STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 13, 2018
[redacted]
AGENCY: MAP
FH #: 7790333Z

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 August 14, 2018, 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

On papers only – Plan appearance waived by the Office of Administrative Hearings

ISSUE

Was the determination of the Appellant's Managed Long Term Care Plan, Centers Plan For Healthy Living, to deny the Appellant's provider's prior approval request for additional occupational therapy sessions for the Appellant correct?

FACT FINDING

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 58, has been in receipt of Medical Assistance benefits provided through a Managed Long Term Care Plan, Centers Plan For Healthy Living (hereinafter, the "Plan").

2. The Appellant's doctor requested prior approval for ten additional occupational therapy sessions for the Appellant.

3. By Initial Adverse Determination dated June 14, 2018, the Plan denied the Appellant's provider's prior approval request on the ground that the service is not medically necessary, reasoning that, based on the reviewed clinical information, the Appellant has had very limited, if any, benefit from receiving occupational therapy, despite the Plan having previously authorized 27 occupational therapy sessions; and that Medicaid provides for occupational therapy only when "the 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 there is reasonable expectation that the therapeutic interventions, based on a beneficiary's rehabilitation potential, will result in objective/measurable outcomes within a reasonable and predictable period of time."

4. On internal appeal, the Plan upheld its initial determination and by Final Adverse Determination of June 20, 2018 so advised the Appellant, stating that, despite 27 previous occupational therapy visits, Appellant remains at maximum assistance for bathing, toileting, dressing, grooming and eating; and that medical necessity was not established since despite therapy, there are no notable improvements.

5. On July 13, 2018, this fair hearing was requested.

APPLICABLE LAW

Section 358-5.9 of the Regulations provide in part that, at a fair hearing concerning the denial of Medical Assistance, the Appellant must establish that the Agency's determination was not correct.

Section 365-a of the Social Services Law provides in part:

2. "Medical Assistance" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized by this title or the regulations..., 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...

Section 364.2 of the Social Services Law provides in part, as follows:

The Department of Health shall be responsible for…

(b) establishing and maintaining standards for all non-institutional health care and services rendered pursuant to this title…

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.

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

Federal Regulations (Title 42) state, in pertinent part:

§ 438.210 Coverage and authorization of services.
(a) ***Coverage.*** Each contract with an MCO, PIHP, or PAHP must do the following:
(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.
(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in § 440.230.
(3) Provide that the MCO, PIHP, or PAHP—
(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;
(iii) May place appropriate limits on a service—
(A) On the basis of criteria applied under the State plan, such as medical necessity; or
(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and
(4) Specify what constitutes "medically necessary services" in a manner that—
(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures [emphasis added]; and
(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:
(A) The prevention, diagnosis, and treatment of health impairments.
(B) The ability to achieve age-appropriate growth and development.
(C) The ability to attain, maintain, or regain functional capacity.
(b) ***Authorization of services.*** For the processing of requests for initial and continuing authorizations of services, each contract must require—
(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.
(2) That the MCO, PIHP, or PAHP—
(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.
(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

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. Pursuant to 18 NYCRR 513.6, the determination to grant, modify or deny a request initially must be made by qualified Department of Health professional staff exercising professional judgment based upon objective criteria and the written guidelines of the Department of Health and regulations, and commonly accepted medical practice.

The New York State Medicaid Program Rehabilitation Services Procedure Codes & Fee Schedule states, in pertinent part:

General Rules and Information
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.

Prior Authorization/Dispensing Validation System (DVS)
When the procedure code description is preceded by "#", Medicaid Eligibility Verification System (MEVS) dispensing validation is required. The request for prior authorization should be submitted before the provision of service. A unique prior authorization number must be obtained through the Dispensing Validation System (DVS) for each visit. The DVS operates on "real time" and will give an immediate response to a request for Prior Authorization. A DVS authorization does not guarantee payment. However, without a Prior Authorization the claim will be denied. A maximum of 20 prior authorization numbers will be issued for each therapy type. Further instructions on obtaining a DVS authorization number can be accessed online at:
https://www.emedny.org/ProviderManuals/AllProviders/supplemental.aspx#MEVS/DVS

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 New York State Medicaid Program Rehabilitation Services Manual Policy Guidelines state, in pertinent part:

Section II - Definitions
For the purposes of the Medicaid program and as used in this Manual, the following terms are defined to mean:

Benefit Limit
Certain beneficiaries are limited to 20 therapy visits per fiscal year for each type of therapy covered (physical, occupational, and speech therapy). The fiscal year begins April 1st and ends March 31st of the next year.
Certain Medicaid enrollees, settings, and circumstances are exempt from the 20-visit limitation. 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)
…
Evaluation
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.
…
Long Term Therapy Services
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 Authorization
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 for 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. The request may be made after the date of the service and can be approved if the beneficiary has not already been authorized for 20 visits. A maximum of 20 prior authorization numbers will be issued for each therapy type. Further instructions on obtaining a DVS authorization number can be accessed online at:
https://www.emedny.org/ProviderManuals/AllProviders/supplemental.aspx#MEVS/DVS
Prior authorization does not ensure payment. Even if a service has been prior authorized, the provider still must verify an enrollee's eligibility via the MEVS before rendering service and the claim must be otherwise payable in accordance with the requirements as found in each related section of the provider manual.
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.
…

Reevaluation
An assessment done to evaluate progress or to modify or redirect therapy services when there are new clinical findings, a rapid change in status, or failure to respond to the therapeutic interventions.

Rehabilitation Potential
The amount of improvement anticipated in a beneficiary in relation to the extent and duration of the therapy service provided. It includes consideration of previous functional status and the effects of the current condition or disease process.

Restorative Therapy
Physical, Occupational, and/or Speech therapy services that require the knowledge or expertise of a licensed practitioner. Services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital abnormalities, or injuries.
…
Section III – Coverage Criteria

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…

The New York State Medicaid Program Rehabilitation Services Manual Policy Guidelines (Version 2015-1).

DISCUSSION

At issue is the Plan's determination to deny the Appellant's provider's prior approval request for ten additional occupational therapy sessions on the ground that the service is not medically necessary, reasoning that, based on the reviewed clinical information, **the Appellant has had very limited, if any, benefit from receiving occupational therapy, despite the Plan having previously authorized 27 occupational therapy sessions**; and that Medicaid provides for occupational therapy only when "the 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 there is reasonable expectation that the therapeutic interventions, based on a beneficiary's rehabilitation potential, will result in objective/measurable outcomes within a reasonable and predictable period of time."

On internal appeal, the Plan upheld its initial determination and by Final Adverse Determination of June 20, 2018 so advised the Appellant, stating that, **despite 27 previous occupational therapy visits, Appellant remains at maximum assistance for bathing,**

toileting, dressing, grooming and eating; and that medical necessity was not established since despite therapy, there are no notable improvements.

It is noted that to the extent that the Plan's determination to deny additional occupational therapy sessions for the Appellant is partly predicated upon Appellant's provider's alleged failure to demonstrate improvement in the Appellant's condition due to the occupational therapy Appellant had been getting, such measure of "medical necessity" is prohibitively restrictive. See 42 CFR 438.210.

Indeed, the New York State Medicaid Program Rehabilitation Services Manual Policy Guidelines (hereinafter, the "Manual") measures medical necessity of the requested service as the service that may be directed at, not just improving or restoring lost or impaired functions, but also at **preventing disability and/or regression** of such functions, which were impaired or lost a result of a specific illness, injury, neurodevelopmental disease or condition, surgery, loss of a body part, or congenital abnormality. It is undisputed that Appellant had suffered stroke in the year 2016 and occupational therapy was being provided to the Appellant as a result.

The Plan, however, also predicated its determination here on the following: Medicaid provides for occupational therapy only when "the 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 there is reasonable expectation that the therapeutic interventions, based on a beneficiary's rehabilitation potential, will result in objective/measurable outcomes within a reasonable and predictable period of time." This is also one of the criteria for "medical necessity" listed in the Manual for the subject service to be covered by Medicaid.

Although the Appellant testified at the hearing and his provider indicated in its prior approval request that the Appellant had experienced minor improvements as a result of the occupational therapy, no clinical documentation was submitted at the hearing to show that there is "reasonable expectation that the therapeutic interventions, based on a beneficiary's rehabilitation potential, will result in objective/measurable outcomes within a reasonable and predictable period of time". See the Manual.

Section 358-5.9 of the Regulations provide in part that, at a fair hearing concerning the denial of Medical Assistance or services, the Appellant must establish that such determination was not correct. Appellant failed to so establish in this case, as fully set forth above. Accordingly, the Plan's determination is sustained. This Decision After Fair Hearing, however, does not prevent the Appellant or his provider from resubmitting a prior approval request for additional occupational therapy sessions meeting the criteria set forth in the New York State Medicaid Program Rehabilitation Services Manual Policy Guidelines.

A home hearing is not necessary in this case, because this Decision After Fair Hearing is based solely on the clinical documentation submitted at the hearing and the New York State Medicaid Program Rehabilitation Services Manual Policy Guidelines.

DECISION

The determination of the Appellant's Managed Long Term Care Plan, Centers Plan For Healthy Living, to deny the Appellant's provider's prior approval request for additional occupational therapy sessions for the Appellant is correct.

DATED: Albany, New York
08/23/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee