STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF

Docket No. 2012-41233 CMH

[redacted]

[redacted]

Appellant

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, an in-person hearing was held on [redacted]. Appellant [redacted] appeared and testified in her own behalf. [redacted] also testified for the Appellant.

Attorney [redacted] Director of Administrative Services, appeared and testified for [redacted] County Community Mental Health (CMH). Dr. [redacted] Ph.D., a Licensed Psychologist, and Dr. [redacted] M.D., Psychiatrist, also appeared as witnesses for CMH.

ISSUE

Was the CMH's denial of the Appellant's request for the purchase of electric generator with Medicaid funds in accordance with policy?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a [redacted] year-old (DOB [redacted] Medicaid beneficiary, receiving developmental disabilities services. Appellant has been diagnosed with motor neuron disease (mulifocal motor neuropathy). (Exhibit 8 and testimony).

2. [redacted] County Community Mental Health (CMH) is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.

3. Appellant lives in her own home with her husband. (Exhibit 8 and Testimony).

4. On [redacted] Appellant was sent a Notice for Medicaid Recipient requesting a non covered item. The notice advised Appellant that her request for a generator was denied. (Exhibits 1, 6, 13).

5. On [redacted], Appellant's current Individual Plan of Service (IPOS) was developed. The IPOS indicates Appellant requested a generator to allow her to plug in her lift, bed, phone, furnace and refrigerator in the event of a power outage. The Appellant's request for the generator was discussed, but the IPOS did not authorize the purchase of the requested generator. (Exhibits 8, 13).

6. On [redacted], Appellant was given an adequate action notice by CMH stating her current IPOS defined the Medicaid services she was being authorized and that the services would go into affect in [redacted] days. The notice indicated that if the Appellant did not agree with the IPOS, she could appeal. The notice included Appellant's rights to a fair hearing. (Exhibits 9, 13 and testimony).

7. The Appellant's request for hearing was received by MAHS on [redacted] The Appellant's request for a hearing stated she was requesting a generator under 17.3 as an Ancillary Support Service. (Exhibit 18).

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.
>
> *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…

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 Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are 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. *See 42 CFR 440.230.*

The CMH witnesses provided testimony that Appellant had requested CMH to purchase an electric generator as a B3 support that would be used to power her assistive technology in the event of a power outage at her home. CMH denied the purchase of the generator with Medicaid funds stating that the purchase of such a generator was not covered as ancillary equipment necessary for proper functioning of Appellant's assistive technology under the pertinent Medicaid policy, i.e., 17.3.A Assistive Technology. Appellant appealed from the CMH denial.

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* Section 17 articulates Medicaid policy for Michigan with regard to B3 Supports and Services. Section 17 states in pertinent parts:

SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)

PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

* * *

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; and
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other

natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDCH encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.

17.3 B3 SUPPORTS AND SERVICES

The B3 supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation.

* * *

17.3.A. ASSISTIVE TECHNOLOGY

Assistive technology is an item or set of items that enable the individual to increase his ability to perform activities of daily living with a greater degree of independence than without them; to perceive, control, or communicate with the environment in which he lives. These are items that are not available through other Medicaid coverage or through other insurances. These items must be specified in the individual plan of service. All items must be ordered by a physician on a prescription as defined in the General Information section of this chapter. An order is valid for one year from the date it was signed.

Coverage includes:

- Adaptations to vehicles
- Items necessary for independent living (e.g., Lifeline, sensory integration equipment)
- Communication devices
- Special personal care items that accommodate the person’s disability (e.g., reachers, full-spectrum lamp)
- Prostheses necessary to ameliorate negative visual impact of serious facial disfigurements and/or skin conditions
- Ancillary supplies and equipment necessary for proper functioning of assistive technology items
- Repairs to covered assistive technology that are not covered benefits through other insurances Assessments by an appropriate health care professional, specialized training needed in conjunction

with the use of the equipment, and warranted upkeep will be considered as part of the cost of the services.

Coverage excludes:

- Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, decorative items) that are routinely found in a home.
- Items that are considered family recreational choices.
- The purchase or lease of a vehicle, and any repairs or routine maintenance to the vehicle.
- Educational supplies required to be provided by the school as specified in the child's Individualized Education Plan.

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase.

In order to cover repairs of assistive technology items, there must be documentation in the individual plan of services that the assistive technology continues to meet the criteria for B3 supports and services as well as those in this subsection. All applicable warranty and insurance coverages must be sought and denied before paying for repairs. The PIHP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents. [Emphasis added, pp. 107-108].

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* Section 15 - *Habilitation/Supports Waiver For Persons With Developmental Disabilities*, sets forth Medicaid policy for individuals who qualify for the Habilitation/Supports Waiver (HSW). It provides some persuasive authority on how the policy in Section 17.A.3 should be interpreted. This section states as follows with regard to HSW supports and services:

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.

* * *

15.1 WAIVER SUPPORTS AND SERVICES

*** * ***

Enhanced Medical Equipment and Supplies

> Enhanced medical equipment and supplies include devices, supplies, controls, or appliances that are not available under regular Medicaid coverage or through other insurances (Refer to the Medical Supplier Chapter of this manual for more information about Medicaid-covered equipment and supplies).
>
> * * *
>
> Generators may be covered for an individual who is ventilator dependent or requires daily use of an oxygen concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment. [pp. 82, 84-85].

The *Medicaid Provider Manual* defines terms in the *Mental Health/Substance Abuse Section dated April 1, 2012*. It defines medical necessity as follows:

> Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.
>
> *Medicaid Provider Manual,*
> *Mental Health/Substance Abuse, April 1, 2012, p. 5.*

The *Medicaid Provider Manual, Section 2.5* lists further specifies Medical Necessity Criteria:

> **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.

Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Section, April 1, 2012, pp. 12-14*.*

Dr. [redacted] stated that he was a licensed psychologist with the State of Michigan and that he was the Director of Care Management Department for the local Prepaid Inpatient Health Plan (PIHP). Dr. [redacted] stated it was his job to determine eligibility and authorizations for Medicaid beneficiaries. Dr. [redacted] stated he reviewed the Appellant's case and determined she was not on the Habilitation/Supports Waiver. Dr. [redacted] stated the Appellant requested CMH to purchase a generator with Medicaid funds for her as an ancillary support to her assistive technology.

Dr. [redacted] stated ancillary support for assistive technology deals with equipment and supplies that are necessary for life support only, such as someone on a ventilator or in need of an oxygen concentrator. But since the Appellant's request was not linked to a life support mechanism, it did not meet the definition of medical necessity. Dr.

[redacted] also stated that a generator was not specifically referenced in the Medicaid Provider manual. Dr. [redacted] stated that it also appeared to meet exclusion criteria because there are other appropriate cost effective Medicaid services to meet the need for services.

Dr. [redacted] stated in his professional opinion a generator would not advance a B3 goal in the Appellant's case, as it is only a substitute for the electricity used to power Appellant's assistive devices that are not linked to life support activities. Dr. [redacted] believed there were other supports and services, including informal supports available to the Appellant. Dr. [redacted] stated he believed the PIHP was correct in denying the Appellant's request for a generator, because medical necessity criteria were not met. Dr. [redacted] also stated that other alternative services were available, such as, natural supports including other locations Appellant could go during a power outage, or other places where her medications could be refrigerated. Dr. [redacted] admitted he was not a technology expert, but he also felt that spare batteries and battery back-ups were available which could meet the Appellant's needs during a temporary power outage.

Attorney Morse testified she was employed by CMH as the Director of Administrative Services. Ms. [redacted] stated the purchase of a generator is not provided for under sections of the Medicaid Provider Manual covering the B3 supports and services. However, such a purchase is provided for under the HSW section of the Manual when the device is linked to a life support device such as a ventilator or oxygen concentrator. Ms. [redacted] urged that the two sections had to be read in conjunction with one another, which would result in the conclusion that the purchase of a generator is not covered as a B3 service. Ms. [redacted] stated if it was covered as a B3 service it would have been specifically listed in the section on B3 services.

Dr. [redacted] testified he was a psychiatrist Board Certified in psychiatry and child psychiatry. Dr. [redacted] stated he was the Medical Director of the local PIHP. Dr. [redacted] stated he agreed with Dr. [redacted] assessment that there alternatives to the purchase of a generator which would allow the Petitioner to safely get through a temporary power outage at her home. Dr. [redacted] agreed with PIHP's denial of the purchase of a generator in this case, because he believed there were other cost effective alternatives. He suggested the use of an ice chest to store her medications to keep them at an adequate temperature for a length of time. Dr. [redacted] also felt that spare batteries or battery back ups would be available to meet the Appellant's needs.

Dr. [redacted] stated for short term outages, Appellant did not need a power bed to avoid bed sores. In the event of a long term outage family and staff persons would be able to assist with moving her and with transfers, and if necessary relocating her to a warm location. It was also stated that a battery operated cell phone with a spare battery would assure that the Appellant was never left without some type of communication. Dr. [redacted] stated a generator to power the whole house was way beyond what was necessary. Dr. [redacted] stated as a physician he could not say that a generator was definitely medically necessary. Dr. [redacted] acknowledged he was aware of the various power outages at the Appellant's home. (See Exhibit 12). He stated the short term

outages wouldn't pose much of a problem, and during the long term outages someone should be available to stop by the home and assist the Appellant. Dr. [redacted] stated the Appellant has her husband, other family members, and paid support available to her during the day if she is in need of assistance.

The Appellant testified she qualified for Medicaid covered services as a person with a developmental disability. Appellant stated her main concern was having heat in her home, she cannot function without heat. Appellant stated they could not come up with a solution besides something as simple as a generator. Appellant indicated her muscles tense up after ten minutes when they are cold, and she just wants a safe room in her home.

Appellant called two companies to get quotes for a generator. Appellant stated she did not need her whole house powered, just enough to power the items she needs including the furnace, a light, a phone, electricity to charge her wheelchairs, her overhead transfer lift, a refrigerator, her elevating bed, her pressure serve mattress, and a small air conditioner in the summer so she doesn't get overheated. She said she received two quotes, the lower quote being [redacted] (Exhibit 17). Appellant stated the companies said the minimum they could do was 8 zones in a home. Appellant asserted this would cover everything that was necessary in her home, i.e., everything medically necessary. Appellant indicated her neurologist said she had to have a generator. (See Exhibit 15).

The Appellant indicated when there is a power outage people can't come and help her because there is no heat or lights. She indicated there was no place to go, that she can't leave her home like other people. Her door openers depend on electricity. Appellant stated someone one could come and get her out of the home, but she would have no where to go. Appellant said she is not supposed to be lifted manually. She is dependent on her transfer system. She did not believe there was any place she could go to be kept safe. Appellant did acknowledge, however, that her mother's home is equipped for her and she could go there if her mother's power is not out.

Appellant stated a generator was the only logical thing that would keep her safe in her home. Appellant urged that a generator was covered as ancillary supplies and equipment necessary to support her assistive technology, under Section 17.3.A, in the Medicaid Provider Manual, Assistive Technology. Appellant concluded by stating that getting a generator was an easy alternative that she believes is covered by the policy in the Medicaid manual.

[redacted] [redacted] stated she is a recently retired advocate with the ARC of [redacted] County. Ms. [redacted] said she now does some contract work and has worked with Appellant for a number of years with her person centered planning and various other issues. Ms. [redacted] referenced the document she prepared for the hearing. (See Exhibit 16). She stressed the Appellant can't move in and out of her home independently if there is no power.

Ms. [redacted] stated all of Appellant's ancillary aids are operated by electricity. She noted there are supportive personnel including some friends and family who can give the Appellant some assistance. Ms. [redacted] urged they would still need to use the lift, because transfers can't be done manually. Ms. [redacted] also acknowledged that an emergency cell phone could be available use, but it may be difficult for the Appellant to operate. Ms. [redacted] stated the CMH has invested heavily in the ancillary aids for the Appellant. She stated she believed the policy on B3 services in Section 17.3.A was applicable to the Appellant's case. Ms. [redacted] also referenced the history of outages documented in Exhibit 12, and believes the purchase of a generator would be a reasonable alternative for the Appellant.

Appellant's request for a hearing specifically cites Section 17.3.A which discusses Medicaid coverage for Assistive Technology. Appellant focuses on the portion of the policy that indicates coverage includes "Ancillary supplies and equipment necessary for proper functioning of assistive technology items". This bullet point by itself can be read to possibly cover an electric generator to be used with assistive technology items whenever the utility power goes out. The language in the bullet point is very general and could arguably include many other supplies or equipment, including the electricity itself, supplied by the power company. However, no one has gone so far to say that the electricity itself should be paid for by Medicaid dollars.

Appellant's reading of the policy fails to place the bullet point in its proper context and further fails to acknowledge the limiting provisions contained within the policy covering B3 services. Section 17.2 states in pertinent part that "Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports."

Section 17.3.A that the Appellant relies upon further provides exclusions from coverage including "Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, decorative items) that are routinely found in a home." The Merriam-Webster Dictionary and Thesaurus (2007) defines "appliance" as "1: an instrument or device designed for a particular use or function. 2: a piece of household equipment (as a stove or a toaster) operated by gas or electricity." In light of these definitions it is reasonable to construe the term "appliance" to include an electric generator powered by gas that may be routinely found in a home that experiences frequent power outages.

Finally, the CMH has stated the generator requested in this case is nothing more than a substitute for the electricity, which is the "supply" that is necessary for the proper functioning of Appellant's assistive technology. As stated above, no one is claiming that the Medicaid policy would cover the electricity itself. As for the generator, CMH has argued that it is simply not covered by the policy covering B3 supports. As evidence of

that fact, the CMH points to policy in the Medicaid manual that does authorize the purchase of a generator.

In Section 15 - *Habilitation/Supports Waiver For Persons With Developmental Disabilities*, which sets forth Medicaid policy for individuals who qualify for the Habilitation/Supports Waiver (HSW), and specifically in subsection 15.1 where it refers to Enhanced Medical Equipment and Supplies, Medicaid policy does provide for the purchase generators. However, the policy limits when such an appliance can be authorized for purchase stating "Generators may be covered for an individual who is ventilator dependent or requires daily use of an oxygen concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment."

As a matter of "statutory construction", which applies equally to the interpretation of policy contained in the Medicaid Provider Manual, the two sections referenced (17.3.A and 15.1) have to be read in conjunction with one another. This leads to the conclusion that the purchase of a generator was not meant to covered as a B3 service. As Ms. [redacted] stated, if a generator was covered as a B3 service it would have been specifically listed in the section on B3 services, just as it is for the HSW in the subsection covering enhanced medical equipment and supplies. In this case since the requested generator is not to be linked to a life system such as a ventilator or oxygen concentrator, it is not a covered by Medicaid policy.

The Appellant bears the burden of proving that the pertinent Medicaid policy in the Medicaid Provider manual covers the purchase of a generator as "ancillary supplies and equipment necessary for proper functioning of assistive technology items". The CMH provided sufficient evidence that the pertinent Medicaid policy does not cover the purchase of a generation as "ancillary equipment" for the proper functioning of assistive technology. The testimony and exhibits offered by the Appellant and her witness do not establish that generators are covered by the policy cited. Accordingly, Medicaid dollars cannot be used to purchase a generator for the Appellant.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH's denial of Appellant's request for the purchase of an electric generator with Medicaid funds was in accordance with policy.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

William D. Bond
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5-25-12

***** NOTICE *****

The Michigan Administrative Hearing System may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.