STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(517) 373-0722; Fax: (517) 373-4147

IN THE MATTER OF:

MAHS Docket No. 15-020387 MHP

[redacted]

Appellant

[redacted]/

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 hearing.

After due notice, a telephone hearing was held on [redacted] Appellant appeared and testified on her own behalf. [redacted] Director of Customer Service, appeared and testified on behalf of [redacted] the Respondent Medicaid Health Plan (MHP). [redacted] Director of Health Services, and [redacted] Clinical Review Nurse, also testified as witnesses for the MHP.

Following the completion of the hearing, the record was left open until [redacted] so that the MHP could submit a [redacted] letter from Appellant's doctor and its [redacted] response to that letter. However, while the MHP did submit the letter, which was entered into the record as Exhibit B, it did not submit any response to the letter. Despite the specific testimony during the hearing to the contrary, the MHP's representative noted in her cover letter that no written response was ever sent.

ISSUE

Did the MHP properly deny Appellant's prior authorization request for additional 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 Medicaid beneficiary who was enrolled in the Respondent MHP. (Exhibit A, page 5; Testimony of Appellant).

2. On or about [redacted], the MHP received a prior authorization request submitted on Appellant's behalf for [redacted] physical therapy visits. (Exhibit A, pages 3-7).

3. The request stated that Appellant needed the physical therapy for "s/p hardware removal from left patella fracture". (Exhibit A, page 5).

4. The supporting documentation submitted along with the prior authorization request contained an Updated Physical Therapy Plan of Care. (Exhibit A, page 6).

5. That Plan of Care indicated that Appellant has had twenty-five previous physical therapy sessions. (Exhibit A, page 6).

6. In its Subjective section, it provided that Appellant reported a pain level of 0/10 on [redacted], but also stated that her knee buckled while on stairs earlier that day; her knee had been cracking more than usual; and that Appellant had been compliant with her home exercise program. (Exhibit A, page 6).

7. In its Objective section, the Plan of Care provided that Appellant's left hip flexion was 4+/5; her left hamstring was 5/5; her left quads 4/5; her left vastus medialis oblique was 4/5; and her left knee extension was a "7 degree extension lag in seated position with LAQ. Crepitus with some medial knee pain with extension." (Exhibit A, page 6).

8. The Plan of Care further provided that:

> Sit to stand transfers and stairs are still difficult. Patient encouraged to bear weight through L LE when standing from chairs every single time and do not rely on arms. Patient was also encouraged to perform step ups with L LE leading at bottom step 2x per day on a daily basis. Grossly the patient's strength has improved; however functionally she continues to have difficulties.
>
> *Exhibit A, page 6*

9. It also identified Appellant's current problems as "Crepitus with L knee extension, decreased AROM due to strength L knee extension" and recommended both that Appellant continue skilled intervention toward her updated goals and that she be referred to a physician to ask about the increased crepitus in left knee. (Exhibit A, page 6).

10. On [redacted], the MHP sent Appellant written notice that the prior authorization request was denied. (Exhibit A, pages 11-13).

11. Specifically, the notice of denial sent to Appellant stated the reason additional physical therapy was denied was because "Reasonable intervention has resulted in significant short term improvement." (Exhibit A, page 11).

12. Appellant then filed a local appeal with the MHP. (Exhibit A, page 14).

13. On or about [redacted], Appellant's physical therapist sent in a letter in support of Appellant's appeal in which the physical therapist described the course of Appellant's past physical therapy and stated that, while Appellant is able to perform all of her home exercises without assistance, Appellant still requires skilled therapy for continued gait training and functional training, including the use of stairs and transferring. (Exhibit A, page 15).

14. On [redacted], the MHP sent written notice to Appellant and her medical providers that her appeal was denied for the same reason identified in the previous notice. (Exhibit A, pages 14, 18-20).

15. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit 1, pages 1-3).

16. Attached to the request for hearing was a letter from Appellant's doctor, dated [redacted], in which the doctor states:

> [Appellant] is still having knee pain, weakness and instability. Her gait is getting better, but she still sates her left leg and quads are very weak. It is out recommendation it is medically necessary for [Appellant] to continue physical therapy for quad strengthening, knee pain, and quadriceps weakness.
>
> *Exhibit 1, page 2*

17. The request for hearing also contained a letter from Appellant's physical therapist, dated [redacted], in which the physical therapist wrote:

> At this time, [Appellant] would require skilled physical therapy services to specifically work on stair safety and gait training. These particular activities to improve stair function and normalize her gait pattern would require supervision in physical therapy in order to complete safely. It is the supervision aspect of

> skilled physical therapy services that would make it necessary for her to continue for these reasons only.
>
> *Exhibit 1, page 3*

18. On or about [redacted] the MHP received a letter from Appellant's doctor, dated [redacted], in which the doctor stated:

> [Appellant] has patella baja, a pos-traumatic sequela of her patella fracture. She would benefit from continued physical therapy at the earliest possible date to prevent further contracture of her patellar tendon.
>
> *Exhibit B, page 3*

19. During the hearing in this matter, the MHP's Director of Health Services testified that the [redacted] letter did not change its decision and Appellant was therefore sent notice that the decision stood. (Testimony of [redacted]

20. However, after the record was left open so that the MHP could submit both the [redacted] letter and the new notice, the MHP only provided the letter and indicated that no other action was taken as there was no mention of an appeal in the letter and it was processed as a reconsideration with no additional information. (Exhibit B, page 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 statutes, 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.
>
> *MPM, October 1, 2015 version*
> *Medicaid Health Plan Chapter, page*

With respect to physical therapy, the MPM also states in part:

> **5.2 PHYSICAL THERAPY [CHANGES MADE 4/1/15]**
>
> MDHHS 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.

MDHHS 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). MDHHS does not cover interventions provided by another practitioner (e.g., teacher, RN, OT, family member, or caregiver).

MDHHS 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. MDHHS 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. MDHHS 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. MDHHS 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.

MDHHS 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, October 1, 2015 version
Outpatient Therapy Chapter, pages 12-14
(Internal highlighting omitted)

Here, as provided in the notice of denial, the MHP denied Appellant's request for additional physical therapy on the basis that "Reasonable intervention has resulted in significant short term improvement." Its witnesses also testified that, based on the clinical information it received regarding Appellant's improvement and current status, as well as the fact that a home exercise program has been established and should be able to further Appellant's progression, additional physical therapy was not medically necessary.

In response, Appellant testified that, while she has made improvement, she is not where she needs to be and still has significant difficulties with stairs, transferring, and her gait. She also testified that her continuing need for physical therapy is outlined in the numerous letters sent by her doctor and physical therapist throughout the course of this case.

Appellant has the ultimate burden of proving by a preponderance of the evidence that the MHP erred in denying her request. However, the MHP also bears the initial burden of going forward with sufficient evidence to show that its action is correct and in accordance with law and policy.

Given the record in this case, the undersigned Administrative Law Judge finds that the MHP erred and that its decision to deny Appellant's request for additional physical therapy must be reversed.

As an initial matter, the undersigned Administrative Law Judge would note that the sole reason given in the notice for the MHP's decision is not a proper basis for denying Appellant's request. The notice states that the request was denied because Appellant's past physical therapy has resulted in significant short-term improvement, but short-term improvement alone does not preclude further physical therapy under the applicable policies. Those policies provide that any functional improvements must be durable, *i.e.* maintainable, and that physical therapy may be approved so long as it is medically necessary for the restoration of a beneficiary to his/her best possible functional level. Whatever short-term improvement has been made, additional physical therapy would still be appropriate pursuant to the above policy if Appellant has not been restored to her best functional level and all the other requirements were met. Accordingly, given the sole reason identified in notice of denial, the MHP's decision was improper.

Moreover, while the MHP's witnesses elaborated on the language found in the notice of denial and specifically testified that additional physical therapy is not medically necessary given Appellant's past improvement, current status and home exercise program, the undersigned Administrative Law Judge does not find that testimony to be persuasive. Appellant credibly testified regarding her general functional level as well as her specific continuing difficulties with her gait, using stairs and transferring. Her physical therapist also consistently identified those difficulties and Appellant's need for skilled physical therapy in both the supporting documentation sent along with the prior authorization request and in the letter sent in support of Appellant's local appeal.

Appellant's doctor likewise described in a letter how Appellant still needs physical therapy for quad strengthening, knee pain, and quadriceps weakness given her continuing knee pain, weakness, instability, and poor gait; and, while the MHP's representative stated that they never received any such letter from Appellant's doctor, the undersigned Administrative Law Judge does not find her credible given the inconsistent and/or incorrect testimony regarding what information the MHP received in this case.

Accordingly, given the extensive documentation supporting the request, in addition to the improper reason identified in the notice of denial, the undersigned Administrative Law Judge finds that the MHP erred and that its decision to deny Appellant's request for additional physical therapy must be reversed.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is **REVERSED** and it must initiate an approval of Appellant's request for [redacted] physical therapy sessions.

Steven Kibit

Steven Kibit
Administrative Law Judge
for Director, Nick Lyon
Michigan Department of Health and Human Services

Date Mailed: [redacted]

SK/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.