STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2009-11480 QHP
Case No. [redacted]
Load No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] (Appellant) appeared and testified on her own behalf. [redacted] represented the MHP.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for physical/pool (aquatic) therapy?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. Appellant is a [redacted]-year-old Medicaid beneficiary who has been enrolled in the MHP since [redacted].

2. Appellant was diagnosed with fibromyalgia.

3. On [redacted], the MHP received a Prior Authorization Request from Appellant's specialty care physician who requested that the MHP approve pool therapy for Appellant's fibromyalgia.

4. On [redacted], the MHP sent Appellant written notice that the request for the pool therapy was denied on the basis that Appellant does not meet the eligibility criteria for coverage under [redacted] evidence of coverage guidelines. (Exhibit 1, pp. 14-24)

5. On [redacted], the State Office of Administrative Hearings and Rules received Appellant's hearing request, protesting the denial of her request for coverage of pool therapy.

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

On May 30, 1997, the Department received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified Medicaid Health Plans.

The Respondent is one of those Medicaid Health Plans.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). **The Contractor may limit services to those which are medically necessary and appropriate**, and which conform to professionally accepted standards of care. **Contractors must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations.** If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 1-Z.
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> Article II-G, Scope of Comprehensive Benefit Package.
> MDCH contract (Contract) with the Medicaid Health Plans,
> September 30, 2004, Page 30.

> The major components of the Contractor's utilization management plan must encompass, at a minimum, the following:
>
> - Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
> - A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
> - Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
> - An annual review and reporting of utilization review activities and outcomes/interventions from the review.
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> The Contractor must establish and use a written prior approval policy and procedure for utilization management purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.
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> *Article II-P, Utilization Management, Contract, September 30, 2004.*

Appellant was denied coverage for pool therapy. The MHP denied the request on the basis that Appellant does not meet its eligibility criteria for pool therapy, and Medicaid does not cover aquatic therapy as a separate reimbursable treatment or modality. The MHP submitted a copy of its Medical Policy for pool therapy which states that it will be covered if: "There are documented rehabilitation goals, a formal treatment plan, and skilled supervision. Pool aquatics that are primarily maintenance or are self-directed or group pool therapies are not covered." In addition, long-term treatment for patients with chronic (non-acute) musculoskeletal aches and pains; all therapies for developmental delays and cognitive disorders, including physical, occupational, speech, cognitive and sensory integration therapy; and therapy for the purpose of maintaining physical condition or maintenance therapy for a chronic condition are excluded from coverage.

Appellant argues that the pool therapy was ordered by her physician to improve her condition and quality of life. She stated that she does not understand how the MHP can deny a benefit if no treatment and evaluation has ever been completed to determine if pool therapy might give her meaningful improvement in her ability to perform functional day-to-day activities; and she disagrees with the MHP overruling her physician's orders because her doctors know what is best for her. Appellant stated further that she is not requesting the approval of pool therapy forever, just long enough for her to learn what to do on her own to improve her life.

The MHP must cover services consistent with the scope of services covered by the Michigan Medicaid fee-for-service program. As stated above, the health plan may limit services to those which are **medically necessary** and appropriate, and which conform to professionally accepted standards of care. According to the Medicaid Provider Manual, Outpatient Therapy section-5.2, effective [redacted], physical therapy must be medically necessary, reasonable and necessary to return the beneficiary to the functional level prior to illness or disability or to a functional level that is appropriate to a stable medical status within a reasonable amount of time. Additionally, the medical services or supplies requested must be the most cost-effective treatment available. Appellant admitted that she would like an opportunity to try pool therapy to see if it will improve her functional ability and quality of life. Although pool therapy might be beneficial to Appellant, she failed to provide adequate objective medical evidence or clinical data to establish that pool therapy is medically necessary to treat her fibromyalgia. The documentary evidence provided by Appellant fails to distinguish pool therapy as anything but a treatment option for patients with fibromyalgia, which is considered a chronic muscle pain condition. Further, the Medicaid Provider Manual, Outpatient Therapy-section 5.2C, states clearly that Medicaid does not cover aquatic therapy as a separately reimbursable treatment or modality. Accordingly, the MHP's denial of Appellant's request must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied Appellant's request for pool therapy.

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IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Marya A. Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

[redacted]
Docket No. 2009-11480
Decision and Order

cc: [redacted]

Date Mailed: 3/20/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.