STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted]

Docket No. 14-015350 PA

[redacted] [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.*, and upon Appellant's request for a hearing.

After due notice, a telephone hearing was held on [redacted]. Appellant appeared and testified on her own behalf. [redacted], Appeals Review Officer, represented the Department of Community Health ("DCH" or "Department"). [redacted], Medicaid Utilization Analyst, testified as a witness for the Department.

ISSUE

Did the Department properly deny Appellant's prior authorization request for physical therapy?

FINDINGS OF FACT

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

1. Appellant is a [redacted] year-old female who has been diagnosed with difficulty walking and general muscle weakness. (Exhibit A, page 8).

2. Since [redacted], Appellant has been continuously enrolled in Medicare Parts A and B. (Exhibit A, page 5).

3. On or about [redacted], Appellant was admitted to the [redacted]) in [redacted]. (Testimony of Appellant).

4. After being admitted, Appellant received skilled outpatient physical therapy at [redacted] through her Medicare. (Exhibit A, page 16).

5. On or about [redacted], [redacted] determined that Appellant no longer required skilled physical therapy and it issued a Notice of Medicare Provider Non-Coverage. (Exhibit A, page 16).

6. Appellant appealed that determination, but, on [redacted] the Michigan Peer Review Organization ("MPRO") upheld the decision to terminate services after it also determined that Appellant no longer required skilled Medicare services. (Exhibit A, pages 13-14).

7. On [redacted], Appellant stopped receiving skilled physical therapy through Medicare. (Exhibit A, page 16).

8. Appellant then filed a request for an expedited appeal through Medicare, but the decision to terminate services was affirmed in a decision issued [redacted]. (Exhibit A, pages 15-19).

9. After her skilled physical therapy through Medicare was terminated, Appellant began paying for the therapy herself. (Exhibit A, page 5).

10. On [redacted], Appellant enrolled in Medicaid. (Exhibit A, page 5).

11. Appellant's physical therapy ended in M[redacted] after she stopped paying for it. (Testimony of Appellant).

12. In [redacted] the Department received a prior authorization request submitted by [redacted] on Appellant's behalf and requesting physical therapy for Appellant for the time period of [redacted] through [redacted] (Exhibit A, page 12; Testimony of [redacted]).

13. On [redacted], the Department sent Appellant and [redacted] a "NO ACTION REQUIRED" notice stating in part that:

> Your request does not require further action because:
>
> - MDCH records indicate that this patient is insured by Medicare and Medicaid. If Medicare covers a procedure, Medicaid will cover the co-pay and deductible without prior authorization. To obtain prior authorization for a service which Medicare has denied payment, a Medicare Explanation of Benefits (EOB) for review MDCH is required.
>
> *Exhibit A, page 12*

14. On [redacted], Appellant and [redacted] resubmitted the prior authorization request for physical therapy, along with documents relating to the termination of physical therapy by Medicare in [redacted] (Exhibit A, pages 8-19).

15. On [redacted], the Department sent Appellant written notice that her request for physical therapy was denied. (Exhibit A, pages 6-7).

16. Regarding the reason for the denial, the notice stated in part:

> The policy this denial is based on is Section 9-Medicaid Covered and Non-covered Services, 9.1-Medicare covered services, 9.2-Medicare Denial of Basic Care, Section 10-Medicaid Service Descriptions and 10.36-Therapies of the Nursing Facilities Coverages chapter of the Medicaid Provider Manual, which indicates:
>
> - Beneficiary has Medicare coverage. If Medicare approves coverage no Prior Authorization is required. If Medicare denies coverage because it is not medically necessary Medicaid will also deny coverage for services including therapy.
>
> - Per submitted documentation Medicare denied coverage for continuation of therapy. Medicaid cannot approve therapy services where Medicare determined the services as ". . . medically inappropriate".
>
> *Exhibit A, page 6*

17. On [redacted] the Michigan Administrative Hearing System ("MAHS" received the request for hearing filed by Appellant in this matter. (Exhibit A, page 4).

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.

Medicaid covered benefits are addressed for the practitioners and beneficiaries in the Medicaid Provider Manual (MPM).

With respect to Medicaid services in a Nursing Facility, the MPM states in part:

> **SECTION 9 – MEDICAID COVERED AND NON-COVERED SERVICES**
>
> Determination of medical necessity and appropriateness of Medicaid services is the responsibility of the attending physician (MD or DO) and is subject to MDCH review. Services must be within the scope of currently accepted medical practice, limitations of the Medicaid Program, and State and Federal requirements.
>
> **9.1 MEDICARE-COVERED SERVICES**
>
> For Medicare Part B covered services, MDCH only pays up to a Medicare-enrolled beneficiary's obligation to pay (i.e., coinsurance and deductibles) or the Medicaid fee screen, whichever is less. In addition, Medicaid covers the coinsurance and deductible amounts on any Medicare-covered service not normally covered by Medicaid.
>
> Medicaid co-insurance payments for Part A are the lower of the co-insurance charge or the current maximum co-insurance rate established under the formula stated in the Social Security Act. The facility's total payments from Medicare, Medicaid and other insurance may be up to, but cannot exceed, the amount established by Medicare as reasonable (i.e., the amount allowed by Medicare).
>
> If the beneficiary has a Medicare benefit available, that benefit must be utilized before Medicaid pays any portion of the claim. If a beneficiary who has Medicare coverage is receiving services under CMHSP or CA capitation, the CMHSP/CA assumes the MDCH payment liability described in this section.
>
> For Medicare coinsurance days billed to Medicaid, the beneficiary may be in either a Medicare certified or Medicare/Medicaid dually certified bed.
>
> Prior authorization is not required for billing the Medicare deductible and coinsurance amounts, even if the service would require prior authorization if Medicaid were the payer.

However, if the facility is uncertain of Medicare coverage, prior authorization from Medicaid should still be obtained. This allows the facility to render the service, bill Medicare and then, if appropriate, bill Medicaid for its share of the service. If Medicare Part B covers an item or service that is included in the Medicaid per diem, the nursing facility is responsible for any coinsurance or deductible, even when billed by an ancillary provider.

Services for which Medicare has made a payment may not be used to offset the patient-pay amount. Coinsurance amounts are charged to the patient-pay amount, and Medicaid reimburses any applicable difference between the patient-pay amount and the coinsurance rate.

If a beneficiary has Medicare Part B coverage, and Medicare does not cover a service, Medicaid considers the service to be included in the Medicaid reimbursement for routine nursing care.

9.2 MEDICARE DENIAL OF BASIC CARE

Medicare covers only skilled care. Medicaid covers both basic and skilled care. In the event a dually eligible Medicare/Medicaid beneficiary requires basic care, Medicaid will cover the service if all other admission criteria are met (e.g., physician order for nursing facility care and beneficiary meets the Medicaid Nursing Facility LOC Determination for NF care).

9.3 MEDICAID REIMBURSEMENT FOR A NURSING FACILITY BED FOLLOWING A QUALIFYING MEDICARE HOSPITAL STAY

A dually eligible beneficiary who resides in a Medicaid-only certified bed and is admitted to a hospital for acute care services may be eligible for Medicare-reimbursed Skilled Nursing Facility (SNF) benefits at the time of hospital discharge. If that beneficiary wants to return to the Medicaid NF bed he originally occupied, he may refuse his Medicare SNF benefit and Medicaid will reimburse for all medically necessary nursing facility days and other medically necessary services. The days billed to Medicaid must be included in the Medicaid census statistics.

The nursing facility must advise beneficiaries of their right to refuse their Medicare SNF benefit in order to return to their Medicaid NF bed. This notice must be in a manner that the beneficiary, family member, or beneficiary's legal representative can understand or have clearly explained to them as needed.

9.3.A. REQUIRED DOCUMENTATION

The facility must maintain, in the beneficiary's clinical and fiscal record, documentation that supports the beneficiary made the choice to forego Medicare-reimbursed services and return to his Medicaid-only certified bed. This documentation must be signed and dated by the beneficiary (or his authorized representative) and a nursing facility representative.

9.3.B. MEDICARE PART B

Required outpatient physical or occupational therapy, or outpatient speech pathology for NF beneficiaries must be provided and billed under Medicare Part B where applicable, even if no payments are made under Medicare Part A for the nursing facility stay.

* * *

9.5 PAYMENT FOR NON-COVERED SERVICES [CHANGE MADE 10/1/14]

For necessary medical or remedial care recognized under State law but not covered by the Medicaid Program, the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, allows nursing facility beneficiaries to access their patient-pay amount to pay for these services. The services would include services rendered by providers not enrolled in the Medicaid program. The offset to the patient-pay amount must be reported for the month that services were provided. (text added 10/1/14) If Medicare covers the medical service, then Medicaid will continue to cover the Medicare deductible and coinsurance in the event it does not exceed the Medicaid fee screen.

* * *

SECTION 10 - MEDICAID SERVICE DESCRIPTIONS

The following table outlines those services that are included in the facility's per diem rate or are an ancillary service that may be provided to beneficiaries in a nursing facility. Following the table is a more detailed description of each service.

* * *

Service Description	Covered		Non-Covered
	Included in Per Diem	Ancillary Service	

* * *

Therapies – Routine maintenance	**X**		
Therapies – Non-routine		**X**	

* * *

10.3 ANCILLARY SERVICES

Ancillary services (i.e., services other than daily care services), excluding physician services, must be ordered and documented, in writing, by the beneficiary's attending physician, and the documentation must be retained in the beneficiary's medical record. The physician's signature on prior authorization forms, treatment plans, etc., certifies the necessity of ancillary services. The physician must review the beneficiary's progress resulting from the ancillary service not less than every 60 days and summarize the progress resulting from the ancillary service provided.

The orders must be for a specific beneficiary (no blanket orders) and prior to the service being rendered. Orders may be received by telephone but must be written in the beneficiary's medical record. Such services must be provided and billed by the appropriate enrolled provider. It is suggested that the facility contact the ancillary provider or the Medicaid Provider Inquiry Line to ascertain whether the service is covered prior to arranging for the provision of the service. (Refer to the Directory Appendix for contact information.)

> The facility is responsible for arranging all ancillary and non-covered medical services. Arranging appointments and transportation for these services is included in the per diem rate.
>
> The beneficiary or beneficiary's representative may choose to purchase non-covered services directly from an ancillary provider. The beneficiary pays the ancillary provider directly for the services provided. The nursing facility must retain, in the beneficiary's fiscal record, receipts showing that the beneficiary paid for the particular non-covered service. Medicaid post-payment reviews will be conducted to assure that the beneficiary's fiscal record contains the receipts.
>
> Nursing facilities may not bill Medicaid for ancillary services except for therapies, oxygen, and the Medicare coinsurance or deductible for ancillary services. Otherwise, the ancillary provider must bill for the service. The Billing & Reimbursement for Institutional Providers Chapter contains the allowable nursing facility provider types that can bill for ancillary services.
>
> Therapies may be billed by the facility regardless of coverage by Medicare. However, Medicaid remains the payer of last resort.
>
> Ancillary services (e.g., physical therapy) provided to a beneficiary on the day of discharge may be billed to Medicaid, even if the beneficiary was admitted and discharged on the same date.
>
> *MPM, October 1, 2014 version*
> *Nursing Facility Coverages Chapter, pages 29-31, 33-35*

Moreover, with respect to therapies and physical therapy in particular, the MPM's chapter on nursing facility coverages also states in part:

> **10.36 THERAPIES**
>
> Nursing facilities must provide or obtain specialized rehabilitative services if required by the beneficiary's plan of care.
>
> Routine maintenance therapy consists of the repetitive services required to maintain function. The development of the therapy and treatment are included in the per diem rate. Such therapy does not require the therapist to perform the

service, nor does it require complex and sophisticated procedures.

Non-routine occupational therapy (OT), physical therapy (PT) and speech/language/pathology (ST) are ancillary services that are covered if prior authorization is obtained and the following conditions are met:

- The therapy must be billed by the facility;
- There must be a written order by the attending physician/licensed physician's assistant for each calendar month of therapy; and
- The written orders must be signed by the attending physician/licensed physician's assistant and retained in the beneficiary's medical record.

Non-routine ancillary therapy is therapy that requires the skills of qualified technical or professional health personnel such as physical therapists, occupational therapists, speech pathologists or audiologists, and is directly provided by or under the general supervision of these skilled personnel to assure the safety of the beneficiary and achieve the medically desired results as ordered by the beneficiary's physician.

Federal regulations require the facility to have a valid contract with the OT, PT, or ST provider. A valid contract allows the facility to retain professional and administrative control over the services provided. Therefore, an agreement that stipulates only the use of facility space does not constitute a valid contract.

If Medicaid funds have inappropriately been paid to a facility for OT, PT, or ST services when a facility did not possess a valid contract, the funds may be recovered by gross adjustment or at the time of cost settlement, as appropriate.

* * *

10.36.B. PHYSICAL THERAPY (PT)

Active, restorative, or specialized maintenance physical therapy (PT) programs, as explained below, are benefits of

the Medicaid Program. There must be the expectation that the beneficiary's condition will improve significantly in a reasonable and generally predictable period of time.

A licensed physical therapist (temporary permit is acceptable), physical therapy assistant, or physical therapy aide must provide the services. If the assistant or aide renders the service, they must be under the supervision of the therapist.

The following are examples of restorative PT services which may be covered by
Medicaid:

- Hot pack, ice pack, infrared treatment, or whirlpool bath is covered when provided as a prerequisite to a skilled physical therapy procedure;

- Gait training is covered when provided to a beneficiary whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;

- Prosthetic and orthotic training is covered when instructing the beneficiary in using the prosthetic or orthotic device; and

- Range of motion exercises are covered when provided as part of the treatment of a specific disability which has resulted in a loss or restriction of mobility.

For specialized maintenance physical therapy, the therapist's initial evaluation of the beneficiary's needs and designing of the program are covered. The program must be appropriate to the beneficiary's capacity, tolerance, and treatment objectives. The instructions to the beneficiary or to other members of the health team (e.g., nursing personnel) in carrying out such an individualized treatment plan and infrequent reevaluations, as may be required, are also covered.

MPM, October 1, 2014 version
Nursing Facility Coverages Chapter, pages 58, 60

Additionally, regarding the coordination of Medicaid and Medicare benefits, the MPM provides in part:

> **SECTION 1 – INTRODUCTION [CHANGE MADE 4/1/14]**
>
> This chapter applies to all providers.
>
> Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. If a beneficiary with Medicare or Other Insurance coverage is enrolled in a Medicaid Health Plan (MHP), or is receiving services under a Prepaid Inpatient Health Plan (PIHP) or Community Mental Health Services Program/Coordination Agency (CMHSP/CA), that entity is responsible for the Medicaid payment liability. **(text deleted per bulletin MSA 13-43)**
>
> Coordination of Benefits (COB) is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, prevention of duplicate payments. Third party liability (TPL) refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or selffunded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a beneficiary's medical coverage. The terms "third party liability" and "other insurance" are used interchangeably to mean any source, other than Medicaid, that has a financial obligation for health care coverage. Providers must investigate and report the existence of other insurance or liability to Medicaid and must utilize other payment sources to their fullest extent prior to filing a claim with the Michigan Department of Community Health (MDCH).
>
> Billing Medicaid prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered.
>
> * * *

2.6 MEDICARE

2.6.A. MEDICARE ELIGIBILITY

Many beneficiaries are eligible for both Medicare and Medicaid benefits. If a provider accepts the individual as a Medicare beneficiary, that provider must also accept them individual as a Medicaid beneficiary.

If a Medicaid beneficiary is eligible for Medicare (65 years old or older) but has not applied for Medicare coverage, Medicaid does not make any reimbursement for services until Medicare coverage is obtained. The beneficiary must apply for Medicare coverage at a Social Security Office. Once they have obtained Medicare coverage, services may be billed to Medicaid as long as all program policies (such as time limit for claim submission) have been met.

Medicaid beneficiaries may apply for Medicare at any time and are not limited to open enrollment periods. Beneficiaries may be eligible for Medicare if they are:

- 65 years of age or older.
- A disabled adult (entitled to SSI or RSDI due to a disability).
- A disabled minor child.

2.6.B. MEDICARE PART A

Since Medicare Part A pays for care in an inpatient hospital, nursing facility (NF), services provided by a home health agency (HHA) or in other institutional settings, Medicaid's reimbursement for services under Medicare Part A may vary.

If MDCH is paying a beneficiary's Medicare Part B premium and the beneficiary does not have free Medicare Part A, MDCH also pays the beneficiary's Medicare Part A premium.

MDCH monitors beneficiary files to identify all beneficiaries who currently have Medicare Part B coverage only, and have Part B buy-in. Once these beneficiaries are identified, MDCH automatically processes Part A buy-in.

When a beneficiary has incurred Medicare Part A charges and is eligible for, but does not have, Medicare Part A buy-in, the claim is rejected. Providers must wait for the beneficiary to obtain Medicare coverage, then bill Medicare for services rendered. After
Medicare's payment is received, Medicaid should be billed for any coinsurance and/or deductible amounts. For Medicare Part A and Part B/Medicaid claims, Medicaid's liability never exceeds that of the beneficiary.

To expedite the buy-in process, providers may notify MDCH, in writing, when a beneficiary age 65 or older, covered by Medicare Part B only, is admitted to an inpatient hospital. (Refer to the Directory Appendix for MDCH Provider Inquiry contact information.)

The following information is required:

- Beneficiary's name, date of birth, and Medicaid identification (ID) number;
- Health insurance claim number (HICN);
- Inpatient hospital admission date; and
- Hospital name, address, and provider NPI number.

Special points to remember:

- Medicaid does not pay for any portion of the services Medicare would have otherwise covered if a provider's error prevents Medicaid from buying-in Medicare Part A.
- To bill a claim when Medicare Part A coverage for Medicare/Medicaid beneficiaries is exhausted prior to an admission or during an inpatient hospital stay, refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual.

- To bill a claim when no Medicare payment has been made because the amount of Medicare coinsurance, plus the amount for lifetime reserve days, is greater than the Medicare diagnosis related group (DRG) amount, refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual.

2.6.C. MEDICARE PART B

Medicare Part B covers practitioner's services, outpatient hospital services, medical equipment and supplies, and other health care services. When a beneficiary is eligible for and enrolled in Medicare Part B, Medicare usually pays for a percentage of the approved Medicare Part B allowable charges and Medicaid pays the applicable deductible and/or coinsurance up to Medicaid's maximum allowable amount. Coverage for outpatient therapeutic psychiatric coverage varies.

Beneficiaries are encouraged to enroll in Medicare Part B as soon as they are eligible to do so. A beneficiary's representative can apply for Medicare Part B benefits on behalf of the beneficiary. After the beneficiary's death, DHS is responsible for making the application to the Social Security Administration (SSA) to cover medical services provided prior to the death.

* * *

2.6.F. MEDICAID LIABILITY

If Medicare has paid 100 percent of the allowable charges and there is no coinsurance involved, then Medicaid has no payment liability.

Neither the beneficiary nor Medicaid is liable for any difference in the amount billed by the provider and Medicare's allowable fee.

If the beneficiary is in a Medicare Risk HMO, MDCH pays fixed copays (except Medicare Part D) on the services up to the lesser of Medicaid's allowable amount minus the Medicare payment for the service or the beneficiary's payment liability, as long as the rules of the HMO are followed.

MDCH reimburses providers for the coinsurance and deductible amounts subject to Medicaid reimbursement limitations on all Medicare approved claims even if Medicaid does not normally cover the service. MDCH payment liability for beneficiaries with Medicare coverage (except Medicare Part D) is the lesser of:

- The beneficiary's liability for coinsurance, copayments, and/or deductibles minus and applicable Medicaid copayment, patient-pay, or deductible amounts.

- The Medicaid fee screen/allowable amount, minus any Medicare or other insurance payments and any applicable Medicaid copayment, patient pay, or deductible amounts.

- The provider's charge, minus any Medicare or other insurance payments, contractual adjustments, and any applicable Medicaid copayment, patient-pay, or deductible amounts.

For inpatient hospital claims, refer to the Hospital Claim Completion - Inpatient section (Medicare subsection) of the Billing & Reimbursement for Institutional Providers chapter for additional information.

* * *

MDCH does not pay for services denied by Medicare or other insurance plans due to noncompliance with Medicare or other insurance plan requirements. If the provider's service would have been covered and payable by Medicare or the other insurance plan but some requirement of the plan was not met, MDCH will deny the claim. The provider and the beneficiary both have equal responsibility for complying with Medicare or the other insurance plan requirements.

Common noncompliance denials include, but are not limited to,:

- Failure to obtain a referral from a participating primary care provider (PCP).

- Failure to be seen by a participating provider.

- Failure to be seen in a participating place of service.
- Failure to obtain a second opinion.
- Failure to obtain prior authorization

In instances where MDCH has denied payment or made a post-payment recovery due to noncompliance, it is the provider's responsibility to remediate with the primary payer prior to re-billing with Medicaid.

NOTE: This also applies to Fee-for-Service pharmacy claims, particularly claims submitted with Other Coverage Code (OCC) "3: Other Coverage Billed – Claim Not Covered." When the National Council for Prescription Drug Programs (NCPDP) standard does not provide MDCH with a point-of-sale (POS) mechanism to verify full compliance with Medicare or commercial health insurance plan requirements, MDCH will review and recover monies for noncompliance on a post-payment basis (e.g., when the primary payer denies the claim with NCPDP rejection code "75: Prior Authorization Required" and MDCH is unable to verify at the POS whether prior authorization was requested and denied versus prior authorization not requested).

When a Medicaid beneficiary is eligible for, but not enrolled in, Medicare Part B and/or Part D, MDCH rejects any claim for Medicare Part B or Part D services. Providers should instruct the beneficiary to pursue Medicare through the SSA.

If Medicare reimburses for the service, Medicaid does not require PA for the service.

MDCH identifies fee-for-service (FFS) beneficiaries who are retroactively eligible for Medicare. Medicaid payment for services provided to these beneficiaries is adjusted to recoup all monies except the Medicaid liability, and recovered via an automated claim adjustment. FFS providers are notified by MDCH when these adjustments occur. The notification includes beneficiary detail. If a discrepancy in payment exists, the provider should contact Provider Inquiry. (Refer to the Directory Appendix for contact information.)

> Beneficiaries cannot be charged for Medicaid-covered services, except for approved copays or deductibles, whether they are enrolled as a FFS beneficiary, MDCH is paying the HMO premiums to a contracted health plan, or services are provided under PIHP/CMHSP or CA capitation. Refer to the Commercial Health Insurance, Traditional Indemnity Policies, and Military/Veteran Insurance subsection of this chapter for exceptions when a beneficiary has third party resources.
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> *MPM, October 1, 2014 version*
> *Coordination of Benefits Chapter, pages 1, 6-11*

Pursuant to the above policies, the Department denied the prior authorization request for physical therapy in this case. Specifically, the Department's witness testified that, when a beneficiary is enrolled in both Medicare and Medicaid, the Medicare benefit must be utilized first when requesting services such as physical therapy. [redacted] also testified that, if a request for physical therapy is approved by Medicare, then Medicaid will pay the Medicare deductible and coinsurance amounts without any prior authorization, even if the service would require prior authorization if Medicaid were the payer. [redacted] further testified that, if Medicare denies the request for physical therapy, then Medicaid will only approve it in certain circumstances and will not pay for it when Medicare determined that the therapy was not medically necessary, as is the case here.

In response, Appellant testified that Medicare erred when terminating her physical therapy and, while she subsequently filed an appeal regarding that termination, she was never properly notified as to why the physical therapy was terminated. Appellant also testified that, while her facility has failed to timely discuss parts of her physical therapy with her, she was ultimately advised to apply for the services through Medicaid and, when the request was denied, to appeal that decision. Appellant further testified that she probably only requires another [redacted] months of physical therapy.

Appellant bears the burden of proving by a preponderance of the evidence that the Department erred in denying her prior authorization request. Moreover, in reviewing the Department's decision, the undersigned Administrative Law Judge is limited to reviewing the decision in light of the information available at the time the decision was made.

Here, based on the available information, the Department's decision must be affirmed. While Appellant believes that Department mistakenly denied her request for physical therapy on the basis that she had not improved enough and the therapy was not medically necessary, it appears that she is confusing the Department's decision with the decision by Medicare to terminate her services. The denial in this case was instead based on how Appellant's benefits are coordinated with each other and, to the extent

Appellant argues that the physical therapy is medically necessary, her dispute is with Medicare. Appellant already appealed the Medicare decision at the time it was made, but she is free to pursue any remedies through Medicare that remain. Moreover, given Medicare's decision was made in [redacted], Appellant could always re-request the physical therapy through Medicare with new or updated information. However, regardless of any future proceedings with Medicare, Appellant has failed to demonstrate that the Department erred in this case.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED THAT:

The Department's decision is **AFFIRMED**.

Steven Kibit
Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

SK/db

cc: [redacted]

***** 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.