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. 2009-34342 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.,* following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared on behalf of his son, [redacted] (Appellant).

[redacted] Director of Customer Service, [redacted] Director of Health Services and [redacted], Grievance and Appeals Coordinator, represented [redacted] Plan ('Medicaid Health Plan' or 'MHP').

ISSUE

Did the MHP properly deny Appellant's prior authorization request for physical therapy?

FINDINGS OF FACT

Based upon the competent, material and substantial evidence presented, I find, as material fact:

1. The Appellant is a [redacted] Medicaid beneficiary. He is diagnosed with Hypotonia. *(Exhibit 1; p. 2)*

2. On [redacted], the [redacted] for Exceptional Families submitted to the MHP a prior authorization request for 12 physical therapy visits for the months of [redacted].

3. On [redacted], the MHP denied the Appellant's request for physical therapy, asserting that this service is required to be covered by another public agency (school-based services), and therefore not the responsibility of the QHP. *(Exhibit 1; p. 13)*

4. At birth, the Appellant suffered blood loss on delivery, and may have also suffered oxygen deprivation. A Magnetic Resonance Imaging (MRI) shows some surface brain damage; however, the extent of the brain damage is unknown. While at school, the Appellant requires extra time to switch classes and to write due to trunk weakness. He suffers frequent falls, and exhibits an unsteady gait at times. He tires quickly, and becomes easily frustrated, conditions which decrease his participation in all activities with peers. *(Exhibit 1; p. 2)*

5. A [redacted], physical examination of the Appellant reveals decreased range of motion in the hamstrings, upper and lower extremities, decreased trunk support and posture, decreased endurance and inefficient gait. His proposed treatment program includes strengthening, endurance training, gait training, passive range of motion stretching, active range of motion training using therapeutic exercise and posture training. *(Exhibit 1; p. 4)*

6. On [redacted], the Appellant submitted a request for hearing to the State Office of Administrative Hearings and Rules.

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.

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 coverage(s) 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.

Fee-for-service Medicaid beneficiaries are subject to the prior approval process found in the Medicaid Provider Manual. MHP beneficiaries are entitled to the same benefits as fee-for-service Medicaid beneficiaries.

Coverage for Occupational and Physical Therapy is addressed in the Medicaid Provider Manual. The MHP has adopted criteria set forth in its Utilization Guidelines. Although the MHP's contract with the Department allows adoption of coverage criteria different from that

found in the Medicaid Provider Manual, the criteria may not be "more restrictive" or applied in a manner that denies otherwise medically necessary services.

SECTION 5 – STANDARDS OF COVERAGE AND SERVICE LIMITATIONS

5.2 PHYSICAL THERAPY

MDCH uses the terms physical therapy, PT and therapy interchangeably. PT is covered when furnished by a Medicaid-enrolled outpatient therapy provider and performed by a Michigan-licensed Physical Therapist (LPT) or an appropriately supervised Certified Physical Therapy Assistant (CPTA).

PT must be medically necessary, reasonable and necessary to return the beneficiary to the functional level prior to illness or disability or to a functional level that is appropriate to a stable medical status within a reasonable amount of time.

For CSHCS beneficiaries:

> PT must be directly related to the CSHCS-eligible diagnosis(es) and prescribed by the specialty physician who is overseeing the beneficiary's care. Functional progress must be demonstrated and documented.

For beneficiaries 21 years of age and older:

> PT is covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant to the beneficiary's life roles despite impairments, activity limitations or participation restrictions.

MDCH anticipates PT will result in significant functional improvement in the beneficiary's ability to perform mobility skills appropriate to his 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). PT making changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered. (Emphasis added by ALJ)

PT must be skilled (i.e., require the skills, knowledge and education of a LPT). DCH does not cover interventions provided by another practitioner (e.g., teacher, RN, OTR, family member, or caregiver).

MDCH covers the physical therapist's initial evaluation of the beneficiary's needs and design of the PT program. The program must be appropriate to the beneficiary's capacity, tolerance, treatment objectives, and include the instructions to the beneficiary and support personnel (e.g., aides or nursing personnel) for delivery of the individualized treatment plan. MDCH covers infrequent reevaluations, if appropriate.

The cost of supplies and equipment used as part of the therapy program is included in the reimbursement for the therapy. MDCH only covers a clinic room charge in addition to PT if it is unrelated.

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.

5.2.A. DUPLICATION OF SERVICES

MDCH recognizes some areas of therapy (e.g., dysphagia, assistive technology, hand therapy) may also be addressed appropriately by multiple disciplines (e.g., OT, PT, speech therapy) in more than one setting. MDCH does not cover two disciplines working on similar areas/goals. The LPT is responsible for coordinating/communicating with other therapists and providing documentation in the medical record.

5.2.B. SERVICES TO SCHOOL-AGED BENEFICIARIES

MDCH recognizes school-aged beneficiaries may be eligible to receive PT through multiple sources. MDCH expects educational PT (e.g., strengthening to play school sports) to be provided by the school system and is not covered by MDCH or CSHCS.

Outpatient therapy provided to school-aged children during the summer months in order to maintain the therapy services provided in the school is considered a continuation of therapy services when there is no change in beneficiary diagnosis or function. Prior authorization is required before initiating a continuation of therapy.

5.2.F. PRESCRIPTION REQUIREMENTS

MDCH requires a physician's/licensed physician's assistant prescription for a PT evaluation and preparation of the treatment plan. It must include the beneficiary's name, prescribed therapy and diagnosis(es) or medical condition. A new prescription is required if PT is not initiated within 30 days of the prescription date.

Evaluation:

MDCH does not require PA for evaluations. An evaluation is formalized testing in the early stages of a beneficiary's treatment program followed by periodic testing and reports to indicate the disposition of the beneficiary's treatment. Evaluations may be provided for the same diagnosis without PA twice in a 365-day period with a physician's/licensed physician's assistant prescription. PA is required for more frequent evaluations.

PT evaluations must be completed by a LPT, include standardized tests and/or measurable functional baselines, and include:

- Treatment and medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with gait treatment);
- PT previously provided, facility/site, dates, duration, and summary of change;
- Current therapy provided in this or other settings;
- Medical history as it relates to current PT;
- Beneficiary's current functional status (i.e., functional baseline);
- Standardized and other evaluation tools used to establish the baseline and to document progress;
- Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion) directly affecting the beneficiary's ability to function; and
- Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory, visual, and comprehensive).

Treatment Plan:

MDCH requires a PT treatment plan immediately follow the evaluation. The treatment plan must include:

- Time-related short-term goals that are measurable, functional, and significant to the beneficiary's function and/or mobility;
- Long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from therapy;
- Anticipated frequency and duration of treatment required to meet short-term and long-term goals;
- Plan for discharge from service, including the development of follow-up activities/maintenance programs;
- Statement detailing coordination of services with other therapies (e.g., medical and educational); and
- Physician signature verifying acceptance of the treatment plan.

CSHCS beneficiaries must have a treatment plan signed by the referring specialty physician.

Initiation of Services:

MDCH requires PT be initiated upon completion of an evaluation and development of a treatment plan that supports the reasonableness and medical necessity of therapy without PA.

For the initial period, PT may be provided up to 36 times in the 90-day outpatient setting. PT must be provided by the evaluating discipline (e.g., OTR cannot provide treatment under a PT's evaluation). Co-signing evaluations and sharing treatment requires PA.

MDCH does not require PA for the initial period of skilled therapy the first 90 consecutive calendar days in the outpatient setting for a new treatment diagnosis or new medical diagnosis if:

- Beneficiary remains Medicaid-eligible during the period therapy is provided; and
- A copy of the physician's/licensed physician's assistant signed and dated (within 30 days of initiation of services) prescription for PT is on file in the medical record.

MDCH does not require PA when PT services are initiated when there is a change in the treatment diagnosis and/or medical diagnosis resulting in decreased functional ability.

Continued Active Treatment:

MDCH requires providers to obtain PA to continue PT beyond the initial 90 days.

Providers must complete the MSA-115. MDCH returns a copy of the PA to the provider after processing the request. The PA must be retained in the beneficiary's medical record.

Requests to continue Active Therapy must contain:

- A treatment summary of the previous period of PT, including measurable progress on each short-term and long-term goal. This should include the treating LPT's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes.

- A progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of PT.

- Documentation related to the period no more than 30 days prior to that time period for which PA is being requested.

- A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.

- A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.

- A copy of the prescription, hand-signed by the referring physician/licensed physician's assistant and dated within 30 days prior to initiation of continued service, must be provided for each request.

- A discharge plan.

Maintenance/ Monitoring Services:

MDCH recognizes that, in some cases, a beneficiary does not require active treatment but the skills of an LPT are necessary for training or monitoring of maintenance programs being performed by family and/or caregivers. PA is not required for these types of services for up to four times in 90 days for the outpatient setting.

If continued maintenance therapy is needed after the initial period specified in the paragraph above, PA is required for up to 90 consecutive calendar days in the outpatient setting.

The LPT must complete an MSA-115 and include:

- A service summary, including a description of the skilled services being provided (including the treatment LPT's analysis of the rate of progress, and justification for any change in the treatment plan). Documentation must relate to the period immediately prior to that time period for which PA is requested.
- A comprehensive description or copy of the maintenance/activity plan.
- A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
- A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.
- A discharge plan.

5.2.G. DISCHARGE SUMMARY

MDCH requires the LPT to document a discharge summary to identify the completion of PT services and the discharge status. This must include:

- Dates of service (i.e., initial and discharge dates);
- Description of services provided;
- Functional status related to treatment areas/goals at discharge;
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status;
- Description or copy of follow-up or maintenance program put into place, if appropriate;
- Identification of adaptive equipment provided (e.g., walker) and its current utilization, if appropriate; and
- Recommendations/referral to other services, if appropriate.

5.2.H. RESUMING THERAPY

MDCH requires PA if PT services must be resumed within a 12-month period for the same diagnosis. Providers must provide a discharge summary for the previous therapy or an explanation of the changes in functional or medical status when requesting PA.

Providers must retain a copy in the beneficiary's medical record. MDCH only covers PT resumed within a 12-month period without PA if there are functional changes due to a change in treatment diagnosis.

Michigan Department of Community Health; Medicaid Provider Manual
Outpatient Therapy
Version Date: January 1, 2008; Pages 13 through 18

The MHP asserts that physical therapy is "not a covered service", because the Appellant is of school age and the school system is responsible for providing all of his therapy needs. I disagree.

The initial PT evaluation supports a conclusion that, despite his participation in school-based PT services, the Appellant's daily functioning continues to be significantly impacted as a direct result of a condition with which he was born, Hypotonia. Thus, a conclusion may be drawn that school-based services may be insufficient to address all of the Appellant's developmental challenges.

Furthermore, policy specifically recognizes that school-aged beneficiaries may be eligible to receive PT through multiple sources. While the MPM expects educational PT (e.g., strengthening to play school sports) to be provided by the school system, policy does not specifically provide that, if a beneficiary receives school-based services, the MHP is

automatically relieved of its coverage responsibilities. The MHP asserts only that PT is non-covered, because the Appellant is a school-age beneficiary. I conclude this is an insufficient basis upon which to deny otherwise medically necessary physical therapy services.

Also noteworthy is this fact. Had the Appellant not been born with Hyptonia, the condition that has undisputedly caused his developmental delays and other impairments, he would need only the type of guidance and training that would normally be taught both at home and/or in the school/educational environment. That is, he likely would not require the level and intensity of physical therapy services requested. This, in my opinion, is the level of intensity attributable to the meaning of "habilitative" or teaching someone developmental skills for the first time.

Current policy specifically covers physical therapy when designed to return the beneficiary to the functional level prior to illness or disability, or to return the beneficiary to a functional level that is appropriate to a stable medical status, or to prevent a reduction in medical or functional status should therapy not be provided. A reasonable interpretation of this section policy supports my conclusion that only one of these three factors must be satisfied.

The medical evidence presented clearly supports a conclusion that, not only is the Appellant making progress in school-based therapy, but that an abrupt termination of therapy would result in a reduction and/or a reversal of that progress. The medical evidence supports a further conclusion that, if therapy is abruptly terminated, the Appellant will not achieve a stable medical status. He therefore satisfies criteria for coverage of these services.

In this case, the Appellant was born with Hypotonia, a condition which has resulted in a variety of impairments and developmental delays. Physical therapy policy does not specifically require that a beneficiary be born "healthy," then suffer an illness or injury, and then require rehabilitative therapy. If that, in fact, is the intent of physical therapy policy, then it should be clearly articulated in that fashion.

As written, policy regarding coverage for physical therapy is difficult to apply, because it is contradictory. For example, policy seemingly excludes coverage related to skills that fall victim to developmental delay. Yet, another section of policy reads as follows:

> *MDCH anticipates PT will result in significant functional improvement in the beneficiary's ability to perform mobility skills appropriate to his 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). PT making changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered. (Emphasis supplied by ALJ)*

Thus, it would appear that physical therapy is a Medicaid-covered service when designed to address the deficiencies experienced by both beneficiaries born with medical conditions

that result in development delay and/or the inability to perform age-appropriate tasks of daily living, and those who suffer illness or injury after birth and are then in need of such services. It also appears that policy recognizes that Medicaid beneficiaries may meet criteria for physical therapy from multiple sources. As a result, the MHP's denial based on his status as a school-age beneficiary is unwarranted, and unsupported by policy as written.

Based on the preponderance of the medical evidence presented, I conclude that therapy for this beneficiary has, and continues to be, medically necessary. And, although he may be receiving "educational" physical therapy through the school system, policy does not preclude eligibility for MHP-covered physical therapy on this basis alone.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide that the MHP's denial of Appellant's request for 12 physical therapy visits for the months of [redacted] is improper, as contrary to current Medicaid policy.

IT IS THEREFORE ORDERED that:

> The MHP's decision is REVERSED. The MHP shall approve coverage for occupational and physical therapy for the number of visits requested.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 11/18/2009

***** 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 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.