Michigan Office of Administrative Hearings and Rules
P.O. BOX 30763
LANSING, MI 48909

Date Mailed: April 30, 2025
Docket No.: 25-007980
Case No.: [redacted]
Petitioner: [redacted]

[redacted]
MI [redacted]

This is an important legal document. Please have someone translate the document.
هذه وثيقة قانونية مهمة. يرجى أن يكون هناك شخص ما يترجم المستند.
এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।
Este es un documento legal importante. Por favor, que alguien traduzca el documento.
这是一份重要的法律文件，请让别人翻译文件。
Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and upon a request for hearing filed on behalf of Petitioner [redacted] (Petitioner).

After due notice, a telephone hearing was held on April 2, 2025. [redacted], the minor Petitioner's mother, appeared and testified on Petitioner's behalf. [redacted], Board Certified Behavior Analyst (BCBA), also testified as a witness for Petitioner. Pamela Fachting, Director of Integrated Services, appeared and testified on behalf of Respondent Gratiot Integrated Health Network (Respondent). Diane Vogrig, Limited License Psychologist, and Dr. Katrina Rhymer, License Psychologist, also testified as witnesses for Respondent.

During the hearing, Petitioner submitted an evidence packet that was admitted into the record without objection as Exhibit #1, pages 1-27. Respondent also submitted an evidence packet that was admitted into the record without objection as Exhibit A, pages 1-290. No other proposed exhibits were submitted by either party.

ISSUE

Did Respondent properly decide to terminate Petitioner's Behavioral Health Treatment (BHT) 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. Petitioner is a [redacted] Medicaid beneficiary who has been diagnosed with a major neurocognitive disorder, secondary to the chromosomal disorder IQSEC2; attention-deficit/hyperactivity disorder; and epilepsy. (Exhibit #1, page 14).

2. In February of 2021, a Limited License Psychologist completed an Initial Autism Evaluation of Petitioner for Respondent. (Exhibit A, pages 13-19).

3. As part of that evaluation, the Limited License Psychologist reviewed Petitioner's records; observed Petitioner at the psychologist's office; performed an Autism Diagnostic Interview – R (ADI-R) with Petitioner's parents; administered the Autism Diagnostic Observation Schedule, Second Edition (ADOS-2) Module 1 to Petitioner; and completed a Developmental Disability-Children's Global Assessment Scale (DD-CGAS). (Exhibit A, pages 13-19).

4. In her subsequent report, the Licensed Psychologist concluded in part:

> [Petitioner] [redacted] was referred for an autism evaluation due to concerns regarding social deficits such as; lack of social-emotional reciprocity, absence of interest in others/peers, and repetitive play. In addition, [Petitioner's] current diagnosis of Epilepsy and Chromosome Disorder IQ SEEQ, testing was recommended due to the high co-morbidity of Autism Spectrum Disorder with these other disorders. The purpose of this evaluation was to determine whether the presenting concerns were consistent with ASD.
>
> [Petitioner] is a delightful [redacted] with a pleasant demeanor and a sweet nature. When unhappy she will whine/scream, may growl, hit or kick.
>
> [Petitioner] demonstrated several strengths throughout the assessment process including pleasantly engaging and cooperating/tolerating the play as she seems to not be interested in the moment. She also demonstrated many traits of Autism Spectrum Disorder, both in substantial functional impairment in Social Communication &

> Social Interaction, as well as substantial restricted repetitive patterns of behavior, examples of which are found elsewhere in this report.
>
> After reviewing and considering all information obtained during testing and utilizing the requirements for Medical Necessity from the State of Michigan, [Petitioner] meets the criteria of an Autism Spectrum Disorder Diagnosis and a recommendation for the Autism Benefit Waiver and ABA Therapy.
>
> [Petitioner] presents with significant features of Autism Spectrum Disorder and the recommended [sic] is intervention ABA Therapy is necessary to promote her communication as well as improving her socialization skills and reducing repetitive behaviors. Applied Behavioral Analysis (ABA) is type of therapy that can improve social, communication and learning skills through positive reinforcement. Many experts consider ABA to be the gold standard treatment for children with autism spectrum disorder or other developmental conditions.
>
> [Petitioner] meets criteria for a diagnosis of ASD . . .

Exhibit A, pages 3-4

5. Petitioner then began receiving BHT services, including ABA therapy, through Respondent. (Exhibit A, pages 20-21, 232-290).

6. On December 8, 2021, another Autism Assessor for Respondent recommended that Petitioner continue with Petitioner's current level of ABA interventions, with progress being reported. (Exhibit A, pages 221-222).

7. Petitioner also received special education services through her school. (Exhibit #1, pages 6-27; Exhibit A, pages 130-170).

8. Overall, Petitioner's symptoms have improved since she began receiving services in 2021. (Testimony of Petitioner's representative; Testimony of BCBA).

9. In November of 2024, a Licensed Psychologist conducted a required re-evaluation of Petitioner for Respondent. (Exhibit A, pages 29-36; Testimony of Respondent's representative).

10. As part of that evaluation, the Licensed Psychologist reviewed Petitioner's records; observed Petitioner at Petitioner's school and the psychologist's office; performed an ADI-R with Petitioner's parents; administered the ADOS-2 Module 2 to Petitioner; and completed a DD-CGAS. (Exhibit A, pages 29-36; Testimony of Licensed Psychologist).

11. In her subsequent report, the Licensed Psychologist concluded in part:

> [Petitioner] [redacted] was referred for a 3-year Autism Re-evaluation. Current concerns include: learning, recalling material that she was taught, difficulty answering yes/no questions, needing choices to make a correct decision, limited social chat, limited back-and-forth conversation, poor social skills, needing to follow a routine, difficulty with transitions at school, chewing on her finger, difficulty with crowds/too many people, and sensory concerns.
>
> In 2021, [Petitioner] [redacted] was diagnosed with autism; however, COVID-19 precautions were in place. Furthermore, [Petitioner] has a rare genetic condition (IQSEC2) and epilepsy. [Petitioner's] cognition, academic achievement, and adaptive skills are well below average. A feature of IQSEC2 is developmental regression and it is not yet known whether lost skills can be re-learned.
>
> After reviewing and considering all information obtained during testing and utilizing the requirements for Medical Necessity from the State of Michigan. [Petitioner] does not meet the criteria of an Autism Spectrum Disorder Diagnosis and a recommendation for the Autism Benefit Waiver and ABA Therapy.
>
> [Petitioner] does not meet criteria for a diagnosis of ASD . . .

Exhibit A, page 33

12. On January 10, 2025, Respondent sent Petitioner's representative an Adverse Benefit Determination stating that, effective January 21, 2025, Petitioner's ABA and related services would be terminated. (Exhibit A, pages 37-44).

13. With respect to the reason for that action, the Adverse Benefit Determination stated that the "clinical documentation does not establish medical necessity". (Exhibit A, page 37).

14. On January 21, 2025, Petitioner's representative filed an Internal Appeal with Respondent regarding that decision. (Exhibit A, pages 45-51)

15. As part of the review of Petitioner's Internal Appeal, Respondent referred Petitioner's case to Diana Vogrig, a Limited License Psychologist. (Exhibit A, pages 84-87).

16. Ms. Vogrig did not meet with Petitioner or evaluate her face-to-face; and, instead, just completed a chart review. (Testimony of Limited License Psychologist).

17. In her subsequent report, she detailed the records, in addition to describing Petitioner's background information and previous testing. (Exhibit A, pages 84-87).

18. Ms. Vogrig's report also concluded:

> Information gathered during this record review do not support a diagnosis of autism spectrum disorder and continuation of the autism benefit (applied behavior analysis/ABA) is not recommended at this time.

Exhibit A, page 87

19. On February 10, 2025, Respondent sent Petitioner's representative written notice that Petitioner's Internal Appeal had been denied. (Exhibit A, pages 88-94).

20. Regarding the reason for the denial, the notice stated in part:

> The most recent evaluations, including the 2024 autism re-evaluation, do not support a diagnosis of autism spectrum disorder. While [Petitioner] has developmental concerns related to a genetic condition, her diagnoses include intellectual disability and ADHD rather than ASD. Academic records further confirm that she does not qualify for special education services due to autism but does receive support under Other Health Impairment (OHI). As a result, the request for continued autism benefits, including ABA therapy, will not be granted at this time.

Exhibit A, page 89

21. On March 3, 2025, MOAHR received the request for hearing filed in this matter with respect to that decision. (Exhibit A, pages 99-100).

CONCLUSIONS OF LAW

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

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

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

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

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

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

Here, as discussed above, Petitioner has been receiving Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA) services through Respondent. With respect to such services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **SECTION 18 – BEHAVIORAL HEALTH TREATMENT SERVICES/APPLIED BEHAVIOR ANALYSIS**
>
> The purpose of this policy is to provide for the coverage of Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA), for children under 21 years of age diagnosed with Autism Spectrum Disorder (ASD). All children, including children with ASD, must receive EPSDT services that are designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services, to correct or ameliorate any physical or behavioral conditions so that health problems are averted or diagnosed and treated as early as possible.
>
> BHT services prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the child. Medical necessity and recommendation for BHT services is determined by a physician, or other licensed practitioner working within their scope of practice under state law. Direct patient care services that treat or address ASD under the state plan are available to children under 21 years of age as required by the EPSDT benefit.
>
> **18.1 SCREENING**
>
> The American Academy of Pediatrics (AAP) endorses early identification of developmental disorders as being essential to the well-being of children and their families. Early identification of developmental disorders through screening by health care professionals should lead to further evaluation, diagnosis, and treatment. Early identification of a developmental disorder's underlying etiology may affect the medical treatment of the child and the parent's/guardian's intervention planning.

Screening for ASD typically occurs during an EPSDT well child visit with the child's primary care provider (PCP). EPSDT well child visits may include a review of the child's overall medical and physical health, hearing, speech, vision, behavioral and developmental status, and screening for ASD with a validated and standardized screening tool. The EPSDT well child evaluation is also designed to rule out medical or behavioral conditions other than ASD, and include those conditions that may have behavioral implications and/or may co-occur with ASD. A full medical and physical examination must be performed before the child is referred for further evaluation.

18.2 REFERRAL

The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the Pre-paid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. The PCP must refer the child to the PIHP in the geographic service area for Medicaid beneficiaries. The PIHP will contact the child's parent(s)/guardian(s) to arrange a follow-up appointment for a comprehensive diagnostic evaluation and behavioral assessment. Each PIHP will identify a specific point of access for children who have been screened and are being referred for a diagnostic evaluation and behavioral assessment of ASD. If the PCP determines the child who screened positive for ASD is in need of occupational, physical, or speech therapy, the PCP will refer the child directly for the service(s) needed.

After a beneficiary is screened and the PCP determines a referral is necessary for a follow-up visit, the PIHP is responsible for the comprehensive diagnostic evaluation, behavioral assessment, BHT services (including ABA) for eligible Medicaid beneficiaries, and for the related EPSDT medically necessary Mental Health Specialty Services. Occupational therapy, physical therapy, and speech therapy for children with ASD who do not meet the eligibility requirements for developmental disabilities by the PIHP are covered by the Medicaid Health Plan or by Medicaid Fee-for-Service.

18.3 COMPREHENSIVE DIAGNOSTIC EVALUATIONS

Accurate and early diagnosis of ASD is critical in ensuring appropriate intervention and positive outcomes. The comprehensive diagnostic evaluation must be performed before the child receives BHT services. The comprehensive diagnostic evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning, and should include validated evaluation tools. Based on the evaluation, the practitioner determines the child's diagnosis, recommends general ASD treatment interventions, and refers the child for a behavior assessment which is provided or supervised by a board certified and licensed behavior analyst (BCBA/LBA) to recommend more specific ASD treatment interventions. The diagnostic evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. A qualified licensed practitioner includes:

- a physician with a specialty in psychiatry or neurology;
- a physician with a subspecialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline;
- a physician with a specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or behavioral health;
- a psychologist;
- an advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health;
- a physician assistant with training, experience, or expertise in ASD and/or behavioral health; or
- a masters level, fully licensed clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD.

The determination of a diagnosis by a qualified licensed practitioner is accomplished by following best practice standards. The differential diagnosis of ASD and related conditions requires multimodal assessment and integration of clinical information. This is a complex assessment procedure in which clinicians must integrate data from caregiver reports, records (e.g., medical, school, other evaluations), collateral reports (e.g., teachers, other treatment providers), data gathered from utilization of standardized psychological tools (e.g., developmental, cognitive, adaptive assessment), and the observational assessment to determine diagnostic and clinical impressions. The utilization of multiple data modes and sources improves the reliability of ASD diagnosis. No one piece of data determines the ASD diagnosis, and evaluators should consider the accuracy of data and confounding factors that may impact data obtained (e.g., parent who seems to be overly negative about the child, child who was intensely shy during observational assessment).

18.4 MEDICAL NECESSITY CRITERIA

Medical necessity and recommendation for BHT services are determined by a physician or other licensed practitioner working within their scope of practice under state law. Comprehensive diagnostic reevaluations are required no more than once every three years, unless determined medically necessary more frequently by a physician or other licensed practitioner working within their scope of practice. The recommended frequency should be based on the child's age and developmental level, the presence of comorbid disorders or complex medical conditions, the severity level of the child's ASD symptoms, and adaptive behavior deficits through a person-centered, family-driven youth-guided process involving the child, family, and treating behavioral health care providers.

The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria A and B (listed below); and require BHT services to address the following areas:

A. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by all of the following:

   1. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.

   2. Deficits in nonverbal communicative behaviors used for social interaction ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.

   3. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.

B. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least two of the following:

   1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases).

   2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take same route or eat the same food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects and/or excessively circumscribed or perseverative interest).

4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, and/or visual fascination with lights or movement).

18.5 DETERMINATION OF ELIGIBILITY FOR BHT

The following is the process for determining eligibility for BHT services for a child with a confirmed diagnosis of ASD. Eligibility determination and recommendation for BHT must be performed by a qualified licensed practitioner through direct observation utilizing valid evaluation tools. BHT services are available for children under 21 years of age with a diagnosis of ASD from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and who have the developmental capacity to clinically participate in the available interventions covered by BHT services. A well-established DSM-IV diagnosis of Autistic Disorder, Asperger's Disorder or PDD-NOS should be given the diagnosis of ASD. Children who have marked deficits in social communication but whose symptoms do not otherwise meet criteria for ASD should be evaluated for social (pragmatic) communication disorder.

To be eligible for BHT, the following criteria must be met:

- Child is under 21 years of age.

- Child received a diagnosis of ASD from a qualified licensed practitioner utilizing valid evaluation tools.

- Child is medically able to benefit from the BHT treatment.

- Treatment outcomes are expected to develop, maintain, or restore, to the maximum extent practicable, the functioning of a child with ASD.

Measurable variables may include increased social-communication skills, increased interactive play/age-appropriate leisure skills, increased reciprocal and functional communication, etc.

- Coordination with the school and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, participation in team meetings (i.e., Individualized Education Plan/Individualized Family Service Plan [IEP/IFSP], Individual Plan of Service [IPOS], etc.).

- Services are able to be provided in the child's home and community, including centers and clinics.

- Symptoms are present in the early developmental period (symptoms may not fully manifest until social demands exceed limited capacities or may be masked by learned strategies later in life).

- Symptoms cause clinically significant impairment in social, occupational, and/or other important areas of current functioning that are fundamental to maintain health, social inclusion, and increased independence.

- Medical necessity and recommendation for BHT services are determined by a qualified licensed practitioner.

- Services must be based on the individual child and the parent's/guardian's needs and must consider the child's age, school attendance requirements, and other daily activities as documented in the IPOS. Families of minor children are expected to provide a minimum of eight hours of care per day on average throughout the month.

18.6 PRIOR AUTHORIZATION

BHT services are authorized for a time period not to exceed 365 days.

The 365-day authorization period for services may be re-authorized annually based on recommendation of medical necessity by a qualified licensed practitioner working within their scope of practice under state law.

18.7 RE-EVALUATION

Comprehensive diagnostic re-evaluations are required no more than once every three years, unless determined medically necessary more frequently by a physician or other licensed practitioner working within their scope of practice. The recommended frequency should be based on the child's age and developmental level, the presence of comorbid disorders or complex medical conditions, the severity level of the child's ASD symptoms and adaptive behavior deficits through a person-centered, family-driven youth-guided process involving the child, family, and treating behavioral health care providers.

18.8 TRANSITION AND DISCHARGE CRITERIA

The desired BHT goals and outcomes for discharge should be specified at the initiation of services, monitored throughout the duration of service implementation, and refined through the behavioral service level evaluation process. Transition and discharge from all BHT services should generally involve a gradual step-down model and require careful planning. Transition and discharge planning from BHT services should include transition goal(s) within the behavioral plan of care or plan, or written plan, that specifies details of monitoring and follow-up as is appropriate for the individual and the family or authorized representative(s) utilizing the PCP process.

Discharge from BHT services should be reviewed and evaluated by a qualified BHT professional for children who meet any of the following criteria:

- The individual has achieved treatment goals and less intensive modes of services are medically necessary and/or appropriate.

- The individual is either no longer eligible for Medicaid or is no longer a State of Michigan resident.

- The individual, family, or authorized representative(s) is interested in discontinuing services.

- The individual has not demonstrated measurable improvement and progress toward goals, and the predicted outcomes as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of the BHT interventions are not able to be maintained or they are not replicable beyond the BHT treatment sessions through the successive authorization periods.

- Targeted behaviors and symptoms are becoming persistently worse with BHT treatment over time or with successive authorizations.

- The services are no longer medically necessary, as evidenced by use of valid evaluation tools administered by a qualified licensed practitioner.

- The provider and/or individual/family/authorized representative(s) are unable to reconcile important issues in treatment planning and service delivery to a degree that compromises the potential effectiveness and outcome of the BHT service.

MPM, January 1, 2025 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 163-167

Here, as discussed above, Respondent decided to terminate Petitioner's BHT services pursuant to the above policies.

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

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has not met her burden of proof and that Respondent's decision must therefore be affirmed.

Respondent's witnesses fully and thoroughly explained the basis for the decision in this case. In particular, the Licensed Psychologist who conducted the re-evaluation, which was required by policy given the length of time that had passed since Petitioner's previous re-evaluation credibly described her review of Petitioner's records, her observations, the tests that she conducted, and the conclusions she reached. Moreover, while she also suggested some reasons for why her evaluation came out different than the one conducted years earlier, such as the previous test being affected by COVID-19 protocols or the presence of Petitioner's other diagnoses, the reason is less important than her well-supported conclusion, based on her thorough evaluation, that Petitioner no longer meets the criteria for an ASD diagnosis or BHT services at this time.

Additionally, while the Limited License Psychologist who evaluated Petitioner as part of the Internal Appeal process only completed a chart review, and did not evaluate Petitioner face-to-face, her credible testimony regarding her review, and the lack of issues with how the re-evaluation was completed and determination that Petitioner no longer met the criteria for BHT services was reached, likewise supports Respondent's determination in this case.

Moreover, while Petitioner's representative and Petitioner's BCBA both testified that Petitioner continues to exhibit symptoms of ASD and meets the criteria for BHT services, their testimony is ultimately unpersuasive given the remainder of the record in this case. Both of them acknowledge that Petitioner's symptoms have improved since she was first diagnosed and, while they dispute some of the Licensed Psychologist's findings, that re-evaluation was conducted by a qualified licensed practitioner, using direct observation and common and valid evaluation tools, and neither could identify any specific flaws in how it was conducted.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent properly decided to terminate Petitioner's BHT services.

IT IS THEREFORE ORDERED that:

Respondent's decision is **AFFIRMED**.

Steven Kibit

SK/sj

Steven Kibit
Administrative Law Judge

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to LARA-MOAHR-DCH@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

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