
In the Matter of the Appeal of
[REDACTED]

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

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**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 6, 2015, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[REDACTED]

For the Managed Care Plan (United Healthcare)

Jennifer Bailey-Jackson, Fair Hearing Representative

ISSUE

Was the determination of the Appellant's Medicaid Managed Care Plan to deny the Appellant's physical therapy provider's request for 15 additional physical therapy treatment prescribed for 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 forty-four, is in receipt of Medical Assistance authorization for Medicaid, managed care.

FH# 7147874P

2. The Appellant has been enrolled in a Medicaid Managed Care Plan, and has received care and services through a Medicaid Managed Care Plan operated by United Healthcare Community Plan (United Healthcare)
3. The Appellant is not under age 21, does not have a traumatic brain injury, and has not been determined developmentally disabled by the Office for People with Developmental Disabilities.
4. On or about October 2, 2015 the Appellant's physical therapy provider, [REDACTED], requested approval for 15 physical therapy visits for the Appellant.
5. At the time of the request, United Healthcare had already approved and paid for 20 physical therapy visits between during the calendar year 2015.
6. On October 3, 2015, United Healthcare issued to the Appellant a written initial adverse determination which advises the Appellant of United Healthcare's determination to deny the Appellant's physical therapy provider's request for 15 additional physical therapy treatments for the Appellant on the grounds that the limitation on the number of physical therapy visits for the calendar year had been exhausted.
7. On October 5, 2015 United Healthcare received the Appellant's request for an expedited internal appeal of the October 3, 2015 denial.
8. On October 7, 2015 United Healthcare determined to uphold its October 3, 2015 determination to deny the request for an additional 15 physical therapy visits on the grounds that the limit of 20 visits per calendar year had already been exhausted.
9. On October 9, 2015, the Appellant requested this fair hearing.

APPLICABLE LAW

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.

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.

Chapter Four of the Protocol describes the Medicaid services covered under the Managed Care Program. Managed care enrollees will be entitled to the same benefits and coverages as are available under the fee-for-service program. The capitated health care benefits package will be comprehensive for HMOs and PHSPs. Emphasis will be on primary, preventive, and acute episodic care. MCOs must provide all services included in the capitated benefit package, to the extent that such services are medically necessary. "Medically necessary" is defined in Social Services law as medical, dental, and remedial care, services and supplies which are necessary to prevent, diagnose, and correct or cure conditions in the person that may cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap [see Social Services Law 365-a(2)]. Also, by statute, EPSDT and family planning services are "deemed" medically necessary and therefore are, by definition, covered.

Chapter Four of the Protocol further provides that all capitated services, except as discussed later in this chapter, covered under the managed care plan's benefit package must be authorized by the enrollee's MCO for any enrollee seeking such care.

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 care, services and supplies 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 his capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title, and the regulations ...

The Regulations at 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.

Social Services Law section 365-a(2), as amended effective September 27, 2011, states:

"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. 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:

* * * *

(h) speech therapy, and when provided at the direction of a physician or nurse practitioner, physical therapy including related rehabilitative services and occupational therapy; provided, however, that speech therapy, **physical therapy and occupational therapy each shall be limited to coverage of twenty visits per year**; such limitation shall not apply to persons with developmental disabilities or, notwithstanding any other provision of law to the contrary, to persons with traumatic brain injury;

The August 2011 edition of the New York State Department of Health Medicaid Update, page 6, contains a summary of who might be exempt from the new twenty visit limit on rehabilitation services. For persons receiving Medicaid Managed Care, the following are exempt from the twenty visit annual limit:

Children (0-20 years old)
Recipients with developmental disabilities
Medicare/ Medicaid dually eligible recipients when
Medicare pays for the rehabilitation service
Recipients with a traumatic brain injury (TBI)

Situational Exemptions

Residents receiving rehabilitation services in a nursing
home in which they reside
Rehabilitation services provided by a certified home health
agency
Rehabilitation services received as a hospital inpatient

Regulation 358-5.9(a) provides:

At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services; or an exemption from work activity requirements the appellant must establish that the agency's denial of assistance or benefits or such an exemption was not correct or that the appellant is eligible for a greater amount of assistance or benefits. Except where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of public assistance, medical assistance, SNAP benefits or services, the social services agency must establish that its actions were correct.

DISCUSSION

The record in this case establishes that Appellant has been in receipt of Medical Assistance benefits and that the Appellant has been enrolled in a Managed Care Plan by United Healthcare. The record further establishes that the Appellant's physician prescribed a course of physical therapy treatments for the Appellant, which was approved by Appellant's Plan. It is not contested that United Healthcare paid for 20 physical therapy sessions during the 2015 calendar year.

On or about October 2, 2015, a request was made on behalf of the Appellant by her physical therapy provider for authorization for additional 15 physical therapy sessions. On October 3, 2015 United Healthcare issued to the Appellant a written initial adverse determination which advises the Appellant of United Healthcare's determination to deny the Appellant's physical therapy provider's request for 15 additional physical therapy treatments for the Appellant on the grounds that the limitation on the number of physical therapy visits for the calendar year had been exhausted.

The record also establishes that on October 5, 2015 United Healthcare received the

FH# 7147874P

Appellant's request for an expedited internal appeal of the October 3, 2015 denial and on October 7, 2015 United Healthcare determined to uphold its October 3, 2015 determination to deny the request for an additional 15 physical therapy visits on the grounds that the limit of 20 visits per calendar year had already been exhausted.

At the hearing, the Appellant testified that she has not had physical therapy since October 2, 2015 and that as a result, she has more difficulty in walking and her legs are giving out more so than ever before. She further testified that she has not been able to sleep properly because rolling over in bed is extremely painful. She further testified that she has difficulty getting in and out of the shower and climbing the two flights of stairs to get from the street to her living space. She further testified that she is due to graduate college in December, but is falling behind in her work because she has difficulty getting to school. She also testified that she has a job interview and believes that her current physical limitations may have a detrimental effect on her job prospects. The Appellant's testimony was detailed, direct, consistent, and supported by her witness's testimony, and therefore was credible.

The Appellant's condition is sympathetic and there is little doubt that additional physical therapy would be beneficial to her. However, effective October 1, 2011, most patients may receive Medicaid coverage for only 20 annual physical therapy (or other rehabilitative services) treatments. It is uncontroverted that Appellant's Medicaid Managed Care Plan has already paid for 20 such visits for year 2015.

Certain categories of patient are exempt from the twenty visit maximum. However, at the hearing, Appellant failed to establish that she met any of the following exceptions:

- Child (0-20 years old)
- Recipient with developmental disabilities (as determined by the Office for People with Developmental Disabilities)
- Medicare/ Medicaid dually eligible recipients when Medicare pays for the rehabilitation service
- Recipient with a traumatic brain injury (TBI)

As to situational exemptions (such as being in-patient in a hospital, rehabilitation services in a nursing home, or services provided by a certified home health agency), the record establishes that Appellant was seeking coverage for outpatient physical therapy.

Since the Social Services Law precludes coverage for more physical therapy out-patient treatments than the 20 treatment limit for Appellant for year 2015, the determination of the Plan must be sustained.

DECISION

The determination of the Appellant's Medicaid Managed Care Plan to deny the Appellant's physical therapy provider's request for 15 additional physical therapy treatment prescribed for

FH# 7147874P

Appellant was correct.

DATED: Albany, New York
11/18/2015

NEW YORK STATE
DEPARTMENT OF HEALTH

By

A handwritten signature in black ink, appearing to read "Paul R. Prentiss". The signature is written in a cursive style with a large initial "P" and a long, sweeping underline.

Commissioner's Designee