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Date Mailed: April 29, 2021
MOAHR Docket No.: 20-007306
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's request for a hearing.

After due notice, on March 17, 2021, a Zoom hearing was commenced. The hearing was not completed during the scheduled time and was continued on April 12, 2021 when it was thereafter completed. Attorneys Kyle Williams and John Schwend appeared on Petitioner's behalf.

Attorney, Seth Koches, appeared on behalf of Respondent, Barry County Community Mental Health Authority (Department).

EXHIBITS

Petitioner:

1. Request for Hearing
2. Letter from [redacted]
3. Letter from [redacted]
4. Psychological Evaluation October 19, 2020
5. Treatment Plan September 16, 2019
6. Treatment Plan November 5, 2020
8. Grievance Regarding Respite
9. MPM Section Natural Support
10. MPM Section Respite Benefit
11. MPM Section Therapy

12. MPM Section Medical Necessity

Respondent: A. Hearing Summary

WITNESSES

[redacted]

ISSUE

Did the Department properly deny Petitioner's request for additional respite, individual therapy sessions, and family therapy sessions?

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 Medicaid beneficiary, born [redacted] 2020, receiving services through the Department. (Exhibit A, p 12; Testimony)

2. The Department is under contract with the Michigan Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in the Department service area. (Exhibit A, p 12; Testimony)

3. Petitioner is diagnosed with epilepsy, bowel disease, gastric problems, asthma, Crohn's disease, developmental delays, and sensory perception problems. Petitioner has also had additional psychiatric diagnoses that have included post-traumatic stress disorder, attention deficit disorder, anxiety disorder, communication disorder, autism, and reading and math disabilities. (Exhibit 4)

4. The Department has provided Petitioner with services since at least 2017/2018. (Exhibit 2)

5. For the 2017-2018 benefit year, Petitioner was approved for 1,560 units of

respite services. (Exhibit 2; Exhibit 7)

6. For the 2017-2018 benefit year, Petitioner never used more than 600 units of respite. (Testimony)

7. For the 2018-2019 benefit year, Petitioner was approved for 1440 units of respite. (Exhibit 2; Exhibit 7)

8. For the 2018-2019 benefit year, Petitioner never used more than 600 units of respite. (Testimony)

9. For the 2019-2020 benefit year, Petitioner's respite units were increased to 6,905 units due to a high-risk pregnancy and various other medical issues. Petitioner was also allocated 53 individual therapy sessions and 12 family therapy sessions. (Exhibit 2; Exhibit 7; Testimony)

10. For the 2019-2020 benefit year, Petitioner used 234 units of respite, 42 individual therapy sessions, and 5 family therapy sessions. (Testimony)

11. From 2017 and continuing through at least April 12, 2021, Petitioner has requested additional assistance in locating and acquiring a provider for respite care. (Exhibit 2; Exhibit 7; Testimony)

12. On October 19, 2020, Petitioner participated in a Confidential Psychological Evaluation. Based on the evaluation, Petitioner qualified for a diagnosis of autism in the moderate to high range. Testing revealed Petitioner had difficulties with communication, reciprocal social interaction, and overall quality of rapport. (Exhibit 3)

13. On or around November 10, 2020, the Petitioner requested a continuation of the 7,200 units of respite, 53 individual therapy sessions and 12 family therapy sessions. (Exhibit A, pp 3-4; Exhibit 2; Exhibit 6; Testimony)

14. On November 10, 2020, the Department issued a Notice of Adverse Benefit Determination. The notice indicated Petitioner would be approved for 1000 units of respite, 40 individual therapy sessions and 12 family therapy sessions. (Exhibit A, p 4; Testimony) The notice stated specifically:

> [Petitioner] has been authorized for 1000 units of respite and weekly therapy consisting of a combination of 40 individual and 12 family therapy sessions. Based on our clinical assessment and/or utilization review on 11/10/20, we believe that the amount of approved services is enough to meet your needs. If more units are needed in the future, this can be reviewed for medical necessity at that time. We made this decision because the amount of units

> requested does not appear to be aligned with medical necessity. The Code of Federal Regulations (42 CFR 440.230 -d) provides the basic legal authority for an agency to place appropriate limits on a services based on such criteria as medical necessity or utilization control procedures…[1]

15. On or around November 18, 2020, Petitioner filed a grievance against the Department for not providing her with a respite provider. (Exhibit 7; Exhibit 8)

16. On November 18, 2020, the Department issued a Notice of Appeal Denial. The denial indicated Petitioner's internal appeal was denied. (Exhibit A, p 8; Testimony) The notice stated specifically:

> We denied your internal appeal for the service/item listed above because: Your appeal was reviewed by [redacted], MA, LLPC. He found that the amount of services we approved (1000 units of respite, 40 individual and 12 family therapy sessions) should be enough to provide good care for [Petitioner]. **This is based on the past use of these services**. Carrie can look at these requests again if [Petitioner's] use of the services increases…[2]

17. On November 24, 2020, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for hearing. (Exhibit 1)

18. On December 15, 2020, CMH conducted a utilization review as part of the appeal process. During the process, CMH acknowledged respite services as being "drastically" reduced due to difficulties in obtaining a provider and due to Petitioner's respite provider (Grandfather) choosing not to be paid for his time thus his services becoming natural supports.[3] (Exhibit A, p 18)

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.

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[1] Exhibit A, p 4.
[2] Exhibit A, p 8.
[3] The utilization review was created after the Petitioner had requested a hearing. The evidence is supportive of Petitioner's position and testimony, that the underutilization was the proximate result of a lack of providers.

> 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.[4]
>
> 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.[5]

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…[6]

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 (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. The Department contracts with the Michigan Department of Health and Human Services to provide services under the waiver pursuant to its contract obligations with the Department.

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[4] 42 CFR 430.0.
[5] 42 CFR 430.10.
[6] 42 USC 1396n(b).

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service.[7]

The Department is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

The Medicaid Provider Manual identifies and addresses medical necessity. It states, in relevant part:

> **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.

[7] *42 CFR 440.230.*

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; and

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

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

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

- Made within federal and state standards for timeliness; and

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

- 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; and

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

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

- 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;

    - 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.[8]

Here, as discussed above, Petitioner had been receiving Respite and therapy services through Department and is now appealing the Department's decision to reduce those services. With respect to those services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)

PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning. NOTE: Certain services found in this section are State
Plan EPSDT services when delivered to children birth-21 years, which include community living supports, family support and training (Parent-to-Parent/Parent Support Partner) peer-delivered services, prevention/direct models of parent education and services for children of adults with mental illness, skill building, supports coordination, and supported employment.

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or

[8] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, October 1, 2020, pp 14-15.

that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to ensure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

Community Inclusion and Participation	The individual uses community services and participates in community activities in the same manner as the typical community citizen. Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with intellectual disability).
Independence	"Freedom from another's influence, control and determination." (Webster's New World College Dictionary, 1996). Independence in the B3 context means how the individual defines the extent of such freedom for him/herself during person-centered planning. For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.
Productivity	Engaged in activities that result in or lead to maintenance of or increased self-sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness. For example, a person who is 76 years old may choose to volunteer or participate in other community or senior center activities rather than have any productivity goals. For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services, individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

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; and

- The service(s) having been identified during person-centered planning; and

- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; and

- 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 . . .[9]

17.3.I. 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

[9] *Id* at 131-132.

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 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
- 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
- Licensed family child care home

Respite care may not be provided in:

- day program settings
- ICF/IIDs, 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.[10]

SECTION 3.5 CHILD THERAPY [CHANGE MADE 7/1/20]

Treatment activity designed to prevent deterioration, reduce maladaptive behaviors, maximize skills in behavioral self-control, or restore or maintain normalized psychological functioning, reality orientation and emotional adjustment, thus enabling the child to function more appropriately in interpersonal and social relationships. A child mental health professional may provide child therapy on an individual or group basis with a family-driven, youth-guided approach.

Telepractice/Telehealth is approved for Individual Therapy or Family Therapy using approved children's evidence-based practices (i.e., Trauma Focused Cognitive Behavioral Therapy, Parent Management Training-Oregon, Parenting Through Change) and utilizes the GT modifier when reporting the service. Qualified providers of children's evidence-based practices have completed their training in the model, its implementation via telehealth, and are able to provide the practice with fidelity.

Telepractice/Telehealth is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services (e.g., access or travel to needed therapy services may be prohibitive). Telepractice/Telehealth must be obtained through real-time interaction between the child's/family's physical location and the provider's physical location. Telepractice/Telehealth services are provided to patients through hardwire or internet connection. It is the expectation that providers involved in telepractice/telehealth are trained in the use of equipment and software prior to servicing children/families.

The technology used must meet the requirements of audio and visual compliance in accordance with current regulations and industry standards. Refer to the General Information for Providers Chapter of this manual for the complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements. **(text added 7/1/20)**.

SECTION 3.9 FAMILY THERAPY [CHANGE MADE 7/1/20]

[10] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, January 1, 2020, pp 132-133, 145-146.

> Family Therapy is therapy for a beneficiary and family member(s), or other person(s) significant to the beneficiary, for the purpose of improving the beneficiary/family function. For children and youth, a family-driven, youth-guided planning process should be utilized. Family therapy does not include individual psychotherapy or family planning (e.g., birth control) counseling. Family therapy is provided by a mental health professional or limited licensed master's social worker supervised by a fully licensed master's social worker. When providing trauma specific intervention for infants, toddlers (birth through 47 months) and their family member(s) or other person(s) significant to the beneficiary (i.e., Child Parent Psychotherapy), the mental health professional, or limited licensed master's social worker supervised by a fully licensed master's social worker, must minimally have endorsement as an Infant Family Specialist by the Michigan Association of Infant Mental Health; Infant Mental Health Specialist is preferred. **(text added 7/1/20**).[11]

The Department argued respite services and therapy services were reduced following a case review and review of an updated treatment plan. The Department went on to indicate that the prior authorization amount being requested was in excess of what was medically necessary, and that Petitioner had routinely failed to utilize the previously authorized services. Additionally, it was indicated that the prior increase was the result of a high-risk pregnancy and that currently, the additional unpaid services being provided by Petitioner's grandfather are considered natural supports.

Petitioner argued the underutilization of past respite authorizations was the direct result of the Petitioner not being provided a provider and not receiving support in acquiring another provider. Respondent responded by indicating Petitioner was in a self-determination arrangement and that Petitioner was responsible for identifying and hiring a respite provider but that they will assist beneficiary's in identifying providers. However, section 2.4 of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, indicates that providers of specialty services and supports are chosen by the beneficiary and **"others assisting him/her during the person-centered planning process".**[12] Moreover, "[s]elf-determination is the value that people served by the public mental health system must be supported to have a meaningful life in the community… Person-centered planning (PCP) is a central element of self-determination… Within the PIHP, choice of providers must be maintained at the provider level. The individual must be able to choose **from at least two providers of each covered support and service and must be able to choose an out-of-network provider under certain circumstances**."[13] In the case at hand, there is no dispute that

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[11] *Id* at 18-19, 148-149.
[12] *Id* at p 12.
[13] Michigan Department of Health and Human Services Behavioral Health and Developmental Disabilities Administration Self-Determination Policy & Practice Guideline, Attachment P4.7.1, pp 1-2. Can be found

there was a lack of providers and that Petitioner had both verbally and in writing requested assistance in finding another provider. The Department however, failed to provide Petitioner with additional options which directly contributed to the underutilization. As a result, the Department should not be using under utilization as a depreciating factor since their own actions directly contributed to the underutilization.

Regarding the underutilization of therapy, the testimony presented indicated there was possibly a small setback with COVID as the Petitioner and Providers became acclimated with the "stay-at-home" orders. While Petitioner's therapist, testified, Petitioner was consistent with appointments and had been making progress but had remaining struggles with several issues that merited continued therapy.

Based on the foregoing, I agree with Respondent that a reduction in services may be warranted based on a lack of medical necessity for 7,500 units of respite and possibly for individual and family therapy services as well. However, the evidence fails to show how the Department calculated the proposed reduction considering Petitioner's inability to acquire a provider for respite services and with the Department failing to provide Petitioner with assistance or provide Petitioner with a second option. Additionally, the rationale and reasoning provided by the Department to support the proposed reduction for individual and family therapy is weak considering Petitioner had a valid reason for any underutilization that may have occurred as a result of Covid-19 and the transition to telepractice/telehealth.

Therefore, based on the evidence presented, Petitioner has proven by a preponderance of the evidence that the Department's proposed reduction was improper. The Department must reassess Petitioner and authorize enough respite services, and individual and family therapy to meet all the goals in Petitioner's IPOS.

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at https://www.michigan.gov/documents/mdhhs/Self-Determination_Policy_and_Practice_Guideline_4-7-1_638423_7.pdf. Accessed on April 27, 2021.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department improperly reduced Petitioner's respite, and individual and family therapy.

IT IS THEREFORE ORDERED that:

The Department decision is REVERSED.

Within 10 days of the issuance of this Decision and Order, the Department must reassess Petitioner and authorize enough respite and individual and family therapy to meet all the goals in Petitioner's IPOS.

CA/dh

Corey Arendt
Administrative Law Judge
for Elizabeth Hertel, 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

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