STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2009-20014 QHP
Case No. [redacted]
Load No. [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 the Appellant's request for a hearing.

After due notice, a hearing was held [redacted], appeared on behalf of the Appellant. [redacted] represented the Health Plan. [redacted] was present and testified. [redacted] was present on behalf of the Health Plan. [redacted] was present on behalf of the Health Plan.

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for physical 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. Appellant is a [redacted] Medicaid beneficiary and member of [redacted].

2. The Appellant is diagnosed with Neurofibromatosis Type I. He has had multiple surgeries attempting to alleviate symptoms and restore functionality to his upper and lower extremities.

3. The Appellant has undertaken physical therapy following his most recent surgery, in [redacted].

4. Following the Appellant's most recent surgery, his upper and lower extremities have become flaccid. He has limited range of motion and is non-ambulatory.

5. The Appellant has participated in 6 weeks of in-patient physical therapy/rehabilitation following his [redacted] surgery. He also had an additional 130 days of out-patient physical therapy after the in-patient physical therapy was concluded.

6. The Appellant has requested authorization for coverage of additional physical therapy from [redacted].

7. The Appellant's providers submitted medical evidence which was reviewed by the [redacted]. The [redacted] determined physical therapy will no longer benefit the Appellant because his deficits are now permanent.

8. The [redacted] denied the request for additional physical therapy on or about [redacted]. The Appellant requested additional occupational and physical therapy services requested due to the determination that no additional rehabilitation/recovery will result in continued physical therapy.

9. The Appellant appealed the denial by [redacted]. [redacted] upheld [redacted] determination and a denial letter was mailed to the Appellant on or about [redacted].

10. On [redacted], the Department received Appellant's Request for Hearing.

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.

On May 30, 1997, the Michigan Department of Community Health (Department or MDCH) received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified Medicaid Health Plans.

The Respondent is one of those Medicaid Health Plans. As such, the MHP contracts with the Department to provide medically necessary Medicaid covered services to eligible Medicaid beneficiaries:

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. *Contractors must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations.* If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the

> Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 1-Z. (Italics added by ALJ).
>
> *Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans, September 30, 2004.*
>
> The major components of the Contractor's utilization management plan must encompass, at a minimum, the following:
>
> - Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
>
> - A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
> - Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
> - An annual review and reporting of utilization review activities and outcomes/interventions from the review.
>
> The Contractor must establish and use a written prior approval policy and procedure for utilization management purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.
>
> *Article II-P, Utilization Management, Contract, September 30, 2004.*

As stated in the Department-MHP contract language above, a MHP "must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations." The pertinent sections of the Michigan Medicaid Provider Manual (MPM) are as follows:

> ***5.2. PHYSICAL THERAPY***
>
> PT services **may** be covered for one or more of the following reasons:
>
> - PT is expected to result in the restoration or amelioration

of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills;
- PT service is diagnostic
- PT service is for a temporary condition and creates decrease mobility; or
- Skilled PT services are designed to set up, train, monitor, and modify a maintenance or prevention program to be performed by family or caregivers. MDCH does not reimburse for routine provision of the maintenance/prevention program.

PT may include:

- Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility);
- Stretching for improved flexibility;
- Instruction of family or caregivers;
- Modalities to allow gains of function, strength, or mobility; and/or
- Training in the use of orthotic/prosetic devices.

MDCH requires a new prescription if PT is not initiated within 30 days of the prescription date.

PT is not covered for beneficiaries of all ages for the following:

- When PT is provided by an independent LPT. (An independent LPT may enroll in Medicaid if they provide Medicare-covered therapy and intend to bill Medicaid coinsurance and/or deductible only.)
- When PT is for educational, vocational, or recreational purposes.
- If PT services are required to be provided by another public agency (e.g. CMHSP services, school-based services (SBS))
- If PT requires PA and services are rendered prior to approval.
- If PT is habilitative therapy. Habilitative treatment includes teaching a beneficiary how to perform a task (i.e. daily living skill) for the first time without compensatory techniques or processes. For example, teaching a child normal dressing techniques or teaching cooking skills to an adult who has not performed meal preparation tasks previously.
- If PT is designed to facilitate the normal progression of development without compensatory techniques or

processes.
- If PT is a continuation of PT that is maintenance in nature.
- If PT services are provided to meet developmental milestones.
- If PT services are not covered by Medicare as medically necessary.

Only medically necessary PT may be provided in the outpatient setting. Coordination between all PT providers must be continuous to ensure a smooth transition between sources.

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The Appellant's sister testified that her brother could still improve with additional therapy. She asserts the sessions are only 30 minutes long and you cannot accomplish much in that short of time. She said he can use his left hand to feed himself but he cannot stand without a walker. She also asserts there has been improvement in that he could not sit up or roll over prior to the physical therapy, post surgery, but he can now. She asserts his balance is much improved.

The Health Plan [redacted], provided testimony indicating the coverage for physical therapy is limited per Medicaid Provider Manual guidelines. The witness continued, stating that a great deal of physical therapy was provided post surgery and review of the medical record indicate no additional improvement is expected or possible, given the Appellant's medical condition. The doctor countered the Appellant's testimony that improvement had occurred as a result of physical therapy (relative to rolling over and sitting up) by stating that post surgery, he would not have been able to do that right away anyway. He stated that immediately following surgery the Appellant would have been too weak to sit up and roll over. He would have had that much improvement following his post surgical recovery. Finally, the doctor pointed to the physical therapist's own notes and comment at discharge indicating the Appellant was discharged from physical therapy due to progress plateau. He stated this is an acknowledgement from the physical therapist that the Appellant had reached his maximum recovery given his medical condition.

Medicaid policy is clear that MDCH Medicaid does not cover physical therapy beyond rehabilitative levels. In other words, once the Appellant's potential for rehabilitation is reached, it will not be provided for maintenance of his medical condition. Although the Appellant is asserting further improvement will occur with additional therapy, there is no medical support for this assertion. In fact, it is contradicted by the medical evidence of record indicating he was discharged due to progress plateau. While it is unfortunate that additional physical therapy will not restore the Appellant to a more functionally independent status, there is no medical support for the assertion that continued therapy will improve his functioning. This ALJ is not unsympathetic to the Appellant's plight, however, the policy does not require the health plan to provide additional coverage given the facts of this case. Without medical evidence supporting the Appellant's assertion, this ALJ cannot reverse the Health Plan's determination.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Medicaid Health Plan properly denied Appellant's request for physical therapy.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 7/15/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.