

**STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE 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:

██████████,

Appellant

_____ /

Docket No. 2010-43226 QHP

██████████

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 ██████████. The Appellant appeared on her own behalf. The Appellant's friend, ██████████, appeared as the Appellant's witness. The Medicaid Health Plan (MHP), ██████████, was represented by ██████████ ██████████ Appeals Coordinator. ██████████, Medical Director, appeared as a witness for ██████████

ISSUE

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

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a ██████████ Medicaid beneficiary.
2. ██████████ is a Department of Community Health contracted MHP.
3. The Appellant injured her back at work and received physical therapy services from ██████████ until ██████████. (Exhibit 1, page 11)
4. On ██████████, the MHP received a prior-authorization request for additional physical therapy for the Appellant. (Exhibit 1, page 21)

5. On ██████████, the MHP denied the request for prior authorization because the Appellant had recently received physical therapy as a result of an ██████████ workplace injury, and it was determined that further treatment was not needed. In addition, the medical documentation submitted with the request did not contain a physical examination or functional status report, nor did it show any weakness or neurological deficit to warrant a need for additional physical therapy. (Exhibit 1, pages 16-19)
6. On ██████████, the State Office of Administrative Hearings and Rules received the 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 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 MHPs.

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. The Contractor 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 2.024.

*Section 1.022(E)(1), Covered Services.
MDCH contract (Contract) with the Medicaid Health Plans,
October 1, 2009.*

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

- (a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- (b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- (c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- (d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
- (e) The UM activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure

The Contractor must establish and use a written prior approval policy and procedure for UM 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 UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

*Section 1.022(AA)(1) and (2),
Utilization Management, Contract,
October 1, 2009.*

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

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).

The LPT must supervise and monitor the CPTA's performance with continuous assessment of the beneficiary's progress. All documentation must be reviewed and signed by the licensed supervising LPT.

PT must be medically necessary and reasonable for the maximum reduction of physical disability and restoration of a beneficiary to his/her best possible functional level.

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.

PT must be skilled (i.e., require the skills, knowledge and education of a LPT). MDCH 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 that creates decreased mobility and/or function; 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.

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- 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.

*Department of Community Health,
Medicaid Provider Manual, Outpatient Therapy Section
Version Date: July 1, 2010, Pages 13-14*

In this case, the MHP's Medical Director testified that the Appellant's request for physical therapy was denied because there was no medical documentation to support that physical therapy was medically necessary. More specifically, he explained that the medical reports that he reviewed in conjunction with the request did not contain any objective evidence of a back injury. He stated that he would expect to see some type of abnormality on physical examination that interferes with normal activity before he would authorize physical therapy.

The Appellant testified that she continues to have back pain. She stated that it is painful to pick up her children and it is uncomfortable for her to drive. She further testified that she has additional medical documentation to support her back injury and that she is now treating with a rehabilitation specialist.

Here, the MHP denied the request because it did not receive any objective medical evidence of a back injury that would warrant additional physical therapy. And while the Appellant may have additional documentation to support her request, the MHP must rely on the documentation that was provided with the request to make its determination. Accordingly, its denial in this case was proper. However, the Appellant may re-apply at any time with the new medical documentation.

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DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that that the MHP properly denied the Appellant's request for physical therapy services.

IT IS THEREFORE ORDERED that:

The MHP's decision is AFFIRMED.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

[REDACTED]

Date Mailed: 10/18/2010

***** 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.