STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRAVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2009-24127 QHP
Case 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 on [redacted]. [redacted], Appellant's mother/guardian appeared and testified on behalf of Appellant. [redacted], Appeals Coordinator, represented [redacted]), the Medicaid Health Plan (MHP). [redacted], the MHP Medical Director, appeared as a witness for the MHP.

ISSUE

Did the Medicaid Health Plan properly deny 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. The Appellant is a [redacted] Medicaid beneficiary.

2. Appellant was diagnosed with hypotonia, difficulty walking, and developmental delay. (Exhibit 1, pp. 9 & 10)

3. On [redacted], the MHP received a referral request from Appellant's Physician for outpatient physical therapy. (Exhibit 1, pp. 7-14)

4. The reason for the referral was: "Not walking, delayed motor skills and seizures"; and the goal was to get Appellant "caught up." (Exhibit 1, p. 10)

5. On [redacted] the MHP sent Appellant written notice, denying authorization for the requested therapy on the basis that: "it is not a covered benefit under [redacted]." (Exhibit 1, p. 2)

6. The MHP stated in its denial letter that: the physical therapy requested for Appellant can be provided through another public agency via the intermediate school district, e.g., "Early On or Project Find"; and physical therapy is not covered when required to be provided by school-based services. (Exhibit 1, p. 2)

7. On [redacted] the State Office of Administrative Hearings and Rules received a hearing request, from Appellant's legal guardian, protesting the denial of physical therapy for Appellant.

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 Department 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.

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 coverage's 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. (Bold emphasis added).

Article II-G, Scope of Comprehensive Benefit Package.
MDCH contract (Contract)
with the Medicaid Health Plans,
September 30, 2004, Page 30.

> 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.

Appellant's mother testified that Appellant has other problems that the MHP did not consider. She said that Appellant was diagnosed with a seizure disorder-cause unknown, and the MHP received information from a physician who is not familiar with Appellant's medical condition. In addition, she testified that Appellant is slow at learning, and the school does not provide the physical therapy that Appellant needs. Appellant's mother testified that Appellant will be harmed if she does not receive the physical therapy that was requested on her behalf.

The MHP testified that its evidence of coverage section state that physical therapy to treat delays in development (progress) is not covered. The MHP determined that the physical therapy requested for Appellant can be provided through another public agency via the intermediate school district, e.g., "Early On or Project Find." In addition the MHP determined that physical therapy is not covered when required to be provided by

school-based services. The MHP's witness/Medical Director did not dispute the argument that the physical therapy is medically necessary for Appellant. He testified that this is a benefit issue, not a medical necessity issue.

As stated in the above Department-MHP contract language, an MHP may limit services as long as the limitations are consistent with applicable Medicaid provider manuals. The Medicaid Provider Manual addresses physical therapy. The current policy, states in pertinent part that:

> 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 is for a temporary condition and creates decreased 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/prosthetic 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 for Medicare 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.

Version Outpatient Therapy
Date: April 1, 2009
Medicaid Provider Manual

This Administrative Law Judge must uphold the MHP's denial of physical therapy requested on Appellant's behalf. The evidence on the record fails to establish that the physical therapy requested is needed to return Appellant to a functional level prior to an illness or injury. Based on the documentary evidence on the record, it appears that Appellant requires physical therapy for the purpose of meeting developmental milestones. The reason for the physical therapy referral was: "Not walking, delayed motor skills and seizures"; and the goal was to get Appellant "caught up." The MHP established that its Evidence of Coverage Guidelines is consistent with the Medicaid policy. Medicaid policy states clearly that physical therapy is not covered if provided to meet developmental milestones.

In conclusion, the evidence on the record fails to establish that Appellant meets the eligibility criteria for physical therapy. Therefore, the Department's denial must be upheld.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Marya Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 7/21/2008

***** 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 receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.