[redacted]
[redacted] MI [redacted]

Date Mailed: April 25, 2022
MOAHR Docket No.: 22-001240
Agency No.: [redacted]
Petitioner: [redacted]

**ADMINISTRATIVE LAW JUDGE: Robert J. Meade**

## DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on April 20, 2022. [redacted] Petitioner's mother and guardian, appeared and testified on Petitioner's behalf. [redacted] family friend, appeared as a witness for Petitioner.

Evan George, Fair Hearing Officer, appeared on behalf of Respondent, Washtenaw County Community Mental Health (hereafter CMH or Department). Katie Hoener, Program Administrator, appeared as a witness for the Department.

## ISSUE

Did the Department properly deny Petitioner's request for Assertive Community Treatment (ACT)?

## 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 diagnosed with unspecified schizophrenia spectrum and other psychotic disorder; schizophrenia; disruptive mood dysregulation disorder; and cannabis use disorder, severe. (Exhibit C, p 14; Testimony).

2. On October 20, 2021, Petitioner's mother and guardian requested ACT services on Petitioner's behalf. (Exhibit A, p 1; Testimony).

3. Petitioner previously received ACT services through CMH from approximately 2014 until May 2021, while those services were court ordered. In 2021, Petitioner was able to get the court order removed and he subsequently requested that all his services through CMH be terminated. (Exhibit H; Testimony).

4. Following the termination of Petitioner's CMH services, his mental health decompensated significantly, and he had to be hospitalized. Mental health services were again court ordered. (Exhibits C, E; Testimony).

5. On November 1, 2021, following a review of the request for ACT services, CMH sent Petitioner a Notice of Adverse Benefit Determination denying the request. (Exhibit B, pp 1-6; Testimony). The Notice indicated, in pertinent part:

> Current treatment team & guardian requested ACT level of care, which is being denied at this time. ACT attempted for many consecutive years to work with [redacted] on his mental health & substance use. [redacted] continues to believe he does not have a mental illness nor does he require medications to help with functioning in his daily life-he has always been clear that he does not want or feel he needs ACT services. Consumer requested a jury trial for his last AOT review (June), in which he was found by his peers not to require a court order for treatment. In addition, guardianship was dissolved during the summer of 2020 which ACT was not informed of until June 2021. [redacted] subsequently stopped taking medications and closed his case with WCCMH. Four months later, he was hospitalized and placed back on an AOT for mental health treatment & mom petitioned for guardianship (approved).
>
> Since 2014, ACT offered and tried medication changes/adjustments, 1:1 therapy, 1:1 peer services, psychoeducation groups, executed pick up orders for shots (preferred language), attempted SUD treatment (marijuana use has been a large barrier to progress), involved behavioral psychology for other treatment ideas, double team staff visits for safety concerns, etc. Even with daily monitoring of his oral medications (Depakote as a mood stabilizer), [redacted] demeanor, attitude and mental health did not improve.
>
> [redacted] meets the acuity for a high level of care, though he has adamantly refused to participate or engage in treatment.
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> (Exhibit B, p 1; Testimony).

6. On January 25, 2022, Petitioner's mother/guardian submitted a request for an internal appeal. (Exhibit D, pp 1-2; Testimony).

7. On February 8, 2022, following a Local Dispute Resolution Committee Meeting, the committee upheld the denial of ACT services. (Exhibit D, pp 1-2; Testimony).

8. On February 15, 2022, CMH sent a Notice of Resolution of Internal Review, which upheld the denial of ACT, concluding, in part:

> On January 25, 2022, Washtenaw County Community Mental Health (WCCMH) received your request for an internal appeal of the November 1, 2021, Adverse Benefit Determination for the denial of ACT services.
>
> The internal appeal was conducted on February 8, 2022, and this notice is to inform you of the outcome of that process.
>
> The WCCMH Local Review Committee determined that the denial of ACT services is upheld. WCCMH is authorizing residential placement, a level of care higher than ACT. WCCMH will begin to make referrals to appropriate co-occurring facilities.
>
> (Exhibit D, p 3; Testimony).

9. On March 24, 2022, the Michigan Office of Administrative Hearings and Rules received Petitioner's hearing request. (Exhibit D, pp 1-2).

## CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services. *See 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. *See 42 CFR 430.10.*

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection(s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS), the Michigan Department of Health and Human Services (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Health and Human Services to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.*

The CMH is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

The *Medicaid Provider Manual* articulates Medicaid policy for Michigan. It states in relevant part:

> **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; and

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and

- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and

- Made within federal and state standards for timeliness; and

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; 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; and

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

**2.5.D. PIHP DECISIONS**

Using criteria for medical necessity, a PIHP may:

- Deny services that are:

  - deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

  - experimental or investigational in nature; or

- for which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or

- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

With regard to ACT services, the Medicaid Provider Manual indicates:

**SECTION 4 – ASSERTIVE COMMUNITY TREATMENT PROGRAM**

Assertive Community Treatment (ACT) is a therapeutic set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team that includes case/care management, psychiatric services, counseling/psychotherapy, housing support, Substance Use Disorders treatment, and employment and rehabilitative services provided in the beneficiary's home or community.

ACT provides basic services and supports essential to maintaining the beneficiary's ability to function in community settings, including assistance with accessing basic needs through available community resources (such as food, housing, medical care and supports) to allow beneficiaries to function in social, educational, and vocational settings.

ACT is an individually tailored combination of services and supports that may vary in intensity over time and is based on individual need. ACT includes availability of multiple daily contacts and 24-hour, 7-days-per-week crisis availability provided by the multi-disciplinary ACT team which includes psychiatric and skilled medical staff. ACT services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of each beneficiary. Services are provided in the beneficiary's

residence or other community locations by all members of the ACT team staff.

The Prepaid Inpatient Health Plans (PIHPs) and the Community Behavioral Health Services Programs (CMHSPs) offer a continuum of adult services including case/care management, outpatient therapy, and psychiatric services that can be used in varying intensities and combinations to assist beneficiaries in a recovery-oriented system of care. The beneficiary's level of need and preferences must be considered in the admission process. ACT is the most intensive non-residential service in the continuum of care within the service array of the public behavioral health system.

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## 4.2 TARGET POPULATION

The intensity of ACT services is intended for the beneficiary with a primary diagnosis of serious mental illness and who, without ACT, would require more restrictive services and/or settings. ACT is not an appropriate service for a beneficiary with a primary diagnosis of a personality disorder, a primary diagnosis of a Substance Use Disorder, or a primary diagnosis of intellectual or developmental disability. A beneficiary with a primary diagnosis of a serious mental illness may also be diagnosed with a personality disorder or co-occurring Substance Use Disorder and benefit from ACT services.

ACT services are targeted to beneficiaries demonstrating acute or severe psychiatric symptoms that are seriously impairing the beneficiary's ability to function independently, and whose symptoms impede the return of normal functioning as a result of the diagnosis of a serious mental illness. Areas of impairment are significant and are considered individually for each beneficiary.

These areas of difficulty may include:

- Maintaining or having interpersonal relationships with family and friends;
- Accessing needed mental health and physical health care;

- Addressing issues relating to aging, especially where symptoms of serious mental illness may be exacerbated or confused by complex medical conditions or complex medication regimens;
- Performing activities of daily living or other life skills;
- Managing medications without ongoing support;
- Maintaining housing;
- Avoiding arrest and incarceration, navigating the legal system, and transitioning back to the community from jail or prison;
- Coping with relapses or return of symptoms given an increase in psychosocial stressors or changes in the environment resulting in frequent use of hospital services, emergency departments, crisis services, crisis residential programs or homeless shelters;
- Maintaining recovery to meet the challenges of a co-occurring Substance Use Disorder;
- Encountering difficulty in past or present progress toward recovery despite participation in long-term and/or intensive services.

**4.3 ESSENTIAL ELEMENTS**

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**In Vivo Settings** ACT teams provide a wide array of clinical, medical and rehabilitative services during face-to-face interactions designed to promote the beneficiary's growth in recovery. ACT services and supports are focused on acquiring needed behavioral health services, substance misuse services, physical health care, performing activities of daily living, obtaining and/or maintaining employment, developing leisure activities, developing and maintaining meaningful relationships, maintaining housing, avoiding arrest and incarceration, navigating the legal system, transitioning successfully into the community from jail or prison, and relapse prevention.

Services for ACT beneficiaries may include those defined elsewhere in this chapter, as well as others that are consistent with individual preferences, professionally

accepted standards of care, and that are medically necessary.

ACT services may be used as an alternative to hospitalization as long as beneficiary health and safety issues can be reasonably well-managed with ACT supports that do not require 24-hour-per-day supervision.

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**4.4 ELIGIBILITY CRITERIA**

Utilization of ACT in high acuity conditions and situations allows beneficiaries to remain in their community of residence and may prevent the use of more restrictive alternatives which may be detrimental to a beneficiary's existing natural supports and occupational roles. This level of care is appropriate for beneficiaries with a history of serious mental illness who may be at risk for inpatient hospitalization or intensive crisis residential or partial hospitalization services, but can remain safely in their communities with the considerable support and intensive interventions of ACT. In addition to meeting the following criteria, these beneficiaries may also be likely to require or benefit from continuing psychiatric rehabilitation.

*Medicaid Provider Manual*
*Behavioral Health and Intellectual and*
*Developmental Disability Supports and Services Chapter*
*October 1, 2021, pp 14-16; 31-37*
*Emphasis added*

CMH's Program Administrator (PA) testified that she has worked for CMH for 11 years and has been a PA overseeing the ACT program for the past 4 years. CMH's PA indicated that when a request for ACT services is received, staff review the beneficiary's diagnostic criteria for medical necessity and then meet with the individual to judge his or her willingness to participate in the services. CMH's PA noted that ACT is a high level of service involving up to ten people delivering medications and treatments to the beneficiary daily. Here, CMH's PA indicated that Petitioner did not indicate a willingness to participate in ACT services and all the information received was through either the hospital or Petitioner's mother/guardian. After this review, CMH's PA indicated that it was determined that Petitioner did not meet medical necessity criteria for ACT services because he was not willing to participate in the process, as evidenced by his refusal to engage in the services now and his history of not engaging in the services in the past. CMH's PA noted that Petitioner's current IPOS has a treatment plan that revolves all around getting Petitioner to engage in treatment.

CMH's PA testified that Petitioner's last IPOS while enrolled in ACT services was from June 2020 through June 2021, although the plan was terminated early (in May 2021) when Petitioner successfully petitioned the court through a jury trial to end court ordered treatment. CMH's PA noted that Petitioner then informed CMH that he wished to terminate all of his services, and after much deliberation, his case was closed. CMH's PA testified that during the period of June 2020 through May 2021, ACT staff attempted 50 face-to-face meetings with Petitioner in the community, but face-to-face meetings only occurred 25 times, or 50% of the time. CMH's PA explained that Petitioner often would not disclose his location to staff, he would not answer or open the door, or his mother/guardian would not wake him when staff arrived. CMH's PA noted that following these failed contacts Petitioner's mother/guardian would sometimes just come to the office, without Petitioner, and pick up his medications. (*See* Exhibit F). CMH's PA testified that on at least three occasions during this period, ACT staff had direct discussions with Petitioner's mother/guardian regarding Petitioner's failure to engage in services. (*See* Exhibit F, pp 41, 42, 50).

CMH's PA testified that after Petitioner discontinued all his services he decompensated quickly and was later hospitalized and treatment was again court ordered. CMH's PA opined that this decompensation likely had more to do with Petitioner stopping his regular injections of medication than his stopping ACT services. CMH's PA also opined that ACT was likely not going to benefit Petitioner now given that he would refuse to engage in the services. CMH's PA testified that Petitioner will be served best by whatever treatment he will engage in, which is not ACT. CMH's PA noted that the best setting to ensure that Petitioner takes his oral medications daily, and receives his regular medication injections, would be in a residential setting. CMH's PA indicated that since Petitioner will not agree to a residential placement, he will need to continue to work through his barriers with his current case manager, who has been very good with Petitioner so far. CMH's PA also noted that Petitioner's treatment continues to be affected by his significant cannabis use, which has been described as Petitioner using cannabis from sun-up until sun-down.

Petitioner's mother/guardian testified that she has basically been Petitioner's guardian for most of the time he has been with CMH. Petitioner's mother/guardian indicated that when she was not the guardian, she still had permission from the court to act on Petitioner's behalf. Petitioner's mother/guardian noted that Petitioner became obsessed with the guardianship, so it was suggested, by CMH and others, that she relinquish the guardianship. Petitioner's mother/guardian indicated, however, that this clearly did not work as Petitioner quit all his services, decompensated quickly, and ended up in the hospital. Petitioner's mother/guardian testified that she has had the guardianship reinstated and will not let it lapse again.

Petitioner's mother/guardian testified that she believes Petitioner's non-compliance with ACT services is simply a symptom of his illnesses and it is not uncommon for people with mental illness to believe they do not need any help. Petitioner's mother/guardian argued that CMH's refusal to properly force the services on Petitioner over the years created a monstrous situation and Petitioner would have done better if they were more forceful with him. Petitioner's mother/guardian noted that Petitioner's current case

manager is more forceful and that has been working well as Petitioner does respect authority.

Regarding the medication visits, Petitioner's mother/guardian testified that Petitioner often had such difficulties at night that she would not want to wake him up when ACT staff came in the morning. Petitioner's mother/guardian indicated that she did not believe Petitioner failed to engage in 25 out of 50 ACT visits in 2020 because she believes she probably drove him to the office 25 times to get his medications. Petitioner's mother/guardian testified that while the new case manager is fine and dandy, Petitioner needs to take his daily medications or there is going to be trouble. Petitioner's mother/guardian testified that if CMH had enforced the court order properly, and reported Petitioner's non-compliance to the judge when appropriate, Petitioner could have gotten to a place where he would engage more in ACT services. Petitioner's mother/guardian indicated that Petitioner does improve when he has more of his medication in his system. Petitioner's mother/guardian noted that Petitioner has now been in the hospital three times in the past six months because he is not regularly taking his medications. Petitioner's mother/guardian also noted that there were times when Petitioner was in ACT that he was in a better mental state. Petitioner's mother/guardian also pointed out that Petitioner was doing good taking his medication before the pandemic, so ACT reduced the daily trips from five per week to three per week, but when visits were reduced to one day per week during the pandemic, Petitioner began to worsen.

Petitioner's family friend testified that she has known Petitioner for many years, even before he had mental illness. Petitioner's family friend testified that the schizophrenics she has known have been aggressive and Petitioner's condition is going to lead to him getting into more trouble with the law. Petitioner's family friend testified that she understands Petitioner has been difficult, but the CMH has a responsibility to help him. Petitioner's family friend noted that Petitioner will abide by a court order and if CMH were tougher with him, he would do better. Petitioner's family friend testified that as it stands now there are no consequences to Petitioner for failure to comply with treatment.

Based on the evidence presented, Petitioner has proven, by a preponderance of the evidence, that the CMH erred in denying the request for ACT services. As indicated above, medically necessary services are those:

- 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.

Here, Petitioner requested ACT services, which, as indicated above, are targeted to:

> . . . beneficiaries demonstrating acute or severe psychiatric symptoms that are seriously impairing the beneficiary's ability to function independently, and whose symptoms impede the return of normal functioning as a result of the diagnosis of a serious mental illness. . . .
>
> These areas of difficulty may include:
>
> - Accessing needed mental health and physical health care;
> - Managing medications without ongoing support;
> - Coping with relapses or return of symptoms given an increase in psychosocial stressors or changes in the environment resulting in frequent use of hospital services, emergency departments, crisis services, crisis residential programs or homeless shelters;
> - Encountering difficulty in past or present progress toward recovery despite participation in long-term and/or intensive services.

Here, despite Petitioner's failure to fully engage in ACT services in the past, and his obviously misguided attempt to cancel not only ACT services, but all services, he clearly meets the medical necessity criteria for ACT services. CMH's only contrary argument is that Petitioner will not benefit from ACT services because of his failure to engage fully in those services in the past. However, the evidence shows that Petitioner was more stable while participating in ACT services than when he was not participating in ACT services. Petitioner's current treatment team has requested ACT services according to the Adverse Benefit Determination sent to Petitioner on November 1, 2021, so those providers also agree that ACT services are in Petitioner's best interest. And, CMH's argument that Petitioner never improved while receiving ACT services is without merit. As indicated above, medically necessary services also include those services that will "stabilize the symptoms of mental illness" or "maintain a sufficient level of functioning". In other words, a beneficiary need not "improve" while receiving a service for that service to be considered medically necessary.

Furthermore, as indicated above, ACT services are designed in part for individuals like Petitioner who have difficulties accessing needed care, managing medications, coping with return of symptoms resulting in frequent use of hospital services, and difficulty despite participation in long-term and/or intensive services. And, given that Petitioner's treatment is court ordered, it should not be a surprise to the CMH that Petitioner has

difficulty engaging in services. Also, while CMH's finding that Petitioner would be better served in a residential setting is certainly true, that finding cannot be a justification for denying Petitioner a lower level of services, especially when it is clear to all involved that Petitioner will never agree to a residential placement. Given Petitioner's refusal for such a placement, the next best option for him is ACT services, even if he does not fully engage in those services. At the very least, ACT services can assist in getting Petitioner the medication that he clearly needs to remain stable and functioning in the community. And, should ACT services somehow worsen Petitioner's conditions or his desire to engage in services, the CMH can always revisit the decision.

Therefore, given the above, the CMH improperly denied Petitioner's request for ACT services.

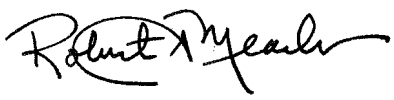
## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department improperly denied Petitioner's request for ACT services.

**IT IS THEREFORE ORDERED** that:

The Department's decision is **REVERSED.**

Within 10 days of the receipt of this Decision, the CMH must take steps to reassess Petitioner's needs consistent with this Decision and Order.



**Robert J. Meade**
Administrative Law Judge

RM:tem

**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**

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**Authorized Hearing Rep.**

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