

**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) 373-4147

**IN THE MATTER OF:**

**Docket No. 2014-19318 CMH**

████████████████████

██████████

██████████

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.*, and upon the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Attorney ██████████ represented Appellant. Appellant; ██████████, Appellant's mother; ██████████, a representative from the ██████████; ██████████, Clinical Psychologist; ██████████, student; ██████████, Appellant's grandfather, and ██████████, Appellant's grandmother; were also present or testified on Appellant's behalf.

██████████, Fair Hearings Officer, represented the Respondent ██████████ (██████████). ██████████, Health Services Supervisor; ██████████, Mental Health Specialist and Appellant's former case worker; and ██████████, Program Administrator at Community Support and Treatment Services (CSTS); were also present or testified on Respondent's behalf.

**ISSUES**

Did ██████████ properly deny Appellant's request for evaluation by and services of a dietician; evaluation by and services of an occupational therapist; additional Community Living Supports; transportation; respite care services; skill-building assistance; and supported integrated employment services?

**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 ██████ year-old Medicaid beneficiary who has been diagnosed with, among other conditions, Pervasive Developmental Disorder; Mood Disorder, NOS; Posttraumatic Stress Disorder; and Undifferentiated Deficit Disorder. (Respondent's Exhibit A, pages 1, 5).

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2. Appellant lives with his mother and she provides him with significant informal supports. (Testimony of Appellant; Testimony of [REDACTED]).
3. Appellant has also been receiving services through [REDACTED] (Testimony of Appellant; Testimony of [REDACTED]).
4. On or about [REDACTED], a meeting was held with respect to Appellant's Individual Plan of Services (IPOS). (Respondent's Exhibit A, pages 1-6).
5. Among others, Appellant; Appellant's mother; and [REDACTED] participated in that meeting. (Respondent's Exhibit A, page 1).
6. During that meeting, Appellant requested a number of services, including an assessment by and services of a dietician; an evaluation by and services of an occupational therapist; Community Living Supports (CLS); transportation to community events, school and medical appointments; respite care services so that his mother could have a break; skill-building assistance; and supported integrated employment services. (Testimony of Appellant; Testimony of [REDACTED]).
7. [REDACTED] forwarded the request for services of a dietician to [REDACTED] Disease Management Team. (Respondent's Exhibit A, page 5; Testimony of [REDACTED]).
8. The Disease Management Team subsequently denied the request for assessment or services by a dietician. (Testimony of [REDACTED]).
9. However, no notice of that denial was ever sent to Appellant. (Acknowledgement of Respondent's representative).
10. [REDACTED] also determined that the request for assessment or services by an occupational therapist should also be denied. (Testimony of [REDACTED]).
11. However, no notice of that denial was ever sent to Appellant either. (Acknowledgement of Respondent's representative).
12. Similarly, [REDACTED] also denied Appellant's request for skill-building assistance and supported integrated employment services without sending notice of any denial. (Testimony of Appellant).
13. Appellant's request for transportation was also denied, but written notice of that denial was sent to Appellant on or about [REDACTED]. (Respondent's Exhibit C, pages 1-2; Testimony of [REDACTED]).

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14. [REDACTED] also denied Appellant's request for respite care services through a separate written notice sent to Appellant on [REDACTED] (Respondent's Exhibit D, pages 1-2; Testimony of [REDACTED]).
15. Appellant was authorized for targeted case management and [REDACTED] hours of CLS per week. (Respondent's Exhibit A, page 5; Testimony of [REDACTED]).
16. On [REDACTED] the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter.
17. Subsequently, a review of Appellant's CLS was performed; and Appellant was authorized for an additional [REDACTED] hours of CLS per week, effective [REDACTED]. (Respondent's Exhibit A, pages 5-6).
18. Appellant was unaware of any additional authorization of CLS and has continued to only utilize [REDACTED] hours per week of such services. (Testimony of Appellant).

**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.

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.

*42 CFR 430.0*

The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State

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plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

*42 CFR 430.10*

Moreover, Section 1915(b) of the Social Security Act provides:

The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection(s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State...

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

Here, as discussed above, Appellant asserts that ██████ improperly denied his requests for evaluation by and services of a dietician; evaluation by and services of an occupational therapist; additional Community Living Supports; transportation; respite care services; skill-building assistance; and supported integrated employment services.

During the hearing, the parties resolved two of those issues. First, the parties agreed that Appellant would be evaluated by an occupational therapist. To the extent Appellant disagrees with the any determination made by ██████ following that evaluation, he will have to file a new request for hearing.

Second, the parties agreed that Appellant would be assessed for additional CLS within █ weeks of the hearing. Appellant's CLS is to remain at █ hours per week at a minimum following that review and, to the extent Appellant disagrees with the any determination made by ██████ following the assessment for additional CLS, he will have to file a new request for hearing.

Each of the remaining issues will discussed in turn and, in each case, Appellant bears the burden of proving by a preponderance of the evidence that ██████ erred.

## **Dietician**

As described above, Appellant requested an evaluation by and the services of a dietician during the IPOS meeting. (Testimony of Appellant; Testimony of █████). █████ then forwarded that request to █████ Disease Management Team, who then denied it. (Respondent's Exhibit A, page 5; Testimony of █████). However, no notice of that denial was ever sent to Appellant. (Acknowledgement of Respondent's representative).

An assessment by a dietician can be a Medicaid-covered service:

### **3.3 ASSESSMENTS [RE-NUMBERED 10/1/13]**

#### **Health Assessment**

Health assessment includes activities provided by a registered nurse, physician assistant, nurse practitioner, or dietitian to determine the beneficiary's need for medical services and to recommend a course of treatment within the scope of practice of the nurse or dietician.

*MPM, October 1, 2013 version*  
*Mental Health/Substance Abuse Chapter, page 15*

As such, Appellant is entitled to a written notice if his request for the covered service is denied. See the Code of Federal Regulations: 42 CFR 431.200 *et seq.* and 42 CFR 438.400 *et seq.* Moreover, the written notice must explain the action being taken, the reasons for the action, Appellant's right to appeal, and the procedure for filing the an appeal. See 42 CFR 431.210; 42 CFR 438.404.

Here, █████ first took the position that no request regarding a dietician was ever made. However, its own witness subsequently confirmed that such a request was received, reviewed, and denied.

█████ then argued that the denial was proper given the applicable policy and evidence. However, it does not dispute that it failed to provide Appellant with the required notice of the denial or the reasons for the denial so that he could have the opportunity to properly contest the decision. Given the lack of proper notice, the undersigned Administrative Law Judge finds that █████ decision to deny Appellant's request for an evaluation by a dietician must be reversed.

Appellant argues that, in addition to reversing the denial, the undersigned Administrative Law Judge should also order an assessment by a dietician. However, it is not clear from the evidence presented that such an assessment would be medically necessary and/or related to Appellant's mental health needs. Appellant is authorized for CLS related to food preparation and planning (Respondent's Exhibit A, page 6 of 6), but he

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is already being treated by a primary care physician for morbid obesity and, while there may be an issue with his private insurance regarding such treatment, it is not clear what, if any, assistance is necessary from a dietician (Testimony of Appellant).

Accordingly, Appellant has failed to demonstrate at this time that any evaluation or services by a dietician are medically necessary and the undersigned Administrative Law Judge will therefore limit his order on this issue to requiring a reassessment of Appellant's request for services.

**Transportation**

Appellant also requested assistance with transportation, but that request was denied through written notice sent to Appellant on or about [REDACTED]. (Respondent's Exhibit C, pages 1-2; Testimony of [REDACTED].)

With respect to such services, the MPM states:

**3.27 TRANSPORTATION [RE-NUMBERED 10/1/13]**

PIHPs are responsible for transportation to and from the beneficiary's place of residence when provided so a beneficiary may participate in a state plan, HSW or additional/B3 service at an approved day program site or in a clubhouse psychosocial rehabilitation program. MHPs are responsible for assuring their enrollees' transportation to the primary health care services provided by the MHPs, and to (non-mental health) specialists and out-of-state medical providers. The DHS is responsible for assuring transportation to medical appointments for Medicaid beneficiaries not enrolled in MHPs; and to dental, substance abuse, and mental health services (except those noted above and in the HSW program described in the Habilitation Supports Waiver for Persons with Developmental Disabilities Section of this chapter) for all Medicaid beneficiaries. (Refer to the local DHS or MHP for additional information, and to the Ambulance Chapter of this manual for information on medical emergency transportation.)

PIHP's payment for transportation should be authorized only after it is determined that it is not otherwise available (e.g., DHS, MHP, volunteer, family member), and for the least expensive available means suitable to the beneficiary's need.

*MPM, October 1, 2013 version  
Mental Health/Substance Abuse Chapter, page 22*

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Given that policy, it is clear that ██████ properly denied Appellant's request for transportation services. Appellant requested assistance with transportation for community events, school, and medical appointments. (Testimony of Appellant; Testimony of ██████). However, as described above, the DHS, and not ██████, would be responsible for assuring transportation to medical appointments for Medicaid beneficiaries if such transportation was necessary. See MPM, October 1, 2013 version, Mental Health/Substance Abuse Chapter, page 22. Moreover, with respect to other activities, it is undisputed that Appellant already has available transportation through his mother and grandparents. (Testimony of Appellant). Appellant may prefer other transportation, but the above policy is clear that "payment for transportation should be authorized only after it is determined that it is not otherwise available". (MPM, October 1, 2013 version, Mental Health/Substance Abuse Chapter, page 22).

The undersigned Administrative Law Judge would also note that transportation to community events may be part of Appellant's CLS and that the parties have agreed to reassess Appellant's request for additional CLS out in the community. Regarding, the denial of transportation at issue in this case, however, the ██████ decision must be affirmed based upon the available evidence.

**Respite Care Services**

During the IPOS meeting, Appellant requested respite care services and, with respect to such services, the MPM states:

**17.3.J. RESPITE CARE SERVICES**

Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite should be decided during person-centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a

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few hours, a few days, weekends, or for vacations).

- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.
- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.
- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).
- Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the child is receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix for additional information.)

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence
- Licensed family foster care home

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- Facility approved by the State that is not a private residence, (e.g., group home or licensed respite care facility)
- Home of a friend or relative chosen by the beneficiary and members of the planning team
- Licensed camp
- In community (social/recreational) settings with a respite worker trained, if needed, by the family

Respite care may not be provided in:

- day program settings
- ICF/MRs, nursing homes, or hospitals

Respite care may not be provided by:

- parent of a minor beneficiary receiving the service
- spouse of the beneficiary served
- beneficiary's guardian
- unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.

*MPM, October 1, 2013 version*  
*Mental Health/Substance Abuse Chapter, pages 125-127*

██████████ denied Appellant's request for respite care services in this case through a written notice sent to Appellant on ██████████ (Respondent's Exhibit D, pages 1-2). However, that notice only provides that the request was denied because the requested service "is not a Medicaid Covered Specialty Service and Support" (Respondent's Exhibit D, page 1) and, as demonstrated in the above policy, respite care services are clearly Medicaid-covered services. Accordingly, the ██████████ denial was improper and must be reversed.

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While not identified as a basis for the adverse action in the notice of denial, ██████████ also argued in its hearing summary provided prior to the hearing and during the hearing itself that the Appellant's request for respite care services was denied on the basis that Appellant was requesting respite care for himself, but he is not an unpaid caregiver and it is not feasible to have respite from himself. However, its own witness, ██████████, expressly testified that Appellant requested respite for his mother/unpaid caregiver so that she could have a break from Appellant. (Testimony of ██████████). Given the undisputed testimony regarding what was properly requested during the hearing and the identified basis for the decision, the denial of respite care services was clearly improper and must be reversed.

Appellant and his representative argue that, in addition to reversing ██████████, the undersigned Administrative Law Judge should order that respite care be authorized. No clear amount was requested, though Appellant's mother did allude to the ██████████ hours per month of respite care she received when Appellant was under the age of ██████████. (Testimony of ██████████). However, it is not clear to this Administrative Law Judge that respite care services are medically necessary given that Appellant can be safely left alone; he attends school ██████████ hours a week; Appellant has not been using all of the CLS he was previously approved for; and he will be getting assessed for even more CLS within ██████████ weeks of the hearing per the agreement of the parties.

Accordingly, the undersigned Administrative Law Judge will not order that respite care services be authorized and, instead, will only order that ██████████ improper denial of respite care be reversed and that it initiate a reassessment of Appellant's request for respite care services.

**Skill-building Assistance/ Supported Integrated Employment Services**

Appellant's final issues on appeal relate to skill-building assistance and supported integrated employment services. Both types of services may be covered by Medicaid when necessary and appropriate:

**17.3.K. SKILL-BUILDING ASSISTANCE**

Skill-building assistance consists of activities identified in the individual plan of services and designed by a professional within his/her scope of practice that assist a beneficiary to increase his economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services provide knowledge and specialized skill development and/or support. Skill-building assistance may be provided in the beneficiary's residence or in community settings.

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Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for sheltered work services provided by Michigan Rehabilitation Services (MRS). Information must be updated when the beneficiary's MRS eligibility conditions change.

Coverage includes:

- Out-of-home adaptive skills training: Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and supports services incidental to the provision of that assistance, including:
  - Aides helping the beneficiary with his mobility, transferring, and personal hygiene functions at the various sites where adaptive skills training is provided in the community.
  - When necessary, helping the person to engage in the adaptive skills training activities (e.g., interpreting).

Services must be furnished on a regularly scheduled basis (several hours a day, one or more days a week) as determined in the individual plan of services and should be coordinated with any physical, occupational, or speech therapies listed in the plan of supports and services. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

- Work preparatory services are aimed at preparing a beneficiary for paid or unpaid employment, but are not job task-oriented. They include teaching such concepts as attendance, task completion, problem solving, and safety. Work preparatory services are provided to people not able to join the general workforce, or are unable to participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Activities included in these services are directed primarily at reaching habilitative goals (e.g., improving attention span and motor skills), not at teaching specific job skills. These services must be reflected in the beneficiary's person-centered plan and directed to habilitative or rehabilitative objectives rather than employment objectives.

- Transportation from the beneficiary's place of residence to the skill building assistance training, between skills training sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

- Services that would otherwise be available to the beneficiary.

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### **17.3.M. SUPPORTED/INTEGRATED EMPLOYMENT SERVICES**

Provide job development, initial and ongoing support services, and activities as identified in the individual plan of services that assist beneficiaries to obtain and maintain paid employment that would otherwise be unachievable without such supports. Support services are provided continuously, intermittently, or on a diminishing basis as needed throughout the period of employment. Capacity to intervene to provide assistance to the individual and/or employer in episodic occurrences of need is included in this service.

Supported/ integrated employment must be provided in integrated work settings where the beneficiary works alongside people who do not have disabilities.

Coverage includes:

- Job development, job placement, job coaching, and long-term follow-along services required to maintain employment.

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- Consumer-run businesses (e.g., vocational components of Fairweather Lodges, supported self-employment)
- Transportation provided from the beneficiary's place of residence to the site of the supported employment service, among the supported employment sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

- Employment preparation.
- Services otherwise available to the beneficiary under the Individuals with Disabilities Education Act (IDEA).

*MPM, October 1, 2013 version*  
*Mental Health/Substance Abuse Chapter, pages 127-128, 130*

According to both ██████████ representative and witness, the IPOS meeting addressed skill-building assistance and supported integrated employment services; some types of those services were offered, and Appellant declined any assistance. (Respondent's Exhibit A, pages 3, 5; Testimony of ██████████).

In response, Appellant testified that he generally requested assistance with skill-building and employment, and that he never declined any assistance or received any notice of denial. (Testimony of Appellant).

The undersigned Administrative Law Judge finds Appellant to be credible as to what he generally requested during the meeting, especially given that, as described above, ██████████ has consistently misrepresented what occurred during the IPOS meeting and what services were requested.

Moreover, given the finding that Appellant requested both skill-building assistance and supported integrated employment services, the undersigned Administrative Law Judge also finds that the ██████████ erred by failing to provide proper notice of the denial of Appellant's requests and it must reassess Appellant's requests for both skill-building assistance and supported integrated employment services.

**DECISION AND ORDER**

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

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assistance while improperly denying Appellant's requests for an evaluation/services by a dietician, respite care services, skill-building assistance, and supported integrated employment services.

**IT IS THEREFORE ORDERED** that:

- (1) Per the agreement of the parties, [REDACTED] will initiate an evaluation of Appellant by an occupational therapist and an assessment of Appellant's request for additional Community Living Supports.
- (2) [REDACTED] decision to deny Appellant's request for transportation assistance is **AFFIRMED**.
- (3) [REDACTED] decision to deny Appellant's requests for evaluation/services by a dietician, respite care services, skill-building assistance and supported integrated employment services, are **REVERSED** and [REDACTED] must initiate a reassessment of Appellant's requests.

*Steven Kibit*

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Steven J. Kibit  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/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.