ISSUE

Did Respondent properly deny Petitioner's request for continued physical therapy (PT) 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 year-old Medicaid beneficiary who has been diagnosed with spastic quadriplegic; cerebral palsy; type 1 diabetes; a right parotid mass; and cramps and spasms. (Exhibit A, pages 26, 31, 49).

2. Due to his diagnoses and needs, Petitioner is approved for services through Respondent. (Exhibit A, pages 10-52).

3. In 2016, when he was REDACTED years-old, Petitioner was approved for PT through Respondent, with the services provided by Crawl, Walk, Jump, Run Therapy Clinic, LLC (CWJRTC). (Exhibit A, pages 71-74; Testimony of Respondent's representative).

4. Petitioner had been approved for PT at his school, but it was inconsistent and he had not received much. (Exhibit A, pages 71-74).

5. The initial evaluation at CWJRTC found that Petitioner had bilateral lower extremity weakness and range of motion deficits. (Exhibit A, page 73).

6. PT was recommended, with functional goals to improve neurological strength in knees and quadriceps; neurological flexibility/muscle length in hamstring; and neurological strength in hips. (Exhibit A, page 73).

7. Petitioner was also to follow a home exercise program. (Exhibit A, page 73).

8. In September of 2020, an evaluation at CWJRTC noted that Petitioner, who was REDACTED years-old at the time, had grown a lot in the past year and that his main goals included addressing Petitioner's standing and mobility, including continue to use a stander and having a desire to utilize a sit to stand wheelchair; stretching; range of motion in legs and arms; and core strength. (Exhibit A, page 67).

9. In September of 2023, an evaluation at CWJRTC provided that Petitioner, who was REDACTED years-old at the time, has been progressing well with PT, with his transfers improving at home. (Exhibit A, pages 62-64).

10. It also identified Petitioner's continuing goals and areas Petitioner was still working on. (Exhibit A, pages 63-65).

11. In September of 2024, Petitioner's PT was terminated by Respondent. (Exhibit A, pages 53-56).

12. In March of 2025, the PT services were reinstated. (Exhibit A, pages 53-56).

13. A March 27, 2025, evaluation at CWJRTC then noted that Petitioner had developed tightness in his lower extremities since the PT was stopped and that he had developed worse body mechanics during transferring due to significant fear of falling. (Exhibit A, pages 53-54).

14. The provider and Petitioner's family then identified new goals related to fall recovery training and increased independence in utilizing handle transfers at home to go along with a goal of Petitioner being more independent with bed mobility. (Exhibit A, pages 54, 56-57).

15. A Progress Note dated May 27, 2025, from CWJRTC provided that Petitioner had met or was progressing toward his goals. (Exhibit A, pages 59-61)

16. On August 15, 2025, Petitioner's Case Manager at Respondent completed a Re-Assessment. (Exhibit A, pages 26-52).

17. In that reassessment, the Case Manager noted that Petitioner had received stem cell therapy approximately 3 years prior, and that the stem cell therapy had helped with some fine motor skills and movement. (Exhibit A, page 33).

18. The Case Manager also noted that Petitioner was authorized for targeted case management, PT, occupational therapy, community living supports (CLS) and respite care services, though Petitioner did not currently have any CLS or respite staffing. (Exhibit A, pages 33, 50).

19. The Case Manager further noted that Petitioner used a motorized wheelchair for mobility, but that he needed hands-on assistance for transferring. (Exhibit A, page 45).

20. On November 12, 2025, an Individual Plan of Services (IPOS) Meeting was held with respect to Petitioner's services for the upcoming plan year, *i.e.,* December 1, 2025, through November 30, 2026. (Exhibit A, pages 10-25).

21. In the IPOS that was subsequently developed, Goal #2 was identified as: "PHYSICAL THERAPY: Per [Petitioner], 'I need to improve my strength.'" (Exhibit A, page 14).

22. Specific objectives in support of that goal included Petitioner staying compliant with home exercise program to supplement skilled therapy. (Exhibit A, page 14).

23. Goal #4 addressed Petitioner working on his independence and included Petitioner completing PT exercises during the implementation of CLS services. (Exhibit A, page 16).

24. Following completion of the IPOS, Petitioner requested reauthorization of services, including PT. (Testimony of Respondent's representative).

25. On November 26, 2025, Respondent sent Petitioner a Letter of Adverse Benefit Determination stating that Petitioner's request for ongoing PT services had been denied. (Exhibit A, pages 6-9).

26. 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 A, page 6).

27. On December 5, 2025, Petitioner filed an Internal Appeal with Respondent regarding that decision. (Exhibit A, page 3).

28. Respondent then had a psychiatrist from PREST review the appeal. (Exhibit A, page 3; Testimony of Respondent's representative).

29. On December 23, 2025, Respondent sent Petitioner a Letter of Appeal Denial. (Exhibit A, pages 3-5).

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

> You are asking for Physical Therapy (PT). We looked at your records. You have had PT for a reasonable amount of time. Your caregiver and staff can help with the skills you have learned. You continue to work on treatment goals with other services and resources available in the community. Medical necessity is not met and denial is upheld.

Exhibit A, page 3

31. On January 21, 2025, MOAHR received the request for hearing filed in this matter regarding PT services. (Exhibit #1, pages 1-3).

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, among other services, PT and CLS services through Respondent. With respect to such services and the requirement of medical necessity for any service, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **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.

* * *

3.23 PHYSICAL THERAPY

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 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. 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.

* * *

17.4.A. COMMUNITY LIVING SUPPORTS (CLS)

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, facilitating a beneficiary's achievement of their goals of community inclusion and participation, independence or productivity. The supports may be provided in the beneficiary's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting (that exceeds State Plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:
  - meal preparation
  - laundry
  - routine, seasonal, and heavy household care and maintenance

- activities of daily living (e.g., bathing, eating, dressing, personal hygiene)

- shopping for food and other necessities of daily living

CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or State Plan services, e.g., Personal Care (assistance with activities of daily living in a certified specialized residential setting) and Home Help (assistance in the beneficiary's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, 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 case manager or supports coordinator must assist them in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment.

- CLS staff providing assistance, support and/or training with activities such as:

  - money management

  - non-medical care (not requiring nurse or physician intervention)

  - socialization and relationship building

  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)

- participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)

- attendance at medical appointments

- acquiring or procuring goods, other than those listed under shopping, and non-medical services

- Reminding, observing and/or monitoring of medication administration

- Staff assistance with preserving the health and safety of the beneficiary in order that they may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through Medicaid FFS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving CLS.

CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help services when the beneficiary's need for this assistance has been officially determined to exceed the allowable parameters. 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. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help.

CLS provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the beneficiary's independence and integration into the community. This service provides skill development related to activities of daily living, 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 beneficiary. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For beneficiaries up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings.

MPM, October 1, 2025 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 14-15, 30, 151-153

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

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 ALJ finds that Petitioner has met his burden of proof; and that Respondent's decision must, therefore, be reversed.

Respondent's notices of action provide that PT was no longer medically necessary because Petitioner had received it for a reasonable amount of time, and his caregivers and staff could help with the skills he had learned.

Respondent's representative also testified and argued during the hearing that the criteria was not met because Petitioner had likely reached his maximum functional potential through PT, and it cannot be anticipated that further PT would result in a significant and durable functional improvement in a reasonable amount of time.

However, as argued by Petitioner's representative, while Petitioner started receiving PT in 2016, the remainder of the record does not support Respondent's findings.

For example, as noted by Petitioner's representative and conceded by Respondent's representative, no physical therapist has evaluated Petitioner and opined that Petitioner has reached his maximum functional outcome with PT. Petitioner's PT provider instead continues to indicate a need for PT while, even given the dispute in this case, Respondent only had Petitioner's Internal Appeal reviewed by a psychiatrist.

Moreover, rather than suggesting that Petitioner had met his maximum functional outcome or that further PT would not result in significant or durable functional improvement, the limited documentation that is in the record, including evaluations and progress notes from Petitioner's PT provider, identified areas of progress, goals that have been met, and new issues that have arisen and are being addressed. Petitioner's representative also credibly testified regarding Petitioner's continued improvement over time and the effect the PT has had on Petitioner's functioning.

Additionally, while Petitioner has been and continues to be approved for CLS to assist with PT exercises, nothing in the record suggests that those services equate to skilled therapies by a licensed therapist.

Respondent ultimately just points to the length of time Petitioner has been receiving PT as support for its decision, but while Petitioner did start receiving PT in 2016, the undersigned ALJ does not find that argument to be persuasive.

The above policy on medical necessity prohibits Respondent from denying services solely on preset limits on the duration of services, and the determination of need for services must be conducted on an individualized basis. And, in this case, the circumstances of Petitioner's individual case do not support a finding that he has reached his potential or that further PT would be ineffective. In particular, the provision of PT services has not even been continuous since 2016, with services stopped for a time; Petitioner has been physically developing and significantly growing since he started PT at age REDACTED PT continues to be recommended by any skilled therapist who has reviewed Petitioner's case; and Petitioner has demonstrated continued progress.

Respondent is correct that, per policy, that skilled therapy is not intended to be a life-long service; but the undersigned ALJ is limited to reviewing the decision at issue in this case, and given the entirety of the record, Petitioner has met his burden of proving by a preponderance of the evidence that Respondent erred in denying continued PT services at this time for the reasons it identified.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

> The Respondent's decision is **REVERSED**, and it must initiate a reassessment of Petitioner's request.