[redacted]
[redacted], MI [redacted]

Date Mailed: April 4, 2022
MOAHR Docket No.: 22-000475
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon a request for a hearing filed on the minor Petitioner's behalf.

After due notice, a telephone hearing was held on March 8, 2022. [redacted], Petitioner's mother, appeared and testified on Petitioner's behalf. Dorian Johnson, Due Process Manager, appeared and testified on behalf of the Respondent Detroit Wayne Integrated Health Network (DWIHN). Kim Hoga, Clinical Specialist, and Jessica Van Hamme, Supports Coordinator, also testified as witnesses for Respondent.

During the hearing, Petitioner's request for hearing was admitted into the record as Exhibit #1, pages 1-7, while his evidence packet was admitted as Exhibit #2, pages 1-57. Respondent also submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-55.

ISSUE

Did Respondent properly deny Petitioner's request for a safety/cubby bed?

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 [redacted] year-old diagnosed with autism spectrum disorder. (Exhibit A, page 5).

2. Since October of 2020, Petitioner has been enrolled with Respondent through the Children's Home and Community Based Services Waiver Program (CWP). (Testimony of Respondent's representative; Testimony of Clinical Specialist).

3. As part of his services through Respondent, Petitioner has been approved for Community Living Supports (CLS) and respite care. (Testimony of Respondent's representative).

4. In 2021, Petitioner's parents also requested a safety bed for Petitioner through Respondent. (Exhibit #2, pages 28-29; Testimony of Clinical Supervisor).

5. That request included a report regarding an Occupational Therapy Evaluation Petitioner underwent on January 5, 2021. (Exhibit #2, pages 21-25)

6. In that evaluation, the occupational therapist (OT) noted that Petitioner had deficits in the following areas: ADLs, sensory integration, motor control/praxis, social interaction, fine motor strength, core strength and stability, postural alignment, and feeding. (Exhibit #2, page 24).

7. On February 8, 2021, the OT also wrote a prescription for a safety bed for Petitioner due to indications of autism; self-injurious behavior; and elopement. (Exhibit #2, page 19).

8. On April 21, 2021, the OT further wrote a letter in support of a safety bed. (Exhibit #2, page 20).

9. In part, that letter stated:

> I am writing this letter on behalf of [Petitioner's family]. I have been seeing their son for a few months now. [Petitioner] is a 3 year old boy diagnosed with Autism. It has come to my attention that they are having difficulty at home with safety and behavior issues at night.
>
> I am recommending a Cubby bed for this family. The Cubby bed is a last resort, since the family has tried several different ways to remedy his behavior, without success. A Cubby bed would help this family prevent [Petitioner] from engaging in self-injurious behavior, sibling injuries, elopement, and family sleep disturbances.
>
> I believe it is in the best interest for the child and family to have a Cubby bed to prevent further injuries and nighttime disruptions.

Exhibit #2, page 20

10. The request for a safety bed for Petitioner in 2021 was denied. (Exhibit #2, pages 28-29; Testimony of Clinical Supervisor).

11. Petitioner's parents did not appeal that denial. (Exhibit #2, pages 28-29; Testimony of Clinical Supervisor).

12. In 2022, Petitioner's parents again requested a safety bed for Petitioner through Respondent. (Exhibit A, pages 5-20, 29-37).

13. That request included the previously submitted letter and prescription from Petitioner's OT. (Exhibit A, pages 8, 10).

14. The request also included a January 27, 2022, Letter from Petitioner's primary care physician. (Exhibit A, page 9).

15. That letter stated in part:

> I am recommending that [Petitioner] get the Cubby bed. He currently has to sleep with his parents because it is not safe to leave him in his crib/bed alone. After many attempts to keep him in the crib, he was moved to a toddler bed. With the toddler bed, he constantly takes his mattress of [sic] the bed and will block the door, making it difficult for his parents to get in. He also has gotten his foot caught in the slates of the bed causing pain and the possibility of a fracture. He has injured his younger brother by throwing objects in his crib in the middle of the night or climbing in and hitting him. In the middle of the night, he will crawl out of parents' bed and will climb on dressers and tables. This is putting him at risk, because the parents are asleep and may not be aware of the dangerous situation. The parents have also added ring cameras to help prevent [Petitioner] from hurting himself. I have been working with the developmental specialist trying to find a medication that will help [Petitioner] sleep better. But he has failed the medications we have tried due to opposite effect of hyperactivity they have on him. Thus, for the safety of my patient and his younger sibling. I am recommending the Cubby bed for [Petitioner].

Exhibit #2, page 18

16. The medications referred to in the letter were Melatonin and Hydroxyzine. (Exhibit #2, page 3; Testimony of Petitioner's representative).

17. The request further included a Justification of Medical Necessity completed by Petitioner's Supports Coordinator with Respondent. (Exhibit A, pages 6-7).

18. In part, that justification stated:

> [Petitioner] is currently sleeping with his mother because it is not safe to leave him in his bed alone. [Petitioner] has climbed out of his crib and was moved to a toddler bed. In the past, [Petitioner] has taken his mattress off the bed and will block the door, making it difficult for his parents to get in. He also has gotten his foot caught in the slates of the bed causing pain and possibility of a fracture. He has injured his brother by throwing objects in his crib in the middle of the night. On 4/28/2021, [redacted] climbed into his brother's crib, sitting on top of his 10 month old brother and pulling his arm, when his mother came in to stop it.
>
> Since the last request, parents have put in ring cameras around the house and his doctor has been trying [Petitioner] on new medications that will help him sleep better. The medications [Petitioner] has tried are giving him an opposite effect of hyperactivity instead of sleep.
>
> Attached are quotes from Cubby and Creative Care Limited. There is only 2 quotes because they are the only 2 that carry that type of bed. Also an OT evaluation from his OT. I also checked other resources to see if I can find other funding; Salvation Army, St Vincent DePaul, Taylor Information Center, Family Resource Center, and Project Freedom. Based on my findings, this is the last resort.
>
> This request has been reviewed by the support coordinator in the Developmental Disabilities Unit at The Guidance Center and I am in agreement with the request being made by his Primary Care Doctor. This is the most cost effective bed currently available to meet

> [Petitioner's] needs. This bed will assist in allowing [Petitioner] to remain in the family home, in his own bed, and least restrictive environment.
>
> *Exhibit A, page 6*

19. On February 10, 2022, Respondent sent Petitioner an Adequate Notice of Adverse Benefit Determination stating that Petitioner's request for a safety bed was denied. (Exhibit #2, pages 11-15; Exhibit A, pages 22-26).

20. With respect to the reason for the denial, the notice stated:

> The clinical documentation provided does not establish medical necessity.
>
> After reviewing the records and the Medicaid Provider Manual for Children's Waiver, it seems that the use of the enclosure, such as the requested Cubby Bed, for behavioral management will be restrictive to [Petitioner's] mobility. There is no clarification if this is being used to prevent [Petitioner] from falling or to management his behavior. [Petitioner's] mother reports it is challenging at night and through the night as he is hyper and will jump all night until he falls asleep or will be running back and forth in his room until he falls asleep. This enclosed space Cubby Bed will make [Petitioner] more hyper and aggressive due to the restrictions. There is no evaluation provided by a Pediatric Psychiatrist to evaluated potential contributors as well as measures that can help with the nighttime behaviors. [Petitioner's] safety is priority, and it is unclear if the enclosed space Cubby Bed will make him more aggressive. Therefore, the request for an enclosure/cubby bed has been denied.
>
> *Exhibit #2, page 11*

21. A letter submitted along with the Adequate Notice of Adverse Benefit Determination further stated that Petitioner's case was reviewed by an independent reviewer organization physician consultant who has been board certified in psychiatry by the American Board of Psychiatry and Neurology since 1998. (Exhibit #2, page 10).

22. On February 10, 2022, Petitioner requested an Internal Appeal with Respondent regarding the denial of the request for a safety bed. (Exhibit #2, page 4).

23. On February 13, 2022, Respondent sent Petitioner a Notice of Appeal Denial stating that Petitioner's Internal Appeal had been denied. (Exhibit #2, pages 4-9; Exhibit A, pages 38-43).

24. With respect to the reason for the decision, the Notice of Appeal stated: "The clinical documentation provided does not establish medical necessity." (Exhibit #2, page 4).

25. On February 14, 2022, Respondent also sent a letter to Petitioner regarding the Internal Appeal decision. (Exhibit #2, page 3).

26. In part, that letter stated:

> [Petitioner's] case was reviewed by DWIHN's Physician Consultant. The Physician Consultant is board certified in psychiatry since 1977.
>
> * * *
>
> Based on the clinical documentation available, we were not able to authorize the above service(s) because:
>
> This consumer does not have enough clinical information indicating medical necessity for a home modification/cubby bed. Evidence based psychosocial interventions as well as pharmacologic interventions need to be implemented before restrictive medical equipment can be approved. Although a primary care physician has prescribed Melatonin and Hydroxyzine, this child has not been evaluated by a psychiatrist who would be able to prescribe medications that could decrease acting-out behaviors. A cubby bed id not in the scope of Medicaid described services for this consumer; using Medicaid Provider Manual SECTION 14 – CHILDREN'S HOME AND COMMUNITY-BASED SERVICES WAIVER (CWP).

Exhibit #2, page 3

27. On February 14, 2022, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter with respect to the denial of Petitioner's request for a safety bed. (Exhibit #1, pages 1-7).

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, Respondent denied Petitioner's request for a safety bed through the CWP. With respect to that program in general and specialized medical equipment specifically, the Medicaid Provider Manual (MPM) states in part:

> **SECTION 14 – CHILDREN'S HOME AND COMMUNITY-BASED SERVICES WAIVER (CWP)**
>
> The Children's Home and Community Based Services Waiver Program (CWP) provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the CWP.
>
> The Children's Waiver is a fee-for-service program administered by the CMHSP. The CMHSP will be held financially responsible for any costs incurred on behalf of the CWP beneficiary that were authorized by the CMHSP and exceed the Medicaid fee screens or amount, duration and scope parameters.
>
> Services, equipment and Environmental Accessibility Adaptations (EAAs) that require prior authorization from MDHHS must be submitted to the CWP Clinical Review Team at MDHHS. The team is comprised of a physician, registered nurse, psychologist, and licensed master's social worker with consultation by a building specialist and an occupational therapist.
>
> **14.1 KEY PROVISIONS**
>
> The CWP enables Medicaid to fund necessary home- and community-based services for children with developmental

disabilities who reside with their birth or legally adoptive parent(s) or with a relative who has been named legal guardian under the laws of the State of Michigan, regardless of their parent's income.

The CMHSP is responsible for assessment of potential waiver candidates. The CMHSP is also responsible for referring potential waiver candidates by completing the CWP "pre-screen" form and sending it to the MDHHS to determine priority rating.

Application for the CWP is made through the CMHSP. The CMHSP is responsible for the coordination of the child's waiver services. The case manager, the child and his family, friends, and other professional members of the planning team work cooperatively to identify the child's needs and to secure the necessary services. All services and supports must be included in the Individual Plan of Services (IPOS). The IPOS must be reviewed, approved and signed by the physician.

A CWP beneficiary must receive at least one children's waiver service per month in order to retain eligibility.

* * *

14.3 COVERED WAIVER SERVICES

Covered Medicaid services that continue to be available to CWP beneficiaries are listed in the Covered Services Section of this chapter. Refer to the Children's Waiver Community Living Support Services Appendix of this chapter for criteria for determining number of hours. Services covered under CWP include:

* * *

Specialized Medical Equipment and Supplies	Specialized medical equipment and supplies includes durable medical equipment, environmental safety and control devices, adaptive toys, activities of daily living (ADL) aids, and allergy control supplies that are specified in the child's individual plan of services. This service is intended to enable the child to increase his abilities to perform ADLs or to

	perceive, control, or communicate with the environment in which the child lives. Generators may be covered for a beneficiary who is ventilator-dependent or requires daily use of oxygen via a concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment. This service also includes vehicle modifications, van lifts and wheelchair tie-downs. Specialized medical equipment and supplies includes items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not covered by Medicaid or through other insurance. (Refer to the Medical Supplier Chapter for information regarding Medicaid-covered equipment and supplies.) Equipment and supplies must be of direct medical or remedial benefit to the child. "Direct medical or remedial benefit" is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that is essential to the implementation of the child's individual plan of services. The plan must include documentation that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the child will be prevented. A prescription is required and is valid for one year from the date of signature. All items must be determined to be essential to the health, safety, welfare, and independent functioning of the child as specified in the individual plan of services. There must be documented evidence that the item is the most cost-effective alternative to meet the child's need following value purchasing standards. All

	items must meet applicable standards of manufacture, design and installation. The CMHSP, or its contract agency, must maintain documentation to support that the best value in warranty coverage (e.g., the most coverage for the least cost, per industry standards) was obtained for the item at the time of purchase. The following are examples of items not covered under this service: ▪ Items that are not of direct medical or remedial benefit or that are considered to be experimental. "Experimental" means that the validity of use of the item has not been supported in one or more studies in a preferred professional journal. ▪ Furniture, appliances, bedding, storage cabinets, whirlpool tubs, and other non-custom items that may routinely be found in a home. ▪ Items that would normally be available to any child and would ordinarily be provided by the family. ▪ Items that are considered family recreational choices (outdoor play equipment, swimming pools, pool decks and hot tubs). ▪ The purchase or lease of vehicles and any repairs or routine maintenance to the vehicle. ▪ Educational supplies and equipment expected to be provided by the school

Pages 98-99, 103-104

Moreover, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. *See* 42 CFR 440.230. Regarding medical necessity, the MPM also provides:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
>
> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
> - Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
> - Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
> - Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
> - Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;

- 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.
>
> *MPM, January 1, 2022 version*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *Pages 14-16*

Here, as discussed above, Respondent denied the request for a safety bed pursuant to the above policies.

In support of that decision, Respondent's representative testified regarding Petitioner's enrollment and services with Respondent, the request made in this case, and the reason that request was denied. She also testified that the Internal Appeal in this case was reviewed by a physician consultant, but that the consultant was not present at the hearing.

Respondent's Clinical Supervisor testified regarding the process for requesting supplies such as safety beds through the CWP and documentation required in support of such requests. She also testified that the request is then reviewed by Respondent or MPRO, an outside contractor, with the request in this case being sent to MPRO because Respondent has already denied a similar request within the past year. She further testified that she cannot speak to the thought process of the reviewer or reviewers at MPRO, but that the bed must be medically necessary.

Petitioner's Supports Coordinator testified that she completed the packet and request for the safety bed, including the recommendations for the bed by the OT and physician, at Petitioner's mother's request. She also testified that she included documentation regarding unsuccessful attempts at securing other funding, but that she did not include anything from a psychiatrist as that is not required for an initial request.

In response, Petitioner's mother testified that, as set forth in the letters from medical professionals, the requested safety is necessary to prevent injuries to Petitioner, injuries to others, and property damage. She also testified that the bed is no more restrictive than a baby gate, and it will allow Petitioner's parents to get necessary sleep.

She further testified that, while Respondent is recommending that Petitioner see a psychiatrist via video conferencing, that is unnecessary given his age, the availability of the safety bed, and the recommendations of a medical professional who have seen

Petitioner. She also testified that Respondent's recommendations are uneducated, and that she does not want Petitioner on medications due to side effects. Petitioner's mother did concede that she is only assuming a psychiatrist would prescribe medications.

Rather than seeing a psychiatrist, Petitioner's mother testified that Petitioner needs behavioral therapy and other services that he is on a waitlist for, and that he has a behavior plan in place. Petitioner's mother further testified that Respondent has continually undermined Petitioner's parents and doctor, put up barriers to services, and failed to make them aware of what services are available.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Respondent's decision in light of the information Respondent had at the time it made that decision.

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet his burden of proof and that Respondent's decision must therefore be affirmed.

The requested safety bed must be medically necessary to be approved, but the record fails to demonstrate medical necessity in this case given that other, less restrictive and more cost-effective alternative options have not been explored. In particular, as found by Respondent, Petitioner should at least be evaluated by a pediatric psychiatrist prior to any safety bed being approved.

Moreover, while the undersigned Administrative Law Judge appreciates that there was no one from Respondent present at the hearing who could answer any questions about the reasons for Respondent's decision, the reasons themselves were clear and limited enough that such witnesses were not required. There was no finding in this case that Petitioner undergo any particular treatment or interventions prior to a safety bed being approved, and, instead, Respondent merely required that Petitioner undergo an evaluation to see what, if any, other alternatives could be pursued. And, while Petitioner submitted letters from an OT and doctor stating that the safety bed is required, they likewise did not appear at the hearing and neither letter discusses why even being evaluated by a psychiatrist is unnecessary or inappropriate.

On her own, Petitioner's mother was adamant that Respondent's decision that Petitioner needed to see a psychiatrist before a safety bed could be approved was uneducated, and that she did not want Petitioner on medications given his age and potential side effects. However, even ignoring the fact that Petitioner's mother was apparently fine with the primary care physician prescribing medications, that argument is premature and unpersuasive given that it is unclear what, if anything, a psychiatrist would recommend. As conceded by Petitioner's mother, Petitioner has not been seen by a psychiatrist and she is only assuming that a psychiatrist would recommend medications and that the recommended medications would be inappropriate.

To the extent Petitioner's circumstances have changed or his parents have additional or updated information to provide, then Petitioner's parents can always request a safety bed again in the future along with that information. With respect to the decision at issue in this case however, Respondent's decision must be affirmed given the available information and applicable policies.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied Petitioner's request for a safety/cubby bed.

IT IS THEREFORE ORDERED that

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

Steven Kibit

SK/tem

Steven Kibit
Administrative Law Judge

NOTICE OF APPEAL: Petitioner may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact	Belinda Hawks 320 S. Walnut St. 5th Floor Lansing, MI 48913 MDHHS-BHDDA-Hearing-Notices@michigan.gov
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