delaware Register.

November 30, 1998
GREGG C. SYLVESTER, MD
SECRETARY

*** Please note that no changes were made to the regulation as originally proposed and published in the October 1998 issue of the Register at page 466 (2:4 Del. R. 466). Therefore, the final regulation is not being republished. Please refer to the October 1998 issue of the Register or contact the Department of Health & Social Services**

DIVISON OF SOCIAL SERVICES

Statutory Authority: 31 Delaware Code, Section 505 (31 **Del.C.** 505)

Medicaid / Medical Assistance Program

IN THE MATTER OF:

REVISION OF THE REGULATIONS OF THE MEDICAID/MEDICAL ASSISTANCE PROGRAM

NATURE OF THE PROCEEDINGS:

The Delaware Department of Health and Social Services ("Department") initiated proceedings to update the Medicaid definition of Medical Necessity. The Department's proceedings to amend its regulations were initiated pursuant to 29 Delaware Code Section 10114 and its authority as prescribed by 31 Delaware Code Section 512.

The Department published its notice of proposed

regulation changes pursuant to 29 Delaware Code Section 10115 in the November 1998 Delaware Register of Regulations, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by December 1, 1998, at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

A recent publication of Federally mandated Medicaid policy required that the definition of medical necessity be revised before being made final. Therefore, following is the revised definition as it will appear in Delaware Medicaid policy.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the November 1998 Register of Regulations should be adopted as amended.

THEREFORE, IT IS ORDERED, that the proposed regulations of the Medicaid/Medical Assistance Program are adopted and shall be final effective January 10, 1999.

December 9, 1998
Gregg C. Sylvester, M.D.
Secretary

MEDICAL NECESSITY DEFINITION

MEDICAL NECESSITY is defined as:

the essential need for medical care or services (all covered State Medicaid Plan services, subject to age and eligibility restrictions and/or EPSDT requirements) which, when prescribed by the beneficiary's primary physician care manager and delivered by or through authorized and qualified providers, will:

- be directly related to the diagnosed medical condition or the effects of the condition of the beneficiary (the physical or mental functional deficits that characterize the beneficiary's condition), and be provided to the beneficiary only;
- be appropriate and effective to the comprehensive profile (e.g. needs, aptitudes, abilities, and environment) of the beneficiary and the beneficiary's family;
- be primarily directed to treat the diagnosed medical condition or the effects of the condition of the beneficiary, in all settings for normal activities of daily living, but will not be solely for the convenience of the beneficiary, the beneficiary's family, or the beneficiary's provider. ~~(this means that services which are primarily used for educational, vocational, social, recreational, or other non-medical purposes are not covered under the Medicaid program) [and not include medications, devices, or services that are used primarily to provide lifestyle enhancements, even if conditions are medically based (for example: Viagra, Weight Watchers, etc.);]~~
- be timely, considering the nature and current state of the beneficiary's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time;
- be the least costly, appropriate, available health service alternative, and will represent an effective and appropriate use of program funds;
- be the most appropriate care or service that can be safely and effectively provided to the beneficiary, and will not duplicate other services provided to the beneficiary;
- be sufficient in amount, scope and duration to reasonably achieve its purpose;
- be recognized as either the treatment of choice (i.e. prevailing community or statewide standard) or common medical practice by the practitioner's peer group, or the functional equivalent of other care and services that are commonly provided;
- be rendered in response to a life threatening condition or pain, or to treat an injury, illness, or other diagnosed condition, or to treat the effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation, including loss of physical or mental functionality or developmental delay;

and will be reasonably determined to:

- diagnose, cure, correct or ameliorate defects and physical and mental illnesses and diagnosed conditions or the effects of such conditions; or
- prevent the worsening of conditions or effects of conditions that endanger life or cause pain, or result in illness or infirmity, or have caused or threaten to cause a physical or mental dysfunction, impairment, disability, or developmental delay; or
- effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an institutional setting or other Medicaid program; or
- restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury or condition; or
- provide assistance in gaining access to needed medical, social, educational and other services required to diagnose, treat, or support a diagnosed condition or the effects of the condition,

in order that the beneficiary might attain or retain independence, self-care, dignity, self-determination, personal safety, and integration into all natural family, community, and facility environments and activities.

DELAWARE HEALTH
AND SOCIAL SERVICES
DIVISION OF MENTAL RETARDATION
EARLY INTERVENTION PROGRAM

MEMBER
CHILD DEVELOPMENT WATCH

June 16, 1998

Mr. Philip Soule
Medicaid Director, Division of Social Services
Herman M. Holloway Sr. Campus
1901 N. DuPont Highway - Lewis Bldg.
New Castle, DE 19720

Dear Mr. Soule:

On behalf of the Division of Mental Retardation Assistive Technology Committee, I am writing to request that the Division of Social Services review Medicaid MCO notices and denial codes.

As background, the DMR Assistive Technology Committee recently reviewed the enclosed correspondence. The Committee has two (2) principal concerns. These were shared with Dave Michalik and Cindy Miller who attended the June 4 Committee meeting.

Chronic Condition Exclusion

First, DSS has approved an exclusion for services directed at "chronic" conditions. Specifically, an MCO may deny a service based on the following reason code:

> Your problem is chronic. It will not significantly improve in the allowed timeframe with physical therapy, speech therapy, occupational therapy...

Such a provision is an "open invitation" to deny services to consumers with mental retardation whose realistic goal may be simply to prevent deterioration or maintain current functional levels. It is also inconsistent with the DSS "medical necessity" regulation which authorizes services which "prevent the worsening of conditions or effects of conditions that endanger life or cause pain, or result in illness or infirmity, or have caused or threaten to cause a physical or mental dysfunction, impairment, disability, or developmental delay." The same regulation similarly includes a goal of retention (as juxtaposed to "improvement") of independence and self-care. The specific reference establishes the following service goal: "the beneficiary might...retain independence, self-care, dignity, self-determination, personal safety,..."

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KENT COUNTY • TELEPHONE: (302) 739 - 4386 • FAX: (302) 739 - 3839 • JESSE S. COOPER BUILDING • FEDERAL STREET • P.O. BOX 637 • DOVER • DELAWARE • 19903
SUSSEX COUNTY • TELEPHONE: (302) 422 - 1335 • FAX: (302) 422 - 1363 • 18 N. WALNUT ST. • MILFORD • DELAWARE • 19963

Finally, it reinforces the acute-care bias which insurers have traditionally adopted to exclude coverage of services to persons with developmental disabilities.

Second, the Committee is concerned that several denial codes lack sufficient specificity to be meaningful. For example, the following reason codes are DSS-approved:

The procedure, service, or item does not meet our medical guidelines for coverage.

More conservative therapy should be considered.

On a practical level, the consumer (or DMR casemanager) can only speculate what unknown "guideline" would be violated. Concomitantly, the puzzled consumer is left to divine what "more conservative therapy" might be. Does this mean the MCO will only approve group versus individual therapy, fewer therapy sessions, or an exercise program in lieu of therapy?

Legally, such obtuse codes also appear "at odds" with the authorities cited in Mr. Hartman's correspondence. DSS regulations mandate that notices must contain "information needed for the claimant to determine from the notice alone the accuracy of the intended action" and "detailed individualized explanation of the reason(s) for the action". DSSM 5301. "Boilerplate" justification codes are the antithesis of such regulatory requirements.

Thank you for your consideration of the Committee's recommendations.

Very truly yours,

Nancy W. Colley

Nancy W. Colley
Chairperson

Enclosure

cc: Mr. David Michalik
Ms. Cindy Miller
Mr. William Love
Brian Hartman, Esq.
Beth Mineo Mollica, Ph.D.

DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF SOCIAL SERVICES

(302) 577 - 4900

TELEPHONE: (302)

July 9, 1998

Nancy W. Colley, Chairperson
DMR Assistive Technology Committee
2055 Limestone Road, Suite 215
Wilmington, De 19808

Dear Mrs. Colley:

Thank you for bringing the DMR Assistive Technology Committee's concerns about the Medicaid Managed Care Organizations' (MCOs) denial notices to my attention.

First, regarding the issue of "a chronic condition" exclusion. In AmeriHealth's denial letter to Easter Seals dated April 4, 1997, the letter stated, "your request has been denied because the medical condition for which speech therapy has been requested is chronic." The Division of Social Services did not approve this exclusion. Medicaid clients cannot be excluded for services related to a chronic condition. AmeriHealth has been instructed to correct this issue. The reason code for "a chronic condition" will be removed from denial letters sent to Medicaid clients.

The second issue raised by your Committee also concerns my staff and I; the MCO denial reasons lack sufficient specificity to be meaningful. We are prepared to address this issue with the MCOs, and begin working with them to provide more detailed explanations in their letters of denial to Medicaid clients.

Again, thank you for bringing these very valid concerns to my attention. I will keep you updated on their progress.

Sincerely,

Philip P. Soule, Sr.
Medicaid Director

PPS/cm/ps

cc: Kay Holmes
David Michalik
Cindy Miller
William Love
Brian Hartman, Esq.
Larry Henderson