[redacted]

Date Mailed: 11/15/2022
MOAHR Docket No.: 22-004389
Agency No.: 1193569586
Petitioner: Connor Brown

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

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

After due notice, a hearing via video conferencing was held on October 26, 2022. [redacted], Petitioner's legal guardian and mother, appeared and testified on Petitioner's behalf. Melissa Reed, an advocate with The Arc of Midland, and [redacted], Petitioner's father, also testified as witnesses for Petitioner. Katharine Squire, Provider Network Manager and Fair Hearing Officer, appeared and testified on behalf of the Respondent, Community Mental Health for Central Michigan (CMHCM or Respondent). Angela Zywicki, Utilization Manager, also testified as a witness for Respondent.

During the hearing, the following exhibits were entered into the record without objection:

Petitioner's Exhibits:

Exhibit #1: Request for Hearing

Exhibit #2: HAB Waiver Psychosocial Assessment – July 2022

Exhibit #3: Agency Data - Loren

Exhibit #4: Agency Data - Jordyn

Exhibit #5: 2016 Sleep Study

Exhibit #6: 2022 Sleep Study

Exhibit #7: 2022 PANDAS Recommendation

Exhibit #8: 2018 PANDAS Recommendation

Exhibit #9: Change in CLS and Mileage

Exhibit #10: Late PCP

Exhibit #11: 2022 PCP

Respondent's Exhibits:

Exhibit A: Hearing Summary

Exhibit B: MPM Excerpt on Medical Necessity

Exhibit C: CB Records

Exhibit D: Emails re: Authorizations

Exhibit E: Utilization Review

Exhibit F: Utilization Report through July 30, 2022

Exhibit G: Utilization Review Tool

ISSUE

Did Respondent properly deny in part Petitioner's request for reauthorization of Community Living Support (CLS) services and mileage?

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 twenty-three (23) year-old Medicaid beneficiary who has a legal guardian and who has been diagnosed with Down Syndrome; an unspecified disorder involving the immune mechanism; and sleep apnea. (Exhibit #1, page 3; Exhibit #2, pages 1, 5, 10, 21).

2. He is also considered medically fragile, and lost a large number of skills, following a pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections (PANDAS) episode. (Exhibit #2, page 15).

3. Due to his diagnoses and need for assistance, Petitioner has been approved for the Habilitation Supports Waiver (HSW) and services through Respondent. (Exhibit B, page 3).

4. Petitioner's services through Respondent include Community Living Supports (CLS), mileage, respite care, and case management. (Exhibit #2, page 10).

5. The contracted provider of Petitioner's CLS is ATI. (Exhibit C, page 9).

6. Beginning when he turned eighteen (18) years-old, Petitioner was approved for 68 hours per week of CLS and 850 miles per month of mileage. (Exhibit #2, page 15; Testimony of Petitioner's representative; Testimony of Utilization Manager).

7. However, beginning in at least 2021, Petitioner has significantly under-utilized those services. (Exhibit #2, pages 10, 15; Testimony of Petitioner's representative; Testimony of Utilization Manager).

8. During a July 7, 2022, Psychosocial Assessment of Petitioner, Respondent noted:

> [Petitioner] continues to need significant support. Services have been helpful this past year (although there still has not always been enough staff to fill his authorized CLS hours), and his parents would like to see the same level of support continue so that he may continue rebuilding skills.

Exhibit #2, page 10

9. The Psychosocial Assessment also provided:

> 2021: [Petitioner's] mom Dawn said that they have seen some improvement with [Petitioner] with plasmapheresis treatments. Currently they would like more staff to be able to fill hours approved, as it has been difficult to find enough staff.
>
> 2022: [Petitioner continues to need support and assistance with his ADLs daily. They are still working to fill all of [Petitioner's] authorized CLS hours, which continues to be a struggle to find enough staff.

Exhibit #2, page 10

10. On August 2, 2022, a meeting was held to develop Petitioner's Person-Centered Plan (PCP) for the upcoming plan year, *i.e.*, August 30, 2022, to June 29, 2023. (Exhibit #10, page 1; Exhibit #11, page 1).

11. In the proposed PCP drafted after that meeting, Petitioner was to receive the same amount of CLS and mileage previously authorized. (Testimony of Petitioner's representative; Testimony of Utilization Manager).

12. The proposed PCP was then sent to Respondent's Utilization Management (UM) Team for review. (Exhibit G; Testimony of Utilization Manager).

13. On August 12, 2022, the UM Team reviewed the requests for CLS and mileage and determined that only a lesser amount of those services should be approved given the past under-utilization. (Exhibit G).

14. That same day, a member of the UM team emailed Petitioner's Case Manager about the case, writing in part:

> [CLS] per week is way underutilized – average has been only 81 per week. I understand you have note that underutilization has been the result of difficulty with the staffing due to the pandemic, however, this pattern was occurring pre-pandemic as well. If staffing is not available at this time, I would recommend authoring the amount that ATI **CAN** commit to staffing and then requesting an increase in the future when there is additional support available. Right now, my recommendation would be 80-100 per week (20-25 hours).
>
> [Mileage] is also underutilized, likely the result of the underutilization of CLS. He has averaged less than 600 miles per month over the last 3-6 months so I would recommend a range of 480-600 per month until time additional staffing support is available.

Exhibit E, page 4

15. On August 15, 2022, the Case Manager emailed UM, writing in part that she would try to explain to Petitioner's guardian that Respondent was not trying to take services away, but only wanted to suspend or hold them until the provider has more staffing available. (Exhibit E, page 2).

16. The next day, another email from the Case Manager provided in part:

> Just wanted to update. I was able to catch up with Tammy from ATI. She let me know a couple things:
>
> * * *
>
> — As far as she knew, [Petitioner's] parents have been happy with the amount of staffing he is receiving and have not requested more, except that just recently they requested that she find someone to fill hours that were normally being worked by their regular staff person Loren
>
> — Tammy spoke to Loren and then emailed me what she said her schedule is going to be: M, W, F and every other Sat 1:30-6:30, and [Petitioner's guardian] has requested that Tammy hire someone for Tues. and Thurs. 2:00-5:00. So the total of that would be 26 hours per week (the one week Loren works the Saturday, and 21 hours the other week.)

Exhibit E, page 2

17. On August 17, 2022, UM emailed the Case Manager again and noted that, while Tammy from ATI was reporting that Petitioner's family was only looking for staffing that was already been provided, it would be beneficial to clarify with the family whether the staffing was adequate or there are unmet needs. (Exhibit E, page 1).

18. On August 19, 2022, Petitioner's Case Manager emailed Petitioner's guardian and wrote in part:

> Utilization Management is not contesting the medical necessity of the amount of CLS and transportation but what is authorized is supposed to closely match what is being used, and both were significantly under-utilized in the past year. I put the auth requests in for the same amount we have in current plan – 68 hours per week of CLS and 950 miles per month. So I am wondering if [Petitioner] still needs that amount of CLS? Tammy was under

> the impression that you were satisfied with the amount of staff he is receiving, except for needed to add the three hours on Tues and Thurs. The average amount has been 20.25 hours per week. UM said they would approve the (same) higher amount if it was actually the amount being utilized / provided, but since it has been so much lower than what was authorized, they are suggesting less and adding more later if and when these were to increase. Based on the utilization, they are suggesting 25-33 hours / week of CLS and 480-600 miles per month (which is well over what has been used.). I completely understand you likely being hesitant about this based on your past experiences with all of this. If you wanted to meet with me and my supervisor . . . to discuss we could definitely do that.

Exhibit D, page 5

19. On August 24, 2022, Petitioner's guardian wrote back in response:

> I'll be honest, I am really reluctant to change anything. I hear nightmare stories from other families that once you surrender your hours/mileage you won't be able to get them back (despite what CMH promises). With the experience we had last year with CMH, I can see that as a reality. [Petitioner] was given those hours at age 18 based on his medical needs and since his medical needs have not changed why would we change the hours/mileage?
>
> Can you clarify: Are his CLS hours/respite hours and mileage based on usage or on his medical needs?

Exhibit D, page 5

20. On August 25, 2022, the Case Manager then wrote in part:

> I can certainly understand your reluctance, but UM and my supervisor are both ensuring that they will increase them if and when the utilization increases. Even though it's based on

> medical necessity they cannot authorize amounts that are not being used because of Medicaid guidelines and the plan of service needing to be in compliance with that. So really it is technically based on both. I was also told by UM that if a higher amount is authorized that what is being provided, it could appear that ATI is not providing the amount they are supposed to and then they would not be in compliance with the rules.

Exhibit D, page 4

21. That same day, Respondent also sent Petitioner's guardian an Adverse Benefit Determination stating that Petitioner's request for CLS and mileage was denied in part, and that only 132 units of CLS per week and 600 units of mileage per month would be approved. (Exhibit D, page 2

22. On August 26, 2022, Respondent sent Petitioner's guardian a copy of a PCP with the reduced authorization for her review and signature. (Exhibit #1, page 5).

23. On August 29, 2022, Petitioner's guardian wrote that they disagreed with any reduction in hours and mileage, and they wanted to know what the next step was. (Exhibit D, pages 4-5).

24. Respondent then advised Petitioner's guardian to request a secondary review of the decision with Respondent. (Exhibit D, pages 2-3).

25. On September 1, 2022, Petitioner's guardian filed an Internal Appeal with Respondent with respect to that Notice of Adverse Benefit Determination. (Exhibit #1, page 7).

26. On September 15, 2022, Respondent sent Petitioner written notice that the Internal Appeal had been denied and that the decision to only approve 132 units of CLS per week and 600 units of mileage per month was being upheld. (Exhibit #1, page 7).

27. With respect to the reason for the Internal Appeal decision, the notice stated:

> In the 1915 c Home and Community Based waiver renewal submitted by MDHHS to the Centers for Medicare and Medicaid there is a performance standard that reads as follows:

> "Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency in the service plan."
>
> In reviewing the prior year's IPOS amount, scope, duration and frequency specified, it is clear that the services were not delivered in accordance with that plan of service which led to the reduction in this year's plan following review of the request. It is important to note that requests to modify the plan and services can be made at any time should circumstances change and a new review of medical necessity can be completed on the updated information. When reviewing the number of CLS units used over the time period of 10/3/21-8/12/22 the weekly average was 83. The highest weekly usage was 132 units in a week. When reviewing the transportation or mileage used on average by month it was 531. With a total usage of 5,541 miles.
>
> Due to the under usage in the prior IPOS the reduction in services is upheld and the appeal denied. It is recommended the Case Manager and family continue to work together for tracking of care needs and updating the IPOS if [Petitioner] is needing more medically necessary services.

Exhibit #1, page 7

28. On September 23, 2022, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter. (Exhibit #1, pages 1-8).

29. Petitioner's services were maintained at their previous level while the State fair hearing process proceeded. (Exhibit #11, page 1).

CONCLUSIONS OF LAW

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

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> *42 CFR 430.10*

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

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s)) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…
>
> *42 USC 1396n(b)*

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

Here, as discussed above, Petitioner has been receiving Community Living Supports (CLS) and related mileage through the HSW, and, with respect to such services, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES**
>
> Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid covered state plan services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process.
>
> * * *
>
> Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are:
>
> - Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with:
>
>   - Meal preparation;

- Laundry;
- Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services);
- Activities of daily living, such as bathing, eating, dressing, personal hygiene; and
- Shopping for food and other necessities of daily living.

- Assisting, supporting and/or training the beneficiary with:
  - Money management;
  - Non-medical care (not requiring nurse or physician intervention);
  - Socialization and relationship building;
  - Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through MDHHS or health plan) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence);
  - Leisure choice and participation in regular community activities;
  - Attendance at medical appointments; and
  - Acquiring goods and/or services other than those listed under shopping and non-medical services.
- Reminding, observing, and/or monitoring of medication administration.

The CLS do not include the costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

For beneficiaries living in unlicensed homes, CLS assistance

with meal preparation, laundry, routine household care and maintenance, ADL, and/or shopping may be used to complement Home Help services when MDHHS has determined the individual's need for this assistance exceeds Home Help service limits. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help. **(revised 4/1/22)** CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings.

If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADL, and/or shopping, the beneficiary must request Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. **(revised 4/1/22)** If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

Developmental Disability Supports and Services Chapter
Pages 110-112
(Internal highlighting omitted)

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

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

2.5.B. DETERMINATION CRITERIA

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

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

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

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

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

- Made within federal and state standards for timeliness;

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

- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;

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

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

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

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

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:

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

  - that are experimental or investigational in nature; or

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

- Employ various methods to determine amount, scope and duration of services, including prior

> authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.
>
> A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.
>
> *MPM, July 1, 2021 version*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *Pages 14-16*

Here, as discussed above, while Petitioner requested a reauthorization of 68 hours per week of Community Living Supports (CLS) and 850 miles per month of mileage, Respondent denied that request and only approved 33 hours of CLS per week and 600 miles per month.

In support of that decision, Respondent's representative noted that the above definition of medical necessity permits Respondent, taking into account a number of factors, including prior authorizations, to deny services that are deemed ineffective or for which there exist other appropriate services that meet the standards for medical necessity; and that Respondent found that a reduced authorization was proper in this case given that policy language and Petitioner's past under-utilization of services. She did acknowledge that the approved PCP was sent to Petitioner's guardian late

Respondent's Utilization Manager also testified regarding the decision in this case and described how Respondent determined that a reduced amount of services was sufficient to meet Petitioner's goals. In particular, she testified that there needs to be a "right-sized" authorization and, while a reduction would not be in order if the under-utilization was due to staffing shortages, here both the contracted provider and Petitioner's guardian reported Petitioner's satisfaction with the amount being used and, even considering the under-utilization, there was no request for more hours.

In response, Petitioner's mother/guardian testified that this was the second year in a row that Petitioner's PCP was late. She also testified that Petitioner's medical needs have not improved, with his sleep issues only worsening. She further testified that she has been continuously working with the contracted provider to find staff for Petitioner's CLS hours, but that that it is an ongoing issue and they do not have coverage for the authorized hours. Petitioner's guardian also testified that, as Petitioner cannot be left unsupervised, Petitioner's parents must cover any staffing shortages themselves.

According to Petitioner's guardian, she has repeatedly emailed Respondent about the staffing shortages and the need for more caregivers. However, she also testified that

she did not include any such emails as part of her exhibits in this matter. She further testified that she reported the staffing issues to Petitioner's Case Manager every month.

The Advocate from Arc of Midland similarly testified regarding Petitioner's difficulties in finding staffing, while also noting that there have been staffing shortages around the county, even predating the COVID-19 pandemic. She further testified that Petitioner's medical needs have not changed and noted that, regardless of what is approved, Petitioner is only billing for the actual hours used.

Petitioner's father testified regarding the mileage reduction and described how the under-utilization of those services is related in part to the staffing shortage.

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

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

Petitioner was previously authorized for the amount of CLS and mileage that he now seeks, and it is undisputed that there has not been any improvement in his conditions or needs that would necessitate a reduction in those services, but that alone does not warrant that the requested services be reauthorized and the record in this case instead demonstrates that the reduced authorization was proper.

For example, it is also undisputed that Petitioner has been significantly under-utilizing his approved CLS and mileage for quite some time, and the new authorization both tracks what he has been using and appears sufficient to meet the goals of his plan given the past usage.

Moreover, while the Psychosocial Assessment noted that the under-utilization was due to staffing shortages, Petitioner's contracted provider expressly reported that Petitioner was mainly satisfied with the services being provided, with no indication that the previously approved amount was necessary.

Similarly, when the Case Manager contacted Petitioner's guardian directly to inquire whether Petitioner needed the additional services, Petitioner's guardian only expressed a desire to maintain the previous amount because she was worried that they would not get them back later if necessary, and there was nothing about the hours currently being needed.

To the extent Petitioner's circumstances change or his guardian has additional or updated information to provide, then Petitioner's guardian can always request

additional services in the future along with that information. With respect to the decision at issue in this case however, Respondent's decision must be affirmed given the available information and applicable policies.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied in part Petitioner's request for CLS and mileage services.

IT IS THEREFORE ORDERED that

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

Steven Kibit

SK/cg

Steven Kibit
Administrative Law Judge

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

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

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

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

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

Via Electronic Mail:

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

DCH Department Representative
Katherine Squire
CMH of Central Michigan
301 South Crapo St.
Mt. Pleasant MI 48858
ksquire@cmhcm.org

Via First Class Mail:

Petitioner
[redacted]

Authorized Hearing Representative
[redacted]