

ISSUE

Did Respondent properly deny Petitioner's request for continued Speech, Hearing, and Language (SHL), and a request for a SHL evaluation?

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 SHL services through Respondent since 2013. (Exhibit A; Testimony).
2. On May 14, 2025, Respondent and Petitioner developed an Individualized Plan of Services (IPOS). The plans effective period was July 1, 2025, through June 30, 2026, with a review scheduled for December 31, 2025.
3. The IPOS speech objectives included, among other things, increasing mastication time and safe oral intake, improving determination of problem "size," comprehension of money (dollar-up strategy), conversational topic maintenance and appropriate information exchange, and sentence-level fluency through self-monitoring with quarterly reporting by the SLP and coordination with CLS for home program carryover. (Exhibit A; Testimony.)
4. On October 6, 2026, the Respondent issued an Adverse Benefit Determination (ABD), denying ongoing SHL therapy citing lack of medical necessity under the Medicaid Provider Manual and Respondent policy. (Exhibit A; Testimony.)
5. On October 29, 2025, Respondent issued a Notice of Appeal Denial. The notice provided Petitioner showed no new or increased symptoms, had worked on similar goals for years, was working on similar goals with CLS, and appeared to have reached maximum benefit; medical necessity was not met. (Exhibit A; Testimony.)
6. On January 29, 2026, Petitioner submitted a request for a Medicaid State Fair Hearing. (Exhibit A; Testimony.)

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.¹

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.²

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.³ Medical necessity is defined by the Medicaid Provider Manual as follows:

2.5 MEDICAL NECESSITY CRITERIA

¹ 42 CFR 430.0.

² 42 CFR 430.10.

³ 42 CFR 440.230.

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.⁴

3.25 Speech, Hearing and Language

Evaluation	Therapy
<p>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 compete evaluations.</p>	<p>Diagnostic, screening, preventative, or corrective services provided on an individual or group basis, as appropriate, when referred by a physician (MD, DO).</p> <p>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...</p>

In this matter, Petitioner bears the burden of proving that Respondent failed to follow applicable law, policy, or procedure in denying ongoing Speech, Hearing, and Language (SHL) therapy and in denying a new SHL evaluation. The record reflects that Respondent based both denials on individualized clinical review under the Medicaid Provider Manual

⁴ Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, January 6, 2025, p 36.

(MPM) and MCCMH Utilization Management Policy 12-004, which requires that SHL services be skilled, acute in nature, reasonable, medically necessary, and expected to result in functional improvement within a reasonable period of time. Respondent also cited 42 CFR 440.230(d), which permits appropriate limits based on such utilization and medical necessity criteria. The evidence presented supports that Respondent applied these standards through review of Petitioner's long treatment history, the stability of his functioning, the long-standing similarity of his speech goals, the absence of a recent medical or functional change, and the longstanding availability of caregiver/CLS reinforcement of strategies previously provided by the speech pathologist.

Petitioner argues that Respondent applied an improper "maintainable" standard that is more restrictive than the Medicaid Provider Manual's requirement that services help a beneficiary "attain or maintain" functioning. Petitioner further argues that Respondent improperly relied on concepts not found in the MPM—such as "maximum potential"—and that Respondent used the length of time Petitioner has been in therapy as a preset limit contrary to 42 CFR 438.210(a)(5) and MPM §§ 2.5 and 2.5(B), which require individualized determinations and prohibit a PIHP from imposing criteria more restrictive than the State Medicaid Program. However, the record shows that Respondent's references to "maintainable progress" and "maximum functional potential" were not applied as rigid limits but were used in the context of Respondent's UM policy defining medical necessity for ongoing *skilled* SHL treatment. Respondent testified that SHL must be acute, time-limited, and linked to measurable functional improvement. The denials explicitly rely on individualized review (including IPOS goals, clinical notes, and functioning) rather than preset time limits. Petitioner did not establish that Respondent replaced State policy with a more restrictive standard, nor that the cited policy criteria conflict with the MPM as applied in this case.

Petitioner further asserts that Respondent violated 42 CFR 440.230(c) by effectively reducing or denying services on the basis of diagnosis, and violated the MPM by failing to tailor services to Petitioner's unique goals. Yet the record demonstrates that Respondent relied on Petitioner's clinical progress history, IPOS goals, and functional abilities, not his diagnosis, to determine that additional skilled SHL therapy and a new evaluation were not medically necessary at the time requested. Respondent reviewed the individualized facts, including Petitioner's long participation in therapy, stable functioning, absence of new medical events, and the historical pattern of working on the same goals for many years with limited change in overall functioning. The mere fact that Respondent considered the long duration of treatment in its medical-necessity analysis does not demonstrate an impermissible preset limit or discrimination based on diagnosis.

Although Petitioner presented credible testimony from both the SLP and Petitioner's mother regarding observed difficulties since therapy ended—including increased coughing, choking episodes, worsened stuttering, and reduced vocabulary use—Petitioner's mother also confirmed that there had been no medically documented change

since September 2025. The SLP testified that she could not determine Petitioner's current status or predict a reasonable timeframe for improvement without a new evaluation, but this does not contradict Respondent's conclusion that existing documentation failed to establish medical necessity for such an evaluation. Respondent's policies require more than anecdotal observations; they require clinical evidence of a new need for skilled services. Petitioner did not show that Respondent's denial was inconsistent with the MPM or with the utilization-management standards Respondent is required to apply.

Accordingly, after considering Petitioner's legal arguments and all testimony presented, the Administrative Law Judge concludes that Petitioner has not demonstrated that Respondent applied improper or more restrictive standards than allowed under Medicaid rules, nor that Respondent failed to individualize the determination, relied on preset limits, improperly substituted natural supports for skilled therapy, or otherwise violated the Michigan Mental Health Code or federal regulations. Respondent's determinations that medical necessity was not met for ongoing SHL therapy or for a new SHL evaluation are supported by the record and consistent with the policy standards cited in the adverse benefit determinations and internal appeal decisions.

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 SHL services and a SHL evaluation.

IT IS THEREFORE ORDERED that:

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