Date Mailed: March 5, 2026
Docket No.: 26-001844
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 February 24, 2026. [redacted] appeared and testified on Petitioner's behalf.

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

ISSUE

Did Respondent properly deny Petitioner's request for continued Speech Therapy (ST)?

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 severe cognitive impairment that includes an IQ of 33. (Exhibit A; Testimony).

3. On [redacted] 2018, a SLP Initial Evaluation documented a profound problem in functional communication and a severe problem in spoken language expression, with goals targeted toward improving ability to follow simple directions, respond to yes/no questions, and produce words/phrases related to personal needs. (Exhibit A; Testimony).

4. On [redacted] 2020, an Occupational Therapy Evaluation took place. Parents reported persistent ADL limitations. (Exhibit A; Testimony).

5. On [redacted] 2023, a SLP Annual Evaluation took place. At the time of the evaluation, Petitioner's strengths included requesting help and gaining attention; areas of difficulty included expressing basic needs, answering yes/no questions, using 2 plus words via AAC, and limited verbal

expression. Recommendations at the time were for SLP 1 time a week for 45 minutes. Petitioner was noted to be progressing on AAC requests without accuracy across sessions being met; minimal progress on speech sound production; and new/continued work on emotion identification and personal questions. (Exhibit A; Testimony).

6. A December 4, 2024, SLP progress note was made reflecting same goals/objectives; but that Petitioner continued to struggle in targeted areas. (Exhibit A; Testimony).

7. On [redacted] 2025, an Integrated Biopsychosocial Re-Assessment took place. At this time, it was noted Petitioner remained mainly non-verbal, communicating wants/needs through two-three word phrases and vocalizations, relying on gestures/picture boards. Petitioner will not express basic needs while family monitors body language for illness/pain. Petitioner can follow one-step directions and answer some simple questions through pointing/gesturing, but answer to yes/no questions are not always correct. Petitioner cannot relate personal experiences and would struggle in an emergency. The assessment recommended continued SLP to increase expressive/receptive language. (Exhibit A; Testimony).

8. On or around June 23, 2025, a Person Centered plan was created. Petitioner's mother had a desire to continue SLP with objectives mirroring earlier evaluations; answering yes/no across multiple communicative functions using 1-2 words via AAC, and practicing SLP exercises greater than or equal to 3 times a week. CLS Objective F directed CLS staff to work on social/communication skills, including communicating choice/wants/needs using AAC, eye contact, and exchanging hello/goodbye; scheduled 2.5 hours/week for this CLS reinforcement. (Exhibit A; Testimony).

9. On November 14, 2025, an Adverse Benefit Determination was issued. The notice indicated Respondent was denying Petitioner's request for 30 minutes per week of SLP. The denial was based on the documentation not establishing medical necessity. (Exhibit A; Testimony).

10. On December 11, 2025, Petitioner submitted an internal appeal, appealing the Adverse Benefit Determination. (Exhibit A; Testimony).

11. On January 2, 2026, the Respondent issued an Internal Appeal Denial Letter. The notice upheld the Adverse Benefit Determination. (Exhibit A; Testimony).

12. Petitioner timely filed a request for a Medicaid State Fair Hearing. (Hearing File).

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

[1] 42 CFR 430.0.
[2] 42 CFR 430.10.

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**
>
> 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

[3] 42 CFR 440.230.

- 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
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.	Diagnostic, screening, preventative, 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

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

	would experience a reduction in medical or functional status were the therapy not provided…

Applying the rules and policies found above to the present case, the record demonstrates that Petitioner has received many ears of therapy, including a documented return to services in 2018 following a break in services, and continuous services thereafter. Across this period, evaluations consistently identified severe and longstanding expressive and receptive language deficits. The evaluations and progress notes show that Petitioner's progress toward functional communication goals had consistently been limited. The June 2025 assessment, while recommending continued SLP, describes functional communication abilities that closely mirror earlier assessments, including his being mainly non-verbal, relying on gestures and picture boards, difficulty expressing basic needs, inconsistent yes/no accuracy, and inability to relate personal experiences, indicators nearly identical to those noted in earlier reports.

Although Petitioner's representative expressed concern that discontinuing SLP could lead to functional regression, the testimony acknowledged that the concern was speculative; and the contemporaneous documentation does not indicate a clinically supported decline attributable to any absence of therapy. The evidence instead shows that the services in dispute continued through December 31, 2025, and that Petitioner's communication profile remained largely unchanged over multiple years despite consistent therapeutic engagement.

Based on the evidence presented, Petitioner did not meet their burden as the Department's decision was consistent with policy. Accordingly, the Respondents decision should be affirmed.

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 SLP services.

IT IS THEREFORE ORDERED that:

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

COREY A. ARENDT
ADMINISTRATIVE LAW JUDGE

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to MOAHR-BSD-Support@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

Via Electronic Mail:

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