

**BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA**

In the Matter of:

Claimant,

and

Frank D. Lanterman Regional Center,

Service Agency.

DDS No. CS0028774

OAH No. 2025080185 (Secondary)

DECISION

Erlinda Shrenger, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter on September 3, 2025, November 4, 2025, and January 8, 2026, at the OAH regional office in Los Angeles.

Claimant's mother (Mother), who is an attorney, was represented claimant. Claimant and her family members are identified by titles to protect their privacy.

Jessica Glassman, Attorney, Waterson Huth & Glassman, represented Frank D. Lanterman Regional Center (Service Agency or FDLRC).

Testimony and documentary evidence were received. At the conclusion of the hearing on January 8, 2026, the record was held open and the hearing was continued to January 16, 2026, to allow the parties to file and serve written closing briefs by January 16, 2026. The parties timely filed their closing briefs. Service Agency's brief was marked and admitted as Exhibit 18. Claimant's brief was marked and admitted as Exhibit C64.

The record closed and the matter was submitted for decision on January 16, 2026.

ISSUE

Should Service Agency be required to purchase pediatric concierge occupational therapy (OT) services from Kinspire Health for parent training, support, education, and coaching?

EVIDENCE RELIED ON

Documentary: Service Agency exhibits 1-18; claimant exhibits C1, C3, C6, C7, and C35-C64.

Testimonial: Jackelyne Vargas, FDLRC Service Coordinator; Eduardo Guillen, FDLRC Regional Manager; and Mother.

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FACTUAL FINDINGS

Jurisdictional Matters

1. Claimant is a six-year-old girl who is eligible for regional center services on the basis of autism. (Exh. S, C54, C52.)

2. By a Notice of Action dated May 29, 2025, Service Agency notified Mother her request to fund parent training, support, education, and coaching through Kinspire Health, a pediatric concierge OT service provider, was denied. On July 28, 2025, Mother filed an Appeal Request to appeal Service Agency's denial.

Claimant's Background

3. Claimant lives at home with Mother. She was placed with Mother as a foster child in March 2023. Mother subsequently adopted claimant and is raising her as a single-parent. Mother has been a special education attorney for over 17 years and was formerly a teacher for four years.

4. In addition to autism, claimant has been diagnosed with sensory processing disorder, pica, attention-deficit/hyperactivity disorder (ADHD), and a speech and language disorder. According to Mother, claimant has been struggling since August 2024 with eating food, condiments, and candy that she finds in the trash, on the floor, or on lunch tables at school. She often eats too quickly and puts too much food in her mouth. Claimant takes food from other students' lunch trays, lunch boxes, and backpacks, hides the food in her shirt, and then runs to the bathroom to eat it. Mother believes these behaviors are due to claimant's sensory processing disorder, pica, autism, and past childhood trauma.

5. According to claimant's Individual Program Plan (IPP) dated March 25, 2025 (Exhibit 3), Mother reported that claimant has sensory issues, and is sensitive to noise, touch, and smells. Claimant gets upset when she does not get her way. She will cry, yell, and throw herself to the ground when she is upset. Her tantrums last from 10 to 15 minutes up to one hour. Claimant also shuts down and will not answer simple questions from her caregivers, school staff, or therapists.

6. Claimant is a first grader at a transitional kindergarten through eighth grade community public school. She is eligible for special education services and supports as a student with speech or language impairment (SLI). Pursuant to claimant's Individualized Education Program (IEP) dated May 23, 2025, the school district assigned a qualified adult assistant to support claimant during school hours and meals to address her tendency to mouth and chew non-food and food items, and to ensure safe transitions. (Exh. C58, p. B333.)

7. The May 23, 2025 IEP also indicates the school district offered to provide 300 minutes per year of school-based OT services, as follows: 30 minutes every other week (180 minutes) and the remaining 120 minutes used to update strategies directly with the student and for collaboration with the classroom teacher and parent to adjust strategies as needed. (Exh. C58, p. B338.) After Mother requested an informal dispute resolution, the school district agreed to provide 30 minutes per week of OT services starting in October 2025. (Exh. C64, p. B365.)

8. The May 23, 2025 IEP states, in part: "[Mother] frequently raised concerns about Pica (tendency to mouth and chew non-food and food items, including paper, pencil shavings, masks, shirts, and food from the floor/trash) and food hoarding, noting it did not occur in preschool, at home, or in the community. She believes [claimant's] pica is an [*sic*] OT related, related to anxiety." (Exh. C58, p. B338.)

9. At all relevant times, claimant has a health insurance plan with Medi-Cal. Effective June 1, 2025, claimant's health insurance plan was changed from Medi-Cal to a private health insurance plan through LA Care. (Exh. C63.)

Kinspire Health

10. Kinspire Health is a pediatric OT services provider that operates in 10 states, including California. Kinspire Health is not a vendored service provider under the Lanterman Act.

11. According to its website, Kinspire Health's occupational therapists develop personalized treatment plans, provide live virtual OT sessions, use parent coaching sessions to align strategies and promote consistency, and provide consultation support via HIPAA-compliant messaging, video, voice, and photo sharing through the Kinspire Health app. (Exh. C60, pp. B354-B355.)

12. According to its website, Kinspire Health does not accept insurance and is an out-of-network provider. (Exh. 6, p. A49.) Kinspire Health provides a "concierge" level of OT services, which means that, for payment of a monthly membership fee, patients receive personalized treatment plans, parent support and coaching, and unlimited 24/7 access to a dedicated occupational therapist for consultation, instruction and support. (Exh. 5, p. A31.)

13. Kinspire Health offers two levels of membership. (Exh. 6, p. A48.) The Virtual Concierge Membership costs \$299.00 per month. The Hybrid In-Person Concierge Membership is \$399 per month, but this membership is not available in Los Angeles. In this case, Mother seeks funding of \$299 per month for a Virtual Concierge Membership with Kinspire Health.

Mother's Funding Request for Parent Training and Coaching

14. Mother is requesting Service Agency fund Kinspire Health for parent training and coaching services that specifically address pica, sensory processing disorder, and executive functioning skills. Mother contends claimant's health insurance and the school district do not offer parent training and 24/7 parent coaching that address these specific areas. Mother has taken multiple parent training courses, attended conferences, researched and read multiple books about claimant's multiple diagnoses, and sought support from parent groups. (Exh. C61, C62.) Mother has found that most of the trainings and resources available provide only general information that she already knows. (Exh. C64, p. B367.) Mother found Service Agency's Koch-Young Resource Center (KYRC) lacked information related to pica. (Exh. C6, p. B77)

15. Mother contends she needs 24/7 access to an OT provider so she can receive real-time support to address claimant's behavioral challenges as they occur. For example, if claimant has a meltdown at the mall, Mother could call Kinspire Health and speak to her dedicated occupational therapist about the situation. Mother acknowledged, however, there may be times when the therapist may not be immediately available to communicate with her. Mother noted Kinspire Health also has a chat function for families to communicate with their dedicated therapist. However, Mother did not fully explain how she would type in a chat while claimant is having a meltdown.

16. Mother contends no one has been able to explain the reason for claimant's behaviors, especially her pica. Mother believes the parent training and coaching from Kinspire Health will help to discover the root cause of claimant's behaviors. Mother claims she has spoken to the Chief Executive Officer (CEO) of

Kinspire Health, who confirmed that Kinspire Health can address Mother's specific concerns.

Service Agency's Contentions

KINSPIRE HEALTH IS A PROVIDER OF OT SERVICES

17. Service Agency contends it is required by law to classify Kinspire Health as a provider of OT, not parent training services. A regional center shall classify a vendor as a provider of OT if the vendor is an occupational therapist validly licensed by the California Board of OT and provides OT evaluation, treatment planning, treatment, instruction and consultative services. (Cal. Code Regs., tit. 17, § 54342, subd. (a)(53)(A).) Kinspire Health's OT services are provided by licensed occupational therapists trained in child development. (Exh. 5, p. A31.) Kinspire Health's occupational therapists develop personalized treatment plans, provide live virtual OT sessions, provide parent coaching sessions and 24/7 consultation support through the secure Kinspire Health app. (Exh. C60, p. B354.)

18. Kinspire Health's OT services include "[p]arent support & coaching." (Exh. 5, p. A31.) The parent coaching sessions are used "to align strategies, address stress, and promote consistency." (Exh. C60, p. B355.) The parent support and coaching are inextricably intertwined with Kinspire Health's OT services. There is no indication on Kinspire Health's website that it provides parent coaching and training separate and apart from its OT services. Under these circumstances, Service Agency contends Mother's funding request for parent support and coaching from Kinspire Health is properly considered a request for OT services. On cross-examination, Mother testified she did not know if Kinspire Health separates its OT services from parent training. There is no indication on the Kinspire Health website that it provides parent training

and coaching separate and apart from its OT services. Mother admitted claimant will receive direct OT services through Kinspire Health's Virtual Concierge Membership if her appeal is granted.

FAILURE TO EXHAUST GENERIC RESOURCES

19. Under the Lanterman Act, when purchasing services and supports, regional centers must ensure that consumers and their families are utilizing generic resources, such as school districts, Medi-Cal, and private health insurance. Service Agency contends claimant's school district and her LA Care Medi-Cal health insurance plan are generic resources responsible for providing claimant's OT services and parent training if needed.

20. At hearing, Mother confirmed claimant is currently receiving OT services through claimant's school district and, therefore, Mother is "not seeking direct [OT] services from Kinspire Health." (Exh. C64, p. B369.) Mother contends the school district's OT services do not include any parent training or coaching. (*Ibid.*) Mother contends the school district and claimant's health insurance "do not offer parent training and 24/7 parent coaching" in the specific areas of pica, sensory processing disorder, and executive functioning skills. (*Id.*, p. B367.) Mother contends she needs "more tailored and consistent support, training, and coaching by a licensed occupational therapist to address [claimant's] pica and her current fixation on eating trash, which Kinspire Health purports to do." (*Id.*, p. B370.)

21. Service Agency's Purchase of Service (POS) policy does not allow the purchase of medical services, such as OT, when the family has private health insurance but chooses not to pursue that resource. (Exh. 9, p. 2.) The POS policy for OT services provides that Service Agency may purchase OT services "once the family has

exhausted all generic sources of payment, including the school district, Medi-Cal, California Children's Services and other public or private third party insurance. Families who are eligible for any of these programs must provide evidence that the requested service is not available from the generic source." (Exh. 10, p. A84.) Here, Mother has not provided evidence that OT services are not available through claimant's LA Care Medi-Cal health insurance plan. Mother's claim that she does not understand Medi-Cal does not relieve her of the obligation to exhaust all generic sources of payment for claimant's OT services.

22. Service Agency is required to consider the parent's responsibility for providing care to a child without a disability. (Welf. & Inst. Code, § 4646.4, subd. (a)(4).) Parents are responsible for the cost of their child's medical services, such as OT, if they choose to receive services from private providers who do not accept insurance. Service Agency contends: "If Claimant's mother wants to receive Pediatric Concierge Occupational Therapy services from Kinspire Health in addition to or instead of in-network medical services, she would be responsible for the cost of these services." (Exh. 16, p. A98.)

KINSPIRE HEALTH IS NOT A VENDORED SERVICE PROVIDER

23. Under the Lanterman Act, regional centers are required to fund services through vendored service providers. (Welf. & Inst. Code, § 4648, subd. (a)(3)(A).) Service providers must complete a detailed application process in order to be approved as a vendored provider. (Cal. Code Regs., tit. 17, § 54310.)

24. Service Agency's POS policy provides: "Typically, services and supports funded by the Regional Center must be purchased from providers who are vendored or otherwise authorized by the Department of Developmental Services (DDS) to

provide such services and supports. However, individuals that are participating in the Self-Determination Program, receiving Participant-Directed Services, or utilizing Social Recreation, Camp and Non-Medical Therapies through community providers may elect to choose a service provider that is not vendored by [Service Agency].” (Exh. 9, p. A81.)

25. Service Agency contends Kinspire Health is not a vendored service provider and DDS has not authorized Kinspire Health’s provision of virtual OT services as a parent training service. Eduardo Guillen, FDLRC Regional Manager, testified Service Agency considered the exception criteria specified in the POS policy and determined the exception criteria do not apply in this case. Claimant does not participate in the Self-Determination Program. Kinspire Health does not provide any of the Participant-Directed Services defined in California Code of Regulations, title 17, section 58886, which include day care services, nursing services, respite, transportation, Independent Living Services, Personal Assistance Services (PAS), supported employment services, and Community-Based Training Service for Adults.

26. Finally, Mr. Guillen explained concierge pediatric OT is not an allowable social recreation activity, camping service, or non-medical therapy because those services are not provided in an inclusive, community-based setting. Mr. Guillen explained that OT services are not analogous to allowable social recreation activities and camping services, such as YMCA programs, local community resource centers, martial arts, swimming, and gymnastics classes. He also explained that OT services are not analogous to allowable non-medical therapies, such as specialized recreation, horseback riding, art, dance, and music classes.

27. In its closing brief, Service Agency argues that it properly denied Mother’s funding request for pediatric concierge OT services from Kinspire Health because: (1) OT services cannot be purchased under the guise of parent training

services, (2) claimant can receive OT services through her LA Care Medi-Cal health insurance plan but Mother is not utilizing her generic resources, (3) parents are responsible for the cost of their children's out-of-network medical services, and (4) regional centers are not allowed to purchase virtual OT services from non-vendored service providers. (Exh. 18.)

LEGAL CONCLUSIONS

Jurisdiction and Burden of Proof

1. The Lanterman Developmental Disabilities Services Act (Lanterman Act) governs this case. (Welf. & Inst. Code, §§ 4500 et seq.)

2. When one seeks government benefits or services, the burden of proof is on that party. (*Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161.) The standard of proof in this case is the preponderance of the evidence, because no law or statute (including the Lanterman Act) requires otherwise. (Evid. Code, § 115.) Preponderance of the evidence means evidence that has more convincing force than that opposed to it. (*Glage v. Hawes Firearms Co.* (1990) 226 Cal.App.3d 314, 324.)

3. In this case, claimant seeks funding for OT services with Kinspire Health that Service Agency has not previously agreed to provide. Therefore, claimant has the burden of proving by a preponderance of the evidence she is entitled to the requested funding. (See Evid. Code, § 500.) Claimant did not meet her burden.

Lanterman Act

4. A regional center is required to secure the services and supports that meet the needs of the consumer, as determined in the consumer's IPP. (§ 4646, subd.

(a)(1.) The determination of which services and supports are necessary for each consumer shall be made through the IPP process. (§ 4512, subd. (b).) The determination shall be made on the basis of the needs and preferences of the consumer or, when appropriate, the consumer's family, and shall include consideration of a range of service options proposed by IPP participants, the effectiveness of each option in meeting the goals stated in the IPP, and the cost-effectiveness of each option. (*Ibid.*)

5. Pursuant to section 4646.4, subdivision (a), when purchasing services and supports for a consumer, a regional center shall ensure the following: (1) conformance with the regional center's purchase of service policies, as approved by the Department of Developmental Services pursuant to section 4434, subdivision (d); (2) use of generic services and supports when appropriate; (3) use of other services and sources of funding as contained in section 4659; and (4) consideration of a family's responsibility for providing similar services and supports for a minor child without disabilities.

6. Regional center funds "shall not be used to supplant the budget of any agency that has a legal responsibility to serve all members of the general public and is receiving public funds for providing those services." (§ 4648, subd. (a)(8).)

7. Regional centers are required to identify and pursue all possible sources of funding for consumers receiving regional center services. Such sources of funding include governmental entities or programs required to provide or pay for the cost of providing services, including Medi-Cal and school districts, and private entities to the extent they are liable for the cost of services, aid, insurance, or medical assistance to the consumer. (§ 4659, subd. (a)(1), (2).)

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8. Pursuant to section 4659, subdivision (c), "regional centers shall not purchase any service that would otherwise be available from Medi-Cal, . . . private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage."

9. Pursuant to section 4659, subdivision (d)(1), "a regional center shall not purchase medical . . . services for a consumer three years of age or older unless the regional center is provided with documentation of a Medi-Cal, private insurance, or a health care service plan denial and the regional center determines that an appeal by the consumer or family of the denial does not have merit." Subdivision (d)(1) further provides that regional centers may pay for medical services during the following periods: "(A) While coverage is being pursued, but before a denial is made. [¶] (B) Pending a final administrative decision on the administrative appeal if the family has provided to the regional center a verification that an administrative appeal is being pursued. [¶] (C) Until the commencement of services by Medi-Cal, private insurance, or a health care service plan."

Discussion

10. In this case, the preponderance of the evidence supports Service Agency's contention that it properly denied Mother's funding request for OT services from Kinspire Health. Service Agency is not permitted to purchase OT services from Kinspire Health, a non-vendored service provider. Also, Service Agency may not purchase OT services from Kinspire Health when claimant can receive OT services under her Medi-Cal health insurance plan but Mother has chosen not to use that generic resource. OT services cannot be purchased under the guise of purchasing parent training services. Mother admitted that if her appeal is granted, claimant would

receive direct OT services from Kinspire Health. The Kinspire Health website does not indicate it provides parent training and coaching separate and apart from OT services.

ORDER

Claimant's appeal is denied. Service Agency is not required to purchase pediatric concierge occupational therapy services from Kinspire Health for parent training, support, education, and coaching.

DATE:

ERLINDA SHRENGER

Administrative Law Judge

Office of Administrative Hearings

NOTICE

This is the final administrative decision. Each party is bound by this decision. Either party may request a reconsideration pursuant to subdivision (b) of Welfare and Institutions Code section 4713 within 15 days of receiving the decision, or appeal the decision to a court of competent jurisdiction within 180 days of receiving the final decision.

**BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA**

In the Matter of:

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and

Frank D. Lanterman Regional Center,

Service Agency.

DDS No. CS0028774

OAH No. 2025080185 (Secondary)

ORDER DENYING CLAIMANT'S MOTION FOR RECONSIDERATION

On February 2, 2026, an administrative law judge from the Office of Administrative Hearings, serving as a hearing officer, issued a final decision in this matter (Decision). The Decision sustained Service Agency's denial of Claimant's request for funding of parent training, support, education, and coaching offered by Kinspire Health, a pediatric concierge occupational therapy service.

On February 17, 2026, Claimant's authorized representative applied to the Office of Administrative Hearings for reconsideration of the Decision (Motion). The

Motion was timely submitted. Service Agency was notified of the Motion but did not file a response.

The undersigned hearing officer did not hear the matter or write the decision for which reconsideration is requested.

A party may apply for reconsideration to correct a mistake of fact or law or a clerical error in the decision, or to address the decision of the original hearing officer not to recuse themselves following a request pursuant to Welfare and Institutions Code section 4712, subdivision (g). (Welf. & Inst. Code, § 4713, subd. (b).) Pursuant to section 4713, subdivision (d), the application for reconsideration must be decided within 15 days of receipt; the hearing officer responsible for deciding the application may deny it, grant it and modify the decision, or grant it and set the matter for another hearing.

The language of Welfare and Institutions Code section 4713, subdivision (b), considered with the expedited deadline for deciding an application set by section 4713, subdivision (d), makes clear that the mistake of fact or law in question must be apparent from the decision (for example, an obvious mathematical error in calculating hours of service, an order that fails to accurately encompass the facts or legal conclusions, citation to the wrong statute, or reliance on a law that is no longer in effect). Nothing in section 4713 suggests that an application for reconsideration contemplates the hearing officer reviewing the entire record, including the admitted exhibits and the recording of the hearing, to determine if the hearing officer made errors in evidentiary rulings or made mistakes of fact or law. That process is undertaken in an appeal of the decision to the Superior Court, not in an application for reconsideration pursuant to section 4713.

Claimant's Basis for Reconsideration

Claimant seeks reconsideration of the following claimed mistakes of fact or law:

(1) The hearing officer improperly admitted and relied on Service Agency's Closing Brief despite its late submission. Claimant avers the hearing officer set a deadline of January 16, 2026, at 5:00 p.m., for the parties' submission of closing briefs. While Claimant filed her closing brief within the deadline, Service Agency did not file its brief until 7:50 p.m. on January 16, 2026, nearly three hours past the deadline. According to Claimant, Service Agency's closing brief therefore "should be excluded as evidence in this case." (Motion, p. 6.)

(2) The hearing officer improperly admitted the testimony of Service Coordinator Jackelyn "Jackie" Vargas (SC Vargas) despite Claimant's inability to complete SC Vargas's cross-examination. According to Claimant, SC Vargas testified on behalf of Service Agency on September 3, 2025, the first day of hearing in the case. Claimant's authorized representative began SC Vargas's cross-examination that same day, but she was unable to complete the cross-examination because of time constraints. Claimant's authorized representative could not resume SC Vargas's cross-examination on the subsequent hearing days because SC Vargas left Service Agency's employ. On November 4, 2025, the second day of hearing, after hearing argument from the parties, the hearing officer excluded SC Vargas's testimony. However, on January 8, 2026, the third day of hearing, before Claimant's authorized representative began her testimony, the hearing officer advised the parties that she had changed her mind and would admit SC Vargas's testimony. According to Claimant, the hearing officer's decision to admit SC Vargas's testimony prejudiced Claimant's case because Claimant's authorized representative "was under the impression that SC Vargas' testimony would be excluded, and therefore the [authorized representative] did not

need to negate all of the statements made by SC Vargas in the [authorized representative's] testimony." (Motion, p. 7.) Claimant asserts that the last-minute introduction of previously excluded evidence raises questions of fairness and impartiality.

(3) The hearing officer failed to consider the arguments in Claimant's closing brief and instead relied solely on the untimely closing brief of Service Agency. Claimant asserts that the hearing officer failed to address the following arguments in Claimant's closing brief: (1) that Kinspire Health is willing to become a vendored service provider; (2) that Claimant's circumstances warrant an exception from the vendored service provider requirement in the Lanterman Developmental Disabilities Services Act (Lanterman Act), and (3) that the requirement that services offered be provided in person is inapplicable.

Analysis

Claimant does not identify any mistakes of fact or law made by the hearing officer.

Regarding the acceptance of a late filing, the hearing officer's decision to accept a closing brief filed three hours late was not only within her discretion as a hearing officer but also consistent with the goal of the Lanterman Act to encourage the free and open exchange of information. (See Welf. & Inst. Code, § 4712, subd. (b)(2) ["training of administrative law judges shall include methods to create an impartial and informal hearing environment that encourages the free and open exchange of information . . ."].) Claimant does not demonstrate any prejudice by the hearing officer's decision to consider Service Agency's brief. Moreover, a closing brief does not constitute evidence; it is merely argument. (Cal. Code Regs., tit. 17, § 50938, subd. (a))

[closing briefs shall not include new or additional evidence].) Accordingly, the hearing officer's consideration of Service Agency's late closing brief does not constitute grounds for reconsideration.

Regarding the admission of SC Vargas's testimony, it is not clear whether the mistakes of fact or law contemplated by Welfare and Institutions Code section 4713 were intended to include evidentiary rulings made during the hearing. A determination concerning the correctness of the hearing officer's rulings regarding the admissibility of testimony can only be decided after reviewing the entire record, which is not contemplated by section 4713. In any event, Claimant fails to articulate the basis of the hearing officer's decision to admit the testimony, making it impossible to determine whether the decision was improper as a matter of law. Claimant also fails to identify the prejudice she sustained by her inability to complete her cross-examination. Moreover, according to Claimant's timeline, Claimant's authorized representative had the opportunity to address SC Vargas's statements during Claimant's authorized representative's own testimony. Nor is there evidence that Claimant's authorized representative requested leave to call additional witnesses or submit additional documents to address SC Vargas's testimony. Accordingly, the hearing officer's admission of SC Vargas's testimony does not constitute grounds for reconsideration.

Regarding the hearing officer's alleged failure to consider the arguments asserted in Claimant's closing briefs and consideration of only Service Agency's closing brief, Claimant's assertions are conclusory and reflect a misunderstanding of the purpose of a closing brief. As noted above, a closing brief does not constitute evidence, and the hearing officer is not required to explicitly address every argument made by a party in the hearing officer's decision and order. That the hearing officer cited arguments made by Service Agency in its closing brief does not demonstrate that

the hearing officer failed to consider the arguments contained in Claimant's closing brief. Moreover, the hearing officer's decision to not respond directly to Claimant's assertions regarding Kindred Health's willingness to become a vendored service provider, expressly address whether Claimant's condition warrants an exception to the vendored service provider requirements, or accept Claimant's characterization of the nature of services received from Kindred Health, does not demonstrate that the hearing officer's legal conclusions are unsupported by the evidence adduced at the hearing. Claimant's disagreement with those conclusions does not constitute grounds for reconsideration.

Based on the foregoing, the motion for reconsideration must be denied.

ORDER

Claimant's motion for reconsideration of the final decision is denied.

DATE:

CINDY F. FORMAN
Administrative Law Judge
Office of Administrative Hearings