STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
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. 2011-53443 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], the Appellant, appeared on her own behalf. [redacted], husband, appeared as a witness for the Appellant.

[redacted], Grievance Coordinator, represented [redacted], the Medicaid Health Plan (hereinafter MHP). [redacted] Medical Director, and [redacted] Clinical and Quality Review Specialist, appeared as witnesses for the MHP.

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for physical therapy services?

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] year old Medicaid beneficiary.

2. The Appellant has been diagnosed with low back pain/chronic back pain/lumbago. (Exhibit 1, pages 6-16)

3. On [redacted], the MHP received a request for coverage for outpatient physical therapy services for the Appellant, indicating that she

had physical therapy services between [redacted], and [redacted]. (Exhibit 1, pages 5-16)

4. On [redacted], the MHP sent the Appellant notice that the request for physical therapy coverage was denied because additional documentation is needed to make a benefit determination. (Exhibit 1, pages 17-19)

5. On [redacted], the Appellant's physician signed a written request for continued physical therapy services, which was sent to the Michigan Administrative Hearing System. (Exhibit 1, page 20)

6. On [redacted], a copy of the physician's request was re-submitted with the Appellant's signature. A copy was sent to the MHP [redacted]. (Exhibit 1, pages 21-23)

7. The MHP conducted an internal grievance procedure. On [redacted] the MHP sent the Appellant a letter indicating the Grievance Committee denied the Appellant's request for physical therapy coverage because the additional information requested by the MHP was not submitted. (Exhibit 1, pages 28-29)

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 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.
>
> *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.
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> *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

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.
- 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.

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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). Cosigning 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, modifying, 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.

Version Outpatient Therapy
Date: July 1, 2011, Pages 13-14, 16-18

The Grievance Coordinator testified that in this case, the MHP followed the Medicaid Provider Manual criteria. The MHP denied the prior authorization request for physical therapy services because additional documentation was needed to make a benefit determination. (Exhibit 1, page 17) The [redacted], request for coverage for outpatient physical therapy services for the Appellant indicated that she had physical therapy services between [redacted], and [redacted]. (Exhibit 1, pages 5-16) The above cited Medicaid policy requires prior authorization if physical therapy services are resumed within a 12-month period for the same diagnosis and providers must provide a discharge summary for the previous therapy or an explanation of the changes in functional or medical status. Resumption of physical therapy within a 12-month period is only covered without PA if there are functional changes due to a change in treatment diagnosis. The Appellant's diagnosis, low back pain/chronic back pain/lumbago, has not changed. (Exhibit 1, pages 6-16)

Even if the [redacted], request was considered a request for a continuation of active treatment, additional documentation would still be required. The above cited policy specifies that daily treatment notes are not sufficient. Rather, treatment and progress summaries, current documentation, a statement of the Appellant's response to treatment, current prescription and discharge plan are required.

The MHP's determination to deny coverage for physical therapy services must be upheld as additional documentation was needed. If she has not already done so, the Appellant can have a new prior authorization request submitted to the MHP with additional documentation.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/20/2011

***** 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.