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[redacted] **MI** [redacted]

Date Mailed: July 8, 2020
MOAHR Docket Nos.: 19-012082
19-012083
20-001027
20-001029
Agency No.: [redacted]
Petitioners: [redacted]
[redacted]

ADMINISTRATIVE LAW JUDGE: Colleen Lack

DECISION AND ORDER

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 *et seq*; 42 CFR 438.400 *et seq*; and Mich Admin Code, R 792.11002.

After due notice, a hearing was held on March 5, 2020. [redacted], mother and Guardian, represented the Petitioners. [redacted], Advocate, appeared as a witness for Petitioners. P. David Vinocur, Attorney, represented the Respondent, Northern Lakes Community Mental Health (NLCMH). Natalie Bowman, Case Manager; Margaret Henning, Case Manager; and Darlene Buchner, IDD Operations Manager, appeared as witnesses for NLCMH.

During the hearing proceeding, the following Exhibits were admitted:

Respondent's Exhibits:

1. Hearing Summary packet for Docket No. 19-012082 (with Attachment A)
2. Hearing Summary packet for Docket No. 19-012083 (with Attachment A)
3. Hearing Summary packet for Docket Nos. 20-001027 and 20-001029 (with Attachments A-E)
4. NLCMH email with the Department regarding clarification of covered services

Petitioner's Exhibits:

A. Petitioner's documentation packet (pp. 1-480)
B. Petitioners additional documentation (pp. 1-6)

As a preliminary matter, Respondent requested a dismissal for Docket Nos. 19-012082 and 19-012083. Respondent asserted that in the October 7, 2019, Decision and Order for MOAHR Docket Nos. 19-006881 and 19-006882, ALJ Meade dismissed those earlier appeals as being filed too late. Respondent asserted that the hearing requests that came in subsequent to that Decision and Order are attempting to enforce some dicta in the decision. Respondent asserts that the hearing request amounts to Petitioner asking for Respondent to be held in contempt of court, which does not confer jurisdiction where the underlying case has been dismissed. Respondent asserts that no action was taken regarding Petitioners' authorized services between the October 7, 2019, Decision and the filing of the hearing request on or about November 19, 2019. Lastly, Respondent explained that Petitioners appealed the October 7, 2019, Decision to the Circuit Court and that remains pending. Two courts cannot have jurisdiction of the same case at the same time. (See Exhibits 1 and 2) However, in reviewing the hearing requests, multiple issues were raised and there is jurisdiction to address some of those issues. Accordingly, the hearing requests cannot be dismissed as a whole.

The November 19, 2019, hearing request, in part, asserts that NLCMH is defying/refusing ALJ Meade's orders from the October 7, 2019, Decision and Order for MOAHR Docket Nos. 19-006881 and 19-006882. (Hearing Request for Docket Numbers 19-012082 and 19-01283) However, in that decision, ALJ Meade upheld the NLCMH's February 11, 2019, decision and only found Petitioner's July 11, 2019, hearing request was untimely. In the Decision and Order portion at the end of the Decision, the NLCMH decision was affirmed and the ALJ did not order NLCMH to take any further specific action. (Exhibit 1, Attachment A, p. 10 of 12) The paragraph Petitioner's Mother/Guardian testified she was referring to was guidance the ALJ provided in the Conclusions of Law Section regarding how NLCMH should consider the Petitioners' living situation when reviewing further requests for services. (Exhibit 1, Attachment A, p. 10 of 12; Mother/Guardian Testimony) There would not be jurisdiction for an administrative hearing regarding that guidance until NLCMH received a further request for such Medicaid covered services and either took a new action or failed to act on the request promptly. See 42 CFR 438.400(a)(1).

The November 19, 2019, hearing request, in part, asserts that NLCMH is refusing to make a new IPOS. On or about October 8, 2019, Petitioner's Mother/Guardian requested new PCP/IPOS for Petitioners. (Hearing Request for Docket Numbers 19-012082 and 19-01283; Mother/Guardian Testimony) Respondent started the process for completing new PCP/IPOS for Petitioner, such as scheduling meetings later that month and the beginning of the next month. (Hearing Request for Docket Numbers 19-012082 and 19-01283; Mother/Guardian and Case Manager Testimony) When the process was completed, new IPOS were written, which are the basis of the contested issues for the hearing requests for Docket Nos. 20-20-001027 and 20-001029. Accordingly, there is no longer a failure to act on Petitioner's Mother/Guardian's request for new PCP/IPOS for Petitioners.

The November 19, 2019, hearing request, in part, asserts that NLCMH made a determination to pay only a portion of the submission for enhanced pharmacy items for Petitioner B.M and did not make a determination regarding the submission for Petitioner

J.M. Petitioner B.M. was notified of the determination by email on October 9, 2019. (Hearing Request for Docket Numbers 19-012082 and 19-01283) Respondent asserts that this did not rise to the level of an action and that Petitioner's would not have a right to a hearing. 42 CFR 438.400(b)(3) states that the denial, in whole or in part, or payment for a service is an adverse benefit determination. Further, in accordance with 42 CFR 438.408 Petitioners are deemed to have exhausted the Internal Appeal process because Respondent has failed to adhere to notice and timing requirements. Accordingly, there is jurisdiction to proceed on the NLCMH determination to deny part, or all, of the claims for payment for enhanced pharmacy services for Petitioners. It is noted that after the November 19, 2019, hearing request was filed, NLCMH took further actions regarding enhanced pharmacy services for Petitioners, which are part of the contested issues of the hearing requests for Docket Nos. 20-20-001027 and 20-001029. Accordingly, all of the actions regarding the enhanced pharmacy services will be reviewed together.

Regarding Docket Nos. 20-001027 and 20-001029, Petitioners' February 19, 2019, Hearing Request raises 20 complaints. However, not all of the 20 complaints are hearable issues. 42 CFR 438.400(b) defines adverse benefit determinaions and grievances:

> *Adverse benefit determination* means, in the case of an MCO, PIHP, or PAHP, any of the following:
>
> (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
>
> (2) The reduction, suspension, or termination of a previously authorized service.
>
> (3) The denial, in whole or in part, of payment for a service.
>
> (4) The failure to provide services in a timely manner, as defined by the State.
>
> (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
>
> (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

> (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.
>
> ***
>
> *Grievance* means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

Petitioners' dissatisfaction with the PCP/IPOS timeliness and process would be considered a grievance rather than an adverse benefit determinaion. As such, there is no jurisdiction to review these concerns in a State Fair Hearing. Similarly, HIPAA/privacy violation issues may be the subject of a grievance or rights complaint, but are not adverse benefit detrminations. As such, there is no jurisdiction to review these issues in a State Fair Hearing.

There is jurisdiction for a State Fair Hearing regarding the service actions (ex. denials, suspensions, terminations, or reductions) as these would be considered adverse benefit determinaions. It appears that NLCMH has effectivly denied multiple requested services by including/not including them in the IPOS for Petitioners, such as family therapy, speech therapy, physical therapy, and supports and service coordination. The IPOS provides notice of appeal rights for any decisions to deny, suspend, terminate, or reduce current services or requeted services. (Exhibit 1, attachements C and D) Further, a Notice of Adverse Benefit determination was issued to at least one Petitioner for some of these services. (Exhibit A, p. 260) It appears that Petitioner's mother/Guardian has raised issues regarding these services in her requests for an Internal Appeal. (Exhibit A, pp. 55-59) While no copy of the Internal Appeal decision was provided, Respondent's Hearing Summary indicates that an adverse result from the local appeal was issued. (Exhibit 3) There is jurisdication to review adverse benefit determinations.

ISSUES

Did Respondent properly authorize Enhanced Pharmacy services for Petitioners?

Did Respondent properly include/not include multiple requested services (ex. Family Therapy, Speech Therapy, Physical Therapy, and Support and Service Coordination) for Petitioners' in the new IPOS?

FINDINGS OF FACT

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

1. Petitioners have been authorized for Enhanced Pharmacy services since at least February 11, 2019. (Exhibit 1, Attachment A, pp. 2-3)

2. On September 30, 2019, a submission was made for $[redacted] of enhanced pharmacy items for B.M. (Hearing Request for Docket Numbers 19-012082 and 19-01283; Mother/Guardian Testimony)

3. On September 30, 2019, a submission was made for $[redacted] of enhanced pharmacy items for J.M. (Hearing Request for Docket Numbers 19-012082 and 19-01283; Mother/Guardian Testimony)

4. On October 9, 2019, Petitioner's mother/Guardian received an email from NLCMH indicating they were refusing to pay $[redacted] of the $[redacted] submission. (Hearing Request for Docket Numbers 19-012082 and 19-01283; Mother/Guardian Testimony)

5. As of November 11, 2019, NLCMH had not paid any portion or issued any notice regarding the enhanced pharmacy submission for J.M. (Hearing Request for Docket Numbers 19-012082 and 19-01283; Mother/Guardian Testimony**)**

6. On November 7, 2019, IPOS Meetings started for Petitioners. (Exhibit 3, Attachments A and B)

7. The IPOS' were electronically signed by the Case Manager on December 20, 2019. (Exhibit 3, Attachments A and B)

8. On December 19, 2019, Notices of Adverse Benefit Determinations were issued to Petitioners stating certain items requested under Enhanced Pharmacy were denied because another entity was paying for some of them and for one item, the prescription was written for insomnia, which is not covered under B3 enhanced pharmacy. (Exhibit 3, Attachments C and D)

9. On December 20, 2019, a Notice of Adverse Benefit Determination was issued to Petitioner B.M. denying multiple services including family therapy and speech therapy. (Exhibit A, pp. 260)

10. Petitioners' requested an internal appeal. (Exhibit A, pp. 55-59)

11. An adverse result from the local appeal was issued to Petitioners. (Exhibit 3)

12. On or about November 19, 2019, and February 19, 220, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioners'

requests for hearing. (Hearing Request for Docket Numbers 19-012082 and 19-01283; Hearing Request for Docket Nos. 20-20-001027 and 20-001029)

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 1396(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).

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. The Medicaid Provider Manual (MPM) sets forth the criteria for medical necessity:

> **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, 2019, version
Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, pages 14-15

The MPM also addresses criteria for authorizing B3 services:

> **17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES**
>
> The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:
>
> - The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter;
> - The service(s) having been identified during person-centered planning;
> - The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter;
> - The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
> - Additional criteria indicated in certain B3 service definitions, as applicable.
>
> Decisions regarding the authorization of a B3 service including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDHHS encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.

> Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter.
>
> *MPM, October 1, 2019, version Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, page 130*

Enhanced Pharmacy

With respect to Enhanced Pharmacy services, the Medicaid Provider Manual (MPM) states:

> **17.3.C. ENHANCED PHARMACY**
>
> Enhanced pharmacy items are physician-ordered, nonprescription "medicine chest" items as specified in the individual's plan of service. There must be documented evidence that the item is not available through Medicaid or other insurances, and is the most cost-effective alternative to meet the beneficiary's need.
>
> The following items are covered only for adult beneficiaries living in independent settings (i.e., own home, apartment where deed or lease is signed by the beneficiary):
>
> - Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies
> - First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads)
>
> The following items are covered for beneficiaries living in independent settings, with family, or in licensed dependent care settings:
>
> - Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, toothbrushes, anti-plaque rinses, antiseptic mouthwashes)
> - Vitamins and minerals
> - Special dietary juices and foods that augment, but do not replace, a regular diet
> - Thickening agents for safe swallowing when the beneficiary has a diagnosis of dysphagia and either:

- A history of aspiration pneumonia, or
- Documentation that the beneficiary is at risk of insertion of a feeding tube without the thickening agents for safe swallowing.

Coverage excludes:

- Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products)

MPM, October 1, 2019, version
Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, page 134

Respondent asserts they are not obligated to conduct a medical assessment to determine what items will be included under enhanced pharmacy; they are not required to include items paid for by other insurers or programs; they are annually required to determine whether specific items requested by Petitioners fit within the categories for allowed items from the MPM policy and to itemize approved items in the IPOS; and that a determination that a requested item is not covered by enhanced pharmacy is not an action, does not require notice, and would not be a hearable issue. (Exhibit 3) Some of these arguments are without merit. For example, Medicaid would not cover items that are not medically necessary. The MPM sets forth the medical necessity criteria that are applied to Medicaid mental health, developmental disability, and substance abuse supports and services. Similarly, the MPM sets forth criteria for authorizing B3 supports and services, which include the services being medically necessary as defined in the medical necessity criteria subsection of this chapter. Regarding Respondents jurisdictional arguments for coverage of a requested item, there are appeal rights for any decisions to deny, suspend, terminate, or reduce current services or requested services. The MPM policy also does not appear to limit determination of what items would be covered by enhanced pharmacy to once per year.

Further, it is clear from the MPM enhanced pharmacy policy that the authorized items must be specified in the IPOS and there must be documented evidence that the items(s) are not available through Medicaid or other insurances. While Respondent asserts that at least some items requested for Petitioners would be covered by other sources, there is insufficient evidence to establish this. For example, Respondent asserted that as of October 1, 2019, the enhanced pharmacy benefit was moved to the 1915(i) waiver and is no longer a B3 service. It is noted that in the January 1, 2020, version of the MPM, Enhanced Pharmacy continues to be listed as a B-3 service. (*MPM, January 1, 2020, version, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, page 134)* Respondent provided a copy of a January 20, 2020, email from the Department that indicated the services Petitioners are requesting, such as enhanced pharmacy, would be the responsibility of the MI Choice Waiver Agency. (Exhibit 4) However, Petitioner provided a February 27, 2020, email from the Department stating MI Choice does not cover enhanced pharmacy and if

qualified, individuals may receive the enhanced pharmacy benefit through behavioral health. (Exhibit B, pp. 2-3) Petitioner also provided a September 27, 2019, letter from the Centers for Medicare and Medicaid Services (CMS) indicating an effective date of October 1, 2022, relating to 1915(i) Behavioral Health. (Exhibit B, pp. 4-5) If Respondent believes that these items would be covered by other sources, such as the MI Choice Waiver, it is not clear that they have coordinated with the MI Choice Waiver Agency Petitioners are enrolled with to verify coverage.

Additionally, while Respondent indicated they have agreed to pay for at least a portion of the submitted claims for Petitioners, they did not provide specific evidence of what was approved, how they calculated the approved payment amount, what was denied, and when or if payment has been issued. Accordingly, there is insufficient evidence to review the actions taken regarding the submitted claims for enhanced pharmacy items for Petitioners. A reassessment is needed regarding Petitioner's needs for enhanced pharmacy services.

Services not included in the IPOS.

Petitioner's Mother/Guardian provided testimony and meeting transcripts indicating multiple additional services were requested during the IPOS, such as Family Therapy, Speech Therapy, Physical Therapy, and Support and Service Coordination services. (Exhibit A, pp. 70-111; Mother/Guardian Testimony) It does not appear that all of these services were included in the IPOS, or that any separate written determination notices were issued.

Regarding Family Therapy, Petitioners' Mother/Guardian noted that the *MPM, January 1, 2020 Version, Coordination of Benefits Chapter, pp. 13-14* appears to allow for Medicaid to pay copayment amounts. When the beneficiary is receiving services under a PIHP/CMHSP capitation, the policy states that the PIHP/CMHSP assumes the Medicaid payment liabilities. Respondent acknowledged that in a prior hearing decision, an ALJ ordered Respondent to pay copays for this service. An out of court settlement was referenced. Respondent's attorney also asserted that there has since been a policy change and the MPM prohibits such coverage for Family Therapy. However, it is noted that Family Therapy remains listed as a covered service. *MPM, January 1, 2020, version, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, p. 18.* Petitioner's attorney did not have a citation to the MPM policy he believes prohibits coverage.

Regarding supports and services coordination, the IPOS show that Petitioners are receiving targeted case management. (Exhibit 3, Attachments A and B) Targeted Case Management core requirements include "Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary." *MPM, January 1, 2020, version, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, pp. 92-93.* Petitioners would also have supports coordination being provided by other Medicaid covered service providers, such as the MI Choice Waiver agency they are enrolled with. Accordingly, this may be why

supports and services coordination was not approved as a separate B3 service for Petitioners. See *MPM, January 1, 2020, version, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, pp. 148-150*. However, the testimony of all parties indicates there needs to be better communication and understanding from all parties regarding coordinating Petitioners' services. Petitioners' mother/Guardian indicated she believes her responsibility as a legal Guardian to secure services is solely to request a service and sign forms such as releases. Respondent would be responsible for the rest. (Mother/Guardian Testimony) While Respondent should be actively coordinating services, they would not be solely responsible for all aspects of this. All agencies providing services to Petitioners that include supports/services coordination, such as Respondent and the MI Choice Waiver Agency, as well as Petitioner's mother/Guardian, should be working together so that the appropriate services are secured for Petitioners.

Regarding physical therapy services, it appears this may be included under specialty services in the IPOS. (Exhibit 3, Attachments A and B) Regarding speech therapy services, Respondent indicated they are awaiting documentation that Petitioner's other insurance will not pay for an evaluation/services. (Exhibit 3) It is appropriate for NLCMH to ensure the requested speech therapy services would not be covered by another payor, such as private insurance or other state plan services. Petitioner's mother stated that the other insurance has denied coverage. (Mother/Guardian Testimony) As Guardian, Petitioner's mother would receive copies of denial notices for requested services for Petitioners. If written denial notices have been issued, Petitioner's Mother/Guardian should provide copies to Respondent. Petitioner's mother's Guardian indicates she believed Respondent could just find a provider and bill their other insurance. (Mother/Guardian Testimony) Respondent's attorney indicated they are not able to bill Petitioners' Blue Cross insurance.

Given the evidence and applicable policies, in this case Petitioner has met their burden of proof regarding Respondent's actions regarding enhanced pharmacy services and including/not including multiple requested services for Petitioners' in the new IPOS. A re-assessment is needed to determine the appropriate supports and services for Petitioners.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent has not properly authorized Enhanced Pharmacy services for Petitioners and has not properly included/not included multiple requested services for Petitioners' in the new IPOS based on the available information.

IT IS THEREFORE ORDERED that

Respondent's decisions are **REVERSED**. Respondent shall initiate completing a new assessment of Petitioners' medically necessary needs for supports and services through NLCMH.

CL/dh

Colleen Lack
Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

DHHS -Dept Contact

Belinda Hawks
320 S. Walnut St.
5th Floor
Lansing, MI 48913

Petitioner

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Authorized Hearing Rep.

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