

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

██████████,
Appellant

Docket No. 2011-17003 QHP
Case No. ██████████

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 was represented by ██████████. ██████████, represented ██████████ a Michigan Department of Community Health contracted Medicaid provider (MHP). ██████████, was present as the MHP's witness.

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for occupational and physical therapies?

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 ██████████ boy and Medicaid beneficiary. He suffers from unspecified hypotonia, behavioral problems, and developmental delay. (Exhibit 1, pages 4-5)
2. On ██████████, the Appellant's primary care physician requested coverage for a physical and occupational therapy evaluation and 12 outpatient physical and occupational therapy sessions. (Testimony of ██████████; Exhibit 1, page 4-5)
3. On ██████████, the MHP denied the Appellant's request for physical and occupational therapy coverage because there is no clinical documentation to support an injury or illness in this case. The notice also indicated that the requested services could be obtained through the local school system.

4. On ██████████, the Appellant's Request for Hearing was received.

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. 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:

- 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 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), 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:

SECTION 5 – STANDARDS OF COVERAGE AND SERVICE LIMITATIONS

5.1 OCCUPATIONAL THERAPY

MDCH uses the terms Occupational Therapy, OT, and therapy interchangeably. OT is covered when furnished by a Medicaid-enrolled outpatient therapy provider when performed by:

- An occupational therapist currently registered in Michigan (OTR);
- A certified occupational therapy assistant (COTA) under the supervision of an OTR (i.e., the COTA's services must follow the evaluation and treatment plan developed by the OTR, and the OTR must supervise and monitor the COTA's performance with continuous assessment of the beneficiary's progress). All

documentation must be reviewed and signed by the appropriate supervising OTR; or

- A student completing his clinical affiliation under the direct supervision of (i.e., in the presence of) an OTR. All documentation must be reviewed and signed by the appropriate supervising OTR.

OT is considered an all-inclusive charge and MDCH does not reimburse for a clinic room charge in addition to OT services unless it is unrelated. MDCH expects OTR's and COTA's to utilize the most ethically appropriate therapy within their scope of practice as defined by state law and/or the appropriate national professional association. OT must be medically necessary, reasonable and required to:

- Return the beneficiary to the functional level prior to illness or disability;
- Return the beneficiary to a functional level that is appropriate to a stable medical status; or
- Prevent a reduction in medical or functional status had the therapy not been provided.

For CSHCS beneficiaries

OT must be directly related to the CSHCS-eligible diagnosis(es) and prescribed by the specialty physician who is overseeing care.

For beneficiaries 21 years of age and older

OT is only 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 in the beneficiary's life roles despite impairments, activity limitations or participation restrictions.

MDCH anticipates OT will result in a functional improvement that is significant to the beneficiary's ability to perform appropriate daily living tasks (per beneficiary's chronological, developmental, or functional status). Functional improvements must be achieved in a reasonable amount of time and must be maintainable. MDCH does not cover therapy that does not have an impact on the beneficiary's ability to perform age-appropriate tasks.

OT must be skilled (i.e., require the skills, knowledge and education of an OTR). MDCH does not cover interventions provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [LPT], family member, or caregiver).

OT may be covered for one or more of the following:

- Therapeutic use of occupations*.
- Adaptation of environments and processes to enhance functional performance in occupations*.
- Graded tasks (performance components) in activities as prerequisites to an engagement in occupations*.
- Design, fabrication, application, or training in the use of assistive technology or orthotic devices.
- Skilled services that are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers.

Routine provision of the maintenance/prevention program is not a covered OT service.

* Occupations are goal-directed activities that extend over time (i.e., performed repeatedly), are meaningful to the performer, and involve multiple steps or tasks. For example, doing dishes is a repeated task. Buying dishes happens once; therefore, does not extend over time and is not a repeated task.

OT is not covered for the following:

- When provided by an independent OTR**.
- For educational, vocational, or recreational purposes.
- *If services are required to be provided by another public agency (e.g., community mental health services provider, school-based services).*
- If therapy requires PA and service is rendered before PA is approved.

- *If therapy is habilitative. Habilitative treatment includes teaching someone how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. This may include teaching a child normal dressing techniques or cooking skills to an adult who has not performed meal preparation tasks in the past.*
- If therapy is designed to facilitate the normal progression of development without compensatory techniques or processes.
- For development of perceptual motor skills and sensory integrative functions to follow a normal sequence. If the beneficiary exhibits severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function, OT may be covered.
- Continuation of therapy that is maintenance in nature.

** An independent OTR may enroll in Medicaid if he provides Medicare-covered therapy and intends to bill Medicaid for Medicare coinsurance and/or deductible only.

* * *

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;

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- PT is for a temporary condition that creates decreased mobility and/or function (revised 4/1/09);
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.

*Department of Community Health,
Medicaid Provider Manual,
Outpatient Therapy
January 1, 2011, pages 13-14, and 19-20
(Emphasis Added)*

The MHP witnesses testified that the therapies sought by the Appellant's physician were denied because the services could be obtained through the local school system. In addition, the MHP asserts that the therapies are not covered because there is no injury or illness in this case requiring the service; rather, it appears that the Appellant suffers from developmental delay, which precludes coverage.

The Appellant's mother testified that the Appellant does not receive physical therapy through his school. She further testified that the services that the Appellant does receive—occupational and speech therapies—are not provided often enough to meet his needs. She also concerned about her son's therapies over the summer months when school is not in session.

The Medicaid policy clearly states that the therapies are not covered in the specific circumstance the Appellant is in. He is experiencing developmental delay. He has not "lost" his abilities and is in need of the therapies to help him recover skills he once had. Accordingly, the therapies sought are all habilitative, not rehabilitative. Beneficiaries in

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the Appellant's circumstances are expected to obtain the needed therapies through the local school systems.

Moreover, the documentation submitted indicated that the physical and occupational therapy services were requested because the Appellant was not meeting developmental milestones, not because of an injury or illness. Accordingly, the MHP's denial, based on the documentation submitted, was consistent with the Department's Medicaid policy. This does not mean that the Appellant does not need the services or that he would not benefit from them but that they are not covered in his case. In addition, the Appellant may reapply at any time if his circumstances should change.

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 Appellant's request for physical and occupational therapy.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is **AFFIRMED**.

Kristin M. Heyse
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc:



Date Mailed: 5/5/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.