Date Mailed: March 6, 2026
Docket No.: 26-002416
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. Petitioner, also appeared as a witness.

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 Occupational Therapy (OT)?

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; Testimony).

2. On June 9, 2021, Petitioner participated in an OT Home Evaluation. At the time the documented diagnoses included Autism, and prior germ cell brain tumor with lingering left upper extremity (LUE) weakness and limited range of motion (ROM); assessments noted decreases LUE AROM/strength, bilateral coordination and motor planning deficits, and assistance with various ADLs/IADLs. (Exhibit A.)

3. On February 7, 2024, Petitioner participated in an OT Home Re-Evaluation. The Re-Evaluation documented persistent LUE limitations (ROM/strength), fine and gross motor deficits, visual motor/perceptual limitations, and continued need for skilled OT; goals included improvements in handwriting, putty tasks, LUE ROM, and 9-Hole Peg test performance. Frequency recommended 60 minutes once weekly with identified home programming and caregiver education. (Exhibit A; Testimony.)

4. On February 21, 2025, Petitioner participated in a re-assessment. The reassessment detailed Petitioner's diagnosis and functional limitations. (Exhibit A; Testimony.)

5. On or around September 9, 2025, an OT Clinical Initial Evaluation took place. The evaluation described LUE weakness impacting ADLs/IADLs with decreased ROM/strength and visual motor deficits. (Exhibit A; Testimony.)

6. On October 30, 2025, an Adverse Benefit Determination was issued denying Petitioner's request for OT at 1 hour a week effective October 29, 2025, citing that the clinical documentation did not establish medical necessity under Medicaid policy. (Exhibit A; Testimony.)

7. On November 4, 2025, Petitioner filed an internal appeal. (Exhibit A.)

8. On November 21, 2025, Respondent issued a Notice of Appeal Denial. The denial indicated the October 30, 2025, decision was affirmed. The notice stated specifically:

> You are asking for a occupational therapy (OT). We looked at your records. OT is meant to help stop or delay the progression of your condition. You have had the same therapy goals for 6 years. OT is meant to help you with your ability to do daily tasks. You should be getting better in a reasonable time. You receive community living support, respite, skill building, and services from your case manager. Medical necessity is not met and denial is upheld.[1]

9. 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,

[1] Exhibit A.

> 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.[2]
>
> 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.[3]

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.[4] 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] 42 CFR 430.0.
[3] 42 CFR 430.10.
[4] 42 CFR 440.230.

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.[5]

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

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

	(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.

Determinations must be individualized, clinically supported, and documented in the individual plan of service, and services must be sufficient in amount, scope, and duration to achieve their purpose. The PIHP may deny services that are ineffective, experimental, or for which there exists another appropriate, less restrictive,

cost-effective service that satisfies medical necessity standards. The PIHP may not deny services solely on preset limits of cost/amount/scope/duration.

OT services must be reasonable, medically necessary, and anticipated to result in a functional improvement significant to the beneficiary's daily living appropriate to their status, achievable in a reasonable amount of time, and durable/maintainable; OT is generally acute/skilled and may include training of caregivers/natural supports for maintenance of improvements after maximum functional potential is reached.

The record demonstrates years of ongoing OT with substantially similar goals focused on LUE ROM/strength, bilateral coordination, fine/visual motor skills, and ADL/IADL supports. While multiple evaluations recommended continued OT, contemporaneous clinical documentation shows limited progress toward functional independence in targeted tasks over an extended period, with substantial reliance on caregiver carry-over programs and CLS supports documented in the plan of service. Importantly, Exhibit A reflects that the caregiver education goal was met, and that recommended continuation involved home program and IADL engagement—consistent with a transition to maintenance rather than new acute, skilled gains.

Respondent's ABD and internal appeal decisions relied on the medical necessity framework and utilization management policy, concluding additional skilled OT was not medically necessary for the requested period because maximum functional improvement had likely been reached and the goals could be addressed through natural supports/CLS without a licensed OT. The hearing testimony further explained that the current OT focus was associated with hemiparesis rather than the behavioral health qualifying diagnoses for specialty plan coverage. On this record, Petitioner did not show that Respondent failed to follow applicable laws/policies or that the denial was inconsistent with § 2.5 medical necessity standards and § 3.19 OT requirements.

Accordingly, Respondent's decision to deny the requested 1 hour/week OT from November 6, 2025, through February 28, 2026, is consistent with the Medicaid Provider Manual and applicable federal and local utilization policies.

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 OT 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.

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