[redacted]
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Date Mailed: February 20, 2020
MOAHR Docket No.: 19-011476
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 the Petitioner's request for a hearing.

After due notice, a telephone hearing was held on January 21, 2020. Student attorney [redacted] and attorney Debra Chopp from the Pediatric Advocacy Clinic at the University of Michigan Law School appeared on Petitioner's behalf. [redacted], Petitioner's mother, testified as a witness for Petitioner. Holly Johnson, Senior Coordinator for Grievances and Appeals, appeared and testified on behalf of Priority Health, the Respondent Medicaid Health Plan (MHP).

During the hearing, Respondent submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-324. Respondent's packet included Petitioner's request for hearing and the proposed exhibits attached to that request.

ISSUE

Did the MHP properly deny Petitioner's prior authorization requests for a continuous glucose monitor (CGM)?

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 Medicaid beneficiary who is enrolled in the Respondent MHP and who has been diagnosed with type 1 diabetes. (Exhibit A, pages 107, 111, 115).

2. On April 8, 2020, 2019, Respondent received a prior authorization request submitted on Petitioner's behalf by her doctor for a CGM. (Exhibit A, pages 107-158).

3. As part of that request, Petitioner's doctor indicated that Petitioner is not currently on CGM therapy and that, instead, she manages her diabetes by doing multiple daily injections and testing her blood glucose levels up to 10 times a day. (Exhibit A, pages 115-116).

4. The request also stated that Petitioner has a history of hypoglycemic unawareness and severe glycemic excursions; recurring episodes of severe hypoglycemia; and day-to-day variations in her work schedule, mealtimes or activity level that confound the degree of regimentation required to self-manage glycemia with multiple insulin injections. (Exhibit A, page 115).

5. Petitioner's doctor also attached a letter in which he stated that, as demonstrated by her last meter download, Petitioner has hypoglycemia with lows less than 50 mg/dL, occurring at random times during the day and night. (Exhibit A, page 116).

6. The letter further stated in part:

> [Petitioner's] last hemoglobin A1c was at 7.5%, which is considered in target. She obviously does well in management of glucose levels bit the A1c does not show how hypoglycemic events are occurring in the day and night. Furthermore, she is now driving, increasing the risk of hypoglycemia.
>
> *Exhibit A, page 116*

7. In addition to the letter, Petitioner's doctor also attached medical records to the prior authorization request. (Exhibit A, pages 118-128).

8. One record was from an October 11, 2018 office visit, and it stated that Petitioner had a trend of mild hyperglycemia at lunch and supper, but no history of severe hypoglycemia or a significant number of non-severe hypoglycemic episodes. (Exhibit A, pages 118-119).

9. The October 11, 2018 office visit note also stated that Petitioner feels symptoms of hypoglycemia, such as being shaky and having headaches, when her levels get as low as 70 mg/dL; she knows how to treat low blood glucose; and that her diabetes in good control, with possible need for more food coverage. (Exhibit A, pages 122-123, 128).

10. Similarly, a January 24, 2019 office visit note stated that Petitioner has a trend of mild hyperglycemia in the afternoon and evening, but no history of severe hypoglycemia or a significant number of non-severe hypoglycemic episodes. (Exhibit A, page 135).

11. The January 24, 2019 office visit note also stated that Petitioner's family reports Petitioner experiencing nocturnal hyperglycemia, but that her diabetes is in good control; she has not had any severe hypoglycemia since last visit; she feels symptoms of hypoglycemia when her levels get as low as 70 mg/dL; and she knows how to treat low blood glucose. (Exhibit A, pages 138, 143).

12. On April 18, 2019, Respondent sent Petitioner written notice that the prior authorization request had been denied due to the applicable medical criteria identified in a Medical Services Bulletin issued by the Michigan Department of Health and Human Services (MDHHS) not being met. (Exhibit A, pages 169-172).

13. On April 30, 2019, Petitioner's doctor sent in another, similar request for a CGM. (Exhibit A, pages 176-190).

14. On May 14, 2019, Respondent sent Petitioner another notice of denial. (Exhibit A, pages 191-193).

15. On June 18, 2020, Petitioner filed an Internal Appeal with Respondent regarding the denial of the prior authorization requests. (Exhibit A, pages 73-100).

16. On June 26, 2019, Respondent sent Petitioner written notice that Petitioner's appeal had been reviewed and that the authorization request was still denied. (Exhibit A, pages 320-324).

17. With respect to the reason for its decision, Respondent wrote in part:

> Your request was not approved. Your Internal Appeal was thoroughly considered. The details you provided in your case were very clear. However, you do not meet medical criteria as outlined in MDHHS MSA Bulletin 19-04. Specifically, records reviewed from [Petitioner's] most recent visit with her Endocrinologist from April 29, 2019 indcated [sic] she is not experiencing severe hypoglycemia, a coexistent morbidity, microvascular complication, ketoacidosis and has not had a recent history of hospitalization or emergency room visits for seizures or other conditions attributed to hypoglycemic events.
>
> During presentation of [Petitioner's] appeal case, you commented to the Appeal Committee that if your request was denied, [Petitioner] would intentionally alter her insulin regimen and purposefully increase her glucose levels in an attempt to demonstrate that

> her glucose levels were uncontrolled; however, [Petitioner] would not meet the criteria for coverage if her glucose levels were uncontrolled due to non-compliance.
>
> *Exhibit A, page 322*

18. On October 31, 2019, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner in this matter regarding Respondent's decision. (Exhibit A, pages 4-72).

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.

In 1997, the Department received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified Medicaid Health Plans.

The Respondent is one of those MHPs and, as provided in the Medicaid Provider Manual (MPM), is responsible for providing covered services pursuant to its contract with the Department:

> The Michigan Department of Health and Human Services (MDHHS) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDHHS website. (Refer to the Directory Appendix for website information.)
>
> MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary

> Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.
>
> **1.1 SERVICES COVERED BY MEDICAID HEALTH PLANS (MHPS)**
>
> The following services must be covered by MHPs:
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> * * *
>
> - Durable medical equipment and medical supplies
>
> * * *
>
> - Well child/EPSDT for individuals under age 21
>
> *MPM, April 1, 2019 version*
> *Medicaid Health Plan Chapter, pages 1-2*

Here, pursuant to the above policy and its contract with MDHHS, Respondent has limited coverage of CGMs to the applicable published Medicaid coverage and limitation policies set forth by MDHHS in Medical Services Administration (MSA) Bulletin 19-04, which states in part:

> Effective April 1, 2019, the Michigan Department of Health and Human Services (MDHHS) will begin coverage of personal use continuous glucose monitoring systems (CGMSs).

I. Definition

CGMSs are devices that measure glucose levels taken from interstitial fluid continually throughout the day and night, providing real-time data to the beneficiary or physician. The CGMS is comprised of three parts: (1) a disposable sensor (attaches to the skin and inserts a tiny wire into the subcutaneous tissue to measure glucose levels), (2) the transmitter (attaches to the sensor and sends the data to a wireless receiver/monitor), and (3) a receiver/monitor (records and stores the data and alerts the beneficiary when glucose levels are too high or too low).

II. Standards of Coverage

MDHHS will cover a personal use CGMS for persons with Type I Diabetes when all the following standards of coverage are met:

- The beneficiary is under the care of one of the following:

  A. An endocrinologist; or

  B. A physician or non-physician practitioner (nurse practitioner [NP], physician assistant [PA], or clinical nurse specialist [CNS]) who is managing the beneficiary's diabetes. (This provider must provide documentation that the beneficiary completed a Medicaid-covered certified diabetes self-management education [DSME] training program within one year prior to the written order);

- The beneficiary has Type I Diabetes requiring the administering of insulin three or more times per day or is currently using an insulin pump; and at least one of the following:

  - Is unable to consistently and reliably identify hypoglycemic events (e.g., hypoglycemic unawareness);
  - A recent history of hospitalization or emergency room visits for seizures or other conditions attributed to a hypoglycemic event;

- Coexistent morbidity that poses an unusual challenge with concomitant hypoglycemia (e.g., uncontrolled epilepsy);
- The presence of microvascular complication (e.g., vasculopathy, retinopathy); or
- Ketoacidosis or uncontrolled glucose.

At least one of the above conditions must be documented (e.g., hypoglycemic unawareness).

- The beneficiary's treatment plan recommends testing blood glucose a minimum of four times per day;
- The beneficiary has poor diabetic control despite attempts to maximally optimize care (e.g., compliance) with hypoglycemic unawareness, seizures, unexplained hypoglycemic episodes, recurrent ketoacidosis, and/or HbA1c not in an acceptable range;
- The beneficiary's current treatment plan requires frequent adjustments to insulin dosage throughout the day;
- The endocrinologist/physician/non-physician practitioner documents beneficiary compliance with their treatment plan; and
- The beneficiary or his/her caregiver is educated on the use of the device and is willing and able to use the CGMS.

III. Documentation

Documentation must be less than 90 days old and include all the following:

- The order is written by the endocrinologist or other physician/non-physician practitioner treating the beneficiary;
- Diagnosis related to the need for the CGMS;
- Length of need;
- Number of finger-stick tests beneficiary performs per day;
- Frequency of insulin administered per day or if the beneficiary is using an insulin pump;
- Records of hypoglycemic events, HbA1c levels, uncontrolled glucose, ketoacidosis, recent

hospitalizations or emergency room visits related to conditions attributed to hypoglycemic events, coexistent morbidity having occurred with hypoglycemia or the presence of a microvascular complication(s), as applicable;

- Current treatment plan and beneficiary's compliance with the plan; and
- Documentation of beneficiary completion of a Medicaid-covered certified DSME training program (if provider other than an endocrinologist is treating the beneficiary's diabetes). The DSME training program must have been completed within one year prior to the written order for the CGMS and include education on the use of a CGMS. (Refer to the Hospital chapter of the Medicaid Provider Manual for additional information. The Medicaid Provider Manual can be accessed on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.)

The initial order must be written for six months. If the beneficiary continues to be compliant with use of the CGMS and treatment plan, the practitioner may write an order for an additional six months. After the first year, an order(s) for replacement sensors, transmitters and receivers (following frequency rules below) may be written for a 12-month period.

Note: For CSHCS beneficiaries, a prescription from a pediatric endocrinologist is required for a CGMS.

IV. External Insulin Pumps Combined with CGMSs

An external insulin pump combined with a CGMS is covered when the external insulin pump policy and the CGMS policy standards of coverage are met. To be considered for coverage, the device must be approved by the Food and Drug Administration (FDA) as a combined insulin pump/CGMS.

Refer to the Medicaid External Infusion (Insulin) Pump policy, Medicaid Medical Supplier database, and the Pricing, Data Analysis and Coding (PDAC) contractor website for appropriate Healthcare Common Procedure

Coding System (HCPCS) code assignment of combination pump/CGMS.

V. Prior Authorization

Prior authorization is not required for infants and toddlers (age 5 and under*) if standards of coverage and documentation requirements are met. Prior authorization is required for all other ages and conditions.

*It is assumed that hypoglycemic unawareness is common within this age group.

MSA Bulletin 19-04, pages 1-3
Exhibit A, pages 68-70

Moreover, with respect to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, the Department's Medicaid Provider Manual (MPM) states in part:

SECTION 1 – GENERAL INFORMATION

Federal regulations require state Medicaid programs to offer early and periodic screening, diagnosis, and treatment (EPSDT) services to Medicaid eligible beneficiaries younger than 21 years of age; however, beneficiary participation is voluntary. The intent of EPSDT is to provide necessary health care, diagnostic services, treatment, and other measures according to section 1905(a) and 1905(r) [42 U.S.C. 1396d] of the Social Security Act (1967) to correct or ameliorate defects and physical and mental illnesses and conditions discovered whether or not such services are covered under the state plan. State Medicaid programs are required to provide for any services that are included within the mandatory and optional services that are determined to be medically necessary for children under 21 years of age. Accordingly, EPSDT well child visits and any needed follow-up services are covered by Medicaid.

EPSDT visits cover any medically necessary screening and preventive support services for children, including nutritional and at-risk assessments as well as resulting health education and mental health services. These services are available to all children for the purpose of screening and identifying children who may be at risk for, but not limited to, drug or alcohol abuse, child abuse or neglect, trauma, failure

to thrive, low birth weight, low functioning/impaired parent, or homeless or dangerous living situations.

EPSDT visits are to be performed in accordance with the American Academy of Pediatrics (AAP) periodicity schedule, its components, and medical guidelines. Michigan recognizes the AAP definition of "medical necessity" as:

> *Health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals to promote optimal growth and development in a child and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities.*

EPSDT requires the coverage of medically necessary inter-periodic screenings outside of the AAP periodicity schedule. Coverage for such screenings is required based on an indication of a medical need to diagnose an illness or condition that was not present at the regularly scheduled screening or to determine if there has been a change in a previously diagnosed illness or condition that requires additional services.

Medically necessary services include habilitative or rehabilitative services that are expected to attain, maintain, or regain functional capacity and to achieve maximum health and function. A service need not cure a condition in order to be covered under EPSDT, and maintenance services or services that improve the child's current health condition are also covered in EPSDT because they ameliorate a condition. The common definition of ameliorate is "to make more tolerable." Thus, services such as physical and occupational therapy are covered when they have an ameliorative, maintenance purpose. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. It is important to identify illnesses and conditions early and to treat any health problems discovered in children before they become worse and more costly. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. Refer to the Special Coverage

Provisions section of the Healthy Michigan Plan chapter for the definition of “habilitative services”.

EPSDT includes a broad range of services that can be covered and includes:

- licensed practitioners services;
- speech, occupational, and physical therapies;
- physician services;
- private duty nursing;
- personal care services;
- home health;
- medical equipment and supplies;
- habilitative and rehabilitative services;
- vision services;
- hearing services; and
- dental services.

In addition, the coverage of other diagnostic, screening, preventive and rehabilitative services is required, and includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. The coverage of EPSDT services is particularly important for children with disabilities, because such services can prevent conditions from worsening, reduce pain, and avert the development of more costly illnesses and conditions. Other less common examples include items of durable medical equipment, such as decubitus cushions, bed rails and augmentative communication devices. Such services are a crucial component of a good, comprehensive child-focused health benefit.

The determination of whether a service is medically necessary must be made on a case-by-case basis, taking into account the particular physical, behavioral, mental, or

dental health needs of the child. While the treating provider is responsible for determining or recommending that a particular service is needed to correct the child's condition, both the Michigan Department of Health and Human Services (MDHHS) and a child's treating provider play a role in determining whether a service is medically necessary. If there is a disagreement between the treating provider, health plan, and/or Medicaid as to whether a service is medically necessary for a particular child, Medicaid is responsible for making a decision for the individual child based on information presented to departmental staff. The MDHHS Office of Medical Affairs consists of a panel of physicians, including pediatricians, who will review the medical necessity of a particular service when there is a disagreement between the treating provider, health plan or Medicaid. These physicians review, on a case-by-case basis, the particular needs of the child based on the medical standards and literature, and in consultation with subspecialists when appropriate in accordance with Michigan Medicaid policy.

A medically necessary treatment service should not be denied to a child based on cost alone, but the relative cost effectiveness of alternative services may be considered as part of the prior authorization process. Services may be covered in the most cost effective mode as long as the less expensive service is equally effective and actually available. Prior authorization must be conducted on a case-by-case basis, evaluating each child’s needs individually. Prior authorization is not required for medically necessary screenings.

The main parts of the EPSDT program that providers are responsible for are:

- Well child visits, including immunizations and developmental screening, using a validated and standardized screening tool at specified intervals as defined in the periodicity schedule by the AAP (hereafter referred to as the “AAP periodicity schedule”). A copy of the AAP periodicity schedule is available on the AAP website. (Refer to the Directory Appendix for website information.)

  NOTE: The AAP periodicity schedule requires a risk assessment to be performed for vision, hearing, and blood lead screening at the specified intervals. MDHHS requires vision, hearing, and blood lead

testing to be performed at the specific ages indicated on the AAP periodicity schedule. A parent/guardian (or person in loco parentis) applying to register a child for the first time in kindergarten or first grade in a school in this state shall present to school officials, at the time of registration or no later than the first day of school, a certificate of hearing and vision testing or screening or a statement of exemption. Refer to the appropriate section within this chapter for MDHHS requirements regarding vision, hearing, and blood lead screening.

- Referrals for:
  - Other preventive health care;
  - Medically necessary follow-up services to treat detected conditions; and
  - Transportation for health care services.

MPM, April 1, 2019 version
EPSDT Chapter, pages 1-3

As discussed above, Respondent both denied two prior authorization requests submitted on Petitioner's behalf for a CGM and upheld the denials following a Local Appeal.

Petitioner has now appealed those decisions and, in doing so, bears the burden of proving by a preponderance of the evidence that the Respondent erred in denying her authorization requests. Moreover, the undersigned Administrative Law Judge is limited to reviewing Respondent's decisions in light of the information that was available at the time the decisions were made.

Given the applicable policies and relevant evidence in this case, Petitioner has failed to meet that burden of proof and Respondent's decisions must therefore be affirmed.

Petitioner first argues that she meets the applicable criteria for CGMs identified above and relied upon by Respondent. In particular, her representatives noted instances of hypoglycemia for Petitioner and her doctor's statements in the prior authorization request that Petitioner has a history of hypoglycemic unawareness and severe glycemic excursions; recurring episodes of severe hypoglycemia; and day-to-day variations in her work schedule, mealtimes or activity level that confound the degree of regimentation required to self-manage glycemia with multiple insulin injections. Similarly, Petitioner's mother testified regarding instances where Petitioner has come close to hyperglycemia and Petitioner's inability to always recognize when her levels are low. She also testified that Petitioner is having diabetic burn out and how the CGM will help her.

However, the medical records attached to prior authorization directly contradict Petitioner's doctor's broad conclusions in the prior authorization request and fail to support Petitioner's mother's testimony. Specifically, rather than identifying a history of hypoglycemic unawareness, severe glycemic excursions or recurring episodes of severe hypoglycemia, the actual records consistently and expressly provide that Petitioner has no history of either severe hypoglycemia or a significant number of non-severe hypoglycemic episodes; her diabetes is under good control; and that Petitioner can both recognize symptoms of hypoglycemia and properly address them.

Among other requirements, the above criteria for the approval of a CGM requires that a beneficiary with Type 1 diabetes have at least one of the following conditions: an inability to consistently and reliably identify hypoglycemic events; a recent history of hospitalization or emergency room visits for conditions attributable to a hypoglycemic event; a coexistent morbidity that poses an unusual challenge with concomitant hypoglycemia; the presence of a microvascular complication; or ketoacidosis or uncontrolled glucose. Petitioner has failed to meet her burden of proving that one of those conditions is present here or that she meets the applicable criteria, and Respondent's decision that Petitioner does not meet the requirements in policy for the approval of a CGM must be affirmed.

In addition to arguing that Petitioner meets the applicable criteria identified above and relied upon by Respondent, Petitioner also argues that Respondent is required to approve the CGM as a medically necessary EPSDT service. In particular, Petitioner's representatives argue that the intent of EPSDT is to provide necessary health care, diagnostic services, treatment, and other measures in order to correct or ameliorate defects and physical and mental illnesses and conditions, whether or not such services are covered under the state plan; the determination of whether a service is medical necessary as an EPSDT service must be made on a case-by-case basis, with the treating physician playing a role in determining whether a service is medically necessary; and that the requested CGM must be approved in this case given that it would ameliorate Petitioner's diabetes by decreasing time spent in hypoglycemia; reducing glycemic variability; lessening the burden on caregivers; and allowing for better diabetic management.

The MPM does provide that a medically necessary service need not cure a condition in order to be covered under EPSDT, and that maintenance services are also covered under EPSDT when they improve a child's current health condition by ameliorating it. However, the medical necessity of an EPSDT service is still determined on a case-by-basis; that determination can include consideration of alternative services; and there has been no showing that a CGM is a medically necessary maintenance service under EPSDT in this case. As demonstrated by how well Petitioner's diabetes is controlled and the lack of any significant issues, Petitioner's current services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. Moreover, while Petitioner's request for hearing identified general benefits of CGMs for people with diabetes, the medical necessity of an EPSDT service

is still determined on a case-by-basis and there has been no showing that a CGM is a medically necessary maintenance service under EPSDT in this case given the lack of significant evidence in support of the assertions made in the request with respect to Petitioner specifically. Similarly, while Petitioner correctly notes that, under the applicable policy, the treating physician plays a role in determining whether a service is medically necessary, the undersigned Administrative Law Judge does not find the treating physician in this case to be persuasive at all given the significant disconnect between what he concluded in the prior authorization request and what was provided in the actual, contemporaneous medical records.

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 prior authorization requests for a continuous glucose monitor.

IT IS, THEREFORE, ORDERED that:

Respondent's decision is **AFFIRMED.**

Steven Kibit

SK/sb

Steven Kibit
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party 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	Managed Care Plan Division CCC, 7th Floor Lansing, MI 48919
Counsel for Petitioner	Debra Chopp University of Michigan 2076 South Hall 701 South State Street Ann Arbor, MI 48109
Petitioner	[redacted] MI
Community Health Rep	Priority Health Choice Kellie McCowan 1231E. Beltline NE Grand Rapids, MI 49525-4501
Authorized Hearing Rep.	[redacted] MI