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

Date Mailed: November 18, 2025
Docket No.: 25-032111
Case No.: [redacted]
Petitioner: [redacted]

[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: November 18, 2025
Docket No.: 25-032111
Case No.: [redacted]
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DECISION AND ORDER

This 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 hearing filed on behalf of Petitioner [redacted] (Petitioner).

After due notice, a telephone hearing was held on October 21, 2025.

Jeremy Walker, a Board-Certified Behavior Analyst (BCBA) and Director of Applied Behavioral Analysis (ABA) Services at Developmental Enhancement Behavioral Health, appeared and testified on Petitioner's behalf. [redacted] Petitioner's father, also testified as a witness for Petitioner.

George Motakis, State Fair Hearing Officer, appeared on behalf of Respondent Lakeshore Regional Entity (Respondent). Angela Ryckaert, a Licensed Behavior Analyst and Utilization Management BCBA at Network 180, and Michelle Anguiano, a Customer Services Manager with Respondent, testified as witnesses for Respondent.

During the hearing, Respondent submitted nine proposed exhibits that were admitted into the record without objection as Exhibits A-I. No other proposed exhibits were submitted.

ISSUE

Did Respondent properly deny in part Petitioner's request for reauthorization of ABA services?

FINDINGS OF FACT

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

1. Petitioner is a seven (7) year-old Medicaid beneficiary who has been diagnosed with autism spectrum disorder. (Exhibit A, pages 22-54).

2. Due to that diagnosis and her symptoms, Petitioner is approved for services through Network 180, a Community Mental Health Service Provider (CMHSP) associated with Respondent, a Prepaid Inpatient Health Plan (PIHP). (Exhibit A, pages 11-20).

3. As part of her services, Petitioner has been approved for 28 hours per week of ABA services. (Exhibit A, pages 55-92).

4. Petitioner does not attend school, and her father has not explored school for her at this time given his beliefs regarding Petitioner's current needs and abilities. (Testimony of Petitioner's father).

5. In July of 2025, Petitioner requested another six-month authorization of 28 hours of ABA services for Petitioner. (Exhibit A, page 10).

6. On August 1, 2025, Network 180 sent Petitioner a Notice of Adverse Benefit Determination stating that Petitioner's request for ABA services had been partially denied. (Exhibit A, pages 1-9).

7. The Notice of Adverse Benefit Determination also stated in part:

> Your child is receiving Applied Behavior Analysis (ABA) services. You asked for 28 hours per week of direct ABA therapy. You asked for 6 months. Coordination of care is needed to help with school planning and guide transition planning for ongoing ABA therapy. 28 hours per week of direct ABA therapy is approved for 3 months. ABA services are approved for 3 months. Please speak to your Supports Coordinator with any questions.
>
> Guideline used to make this decision: Michigan Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, Section 18: Behavioral Health Treatment Services/Applied Behavior Analysis
>
> The clinical documentation provided does not establish medical necessity.

Exhibit A, page 1

8. On August 6, 2025, Petitioner filed an Internal Appeal with Respondent regarding the decision to deny in part the request for reauthorization of ABA services. (Exhibit B, pages 1-11; Exhibit C, pages 1-4).

9. In that Internal Appeal, Petitioner's representative argued in part that the medical necessity for Petitioner's ABA services is established and that educational supports are not a substitute for the necessary medical treatment. (Exhibit B, pages 1-11).

10. On August 18, 2025, Respondent sent Petitioner a Notice of Appeal Denial. (Exhibit D, pages 1-6).

11. With respect to the reason for the denial, the notice stated in part:

> Your appeal was not approved for the service(s)/item(s) listed above because:
>
> Your child is receiving Applied Behavior Analysis (ABA) services. You asked for 28 hours per week of direct ABA therapy. You asked for 6 months. Your providers should coordinate your care to help with school planning and guide the plan for ongoing ABA therapy. 28 hours per week of direct ABA therapy is approved for 3 months. Please speak to your Supports Coordinator with any questions.
> The legal basis for this decision is:
> Michigan Mental Health Code (Act 258 of 1974), Sections 330.1100a (Definitions: A to E), 330.1100b (Definitions; F to N), 330.1100c (Definitions; P to R); 330.1100d (Definitions; S to W), and 330.1208 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.
> Managed Care Rule, 42 CFR 438.400(b)(1).
> MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5 A-D, Medical Necessity Criteria
> There is a law [42 CFR §440.230(d)] that allows us to place appropriate limits on service requests based on the reason for the medical need.
>
> Guideline used to make this decision: Michigan Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, Section 18: Behavioral Health Treatment Services/Applied Behavior Analysis

Exhibit D, page 1

12. On September 10, 2025, MOAHR received the request for hearing filed in this matter. (Exhibit F, pages 1-13).

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program:

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> *42 CFR 430.10*

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…
>
> *42 USC 1396n(b)*

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915 (c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, Petitioner has been receiving Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA) services through Respondent. With respect to such services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **SECTION 18 – BEHAVIORAL HEALTH TREATMENT SERVICES/APPLIED BEHAVIOR ANALYSIS**
>
> The purpose of this policy is to provide for the coverage of Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA), for children under 21 years of age diagnosed with Autism Spectrum Disorder (ASD). All children, including children with ASD, must receive EPSDT services that are designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services, to correct or ameliorate any physical or behavioral conditions so that health problems are averted or diagnosed and treated as early as possible.
>
> BHT services prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the child. Medical necessity and recommendation for BHT services is determined by a physician, or other licensed practitioner working within their scope of practice under state law. Direct patient care services that treat or address ASD under the state plan are available to children under 21 years of age as required by the EPSDT benefit.
>
> **18.1 SCREENING**
>
> The American Academy of Pediatrics (AAP) endorses early identification of developmental disorders as being essential to the well-being of children and their families. Early identification of developmental disorders through screening by health care professionals should lead to further evaluation, diagnosis, and treatment.

Early identification of a developmental disorder's underlying etiology may affect the medical treatment of the child and the parent's/guardian's intervention planning. Screening for ASD typically occurs during an EPSDT well child visit with the child's primary care provider (PCP). EPSDT well child visits may include a review of the child's overall medical and physical health, hearing, speech, vision, behavioral and developmental status, and screening for ASD with a validated and standardized screening tool. The EPSDT well child evaluation is also designed to rule out medical or behavioral conditions other than ASD, and include those conditions that may have behavioral implications and/or may co-occur with ASD. A full medical and physical examination must be performed before the child is referred for further evaluation.

18.2 REFERRAL

The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the Pre-paid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. The PCP must refer the child to the PIHP in the geographic service area for Medicaid beneficiaries. The PIHP will contact the child's parent(s)/guardian(s) to arrange a follow-up appointment for a comprehensive diagnostic evaluation and behavioral assessment. Each PIHP will identify a specific point of access for children who have been screened and are being referred for a diagnostic evaluation and behavioral assessment of ASD. If the PCP determines the child who screened positive for ASD is in need of occupational, physical, or speech therapy, the PCP will refer the child directly for the service(s) needed.

After a beneficiary is screened and the PCP determines a referral is necessary for a follow-up visit, the PIHP is responsible for the comprehensive diagnostic evaluation, behavioral assessment, BHT services (including ABA) for eligible Medicaid beneficiaries, and for the related EPSDT medically necessary Mental Health Specialty Services. Occupational therapy, physical therapy, and speech therapy for children with ASD who do not meet the eligibility requirements for developmental disabilities by the PIHP are covered by the Medicaid Health Plan or by Medicaid Fee-for-Service.

18.3 COMPREHENSIVE DIAGNOSTIC EVALUATIONS

Accurate and early diagnosis of ASD is critical in ensuring appropriate intervention and positive outcomes. The comprehensive diagnostic evaluation must be performed before the child receives BHT services. The comprehensive diagnostic evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning, and should include validated evaluation tools. Based on the evaluation, the practitioner determines the child's diagnosis, recommends general ASD treatment interventions, and refers the child for a behavior assessment which is provided or supervised by a board certified and licensed behavior analyst (BCBA/LBA) to recommend more specific ASD treatment interventions. The diagnostic evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. A qualified licensed practitioner includes:

- a physician with a specialty in psychiatry or neurology;
- a physician with a subspecialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline;
- a physician with a specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or behavioral health;
- a psychologist;
- an advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health;
- a physician assistant with training, experience, or expertise in ASD and/or behavioral health; or
- a masters level, fully licensed clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD.

The determination of a diagnosis by a qualified licensed practitioner is accomplished by following best practice standards. The differential diagnosis of ASD and related conditions requires multimodal assessment and integration of clinical information. This is a complex assessment procedure in which clinicians must integrate data from caregiver reports, records (e.g., medical, school, other evaluations), collateral reports (e.g., teachers, other treatment providers), data gathered from utilization of standardized psychological tools (e.g., developmental, cognitive, adaptive assessment), and the observational assessment to determine diagnostic and clinical impressions. The utilization of multiple data modes and sources improves the reliability of ASD diagnosis. No one piece of data determines the ASD diagnosis, and evaluators should consider the accuracy of data and confounding factors that may impact data obtained (e.g., parent who seems to be overly negative about the child, child who was intensely shy during observational assessment).

18.4 MEDICAL NECESSITY CRITERIA

Medical necessity and recommendation for BHT services are determined by a physician or other licensed practitioner working within their scope of practice under state law. Comprehensive diagnostic reevaluations are required no more than once every three years, unless determined medically necessary more frequently by a physician or other licensed practitioner working within their scope of practice. The recommended frequency should be based on the child's age and developmental level, the presence of comorbid disorders or complex medical conditions, the severity level of the child's ASD symptoms, and adaptive behavior deficits through a person-centered, family-driven youth-guided process involving the child, family, and treating behavioral health care providers.

The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria A and B (listed below); and require BHT services to address the following areas:

A. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by all of the following:

1. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.

2. Deficits in nonverbal communicative behaviors used for social interaction ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.

B. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least two of the following:

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases).

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take same route or eat the same food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects and/or excessively circumscribed or perseverative interest).

4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, and/or visual fascination with lights or movement).

18.5 DETERMINATION OF ELIGIBILITY FOR BHT

The following is the process for determining eligibility for BHT services for a child with a confirmed diagnosis of ASD. Eligibility determination and recommendation for BHT must be performed by a qualified licensed practitioner through direct observation utilizing valid evaluation tools. BHT services are available for children under 21 years of age with a diagnosis of ASD from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and who have the developmental capacity to clinically participate in the available interventions covered by BHT services. A well-established DSM-IV diagnosis of Autistic Disorder, Asperger's Disorder or PDD-NOS should be given the diagnosis of ASD. Children who have marked deficits in social communication but whose symptoms do not otherwise meet criteria for ASD should be evaluated for social (pragmatic) communication disorder.

To be eligible for BHT, the following criteria must be met:

- Child is under 21 years of age.

- Child received a diagnosis of ASD from a qualified licensed practitioner utilizing valid evaluation tools.

- Child is medically able to benefit from the BHT treatment.

- Treatment outcomes are expected to develop, maintain, or restore, to the maximum extent practicable, the functioning of a child with ASD.

Measurable variables may include increased social-communication skills, increased interactive play/age-appropriate leisure skills, increased reciprocal and functional communication, etc.

- Coordination with the school and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, participation in team meetings (i.e., Individualized Education Plan/Individualized Family Service Plan [IEP/IFSP], Individual Plan of Service [IPOS], etc.).

- Services are able to be provided in the child's home and community, including centers and clinics.

- Symptoms are present in the early developmental period (symptoms may not fully manifest until social demands exceed limited capacities or may be masked by learned strategies later in life).

- Symptoms cause clinically significant impairment in social, occupational, and/or other important areas of current functioning that are fundamental to maintain health, social inclusion, and increased independence.

- Medical necessity and recommendation for BHT services are determined by a qualified licensed practitioner.

- Services must be based on the individual child and the parent's/guardian's needs and must consider the child's age, school attendance requirements, and other daily activities as documented in the IPOS. Families of minor children are expected to provide a minimum of eight hours of care per day on average throughout the month.

18.6 PRIOR AUTHORIZATION

BHT services are authorized for a time period not to exceed 365 days.

The 365-day authorization period for services may be re-authorized annually based on recommendation of medical necessity by a qualified licensed practitioner working within their scope of practice under state law.

18.7 RE-EVALUATION

Comprehensive diagnostic re-evaluations are required no more than once every three years, unless determined medically necessary more frequently by a physician or other licensed practitioner working within their scope of practice. The recommended frequency should be based on the child's age and developmental level, the presence of comorbid disorders or complex medical conditions, the severity level of the child's ASD symptoms and adaptive behavior deficits through a person-centered, family-driven youth-guided process involving the child, family, and treating behavioral health care providers.

18.8 TRANSITION AND DISCHARGE CRITERIA

The desired BHT goals and outcomes for discharge should be specified at the initiation of services, monitored throughout the duration of service implementation, and refined through the behavioral service level evaluation process. Transition and discharge from all BHT services should generally involve a gradual step-down model and require careful planning. Transition and discharge planning from BHT services should include transition goal(s) within the behavioral plan of care or plan, or written plan, that specifies details of monitoring and follow-up as is appropriate for the individual and the family or authorized representative(s) utilizing the PCP process.

Discharge from BHT services should be reviewed and evaluated by a qualified BHT professional for children who meet any of the following criteria:

- The individual has achieved treatment goals and less intensive modes of services are medically necessary and/or appropriate.

- The individual is either no longer eligible for Medicaid or is no longer a State of Michigan resident.

- The individual, family, or authorized representative(s) is interested in discontinuing services.

- The individual has not demonstrated measurable improvement and progress toward goals, and the predicted outcomes as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of the BHT interventions are not able to be maintained or they are not replicable beyond the BHT treatment sessions through the successive authorization periods.

- Targeted behaviors and symptoms are becoming persistently worse with BHT treatment over time or with successive authorizations.

- The services are no longer medically necessary, as evidenced by use of valid evaluation tools administered by a qualified licensed practitioner.

- The provider and/or individual/family/authorized representative(s) are unable to reconcile important issues in treatment planning and service delivery to a degree that compromises the potential effectiveness and outcome of the BHT service.

18.9.B. BEHAVIORAL INTERVENTION

BHT services include a variety of behavioral interventions which have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence. BHT services are designed to be delivered primarily in the home and in other community settings.

BHT treatment services may also include any other intervention supported by credible scientific and/or clinical evidence, as appropriate for each individual. Based on the behavioral plan of care which is adjusted over time based on data collected by the qualified provider to maximize the effectiveness of BHT treatment services, the provider selects and adapts one or more of these services, as appropriate for each individual.

18.10 BHT SERVICE LEVEL

BHT services are available for Medicaid beneficiaries diagnosed with ASD and are provided for all levels of severity of ASD. The behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) within the individual's community for an appropriate period of time, depending on the needs of the individual and their family or authorized representative(s). Clinical determinations of service intensity, setting(s), and duration are designed to facilitate the individual's goal attainment. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant responsibilities of educational or other authorities. Each individual's IPOS must specify how identified supports and services will be provided as part of an overall, comprehensive set of supports and services that does not duplicate services that are the responsibility of another entity, such as a private insurance or other funding authority, and do not include special education and related services defined in the Individuals with Disabilities Education Act (IDEA) that are available to the individual through a local education agency. The recommended service level, setting(s), and duration will be included in the individual's IPOS, with the planning team and the family or authorized representative(s) reviewing the IPOS no less than annually and, if indicated, adjusting the service level and setting(s) to meet the individual's changing needs. The service level includes the number of hours of intervention provided to the individual. The service level determination will be based on research-based interventions integrated into the behavioral plan of care with input from the planning team. Service intensity will vary with each individual and should reflect the goals of treatment, specific needs of the individual, and response to treatment. The PIHP's Utilization Management will authorize the level of services prior to the delivery of services.

- **Focused Behavioral Intervention:** Focused behavioral intervention is provided an average of 5-15 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).

- **Comprehensive Behavioral Intervention:** Comprehensive behavioral intervention is provided an average of 16-25 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).

MPM, July 1, 2025 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 165-170

Here, as discussed above, Respondent decided to deny in part Petitioner's request for reauthorization of ABA services pursuant to the above policies. Specifically, Respondent only approved the requested services for 3 months rather than the requested 6 months.

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

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has not met her burden of proof and that Respondent's decision must therefore be affirmed.

It is undisputed in this case that ABA services remain medically necessary for Petitioner and that they have been reauthorized. However, the record also reflects that the coordination of care required by the above policies has not been completed with respect to school services.

As emphasized above, the MPM expressly provides, with respect to eligibility for BHT services like ABA, that coordination with the school is both critical and needed. Similarly, with respect to the service level of such services, the MPM likewise expressly provides that supports may serve to reinforce skills or lessons taught in school, but are not intended to supplant the responsibilities of educational authorizations.

Accordingly, given that Petitioner is school-aged but the required coordination with the local school has not been completed, Respondent properly authorized a shorter authorization period given the need for such coordination. That decision maintains Petitioner's services while the necessary determinations are made.

In finding that Respondent's decision is proper, the undersigned ALJ would note that, as testified to by the witness from Network 180, it is not clear what effect, if any, the required coordination of care would have on Petitioner's individual case. Coordination of care itself does not necessarily mandate fewer ABA hours for Petitioner or any other specific changes. Moreover, if Respondent takes any negative action following the

required coordination of care, or any future negative action if the required coordination of care is not completed, Petitioner could appeal that decision and, if that appeal is denied, request a State fair hearing.

Petitioner's father testified in response to Respondent's decision as to why he believes attending school is inappropriate for Petitioner at this time given her current abilities and needs, with her needs best met through ABA services. However, while the undersigned ALJ finds Petitioner's father to be credible regarding his reasoning and decision, it is also clear that the testimony is speculative as Petitioner's father conceded that he has not explored any school services for Petitioner and has no knowledge of what services are available there. Given the above policies, Petitioner still has to investigate what services may be available, even if it is subsequently determined that the services are inappropriate for Petitioner at this time.

Similarly, Petitioner's representative's testimony and argument are likewise unpersuasive regarding the medical necessity for a six-month authorization period. Petitioner's representative argued that, as treatment plans are developed for a six-month period, a shorter authorization might not properly demonstrate Petitioner's progress. However, even if true, that argument does not show medical necessity and should instead be raised if Respondent ever moved to terminate or reduce the amount of Petitioner's services due to a lack of progress, and there has been no such action here. Having to re-request services more frequently for Petitioner may be a nuisance for the provider and Petitioner, but, given the above policies and need for coordination of care, they have not shown medical necessity for a longer authorization period or that Respondent erred.

The undersigned ALJ will reiterate that only the partial denial regarding the length of the requested authorization period is at issue in this case and within the ALJ's scope of jurisdiction; and that Respondent's decision is proper given the entirety of the record and the applicable policies. The undersigned ALJ and this decision takes no position, and has no effect, on any future actions that would be beyond the scope of this case. If Respondent decides to take any negative action with respect to Petitioner's ABA services, then Petitioner would have the right to file an appeal with Respondent and, if necessary, request a State fair hearing.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied in part Petitioner's request for reauthorization of ABA services.

IT IS THEREFORE ORDERED that:

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

Steven Kibit

STEVEN KIBIT
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 LARA-MOAHR-DCH@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 & Electronic Mail:

Authorized Hearing Representative

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