STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: April 18, 2018
[redacted]
AGENCY: Nassau
FH #: 7741607M

In the Matter of the Appeal of

[redacted]

from a determination by the Nassau County 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 June 1, 2018, in Nassau County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Care Plan

Managed Care Plan appearance waived by the Office of Administrative Hearings

ISSUE

Was the Managed Care Plan's determination to deny coverage for occupational therapy on the grounds that Medicare must first make a determination 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 80, is a Medicare/Medicaid dual eligible who is in receipt of Medicaid Managed Long Term Care through Centers Plan for Healthy Living (Managed Care Plan).

2. By notice dated April 13, 2018, the Managed Care Plan denied coverage for occupational therapy (OT) services for the Appellant on the grounds that the requested service must first be reviewed by the Appellant's primary insurance, Medicare, and denied before the service can be authorized by the Managed Care Plan. The notice stated that if denied by the primary insurer, a copy of the denial notice should be provided with a new request for occupational therapy.

3. By notice dated May 15, 2018, the Managed Care Plan upheld the determination contained in the April 13, 2018 notice on the same grounds, stating that if denied by the primary insurer, a copy of the denial notice should be provided with a new request for occupational therapy.

4. On April 18, 2018, the Appellant requested this fair hearing.

APPLICABLE LAW

Social Services Law §365-a(2) provides that "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 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.

Social Services Law §365-a(2)(k) provides that such care, services and supplies shall include care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

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. An "Operational Protocol" (Protocol) has been approved by the Health Care Finance Administration as required by the Terms and Conditions governing the demonstration waiver. Such Protocol details the day-to-day operations of the program.

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.

Managed Long Term Care Partial Capitation Contract
APPENDIX G
Managed Long Term Care Covered/Non-Covered Services,

Services When Provided, Would Be Covered by the Capitation Services Provided as Medically Necessary:

Social and Environmental Supports
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Home Care
a. Nursing
b. Home Health Aide
c. Physical Therapy (PT)
d. Occupational Therapy (OT)
e. Speech Pathology (SP)
f. Medical Social Services

DISCUSSION

The Appellant's Representative acknowledged that the Appellant is in receipt of both Medicare and Medicaid. The Representative stated that the Appellant has been receiving occupational therapy (OT) on an ongoing basis due to residual effects of aneurism and stroke. The Representative stated that the Appellant continues to need occupational therapy to maximize her ability to participate in her activities of daily living (ADLs). The Representative acknowledged that a request for occupational therapy has not been submitted to Medicare and that therefore no Medicare denial for occupational therapy has been received.

In general, a Medicaid Managed Long Term Care Plan can require a member to submit medical bills, including prior approval requests, to Medicare first if Medicare is the primary insurance. In this case, the Appellant did not assert that occupational therapy would not be covered by Medicare, that there have been any prior Medicare denials, or that an appropriate prior approval request has been made to Medicare at any time. Therefore, the record does not demonstrate any reason that Medicare, as the primary insurer, should not review and deny occupational therapy coverage prior to evaluation for secondary coverage by the Medicaid Managed Care Plan. The Managed Care Plan's determination must therefore be upheld and this decision may be issued, as a matter of law on undisputed facts. If desired, a new request for

occupational therapy services may be made to the Managed Care Plan if the requested services are denied by Medicare.

DECISION

The Agency's determination to deny coverage occupational therapy on the grounds that Medicare must first make a determination is correct.

DATED: Albany, New York
06/07/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee