State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
2699 Park Avenue, Suite 100
Huntington, WV 25704

Joe Manchin III
Governor

Patsy A. Hardy, FACHE, MSN, MBA
Cabinet Secretary

November 20, 2009

Dear -----:

Attached is a copy of the findings of fact and conclusions of law on your hearing held September 15, 2009. Your hearing request was based on the Department of Health and Human Resources' decision to deny physical therapy services.

In arriving at a decision, the State Hearing Officer is governed by the Public Welfare Laws of West Virginia and the rules and regulations established by the Department of Health and Human Resources. These same laws and regulations are used in all cases to assure that all persons are treated alike.

Medicaid regulations set the service limit for physical therapy at 20 visits per year, and require prior authorization to exceed that limit. Excessive sessions for chronic conditions are considered non-covered services, except in cases of clearly documented exacerbated episodes of chronic conditions. Failure to obtain prior authorization results in denial of the service. (West Virginia Bureau for Medical Services Provider Manual, Chapter 515: OT/PT Services, §§515.3 – 515.6)

Information submitted at your hearing revealed that the requested physical therapy services were in excess of the service limit and were for a chronic condition without clearly documented exacerbation.

It is the decision of the State Hearing Officer to **uphold** the action of the Department to deny physical therapy services.

Sincerely,

Todd Thornton
State Hearing Officer
Member, State Board of Review

cc: Erika H. Young, Chairman, Board of Review
Lorna Harris, Department Representative

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

-----,

Claimant,

v. **Action Number: 09-BOR-1306**

West Virginia Department of Health and Human Resources,

Respondent.

DECISION OF STATE HEARING OFFICER

I. INTRODUCTION:

This is a report of the State Hearing Officer resulting from a fair hearing concluded on November 20, 2009 for -----. This hearing was held in accordance with the provisions found in the Common Chapters Manual, Chapter 700 of the West Virginia Department of Health and Human Resources. This fair hearing was convened on September 15, 2009 on a timely appeal, filed June 3, 2009.

II. PROGRAM PURPOSE:

The 1965 Amendments to the Social Security Act established, under Title XIX, a Federal-State medical assistance program commonly known as Medicaid. The Department of Health and Human Resources administers the Medicaid Program in West Virginia in accordance with Federal Regulations. The Bureau for Medical Services is responsible for the development of regulations to implement Federal and State requirements for the program. The Department of Health and Human Resources processes claims for reimbursements to providers participating in the program.

III. PARTICIPANTS:

-----, Claimant
-----, Claimant's witness
Virginia Evans, Department Representative, Bureau for Medical Services
Jenny Craft, RN, West Virginia Medical Institute

Presiding at the Hearing was Todd Thornton, State Hearing Officer and a member of the State Board of Review.

IV. QUESTION TO BE DECIDED:

The question to be decided is whether the Department was correct to deny physical therapy services to the Claimant.

V. APPLICABLE POLICY:

West Virginia Bureau for Medical Services Provider Manual, Chapter 515: OT/PT Services, §§515.3 - 515.6

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 West Virginia Bureau for Medical Services Provider Manual, Chapter 515: OT/PT Services, §§515.3 - 515.6
D-2 Physical Therapy Screening Criteria
D-3 Physical/Occupational Therapy Prior Authorization Request Form; Information from Physician
D-4 Notices of Denial for Physical Therapy Services dated May 22, 2009
D-5 Resubmitted request for authorization dated May 26, 2009
D-6 Physician Notice of Preadmission Reconsidered Determination dated June 5, 2009

VII. FINDINGS OF FACT:

1) Jenny Craft, RN for the West Virginia Medical Institute (WVMI), testified that, in response to a request (Exhibit D-3) for physical therapy services for the Claimant, denial notices were issued on or about May 22, 2009 to the Claimant, her prescribing practitioner, and the servicing provider (Exhibit D-4). The notice provided the reason for denial as follows, in pertinent part:

> Documentation provided does not indicate medical necessity - specifically:
>
> The request for continued physical therapy for 15 visits for 3 – 5 weeks was denied due to not meeting WV Medicaid criteria.
> The documentation provided reflected a condition that is at maintenance level. There was no initial evaluation, no specific ROM or pain levels given.

2) In response to a request for reconsideration dated May 26, 2009 (Exhibit D-5), a second denial notice (Exhibit D-6) was sent to the Claimant on or about June 5, 2009. This notice states, in pertinent part:

> WVMI received your request for reconsideration of the initial denial of authorization for the above listed patient. After due consideration of all relevant factors including documentation in the medical record and any additional information provided, WVMI upheld the initial denial.
>
> Upon physician review of the additional information provided through the reconsideration process, it was noted that there was insufficient medical information documented to approve the PT services requested. The condition, Rheumatoid Arthritis is a chronic condition.

3) Virginia Evans, the representative for the Department's Bureau for Medical Services, presented the policy (Exhibit D-1) and the physical therapy screening criteria (Exhibit D-2) used by WVMI in determining medical necessity. The screening therapy noted scenarios that are excluded from consideration for physical therapy, and these included: services not complex enough to require a physical therapist, more than 20 sessions per calendar year for chronic conditions, or services intended as maintenance therapy rather than for improvement of functional status. The screening criteria additionally defined maintenance programs as follows:

> Maintenance programs: The repetitive services required to maintain function generally do not involve complex and sophisticated physical therapy procedures, and, consequently, the judgement [*sic*] and skill of a qualified physical therapist are not required for safety and effectiveness. Maintenance programs would not be considered for payment beyond 20 sessions, as it would be viewed as a chronic condition.

4) Policy from the West Virginia Bureau for Medical Services Provider Manual, Chapter 515: OT/PT Services, §515.4, states, in pertinent part:

> **515.4 PRIOR AUTHORIZATION**
>
> Prior authorization (PA) is required when service limits exceed the Medicaid limit defined in 515.3.1. Service limits for occupational/physical therapy services are 20 visits in a calendar year. One visit may include any combination of occupational/physical therapy procedures performed on the same day, excluding the evaluation and re-evaluation codes.

Policy from the West Virginia Bureau for Medical Services Provider Manual, Chapter 515: OT/PT Services, §515.6, states, in pertinent part (emphasis added):

> **WV Medicaid does not cover the following occupational / physical therapy services.**
>
> • Occupational / physical therapy services that are rendered to an inpatient in a hospital, skilled nursing facility, or other facility.
>
> • Occupational / physical therapy services **in excess of 20 visits provided for chronic conditions**, such as arthritis, cerebral palsy, and developmental delay.

Policy from the West Virginia Bureau for Medical Services Provider Manual, Chapter 515: OT/PT Services, §515.3, states, in pertinent part (emphasis added):

> Continuous progress/improvement must be documented for coverage of therapy. The member must show compliance with therapy and the home regimen plan. **Continuation of services may be considered, when an exacerbated episode of a chronic condition is clearly documented; otherwise chronic conditions are non-covered.**

5) The WVMI nurse testified that when the request (Exhibit D-3) was submitted to WVMI, it was only three pages, including the form and a physician's order. She testified that it did not include an initial evaluation, as requested on the form (Exhibit D-3, page 2). She testified that there is medical review by WVMI after 20 visits, and the purpose of the initial evaluation is to measure the progress made with the physical therapy sessions already completed by the Claimant. She noted that the request form (Exhibit D-3) stated that the Claimant has a "[history] of fibroblastic rheumatoid arthritis since age 15," which she testified was a chronic condition. She noted the form lacked any discussion of the Claimant's range of motion or anything indicating a "flare up" or exacerbation of that chronic condition. She testified that this information was not provided with the resubmission request (Exhibit D-5). The denial notifications corresponding with the initial (Exhibit D-4) and reconsidered (Exhibit D-6) requests reflected the chronic condition status, the maintenance program status, and the lack of information as reasons for denial.

6) The Claimant and her mother testified regarding the Claimant's medical history. When asked if the conditions described in that testimony met the definition of "exacerbated episode," the WVMI nurse agreed that it did; however, she testified that the testimony provided information that the initial and secondary requests for services lacked.

VIII. CONCLUSION OF LAW:

1) Policy provides that prior authorization is required for the proposed physical therapy services in excess of service limits. The Department clearly showed that the Claimant's request did not include sufficient information to define an exacerbated episode of a chronic condition. Without an initial evaluation to measure therapeutic progress, it was correct to consider the request to be for a maintenance program. Screening criteria clearly identifies maintenance programs as ineligible for payment beyond the annual service limit of 20 sessions because the underlying condition would be viewed as chronic. The Department was correct in its decision to deny physical therapy services.

IX. DECISION:

It is the decision of the State Hearing Officer to **uphold** the Department's denial of physical therapy services for the Claimant.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this _____ Day of November, 2009.

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Todd Thornton
State Hearing Officer