

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:

██████████

Appellant

_____ /

Docket No. 2011-54175 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.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. ██████████ appeared on the Appellant's behalf. She had no witnesses. ██████████, Medicaid Director, represented the health plan. She had no witnesses.

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for continued 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 ██████-year-old Medicaid beneficiary.
2. The Appellant has been diagnosed with Reflex Sympathetic Dystrophy (RSD). (Respondent's Exhibit A, page 1)
3. The Appellant has been enrolled in ██████████ since ██████████. (Respondent's Exhibit A, page 1)
4. The Appellant sustained an ankle injury on ██████████, absent a fracture the Appellant was subsequently diagnosed with RSD. (Respondent's Exhibit A, page 1)
5. The Respondent provided coverage (physical therapy) between the dates of ██████████, through ██████████, for a total of 45 covered visits. (Respondent's Exhibit A, page ii)

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6. The Respondent again approved coverage (more physical therapy) between the dates of ██████████, through ██████████, for a total of 34 additional sessions. This represented a total of 79 visits for the Appellant's injury. (Respondent's Exhibit A, page iii)
7. On or about ██████████, the MHP received a request for coverage for continued outpatient physical therapies for the Appellant. (Respondent's Exhibit A, p. 19)
8. On ██████████, the MHP sent the Appellant notice that the request for additional physical therapy coverage was denied because the submitted documentation did not establish that the Appellant's condition had shown meaningful improvement. (Respondent's Exhibit A, p. 6, see Appellant's Exhibits 1 and 2)
9. Unknown to the parties there was a clerical error in the denial notice wherein the word 'NOT' was omitted – thus changing the message conveyed in the notice. (See Testimony and Respondent's Exhibit A, page ii)
10. The Respondent denied coverage for lack of meaningful improvement for an acute condition. (Respondent's Exhibit A, page ii)
11. On ██████████, the Michigan Administrative Hearing System for the Department of Community Health received the Appellant's Request for Hearing. (Appellant's Exhibit #1)

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. 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.

Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor

- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSTD for persons under age 21

Article 1.020 Scope of [Services],
at §1.022 E (1) contract, 2010, p. 22.

(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.

....

Contract, *Supra*, p. 49.

As stated in the 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 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;

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- 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. (Emphasis supplied)

MPM, Outpatient Therapy, pages 13, 14, October 1, 2011

The MHP denied the prior authorization request for continued physical therapy services because the documentation did not establish that the Appellant's condition was subject to meaningful improvement beyond existing gains. Additional sessions were shown to be unnecessary and lacked durability. The MHP witness stated that the Appellant had entered the realm of maintenance – which is not a covered benefit.

The Appellant's representative disagreed stating that her daughter had made significant gains, including the ability to walk with a four-pronged cane, normal skin tone, no swelling, increased range of motion and increased strength. The Appellant's argument, beyond the unfortunate typographic error, focused on the initial weeks of futile physical therapy which failed to accomplish "...all that was required."

The MHP's limitation of coverage for only short term therapy services that are expected to result in significant improvement is consistent with the above cited Medicaid policy. The documentation by the Appellant's physician did not establish evidence of meaningful improvement in the Appellant's condition – or suggest – for that matter whether the additional treatments would cause the Appellant's recovery to be sustainable. This does not imply that the Appellant would not receive any benefit from continued therapy - only that the expected improvements would be short lived based on the evidence reviewed by the MHP.

The Appellant failed to preponderate her burden of proof.

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 continued physical therapy.


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IT IS THEREFORE ORDERED that:

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

Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc:



Date Mailed: 12/27/2011

***** 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.