

**STATE OF MICHIGAN**  
**MICHIGAN ADMINISTRATIVE HEARING SYSTEM**  
**FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
P.O. Box 30763, Lansing, MI 48909  
Phone: (517) 335-3997; Fax: (517) 373-4147

**IN THE MATTER OF:**

**Docket No.** 15-003354 MHP

██████████  
Appellant  
\_\_\_\_\_ /

**DECISION AND ORDER**

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

After due notice, a telephone hearing was held on ██████████. Appellant appeared and testified. ██████████, Inquiry Dispute Resolution Coordinator and ██████████, Medical Director appeared and testified on behalf of Respondent ██████████ (██████████ or Respondent or MHP).

Respondent's Exhibit A pages 1-12 were admitted as evidence.

**ISSUE**

Did the Respondent properly deny the Appellant's request for Aquatic therapy?

**FINDINGS OF FACT**

Based on the competent, material, and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. ██████████ (██████████) is a Qualified Health Plan contracted with the State of Michigan Comprehensive Health Care Program.
2. Appellant is a Medicaid benefit recipient, who was an enrolled member of ██████████ at the time of the request for services and continues to be enrolled.
3. The MHP member handbook and certificate of coverage were sent at the time of enrollment.
4. The Member Handbook outlines coverage limitations, prior authorization requirements, limitations and exclusions, and pharmacy guidelines.

5. Respondent received a Prior Authorization request from Appellant's physician for Aquatic therapy.
6. On ██████████, Respondent sent Appellant Notice of Denial for Aquatic Therapy stating that Medicaid does not cover Aquatic Therapy as a separately reimbursable treatment or modality. Therefore, Aquatic Therapy is not a covered benefit.
7. On ██████████, the Michigan Administrative Hearing System received a request for a hearing from Appellant contesting Respondent's Negative Action.

### **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 MHPs.

The Respondent is one of those MHPs.

The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below. The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Contractor 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 2.024.

Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services

- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSTD for persons under age 21 [Article 1.020 Scope of [Services], at §1.022 E (1) contract, 2010, p. 22].

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

- (a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- (b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- (c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- (d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
- (e) The UM activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure

The Contractor must establish and use a written prior approval policy and procedure for UM 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 UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review. [Contract, *Supra*, p. 49].

As stated in the Department-MHP language, a MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations."

Medicaid Provider Manual, Outpatient Therapy, Section 5.2.C, states:

Medicaid does not cover aquatic therapy as a separately reimbursable treatment or modality. A covered therapeutic procedure performed in a pool would be reimbursed when billed by the same therapist. Covered therapeutic procedures require direct (one-on-one) patient contact by the therapist.

[REDACTED]  
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Appellant failed to satisfy her burden of proving by a preponderance of the evidence that Respondent improperly denied the request for Aquatic Therapy.

**DECISION AND ORDER**

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP's denial of the Appellant's request for Aquatic Therapy was proper.

**IT IS THEREFORE ORDERED** that:

The MHP's decision is **AFFIRMED**.



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Landis Lain  
Administrative Law Judge  
for Director, Nick Lyon  
Michigan Department of Health and Human  
Services

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

LYL/db

cc: [REDACTED]

**\*\*\* 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.