STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

MARLON I. BROWN, DPA
ACTING DIRECTOR

[redacted]
[redacted] MI [redacted]

Date Mailed: October 11, 2023
MOAHR Docket No.: 23-004182, 23-004183
Agency No.:
Petitioners: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

The above two matters are before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) upon Petitioners' requests for hearing and pursuant to MCL 400.9; 42 CFR 431.200 *et seq.*; and 42 CFR 438.400 *et seq.*

On July 28, 2023, Petitioners [redacted] and [redacted] (Petitioners) each filed requests for hearing through their guardian against Respondent Area Agency on Aging of Northwest Michigan (Respondent or AAANM).

With due notice, separate telephone hearings were scheduled for August 29, 2023.

On August 8, 2023, MOAHR received a Notice of Appearance and Request for Adjournment from the Respondent. In that request, Respondent asked that the hearings be rescheduled due to an unavoidable scheduling conflict.

The ALJ then found good cause for granting the request for adjournment. He also determined that the matters should be consolidated for purposes of hearing given that Petitioners filed a joint request for hearing; Respondent filed a joint motion for adjournment; and past administrative hearings involving the parties have always been consolidated by agreement of the parties. He further determined that, given the large number of issues identified in the joint request for hearing, the parties should submit their proposed exhibits two weeks prior to the hearing and that the hearing should be scheduled for an entire day.

After due notice, a telephone hearing was held and completed on September 13, 2023. [redacted] Petitioners' mother and legal guardian, appeared and testified on Petitioners' behalf. Attorney Leslie Dickinson represented Respondent, with Amanda Moleski, Respondent's Director of Quality and Utilization Management, testifying as a witness.

During the hearing, Petitioners' representative submitted an evidence packet that was admitted into the record as Exhibit #1. Respondent also submitted twenty-eight (28) exhibits that were admitted into the record as Exhibits A-BB, with Exhibits H, V, AA, and BB admitted over Petitioners' representative's objections.[1]

As discussed during the hearing, Petitioners are receiving services through Respondent pursuant to MI Choice, a waiver program operated by the Michigan Department of Health and Human Services (Department) to deliver home and community-based services to elderly persons and persons with physical disabilities who meet the Michigan nursing facility level of care criteria.

The program is funded through the federal Centers for Medicare & Medicaid Services (CMS) to the Department, with regional agencies, in this case Respondent, functioning as the Department's administrative agency.

> Waivers are intended to provide the flexibility needed to enable States to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of beneficiaries. Waivers allow exceptions to State plan requirements and permit a State to implement innovative programs or activities on a time-limited basis, and subject to specific safeguards for the protection of beneficiaries and the program. Detailed rules for waivers are set forth in subpart B of part 431, subpart A of part 440, and subpart G of part 441 of this chapter.
>
> *42 CFR 430.25(b)*

A waiver under section 1915(c) of the Social Security Act allows a State to include as "medical assistance" under its plan, home and community-based services furnished to recipients who would otherwise need inpatient care that is furnished in a hospital, SNF (Skilled Nursing Facility), ICF (Intermediate Care Facility), or ICF/MR (Intermediate Care Facility/Mentally Retarded) and is reimbursable under the State Plan. *See* 42 CFR 430.25(c)(2).

Types of services that may be offered through the waiver program include:

> Home or community-based services may include the following services, as they are defined by the agency and approved by CMS:
>
> (1) Case management services.
>
> (2) Homemaker services.

[1] Petitioners objected on the basis that past actions or decisions were irrelevant, but the ALJ found that they were relevant, at the very least, to the history of the cases and as potentially persuasive authority.

(3) Home health aide services.

(4) Personal care services.

(5) Adult day health services.

(6) Habilitation services.

(7) Respite care services.

(8) Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness, subject to the conditions specified in paragraph (d) of this section.

(9) Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization.

42 CFR 440.180(b)

Here, eleven issues through MI Choice were specifically identified in Petitioners' request and addressed during the hearing. The issues were numbered #1-#6, #8-#10 and #12-#13, with no Issue #7 and Issue #11 withdrawn at the onset of the hearing.

Each of those eleven remaining issues will now be addressed in turn, and, for the reasons discussed below, the undersigned ALJ finds that Respondent's actions should be affirmed in part and reversed in part.

Issue #1

ISSUE

Whether Respondent properly denied Petitioners' requests for hand sanitizer?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On March 10, 2023, Respondent sent Petitioners a Notice of Adverse Benefit Determination stating that their request for hand sanitizer through Respondent had been denied. (Exhibit A, pages 2-4).[2]

[2] Respondent's Exhibits were collectively Bates-stamped, and the ALJ will refer to the Bates-stamped number when citing to the exhibits for convenience.

2. With respect to the reason for the decision, the notice stated:

> **The CDC recommends the use of soap and water over hand sanitizer to reduce spread of germs and clean hands. Per the last assessment, soap and water are available to workers and guests. However, per guardian request, supports coordination has been done to provide liquid hand sanitizer through local donated sources for ease and convenience of guests and workers. At this time, gel hand sanitizer is not available through donated sources. The Medicaid Provider Manual, section 4.1.O Specialized Medical Equipment and Supplies, states: "This service excludes items that are not of direct or remedial benefit to the participant". Gel hand sanitizer is not deemed to provide direct medical or remedial benefit, in comparison to handwashing or liquid sanitizer that has been made available per guardian request. Previous supports coordinators have assessed that effected and appropriate hand cleaning methods are available in this participant's home.**

Exhibit A, page 2

3. On March 12, 2023, Petitioners filed an Internal Appeal with Respondent regarding that decision. (Exhibit #1, page 9; Exhibit D, page 21).

4. On March 31, 2023, Respondent sent Petitioners a Notice of Internal Appeal Decision-Denial stating that their Internal Appeal had been denied. (Exhibit #1, pages 9-12; Exhibit D, pages 21-24).

5. With respect to the reason for the decision, the notice stated:

> Review of the record and assessment data indicates access to soap and water in the beneficiaries' home is available and accessible by caregiver staff and can be accessed and used for appropriate hand hygiene practices to reduce the risk and spread of infection.
>
> Per The Centers for Disease Control and Prevention (CDC), best practices recommend that:
>
> > "washing hands with soap and water whenever possible because handwashing reduces the amounts of all types of germs and chemicals on hands."

Due to complex nature of beneficiaries' condition, handwashing practices are necessary. Additionally, recent letter provided by Dr. Singer from beneficiary guardian recommends to maintain as much hygiene as possible due to abnormal immune responses. Record indicates supports coordinators have assessed and identified that effective and appropriate hand hygiene methods are available and accessible within the home, as recommended by the Centers for Disease Control and Prevention, through soap and water, as most effective way to reduce spread of infection. Requested service item was identified to not be appropriate, as mechanisms and access to soap and water are available and accessible to caregivers and all others in the home.

Upon initial request of service item, it was identified that this item was not an eligible service item and was not appropriate, as alternative, and more effective methods for hand washing are available and accessible in the home. At that time, supports coordination was performed to assist in guardian in obtaining hand sanitizer available in the community through donated supplies. AAANM is able to assist in obtaining hand sanitizer through donated resources, as they remain available, and has offered beneficiary guardian the option of donated hand sanitizer, as requested. The service item is not obtained through Medicaid MI Choice Waiver as was identified as not appropriate service item. AAANM plans to continue coordination and assist in obtaining available hand sanitizer from donations in the community, as it remains available. When the donated hand sanitizer is no longer available, AAANM is no longer able to provide this item.

42 CFR 440.230(d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

Exhibit #1, pages 9-10
Exhibit D, pages 21-22

6. On April 17, 2023, Petitioners again requested hand sanitizer through Respondent. (Exhibit #1, page 105).

7. As part of that request, Petitioners included letters from a Dr. Scott Selle, M.D., stating that Petitioners' home "should be treated as a medical setting in regard to hand hygiene guidelines from the CDC." (Exhibit #1, pages 109-110).

8. Petitioners also included a progress note from a Dr. Benjamin Herschel Singer, M.D., stating in part:

> [Petitioner's guardian] questions whether hand sanitizer is medically necessary and should be covered by [Respondent] as part of nursing care. I agree that since both [Petitioners] have now grown distinct respiratory pathogens (with [redacted] having grown E coli and both growing PsA) that it is to their advantage to maintain as much hygiene as possible. In addition, they have abnormal immune responses due to AGS.

Exhibit #1, page 112

9. On April 21, 2023, Respondent sent Petitioners a Notice of Adverse Benefit Determination stating that the new request for Respondent to purchase hand sanitizer had been denied, identifying the same reason the previous request was denied as the basis for the action. (Exhibit E, pages 30-32).

10. On May 11, 2023, Petitioners filed an Internal Appeal with Respondent regarding that decision. (Exhibit #1, page 19; Exhibit E, page 26).

11. On June 7, 2023, Respondent sent Petitioners a Notice of Internal Appeal Decision-Denial stating that their Internal Appeal had been denied for the same reason the previous Internal Appeal was denied. (Exhibit #1, pages 19-20; Exhibit E, pages 26-29).

12. On June 28, 2023, MOAHR received the request for hearing filed by Petitioners in these consolidated matters, including a request with respect to hand sanitizer. (Exhibit #1, pages 1-8).

CONCLUSIONS OF LAW

The Medicaid Provider Manual (MPM) outlines the governing policy for the MI Choice and, with respect to services in general and goods and services, including specialized good and services, in particular, the applicable version of the MPM states in part:

> **SECTION 4 – SERVICES**
>
> The array of services provided by the MI Choice program is subject to the prior approval of CMS. Waiver agencies are required to provide any waiver service from the federally approved array that a participant needs to live successfully in the community, that is:
>
> - indicated by the current assessment;
> - detailed in the person-centered service plan (PCSP); and
> - provided in accordance with the provisions of the approved waiver.
>
> Services must not be authorized unless they are defined in the PCSP and must not precede the establishment of a PCSP. Waiver agencies cannot limit in aggregate the number of participants receiving a given service or the number of services available to any given participant. Participants have the right to receive services from any willing and qualified provider within the waiver agency's provider network. When the waiver agency does not have a willing and qualified provider within their network, the waiver agency must utilize an out-of-network provider at no cost to the participant until an in-network provider can be secured. (Refer to the Providers section of this chapter for information on qualified provider standards.)
>
> MDHHS, waiver agencies, and direct service providers must not impose a copayment or any similar charge upon participants for waiver services. MDHHS and waiver agencies do not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
>
> Although MI Choice participants must have services approved by the waiver agency, participants have the option to select any participating provider in the waiver agency's provider network, thereby ensuring freedom of choice.

Services paid for with MI Choice funds must not duplicate nor replace services available through the State Plan. Where applicable, the participant must use State Plan, Medicare, or other available payers first. MI Choice is the funding source of last resort. The participant's preference for a certain provider is not grounds for declining another payer in order to access waiver services.

Providers must have previous relevant experience or training for the tasks specified and authorized in the PCSP. The waiver agency must deem the chosen provider capable of performing the required tasks.

For services involving transportation paid for with MI Choice funds, the Secretary of State must appropriately license all drivers and vehicles, and all vehicles must be appropriately insured as required by law.

Healthcare Common Procedure Coding System (HCPCS) codes for each service can be found in the Directory Appendix of the Medicaid Provider Manual.

* * *

4.1.I. GOODS AND SERVICES

Definition	Goods and Services are services, equipment or supplies not otherwise provided through either the MI Choice Waiver or the State Plan that address an identified need in the person-centered service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements.
Requirements	Each item or service specified in the PCSP must meet the following requirements: ▪ Decrease the need for other Medicaid services. ▪ Promote inclusion in the community. ▪ Increase the participant's safety in the

	home environment. ▪ The participant does not have the funds to purchase them or they are not available through another source. Goods and Services are only approved by CMS for participants choosing the self-determination option. Self-directed Goods and Services are purchased from the participant-directed budget. Experimental or prohibited treatments are excluded. Goods and Services must be documented in the person-centered service plan.
Limitations	This service is only available to those participants choosing self-determination. This service excludes experimental or prohibited treatments.

* * *

4.1.O SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

Definition	Specialized Medical Equipment and Supplies includes devices, controls, or appliances which enable participants to increase their abilities to perform ADL, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items. This includes durable and non-durable medical equipment and medical supplies not available under the State Plan that are necessary to address the participant's functional limitations. All items must be specified in the PCSP. This service excludes those items that are not of direct medical or remedial

	benefit to the participant. Durable and non-durable medical equipment and medical supplies not available under the State Plan that are necessary to address the participant's functional limitations may be covered by this service. Medical equipment and supplies furnished under the State Plan must be procured and reimbursed through that mechanism and not through MI Choice. All items must be specified in the participant's PCSP. All items must meet applicable standards of manufacture, design and installation. Coverage includes training the participant or caregiver(s) in the operation and maintenance of the equipment or the use of a supply when initially purchased. Waiver funds may also be used to cover the maintenance costs of equipment.
Requirements	Waiver agencies may obtain some items directly from a retail store that offers the item to the public (i.e., Wal-Mart, Meijer, Costco, etc.). When utilizing retail stores, the waiver agency must ensure the item purchased meets the service standards. The waiver agency may choose to open a business account with a retail store for such purchases. The waiver agency must maintain the original receipts and maintain accurate systems of accounting to verify the specific participant who received the purchased item. The waiver agency must document the medical or remedial benefit the equipment or supply provides to the participant in the participant's case record. Where feasible, the waiver agency or direct service provider must seek affirmation of the need for the item provided from the participant's physician. The waiver agency may provide liquid

	nutritional supplements as a specialized medical supply. The participant's physician or other health care professional must first order liquid nutritional supplements as described in the HDM service standards. When liquid nutrition supplements a participant's diet, the supports coordinator must ensure the physician or other health care professional renews the order for liquid nutritional supplements every six months.
Limitations	The waiver agency may not authorize MI Choice payment for prescription medications not found on the Medicaid prescription drug formulary. If a participant requires a medication not found on the formulary, the waiver agency, participant, or pharmacy must seek prior authorization of payment through the State Plan. Regardless of approval or denial of State Plan prior authorization, MI Choice funds must not pay for the medication. The waiver agency must not authorize MI Choice payment for herbal remedies or other over-the-counter medications for uses not authorized by the Food and Drug Administration (FDA).

MPM, April 1, 2023 version
MI Choice Chapter, pages 18, 34, 45-46

Moreover, while specialized medical equipment and supplies are covered services, they must still be medically necessary to be approved. *See* MPM, April 1, 2023 version, MI Choice Chapter, page 18; 42 CFR 440.230(d).

Here, Respondent denied Petitioners' requests for hand sanitizer pursuant to the above policies and on the basis that the requested hand sanitizer is not medically necessary.

In appealing the denials, Petitioners bear the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned ALJ is limited to reviewing Respondent's decisions in light of the information available at the time the decisions were made.

Given the available information and applicable policies in this case, Petitioners have not met that burden of proof and Respondent's decisions must therefore be affirmed.

Both parties agree that diligent hand hygiene is necessary in caring for Petitioners, but the record does not demonstrate that hand sanitizer, as part of specialized medical equipment and supplies, is a necessary part of that hand hygiene given the undisputed availability of soap and water.[3]

In response, Petitioners' representative asserts that the CDC recommends the use of an alcohol-based hand rub (Exhibit #1, pages 115-116) in medical settings and that Petitioners' home should be treated as a medical setting, as it was during the COVID-19 pandemic. However, that testimony is unsupported and unpersuasive.

Moreover, while Petitioners' representative points to documentation from Petitioners' medical providers in support of her argument, that documentation is also unpersuasive. For example, while Dr. Selle wrote that Petitioners' home should be treated as a medical setting and that alcohol-based hand sanitizer should be used as the primary method of hand hygiene, he failed to explain the basis of those opinions or identify any specific supporting details. Also, Dr. Singer's note merely stated that it would be to Petitioners' advantage to maintain as much hygiene as possible, and he did not assert that that hand sanitizer was medically necessary, despite noting that Petitioners' representative had directly asked for an opinion on that.

Petitioners do not have sinks next to their beds, with a bathroom between their two bedrooms, and it may be more convenient to have hand sanitizer nearby, but Petitioners have failed to show by a preponderance of the evidence that the requested supplies are medically necessary and the denials in dispute for Issue #1 should therefore be affirmed.

Issue #2

ISSUE

Whether Respondent properly denied Petitioners' requests for deep cleaning chore services?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. At all times relevant to this matter, Petitioners have been approved for deep cleaning chore services. (Testimony of Petitioner's representative;

[3]The requested hand sanitizer and other items discussed below cannot be covered as "goods and services" as that service is only available to participants choosing self-determination and Petitioner do not utilize self-determination.

Testimony of Director of Quality and Utilization Management).

2. However, the services have not been provided consistently or in the amounts approved. (Testimony of Petitioner's representative; Testimony of Director of Quality and Utilization Management).

3. On March 18, 2023, Petitioners filed an Internal Appeal with Respondent regarding their deep cleaning chore services. (Exhibit #1, page 13; Exhibit F, page 38).

4. In that appeal, Petitioners discussed Respondent's failure to provide the approved services and a refusal to extend the authorization of unused services to make up for its failure. (Exhibit #1, page 121).

5. On April 3, 2023, Respondent sent Petitioners a Notice of Appeal Decision-Not Applicable. (Exhibit #1, pages 13-14; Exhibit F, pages 38-40).

6. Specifically, that notice stated in part:

> We found your internal appeal request to be not applicable for appeal as service request of deep cleaning/chore services through Medicaid MI Choice Waiver was not denied. No Adverse Benefit Determination was issued for this request, as the service was not denied. Service request has been approved, and AAANM has been providing supports coordination since October 2022 to assist in finding a provider to provide service. Communications of searching for a provider have been provided to beneficiary guardian, with updates on status of providers for service. Unable to secure service provider due to lack of availability from caregiver/provider agencies.
>
> At time of request for appeal (March 18, 2023), AAANM Supports Coordinators had not found a provider for the service. Routine calls over the last 6 months took place in search of a provider for service. On March 29, 2023, AAANM Supports Coordinator was able to secure and schedule a provider for deep cleaning/chore services. Deep cleaning/chore services available for Monday April 2, 2023 Tuesday April 4, 2023 and Thursday April 6, 2023 based on provider availability. Provider availability for service communicated to beneficiary guardian on March 31, 2023 via email. Response from beneficiary guardian

> received April 3, 2023 indicating dates of Tuesday April 4, 2023 and Thursday April 6, 2023 for deep cleaning/chore services, based on provider availability and beneficiary/guardian availability and preference. Communicated dates of service-to-service provider on April 3, 2023 and secured dates of services. No service has been denied. Service delayed in delivery due to provider unavailable for service delivery.
>
> *Exhibit #1, page 13*
> *Exhibit F, page 38*

7. On April 6, 2023, Petitioners filed another Internal Appeal regarding their deep cleaning chore services. (Exhibit #1, page 15; Exhibit F, page 34).

8. On April 13, 2023, Respondent sent Petitioners a Notice of Internal Appeal Decision-Approved stating that Petitioners' Internal Appeal had been approved. (Exhibit #1, pages 15-18; Exhibit F, pages 34-37).

9. Specifically, the notice stated in part:

> We found your internal appeal request to be approved for deep cleaning/chore services. The services requested of deep cleaning/chore services through Medicaid MI Choice Waiver was not denied. No Adverse Benefit Determination was issued for this request, as the service was not denied. Service request has been approved, and AAANM has been providing supports coordination since October 2022 to assist in finding a provider to provide service. Communications of searching for a provider have been provided to beneficiary guardian, with updates on status of providers for service. AAANM has been unable to secure service provider due to lack of availability from caregiver/provider agencies within the region.
>
> According to the Medicaid Provider Manual, version dated April 1, 2023, MI Choice Waiver chapter, section 6.6 Follow-up Monitoring states:
>
> > When SCs attempt to arrange a service that cannot start within 30 days, they must contact the provider agency every 30 days until a provider can implement the service.

> When a network provider is not available, the waiver agency must use an out-of-network provider to furnish approved services until an in-network provider is secured.

At time of initial request for appeal (March 18, 2023), AAANM Supports Coordinators had not found a provider for the service. Routine calls, every 30 days at a minimum, over the last 6 months took place in search of a provider for service. On March 29, 2023, AAANM Supports Coordinator was able to secure and schedule a provider for deep cleaning/chore services. Deep cleaning/chore services available for Monday April 2, 2023 Tuesday April 4, 2023 and Thursday April 6, 2023 based on provider availability. Provider availability for service communicated to beneficiary guardian on March 31, 2023 via email. Response from beneficiary guardian received April 3, 2023 indicating dates of Tuesday April 4, 2023 and Thursday April 6, 2023 for deep cleaning/chore services, based on provider availability and beneficiary/guardian availability and preference. Communicated dates of service-to-service provider on April 3, 2023 and secured dates of services. No service has been denied. Service delayed in delivery due to provider unavailable for service delivery. An appeal response was sent to guardian and on 4/6/2023 a new appeal was filed, indicated concerns were not addressed.

A new appeal was opened. As of 4/13/2023, AAANM received notice that due to unexpected circumstances, deep cleaning services were only able to be provided for a total of 4 hours on 4/6/2023. The other previously scheduled dates to provide service were cancelled due to worker inability to perform the service as scheduled. The information on cancellation was communicated to beneficiaries' guardian on 4/10/2023 by Kristi, at Bay Home Health, who was the scheduled provider of service.

AAANM has resumed the process of contacting providers within the region, including out of network providers, to find and secure a provider available to conduct the service as requested. As of 4/13/2023, AAANM has not yet been able to secure a provider.

> AAANM is approving the hours of deep cleaning from the first quarter (up to 12 hours total) and will approve up to additional 12 hours for second quarter deep cleaning service for adequate cleaning to take place, upon finding and securing a provider for service. On 4/6/2023, 4 of those authorized hours were conducted for the service of deep cleaning. A total of up to 20 hours will be approved for the remaining authorized service to account for previously authorized first and second quarter of services that have yet to be provided due to lack of provider staff able to perform the service.

Exhibit #1, pages 15-16
Exhibit F, pages 34-35

10. On May 1, 2023, Respondent also sent Petitioners a written response to grievances filed regarding the provision, or lack thereof, of Petitioners' authorized deep cleaning chore services. (Exhibit G, page 42).

11. On June 28, 2023, MOAHR received the request for hearing filed by Petitioners in these consolidated matters. (Exhibit #1, pages 1-8).

CONCLUSIONS OF LAW

With respect to chore services, the applicable version of the MPM states in part:

4.1.B. CHORE SERVICES

Definition	Chore Services are needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, securing loose rugs and tiles, and moving heavy items of furniture in order to provide safe access and egress. Other covered services might include yard maintenance (mowing, raking and clearing hazardous debris such as fallen branches and trees) and snow plowing to provide safe access and egress outside the home. These types of services are allowed only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver,

	landlord, community or volunteer agency, or third-party payer is capable of, or responsible for, their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.
Requirements	Waiver funds used to pay for chore services may include materials and disposable supplies used to complete the chore tasks. The waiver agency may also use waiver funds to purchase or rent the equipment or tools used to perform chore tasks for waiver participants. Only properly licensed suppliers may provide pest control services.

MPM, January 1, 2023 version
MI Choice Waiver Chapter, page 22

Moreover, while chore services are covered services, they must still be medically necessary to be approved. *See* MPM, January 1, 2023 version, MI Choice Chapter, page 18; 42 CFR 440.230(d).

Here, it is undisputed that the deep cleaning chore services are medically necessary and that they have been approved by Respondent for both Petitioners. However, it is also undisputed that the approved services have not been consistently provided due to staffing issues.

To the extent Petitioners requested a hearing with respect to Respondent's failure to provide the authorized chore services, their appeal should be dismissed as there has been no adverse benefit determination that the undersigned ALJ would have jurisdiction over.

42 CFR 438.402(a) requires that Respondent have a grievance and appeal system in place for enrollees such as Petitioners. Moreover, in defining specific terms, 42 CFR 438.400(b) provides:

> As used in this subpart, the following terms have the indicated meanings:
>
> *Adverse benefit determination* means, in the case of an MCO, PIHP, or PAHP, any of the following:
>
> (1) The denial or limited authorization of a requested service, including determinations based on the type or

level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” at § 447.45(b) of this chapter is not an adverse benefit determination.

(4) The failure to provide services in a timely manner, as defined by the State.

(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.

(7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Appeal means a review by an MCO, PIHP, or PAHP of an adverse benefit determination.

Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

Grievance and appeal system means the processes the MCO, PIHP, or PAHP implements to handle appeals of an

> adverse benefit determination and grievances, as well as the processes to collect and track information about them.
>
> *State fair hearing* means the process set forth in subpart E of part 431 of this chapter.

Additionally, as described in 42 CFR 438.408, the State fair hearing like the one requested in this case is only available in cases where Respondent upheld its decision following an appeal of an adverse benefit determination, and there is no provision for State fair hearings with respect to grievances, even if a beneficiary is not satisfied by the outcome of the grievance process.

Accordingly, pursuant to the above policies, there has been no adverse benefit determination with respect to chore services, as they have been approved, and Petitioners' arguments with respect to the failure to provide the approved services are grievances that are outside of the scope of this case.

A denial of a request to extend the authorizations of previously approved, but unused chore services, is an adverse benefit determination that the undersigned Administrative Law Judge would have jurisdiction over.

In appealing such a denial, Petitioners' bear the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned ALJ is limited to reviewing Respondent's decisions in light of the information available at the time the decisions were made.

Given the available information and applicable policies in this case, Petitioners have not met that burden of proof and Respondent's decisions must therefore be affirmed.

It is clear that the approved chore services are medically necessary, but, as credibly testified to by Respondent's witness, the record does not reflect that an extension of unused hours would be medically necessary given the nature of the chore services. Nothing suggests that a delay in the provision of chore services means that more deep cleaning will be required when the services are actually provided; and, if that proves to be the case, Petitioners can always request that more services be provided if and when appropriate.

Accordingly, Respondents' denials for Issue #2 should therefore be affirmed.

Issue #3

ISSUE

Whether Respondent properly denied Petitioners' requests reimbursement for the purchase of probe covers?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On January 3, 2023, Petitioners requested 750 thermometer probe covers through Respondent for the month of January of 2023. (Exhibit H, page 45).

2. On January 20, 2023, Respondent sent Petitioners a Notice of Adverse Benefit Determination stating that Petitioners' request had been denied, noting that it was unable to make a decision to a lack of release paperwork allowing for the coordination of benefits. (Exhibit H, page 46).

3. On January 25, 2023, Petitioners filed an Internal Appeal with Respondent regarding that determination. (Exhibit A, page 46).

4. On January 26, 2023, Respondent sent Petitioner a Notice of Internal Appeal decision stating that 250 probe covers would be authorized for the month. (Exhibit H, page 47).

5. On February 2, 2023, Petitioners requested a Medicaid fair hearing with respect to that decision. (Exhibit H, page 48).

6. While that matter was pending, Petitioners requested 1000 probe covers for the month of February of 2023. (Exhibit #1, page 136).

7. On February 10, 2023, Respondent sent Petitioners an email stating in part:

> Regarding the thermometer probe cover order: This has been requested, denied, and is in appeal. We will continue to provide the current allowed amount of 250 probe covers.

Exhibit #1, page 137

8. Petitioners then purchased an additional 750 probe covers themselves for February of 2023. (Testimony of Petitioners' representative).

9. On March 15, 2023, ALJ Corey Arendt issued a Decision and Order in which he affirmed Respondent's decision with respect to probe covers for January of 2023. (Exhibit H, page 54).

10. In part, ALJ Arendt found:

> Based on the above findings of fact and conclusions of law, I find the Petitioners have failed to prove, by a preponderance of the evidence, that the Department erred in determining the January, 2023, allotment of thermometer probe covers. As noted above, the Department is tasked with protecting Medicaid funds and thus, must determine if they are the payor of last resort and determine the ongoing medical necessity of the items being requested. In this case, they were unable to determine whether there were other payors with priority due to the lack of release forms on file with Priority Health. Furthermore, at the time of the internal appeal, the most up-to-date information from the PCP indicated a quantity of probes less than what Petitioners were requesting. As such, the Waiver's Agency's decision is proper and must be upheld.

Exhibit H, page 54

11. Petitioners subsequently requested reimbursement from Respondent for the costs of probe covers purchased in February of 2023. (Testimony of Petitioners' representative).

12. On April 21, 2023, Respondent sent Petitioners a Notice of Adverse Benefit Determination denying Petitioners' request for reimbursement for previously purchased prober covers. (Exhibit I, pages 59-61).

13. Regarding the reason for the decision, the notice stated:

> **The Area Agency on Aging paid for the authorized amount of 250 probe covers on February 17, 2023. Personal reimbursement of medical supplies is not available to clients unless previously approved by the Area Agency on Aging (see section 9 of the Medicald [sic] Provider manual for more information on prior authorizations).**

Exhibit I, page 59

14. On May 11, 2023, Petitioners filed an Internal Appeal with Respondent with respect to the denial of their request for reimbursement for the purchase of probe covers in February of 2023. (Exhibit #1, page 23; Exhibit I, pages 63-65).

15. On June 7, 2023, Respondent sent Petitioners a Notice of Internal Appeal Decision-Denial. (Exhibit #1, pages 23-25; Exhibit I, pages 63-65).

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

> Review of records indicate 250 probe covers per beneficiary were authorized and purchased for February 2023 request. A request for reimbursement of additional probe covers above the authorized amount was requested by beneficiary guardian.
>
> Per the Medicaid Provider Manual, MI Choice Waiver Chapter, it states:
>
> *All waiver services furnished shall be included in the person-centered service plan and authorized by the supports coordinator.*
>
> The amount of probe covers authorized was 250 per beneficiary. Records indicate the probe covers were purchased and delivered to beneficiary home, as authorized. AAANM is denying payment above the authorized amount.

Exhibit #1, page 23
Exhibit I, page 63

17. On June 28, 2023, MOAHR received the request for hearing filed by Petitioners in these consolidated matters. (Exhibit #1, pages 1-8).

CONCLUSIONS OF LAW

As discussed above, specialized medical equipment and supplies may be covered services through MI Choice. *See* MPM, April 1, 2023 version, MI Choice Chapter, pages 45-46.

Here, Petitioners requested 1000 probe covers for the month of February of 2023 as specialized medical supplies; their request was denied in part, with only 250 probe covers approved; Petitioners subsequently purchased the remaining 750 probe covers and requested reimbursement from Respondent; and Respondent denied Petitioners' requests for reimbursement.

In appealing Respondent's actions, Petitioners bear the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned ALJ is limited to reviewing Respondent's decisions in light of the information available at the time the decisions were made.

Given the available information and applicable policies in this case, Petitioners have met that burden of proof with respect to Issue #3, and Respondent's decisions with respect to probe covers must therefore be reversed.

Respondent denied the initial request in February on the basis that the requested probe covers were already part of the pending hearing before ALJ Arendt, and then denied the subsequent request for reimbursement on the basis that the purchased probe covers had not been approved prior to purchase as required.

However, in doing so, Respondent erred. While Respondent may have believed the administrative matter before ALJ Arendt would encompass more than just the request for probe covers in January, ALJ Arendt' subsequent decision was clearly limited to that single month and did not address any request for probe covers in February or after. Consequently, based on its mistaken belief about the scope of the previous case, Respondent both denied the February 2023 request for probe covers and failed to send the required adverse benefit determination regarding its denial.

Moreover, while Respondent did send proper notice of its denial of Petitioners' subsequent request for reimbursement, its earlier actions still tainted that decision. Respondent specifically denied reimbursement on the basis that no prior authorization was made, but it had also improperly responded to the prior authorization request that was made and failed to send Petitioners the required notice of its decision, which denied Petitioners their right to challenge that denial. Respondent cannot mishandle a prior authorization request; deny Petitioners a chance to appeal that mishandling and require that Petitioners purchase the items themselves; and then deny a request for reimbursement based on the fact that Petitioner did not have prior authorization.

It is not clear from the record whether Petitioners' requests for reimbursement for probe covers in February of 2023 should have been approved, especially given that the denial for January was affirmed while Respondent approved probe covers in March. Regardless, what is clear is that Respondent erred; its decisions must be reversed; and it must initiate a reassessment of Petitioners' requests with respect to probe covers in Issue #3.

Issue #4

ISSUE

Whether Respondent properly denied a request for an assessment of the heating, ventilation, and air conditioning (HVAC) system for Petitioner Benjamin Miller's bedroom?

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 [redacted] has his own bedroom, with the thermostat for the bedroom located outside the room. (Testimony of Petitioners' representative).

2. On May 9, 2023, Petitioners' representative requested, in part, an assessment of the current HVAC system to see if the temperature in Petitioner [redacted] room could be better controlled. (Exhibit #1, page 151).

3. On May 15, 2023, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that his request for an assessment had been denied. (Exhibit K, pages 67-69).

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

> **This denial is based on assessment of appropriateness. Assessment of HVAC System for improvement and moving the thermostat is not an appropriate service covered by MI Choice Waiver. Other means of temperature [sic] control are readily available and accessible in the home. The participant currently has 24/7 Private Duty Nursing and Community Living Supports. Participant receives routine tempurature [sic] checks, hot/cold packs for tempurature [sic] regulation.**
>
> **AAANM will provide Supports Coordination to arrange requested HVAC Assessment however, the assessment will be at the expense of the participant and/or landlord. As stated in the Medicaid Provider Manual- MI Choice Waiver Chapter- Environmental Adaptations excluded include those that are not of direct medical or remedial benefit.**
>
> *Exhibit K, page 67*

5. On May 15, 2023, Petitioner filed an Internal Appeal with Respondent regarding that decision. (Exhibit #1, page 26; Exhibit K, page 71).

6. On June 7, 2023, Respondent sent Petitioner a Notice of Internal Appeal Decision-Denial. (Exhibit #1, pages 26-29; Exhibit K, pages 71-74).

7. With respect to the reason for the denial, the notice stated in part:

> Review of record indicates a necessity for controlled temperature, due to complexity of beneficiaries' conditions. Current need for controlled temperature and monitoring is currently in place, with two caregivers present at all times, 24 hours per day, 7 days per week, with Private Duty Nursing and Community Living Support staff to assess for and assist in temperature control in the home setting. Temperature regulation practices and interventions are found to be present and in place for adequate care of beneficiaries and to maintain safety in the home setting. Beneficiaries reside in a rental unit within the guardians [sic] home. AAANM does provide annual maintenance and evaluation of the current air conditioning unit that provides temperature control to the beneficiaries' rental unit within the home of guardian.
>
> Per most recent assessment, environmental assessment indicates no disrepair to the home, no inadequate heating or cooling, no lack of person safety. Record indicates beneficiary guardian has sought out HVAC specialists for recommendations of heating/cooling system for more consistent temperature control. Service requested would not replace the need for paid caregivers, as indicated in standards for environmental control devices and current supports and services are in place to assist with temperature regulation and control to meet assessed need. Excluded adaptations include those that are of general utility and standard housing obligations or general home repairs.
>
> AAANM has provided, and will continue to provide, supports coordination and assistance in obtaining companies to provide the assessment and change of the system, as requested.

Exhibit #1, page 27
Exhibit K, page 72

8. On June 28, 2023, MOAHR received the request for hearing filed by Petitioners in these consolidated matters. (Exhibit #1, pages 1-8).

CONCLUSIONS OF LAW

With respect to environmental accessibility adaptions, the applicable version of the MPM states in part:

4.1.G. ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

Definition	Environmental Accessibility Adaptations (EAA) include physical adaptations to the home required by the participant's person-centered service plan that are necessary to ensure the health and welfare of the participant or that enable the participant to function with greater independence in the home, without which the participant would require institutionalization.
Requirements	Adaptations may include: ▪ Installation of ramps and grab bars; ▪ Widening of doorways; ▪ Modification of bathroom facilities; ▪ Modification of kitchen facilities; ▪ Installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant; and ▪ Environmental control devices that replace the need for paid staff and increase the participant's ability to live independently, such as automatic door openers. Assessments and specialized training needed in conjunction with the use of such environmental adaptations are included as a part of the cost of the service. The case record must contain documented evidence that the adaptation is the most cost-effective and reasonable alternative to meet

	the participant's need(s). An example of a reasonable alternative, based on the results of a review of all options, may include changing the purpose, use or function of a room within the home or finding alternative housing. The participant must agree to the reasonable alternative prior to starting the modifications. Environmental adaptations required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a participant's home. The waiver agency must ensure there is a signed contract or bid proposal with the licensed builder or contractor prior to the start of an environmental adaptation. It is the responsibility of the waiver agency to work with the participant and the licensed builder or contractor to ensure the work is completed as outlined in the contract or bid proposal. The waiver agency must document approval of all EAA in the participant's record. This documentation must minimally include dates, tasks performed, materials used, and cost. All services must be provided in accordance with applicable state or local building codes. The existing structure must have the capability to accept and support the proposed changes. The environmental adaptation must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values. Under the EAA service, waiver agencies may use MI Choice funds to purchase materials

	and labor used to complete the modifications to prevent or remedy a sub-standard condition or safety hazard. The direct service provider must provide equipment or tools needed to perform modifications or adaptations unless another source can provide the tools or equipment at a lower cost or free of charge and the provider agrees to use such equipment or tools. The waiver agency may purchase supplies for the modification or adaptation, such as grab bars, lumber, or plumbing supplies, and provide them to the direct service provider at their discretion. The participant, with the direct assistance of the waiver agency's supports coordinator, when necessary, must make a reasonable effort to access all available funding sources such as housing commission grants, Michigan State Housing Development Authority (MSHDA), and community development block grants. Before approving MI Choice payment for each modification or adaptation, each waiver agency must determine whether a participant is eligible to receive services through a program supported by other funding sources. The participant's case record must include evidence of efforts to apply for alternative funding sources and the acceptances or denials of these funding sources. Adaptations may be made to rental properties when the lease or rental agreement does not indicate that the landowner is responsible for such adaptations and the landowner agrees to the adaptation in writing. A written agreement between the landowner, the participant, and the waiver agency must specify any requirements for restoration of the property to its original condition if the occupant moves. Providers of EAA must be licensed in the State of Michigan.

Limitations	Excluded are those adaptations or improvements to the home that: ▪ Are of general utility. ▪ Are considered to be standard housing obligations of the participant or homeowner. ▪ Are not of direct medical or remedial benefit. Examples of exclusions include, but are not limited to: ▪ Carpeting ▪ Roof repair ▪ Sidewalks and driveways ▪ Heating ▪ Central air conditioning (except under exceptions noted in the service definition) ▪ Garages and raised garage doors ▪ Storage and organizers ▪ Hot tubs, whirlpool tubs, and swimming pools ▪ Landscaping ▪ General home repairs MI Choice does not cover general construction costs in a new home or additions to a home purchased after the participant is enrolled in the waiver. If a participant or the participant's family purchases or builds a home while receiving waiver services, it is the participant's or family's responsibility to ensure the home will meet basic needs, such as having a ground floor bath or bedroom if

	the participant has mobility limitations. MI Choice funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways, bathroom modifications, etc.) for a home recently purchased. If modifications are needed to a home under construction that require special adaptation to the plan (e.g., roll-in shower), the MI Choice program may be used to fund the difference between the standard fixture and the modification required to accommodate the participant's need. The infrastructure of the home involved in the funded adaptations (e.g., electrical system, plumbing, well or septic, foundation, heating and cooling, smoke detector systems, or roof) must be in compliance with any applicable local codes. Environmental adaptations shall exclude costs for improvements exclusively required to meet applicable state or local building codes. The existing structure must have the capability to accept and support the proposed changes.

MPM, April 1, 2023 version
MI Choice Waiver Chapter, pages 30-32

Moreover, while environmental accessibility adaptions are covered services, they must still be medically necessary to be approved. *See* MPM, April 1, 2023 version, MI Choice Chapter, page 18; 42 CFR 440.230(d).

Here, Respondent denied Petitioner [redacted] request for an assessment of the HVAC system pursuant to the above policies.

In appealing the denial, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned ALJ is limited to reviewing Respondent's decisions in light of the information available at the time the decisions were made.

Given the available information and applicable policies in this case, Petitioner has not met that burden of proof and Respondent's decision must therefore be affirmed.

Petitioner only requested an assessment of the HVAC system given his need for controlled temperatures, but even that limited request was still properly denied given his other services, including around-the-clock nursing or Community Living Supports; those caregivers' ability to monitor him; and the policy provision requiring that any adaptation be the most cost-effective and reasonable alternative that can meet Petitioner's needs. No environmental modification on its fact is going to the most-effective method for meeting Petitioner's needs and no assessment is therefore necessary.

Accordingly, Petitioner [redacted] has failed to meet his burden of proof with respect to Issue #4 and Respondent's decision with respect to an HVAC assessment is affirmed.

Issue #5

ISSUE

Whether Respondent properly denied Petitioners' requests for backboards?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. The local fire department has evaluated Petitioners' home, and it made certain recommendations for their fire safety. (Testimony of Petitioners' representative).

2. The recommendations did not include backboards for caregivers to use in evacuating Petitioners from their home in case of a fire. (Testimony of Petitioners' representative).

3. On April 17, 2023, Petitioners' representative requested foldable backboards for Petitioners for fire evacuation. (Exhibit #1, pages 158-161).

4. Along with the request, she provided a Medical Supply Order from Petitioners' doctor for each Petitioner stating in part:

> Additional Data: Necessary in case of fire emergency and patient needs to be emergently evacuated out of fire escape at home. Patient needs to be handled with care due to osteoporosis and risk of bone fracture.

Exhibit #1, pages 162-163

5. On April 21, 2023, Respondent sent Petitioners a Notice of Adverse Benefit Determination stating that their request for foldable backboards had been denied. (Exhibit M, pages 76-78).

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

> **Based on environmental assessment there is an accessible egress available for exit from the home. Previously the Fire Department had been contacted regarding fire safety and accessibility. The Fire Department indicated they could arrive at the home within 4 minutes of notification. The Fire Department provided education to guardian on fire extinguishers, fire prevention, and preparation for evacuation. The prepared care plan indicates that Albridge nursing staff is avilable [sic] 24 hours per day, 7 days per week, and that a back-up caregiver is always available.**

Exhibit M, page 76

7. On May 11, 2023, Petitioners filed an Internal Appeal with Respondent regarding that decision. (Exhibit #1, page 30; Exhibit N, page 80).

8. On June 11, 2023, Respondent sent Petitioners a Notice of Appeal Decision-Denial. (Exhibit #1, pages 30-33; Exhibit N, pages 80-83).

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

> Review of records and environmental assessment indicates accessible egress options from the home in case of necessary evacuation. Record indicates evaluation and communication with [redacted] Metro Fire Department in February 2021 that discussed fire prevention and evacuation methods in case of emergency. Methods for evacuation were provided from the fire department, including use of sheets and suggestions to practice escape plans. Further communication with the fire department indicated and reported that fire department could be onsite within 4 minutes of being notified to assist in evacuation. Twenty-four hours per day, seven days per week, two caregivers are present at all times to assist in evacuation, if necessary.
>
> Per Medicaid Provider Manual, MI Choice Waiver chapter, Section 4 Services, specialized medical equipment and supplies excludes items that are not of direct medical or remedial benefit to the participant. Given current environmental assessment and availability of a minimum of two caregivers twenty-four

> hours per day, seven days per week, with training and evacuation plans established and identified with the local fire department, emergency egress options, and ability for additional support and assistance with the fire department within 4 minutes of notification, foldable backboards are not indicated for approval. Current evacuation plans and egress options are available and accessible in the home, with local proximity to fire department available.
>
> *Exhibit #1, pages 30-31*
> *Exhibit N, pages 80-81*

10. On June 28, 2023, MOAHR received the request for hearing filed by Petitioners in these consolidated matters. (Exhibit #1, pages 1-8).

CONCLUSIONS OF LAW

As discussed above, specialized medical equipment and supplies may be covered services through MI Choice, though they must still be medically necessary to be approved. *See* MPM, April 1, 2023 version, MI Choice Chapter, pages 18, 45-46; 42 CFR 440.230(d).

Moreover, with respect to participant management of risk, the MPM further states in part:

> **Emergency Plans**
>
> - An emergency is a situation or event that places participant health or life in danger and requires immediate action or medical attention to prevent physical harm or hospitalization. Emergencies include natural disasters (tornados, floods, drought, heat waves, blizzards, etc.), unnatural disasters (fires, bomb threats, terrorism, etc.), and sudden onset of medical crises.
>
> - The waiver agency encourages participants to use a PERS or dial "911" during an emergency.
>
> - Participants whose life depends upon equipment that requires electricity have an emergency plan that addresses what to do during a power outage, or clearly states the participant's preference not to include such measures.

- Participants who need assistance to ambulate have an emergency plan that includes the notification of someone who will assist them in evacuating their residence if necessary, or clearly state the participant's preference not to include such measures.

- MDHHS urges all participants to have escape routes defined for various disasters.

- MDHHS urges all waiver agencies to be involved with law enforcement officials and other disaster preparedness agencies at the local level to help these agencies identify and assist MI Choice participants during emergencies.

MPM, April 1, 2023 version
MI Choice Waiver Chapter, page 60

Here, Respondent denied Petitioners' requests for foldable backboards pursuant to the above policies and on the basis that the requested equipment was not medically necessary.

In appealing those determinations, Petitioners bear the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned ALJ is limited to reviewing Respondent's decisions in light of the information available at the time the decisions were made.

Given the record in this case, Petitioners have failed to meet their burden of proof and Respondent's decisions should therefore be affirmed.

Petitioners have an emergency plan in case of a fire and the parties have, as provided in policy, involved the local fire department to assist in the emergency planning process, with the fire department having provided education on fire prevention; indicating that it could arrived within 4 minutes; and not specifically recommending backboards. Moreover, while Petitioners' representative doubts that the fire department could arrive so quickly, her testimony is only supported by an internet search that even she concedes was based on regular cars and traffic, and not a fire truck utilizing a siren.

Petitioners' representative did credibly testify as to how a backboard will be needed for evacuation given Petitioners' medical conditions and the limitations of their caregivers, but that testimony only further raised concerns about whether the caregivers would even be able to utilize the backboards to evacuate Petitioners and, assuming they can, whether they could be able to do so quicker than the fire department would arrive and professionals could take care of Petitioners.

Accordingly, Petitioners have failed to meet their burden of proof with respect to Issue #5, and Respondent's decisions with respect to backboards are affirmed.

Issue #6

ISSUE

Whether Respondent properly terminated the provision of baby wipes for Petitioners?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. Petitioners' plans of care with Respondent identify certain items, including baby wipes, that Petitioners may need each month. (Testimony of Petitioners' representative; Testimony of Director of Quality and Utilization Management).

2. Petitioners' representative then sends in requests each month for items and identifies the quantities needed. (Testimony of Petitioners' representative; Testimony of Director of Quality and Utilization Management).

3. In April of 2023, Petitioners requested, and Respondent provided, 5 boxes of baby wipes to Petitioners. (Exhibit #1, page 170; Testimony of Petitioners' representative).

4. Petitioners were also receiving baby wipes through the Medicaid State Plan at that time. (Testimony of Petitioners' representative).

5. Petitioners' representative again requested 5 boxes of baby wipes in May of 2023. (Testimony of Petitioners' representative).

6. Petitioners were also receiving baby wipes through the Medicaid State Plan at that time. (Testimony of Petitioners' representative).

7. On May 19, 2023, Respondent sent Petitioners Notices of Adverse Benefit Determination stating that their request for 5 boxes of Costco Baby Wipes had been denied. (Exhibit #1, pages 171-174).

8. With respect to the reason for the denial, the notices stated:

> **This denial is based on assessment of type/level of service. Wipes are available through the Medicaid State Plan. AAANM will continue to provide Supports Coordination to assist in obtaining necessary quantity of wipes provided by J&B Medical.**

Exhibit #1, pages 171, 174

9. That same day, Petitioner filed an Internal Appeal with Respondent with respect to the denial of baby wipes. (Exhibit #1, page 34; Exhibit P, page 89).

10. No baby wipes were approved for June of 2023 either. (Testimony of Petitioners' representative).

11. On June 15, 2023, Respondent sent Petitioner a Notice of Internal Appeal Decision-Denial. (Exhibit #1, pages 34-37; Exhibit P, pages 89-92).

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

> Review of the record and coordination activities performed by the supports coordinator team has identified and found baby wipes (incontinence supply) to be covered under Medicaid State Plan services/other payer sources. Per Medicaid Provider Manual, MI Choice Waiver chapter, Section 4-Services, version dated April 1, 2023, it states:
>
> *Services paid for with MI Choice funds must not duplicate nor replace services available through the State Plan. Where applicable, the participant must use State Plan*, Medicare, or other available payers first. MI Choice is the funding source of last resort.
>
> Per Medicaid Provider Manual, MI Choice Waiver chapter, Section 4- Services, 4.1.O- Specialized Medical Equipment and Supplies, version dated April 1, 2023, it states:
>
> *Medical equipment and supplies furnished under the State Plan must be procured and reimbursed through that mechanism and not through MI Choice.*
>
> Record review indicates most recent assessment and person-centered service plan identifies incontinence

supplies of wipes are provided through an arranged service through durable medical equipment suppliers Carelinc and J&B medical, provided and purchased through Medicaid State Plan services and/or Priority health (beneficiaries' private insurance). Record supports coordination of services and procurement of service item requested through other available payers and therefore item not authorized for purchase under the Medicaid MI Choice Waiver program.

Record additionally indicates request for wipes above state plan allotted amount. Supports coordination has been conducted to evaluate and procure amount above state plan coverage, as requested by beneficiary guardian, through arranged service under other payer sources. Record indicates communication and coordination with J&B Medical on 5/31/2023, in which J&B Medical confirmed a nurse assessment to be conducted with beneficiary guardian to obtain prior authorization for additional wipes above previously designated amount covered by insurance. The assessment for prior authorization is for coverage under Medicaid State Plan services and/or other payer source, as arranged through Medicaid MI Choice waiver, yet not purchased through MI Choice Waiver as other funding source accessible for coverage of requested item. Communication to guardian was provided on 6/2/2023 informing of status of request and prior authorization process with J&B Medical for requested amount above current coverage through State Plan and/or Priority Health.

As service item is provided and covered through other payer source, and prior authorization process for additional amounts has been coordinated and communicated with guardian for coverage under other payer source, Medicaid MI Choice Waiver is not authorizing and purchasing item of wipes, per program requirements as described above.

Exhibit #1, pages 34-35
Exhibit P, pages 89-90

13. On June 28, 2023, MOAHR received the request for hearing filed by Petitioners in these consolidated matters. (Exhibit #1, pages 1-8).

14. In July of 2023, Respondent again provided Petitioners with baby wipes. (Exhibit #1, page 176).

CONCLUSIONS OF LAW

As discussed above, specialized medical equipment and supplies may be covered services through MI Choice, though they must still be medically necessary to be approved *See* MPM, April 1, 2023 version, MI Choice Chapter, pages 18, 45-46; 42 CFR 440.230(d).

Moreover, the policy regarding those items also states that medical equipment and supplies furnished under the State Plan must be procured and reimbursed through that mechanism, and not through MI Choice. *See* MPM, April 1, 2023 version, MI Choice Chapter, pages 45-46.

Here, Respondent denied Petitioners' request for baby wipes pursuant to the above policies and on the basis that the supplies can be procured and reimbursed through the State Plan.

In appealing Respondent's actions, Petitioners bear the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned ALJ is limited to reviewing Respondent's decisions in light of the information available at the time the decisions were made.

Given the record in this case, Petitioners have met that burden of proof and Respondent's decisions should therefore be reversed.

As a preliminary matter, the undersigned ALJ finds that, to the extent Petitioners' representative is disputing the process for approving items, with monthly requests submitted and approved or denied, as opposed to a permanent order regarding the provision of items, that dispute should be the subject of a grievance as it involves the provision of services and there is no specific denials or adverse benefit determinations.

With respect to the specific denials of baby wipes, Petitioners' representative has demonstrated that, while it is undisputed that some baby wipes are covered by the State Plan, Petitioners always require a greater amount of those supplies, with their usage never varying, and Respondent approved the requested baby wipes both before and after the denials at issue here, as provided by Petitioners' plans of care and with nothing changing during the months where the additional wipes were denied.

Moreover, while Respondent's witness testified that Respondent periodically reviews requests for coordination of benefits, and it denied requests for wipes above the state plan allotted amount after its supports coordination reviewed the state plan coverage and communicated with the medical supplier about what it could obtain, that testimony is unsupported by any documentation and Respondent's sole witness did not speak to anyone or have any personal knowledge of what was reported.

The mere fact that Petitioners received the requested supplies before and after the denials at issue is insufficient on its own to demonstrate that Respondent erred, but Petitioners representative also credibly testified regarding Petitioners' continuing needs and the lack of sufficient supplies through the State Plan while Respondent provided absolutely no evidence for its findings and alleged assessments or communications with the medical supplier.

Accordingly, Petitioners have met their burden of proof with respect to Issue #6; Respondent's decisions with respect to baby wipes are reversed; and it must initiate a reassessment of Petitioner's requests.

Issue #8

ISSUE

Whether Respondent properly denied a request for a Theraworx U-Pack for Petitioner Benjamin Miller?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On April 17, 2023, Petitioners' representative requested a Theraworx U-Pack for Petitioner [redacted] (Exhibit #1, pages 179-181).

2. Along with that request, she included a Medical Supply Order signed by Petitioner's doctor and listing his diagnoses, but not providing any further information. (Exhibit #1, page 182).

3. On May 19, 2023, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that Petitioner [redacted] request for a Theraworx U-Pack had been denied. (Exhibit Q, pages 94-96).

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

> **This denial is based on assessment of medical necessity. Participant has 24-hour CLS that can adequately provide peri-care as needed to prevent skin breakdown. Supports Coordination will continue to determine if this product or a similar item would be covered through any other provider such as Priority Health or Medicaid State Plan.**
>
> *Exhibit Q, page 94*

5. That same day, Petitioner filed an Internal Appeal with Respondent regarding the denial. (Exhibit #1, pages 38-40; Exhibit R, page 98).

6. On June 15, 2023, Respondent sent Petitioner a Notice of Appeal Decision-Denial. (Exhibit #1, pages 38-Exhibit R, pages 98-101).

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

> Review of the record and coordination activities performed by the supports coordinator team has identified and found theraworx to be potentially covered under Medicaid State Plan services/other payer sources. Per Medicaid Provider Manual, MI Choice Waiver chapter, Section 4- Services, version dated April 1, 2023, it states:
>
> *Services paid for with MI Choice funds must not duplicate nor replace services available through the State Plan. Where applicable, the participant must use State Plan, Medicare, or other available payers first. MI Choice is the funding source of last resort.*
>
> Per Medicaid Provider Manual, MI Choice Waiver chapter, Section 4- Services, 4.1.O- Specialized Medical Equipment and Supplies, version dated April 1, 2023, it states:
>
> *Medical equipment and supplies furnished under the State Plan must be procured and reimbursed through that mechanism and not through MI Choice.*
>
> Record review indicates supports coordination activities have occurred, and continue to occur, to obtain the requested item for beneficiary. AAANM has received notice that item is not covered by Priority Health. Supports coordination activities and communication continues with medical supply companies to identify coverage through Medicaid State Plan services, as required per Medicaid MI Choice Waiver program.
>
> Communication with J&B Medical (durable medical equipment supplier) indicates an assessment is required by J&B medical and representative from J&B Medical states they must speak with beneficiary guardian to obtain a request for prior authorization, assessment of need, and potential comparable

> substitutes that are covered under the State Plan services. Communications received5/31/2023 indicated J&B Medical confirmed a nurse assessment was necessary to be conducted with beneficiary guardian regarding request to receive peri-care wash as a comparable substitute. The information received from J&B Medical and the request for prior authorization was communicated to beneficiary guardian on 6/2/2023. Orders received by primary care provider have been submitted and provided to Carelinc and J&B Medical to assist in the prior authorization process and coordination of services.
>
> At this time, requested service item is found to be potentially covered by another payer source, with current need for peri-care appropriately met through nursing services and community living supports provided twenty-four hours per day, seven days per week and item is not authorized for purchase under the Medicaid MI Choice Waiver program, per program requirements for service authorization. Prior authorization process and necessity to communicate with J&B Medical has been communicated to beneficiary guardian.

Exhibit #1, pages 38-39
Exhibit R, pages 98-99

8. On June 28, 2023, MOAHR received the request for hearing filed by Petitioners in these consolidated matters. (Exhibit #1, pages 1-8).

CONCLUSIONS OF LAW

As discussed above, specialized medical equipment and supplies may be covered services through MI Choice, though they must still be medically necessary to be approved *See* MPM, April 1, 2023 version, MI Choice Chapter, pages 18, 45-46; 42 CFR 440.230(d).

Moreover, the policy regarding those items also states that medical equipment and supplies furnished under the State Plan must be procured and reimbursed through that mechanism, and not through MI Choice. *See* MPM, April 1, 2023 version, MI Choice Chapter, pages 45-46.

Here, Respondent denied Petitioner [redacted] request for a Theraworx U-Pack pursuant to the above policies and on the basis that the requested items can be procured through the State Plan and/or are not medically necessary.

In appealing the denial, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned ALJ is limited to reviewing Respondent's decision in light of the information available at the time the decisions were made.

Given the available information and applicable policies in this case, Petitioner has not met that burden of proof and Respondent's decision must therefore be affirmed.

Petitioners' representative testified that Petitioner [redacted] needs the Theraworx U-Pack due to his urinary tract infections, which is the same condition for which his brother is authorized the same item. She also testified that Petitioner's medical provider prescribed the Theraworx U-Pack, which trumps whoever Respondent spoke to, and that Respondent already knows from Petitioner's brother's experiences that the item is not covered under the State plan.

However, while Petitioner [redacted] case has been consolidated with his brother's case, and they share many of the same needs and issues, their specific claims are separate from each other and the mere fact that his brother has been approved for a Theraworx U-Pack does not mean that Petitioner should be or that the required process need not be followed.

Moreover, Respondent credibly noted differences between the two brothers' cases, with Petitioner [redacted] not having an indwelling catheter while the doctor's order simply prescribed the item without any explanation as to why it is needed.

Accordingly, Petitioner [redacted] has failed to meet his burden of proof with respect to Issue #8 and Respondent's decision with respect to the Theraworx U-Pack is affirmed.

Issue #9

ISSUE

Whether Respondent properly denied Petitioners' request for pipe cleaners?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. Since 2021, Respondent has provided Petitioners with pipe cleaners for respiratory care. (Exhibit #1, pages 191-196; Testimony of Petitioners' representative).

2. In May of 2023, Petitioners' representative again requested 200 pipe cleaners for Petitioners for that month. (Testimony of Petitioners' representative).

3. On May 19, 2023, Respondent sent Petitioners an Adverse Benefit Determination stating that their request for 200 pipe cleaners had been denied. (Exhibit S, pages 103-105).

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

> **This denial is based on assessment of appropriateness. As pipe cleaners are being used for respiratory care, all respiratory supplies are provided through Carelinc and purchased by primary health insurance provider. Supports Coordination will continue to assist participant/guardian in finding an appropriate alternative.**

Exhibit S, page 103

5. That same day, Petitioners filed an Internal Appeal with Respondent regarding that denial. (Exhibit #1, page 42; Exhibit T, page 107).

6. On June 15, 2023, Respondent sent Petitioners a Notice of Internal Appeal Decision-Denial. (Exhibit #1, pages 42-45; Exhibit T, pages 107-108).

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

> Review of the record and coordination activities performed by the supports coordinator team has identified and found pipe cleaners (respiratory supply) to be covered under Medicaid State Plan services/other payer sources. Per Medicaid Provider Manual, MI Choice Waiver chapter, Section 4-Services, version dated April 1, 2023, it states:
>
> *Services paid for with MI Choice funds must not duplicate nor replace services available through the State Plan. Where applicable, the participant must use State Plan, Medicare, or other available payers first. MI Choice is the funding source of last resort.*

> Per Medicaid Provider Manual, MI Choice Waiver chapter, Section 4- Services, 4.1.O- Specialized Medical Equipment and Supplies, version dated April 1, 2023, it states:
>
> *Medical equipment and supplies furnished under the State Plan must be procured and reimbursed through that mechanism and not through MI Choice.*
>
> Record review indicates most recent assessment and person-centered service plan identifies respiratory supplies are provided through an arranged service through durable medical equipment supply company, Carelinc, provided and purchased through Medicaid State Plan services and/or Priority health (beneficiaries' private insurance) for oxygen and supplies, tracheostomy supplies. Record indicates coordination of services and procurement of service item requested through other available payers and therefore item not authorized for purchase under the Medicaid MI Choice Waiver program.
>
> Record indicates Supports Coordinator communication and coordination with Carelinc on 5/19/2023, with response and confirmation from Carelinc on 5/23/2023 stating Carelinc has a valid prescription for pipe cleaners and will send the order out to beneficiary. The information received from Carelinc and coverage through other payer sources was communicated to beneficiary guardian on 5/26/2023.
>
> As service item is provided and covered through other payer source, Medicaid MI Choice Waiver is not authorizing and purchasing item of pipe cleaners, per program requirements as described above.
>
> *Exhibit #1, pages 42-43*
> *Exhibit T, pages 107-108*

8. On June 28, 2023, MOAHR received the request for hearing filed by Petitioners in these consolidated matters. (Exhibit #1, pages 1-8).

CONCLUSIONS OF LAW

As discussed above, specialized medical equipment and supplies may be covered services through MI Choice, though they must still be medically necessary to be approved *See* MPM, April 1, 2023 version, MI Choice Chapter, pages 18, 45-46; 42 CFR 440.230(d).

Moreover, the policy regarding those items also states that medical equipment and supplies furnished under the State Plan or private insurance must be procured and reimbursed through those mechanisms when available. *See* MPM, April 1, 2023 version, MI Choice Chapter, pages 45-46.

Here, Respondent denied Petitioners' request for pipe cleaners pursuant to the above policies and on the basis that the supplies can be procured and reimbursed through Petitioners' private insurance and/or the Medicaid State Plan.

In appealing Respondent's actions, Petitioners bear the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned ALJ is limited to reviewing Respondent's decisions in light of the information available at the time the decisions were made.

Given the record in this case, Petitioners have met their burden of proof and Respondent's decisions should therefore be reversed.

As discussed above, the undersigned ALJ finds as a preliminary matter that, to the extent Petitioners' representative is disputing the process for approving items, with monthly request submitted and approved or denied, as opposed to a permanent order regarding the provision of items, that dispute should be the subject of a grievance as it involves the provision of services and there is no specific denials or adverse benefit determinations.

With respect to the specific denial of pipe cleaners however, Petitioners' representative demonstrated through her testimony and exhibits that Petitioners have been approved for pipe cleaners since 2021; the items are not available through the State Plan or private insurance, as found by Respondent at the time of the initial approval; and nothing has changed since.

Moreover, while Respondent's witness testified that Respondent periodically reviews requests for coordination of benefits and it denied requests for pipe cleaners after its supports coordination assessed Petitioners' services and communicated with the medical supplier about where it could obtain the requested items, that testimony is unsupported by any documentation, Respondent's sole witness did not speak to anyone or have any personal knowledge of what was reported.

The mere fact that Petitioners have received the requested supplies before is insufficient on its own to demonstrate that Respondent erred, but Petitioners representative also credibly testified regarding Petitioners' continuing needs and the lack of sufficient supplies through the State Plan or private insurance while Respondent provided absolutely no evidence for its findings or the alleged assessments and communications with the medical supplier.

Accordingly, Petitioners have met their burden of proof with respect to Issue #9; Respondent's decisions with respect to pipe cleaners are reversed; and it must initiate a reassessment of Petitioner's requests.

Issue #10

ISSUE

Whether Respondent properly terminated the provision of sanitation supplies and masks for Petitioners?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. Petitioners' representative previously requested sanitation supplies and N-95 masks for Petitioners, with her requests subsequently approved for years. (Testimony of Petitioners' representatives).

2. On November 2, 2021, Respondent notified Petitioners' representative via email that it "would be able to continue covering the disinfecting supplies beyond the state's pandemic status. (Exhibit #1, page 206).

3. Petitioners continued to request the items, as needed, on a monthly basis. (Testimony of Petitioners' representatives).

4. On May 19, 2023, Respondent sent Petitioners an Adverse Benefit Determination stating that their request for various supplies, including sanitation supplies and masks, had been denied. (Exhibit #1, pages 207-210).

5. With respect to the reason for those decision, the notices stated in part:

> This denial is based on assessment of type of service. Household cleaning products, available over the counter, was provided during public health emergency as related to shortage of supplies available, public health emergency ended, supplies readily available to purchase by guardian/participant.

* * *

> 30 N-95 masks are no longer necessary following end of the PHE. MI Choice will supply regular disposable masks.
>
> *Exhibit #1, pages 207, 210*

6. Petitioners subsequently filed an Internal Appeal with Respondent regarding that decision. (Exhibit #1, pages 211-212; Exhibit W, page 144).

7. As part of that Internal Appeal, Petitioners' representative stated that the items were never requested as part of the pandemic emergency, and that they were and are medically needed. (Exhibit #1, page 211).

8. On June 22, 2023, Respondent sent Petitioners Notices of Appeal Decision-Denial. (Exhibit #1, pages 46-49; Exhibit W, pages 144-147).

9. With respect to the reason for the appeal denial, the notices stated in part:

> Household cleaning products intended to maintain a clean environment are readily available and accessible, as the public health emergency has ended as of May 11, 2023. Per Medicaid Mi Choice Waiver exceptions during the public health emergency, goods and services, supplies, and other items were expanded in efforts to assist beneficiaries in securing and obtaining items that may be necessary to maintain a safe and clean environment during the public health emergency. During the time frame of the public health emergency, cleaning supplies and other supplies were provided to beneficiaries, with the expansion and exceptions of the Medicaid MI Choice Waiver program in place during the public health emergency. As of May 11, 2023, the public health emergency has ended, and therefore exceptions and expanded services being provided are being terminated as a result of the end of the public health emergency.
>
> * * *
>
> Bleach, Clorox wipes, and Clorox spray are household cleaning supplies that are readily available and accessible at this time at various retail locations. At time when Clorox wipes, spray, and bleach was provided through Medicaid MI Choice Waiver, there

was an identified shortage of supplies and difficulty obtaining items during the public health emergency. Items were additionally provided through the exceptions and expanded services of the Medicaid MI Choice Waiver contract in place during the public health emergency. The household cleaning supplies of bleach, Clorox wipes, and Clorox spray are being denied through this notice, as a result of changes to the MI Choice Waiver program good and services expanded and exceptions to services and items during the public health emergency.

A request for 30 N-95 masks per month has been made. Appropriate personal protective equipment necessary for best practice is provided and obtained through the provider agency for direct care of beneficiaries, including private duty nursing services and caregiver services through community living supports. Currently, beneficiaries receive direct care services from Albridge Skilled Home Care. Please contact Albridge for reference and additional information regarding personal protective equipment necessary for staff of the provider agency providing direct care services for daily protective equipment. Masks for beneficiary use have been provided prior to the public health emergency, with surgical masks purchased and provided through MI Choice Waiver, for beneficiary use when traveling outside of the home. During the public health emergency, N-95 masks were provided through exceptions and expanded services allowed through program exceptions, including challenges in obtaining and securing N-95 masks during the public health emergency. As the public health emergency has ended, as of May 11, 2023, the coverage of N-95 masks are being terminated. Surgical masks may be provided and covered, similar to coverage benefits prior to the public health emergency, for beneficiary use when traveling outside of the home. Please contact your supports coordinator to initiate the request for surgical masks, if required for use outside of home.

All supplies requested and responded to in this notice are supplies that are requested by beneficiary guardian on a monthly basis and evaluated monthly

> prior to authorization of service/item. No services and supplies included in this notice are ongoing services and are services/items that are evaluated monthly prior to authorization for review of necessity. Services/items will not continue to be provided at this time, as items are evaluated monthly and not an ongoing service.

Exhibit #1, pages 46-47
Exhibit W, pages 144-145

10. On June 28, 2023, MOAHR received the request for hearing filed by Petitioners in these consolidated matters. (Exhibit #1, pages 1-8).

CONCLUSIONS OF LAW

As discussed above, specialized medical equipment and supplies may be covered services through MI Choice, though they must still be medically necessary to be approved *See* MPM, April 1, 2023 version, MI Choice Chapter, pages 18, 45-46; 42 CFR 440.230(d).

Here, Petitioners have re-requested previously approved sanitation supplies and masks through Respondent, with those requests subsequently denied in May of 2023.

In appealing Respondent's actions, Petitioners bear the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned ALJ is limited to reviewing Respondent's decisions in light of the information available at the time the decisions were made.

Given the record in this case, Petitioners have met that burden of proof and Respondent's decisions should therefore be reversed.

Respondent denied the request on the basis that the requested items are no longer available through public health emergency rules, which ended as of May 11, 2023.

However, as credibly testified to by Petitioners' representative and expressly stated in Petitioners' Internal Appeal, Petitioners were not seeking the sanitation supplies and masks pursuant to the public health emergency; and, instead, they had initially and continually requested them pursuant to their plans of care and on the basis of medical necessity.

Whether or not the requested items are medically necessary, it is clear that Respondent never reviewed them on those grounds and, by failing to do so, it erred.

Accordingly, Petitioners have met their burden of proof with respect to Issue #10; Respondent's decisions with respect to sanitation supplies and masks are reversed; and it must initiate a reassessment of Petitioner's requests.

Issue #12

ISSUE

Whether Respondent properly denied a request for Community Living Supports (CLS) for Petitioner [redacted] while he was hospitalized?

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 [redacted] has been approved for CLS through Respondent. (Exhibit Y, page 154; Testimony of Petitioners' representative).

2. On May 27, 2023, he was hospitalized. (Exhibit #1, page 221; Testimony of Petitioners' representative).

3. On June 2, 2023, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that some services, including CLS, would be put on hold because he had been admitted to the hospital. (Exhibit Y, pages 154-156).

4. On June 19, 2023, Petitioner filed an Internal Appeal with Respondent regarding that decision. (Exhibit #1, page 54; Exhibit Z, page 158).

5. On July 18, 2023, Respondent sent Petitioner a Notice of Internal Appeal Decision-Denial. (Exhibit #1, pages 54-57; Exhibit Z, pages 158-161).

6. With respect to the reason for the appeal denial, the notice stated in part:

> Review of records indicates beneficiary was admitted to an inpatient hospital facility 5/28/2023 through 5/30/2023. An Adverse Benefit Determination notice was provided to beneficiary guardian on 5/28/2023 indicating that services of CLS would be temporarily suspended, following Medicaid MI Choice Waiver program requirements. The beneficiary remained enrolled in the program during hospitalization. Services of CLS were resumed upon discharge and return to the home setting.

> Community Living Support services have been denied while beneficiary hospitalized as not a covered benefit under the Medicaid MI Choice Waiver program to receive services while in the hospital setting, as per program standards, the hospital setting is not a residence or community setting for which CLS services are provided. Services and supports of necessary activities of daily living and instrumental activities of daily have been provided by hospital personnel and trained staff to provide services of support and maintain safety while in the hospital setting that would otherwise be provided in the home through the CLS service. Therefore, the CLS service has been denied under Medicaid MI Choice Waiver while beneficiary is in the hospital and receiving supportive services by hospital personnel, per program standards.

Exhibit #1, pages 54-55
Exhibit Z, pages 158-159

7. On June 28, 2023, MOAHR received the request for hearing filed by Petitioners in these consolidated matters. (Exhibit #1, pages 1-8).

CONCLUSIONS OF LAW

Regarding hospital admissions and CLS, the applicable version of the MPM states in part:

> ### 3.1.A.4. HOSPITAL ADMISSIONS
>
> A hospital admission is not an enrollment in a Benefit Plan or PET. Generally, waiver agencies do not provide MI Choice services, other than supports coordination (SC) and possibly continuation of a personal emergency response system (PERS), to participants while hospitalized.
>
> A MI Choice participant admitted to a hospital may remain enrolled in MI Choice for up to 30 days. *The waiver agency must provide the participant with an adverse benefit determination upon notification of a hospitalization if it is necessary for the agency to suspend MI Choice services during the hospitalization.* When the participant is hospitalized for less than 30 days, the participant's services may restart upon discharge from the hospital. If the participant is discharged after 30 days, the participant may

reenroll in MI Choice using standard enrollment procedures. If a participant is admitted to a nursing facility from a hospital before the 30th day of hospital stay, the last MI Choice eligibility date is the day before the date of nursing facility admission.

* * *

3.1.B. INSTITUTIONAL STAYS

There are occasions when a MI Choice participant requires a short-term admission to an institutional setting for treatment. The impact of such an institutional stay is dependent on the type of admission and the length of the stay.

A short-term hospital admission does not necessarily impact a participant's MI Choice enrollment status. The participant's supports coordinator must temporarily suspend the delivery of MI Choice waiver services during the hospital stay to avoid duplication of services from the hospital and MI Choice; however, the participant may remain enrolled in MI Choice. A participant who is hospitalized for more than 30 consecutive days must be disenrolled.

A participant admitted to a nursing facility for rehabilitation services or for any reason other than an approved short-term out-of-home respite stay must be disenrolled from MI Choice on the date prior to the nursing facility admission. The individual may be re-enrolled into MI Choice upon discharge from the nursing facility as long as the individual meets eligibility criteria as described in the Eligibility section of this chapter.

MPM, April 1, 2023 version
MI Choice Waiver Chapter, page 6
(italics added for emphasis)

4.1.D. COMMUNITY LIVING SUPPORTS

Definition	Community Living Supports (CLS) facilitate an individual's independence and promote participation in the community. CLS can be provided in the participant's residence or in community settings. CLS includes assistance to enable participants to accomplish tasks that they would normally

	do for themselves if able. The services may be provided on an episodic or a continuing basis. The participant oversees and supervises individual providers on an ongoing basis when participating in self-determination options. These services are provided only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third-party payer is capable of or responsible for their provision.
Requirements	CLS includes: ▪ Assisting, reminding, cueing, observing, guiding and/or training in: ➢ Activities of Daily Living (ADL) such as bathing, eating, dressing, personal hygiene, toileting, transferring, etc. * ➢ Laundry and other household activities ➢ Non-medical care (not requiring nurse or physician intervention) * ➢ Meal preparation (does not include the cost of the meals themselves); ➢ Money management; ➢ Shopping for food and other necessities of daily living; ➢ Social participation, relationship maintenance, and building community connections to reduce personal isolation; ➢ Training and assistance on activities that promote community participation

	such as using public transportation, using libraries, or volunteer work; * ➢ Transportation from the participant's residence to medical appointments, community activities, among community activities, and from the community activities back to the participant's residence; and ➢ Routine, seasonal, and heavy household care and maintenance ➢ Attendance at medical appointments ➢ Participation in regular community activities incidental to meeting the individual's community living preferences. ▪ Reminding, cueing, observing or monitoring of medication administration.* ▪ Dementia care including, but not limited to, redirection, reminding, modeling, socialization activities, and activities that assist the participant as identified in the individual's PCSP.* ▪ Staff assistance with preserving the health and safety of the participant in order that he/she may reside and be supported in the most integrated independent community setting.* ▪ Observing and reporting any change in the participant's condition and the home environment to the supports coordinator.* As applicable to the tasks being performed, the direct service provider furnishing CLS must have previous relevant experience or training and skills in housekeeping, household management, good health

	practices, observation, reporting, and recording information. Additionally, skills, knowledge, and experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable. When the CLS services provided to the participant include tasks identified with an asterisk (*) above, the direct service providers furnishing CLS must also: ▪ Be supervised by a RN licensed to practice nursing in Michigan. At the State's discretion, other qualified individuals may supervise CLS providers. For licensed residential settings, persons employed as facility owners or managers qualify to provide this supervision. The direct care worker's supervisor must be available to the worker at all times the worker is furnishing CLS services. ▪ Develop in-service training plans and ensure all workers providing CLS services are confident and competent in the following areas before delivering CLS services to MI Choice participants, as applicable to the needs of that participant: safety, body mechanics, and food preparation including safe and sanitary food-handling procedures. ▪ Provide an RN to individually train and supervise CLS workers who perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care for each participant who requires such care. The supervising RN must ensure each worker's confidence and competence in the performance of each task required. ▪ MDHHS strongly recommends each

	worker delivering CLS services complete a certified nursing assistant (CNA) training course, first aid, and CPR training. When the CLS services provided to the participant include transportation, the following standards apply: ▪ Waiver agencies may not use waiver funds to purchase or lease vehicles for providing transportation services to waiver participants. ▪ All paid drivers for transportation providers supported entirely or in part by MI Choice funds must be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider must offer such assistance unless expressly prohibited by either a labor contract or insurance policy. ▪ The provider must train all paid drivers for transportation programs supported entirely or in part by MI Choice funds to cope with medical emergencies unless expressly prohibited by a labor contract or insurance policy. ▪ Each provider must operate in compliance with PA 1 of 1985 regarding seat belt usage. ▪ When transportation incidental to the provision of CLS is included, it shall not also be authorized as a separate waiver service for the participant. Individuals providing CLS must be at least 18 years old, and able to communicate effectively both orally and in writing and follow instructions. Members of a participant's family may

	provide CLS to the participant. However, waiver agencies must not directly authorize MI Choice funds to pay for services furnished to a participant by that person's spouse. Family members who provide CLS must meet the same standards as providers who are not related to the participant. The waiver agency or provider agency must train each worker to perform properly each task required for each participant the worker serves before delivering the service to that participant. The supervisor must ensure that each worker competently and confidently performs every task assigned for each participant served. Each direct service provider who chooses to allow staff to assist participants with self-medication must establish written procedures that govern the assistance given by staff to participants with self-medication. These procedures must be reviewed by a consulting pharmacist, physician, or RN and must include, at a minimum: ▪ The provider staff authorized to assist participants with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the participant takes and its impact upon the participant. ▪ Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers. ▪ Instructions for entering medication information in participant files.

	▪ A clear statement of the participant's and participant's family's responsibility regarding medications taken by the participant and the provision for informing the participant and the participant's family of the provider's procedures and responsibilities regarding assisted self-administration of medications. CLS providers may only administer medications in compliance with Michigan Administrative Rule 330.7158: ▪ A provider must only administer medication at the order of a physician and in compliance with the provisions of section 719 of the act, if applicable. ▪ A provider must ensure that medication use conforms to federal standards and the standards of the medical community. ▪ A provider must not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment. ▪ A provider must review the administration of a psychotropic medication periodically as set forth in the participant's PCSP and based upon the participant's clinical status. ▪ If a participant cannot administer his or her own medication, a provider must ensure that medication is administered by or under the supervision of personnel who are qualified and trained. ▪ A provider must record the administration of all medication in participant's clinical record. ▪ A provider must ensure that staff report medication errors and adverse drug

	reactions to the participant's physician immediately and properly and record the incident in the participant's clinical record. CLS provided in a residential setting like assisted living, Adult Foster Care, or Homes for the Aged, includes only those services and supports that are in addition to, and must not replace, usual and customary supports and services furnished to residents in the licensed setting. CLS does not include the costs associated with room and board. Documentation in the participant's record must clearly identify the participant's need for additional supports and services not covered by licensure. The PCSP must clearly identify the portion of the participant's supports and services covered by CLS. Homemaking tasks incidental to the provision of assistance with ADL may also be included in CLS but must not replace usual and customary homemaking tasks required by licensure. When CLS services are provided to the participant under a self-determination arrangement, the individual furnishing CLS must also be trained in cardiopulmonary resuscitation. This training may be waived when the provider is furnishing services to a participant who has a "Do Not Resuscitate" order. These service needs differ in scope, nature, supervision arrangements, or provider type (including provider training and qualifications) from services available in the State Plan. The differences between the waiver coverage and the State Plan are that the provider qualifications and training requirements are more stringent for CLS tasks as provided under the waiver than the requirements for these types of services under the State Plan.

Limitations	CLS does not include the costs associated with room and board. When transportation incidental to the provision of CLS is included, the waiver agency must not also authorize transportation as a separate waiver service for the participant. CLS excludes nursing and skilled therapy services. The phrase "These services are provided only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third-party payer is capable of or responsible for their provision" included in the definition of this service shall be interpreted as follows: ▪ All informal supports must agree to provide the uncompensated (informal) services and supports to the participant as specified in the PCSP. Specifically, the record must show the following: ➢ All persons providing informal services and supports included on the PCSP are aware of and capable of performing the tasks assigned to them for the benefit of the participant as included in the person-centered service plan. ➢ All informal supports agree to any financial liability related to the informal services and supports assigned to them on the person-centered service plan. This includes uncompensated or voluntary transportation of the participant. ➢ Supports coordinators or other waiver agency staff did not arbitrarily assign the completion of services

	and supports that could otherwise be included as CLS to informal supporters. Rather, both the participant (or their responsible party) and the informal support agree in writing (by their signature on the person-centered service plan) to the provision of the identified services and supports as discussed during a person-centered planning meeting. Relatives, caregivers, landlords, community or volunteer agencies, or other third-party payers have been contacted on behalf of the participant and agree to provide services and supports to the participant because they are both capable of and responsible for the provision of the identified services and supports. This agreement is noted by an authorized signature on the person-centered service plan from a representative of the entity identified as responsible for the services and supports.

MPM, April 1, 2023 version
MI Choice Waiver Chapter, pages 23-27

Here, Respondent denied Petitioner [redacted] request for CLS while he was hospitalized pursuant to the above policies and on the basis that CLS must be suspended while a beneficiary is hospitalized.

In appealing that decision, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred.

Given the record in this case, Petitioner has failed to meet that burden of proof and Respondent's decision must therefore be affirmed.

As noted by Respondent, this issue has been the subject of previous administrative hearings involving the parties and, in both cases, the hearing officers upheld the denial of CLS while Petitioners were hospitalized. *See* Exhibit AA.

Moreover, even reviewing the decision and Petitioner's new arguments, the undersigned ALJ reaches the same conclusion because the specific policy found in the MPM regarding MI Choice waiver services still expressly states: "The participant's

supports coordinator must temporarily suspend the delivery of MI Choice waiver services during the hospital stay to avoid duplication of services from the hospital and MI Choice". MPM, April 1, 2023 version, MI Choice Waiver Chapter, page 6.

Moreover, while Petitioner correctly asserts that Respondent must comply with the Federal Home and Community Based Services Settings Requirements as specified in 42 CFR 441.301 *et seq.*, as well as in the Home and Community-Based Services Chapter in the MPM, neither of those authorities support Petitioner's argument here.

For example, the Home and Community-Based Services Chapter in the MPM provides in part:

> **3.2 SETTINGS NOT COMPLIANT WITH THE HCBS FINAL RULE REQUIREMENTS**
>
> *Some settings have been identified by CMS as not HCB due to institutional status and will never be considered HCB. These settings are:*
>
> - Nursing facilities
> - Institutions for mental disease
> - Intermediate care facilities for individuals with intellectual disabilities
> - *Hospitals*
> - Other locations that have characteristics of an institution (e.g., Child Caring Institutions)
>
> *MPM, April 1, 2023 version*
> *Home and Community Based Services Chapter, page 8*
> *(italics added for emphasis)*

Similarly, 42 CFR §441.301 continues to provide:

> *(b) If the agency furnishes home and community-based services, as defined in § 440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must—*
>
> *(1) Provide that the services are furnished—*
>
> (i) Under a written person-centered service plan (also called plan of care) that is based on a person-

centered approach and is subject to approval by the Medicaid agency.

(ii) *Only to beneficiaries who are not inpatients of a hospital, NF, or ICF/IID;* and

42 CFR 441.301(b)(1)(ii)
(italics added for emphasis)

(c) A waiver request under this subpart must include the following—

* * *

(4) **Home and Community-Based Settings.** Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

* * *

(5) ***Settings that are not Home and Community-Based.*** *Home and community-based settings do not include the following:*

(i) A nursing facility;

(ii) An institution for mental diseases;

(iii) An intermediate care facility for individuals with intellectual disabilities;

(iv) *A hospital*; or

(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid

> HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

42 CFR 441.301(c)
(italics added for emphasis)

Accordingly, while Petitioner presents some persuasive authority suggesting that the prohibition against services such as CLS while a beneficiary is hospitalized only applies to hospitals certified for and providing long-term care services, as opposed to general acute Medicaid hospital services, the applicable policies remain clear in this case; both Respondent and the undersigned ALJ are bound by them; and Respondent's decision with respect to CLS while Petitioner [redacted] was hospitalized must be affirmed.

Issue #13

ISSUE

Whether Respondent properly refused to implement Petitioners' May 11, 2023, plans of care?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On May 11, 2023, person-centered planning meetings were held with respect to Petitioners' needs and services, with both Petitioners' representative and supports coordinators present. (Exhibit #1, page 263).

2. That same day, plans of care were drafted for Petitioners and signed by Petitioners' representative and supports coordinators. (Exhibit #1, pages 263-285).

3. Subsequently, requests were made for specific items outlined in the plans of care. (Testimony of Petitioners' representative; Testimony of Director of Quality and Utilization Management).

4. Some of those specific requests were approved, some denied, and some approved in part and denied in part. (Testimony of Petitioners' representative; Testimony of Director of Quality and Utilization Management).

5. On June 19, 2023, Petitioners filed an Internal Appeal with Respondent regarding the implementation of their plans of care. Exhibit #1, pages 58, 60).

6. On July 18, 2023, Respondent sent Petitioner Notices of Internal Appeal Decision-Not Applicable. Exhibit #1, pages 58-61).

7. In part, those notices stated:

> We found your appeal request to be Not Applicable for Internal Appeal for the service/item listed above because:
>
> Review of records indicates specific services requested and denied have been provided an Adverse Benefit Determination and reviewed and appealed, as applicable and requested, in separate denial and/or appeal responses. The request of appeal for not implementing the plan of care as written by the guardian from May 11, 2023 is not applicable for internal appeal, as no denial or termination of the plan of care in whole has occurred.
>
> The request will be reviewed as a grievance and responded to separately through AAANM's grievance response system. For individual and specific services written in the plan of care by beneficiary guardian that have been denied, Adverse Benefit Determination notices have been provided and appealed, as requested, through the appeal process.

Exhibit #1, page 58
Exhibit #1, page 60

8. On June 28, 2023, MOAHR received the request for hearing filed by Petitioners in these consolidated matters. (Exhibit #1, pages 1-8).

CONCLUSIONS OF LAW

As discussed above, with respect to services through MI Choice, the MPM states in part:

> **SECTION 4 – SERVICES**
>
> The array of services provided by the MI Choice program is subject to the prior approval of CMS. Waiver agencies are required to authorize all approved waiver services that a

participant needs to live successfully in the community that are:

- indicated by the current assessment;
- detailed in the person-centered service plan (PCSP); and
- authorized in accordance with the provisions of the approved waiver.

Services must not be authorized unless they are defined in the PCSP and must not precede the establishment of a PCSP. Waiver agencies cannot limit in aggregate the number of participants receiving a given service or the number of services available to any given participant. Participants have the right to receive services from any willing and qualified provider within the waiver agency's provider network. When the waiver agency does not have a willing and qualified provider within their network, the waiver agency must utilize an out-of-network provider at no cost to the participant until an in-network provider can be secured. (Refer to the Providers section of this chapter for information on qualified provider standards.) MDHHS, waiver agencies, and direct service providers must not impose a copayment or any similar charge upon participants for waiver services.

MDHHS and waiver agencies do not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Although MI Choice participants must have services approved by the waiver agency, participants have the option to select any participating provider in the waiver agency's provider network, thereby ensuring freedom of choice.

Services paid for with MI Choice funds must not duplicate nor replace services available through the State Plan. Where applicable, the participant must use State Plan, Medicare, or other available payers first. MI Choice is the funding source of last resort. The participant's preference for a certain provider is not grounds for declining another payer in order to access waiver services.

Providers must have previous relevant experience or training for the tasks specified and authorized in the PCSP. The

> waiver agency must deem the chosen provider capable of performing the required tasks.
>
> For services involving transportation paid for with MI Choice funds, the Secretary of State must appropriately license all drivers and vehicles, and all vehicles must be appropriately insured as required by law.
>
> Healthcare Common Procedure Coding System (HCPCS) codes for each service can be found in the Directory Appendix of the Medicaid Provider Manual.
>
> *MPM, April 1, 2023 version*
> *MI Choice Waiver Chapter, page 18*

Here, Petitioners seek a hearing with respect to Respondent's implementation of their plans of care.

However, for the same reasons discussed in a previous Decision and Order issued in a case involving the parties, the undersigned ALJ finds that he lacks jurisdiction over these claims, and they must therefore be dismissed.

Petitioners' services are to be developed through the person-centered process and identified in the plan of service, with meetings typically held between beneficiaries, their case managers, and others as part of the process of developing a plan.

However, Petitioners point to no authority that all provisions of the plan are enforceable simply because a plan was developed; and, as provided in the above policy, services must be both detailed in a plan and authorized in accordance with the provisions of the approved waiver to be approved.

Here, as discussed above, Respondent approved or denied specific requests as they came in, and, to the extent requests were denied or denied in part, Petitioners were able to appeal any denial of specific services, with many of the denials discussed above.

Moreover, to the extent there is any dispute about Respondent's handling of the person-centering planning process, that dispute is outside the undersigned ALJ's jurisdiction in this matter. *See* 42 CFR 438.400; 42 CFR 438.402; 42 CFR 438.408.

Accordingly, while denials of specific services may be appealable, with many such denials addressed above, Petitioners' general claims regarding the implementation of their plans of care do not constitute an action that the undersigned Administrative Law Judge has jurisdiction over here.

DECISION AND ORDER

As discussed above, eleven issues were raised in Petitioners' request for hearing and addressed during the hearing itself, with the issues numbered as #1-#6, #8-#10, #12-#13 as Petitioners had no Issue #7 and Issue #11 was withdrawn at the onset of the hearing.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, now decides that Respondent's actions should be affirmed in part and reversed in part, with Issue #13 outside of the ALJ's jurisdiction; Respondent's actions with respect to Issues #1, #2, #4, #5, #8 and #12 proper; and Respondent's actions with respect to Issues #3, #6, #9 and #10 improper.

IT IS THEREFORE ORDERED that:

- Petitioners' claim with respect to the implementation of their plans of care is **DISMISSED.**

- Respondent's actions with respect to requests for hand sanitizer, deep cleaning chore services, an HVAC assessment, backboards, a Theraworx U-Pack, and CLS are **AFFIRMED.**

- Respondent's actions with respect to requests for probe covers, baby wipes, pipe cleaners, sanitation supplies, and masks are **REVERSED,** and it must initiate a reassessment of those requests.

Steven Kibit

SK/sj

Steven Kibit
Administrative Law Judge

NOTICE OF APPEAL: Petitioners 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

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 11th day of October 2023.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

Via Electronic Mail:

Petitioner
[redacted] MI [redacted]

Petitioner
[redacted] MI [redacted]

Authorized Hearing Representative
[redacted] MI [redacted]

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