Michigan Office of Administrative Hearings and Rules
P.O. BOX 30763
LANSING, MI 48909

Date Mailed: September 2, 2025
Docket No.: 25-026211
Case No.: [redacted]
Petitioner: [redacted]

[redacted]
[redacted] MI [redacted]

This is an important legal document. Please have someone translate the document.

هذه وثيقة قانونية مهمة. يرجى أن يكون هناك شخص ما يترجم المستند.

এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।

Este es un documento legal importante. Por favor, que alguien traduzca el documento.

这是一份重要的法律文件。请让别人翻译文件。

Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

Date Mailed: September 2, 2025
Docket No.: 25-026211
Case No.: [redacted]
Petitioner: [redacted]

DECISION AND ORDER

The above-captioned matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and upon a request for a hearing filed on behalf of the minor Petitioner [redacted] (Petitioner). On August 27, 2025, a telephone hearing took place regarding Petitioner's request for hearing. [redacted] Petitioner's mother, appeared at the hearing on behalf of Petitioner. Benita Brown, Due Process Manager, appeared on behalf of Respondent, OCHN (Department). Adam Hamilton, Clinical Director, appeared as a witness for the Department.

Exhibits:

Petitioner	1. Misc. Documents
Respondent	A. Hearing Summary

ISSUE

Did Department properly deny Petitioner's request for placement at Great Lakes Center?

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 [redacted] year old Medicaid beneficiary seeking to move back to Michigan from Virginia. (Exhibit A; Testimony.)

2. Petitioner currently resides at [redacted] in [redacted] paid for by private insurance.

3. On April 10, 2025, the Department issued an adverse benefit determination letter. The notice indicated Petitioner's request for residential placement was denied. The noticed specifically provided the following:

> Your 3/14/25 Easter Seals MORC request for residential placement for 3/14/25-1/31/26 is denied. Our Physician Advisor, Karam Radwan, MD, reviewed the medical necessity criteria and what was sent by your provider. The Michigan Medicaid Provider Manual

(Section 2.5.A. MEDICAL NECESSITY CRITERIA within the Behavioral Health and Intellectual Developmental Disability Supports and Services) was not met for the denied services.

[redacted] does not meet medical necessity criteria for the treatment t the mental health residential level of care, as requested. [redacted] has been in a 24-hour setting since December 2022 with limited progress. There are safety concerns in a structured environment with difficulties showing improvement in daily functioning. Prior to treatment, [redacted] had a hard time getting services. [redacted] continues to have physical aggression, school refusal, and disruptions. There was no report of [redacted] making progress with family engagement. There was no sign that [redacted] was ready to move out of the current setting. [redacted] is receiving specialized care. There are no documents to suggest this service would treat, improve, or reduce [redacted] symptoms. No documents to suggest that moving [redacted] to a residential program in the state of Michigan will help.[1]

4. On April 28, 2025, Petitioner submitted to Department, an expedited appeal. (Exhibit A.)

5. On June 10, 2025, the Department issued a letter of appeal denial upholding their denial for ICF/IDD Residential Placement. (Exhibit A; Testimony.)

6. On July 17, 2025, the Michigan Office of Administrative Hearings and Rules received from Petitioner, a request for hearing. (Hearing File.)

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,

[1] Exhibit A, pp 17-18.

> 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.[2]
>
> 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.[3]

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…[4]

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, the minor Petitioner has been receiving services through Department (Support Coordination) while residing at Cumberland in an inpatient setting that has a residential program that is being paid for with private insurance. Petitioner is now seeking to relocate to Michigan and subsequently requested placement at a residential facility which was denied by the Department.

---

[2] 42 CFR 430.0.
[3] 42 CFR 430.10.
[4] 42 USC 1396n(b).

The Department denied the request after they had determined that the clinical information provided did not meet the medical necessity criteria for residential placement and as outlined in the Medicaid Provider Manual.

With respect to the location and medical necessity of services through Department, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **2.3 LOCATION OF SERVICE**
>
> Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in this manual, PIHPs are encouraged to provide mental health and developmental disabilities services in integrated locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence.
>
> Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. Mental health case management may be provided off-site, as necessary, to meet individual needs when case management is purchased as a component of a licensed service. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's home.
>
> * * *
>
> **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.[5]

Here, the Department concluded that Petitioner does not require additional treatment in a 24-hour setting to arrest or delay the progression of her mental illness or developmental disability; and further, that Petitioner as attained a level of functioning which can achieve her goal of treatment in an ambulatory care setting. The Department also concluded that the Petitioner no longer poses a risk of harm to self or others that would require treatment in a residential setting. The Department believes Petitioner would benefit from treatment in a less restrictive setting that includes outpatient services and community supports.

In appealing that decision, Petitioner bears the burden of proving by a preponderance of the evidence, that Department erred in denying the request. Moreover, the undersigned ALJ is limited to reviewing Department's decision in light of the information it had at the time it made the decision.

[5] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, July 1, 2025, pp 10, 13-15.

Given the record and applicable policies in this case, the undersigned ALJ finds that Petitioner has failed to meet the burden of proof and that Department's decision must, therefore, be affirmed.

It is undisputed in this case that Petitioner has significant diagnoses and extensive care needs.

However, even if the requested residential placement would meet their medical needs, that alone is insufficient to meet Petitioner's burden in this case; as per policy, Department may deny services 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.

Moreover, it is also undisputed that a residential placement would be more restrictive than Petitioner receiving services while residing in the community.

Petitioner did argue that the services suggested by the Department came with wait lists that would prevent the Petitioner from getting the care needed. These concerns though at this time are not yet ripe for consideration. If the Department determines a service is needed, it is their responsibility to provide those services immediately. If those services are delayed for any reason, the Petitioner has a right to request a Medicaid Fair Hearing.

Petitioner has, therefore, failed to show that less-restrictive services are unavailable, inappropriate or insufficient to meet Petitioner's medical needs; and the undersigned ALJ consequently finds that Department's denial of Petitioner's request for residential placement should be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Department properly denied Petitioner's request for a residential placement.

IT IS THEREFORE ORDERED that:

Department's decision is **AFFIRMED**.

COREY A. ARENDT
ADMINISTRATIVE LAW JUDGE

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to MOAHR-BSD-Support@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

Via Electronic Mail:

Petitioner

[redacted]
[redacted] MI [redacted]
[redacted]

Department Contact
BELINDA HAWKS
MDHHS-BPHASA
320 S WALNUT ST 5TH FL
LANSING, MI 48933
MDHHS-BHDDA-HEARING-NOTICES@MICHIGAN.GOV

Community Health Representative
OAKLAND COMMUNITY HEALTH NETWORK
C/O BENITA BROWN - 63
5505 CORPORATE DRIVE
TROY, MI 48098
DUEPROCESS@OAKLANDCHN.ORG

Via First Class Mail:

Authorized Hearing Representative

[redacted]
[redacted] MI [redacted]