RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: June 30, 2016
MAHS Docket No.: 16-004944
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Colleen Lack

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 Petitioner's request for a hearing.

After due notice, a telephone hearing was held on June 1, 2016. [redacted], the Petitioner, appeared on her own behalf. The Department of Health and Human Services contracted Medicaid Health Plan (MHP), [redacted] was represented by [redacted], Inquiry Dispute Appeal Resolution Coordinator. [redacted], Medical Director, appeared as a witness for the MHP.

During the hearing proceedings, the MHP's Hearing Summary packet was admitted as Exhibit A, pp. 1-23.

ISSUE

Did the Department properly deny Petitioner's request for a continuation of outpatient physical therapy visits?

FINDINGS OF FACT

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

1. Petitioner is a Medicaid beneficiary enrolled in the MHP.

2. Petitioner has been diagnosed with osteoarthritis of the right knee. (Exhibit A, p. 4)

3. On or about [redacted], the MHP received a Prior Authorization Request for an additional 12 physical therapy visits. (Exhibit A, pp. 4-8)

4. Petitioner received at least 144 units during an initial outpatient physical therapy period within the past year. (Exhibit A, p. 4; Medical Director Testimony)

5. On [redacted], the MHP sent a letter to the Petitioner and her medical provider stating that the request for additional outpatient physical therapy visits was denied because for the initial period, 144 units are allowed in 12 months and Petitioner had already gone beyond the limit allowed. Notice of Petitioner's appeal rights was included. (Exhibit A, pp. 9-13)

6. On [redacted], the Michigan Administrative Hearing System received Petitioner's request for hearing. (Exhibit A, pp. 2-3)

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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 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 Health and Human Services (MDHHS) 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 MDHHS 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, Medicaid Health Plans Chapter,
April 1, 2016, p. 1

In this case, the MHP utilized the MPM policy regarding billing and reimbursement for institutional providers as well as the MPM policy regarding outpatient therapy:

Physical Therapy (PT)

- PT does not require PA for maximum of 144 units within the first 12 consecutive calendar months of therapy.
- For PT services, use a revenue code with the appropriate HCPCS code on the claim line. The quantity should reflect the appropriate quantity per code description. If the procedure is not defined by a specific time frame, report "1" as the quantity. The fee screen for PT includes all services. Hospitals cannot bill a clinic room charge in addition to the therapy unless the visit is unrelated to PT.
- Evaluation or re-evaluation may be billed with other PT services on the same day. Therapy must be provided by the evaluating discipline.
- PA is required for continuing therapy beyond the initial 12 consecutive calendar months of therapy.

MPM, Billing & Reimbursement for Institutional Providers Chapter,
April 1, 2016, p. 37
(underline added by ALJ)

Continued Active Treatment

MDHHS requires providers to obtain PA to continue PT beyond the initial 12 months. Providers must complete the MSA-115. MDHHS returns a copy of the PA to the provider after processing the request. The PA must be retained in the beneficiary's medical record.

Requests to continue Active Therapy must contain:

- A treatment summary of the previous period of PT, including measurable progress on each short-term and long-term goal. This should include the treating PT's analysis of the therapy provided

during the previous month, the rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes.

- A progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of PT.
- Documentation related to the period no more than 30 days prior to that time period for which PA is being requested.
- A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
- A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.
- A copy of the prescription, hand-signed by the referring provider and dated within 30 days prior to initiation of continued service, must be provided for each request.
- A discharge plan.

When a beneficiary completes 144 units of initial therapy and then chooses to change providers for continued therapy, prior authorization for the continued therapy is required.

MPM, Outpatient Therapy Chapter,
April 1, 2016, p. 17

On or about [redacted], the MHP received a Prior Authorization Request for an additional 12 physical therapy visits. (Exhibit A, pp. 4-8) However, the evidence establishes that Petitioner received at least 144 units during an initial outpatient physical therapy period within the past year. (Exhibit A, p. 4; Medical Director Testimony) On [redacted], the MHP sent a letter to the Petitioner and her medical provider stating that the request for additional outpatient physical therapy visits was denied because for the initial period, 144 units are allowed in 12 months and Petitioner had already gone beyond the limit allowed. (Exhibit A, pp. 9-13)

The Medical Director also testified that medical necessity for the additional 12 physical therapy visits requested on the [redacted], prior authorization request form was not established based on the available information. As noted, Petitioner had already exhausted the 144 units allowed, which would equate to going three times a week for 48 straight weeks. If the physical therapy was not working as expected from the at least 144 units already received, there would be no reason to suspect that continuing physical therapy would do any better. The Medical Director also noted that Petitioner's hearing request and testimony indicate she is scheduled for another complete knee surgery. Therefore, physical therapy services would be much better rendered after the surgery, and may actually help Petitioner at that time. Any services rendered prior to the surgery would be negated when the surgery is completed. Accordingly, additional

physical therapy services would not be warranted prior to Petitioner's pending third surgical procedure. (Medical Director Testimony)

Petitioner disagrees with the denial and testified she has had two failed surgeries and is getting ready for the third surgery. Petitioner indicated she stopped physical therapy to have the third surgery, but will need the physical therapy after this surgery. (Petitioner Testimony)

Overall, the evidence supports the MHP's determination to deny the [redacted], Prior Authorization Request for an additional 12 physical therapy visits. This was a request for a continuation of physical therapy services at that time. The physical therapy provider noted on the prior authorization form that Petitioner had exhausted the 144 units allowed. It appears there was only limited improvement with the physical therapy Petitioner received. Further, the evidence indicates there has been a change in Petitioner's treatment plan since this prior authorization request was filed and Petitioner is now going to have a third surgical procedure. (Exhibit A, pp. 2 and 4-7; Petitioner Testimony) As indicated by the Medical Director's testimony, medical necessity has not been established for the [redacted], Prior Authorization Request for an additional 12 physical therapy visits for a continuation of therapy at that time.

As noted during the hearing proceedings, there is no evidence that a prior authorization request had yet been made, let alone denied, for physical therapy services Petitioner may need after her upcoming surgery. The MHP confirmed that if a new prior authorization request is submitted after Petitioner's surgery, such as a request for rehabilitation therapy, the MHP will review that request and the updated supporting documentation to make a determination for that prior authorization request.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the MHP properly denied Petitioner's [redacted] Prior Authorization Request for an additional 12 physical therapy visits for a continuation of therapy based on the information available at that time.

IT IS, THEREFORE, ORDERED that:

The Medicaid Health Plan's decision is **AFFIRMED**.

Colleen Lack

CL/cg

Colleen Lack
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact [redacted]

Petitioner [redacted]

Community Health Rep [redacted]