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) 373-4147

IN THE MATTER OF:

Docket No. 2013-52660 QHP
[redacted], **Case No.** [redacted]

Appellant
_____/

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 without representation. He had no witnesses. [redacted], Director Customer Serves for [redacted] represented the MHP. Her witness was [redacted], R.N. manager of health services.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for "additional" hours of physical therapy (PT)?

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-SSI beneficiary. (Appellant's Exhibit #1)

2. The Appellant is afflicted with joint pain – shoulder. (See Testimony and Respondent's Exhibit A, p. 2)

3. On [redacted], the MHP advised the Appellant that the requested additional hours of PT were denied as he had reached maximum medical improvement for strength and range of motion. Additional hours, the MHP witness opined, would not produce significant short term results. (Respondent's Exhibit A, pp. 2 and 6 and See Testimony)

4. The Appellant advised at hearing that his request was actually for rotator cuff repair surgery. (See Testimony)

5. The Respondent ([redacted]) immediately assigned the Appellant a case manager to guide his amended request through their evaluation process. (See Testimony)

6. As for the PT request the provider and the Appellant were advised of the denial on [redacted]. Their further appeal rights were contained therein. (Respondent's Exhibit A, pages 12 and 13)

7. The instant request for hearing was received by the Michigan Administrative Hearing System on [redacted]. (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 Health Plan of Michigan 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/EPSDT for persons under age 21

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

....

Utilization Management

(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.
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> **....**
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> Contract, *Supra,* at page 49.

The MHP witness ([redacted]) testified that the Appellant failed to meet plan requirements for approval of additional PT hours having achieved maximum medical improvement through prior PT sessions – with little possibility for additional short term gains in strength or ROM.

The Appellant testified that he wanted to be able to carry his groceries and to forestall future debilitating shoulder pain. At hearing he said he was seeking evaluation for rotator cuff repair surgery – not additional physical therapy.

On review, based on his documents – the Appellant sought approval of additional PT hours. [*See* Appellant's Exhibit #1] The MHP upon learning of the *surgical* request immediately assigned the Appellant a case manager to negotiate the required utilization review. The Appellant said the diagnosis on a rotator cuff tear was unknown at the time of placing his appeal.

The Petitioner has the burden of proving by a preponderance of evidence that the requested service was medically necessary – and that the request met established guidelines via supporting clinical documentation.

The MHP established in its PA review and testimony that Appellant did not satisfy threshold guideline requirements. The Appellant failed to preponderate his burden of proof to establish medical necessity for additional hours of PT.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Respondent health plan properly denied the Appellant's request for additional hours of PT.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

\s\
Dale Malewska
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Signed: 9/27/2013

Date Mailed: 9/27/2013

***** 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.