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

IN THE MATTER OF:

Docket No. 15-015528 MHP

[redacted] [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.,* upon a request for hearing filed on the minor Appellant's behalf.

After due notice, a telephone hearing was held on [redacted] [redacted] Appellant's mother, appeared and testified on Appellant's behalf. [redacted] Associate General Counsel, represented [redacted], the Respondent Medicaid Health Plan (MHP). [redacted], the MHP's Medical Director, and [redacted], Grievance Coordinator, appeared as witnesses for the MHP.

ISSUE

Did the MHP properly deny Appellant's prior authorization request for physical therapy (PT) 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. Appellant is a [redacted] year old Medicaid beneficiary, born [redacted] (Exhibit B, p 2; Testimony)

2. On [redacted], the MHP received a prior authorization request submitted on Appellant's behalf requesting PT services through the MHP. The request was for one PT evaluation and 12 PT sessions for a diagnosis of toe walking and abnormality of gait. (Exhibit B, pp 1-9; Testimony)

3. On [redacted], the MHP sent Appellant's representative written notice that the request for PT services had been denied because the MHP had determined that the services were not medically necessary. Specifically, the denial notice stated:

> Available information does not show [redacted] has a temporary medical condition that causes decreased movement of the inability to perform tasks that with physical therapy would reduce the physical disability and return him to his best functional level. The request for outpatient physical therapy is not covered.
>
> **According to available information, the requested services may be available through the school system**.
>
> (Exhibit A, pp 6-8; Testimony)

4. On [redacted] the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (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.

In 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 MHPs and, as provided in the Medicaid Provider Manual (MPM), is responsible for providing covered services pursuant to its contract with the Department:

> The Michigan Department of Community Health (MDCH) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should

be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDCH website. (Refer to the Directory Appendix for website information.)

MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

1.1 SERVICES COVERED BY MEDICAID HEALTH PLANS (MHPS)

The following services must be covered by MHPs:

- Ambulance and other emergency medical transportation
- Blood lead services for individuals under age 21
- Certified nurse-midwife services
- Certified pediatric and family nurse practitioner services
- Childbirth and parenting classes
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and medical supplies
- Emergency services

- End Stage Renal Disease (ESRD) services
- Family planning services
- Health education
- Hearing and speech services
- Hearing aids
- Home health services
- Hospice services (if requested by enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility) for up to 45 days
- Medically necessary transportation for enrollees without other transportation options
- Medically necessary weight reduction services
- Mental health care (up to 20 outpatient visits per calendar year)
- Out-of-state services authorized by the MHP
- Outreach for included services, especially pregnancy-related and well-child care
- Pharmacy services
- Podiatry services
- Practitioner services (such as those provided by physicians, optometrists, or oral maxillofacial surgeons)
- Prosthetics and orthotics

- Therapies (speech, language, physical, occupational)
- Tobacco cessation treatments, including pharmaceutical and behavior support
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for individuals under age 21

1.2 SERVICES EXCLUDED FROM MHP COVERAGE BUT COVERED BY MEDICAID

The following Medicaid services are not covered by MHPs:

- Custodial care in a licensed nursing facility; restorative or rehabilitative nursing care in a licensed nursing care facility beyond 45 days
- Certain dental services (Refer to the Dental chapter of this manual for additional information.)
- Specific injectable drugs administered through a PIHP/CMHSP clinic to MHP enrollees are reimbursable by MDCH on a fee-for-service basis. (Refer to the Injectable Drugs and Biologicals subsection of the Practitioner Chapter of this manual for additional information.)
- Home and Community Based Waiver program services
- Inpatient hospital psychiatric services (MHPs are not responsible for the physician cost related to providing a psychiatric

admission physical and histories. However, if physician services are required for other than psychiatric care during a psychiatric inpatient admission, the MHP would be responsible for covering the cost, provided the service has been prior authorized and is a covered benefit.)

- Maternal Infant Health Program (MIHP)
- Mental health services outside the MHP's contractual responsibility
- Outpatient partial hospitalization psychiatric care
- Personal care or home help services
- Private Duty Nursing services
- Services provided to persons with developmental disabilities and billed through the Community Mental Health Services Program (CMHSP)
- Services provided by a school district and billed through the Intermediate School District
- Substance abuse services through accredited providers, including:
- Screening and assessment;
- Detoxification;
- Intensive outpatient counseling and other outpatient services; and
- Methadone treatment
- Transportation for services not covered by the MHP.

1.3 SERVICES THAT MHPS ARE PROHIBITED FROM COVERING

- Elective therapeutic abortions and related services. Abortions and related services are covered when medically necessary to save the life of the mother or if the pregnancy is a result of rape or incest;
- Experimental/Investigational drugs, procedures or equipment;
- Elective cosmetic surgery; and
- Services for treatment of infertility.

MPM, January 1, 2015 version
Medicaid Health Plan Chapter, pages 1-3
(Emphasis added by ALJ)

This case involves a request for PT and, with respect to such services, the MPM states in pertinent part:

SECTION 5 – STANDARDS OF COVERAGE AND SERVICE LIMITATIONS

5.2 PHYSICAL THERAPY [CHANGES MADE 4/1/15]

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 licensed Physical Therapist (PT) or an appropriately supervised licensed Physical Therapy Assistant (PTA).

The PT must supervise and monitor the PTA's performance with continuous assessment of the beneficiary's progress. All documentation must be reviewed and signed by the supervising PT.

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 PT). MDCH does not cover interventions provided by another practitioner (e.g., teacher, RN, OT, 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 the following: **(revised 4/1/15)**

- When PT is provided by an independent PT. (An independent PT 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.

Note: Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative therapy services. **(text added 4/1/15)**

- 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.

MPM, April 1, 2015 version
Outpatient Therapy Chapter, pages 12-14
(Emphasis added by ALJ)

The MHP's Medical Director testified that the diagnoses submitted with the request, toe walking and abnormality of gait, are not medical diagnoses that would support the request for PT. The MHP's Medical Director indicated that while Appellant does have autism, that diagnosis would not give rise to a medical reason for Appellant's toe walking and abnormality gait.

Appellant's mother testified that Appellant does toe walk and is autistic, but she is not sure if the condition is temporary. Appellant's mother indicated that if PT would help,

she would like to try it. Appellant's mother testified that the muscle in Appellant's ankle is tightening and PT might help with that. Appellant's mother indicated that Appellant has come a long way and is talking now. Appellant's mother testified that the toe walking has been improving and normally only happens when Appellant is very excited or upset.

Appellant's representative bears the burden of proving by a preponderance of the evidence that the Department erred in denying the prior authorization request for PT. Given the record in this case, Appellant's representative has failed to meet her burden of proof and the MHP's decision must be affirmed. As indicated above, policy indicates that 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." Here, the diagnoses submitted with the request, toe walking and abnormality of gait, are not medical diagnoses that would support the request for PT. And, while Appellant does have autism, that diagnosis would not give rise to a medical reason for Appellant's toe walking and abnormality gait. As such, the denial was proper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied Appellant's prior authorization request for physical therapy services.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: [redacted]
Date Mailed: [redacted]
RJM/db
cc: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System 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.