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

Date Mailed: September 10, 2025
Docket No.: 25-026362
Case No.: [redacted]
Petitioner: [redacted]

[redacted]

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

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Docket No.: 25-026362
Case No.: [redacted]
Petitioner: [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on September 2, 2025. [redacted], Petitioner's sister, appeared on behalf of Petitioner. Attorney David Vinocur appeared on behalf of Respondent, Northern Lakes Community Mental Health Authority (Department). Dr. Paula Colombo, M.D., and Lisa Wiesemann appeared as witnesses for the Department.

Exhibits:

Petitioner	A – Misc. Documents
Department	1 – Letter of Adverse Benefit Determination
	2 – Court-Ordered Psychological Evaluation
	3 – Pine Rest Christian Mental Health Services Discharge
	4 – UofM Neurology Clinic Progress Note
	5 – Medical Director's Note (January 31, 2024)
	6 – Medical Director's Note (May 23, 2025)
	7 – Ascension MRI (December 10, 2023)

ISSUE

Did Respondent properly decide to terminate Petitioner's Personal Care and CLS, in a Specialized Residential Setting?

FINDINGS OF FACT

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

1. Beginning in November of 2021, Petitioner began experiencing increasingly debilitating cognitive, behavioral and functional impairments. (Testimony.)

2. In August of 2022, Petitioner's sister was appointed as Petitioner's guardian. (Testimony.)

3. In September of 2022, Petitioner began inpatient psychiatric hospitalization at HealthSource Saginaw. (Testimony.)

4. On October 7, 2022, Petitioner was evaluated and diagnosed with unspecified schizophrenia. Documentation from the evaluation indicate a CT scan of Petitioner's head revealed "slightly more pronounced cerebral substance loss and sulcal prominence than typically observed in a patient of his age." (Testimony; Exhibit 2.)

5. On October 21, 2022, Respondent began offering Petitioner CMH services. During the intake process, both Petitioner's guardian and treating clinicians were concerned Petitioner had an undiagnosed medical or neurological issue in part due to standard schizophrenia treatments not helping. (Testimony; Exhibit A; Exhibit 3.)

6. Following discharge, Petitioner was placed in adult foster care. (Testimony.)

7. On May 6, 2023, Petitioner was involuntarily hospitalized at Pine Rest Christian Mental Health Services. Petitioner presented with impulsivity and stimulus bound behaviors and could not hold a meaningful conversation. (Testimony; Exhibit 4.)

8. On October 3, 2023, Petitioner was discharged to a group home. (Testimony; Exhibit 4.)

9. On January 31, 2024, Petitioner was seen at U of M Neurology Clinic where he was evaluated by Dr. Marrissa D'Souza, M.D. The assessment stated in part:

> … the patient's presentation is most concerning for early-onset behavioral variant frontotemporal dementia (bvFTD). He meets diagnostic criteria for at least possible bvFTD; consistent imaging findings (i.e. frontal and/or anterior temporal atrophy) is required to meet diagnostic criteria for probable bvFTD.[1]

10. In May of 2025, clinical staff asked for a review of Petitioner's case. (Testimony.)

11. Dr. Curtiss Cummins, M.D., conducted the review and found evidence to support a primary diagnosis of neurocognitive disorder and psychotic disorder secondary to FTD. (Testimony.)

[1] Exhibit 5.

12. On May 29, 2025, the Respondent sent Petitioner an Adverse Benefit Determination. The notice indicated Petitioner's services would be terminated as a result of Petitioner not meeting the Medicaid eligibility criteria. (Exhibit 1; Testimony.)

13. At the time of the hearing, Petitioner was no longer taking psychotropic medications. (Testimony.)

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.[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:

[2] 42 CFR 430.0.
[3] 42 CFR 430.10.

> 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).

Eligibility for services through Department is set by Michigan Department of Health and Human Services policy as outlined in the Medicaid Provider Manual (MPM). Specifically, the applicable version of the MPM states in the pertinent part that:

> **1.6 BENEFICIARY ELIGIBILITY**
>
> A Medicaid beneficiary with mental illness, serious emotional disturbance or developmental disability who is enrolled in a Medicaid Health Plan (MHP) is eligible for specialty mental health services and supports when his needs exceed the MHP benefits. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.) Such need must be documented in the individual's clinical record…
>
> The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

[4] 42 USC1396n(b).

In general, MHPs are responsible for outpatient mental health in the following situations:	**In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:**
▪ The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. ▪ The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports.	▪ The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills). ▪ The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments,

	promote recovery and/or prevent relapse.

> The "mental health conditions" listed in the table above are descriptions and are intended only as a general guide for PIHPs and MHPs in coverage determination decisions. These categories do not constitute unconditional boundaries and hence cannot provide an absolute demarcation between health plan and PIHP responsibilities for each individual beneficiary. Cases will occur which will require collaboration and negotiated understanding between the medical directors from the MHP and the PIHP. The critical clinical decision-making processes should be based on the written local agreement, common sense and the best treatment path for the beneficiary.[5]

The State of Michigan's Mental Health Code defines serious mental illness and serious emotional disturbance as follows:

> (3) "Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:
>
> (a) A substance abuse disorder.
> (b) A developmental disorder.
> (c) "V" codes in the diagnostic and statistical manual of mental disorders.
>
> (4) "Serious mental illness" means a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and

[5] MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, April 1, 2025, pp 3-4.

> approved by the department and that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness:
>
> (a) A substance abuse disorder.
> (b) A developmental disorder.
> (c) A "V" code in the diagnostic and statistical manual of mental disorders.[6]

The Medicaid program in Michigan provides specialty mental health services and supports through Community Mental Health Service Programs and Prepaid Inpatient Health Plans to beneficiaries who meet eligibility criteria for series mental illness, developmental disability, or substance use disorder, as set forth in the Michigan Mental Health Code, MCL 330.1100 et seq., and the Medicaid Provider Manual, Mental Health/Substance Abuse Section.

In this case, the Petitioner was initially diagnosed with schizophrenia, a qualifying serious mental illness. Based upon that diagnosis, the Petitioner was determined eligible for and received CMHSP services. Subsequent medical evaluation, including MRI and clinical review, established that the Petitioner's symptoms were not attributable to schizophrenia but instead to frontal temporal dementia, a neurocognitive disorder. Dementia, while a serious medical condition, is not define din the Medicaid Provider Manual or the Mental Health Code as a qualifying condition for CMHSP/PIHP services absent a co-occurring qualifying serious mental illness.

Because Petitioner's current diagnosis of frontal temporal dementia does not meet the statutory and policy criteria for specialty mental health services under Medicaid, the CMHSP acted in accordance with law and policy when it determined Petitioner is no longer eligible for CMHSP-funded services. The Petitioner remains eligible for medically necessary services under the general Medicaid program, including medical and long-term care benefits appropriate for individuals with dementia.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Department properly terminated Petitioner's services.

[6] MCL 330.1100d.

IT IS THEREFORE ORDERED that:

The 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 First Class and Electronic Mail:

Respondent
NORTHERN LAKES COMMUNITY MENTAL HEALTH
105 HALL ST STE A
TRAVERSE CITY, MI 49684
CUSTOMER.SERVICE@NLCMH.ORG

Via Electronic Mail:

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

Via First Class Mail:

Petitioner
[redacted]

Authorized Hearing Representative
[redacted]

Respondent Representative
P. DAVID VINOCUR
2644 WESTWARD DRIVE
TRAVERSE CITY, MI 49685