STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Docket No. 15-000451 MHP
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 was represented by [redacted], Authorized Hearing Representative for [redacted], parent and full guardian.

Respondent is [redacted], subcontractor for the Medicaid Health Plan with Michigan Department of Community Health (MHP). Witnesses on behalf of the MHP included [redacted], Director of Customer Service, [redacted], Director of Health Services, and [redacted], Denials and Appeals Supervisor.

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for 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. Appellant is a [redacted] year-old female Medicaid beneficiary whose date of birth is [redacted].

2. On [redacted] Appellant went into anaphylaxis from a peanut allergy, following by an induced coma and on life support. Appellant was taken off life support 2 months later, and resided at [redacted] from [redacted], to [redacted]. Following, Appellant went home to her parents' for care. Appellant has severe anoxic encephalopathy with cerebral spastic quadriparesis and spasticity requiring an intrathecal baclofen pump. Appellant requires 24 hour care, full assist transfers, and a wheelchair for mobility. Appellant's diagnosis is Anoxic Brain Injury. (Exhibit A.2, 12 & 17; Testimony).

3. Beginning on or about [redacted] Appellant had 28 PT sessions approved by Respondent MHP. (Testimony).

4. On [redacted] Appellant's physician requested "continue PT for ROM, Strengthening and stretching B/W 2 s mo." (Exhibit A.23; Testimony).

5. On [redacted], the MHP issued a denial letter stating in part that:

> …our physician reviewer, who was not involved in any previous level of decision-making, has reviewed a request for Ongoing PT for passive range of motion… The reasons for denial are as follows:
>
> - Care givers have been trained in passive range of motion for more than one occasion.
> - It is expectation that care givers are capable, after training, of providing passive range of motion to maintain joint mobility.
> - The Medicaid Provider Manual (MPM) Section 5.2 Physical Therapy states the MDCH anticipates physical therapy 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). (Exhibit A.8-10).

6. The unsigned Denial Notice from the MHP does not indicate the name of the physician whom the MHP stated reviewed the request and/or any other physician(s) involved in the denial and/or review.

7. No physician was present at the administrative hearing on behalf of the MHP for testimony and/or cross-examination by the Appellant.

8. On 1[redacted], [redacted], RN, Advanced Care Infusion documented that since [redacted], Appellant's PT and combination of the pump, Appellant's tone has improved "1" for all limbs. (Exhibit A.6).

9. On [redacted] M.D. wrote a letter stating that due to Appellant's medical states and inability to move independently, Appellant medically requires ongoing physical therapy. (Exhibit A.16).

10. On [redacted], [redacted] from Dynasplint Systemx, Inc. documented that during the period of time from [redacted] to [redacted] the therapy and range of motion exercise resulted in improved wrist contracture and tone bilaterally. (Exhibit A.13).

11. On [redacted], the PT-Kelli Weak, wrote a statement stating that Appellant is progressively improving in sitting without maximal support, including propped forward on elbows with minimal PA for trunk support, able to keep head in midline without maximal support and beginning to show signs of active cervical rotation with head in an un-weighted position. (Exhibit A.15).

12. On [redacted], M.D., specialist in rehabilitation documented that due to immobility, Appellant is at great risk for muscle atrophy, decubitus ulcers, and contractures; ongoing physical therapy is essential; PT provides strengthening to many muscles that aid in better balance and trunk control.; requires regular range of motion to keep joints and muscles from stiffening; and that continuing PT is medically necessary for her rehabilitation and recovery. (Exhibit A.12).

13. On [redacted], a Request for Hearing was submitted on the Appellant's behalf.

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 Michigan Department of Community Health (Department or MDCH) 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 MHPs.

> 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,
.

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

(a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
(b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
(c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
(d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
(e) 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)(1) and (2),
Utilization Management, Contract.

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 are as follows:

SECTION 5 – STANDARDS OF COVERAGE AND SERVICE LIMITATIONS

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, and 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.

5.2.B. SERVICES TO SCHOOL-AGED BENEFICIARIES

MDCH recognizes school-aged beneficiaries may be eligible to receive PT through multiple sources. MDCH expects educational PT (e.g., strengthening to play school sports) to

> be provided by the school system and is not covered by MDCH or CSHCS.
>
> Outpatient therapy provided to school-aged children during the summer months in order to maintain the therapy services provided in the school is considered a continuation of therapy services when there is no change in beneficiary diagnosis or function. Prior authorization is required before initiating a continuation of therapy.
>
> *Department of Community Health,*
> *Medicaid Provider Manual, Outpatient Therapy Section*
> *Version Date: January 1, 2015, Pages 12-14.*

The purview of an administrative law judge (ALJ) is to review the Department's action and to make a determination if those actions are in compliance with Department policy, and not contrary to law. The ALJ must base the hearing decision on the preponderance of the evidence offered at the hearing or otherwise included in the record.

Here, the MHP argues that it denied on the grounds that continuing PT will be "passive range of motion," and that the family is trained in the same.

Appellant argues that the requested PT is not passive, and that passive is not a term found in the MPM, the PA, or even the MHPs policy. Appellant further argues that its evidence supports that ongoing PT meets the requirements of 'functional improvement' as required by the MPM, Section 5.2.

First, it is noted that Appellant is correct in that the phrase the MHP used in denying ongoing therapy, that it is 'passive range of motion,' is not a phrase found in the MPM, the PA, or in the policy submitted by the MHP. Appellant objected to the use of this term and requested its definition or clarification. As the term is not found in the law or policy, there is no definition of this phrase and thus, much argument ensued at the administrative hearing as to the nature of the type of physical therapy envisioned by both parties. The MHP argues that the family is engage in such therapy; Appellant argues that the therapy a physical therapist would provide is necessary and required to continue the functional improvement documented by the medical evidence.

In support of its position, the MHP's denial included the statement in the [redacted] denial that a 'physician reviewer' re-reviewed the Appellant's "request for ongoing PT for passive range of motion" and evidently upheld the initial denial. (Exhibit A.5). However, that physician did not sign the denial, and, in fact, that physician is not named in the denial. Nor was that physician nor any other physician present at the administrative hearing and available for testimony and/or cross-examination.

Appellant argues that the family is engaged in stretching exercises at home but the PT that Appellant needs is to improve her function and requires more skill and knowledge that a physical therapist would perform. In support of its position, the Appellant

referenced a number of documents. Alll of these documents were part of the Respondent MHP's evidentiary packet and submitted by the MHP: [redacted] documentation that Appellant's tone is improving (Exhibit A.6); [redacted] letter indicating Appellant requires ongoing PT (Exhibit A.16); [redacted] documentation that due to the exercise Appellant's wrist contractures and tone have improved bilaterally (Exhibit A.13); PH [redacted] statement indicating progressive improvement in sitting, being propped forward on elbows, and holding her head without maximal support, begging to show signs of cervical rotation with head in an un-weighted position (Exhibit A.15); [redacted] documentation that ongoing PT is essential and that Appellant is showing better balance and trunk control, rehabilitation and recovery (Exhibit A.12). (See Finding of Facts 5-9).

After a careful review of the credible and substantial evidence of record, this ALJ finds that the evidence submitted by Appellant supports, by a preponderance of evidence, that the MHP's denial is not supported by the great weight of evidence-Appellant is, has been, and continues to show significant functional improvement in her ability to perform mobility skills appropriate for her functional status. All of the evidence submitted by the numerous doctors, PT, infusion nurse, and the Dynasplint Systemx indicate that Appellant continues to functionally improve. Moreover, the 'passsive range of motion' requirement is not found or defined in the federal and state law as a basis for denial; even so, Appellant significantly rebutted the therapy requested for Appellant is not passive in any general meaning of the word. Appellant pointed out that the family engages in stretching range of motion at home; these are not the skilled therapies for which Appellant's physician applied for, and, for which would result and has resulted in functional improvements on behalf of Appellant. The request here is for the training and expertise of a physical therapist to improve Appellant's functional ability to perform mobility skills. MPM Section 5.2. While it is conceivable that in the future Appellant may reach a plateau, the evidence here shoes that Appellant continues to functionally improve meeting the MPM requirements found in Section 5.2.

For these reasons, and for the reasons state above, Appellant has rebutted the MHP's denial with credible and substantial evidence and thus, is MHP's denial is reversed.

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 incorrectly denied the Appellant's request for, physical therapy.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is REVERSED.

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

cc: [redacted]

JS[redacted]

Date Signed: [redacted]

Date Mailed: [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.