Date Mailed: January 27, 2026
Docket No.: 25-044818
Case No.: [redacted]
Petitioner: [redacted]

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, a hearing was held on January 22, 2026. [redacted] Petitioner's mother, appeared and testified on Petitioner's behalf.

Stacy Coleman, Fair Hearing Officer, appeared and testified on behalf of Respondent, Macomb County Community Mental Health (CMH).

ISSUE

Did Respondent properly deny Petitioner's request for continued Occupational and Physical Therapy (OT & PT)?

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 who has been receiving services through Respondent. (Exhibit A, p 1; Testimony).

2. Petitioner is diagnosed with mild intellectual disability, spastic diplegic cerebral palsy, quadriplegia, seizure disorder, and gait abnormalities (Exhibit A, p 43; Testimony).

3. Petitioner is authorized to receive CMH specialty supports and services, including Targeted Case Management, Community Living Supports (CLS), Respite, and Adult Home Help. Her FY 2025–26 Person-Centered Plan authorizes 22.5 CLS hours per week and related supports to carry out home exercise programs and community inclusion objectives (Exhibit A, pp. 18–20; Testimony).

4. In September 2025, Petitioner submitted a request for continued OT & PT and, after review, Respondent concluded that Petitioner no longer met the medical necessity criteria for continued OT & ST. (Exhibit A, pp 1; 8-15; Testimony).

Specifically, CMH concluded that Petitioner has received OT and PT since 2015, made progress on treatment goals, is compliant with CLS-implemented home exercise plans, appears to have met functional potential in OT/PT, and can continue to reinforce skills with a caregiver in addition to CLS staff. As such, Respondent concluded medical necessity is not met for the requested OT/PT services. (*Id*.)

5. On September 23, 2025, CMH issued an Adverse Benefit Determination (ABD) denying the request for continued OT & ST, effective October 3, 2025, stating the clinical documentation did not establish medical necessity. (Exhibit A, pp. 9-15).

6. On November 21, 2025, CMH denied Petitioner's internal appeal and again found medical necessity unmet for both OT and PT based on record review, specifically noting that the PT evaluation dated October 16, 2024, did not recommend PT, and that the records showed no new symptoms and that CLS staff could meet the member's needs (Exhibit A, pp. 3-8).

7. Petitioner's PCP documents detailed CLS-implemented home exercise programs for both PT and OT (e.g., clams, bridging, sit-to-tall-kneeling; multi-step cooking, folding clothes, typing goals) with specified weekly frequencies and progress measurement through CLS service notes, indicating the plan of care relies on CLS prompting/guidance rather than skilled therapist intervention at each session (Exhibit A, pp. 18–20).

8. On December 10, 2025, Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules. (Exhibit 1.)

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.

> 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…

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 Michigan Department of Health and Human Services (MDHHS) operates a section 1915(b) Medicaid Managed Specialty Services waiver. Respondent contracts with MDHHS to provide specialty mental health services. Services are provided by Respondent pursuant to its contract obligations with the Department and in accordance with the federal waiver.

Medicaid beneficiaries are only 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. *See 42 CFR 440.230.* Medical necessity is defined by the Medicaid Provider Manual as follows:

> **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; 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.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
July 1, 2025, pp 12-14

Occupational and Physical Therapy services are also defined in the Medicaid Provider Manual:

3.19 OCCUPATIONAL THERAPY

Evaluation	Therapy
Physician/licensed physician assistant/family nurse practitioner -prescribed activities provided by an occupational therapist licensed by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment. An occupational therapy assistant may not complete evaluations.	It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to his chronological developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy to make changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered. Therapy must be skilled (requiring the skills, knowledge, and education of a licensed occupational therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical

	therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage. Services must be prescribed by a physician/licensed physician's assistant/family nurse practitioner and may be provided on an individual or group basis by an occupational therapist or occupational therapy assistant, licensed by the State of Michigan or by an occupational therapy aide who has received on-the-job training. The occupational therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress, but on-site supervision of an assistant is not required. An aide performing an occupational therapy service must be directly supervised by a qualified occupational therapist who is on site. All documentation by an occupational therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising occupational therapist.

Michigan Medicaid Provider Manual
Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter
July 1, 2024, pp 21-22

With regard to physical therapy, the MPM provides:

Evaluation	Therapy
Physician/licensed physician's assistant-prescribed activities provided by a physical therapist currently licensed by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment. A physical therapy assistant may not complete an evaluation.	It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to his chronological, developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy to make changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered. Physical therapy must be skilled (it requires the skills, knowledge, and education of a licensed physical therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed occupational therapist, family member or caregiver) would not be considered as a Medicaid cost under this coverage. Services must be prescribed by a physician/licensed physician's assistant and may be provided on an individual or group basis by a physical therapist or a physical therapy assistant

	currently licensed by the State of Michigan, or a physical therapy aide who is receiving on-the-job training. The physical therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress. On-site supervision of an assistant is not required. An aide performing a physical therapy service must be directly supervised by a physical therapist that is on-site. All documentation by a physical therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising physical therapist.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
July 1, 2025, pp 21-22, 33
Emphasis added

Respondent's representative argued that the denial of continued OT & ST was proper because Petitioner has received OT and PT since 2015, has made progress on treatment goals, is compliant with CLS-implemented home exercise plans, appears to have met functional potential in OT/PT, and can continue to reinforce skills with a caregiver in addition to CLS staff. Respondent's representative indicated that lengthy OT & ST without progress or improvement was not supported by medical necessity under Medicaid policy.

Petitioner's mother testified that Petitioner cooperates well in clinic but resists home exercises and that compliance at home is minimal despite CLS prompting. Petitioner's mother indicated that therapy goals at home are often incomplete and tasks like cutting and typing are rarely done. Petitioner's mother testified that Petitioner's motivation differs between therapy and home as she performs better in structured environments. Petitioner's mother pointed out that Medicaid policy allows skilled intervention for adults with cerebral palsy to maintain function and prevent decline and she believes Petitioner qualifies under this standard. Petitioner's mother indicated that the goal is to prevent decline and achieve independent walking as Petitioner currently requires HKAFO braces and forearm crutches.

Petitioner's mother testified that since therapy stopped in October, [redacted] strength and confidence have declined. Petitioner's mother referenced a letter from a certified orthotist stating therapy is "imperative" to maintain strength for orthoses and independence. Petitioner's mother testified that OT would help with school-related tasks (typing, money skills), though full independence is unlikely. Petitioner's mother indicated that Petitioner receives minimal PT at school (group sessions monthly) and has had therapy for approximately 15 years. Petitioner's mother emphasized a desire to keep Petitioner strong and safe, especially for walking with fewer supports.

Based on the evidence presented, Respondent properly denied Petitioner's request for continued OT & PT services. As indicated above, to be medically necessary OT ". . . will result in a functional improvement that is significant, and . . . should be able to be achieved in a reasonable amount of time." For PT to be deemed medically necessary, "It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to his chronological, developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable).". Here, Petitioner has been receiving OT & PT for 10 years but has shown little to no progress within the past few years. As such, Petitioner does not meet the above medical necessity criteria for OT & PT because she has not continued to show a significant functional improvement over a reasonable amount of time.

While Petitioner's policy excerpts correctly note that adults with chronic neurological conditions may receive skilled interventions to maintain function and prevent decline, the determination remains case-specific: the record must demonstrate (a) the necessity of skilled therapy, not simply exercises achievable through trained caregivers/CLS, and (b) the ineffectiveness or insufficiency of non-skilled supports to maintain function. Here, Respondent reasonably found that Petitioner had been in OT and PT for over 10 years, there were no documented new symptoms, goals remained relatively the same, and CLS and natural supports were already implementing detailed home exercise programs aligned to functional goals.

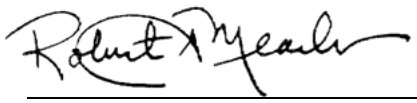
Should Petitioner's condition deteriorate, she can always request the services again. However, based on the information available to the CMH at the time the decision was made, the decision was proper and should be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Respondent properly denied Petitioner's request for continued Occupational and Physical Therapy services.

IT IS THEREFORE ORDERED that:

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



ROBERT J. MEADE
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 Electronic Mail:

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