Date Mailed: March 9, 2026
Docket No.: 26-000781
Case No.: [redacted]
Petitioner: [redacted]

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 February 10, 2026. [redacted], Petitioner's father, appeared and testified on Petitioner's behalf. Stacy Coleman, Contractor, appeared and testified on behalf of the Respondent Macomb County Community Mental Health (Respondent).

During the hearing, Petitioner submitted three exhibits that were admitted into the record without objection as Exhibits A-C. Respondent also submitted sixteen exhibits that were admitted into the record without objection as Exhibits #1-#13, #15-#17.[1]

ISSUE

Did Respondent properly deny Petitioner's requests for continued speech therapy (ST) and occupational therapy (OT) 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 [redacted] Medicaid beneficiary who has a legal guardian and who has been diagnosed with autism spectrum disorder; moderate intellectual disability; and obsessive-compulsive disorder. (Exhibit C, pages 6-9; Exhibit #5, page 9; Exhibit #6, page 1).

2. Due to his diagnoses and need for assistance, Petitioner has been approved for the Michigan's Habilitation Supports Waiver (HSW) and services through Respondent. (Exhibit A, page 1; Testimony of Respondent's representative).

3. Since 2013, Petitioner's services have included ST services. (Testimony of Respondent's representative).

[1] Respondent had no proposed exhibit #14.

4. Since 2014, Petitioner's services have also included OT services. (Testimony of Respondent's representative).

5. Other services through Respondent include targeted case management and community living supports (CLS). (Testimony of Respondent's representative).

6. Petitioner has also been approved Home Help Services (HHS) through the Michigan Department of Health and Human Services (MDHHS). (Exhibit C, page 11).

7. Petitioner's ST and OT progress would be documented in periodic evaluations, daily notes, and progress notes. (Exhibit #6, pages 1-11; Exhibit #9, pages 1-5; Exhibit #10, pages 1-5; Exhibit #11, pages 1-11).

8. On June 12, 2025, an Individual Plan of Services (IPOS) Meeting was held with respect to Petitioner's services for the upcoming plan year, *i.e.,* August 1, 2025, through July 31, 2026. (Exhibit #4, pages 1-26).

9. The IPOS that was subsequently developed again identified goals relating to ST, OT and CLS, including CLS for assistance with SLH and OT exercises. (Exhibit #4, pages 6-10, 16-17).

10. Services, including SLH and OT services, were then approved for six months, with Petitioner's IPOS to be reviewed on December 18, 2025. (Exhibit #4, pages 1, 18-20).

11. Following that approval, the provider continued to document Petitioner's ST and OT. (Exhibit #7, pages 1-6; Exhibit #12, pages 1-7; Exhibit #13, pages 1-22; Exhibit #15, pages 17-20)

12. In December of 2025, Petitioner requested the reauthorization of his services. (Testimony of Respondent's representative).

13. On December 16, 2025, Respondent sent Petitioner a Letter of Adverse Benefit Determination stating that Petitioner's request for ongoing SLH and OT services had been denied. (Exhibit C, pages 4-5).

14. With respect to the reason for the denial the Letter of Adverse Benefit Determination stated: "The clinical documentation provided does not establish medical necessity." (Exhibit C, page 4).

15. On December 15, 2025, Petitioner filed an Internal Appeal with Respondent regarding that decision. (Exhibit #2, page 1).

16. On January 7, 2026, Respondent sent Petitioner a Letter of Appeal Denial. (Exhibit #2, pages 1-5).

17. With respect to the reason for the denial, the letter stated in part:

> You are asking for continued Occupational Therapy (OT) and Speech therapy (SLP). We reviewed [Petitioner's] records. This service is meant to help with his symptoms. He has had the same therapy goals for 11 years. He should be getting better in a reasonable time. He is not getting better with this care. OT and SLP skills can be provided through caregiver led home programs, family training this is in treatment, and support from CLS staff. Medical necessity is not met and the denial is upheld.

Exhibit #2, page 1

18. On January 9, 2026, MOAHR received the request for hearing filed in this matter regarding Petitioner's SLH and OT services. (Exhibit C, pages 1-9).

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 ST, OT and CLS through Respondent through the HSW. With respect to the HSW, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES**
>
> Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid State Plan covered services. A HSW beneficiary must receive at least one HSW habilitative service per month to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in their individual plan of services (IPOS) developed through the person-centered planning process.

HSW beneficiaries must be enrolled through the MDHHS enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/IID level of care services; and
- Chooses to participate in the HSW in lieu of ICF/IID services.

The PIHP's enrollment process responsibilities also include confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. MDHHS continues to review bed size as part of the waiver enrollment which includes a limit of no more than 12 beds. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, does not receive at least one HSW habilitative service per month, moves out of the state, withdraws from the program voluntarily, or dies. An OBRA assessment must be provided for disenrollment due to nursing facility placement. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Bureau of Specialty Behavioral Health Services. (Refer to the Directory Appendix for contact information.)

PIHPs must report inactive status on HSW beneficiaries not living in community settings (e.g., hospital, nursing facility, Child Caring Institution [CCI], jail, prison, or juvenile detention facility). HSW beneficiaries can be on inactive status for 90 days. After the 90-day period, the PIHP shall start the disenrollment process if there is no transition planning for returning to the community.

> The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.
>
> Reimbursement for services rendered under the HSW is included in the PIHP capitation rate. Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.
>
> Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.
>
> *MPM, October 1, 2025 version*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *Pages 123-124*

Moreover, with respect to medical necessity criteria for services in general and the specific standards of coverage for ST, OT and CLS, the MPM also states:

> **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 their 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.

* * *

3.19 OCCUPATIONAL THERAPY

Evaluation	Therapy
Physician/licensed physician assistant/family nurse practitioner / clinical nurse specialist 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 their 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 assistant/family nurse practitioner/clinical nurse specialist 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.

* * *

3.25 SPEECH, HEARING, AND LANGUAGE

Evaluation	Therapy
Activities provided by a licensed speech-language pathologist or licensed audiologist to determine the beneficiary's need for services and to recommend a course of treatment. A speech-language pathology assistant may not complete evaluations.	Diagnostic, screening, preventive, or corrective services provided on an individual or group basis, as appropriate, when referred by a physician (MD, DO). Therapy must be reasonable, medically necessary and anticipated to result in an improvement and/or elimination of the stated problem within a reasonable amount of time. An example of medically necessary therapy is when the treatment is required due to a recent change in the beneficiary's medical or functional status affecting speech, and the beneficiary would experience a reduction in medical or functional status were the therapy not provided. Speech therapy must be skilled (i.e., requires the skills, knowledge, and education of a licensed speech-language pathologist) to assess the beneficiary's speech/language function, develop a treatment program, and provide therapy. Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, licensed occupational therapist, family member, or caregiver) would not be considered as a

	Medicaid cost under this coverage. Services may be provided by a licensed speech-language pathologist or licensed audiologist or by a speech pathology or audiology candidate (i.e., in their clinical fellowship year or having completed all requirements but has not obtained a license). All documentation by the candidate must be reviewed and signed by the appropriately licensed supervising speech-language pathologist or audiologist.

* * *

15.1.A. COMMUNITY LIVING SUPPORTS (CLS)

NOTE: This is a habilitative service.

Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or Medicaid State Plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential setting, respite). The supports are:

- Assisting (that exceeds the Medicaid State Plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with:
  - Meal preparation;
  - Laundry;

- Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services);

- Activities of daily living, such as bathing, eating, dressing, personal hygiene; and

- Shopping for food and other necessities of daily living.

- Assisting, supporting and/or training the beneficiary with:

  - Money management;

  - Non-medical care (not requiring nurse or physician intervention);

  - Socialization and relationship building;

  - Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through Medicaid Fee for Service [FFS] or the Medicaid Health Plan [MHP]) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence);

  - Leisure choice and participation in regular community activities;

  - Attendance at medical appointments; and

  - Acquiring goods and/or services other than those listed under shopping and non-medical services.

- Reminding, observing, and/or monitoring of medication administration.

CLS does not include costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADL, and/or shopping may be used to complement Home Help services when the beneficiary's needs for this assistance have been officially determined to exceed MDHHS allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, Medicaid State Plan coverage of Personal Care in Specialized Residential Settings.

If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADL, and/or shopping, the beneficiary must request Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect their needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision.

CLS provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to ADL, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings.

> For children and adults up
> to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.
>
> *MPM, October 1, 2025 version*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *Pages 14-16, 21-22, 33, 124-125*

Here, as discussed above, Respondent decided to deny Petitioner's request for continued ST and OT services pursuant to the above policies.

In appealing those decisions, 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 ALJ finds that Petitioner has failed to meet his burden of proof and that Respondent's decisions must therefore be affirmed.

As indicated above, ST services "must be reasonable, medically necessary and anticipated to result in an improvement and/or elimination of the stated problem within a reasonable amount of time." Similarly, for OT services, "[i]t 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 their 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 ST and OT since 2013 and 2014 respectively and, while he has had some progress in the past, he also appears to have plateaued, with little recent improvement, no documented new symptoms, and goals remaining relatively the same. Accordingly, Petitioner no longer meets the above criteria for either ST or OT as neither service can be anticipated to result in improvement in a reasonable amount of time.

In response, Petitioner's representative argues that continued improvement is not required for continued medical necessity, but that argument is unpersuasive. For example, while Petitioner's representative correctly notes that the required medical necessity criteria can be met with services that are intended to stabilize Petitioner's symptoms, his argument ignores the additional and specific requirements in the MPM for the skilled therapies in question.

Moreover, the record in this case does not demonstrate that the continued skilled therapies are necessary for stabilization given the approval of CLS for assistance with home exercises to address Petitioner's speech and occupational needs.

To the extent Petitioner's condition deteriorates, then he can always request the services again in the future. With respect to the decision at issue in this case however, Respondent's decision must be affirmed given the information it had at the time.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied Petitioner's requests for continued ST and OT services.

IT IS THEREFORE ORDERED that:

- Respondent's decisions are **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.

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