STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: September 22, 2017
[redacted]
AGENCY: MAP
FH #: 7613802Q

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on November 15, 2017, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long Term Care Plan (Centers Plan for Healthy Living)

Alisha Jacob, Fair Hearing Representative

ISSUE

Was the determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny coverage for 10 physical therapy sessions for the Appellant, correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 54, is in receipt of authorization for Medical Assistance and is enrolled in a Medicaid managed long term care plan operated by Centers Plan for Healthy Living (Centers Plan).

2. On or about August 2, 2017, the Appellant's provider requested approval for 10 physical therapy visits for the Appellant.

3. By notice dated August 4, 2017, Centers Plan denied the request for physical therapy visits, stating assessments of the Appellant did not show evidence of "significant improvement in the strength of your lower legs".

4. The Appellant appealed this determination

5. By Notice dated September 7, 2017, Centers Plan upheld its initial determination to deny the requested physical therapy visits, stating, in part, "Based upon information submitted, you have derived maximum benefit from physical therapy services and continued physical therapy services are no longer medically necessary".

6. On September 22, 2017, this fair hearing was requested.

APPLICABLE LAW

Section 365-a. of the Social Services Law regarding character and adequacy of medical assistance advises in relevant part that the amount, nature and manner of providing medical assistance for needy persons shall be determined by the public welfare official with the advice of a physician and in accordance with the local medical plan, this title, and the rregulations of the department. "Standard coverage" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department. Such care, services and supplies shall include the following medical care, services and supplies, together with such medical care, services and supplies provided for in subdivisions three, four and five of this section, and such medical care, services and supplies as are authorized in the regulations of the department:

Pursuant to regulations at 18 NYCRR 513.0, where prior approval of medical, dental and remedial care, services or supplies is required under the MA program, such prior approval will be granted when the medical, dental and remedial care, services or supplies are shown to be medically necessary to prevent, diagnose, correct or cure a condition of the recipient which: (1) causes acute suffering; (2) endangers life; (3) results in illness or infirmity; (4) interferes with the capacity for normal activity; or (5) threatens to cause a significant handicap.

18 NYCRR 513.1 provides the following definition of medical necessity:

(c) Necessary to prevent, diagnose, correct or cure a condition means that requested medical, dental and remedial care, services or supplies would: meet the recipient's medical needs; reduce the recipient's physical or mental disability; restore the recipient to his or her best possible functional level; or improve the recipient's capacity for normal activity. Necessity to prevent, diagnose, correct or cure a condition must be determined in light of the recipient's specific circumstances and the

recipient's functional capacity to use or make use of the requested care, services or supplies and appropriate alternatives.

Section 364-j (1)(c) of the Social Services Law defines "Managed Care Program" as a program in a social services district in which medical assistance recipients enroll on a voluntary or mandatory basis to receive medical assistance services, including case management, directly or indirectly (including by referral) from a managed care provider ("Medicaid Managed Care Health Plan"), or, if applicable, a mental health special needs plan or a comprehensive HIV special needs plan.

The United State Department of Health and Human Services (Health Care Finance Administration) has granted the State of New York a waiver under Section 1115 of the Social Security Act to permit the operation of a demonstration waiver program for Managed Care Programs in which certain eligible Medicaid recipients are subject to mandatory enrollment.

The Medicaid Managed Care Model Contract delineates the terms by which Medicaid Managed Care Plans agree to cover specified healthcare services in accordance with New York State Medicaid Guidelines. Chapter 10 of the Medicaid Managed Care Model Contract states, in part:

10.1 Contractor Responsibilities

a) Contractor must provide or arrange for the provision of all services set forth in the Benefit Package for MMC Enrollees and FHPlus Enrollees subject to any exclusions or limitations imposed by Federal or State Law during the period of this Agreement. SDOH shall assure that Medicaid services covered under the Medicaid fee-for-service program but not covered in the Benefit Package are available to and accessible by MMC Enrollees.

10.2 Compliance with State Medicaid Plan, Applicable Laws and Regulations

a) All services provided under the Benefit Package to MMC Enrollees must comply with all the standards of the State Medicaid Plan established pursuant to Section 363-a of the SSL and shall satisfy all other applicable requirements of the SSL and PHL.

b) Benefit Package Services provided by the Contractor through its FHPlus product shall comply with all applicable requirements of the PHL and SSL.

c) Pursuant to 42 CFR 438.210, the Contractor may establish appropriate limits on a service for utilization control and/or medical necessity. The Contractor must ensure that Covered Services are provided in sufficient amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor will not define medically necessary services in a manner that limits the

scope of benefits provided in the SSL, the State Medicaid Plan, State regulations or the Medicaid Provider Manuals.

The Regulations at 18 NYCRR Section 505.11 describe the provision of rehabilitative services under the Medical Assistance program and state in pertinent part as follows:

Section 505.11 - Rehabilitation services.

(a) Provision of care. Rehabilitation services, with the exception of services provided under subparagraph (c)(1)(iv) of this section, are available only if a physician provides a written order for the services to the medical assistance recipient and the services are an integral part of a comprehensive medical care program. Services provided under subparagraph (c)(1)(iv) of this section may be made available only if a physician, registered nurse, nurse practitioner, physical therapist, occupational therapist, or speech pathologist, who is acting within the scope of his or her practice under New York State law, recommends the medical assistance recipient for such services and the services are part of an individualized education program or an interim or final individualized family services plan. The health professional must be licensed, registered, and/or certified in accordance with the New York State Education Law and the rules of the Commissioner of Education. Such recommendation must be reflected in the individualized education program or an interim or final individualized family services plan. Rehabilitation services include not only services to the recipient but also instructions to responsible members of the family in follow-up procedures necessary for the care of the recipient.

(b) Where care may be provided. Rehabilitation services may be provided in the recipient's home, in a hospital outpatient department, in an approved clinic or outpatient medical facility not part of a hospital, in an approved medical institution or facility, in an approved home health agency, in the office of a qualified private practicing therapist or speech pathologist and, with respect to a child receiving rehabilitation services pursuant to an individualized education program or an interim or final individualized family services plan, in a school, an approved pre-school or natural environment, including home and community settings, where such child would otherwise be found.

(c) Who may provide care. Rehabilitation services may be provided by:

(1) Qualified professional personnel employed by or under contract to:

(i) an approved home health agency;

(ii) a hospital;

(iii) an approved clinic or outpatient medical facility not part of a hospital; or

(iv) a school district; an approved pre-school; a county in the State or the City of New York; an approved early intervention program; or a municipality in the State. Such services will be furnished as part of the development of or pursuant to an individualized education program or an interim or final individualized family services plan.

***

(e) Physician's written order required.

(1) Rehabilitation services must be supported by a written order of a qualified physician and must be carried out under his or her medical direction. The written order constitutes medical direction of the physician.

(2) Such written order must include a diagnostic statement and purpose of treatment.

(3) Such written order is required prior to treatment.

(4) In extraordinary circumstances and for valid reasons which must be documented, rehabilitation evaluation in the home may be initiated by a home health agency before the physician examines the recipient. Reimbursement cannot be made for more than one such rehabilitation evaluation visit to a recipient in the recipient's home before a physician's specific written order is obtained.

(5) Payment is available for a rehabilitation evaluation of a child who is suspected of having a handicapping condition or a disability and for whom an individualized education program or an interim or final individualized family services plan is being developed if the evaluation is performed in a school, an approved pre-school or a natural environment, including home and community settings, where such child would otherwise be found and the evaluation is initiated by a speech pathologist, occupational therapist, or a physical therapist.

The NYS Medicaid Rehabilitation Services Procedure Codes & Fee Schedule advises in relevant part that effective October 1, 2011, physical therapy, occupational therapy, and speech therapy visits in private practitioners' offices, certified hospital out-patient departments, and diagnostic and treatment centers (free-standing clinics) are limited to 20 each per twelve-month benefit year. Medicaid will pay for up to 20 physical therapy visits, 20 occupational therapy visits, and 20 speech therapy visits per enrollee in a twelve-month benefit year.

For Medicaid fee-for-service (FFS) enrollees, the twelve-month benefit year is a state fiscal year beginning April 1 of each year and running through March 31 of the following year. Utilization of a prior authorization (PA) process allows both the Department of Health and rehabilitation providers to track the number of therapy visits authorized for each beneficiary.

Exemptions

Certain Medicaid enrollees, settings, and circumstances are exempt from the 20-visit limitation and prior authorization process. These include:

Children from birth to age 21 (until their 21st birthday)

Recipients with a developmental disability (R/E code 95)

Recipients with a traumatic brain injury (TBI) (waiver recipients R/E code 81, or any claim with a primary diagnosis code (850-854) for traumatic brain injury)

Recipients with both Medicare Part B and Medicaid coverage (dually eligible enrollees) when Medicare Part B payment is approved

Rehabilitation services received as a hospital inpatient

Recipients receiving rehabilitation services in a nursing home in which they reside

Rehabilitation services provided by a certified home health agency (CHHA)

The NY State Medicaid Policy Guidelines for Rehabilitation Services advise:

An assessment of the beneficiary's physical and functional status used to determine if PT, OT, or ST services are medically necessary, gather baseline data including objective findings, and establish a treatment plan with reasonable and attainable goals within a defined period of time. Evaluations are administered with appropriate and relevant assessments using objective measures and/or tools. An evaluation is required prior to implementing any treatment plan.

Physical, Occupational, and/or Speech therapy services, that due to a beneficiary's unique physical, cognitive or psychological status, require the knowledge or expertise of a licensed practitioner in order to maintain their physical and/or functional status. Outcomes must be functional, individualized, relevant, and transferrable to the current or anticipated environment. Therapeutic goals must meet at least one of the following characteristics: prevent deterioration and sustain function; provide interventions that enable the beneficiary to live at their highest level of independence in the case of a chronic or progressive disability; and/or provide treatment interventions for a beneficiary who is progressing, but not at a rate comparable to the expectations of restorative care.

Prior authorizations allow tracking of the number of rehabilitation visits per discipline an enrollee receives per benefit year. A prior authorization (PA) must be obtained before each therapy visit for enrollees not exempt from the 20-visit limitation (See Benefit Limit definition). A unique prior authorization number must be obtained through the Dispensing Validation System (DVS) for each visit. Modifiers will be used to distinguish therapy types when requesting a DVS prior authorization number. A request for a prior authorization should be submitted before the provision of service. A maximum of 20 prior authorization numbers will be issued for each therapy type. NOTE: Providers do not need to get a PA for enrollees that are exempt from the benefit limit (e.g., R/E 95 and R/E 81 enrollees) or for rehabilitation therapy provided in

exempt settings (e.g., hospital inpatient), or for rehabilitation services provided by a certified home health agency (CHHA). See Benefit Limit for more information.

Restorative or Long Term Physical, Occupational, or Speech therapy services are considered medically necessary when:

The therapy services require the skills of, and are delivered by, a qualified practitioner; and

The beneficiary has been evaluated or reevaluated for continuation of therapy services, and has an established treatment plan with reasonable and attainable goals that can be objectively measured by the use of standardized or non-standardized measures and tools; and

The beneficiary has an identifiable clinical condition/diagnosis, is symptomatic, and the therapeutic interventions are directed at preventing disability and/or regression, improving, adapting, or restoring functions impaired or lost as a result of a specific illness, injury, neurodevelopmental disease or condition, surgery, loss of a body part, or congenital abnormality; and

Therapeutic benefit has not been reached and the therapeutic interventions are for conditions that require the unique knowledge, skills, and judgment of a qualified practitioner and cannot or have not been met by a comprehensive maintenance services program or home program; and

There is reasonable expectation that the therapeutic interventions, based on a beneficiary's rehabilitation potential, will result in objective/measurable functional outcomes within a reasonable and predictable period of time and the outcomes are documented in the beneficiary's file; and
The treatments are not routine education, training, conditioning, or fitness and the beneficiary's function could not reasonably be expected to improve as they gradually resume normal activities; and

The treatments are not a duplicate therapy; and
The treatments are not solely recreational (such as hobbies and/or arts and crafts), and

The beneficiary has not refused therapy.

A Physical, Occupational, or Speech therapy treatment session should be based on the beneficiary's specific medical condition and be supported in the treatment plan. A treatment session may include:

Reassessment of the beneficiary's deficits, progress, rehabilitation potential, plan, and goals;
Therapeutic exercise, including neuromuscular reeducation, coordination, and balance;
Therapeutic oral motor, laryngeal, pharyngeal, or breathing exercises;
Functional skills development and training;

Manual therapy techniques, including soft tissue mobilization, joint mobilization, and manual lymphatic drainage;
Assessment, design, fabrication, application, fitting, and training in assistive technology, adaptive devices, orthotics, and prosthetic devices;
Airway clearance techniques;
Compensatory or adaptive communication/swallowing techniques and skills;
Integumentary repair and protection techniques;
Management of positioning, eating, and swallowing to enable/progress safe eating and swallowing;
Electrotherapeutic modalities, physical agents and mechanical modalities when used in preparation for other skilled treatment procedures;
Management of positioning, eating, and swallowing to enable/progress safe eating and swallowing;
Training in assistive technology and adaptive devices, e.g., speech generating devices;
Training in the use of prosthetic devices;
Training of the beneficiary, caregivers, and family in home exercises, activity programs, and the development of a comprehensive maintenance program.

Section 358-5.9 of the Regulations provide in part:

(a) At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services, the appellant must establish that the agency's denial of assistance or benefits was not correct or that the appellant is eligible for a greater amount of assistance or benefits.

DISCUSSION

The record establishes that by notice dated September 7, 2017, the Appellant's Medicaid managed long term care plan, Centers Plan for Healthy Living (Centers Plan), upheld its initial August 4, 2017 determination to deny the request for 10 physical therapy visits for the Appellant, on the grounds they were not medically necessary, because the Appellant's condition has not improved and she has derived maximum benefit from physical therapy services.

There is no dispute between the parties that the Appellant's request for physical therapy is related to a sustained back injury.

At the hearing, Center's Plan stated that the Appellant has already been approved for 17 physical therapy sessions, and provided documentation is support of this testimony; an authorization for 7 visits in December 2016, and an authorization for 10 visits in April and May 2017.

The Appellant credibly stated that she is in pain and still needs physical therapy, which thus far has helped improved her ability to walk, and she wants to continue to improve. The Appellant's testimony during the hearing rebutted the plan's assertion that continued physical

therapy is not medically necessary. In addition, the NYS Medicaid Rehabilitation Services Procedure Codes & Fee Schedule advises in relevant part that physical therapy, occupational therapy, and speech therapy visits in private practitioners' offices, certified hospital out-patient departments, and diagnostic and treatment centers (free-standing clinics) are limited to 20 each per twelve-month benefit year. The record reflects that for the calendar year 2017, the Appellant had been authorized for 10 visits, such that 10 remaining visits were available to Appellant for calendar year 2017.

Based on the foregoing, the Centers Plan determination is not sustained.

DECISION AND ORDER

The determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny coverage for 10 physical therapy sessions for the Appellant, was not correct and is reversed. Centers Plan is directed to:

1. Cancel the notices dated August 4, 2017 and September 7, 2017 and take no action thereon.
2. Authorize Appellant for the 10 additional physical therapy sessions originally meant to occur in calendar year 2017, without prejudice to Appellant's statutory right to be approved for up to 20 additional physical therapy sessions attributable to calendar year 2018 (should medical necessity exist for said additional 20 physical therapy sessions).
3. Advise the Appellant and the Appellant's provider, in writing, of compliance with this Decision.

Should Centers Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Plan promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, Centers Plan must comply immediately with the directives set forth above.

DATED: Albany, New York
12/08/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee