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Date Mailed: March 25, 2020
MOAHR Docket No.: 19-013281
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Colleen Lack

DECISION AND ORDER

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 *et seq*; 42 CFR 438.400 *et seq*; and Mich Admin Code, R 792.11002.

After due notice, a hearing was held on February 19, 2020. [redacted], Mother and Authorized Hearing Representative (AHR), appeared on behalf of the Petitioner. [redacted], Father, and [redacted], Supports Coordinator, appeared as witnesses for Petitioner. Stacy Coleman-Ax, Chief Compliance and Privacy Officer (CCPO), represented the Respondent, Macomb County Community Mental Health (CMH).

During the hearing proceeding, Respondent's Hearing Summary packet was admitted as Exhibit A, pp. 1-23; and Petitioner's additional documentation was admitted as Exhibit 1, pp. 1-44 and Exhibit 2, pp. 1-44.

ISSUE

Did Respondent properly deny Petitioner's request for an 11" Apple iPad pro with Wi-Fi and Cellular Service?

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, date of birth [redacted] 1991. (Exhibit 2, p. 17)

2. Petitioner has been diagnosed with Autism disorder as well as expressive and receptive language disorder. (Exhibit 1, p. 33)

3. On September 28, 2011, Respondent received a request for an iPad 2 for Petitioner and subsequently provided funding for the requested iPad. (Exhibit 1, pp. 9-26; CCPO Testimony)

4. On July 10, 2019, a Person Centered Plan (PCP) meeting was held. The PCP indicates the iPad would be utilized for goals and objectives such as cooking simple meals/snacks for menu planning or recipes; communicating within the community with CLS staff ensuring he either uses his iPad or other means of communicating throughout the day and his communication needs, both expressive and receptive, are met; as a communication device within his home and community daily to relieve him of the frustration caused by his expressive/receptive language disorder; to learn how to successfully communicate appropriately with others by email, messaging, and face time; for executive functioning including weekly appointments and a daily visual schedule; and learning to use his calendar and reminder applications on his iPad. (Exhibit 2, pp. 17-24)

5. On October 18, 2019, Respondent received a request for an 11" Apple iPad pro with Wi-Fi and Cellular Service for Petitioner. (Exhibit 1, pp. 27-44)

6. On November 13, 2019, a Notice of Adverse Benefit Determination was issued to Petitioner stating the request for the iPad was denied because iPads are not a covered item based on MSA Bulletin 17-18. (Exhibit 2, p. 4)

7. On November 18, 2019, a local appeal was requested. (Exhibit A, p. 2)

8. On December 17, 2019, written notice of the local appeal decision was issued. The appeal for the iPad was denied because iPads are not a covered Medicaid specialty support and service based on MSA Bulletin 17-18. (Exhibit A, pp. 2-6)

9. On December 27, 2019, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's request for hearing. (Exhibit 1, pp. 1-44)

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.
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> *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 1396(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).

With respect to the Habilitation Supports Wavier and goods and services, the Medicaid Provider Manual (MPM) states:

> The purpose of Goods and Services is to promote individual control over, and flexible use of, the individual budget by the HSW beneficiary using arrangements that support self-determination and facilitate creative use of funds to accomplish the goals identified in the individual plan of services (IPOS) through achieving better value or an improved outcome. Goods and services must increase independence, facilitate productivity, or promote community inclusion and substitute for human assistance (such as personal care in the Medicaid State Plan and community living supports and other one-to-one support as described in the HSW or §1915(b)(3) Additional Service definitions) to the extent that individual budget expenditures would otherwise be made for the human assistance.
>
> A Goods and Services item must be identified using a person-centered planning process, meet medical necessity criteria, and be documented in the IPOS. Purchase of a warranty may be included when it is available for the item and is financially reasonable.
>
> Goods and Services are available only to individuals participating in arrangements of self-determination whose individual budget is lodged with a fiscal intermediary.
>
> This coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle.
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> *MPM, October 1, 2019, version*
> *Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, page 113*

Medical Services Administration (MSA) Bulletin 17-18 addresses changes to speech generating device (SGD) policy and was effective July 1, 2017. The new SGD definition states that SGDs are defined as durable medical equipment (electric or nonelectric) that provide an individual with a severe speech impairment, who is unable to communicate using natural means (e.g., spoken, written, gestures, sign language), the ability to meet his or her basic functional communication needs. Regarding noncovered items, this policy specifies that items that are not medical in nature or dedicated durable medical equipment, such as iPads, are not covered. *Medical Services Administration (MSA) Bulletin 17-18, issued June 1, 2017, pp. 1-2.*

With respect to the Habilitation Supports Wavier and goods and services, the Medicaid Provider Manual (MPM) states:

Environmental Modifications

Physical adaptations to the home and/or workplace required by the beneficiary's support plan that are necessary to ensure the health, safety, and welfare of the beneficiary, or enable him to function with greater independence within the environment(s) and without which the beneficiary would require institutionalization.

Adaptations may include:

- The installation of ramps and grab bars;
- Widening of doorways;
- Modification of bathroom facilities;
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary; and
- Environmental control devices that replace the need for paid staff and increase the beneficiary's ability to live independently, such as automatic door openers.

Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of the beneficiary and are not of direct medical or remedial benefit. Examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning (except under exceptions noted in the service definition), garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs. The HSW does not cover construction costs in a new home or additions to a home purchased after the beneficiary is enrolled in the waiver.

MPM, October 1, 2019, version
Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, page 110

With respect to the Habilitation Supports Wavier and enhanced medical equipment and supplies, the Medicaid Provider Manual (MPM) states:

> **Enhanced Medical Equipment and Supplies**
>
> Enhanced medical equipment and supplies include devices, supplies, controls, or appliances that are not available under regular Medicaid coverage or through other insurances. (Refer to the Medical Supplier Chapter of this manual for more information about Medicaid-covered equipment and supplies.) All enhanced medical equipment and supplies must be specified in the plan of service and must enable the beneficiary to increase his abilities to perform activities of daily living; or to perceive, control, or communicate with the environment.
>
> Items that are not of direct medical or remedial benefit, or that are considered to be experimental to the beneficiary, are excluded from coverage.
>
> - "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the individual plan of service.
> - "Experimental" means that the validity of the use of the item has not been supported in one or more studies in a refereed professional journal.
>
> The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary's need. All items must be ordered on a prescription as defined in the General Information Section of this chapter. An order is valid one year from the date it was signed. This coverage includes:
>
> - Adaptations to vehicles;
> - Items necessary for life support;
> - Ancillary supplies and equipment necessary for proper functioning of such items; and
> - Durable and non-durable medical equipment not available under the Medicaid state plan.

Generators may be covered for an individual who is ventilator dependent or requires daily use of an oxygen concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment.

Assessments and specialized training needed in conjunction with the use of such equipment, as well as warranted upkeep and repair, shall be considered as part of the cost of the services.

Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, and decorative items) that are routinely found in a home are not included.

Items that are considered family recreational choices are not covered. The purchase or lease of a vehicle, as well as any repairs or routine maintenance to the vehicle, is not covered. Educational equipment and supplies are expected to be provided by the school as specified in the Individualized Education Plan and are not covered. Eyeglasses, hearing aids, and dentures are not covered.

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase. The PIHP should have a process in place that gives notice to a medical equipment supplier that purchase of the equipment or supply has been authorized.

Repairs to enhanced medical equipment that are not covered benefits through other insurances may be covered. There must be documentation in the individual plan of services that the enhanced medical equipment continues to be of direct medical or remedial benefit. All applicable warranty and insurance coverage must be sought and denied before paying for repairs. The PIHP must document the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

> The PIHP must assure that all applicable private insurance, Medicare and/or Medicaid requirements for the procurement of durable medical equipment and supplies have been met. The PIHP may not use the waiver service to purchase equipment or supplies that would have been covered by another program if the program's rules were followed, including using providers who participate with that program.
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> *MPM, October 1, 2019, version*
> *Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, pages 108-109*

With respect to the B3 Additional Mental Health Services and assistive technology, the Medicaid Provider Manual (MPM) states:

> **17.3.A. ASSISTIVE TECHNOLOGY**
>
> Assistive technology is an item or set of items that enable the individual to increase his ability to perform activities of daily living with a greater degree of independence than without them; to perceive, control, or communicate with the environment in which he lives. These are items that are not available through other Medicaid coverage or through other insurances. These items must be specified in the individual plan of service. All items must be ordered by a physician on a prescription as defined in the General Information section of this chapter. An order is valid for one year from the date it was signed.
>
> Coverage includes:
>
> - Adaptations to vehicles
> - Items necessary for independent living (e.g., Lifeline, sensory integration equipment)
> - Communication devices
> - Special personal care items that accommodate the person’s disability (e.g., reachers, full-spectrum lamp)
> - Prostheses necessary to ameliorate negative visual impact of serious facial disfigurements and/or skin conditions
> - Ancillary supplies and equipment necessary for proper functioning of assistive technology items
> - Repairs to covered assistive technology that are not covered benefits through other insurances

Assessments by an appropriate health care professional, specialized training needed in conjunction with the use of the equipment, and warranted upkeep will be considered as part of the cost of the services.

Coverage excludes:

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

MPM, October 1, 2019, version
Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, page 131

With respect to the B3 Additional Mental Health Services and environmental modifications, the Medicaid Provider Manual (MPM) states:

17.3.D. ENVIRONMENTAL MODIFICATIONS

Physical adaptations to the beneficiary's own home or apartment and/or workplace. There must be documented evidence that the modification is the most cost-effective alternative to meet the beneficiary's need/goal based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing, or in the case of vehicle modification, alternative transportation. All modifications must be prescribed by a physician. Prior to the environmental modification being authorized, PIHP may require that the beneficiary apply to all applicable funding sources (e.g., housing commission grants, MSHDA, and community development block grants), for assistance. It is expected that the PIHP case manager/supports coordinator will assist the beneficiary in his pursuit of these resources. Acceptances or denials by these funding sources must be documented in the beneficiary's records. Medicaid is a funding source of last resort.

Coverage includes:

- The installation of ramps and grab-bars.
- Widening of doorways.
- Modification of bathroom facilities.
- Special floor, wall or window covering that will enable the beneficiary more independence or control over his environment, and/or ensure health and safety.
- Installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary.
- Assessments by an appropriate health care professional and specialized training needed in conjunction with the use of such environmental modifications.
- Central air conditioning when prescribed by a physician and specified as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use.
- Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, limited to the requirements for safe operation of the specified equipment.
- Adaptations to the work environment limited to those necessary to accommodate the beneficiary's individualized needs.

MPM, October 1, 2019, version
Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, page 134-135

Medicaid beneficiaries are only still entitled to medically necessary Medicaid covered services. The Medicaid Provider Manual (MPM) sets forth the criteria for medical necessity and for authorizing B3 Supports and Services:

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, October 1, 2019, version
Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, pages 14-15

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

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

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

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of

> care they would provide to their children without disabilities. MDHHS encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.
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> *MPM, October 1, 2019, version*
> *Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, pages 129-130*

The CCPO explained that Petitioner's request for a new iPad identified goods and services as the Medicaid covered specialty support and service. The above cited Medicaid Provider Manual policy regarding goods and services under the HSW states that this coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations. MSA 17-18, specifies that iPads are not covered as they are not medical in nature or dedicated durable medical equipment. During the internal appeal, Petitioner's request was also considered under alternative B3 supports and services, specifically assistive technology and environmental modifications. Petitioner's request for an iPad could not be approved as medically necessary under goods and services, assistive technology, or environmental modifications. (Exhibit A, pp. 1-2; Exhibit 2, p. 4; and CCPO Testimony)

Petitioner's AHR asserted that the contested action was a discontinuation of a prior service and support. (Exhibit 1, p. 3; AHR Testimony) This argument is without merit. It is understood that the Petitioner utilized the 2011 iPad for many years. However, the purchase of the iPad would have been completed as a one-time transaction, not an ongoing transaction. Additionally, Petitioner's father testified that Petitioner's parents have been paying for the cost of the cellular service for that iPad. (Father Testimony) Further, the documentation Petitioner submitted shows the 2011 iPad was requested as a Medicaid covered service and support but does not establish that the purchase was authorized as a Medicaid covered service and support. Respondent could have utilized non-Medicaid funds, such as general fund, grant funding, or some other finding source. (CCPO Testimony) Lastly, even if the 2011 iPad was authorized as a Medicaid covered service and support, polices changes have occurred since 2011. Petitioner's 2019 request for an iPad must by reviewed under the current policy.

Petitioner's AHR noted that the documentation submitted with the 2019 request does not indicate it would be used as an SGD. Further, Petitioner's AHR argues that the requested iPad should be covered either as a communication device as assistive technology, or as enhanced medical equipment and supplies. (Exhibit 2, pp. 29-30 and 34-35)

Given the evidence and applicable policies in this case, Petitioner has not met his burden of proof regarding Respondent's determination to deny Petitioner's request for an 11" Apple iPad pro with Wi-Fi and Cellular Service based on the available information. The evidence does not establish the medical necessity for the requested iPad under the policy for any of the supports and services referenced by the parties. For example, PCP indicates the iPad would not substitute for human assistance. Rather, CLS staff still ensure Petitioner uses the iPad, or other means, for communication in the community and must provide direct assistance when Petitioner is using the iPad for attempting written communication. (Exhibit 2, p. 21) It is not clear that the requested iPad is the most cost-effective alternative to meet Petitioner's needs regarding communication as the other means referenced in the PCP are not specified. The iPad is also not the only way Petitioner could work on menu planning/recipes or daily/weekly schedules and using a calendar. Other alternatives could be utilized that are more cost effective. (CCPO Testimony) The evidence does not establish that the requested iPad would prevent institutionalization of Petitioner. The October 10, 2019, letter from the speech language pathologist indicates Petitioner would also be utilizing the iPad for other activities, such as downloading and watching movies. (Exhibit 1, p. 33) Further, other funding may be available for the iPad. The CCPO testified that upon learning there is a policy prohibiting coverage of iPads, The Center for TLC indicated they would look into grant funding to cover an iPad for Petitioner. (CCPO Testimony) Accordingly, the determination to deny Petitioner's request for an 11" Apple iPad pro with Wi-Fi and Cellular Service is upheld.

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 an 11" Apple iPad pro with Wi-Fi and Cellular Service.

IT IS THEREFORE ORDERED that

The Respondent's decision is AFFIRMED.

CL/dh

Colleen Lack
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	Belinda Hawks 320 S. Walnut St. 5th Floor Lansing, MI 48913
Authorized Hearing Rep.	[redacted] [redacted] [redacted] MI [redacted]
DHHS-Location Contact	David Pankotai Macomb County CMHSP 22550 Hall Road Clinton Township, MI 48036
Petitioner	[redacted] [redacted] [redacted] MI [redacted]
Agency Representative	Stacy Coleman-Ax 22550 Hall Road Clinton Twp., MI 48036