RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

IN THE MATTER OF:

MAHS Docket No.: 16-006089

[redacted]

Agency Case No.:

Petitioner

Case Type: PR

v

[redacted]

_____/

Issued and entered
this 28th day of February, 2017
by:
Steven Kibit
Administrative Law Judge

PROPOSAL FOR DECISION

This matter is before the Michigan Administrative Hearing System (MAHS) pursuant to the provisions of Section 6411 of the Patient Protection and Affordability Care Act of 2010, as well as the Michigan Medicaid State Plan, The Social Welfare Act, MCL 400.1 *et seq.*, The Administrative Procedures Act, MCL 24.271 *et seq*., and Michigan Administrative Rules 400.3401 *et seq.* and 792.10101 *et seq.*

SUMMARY

This is an appeal of a decision by the Michigan Department of Health and Human Services (MDHHS or Department) to recover payments made to Petitioner [redacted] for services provided to a Medicaid beneficiary between March 15, 2013 and March 16, 2013 following an audit by Health Management Systems, Inc. (HMS), the Recovery Audit Contractor (RAC) for the Department.

On May 16, 2016, Petitioner requested an Administrative Hearing. A Telephone Pre-Hearing Conference was held on June 23, 2016 and an Administrative Hearing was held on August 18, 2016.

[redacted], M.D. and Physician Advisor with [redacted], appeared and testified on Petitioner's behalf.

[redacted] Appeals Review Officer, represented the Respondent Department. [redacted], testified as a witness for Respondent. [redacted], a representative from the Office of Office of Inspector General (OIG), and [redacted], Program Director for HMS, were also present for the Respondent during the hearing.

During the hearing, Petitioner offered five exhibits that were admitted into the record:

Exhibit #1: Request for Hearing and Appointment of Representation
Exhibit #2: Final Notice and Audit Detail Report
Exhibit #3: Request for Reconsideration
Exhibit #4: Preliminary Notice and Audit Detail Report
Exhibit #5: Medical Records

Respondent offered one exhibit that was admitted into the record:

Exhibit A: Michigan RAC Audit Appeal Packet

ISSUE

Was the Department's decision to recover payment for the inpatient hospital admission of a Medicaid beneficiary with the initials [redacted]?

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 an enrolled provider in the State of Michigan's Medicaid program and licensed by the State of Michigan to provide Medicaid covered hospital services to Medicaid beneficiaries.

2. On March 10, 2013, [redacted] a forty-one-year-old female Medicaid beneficiary underwent a History and Physician in preparation for an upcoming surgery with Petitioner. (Exhibit 5, pages 24-25).

3. Specifically, the History and Physician noted that [redacted] had a left ureteropelvic junction obstruction and was presenting for a robot-assisted laparoscopic left pyeloplasty. (Exhibit 5, page 24).

4. [redacted] was also noted to be otherwise healthy and the plan was to proceed with the robot-assisted laparoscopic left pyeloplasty. (Exhibit 5, page 24).

5. The plan of care at that time did not include admitting [redacted] as an inpatient. (Testimony of [redacted]).

6. On March 15, 2013, at approximately 1:19 p.m., [redacted] underwent the robot-assisted laparoscopic left pyeloplasty. (Exhibit 5, page 29).

7. The subsequent Operative Report did not identify any complication during or after the procedure. (Testimony of [redacted]).

8. It did state that there was considerable amount of edema in the tissues around the left colon, with the doctor unsure of its etiology, and that:

> This made the portion of the surgery much more challenging than usual since I did not have the usual planes of dissection that are normally present. However, it [sic] took my time in making sure that it was lateral to the colon at all times and mobilizing it medially in a safe fashion.
>
> *Exhibit 5, page 29*

9. The Operative Report concluded by stating that [redacted] was transferred to the recovery room in satisfactory condition; her estimated blood loss was minimal; and she tolerated the procedure well." (Exhibit 5, page 30).

10. Following the surgery, [redacted] was placed in the post-anesthesia care unit (PACU) and admitted as an inpatient. (Exhibit 5, page 66).

11. The inpatient admission order was issued at 4:13 p.m. on [redacted]. (Exhibit 5, page 66).

12. Soon after she was admitted, [redacted] underwent an abdominal x-ray at 4:39 p.m. on [redacted]. (Exhibit 5, page 126).

13. The reason for the x-ray is not described in any progress notes. ([redacted]).

14. At 5:30 p.m. on [redacted], [redacted] was moved from the PACU to a Nursing unit. (Exhibit 5, page 28).

15. In a Progress Report entered the next morning, on [redacted], it was noted that JW was doing well and that the doctors would advance her along the pathway, remove her foley, check JP for creatinine, advance diet, and consider her discharge later that day. (Exhibit 5, page 27).

16. At 3:26 p.m. on [redacted], [redacted] was discharged from the hospital. (Exhibit 5, page 52).

17. Regarding the course of treatment, a Discharge Summary stated in part:

> 1. UPJ Obstruction – underwent a robotic assisted laparoscopic left pyeloplasty. Postoperative course was uncomplicated. Vital signs were stable and she remained afebrile throughout the hospitalization. Abdominal incisions remained intact and free from signs of infection. Her foley catheter was removed POS#1 and she was able to void and empty without difficulty. The JP drain demonstrated expected outputs of serous/lymphatic fluid and was removed prior to discharge. By discharge, she was ambulating independently, tolerating a solid diet without nausea/vomiting, passing flatus, and had pain well controlled on oral pain medications . . .

Exhibit 5, page 6

18. The Discharge Summary also provide that there were no specific follow up issues for [redacted] primary care physician or any specialists. (Exhibit 5, page 6).

19. On March 1, 2016, [redacted] sent Petitioner written notice that it had conducted a post-payment review of selected claims and medical records submitted by Petitioner and had enclosed audit detail reports regarding preliminary findings of overpayments with respect to specific claims. (Exhibit 4, pages 1-2).

20. Among the audit detail reports provided to Petitioner by HMS was a report in which HMS found that the review of the medical record in this case did not justify medical necessity for the inpatient admission. (Exhibit 4, page 2).

21. The notice sent by HMS also advised Petitioner that it had thirty days to submit any additional documentation if it disagreed with the preliminary findings. (Exhibit 4, page 1).

22. On March 22, 2016, Petitioner sent HMS a Request for Reconsideration. (Exhibit 3, pages 1-3).

23. In that request, Petitioner argued that the inpatient admission was medically necessary and appropriate given the intensity of medical, nursing and ancillary services provided to [redacted] (Exhibit 3, page 1).

24. In particular, Petitioner argued that the specific procedure [redacted] underwent placed her at a 1% to 5% intermediate risk of cardiac death or non-fatal myocardial infarction, thus supporting the necessity of an inpatient admission. (Exhibit 3, page 2).

25. On April 1, 2016, [redacted], completed a Michigan RAC Audit Reconsideration Physician Review. (Exhibit A, page 5).

26. In that review, [redacted] concluded that [redacted] should have been admitted to observation as her presentation and medical necessity did not warrant inpatient admission in the absence of hemodynamic instability or clinically significant complications from anesthesia or the surgical procedure. (Exhibit A, page 5).

27. On April 13, 2016, [redacted] sent Petitioner a Final Notice of Recovery in which it stated that, even after considering the additional documents submitted by Petitioner, it was upholding its preliminary findings and seeking to recover the payment made for [redacted] inpatient hospital admission. (Exhibit 2, pages 1-4).

28. On May 16, 2016, the Michigan Administrative Hearing System (MAHS) received the Request for Hearing filed by Petitioner in this matter. (Exhibit 1, pages 1-4).

29. In that request, Petitioner argued that surgical interventions that involve extensive lysis of adhesions, such as the one [redacted] underwent, increase operative complexity, the length of operative time and the risk posed to the patient, and therefore requires inpatient hospitalization. (Exhibit 1, page 2).

CONCLUSIONS OF LAW

The Michigan Department of Health and Human Services is the single state agency responsible for health policy, the purchase of health care services, and accountability of those services to ensure only appropriate, medically necessary services are provided to the Medicaid population or paid for by the Department.

Section 1902(a)(30)(A) of the Social Security Act (the Act) requires that State Medicaid Agencies provide methods and procedures to safeguard against unnecessary utilization of care and services and to assure payments are consistent with "efficiency, economy and quality of care . . ." Under section 1902(d), a State can contract with an entity that

meets the requirements of section 1152 of the Act to perform medical or utilization review functions requires under the Act.

Section 6411 of the Affordable Care Act (ACA) expands the Recovery Audit Contractor Program (RAC) to the Medicaid program. Section 6411 provides, in pertinent part:

> SEC. 6411. EXPANSION OF THE RECOVERY AUDIT CONTRACTOR (RAC)
> PROGRAM.
>
> (a) EXPANSION TO MEDICAID.—
>
> (1) STATE PLAN AMENDMENT.—Section 1902(a)(42) of the Social Security Act (42 U.S.C. 1396a(a)(42)) is amended— (A) by striking ‘‘that the records’’ and inserting ‘‘that— ‘‘(A) the records’’; (B) by inserting ‘‘and’’ after the semicolon; and (C) by adding at the end the following: ‘‘(B) not later than December 31, 2010, the State shall— ‘‘(i) establish a program under which the State contracts (consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1893(h), subject to such exceptions or requirements as the Secretary may require for purposes of this title or a particular State) with 1 or more recovery audit contractors for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver; and ‘‘(ii) provide assurances satisfactory to the Secretary that— ‘‘(I) under such contracts, payment shall be made to such a contractor only from amounts recovered; ‘‘(II) from such amounts recovered, payment— ‘‘(aa) shall be made on a contingent basis for collecting overpayments; and ‘‘(bb) may be made in such amounts as the State may specify for identifying underpayments; ‘‘(III) the State has an adequate process for entities to appeal any adverse determination made by such contractors; and ‘‘(IV) such program is carried out in accordance with such requirements as the Secretary shall specify, including— ‘‘(aa) for purposes of section 1903(a)(7), that amounts expended by the State to carry out the program shall be considered amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan; ‘‘(bb) that section 1903(d) shall apply to amounts recovered under the program; and ‘‘(cc) that the

> State and any such contractors under contract with the State shall coordinate such recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, including efforts with Federal and State law enforcement with respect to the Department of Justice, including the Federal Bureau of Investigations, the Inspector General of the Department of Health and Human Services, and the State Medicaid fraud control unit; and''. H. R. 3590—657
>
> (2) COORDINATION; REGULATIONS.— (A) IN GENERAL.— The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall coordinate the expansion of the Recovery Audit Contractor program to Medicaid with States, particularly with respect to each State that enters into a contract with a recovery audit contractor for purposes of the State's Medicaid program prior to December 31, 2010. (B) REGULATIONS.— The Secretary of Health and Human Services shall promulgate regulations to carry out this subsection and the amendments made by this subsection, including with respect to conditions of Federal financial participation, as specified by the Secretary.

The Code of Federal Regulations requires that appeals rights be given to providers who have received notice of adverse Medicaid RAC determinations. 42 CFR 455.512 provides, in pertinent part:

> 455.512 Medicaid RAC provider appeals.
>
> States must provide appeal rights under State law or administrative procedures to Medicaid providers that seek review of an adverse Medicaid RAC determination.

Health Management Systems (HMS) is the Michigan Department of Health and Human Services' Recovery Audit Contractor (RAC). Pursuant to Section 6411 of the Patient Protection and Affordability Care Act of 2010, HMS is authorized to audit provider payments and associated financial records for fee-for-service and managed care Medicaid populations. The purpose is to ensure services are medically necessary and billed correctly by the provider.

The Social Welfare Act, MCL 400.1 *et seq*., provides that as a condition of participation in the Medicaid program a provider must meet all the requirements listed in MCL 400.111b:

> Requirements as condition of participation by provider.
>
> Sec. 111b.
>
> (1) As a condition of participation, a provider shall meet all of the requirements specified in this section except as provided in subsections (25), (26), and (27). . .

The Director of the Michigan Department of Health and Human Services may develop Medicaid Program policy and procedures and must notify enrolled Medicaid Providers of any changes.

> Sec. 111a.
>
> (1) The director, after appropriate consultation with affected providers and the medical care advisory council established pursuant to federal regulations, may establish policies and procedures that he or she considers appropriate, relating to the conditions of participation and requirements for providers established by section 111b and to applicable federal law and regulations, to assure that the implementation and enforcement of state and federal laws are all of the following:
>
> (a) Reasonable, fair, effective, and efficient.
> (b) In conformance with law.
> (c) In conformance with the state plan for medical assistance adopted pursuant to section 10 and approved by the United States department of Health and Human Services.
>
> *MCL 400.111a(1)*

A Medicaid provider must comply with all Department policies and procedures related to the conditions of participation in the Medicaid program, requirements for Medicaid providers, and with all applicable federal laws and regulations:

> (18) A provider shall comply with all requirements established under section 111a (1), (2), and (3).
>
> *MCL 400.111b(18)*

Medicaid providers have the burden of proof, and the burden of establishing via auditable documentation that the audit adjustments at issue were erroneous. Providers must comply with MCL 400.1 *et seq*, state-published manuals and certain relevant federal principles, all of which state the conclusion that the provider bears the burden of proof. The statute provides: "Submission of a claim or claims for services rendered under the (Medicaid) program does not establish in the provider a right to receive payment from the program." MCL 400.111b (10). And, "[b]efore billing for any medical services," MCL 400.111b(6), (7), (8) require the provider to have records to support each claim for Medicaid reimbursement. Thus, MCL 400.111b(6) states in pertinent part: "A provider shall maintain records necessary to document fully the . . . cost of services, supplies, or equipment provided to a medically indigent individual."

Thus it is up to Petitioner to establish by a preponderance of the evidence that the audit adjustment at issue in this appeal was improper. See Director's Final Order in *Ciena Healthcare Management, et al v Dep't of Health and Human Services*, MAHS Docket No. 2010-37557-AAH, *et al*, dated March 6, 2013. See also *Prechel v Dep't of Social Services*, 186 Mich App 547; 465 NW2d 337 (1990) (holding that placing the burden of proof on audited Medicaid providers is consistent with the legislative scheme underlying the program).

Policy with respect to hospital admissions is contained in the Medicaid Provider Manual (MPM). That policy provides in pertinent parts:

> **SECTION 9 – INPATIENT HOSPITAL AUTHORIZATION REQUIREMENTS**
>
> The information in this section applies to instate and borderland hospitals. Information regarding out-of-state hospital authorization requirements can be found in the Out-of-State/Beyond Borderland Providers subsection of this chapter.
>
> All inpatient admissions must be medically necessary and appropriate, and all services must relate to a specific diagnosed condition. In the event that an inpatient stay is deemed medically inappropriate or unnecessary, either through a pre-payment predictive modeling review or a post-payment audit, providers are allowed to submit an outpatient claim for all outpatient services and any inpatient ancillary

services performed during the inpatient stay. Elective admissions, readmissions, and transfers for surgical and medical inpatient hospital services must be authorized through the Admissions and Certification Review Contractor (ACRC). The physician/dentist should refer to the Prior Authorization Certification Evaluation Review (PACER) subsection of this chapter for specific requirements.

Medically inappropriate or unnecessary inpatient admissions may be resubmitted as outpatient claims for all outpatient services and any inpatient ancillary services performed during the inpatient stay. When an inpatient claim is deemed medically inappropriate or unnecessary through a pre-payment predictive modeling review or a post-payment audit, hospitals are allowed to submit a hospital outpatient Type of Bill (TOB) 013X for all outpatient services and any inpatient ancillary services performed during the inpatient stay. Examples of services related to medically inappropriate or unnecessary inpatient admission include:

- all elective admissions, readmissions, and transfers that are not authorized through the PACER system;
- admissions or readmissions which have been inappropriately identified as emergent/urgent;
- selected ambulatory surgeries inappropriately performed on an inpatient basis; and
- any other inpatient admission determined to have not been medically necessary.

MPM, April 1, 2016 version
General Information for Providers Chapter, page 19

SECTION 1 – GENERAL INFORMATION

This chapter applies to services provided to Fee for Service (FFS) beneficiaries in an inpatient and/or outpatient hospital setting unless otherwise indicated. Medically necessary services provided to Medicaid beneficiaries by an enrolled hospital are generally covered by Medicaid, administered through the Michigan Department of Health and Human Services (MDCH). The attending physician (MD or DO) is responsible for determining medical necessity and

appropriateness of service within the scope of current medical practice and Medicaid guidelines. Services described in this chapter must also be available to Medicaid Health Plan (MHP) enrollees; however, the MHPs may implement different authorization and service criteria. For billing purposes, a revenue code is identified as a specific accommodation, ancillary service or billing calculation for all institutional claims.

* * *

1.1 INPATIENT HOSPITAL

An inpatient hospital is defined as a facility, other than psychiatric, which primarily provides medically necessary diagnostic, therapeutic (both surgical and nonsurgical) or rehabilitation services to inpatients. Services provided to inpatients include bed and board; nursing and other related services; use of facility; drugs and biologicals; supplies, appliances and equipment; diagnostic, therapeutic and ancillary services; and medical or surgical services. Services of professionals (e.g., physician, oral-maxillofacial surgeon, dental, podiatric, optometric) are not included and must be billed separately. Inpatient hospital services are:

- Ordinarily furnished in a facility for the care and treatment of inpatients.

- Furnished under the direction of a physician (MD or DO) or a dentist.

- Furnished in a facility that is:

  - Maintained primarily for the care and treatment of inpatients with disorders other than mental diseases;

  - Licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and

  - Medicare-certified to provide inpatient services.

An inpatient is an individual who has been admitted to a hospital for bed occupancy with the expectation that he will remain at least overnight, even when it later develops that he

can be discharged or is transferred to another hospital and does not use the bed overnight. Days of care provided to a beneficiary are in units of full days, beginning at midnight and ending 24 hours later. Medicaid covers the day of admission but not the day of discharge. If the day of admission and the day of discharge are the same, the day is considered an admission day and counts as one inpatient day.

* * *

SECTION 4 – UTILIZATION REVIEW

4.1 NONCOVERED ADMISSIONS

For Medicaid reimbursement, all inpatient admissions must be medically necessary and appropriate. MDHHS does not cover inpatient hospital admissions for the sole purpose of:

- Cosmetic surgery (unless prior authorized)
- Custodial or protective care of abused children
- Diagnostic procedures that can be performed on an outpatient basis
- Laboratory work, electrocardiograms (EDJs), electroencephalograms (EEGs), diagnostic x-rays
- Observation

* * *

Services during inpatient stays or parts of stays where that stay has been denied as inappropriate or unnecessary may not be resubmitted to MDCH as outpatient charges. Charges resubmitted as outpatient charges are monitored, and any payment made may be recovered during a post-payment audit.

Hospitals may not bill beneficiaries for any medical charges for goods and services provided during a nonallowable admission. The beneficiary is assumed to be following the physician's advice.

Any accommodations or ancillary services provided during nonallowable admissions or parts of stays will not be reimbursed.

4.2 INPATIENT AND OUTPATIENT POST-PAYMENT REVIEWS

MDHHS and/or its audit contractor will perform automated reviews and medical record reviews on inpatient and outpatient services that have been paid. An automated review is a re-examination of a claim payment at the system level. These reviews will focus on errors in pricing, coverage, coding determinations and payment of duplicate claims. A medical record review is a more comprehensive comparison of a hospital's Medicaid claims against the hospital's medical records.

The objective of the MDHHS post-payment review process is to ensure that MDHHS reimbursement is for medically necessary care provided in the appropriate setting, that diagnostic and procedural information is valid, and that the care rendered meets current clinical and quality standards of practice. Cases are reviewed using Medicaid-approved Severity of Illness/Intensity of Services (SI/IS) criteria, clinical judgment and generic quality screens.

All reviews include consideration of medical necessity, appropriateness of setting, coding validity/accuracy, and the quality and intensity of care provided to the beneficiary. The audit will also ensure that the quality and intensity of hospital services conform to current and acceptable standards of medical practice and Medicaid policies, procedures, and coding guidelines.

MPM, April 1, 2016 version
Hospital Chapter, pages 1, 32-33
(Emphasis added)

Here, following an audit by [redacted], the Department seeks to recover payments made to Petitioner for [redacted] inpatient admission.

In support of that decision, the Department's physician witness testified that JW was admitted for a scheduled procedure that is not on the list of inpatient-only procedures provided by the [redacted] (CMS) and, while that list is not exclusive, there were no complications or other factors that would justify an inpatient admission in this case. In particular, the Department's witness noted that,

even if the surgery proved to be more difficult than expected, it was performed without complications and there were no subsequent complications or treatment that required inpatient care. He further noted that there was no documentation in the record regarding the reason for the abdominal x-ray performed after admission. In making his determination, the Department's witness also testified that he is looking at medical necessity and not using InterQual Guidelines, though those guidelines are used by others in an earlier part of the HMS decision process.

In response, the Petitioner's physician representative testified that, while the planned surgery did not initially included an inpatient admission, [redacted] was properly admitted after the surgery based on what happened. Specifically, as noted in the Operative Report, the inter-operative finding of a considerable amount of edema in the tissues around the left colon increased the length and complexity of the procedures, including the time [redacted] spent under general anesthesia, and increased the risk of complications occurring during and after the surgery. Petitioner's representative also testified that [redacted] did not have any identified complications, but she was being monitored for them and the expectation was that she would remain overnight. He also noted that [redacted] received an abdominal x-ray, which is not typical and was probably for abdominal pain, though it is not clear when she had that pain and the reason for the x-ray is not documented. Regardless, Petitioner's representative testified that there does not need to be complications to admit and the risk of complications is enough given that the Department cannot look retrospectively at the decision to admit. He also noted that the inpatient-only list provided by [redacted] is not exclusive, and therefore irrelevant here, and that any use of InterQual Guidelines has not been endorsed by CMS.

As indicated above, the Petitioner must prove, by a preponderance of the evidence, that the Department's recovery of payment for the inpatient hospitalization for [redacted] was improper.

Based on the record in this case, the Petitioner has failed to meet that burden and the Department's decision should be affirmed. As provided above, the MPM requires that all inpatient admissions be medically necessary and appropriate, and that all services relate to a specific diagnosed condition. Here, while [redacted] stayed in the hospital overnight following her surgery, the inpatient admission was not medically necessary given the circumstances of this case. It is undisputed that the surgery [redacted] underwent is typically an outpatient procedure and, while it could be performed as an inpatient procedure or justify a subsequent inpatient admission when necessary, there was an insufficient basis identified in the record or during the hearing for why [redacted] should have been admitted as an inpatient following the surgery here. The inpatient admission was not planned and, while the surgery was more difficult and took longer than expected, the difficulties were addressed during the procedure itself and no complications, either during the surgery or afterward, were identified. The mere fact that [redacted] underwent a lengthy, outpatient surgery does not establish medical necessity for an inpatient admission.

In making the determination that the inpatient admission was not necessary, the undersigned Administrative Law Judge would also note that InterQual Criteria is irrelevant and that, while HMS used those guidelines in one step of its review, they are not the standard in this case and the only issue is whether the inpatient admission was medically necessary and appropriate.

Accordingly, while the care and monitoring that [redacted] received was appropriate, the setting was not and Petitioner has therefore failed to demonstrate by a preponderance of the evidence that the Department erred.

PROPOSED DECISION

Now therefore, based on the above findings of fact and conclusions of law, the undersigned Administrative Law Judge recommends that the Department's decision be AFFIRMED.

EXCEPTIONS

Any party may, within ten (10) days from the date of mailing this decision, file exceptions with the Michigan Administrative Hearing System for the Department of Health and Human Services, P.O. Box 30639, 611 W. Ottawa, 2nd Floor, Lansing, Michigan 48909-8143. Exceptions shall be served on all parties.

Steven

SK/tm

Steven Kibit
Administrative Law Judge

PROOF OF SERVICE

I hereby state, to the best of my knowledge, information and belief, that a copy of the foregoing document was served upon all parties and/or attorneys of record in this matter by Inter-Departmental mail to those parties employed by the State of Michigan and by UPS/Next Day Air, facsimile, and/or by mailing same to them via first class mail and/or certified mail, return receipt requested, at their respective addresses as disclosed below this 28th day of February, 2017.

[redacted]