RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: January 23, 2017
MAHS Docket No.: 16-015897
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and upon a request for a hearing filed on Petitioner's behalf.

After due notice, a telephone hearing was begun on January 3, 2017. However, the hearing was not completed during the scheduled time and the Administrative Law Judge determined that the hearing should be continued at a later date. The hearing was subsequently continued and completed on January 17, 2017.

[redacted] Petitioner's father and legal guardian, appeared and testified on Petitioner's behalf. [redacted], Petitioner's co-guardian and step-mother, was also present during the hearing.

Attorney [redacted] represented the Respondent [redacted]. [redacted], [redacted], and [redacted], testified as witnesses for Respondent.

During the hearing, Petitioner offered sixteen exhibits that were admitted into the record (Exhibits 1-16). While admitted separately, the exhibits were numbered collectively and the parties and undersigned ALJ referred to the hand-written page numbers when referring to the exhibits during the hearing. The undersigned ALJ will therefore continue to do the same in this decision and order.

Respondent also one exhibit that was admitted into the record (Exhibit A).

ISSUE

Did Respondent properly prohibit Petitioner from using his Community Living Supports (CLS) while Petitioner is sleeping?[1]

FINDINGS OF FACT

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

1. Petitioner is a thirty-year-old Medicaid beneficiary who has been diagnosed with cerebral palsy; grand mal seizures; irritable bowel syndrome; constipation; and significant developmental delays. (Exhibit 2, page 16; Exhibit 11, pages 185; Exhibit A, page 16).

2. Due to his conditions, Petitioner is unable to complete any home living activities; community living activities; lifelong learning activities; employment activities; health and safety activities; or social activities; without significant assistance. (Exhibit 9, pages 163-169).

3. He also requires seizure management and repositioning three times a night to prevent bed sores. (Exhibit 2, page 18; Exhibit 9, page 171).

4. Moreover, if he does not receive assistance in getting up for a bowel movement, he tends to become constipated, which exacerbates his cerebral palsy and may cause seizures. (Exhibit 2, page 18).

5. Petitioner lives alone in his own apartment connected to the family home and, in his home, he has been receiving services through Respondent pursuant to the Habilitation Supports Waiver (HSW). (Exhibit A, pages 15, 28-30).

6. His services include Community Living Supports (CLS); skill-building assistance; non-emergency transportation, supports coordination; and therapeutic camp. (Exhibit A, pages 15-16, 20-23).

7. Petitioner also receives Home Help Services (HHS) through a program administered by the Michigan Department of Health and Human Services. (Exhibit A, pages 15, 28-30).

8. In March of 2015, Respondent reduced Petitioner's CLS in order to reflect the amount of HHS he was receiving. (Exhibit A, page 139).

[1] Petitioner's original request for hearing also appealed a denial of a request for additional CLS hours. However, during the second day of hearing, Petitioner's representative expressly stated the number of authorized hours is no longer in dispute.

9. Respondent also advised Petitioner's guardian that the CLS hours had to be for face-to-face time with Petitioner and could not be used during periods when Petitioner was sleeping. (Exhibit A, page 139).

10. On March 16, 2015, the Michigan Administrative Hearing System (MAHS) received Petitioner's Request for Hearing with respect to that decision. (Exhibit A, page 139).

11. After due notice, an in-person hearing was conducted by Administrative Law Judge (ALJ) Robert Meade on July 30, 2015. (Exhibit A, page 138).

12. On August 5, 2015, ALJ Meade issued a Decision and Order affirming Respondent's decision. (Exhibit A, pages 138-149).

13. Specifically, he found that Respondent both properly reduced Petitioner CLS to offset Petitioner's receipt of HHS and properly instructed Petitioner's father that he could no longer utilize CLS while Appellant is asleep. (Exhibit A, page 149).

14. ALJ Meade also denied a motion by Petitioner for reimbursement for money Petitioner's guardian spent while the appeal was pending to provide CLS to Petitioner while Petitioner was sleeping. (Exhibit A, page 148).

15. Petitioner did not appeal ALJ Meade's decision to circuit court. (Testimony of Petitioner's representative),

16. Since that past decision was affirmed, Petitioner has received 81 hours per week of CLS, in addition to his HHS; skill-building assistance; supports coordination; non-emergency transportation; and therapeutic camp. (Exhibit A, pages 15-16; 20-23; Testimony of Case Manager).

17. Overall, his paid services add up to approximately 20.6 hours per day of paid services. (Testimony of Case Manager).

18. On October 14, 2016, a person-centered plan (PCP) meeting was held in order to amend Petitioner's PCP. (Exhibit A, pages 15-25).

19. The plan was being amended to reflect a change from Petitioner using a self-determination agreement to now using a staffing agency. (Exhibit A, page 15).

20. The PCP continued to provide that "CLS can only be paid for face to face time. CLS cannot be provided during the night time sleeping hours. CLS for 2 hour toileting for 15 minutes each (up to an hour during the off shift). [Petitioner] goes to bed at various times and gets up at various times." (Exhibit A, page 15).

21. However, regarding Petitioner's seizure protocol, the PCP does authorize some CLS while Petitioner was sleeping:

> There are times when [Petitioner] will be tired and sleep after a seizure. It is medically necessary for staff to continue monitoring his status. If [Petitioner] sleeps after a seizure staff will monitor and watch for distress. Staff will fill out a seizure report. Staff will also report in progress notes the length of seizure and if there were any injuries. Any injuries will be written on an incident report.

Exhibit A, page 16

22. Subsequently, when signing the amended PCP on November 4, 2016, Petitioner's guardian also wrote that they objected "to the face-face restriction on grounds that it is a misapplication of Medicaid law. We will appeal this decision." (Exhibit A, page 25).

23. On November 4, 2016, the MAHS received the request for hearing filed on Petitioner's behalf in this matter. (Exhibit A, page 6).

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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 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*

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…
>
> *42 USC 1396n(b)*

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 Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, Petitioner has been receiving CLS through Respondent pursuant to the HSW and, with respect to such services, the applicable version of the Medicaid Provider Manual (MPM) states:

> **SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES**
>
> Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. ***HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services.*** A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. ***Medical necessity criteria should be used***

in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process.

HSW beneficiaries must be enrolled through the MDHHS enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/IID level of care services; and
- Chooses to participate in the HSW in lieu of ICF/IID services.

The enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, or does not receive at least one HSW service per month, or withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Bureau of Community Mental Health Services. (Refer to the Directory Appendix for contact information.)

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.

Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.

15.1 WAIVER SUPPORTS AND SERVICES

Community Living Supports (CLS)	Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home nonvocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are: ▪ Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with: ➢ Meal preparation; ➢ Laundry; ➢ Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or

	licensee, has responsibility for provision of these services); ➢ Activities of daily living, such as bathing, eating, dressing, personal hygiene; and ➢ Shopping for food and other necessities of daily living. ▪ Assistance, support and/or training the beneficiary with: ➢ Money management; ➢ Non-medical care (not requiring nurse or physician intervention); ➢ Socialization and relationship building; ➢ Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through DHS or health plan) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence); ➢ Leisure choice and participation in regular community activities; ➢ Attendance at medical appointments; and ➢ Acquiring goods and/or services other than those listed under shopping and

	non-medical services. ▪ Reminding, observing, and/or monitoring of medication administration. The CLS do not include the costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian. For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed DHS' allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings. If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping, the beneficiary must request Home Help and, if necessary, Expanded Home Help from MDHHS. CLS

	may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in

	school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

MPM, October 1, 2016 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
Pages 102-104
(Emphasis added)

Regarding medical necessity, the MPM also provides:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
>
> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
> - Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
> - Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
> - Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
> - Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community

inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;

- Made within federal and state standards for timeliness;

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and

- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:

  - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

- that are experimental or investigational in nature; or

- for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or

- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

MPM, October 1, 2016 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
Pages 13-14

Here, it is undisputed that Petitioner should be approved for CLS and that such services are medically necessary. Moreover, the amount of CLS to be approved is now undisputed as well, with Petitioner's representative expressly stating on the record that the number of CLS authorized is no longer in dispute. Instead, the issue in this case solely involves Respondent's decision to prohibit Petitioner from using his CLS while he is sleeping

In support of that decision, Respondent's Provider Network Manager cited to the PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes used by Respondent (Exhibit A, pages 35-85). In particular, she noted that the reporting and costing considerations for the H2015 encounter code at issue in this case expressly provide that the CLS "[m]ust be Face-to-face" (Exhibit A, page 51). She further testified that, based on that provision, CLS cannot be provided while Petitioner is sleeping. During cross-examination, she did agreed that a PIHP may not deny services solely based on preset limits of the cost, amount, scope, and duration of services

Respondent's Case Manager testified regarding Petitioner's diagnoses; needs; living situation; and services. She also testified that Petitioner's CLS, skill-building assistance and HHS add up to approximately 20.6 hours per day of paid services, but that the

Department of Health and Human Services determines amount of HHS approved. She further testified about the prior decision by ALJ Robert Meade regarding the past reduction in Petitioner's CLS and noted that Petitioner's needs and services are unchanged since that decision was issued.

Regarding CLS in general, the Case Manager testified that CLS can be provided at any time, day or night, but that it cannot be provided when Petitioner is asleep because there would be no training or learning component to the service if the Petitioner was asleep and such a component is required by policy. She also noted that there is no provision for assistance with preserving health and safety as part of CLS pursuant to the HSW.

With respect to Petitioner's CLS in particular, the Case Manager testified that it can be provided at night if Petitioner is awake and that Petitioner's need for nighttime interventions, such as toileting and repositioning assistance, is addressed in the plan. She also testified that the plan does identify CLS for times when Petitioner is asleep after he has seizures and that such assistance is medical necessary.

The Case Manager further testified regarding other options that may address any needs Petitioner may have when he is sleeping, including a Personal Emergency Response System (PERS) unit; having Petitioner lives in an Adult Foster Care (AFC) for one; having live-in staff; sharing his home and safe with a roommate; video monitoring; or increased HHS. With respect to HHS, she also testified that the hours are flexible; they can be used at night; and that they are more appropriate than CLS for monitoring at night.

In response, Petitioner's representative testified that, while he no longer disputes the number of CLS hours that have been authorized and that the authorized hours would be sufficient if Petitioner could make full use of them, the 20.6 hours per day of paid services identified by Respondent is a false promise if Petitioner is not allowed to use them during the night while he is sleeping.

Petitioner's representative also testified that Petitioner needs services overnight and, while Respondent has approved one hour a night for assistance with toileting, the authorized time is insufficient as Petitioner goes to the bathroom three times a night and it is economically infeasible for a worker to drive to Petitioner's home three times a night for one hour of work given where Petitioner lives; which Petitioner's representative equates to discrimination based on geographic area. He also noted that a failure to meet Petitioner's needs would make him lay in own waste for most of the night.

Regarding Respondent's position that CLS can only be provided on a face-to-face basis when Petitioner is awake, Petitioner's representative argued that there is no evidence that the face-to-face restriction identified in the encounter codes had been vetted through waiver process. He also cited to other administrative decisions issued by MAHS where CLS was provided at night and/or when a beneficiary was sleeping. He

did acknowledge that ALJ Meade decided otherwise during Petitioner's last appeal, and that Petitioner never appealed the previous decision, but also argued that, since that decision was made, the Department issued a Memorandum regarding CLS that expressly provided that there are no restrictions on the time of day that CLS can be used (Exhibit 3, page 21).

As relief, Petitioner's representatives wants the prohibition on the use of CLS while Petitioner is sleeping removed and reimbursement for the approximately [redacted] of nighttime services Petitioner's family has privately paid for since March 6, 2015, when Respondent first terminated the sleep stipend and prohibited CLS while Petitioner was sleeping. He also noted that he will be needing surgery in the future and that Petitioner's services will need to be reassessed in light of the change in his formal and informal supports.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred by prohibiting Petitioner from using CLS while Petitioner is sleeping

Given the record and applicable policies in this case, Petitioner has met that burden of proof and the Respondent's decision should therefore be reversed.

The PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes cited to by Petitioner provide in both there general rules and the specific provisions regarding the type of CLS at issue in this case that the CLS must be face-to-face. (Exhibit A, pages 36, 51). However, even accepting for the sake of argument that "face-to-face" means that the Petitioner cannot be sleeping, the encounter codes do not supersede the applicable policies found in the MPM and the definition of CLS through the HSW in the MPM does not expressly contain any such restriction.

Moreover, while, as noted by Respondent, the described purpose and types of services included under the definition of CLS for the HSW does suggest Petitioner should not be sleeping, as they all involve a beneficiary being awake, doing something or being trained to do something, the definition of CLS found in the MPM for additional mental health services (B3s), indicates that CLS may be used for "[s]taff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting"[2] and there is no indication in the MPM that CLS through the HSW waiver is more limited. Additionally, to the extent the types of CLS are different, the MPM also provides that HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services and, consequently, Petitioner could receive CLS through Respondent pursuant to two separate provisions of the MPM to the extent they are different and the services are medically necessary. *See* MPM, October 1, 2016 version, Behavioral Health and Intellectual and Developmental Disability Supports and Services, page 102.

[2] MPM, October 1, 2016 version, Behavioral Health and Intellectual and Developmental Disability Supports and Services, page 129.

Rather than focusing on whether a beneficiary is sleeping, the focus should be on whether the services are medically necessary. As quoted above, the MPM expressly states that "[m]edical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be approved through the HSW". *See* MPM, October 1, 2016 version, Behavioral Health and Intellectual and Developmental Disability Supports and Services, page 102. Similarly, while not directly addressing the issue of whether CLS can be provided while a beneficiary is sleeping, the memorandum from the Department cited to by Petitioner not only provides that CLS can be provided at any time, day or night, but also reiterates that the "focus for the provision of CLS should be on the service and that it is medically necessary to meet the needs of the individual." *See* Exhibit 3, page 21.

When focusing on medical necessity in this case, it is clear that CLS during times when Petitioner is sleeping is medically necessary and that the services should therefore be approved. For example, despite Respondent's position that it cannot pay for CLS when Petitioner is sleeping, it is in fact already doing so as Petitioner's plan expressly authorizes CLS while Petitioner is sleeping after seizures: "There are times when [Petitioner] will be tired and sleep after a seizure. It is medically necessary for staff to continue monitoring his status. If [Petitioner] sleeps after a seizure staff will monitor and watch for distress." *See* Exhibit A, page 16. Additionally, Petitioner's other needs during the night, such as toileting and repositioning needs, are undisputed and, given Petitioner's acknowledged limitations, it does not appear that the PERS unit or video monitoring system would be sufficient to meet those needs. Similarly, to the extent Respondent suggests that HHS could be used for monitoring Petitioner while he is sleeping, its argument is also clearly wrong as the policy found in Adult Services Manual 101 (8-1-2016), page 5 of 5, expressly states that HHS must not be approved for supervising or monitoring a beneficiary.

Accordingly, the undersigned ALJ finds that Respondent erred by prohibiting Petitioner from using CLS while Petitioner is sleeping and its decision to do so is reversed.[3]

[3] While Respondent's decision is reversed, the undersigned ALJ finds no basis for ordering reimbursement to Petitioner or his family for services they may have privately paid for after Respondent prohibited CLS when Petitioner was sleeping. ALJ Meade already denied Petitioner's request for reimbursement for the time period up to the past decision and Petitioner never appealed that decision. Moreover, it is undisputed that CLS while Petitioner is sleeping has never been approved since that past decision and that Petitioner and his family chose to pay for services themselves despite knowing that it was not authorized.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent improperly prohibited Petitioner from using CLS while Petitioner is sleeping.

IT IS THEREFORE ORDERED that

The Respondent's decision is **REVERSED**.

SK/tm

Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS-Location Contact

[redacted]

[redacted]

[redacted]

[redacted]

Counsel for Petitioner

[redacted]

[redacted]