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. 2009-35687 ABW
Case 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] appeared on her own behalf. [redacted] represented the [redacted] a County-Administered Health Plan (CHP). [redacted]; and [redacted], appeared as witnesses for the CHP. [redacted], was also present.

ISSUE

Did [redacted] properly deny Appellant's physical therapy request?

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 enrolled in the [redacted] as an Adult Benefit Waiver beneficiary.

2. The CHP contracts with [redacted] to provide services covered by the Adult Benefit Waiver.

3. Appellant is a [redacted] female.

4. In [redacted] Appellant received a CT scan of her lumbar spine. (Exhibit 1, pp 5-6; Exhibit 4, pp 1-2).

5. On [redacted], Appellant's primary care physician requested physical therapy for Appellant to treat "chronic abdominal pain." (Exhibit 1, p 8; Exhibit 4, p 4).

6. On [redacted], [redacted] sent Appellant a notice of denial for physical therapy indicating as the reason for denial: "According to the Medicaid Provider Manual (Section 2) under coverage and limitations, therapy services are not covered in any setting." (Exhibit 2).

7. On [redacted], the Department of Community Health (DCH) received the Appellant's request for an Administrative Hearing.

8. Subsequent to submitting her request for hearing the Appellant submitted her CT scan results and additional physical therapy prescriptions to this State Office of Administrative Hearings and Rules for the Department of Community Health (SOAHR). The additional medical documentation was immediately forwarded to and reviewed by the CHP as well as was incorporated in its hearing summary.

CONCLUSIONS OF LAW

On January 16, 2004, the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, approved the Adult Benefit Waiver to permit the state to use state funds and funds authorized under Title XXI of the Social Security Act to provide coverage to uninsured adults who were not otherwise eligible for Medicaid or Medicare. The program utilizes the Medicaid provider network and County-Administered Health Plans (CHPs) as managed care providers.

The Department's policy with regard to the Adult Benefits Waiver is found in the Medicaid Provider Manual:

> **SECTION 1 - GENERAL INFORMATION**
>
> This chapter applies to all providers.
>
> The Adult Benefits Waiver (ABW), provides health care benefits for Michigan's childless adult residents (age 18 through 64) with an annual income at or below 35 percent of the Federal Poverty Level (FPL). Covered services and maximum co-payments for beneficiaries in this eligibility category are detailed in the following sections. Unless noted in Medicaid provider-specific chapters, service coverage and authorization requirements for the fee-for-service (FFS) beneficiaries enrolled in the ABW program mirror those required for Medicaid. Only those providers enrolled to provide services through the Michigan Medicaid Program may provide services for FFS ABW beneficiaries.

SECTION 1.1 - COUNTY ADMINISTERED HEALTH PLANS

ABW beneficiaries enrolled in CHPs are subject to the requirements of the respective CHP. In those counties operating nonprofit CHPs, all covered services for ABW beneficiaries must be provided through the health plan. CHPs administering the ABW program are required to provide the services as noted in the Coverage and Limitations Section of this chapter to ensure that benefits are consistent for all ABW beneficiaries across the FFS and CHP programs.

Medicaid Provider Manual, Adult Benefits Waiver, July 1, 2009, Page1.

The Appellant's request for hearing stated, "I have been given two referrals by two different doctors to receive physical therapy & (ABW) will not cover these expenses." (Exhibit 3).

The CHP stated that it implements the ABW program consistent with Department Medicaid policy. The CHP testified and submitted evidence that its coverage policy is consistent with the Department's Medicaid policy, and both explicitly excludes coverage for physical therapy.

A review of the Medicaid Provider Manual demonstrates that physical therapy is not a covered benefit under the Adult Benefits Waiver. Section 2 of the Medicaid Provider Manual, Adult Benefits Waiver chapter, provides in pertinent part.

SECTION 2 – COVERAGE AND LIMITATIONS

The table below outlines beneficiary coverage under ABW. Special instructions for CHP beneficiaries are noted when applicable…

Therapies

…Therapy services are not covered in any setting.

Medicaid Provider Manual, Adult Benefits Waiver, July 1, 2009, Pages 4 and 7.

The CHP non-physical therapy coverage is consistent with Medicaid physical therapy coverage prohibition. The CHP is bound by Department Medicaid policy. As such, the CHP is not required to provide coverage for physical therapy services and its denial was proper.

Subsequent to submitting her request for hearing the Appellant submitted her CT scan results and additional physical therapy prescriptions to this State Office of Administrative Hearings and Rules for DCH (SOAHR). The additional medical documentation was immediately

forwarded to and reviewed by the CHP as well as was incorporated in its hearing summary. All medical documents provided by Appellant are part of the evidentiary record and reviewed by the Administrative Law Judge prior to rendering this Decision and Order.

The Appellant testified she understood that physical therapy services were not covered under the ABW. The Appellant stated that the issue she wished to address at hearing was her desire to be "switched" to an "insurance" that would cover physical therapy. Appellant produced no evidence that she had been denied eligibility for any other Medicaid insurance in the 90 days prior to her request for hearing and as such this SOAHR for DCH lacks jurisdiction to conduct a Medicaid fair hearing and decide the issue. If the Appellant desires information regarding other public health benefits programs for which she may be eligible and for which she may engage in a benefits program application process, she may do so by contacting her Department of Human Services eligibility specialist case worker.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the [redacted] properly denied Appellant's physical therapy request.

IT IS **THEREFORE ORDERED** THAT:

The Wayne County Health Plan's decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/23/2009

***** 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.