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

IN THE MATTER OF:

Docket No. 2012-26403 EDW[1]

[redacted] [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to M.C.L. § 400.9 and 42 C.F.R. § 431.200 *et seq.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared on her own behalf. [redacted], [redacted] Government Programs for Priority Health, represented the Medicaid Health Plan.

ISSUE

Did the Medicaid Health Plan (MHP) properly deny Appellant's request for payment of gym membership fees?

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 woman who has been diagnosed with, among other things, fibromyalgia, cervical degenerative disc disease, urinary incontinence, and severe depression. (Exhibit 1, pages 11-12).

2. Appellant is a Medicaid beneficiary and is currently enrolled in the MHP.

3. On or around [redacted], Appellant's physician made a request on her behalf for payment of gym membership fees. As stated in the doctor's letter: "It is my medical opinion that, if not medically necessary, an ongoing membership at a fitness facility would be extremely beneficial." (Exhibit 1, page 11).

[1] This case was mistakenly coded as an EDW case, but it should be coded as a QHP case.

4. On [redacted], the MHP denied Appellant's request for gym membership fees. (Exhibit 1, pages 9-10). The MHP sent Appellant a written notice of denial which stated, in part, that therapy for the purpose of maintaining a physical condition or maintenance therapy for a chronic condition is not covered. (Exhibit 1, page 11).

5. On [redacted], the Michigan Administrative Hearing System (MAHS) received Appellant's Request for Administrative Hearing. (Exhibit 1, pages 5-8).

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 October 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 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 I-Z.
>
> (Article 1, 1.022 E. 1, Comprehensive Health Care Program for the Michigan Department of Community Health (Contract) with the Medicaid Health Plans, 2010)

The MDCH-MHP contract language allows a health plan such as Priority Health to limit services to those that are medically necessary and consistent with Medicaid policy. The Michigan Medicaid Provider Manual (MPM) Outpatient Therapy Chapter provides the

coverage criteria for Medicaid covered physical therapy. In the pertinent part, the MPM provides:

> MDCH anticipates PT will result in significant functional improvement in the beneficiary's ability to perform mobility skills appropriate to his chronological, developmental, or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). PT making changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered.
>
> PT must be skilled (i.e., require the skills, knowledge and education of a PT). MDCH does not cover interventions provided by another practitioner (e.g., teacher, RN, OT, family member, or caregiver).
>
> MDCH covers the physical therapist's initial evaluation of the beneficiary's needs and design of the PT program. The program must be appropriate to the beneficiary's capacity, tolerance, treatment objectives, and include the instructions to the beneficiary and support personnel (e.g., aides or nursing personnel) for delivery of the individualized treatment plan. MDCH covers infrequent reevaluations, if appropriate.
>
> The cost of supplies and equipment used as part of the therapy program is included in the reimbursement for the therapy. MDCH only covers a clinic room charge in addition to PT if it is unrelated.
>
> PT services may be covered for one or more of the following reasons:
>
> - PT is expected to result in the restoration or amelioration of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills;
> - PT service is diagnostic;
> - PT is for a temporary condition that creates decreased mobility and/or function; or
> - Skilled PT services are designed to set up, train, monitor, and modify a maintenance or prevention program to be performed by family or caregivers. MDCH does not reimburse for routine provision of the maintenance/prevention program.

PT may include:

- Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility);
- Stretching for improved flexibility;
- Instruction of family or caregivers;
- Modalities to allow gains of function, strength, or mobility; and/or
- Training in the use of orthotic/prosthetic devices.

MDCH requires a new prescription if PT is not initiated within 30 days of the prescription date.

PT is not covered for beneficiaries of all ages for the following:

- When PT is provided by an independent PT. (An independent PT may enroll in Medicaid if they provide Medicare-covered therapy and intend to bill Medicaid for Medicare coinsurance and/or deductible only.)
- When PT is for educational, vocational, or recreational purposes.
- If PT services are required to be provided by another public agency (e.g., CMHSP services, school-based services [SBS]).
- If PT requires PA and services are rendered prior to approval.
- If PT is habilitative therapy. Habilitative treatment includes teaching a beneficiary how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. For example, teaching a child normal dressing techniques or teaching cooking skills to an adult who has not performed meal preparation tasks previously.
- If PT is designed to facilitate the normal progression of development without compensatory techniques or processes.
- If PT is a continuation of PT that is maintenance in nature.
- If PT services are provided to meet developmental milestones.
- If PT services are not covered by Medicare as medically necessary.

> Only medically necessary PT may be provided in the outpatient setting. Coordination between all PT providers must be continuous to ensure a smooth transition between sources.
>
> (MPM, Outpatient Therapy Chapter, pages 13-14)

As stated in the above Department/MHP contract language, a MHP such as Priority Health may limit services as long as the limitations are consistent with applicable Medicaid provider manuals. Here, the MHP's representative testified that the gym membership is not medically necessary and that physical therapy is not a covered service with respect to chronic conditions, such as Appellant's fibromyalgia.

Appellant testified, and her doctor wrote, that a gym membership is cheaper than physical therapy and that it would be beneficial in combating her fibromyalgia. However, even Appellant's own doctor stated that the gym membership is not medically necessary and there is no prescription for physical therapy.

The MHP's determination to deny Appellant's request for gym membership fees must be upheld as those fees are not a medically necessary Medicaid covered service. While a gym membership might be beneficial for Appellant, Appellant's own doctor failed to find that is medically necessary and a gym membership is not a covered service. Moreover, to the extent that Appellant argues that the fees are related to the covered service of physical therapy, Appellant has completely failed to demonstrate that she is entitled to such therapy.

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 gym membership fees.

IT IS THEREFORE ORDERED that the Medicaid Health Plan's decision is AFFIRMED.

Steven Kibit
Administrative Law Manager
For Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3-29-12

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.