STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF: [REDACTED],

Claimant

Reg. No.: 2009-24060
Issue No.: 2009/4031
Case No.: [REDACTED]
Load No.: [REDACTED]
Hearing Date:
July 16, 2009
Wayne County DHS (76)

ADMINISTRATIVE LAW JUDGE: Colleen M. Mamelka

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Claimant's request for a hearing. After due notice, a telephone hearing was conducted from Detroit, Michigan on July 16, 2009. The Claimant appeared and testified. [REDACTED] appeared on behalf of the Department. At the Claimant's request, the record was extended to allow for the submission of additional medical records.

The additional records were received, reviewed, and entered in to the record as Exhibit 6. This matter is now before the undersigned for a final determination.

ISSUE

Whether the Department properly determined that the Claimant was no longer disabled for purposes of continued State Disability Assistance ("SDA") and was not disabled for purposes of Medical Assistance ("MA") program?

FINDINGS OF FACT

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

1. The Claimant submitted an application for public assistance seeking Medical Assistance ("MA-P") and State Disability Assistance ("SDA") benefits on July 17, 2008.
2. On March 6, 2009, the Medical Review Team ("MRT") deferred the MA-P disability determination in order to allow time for the Department to obtain additional medical records. (Exhibit 1, p. 13)
3. On this same date, March 6th, the Claimant was approved for SDA benefits with a review date set for April 2009. (Exhibit 1, p. 13)
4. On March 17, 2009, the Claimant attended a Department scheduled examination. (Exhibit 1, pp. 5 – 12)
5. On March 27, 2009, the MRT found the Claimant not disabled for purposes of the MA-P program and no longer disabled for purposes of continued SDA benefits. (Exhibit 1, pp. 3, 4)
6. On March 30, 2009, the Department sent an Eligibility Notice to the Claimant informing him that he was found not disabled. (Exhibit 1, p. 1)
7. On April 14, 2009, the Department received the Claimant's written Request for Hearing. (Exhibit 2, pp. 1 – 3)
8. On June 9, 2009, the State Hearing Review Team ("SHRT") determined the Claimant not disabled. (Exhibit 5)
9. The Claimant's alleged physical disabling impairment(s) are due to chronic back, neck, shoulder, and knee, lumbar disc herniation, headaches, dizziness, and closed head injury.
10. The Claimant's alleged mental impairments are due to post-traumatic stress disorder, depression, and neurological deficits.

11. At the time of hearing, the Claimant was 38 years old with an [redacted] birth date; was 6'2" in height; and weighed 180 pounds.

12. The Claimant has the equivalence of a high school education with a work history in home improvement.

13. The Claimant's impairment(s) have lasted, or are expected to last, continuously for a period of 12-months or longer.

CONCLUSIONS OF LAW

The Medical Assistance ("MA") program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department of Human Services ("DHS"), formally known as the Family Independence Agency, pursuant to MCL 400.10 *et seq* and MCL 400.105. Department policies are found in the Program Administrative Manual ("PAM"), the Program Eligibility Manual ("PEM"), and the Program Reference Manual ("PRM").

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a) The person claiming a physical or mental disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-relate activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913 An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a) Similarly, conclusory statements by a

physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.929(a)

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicants takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3) The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2)

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1) The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (i.e. age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need evaluate subsequent steps. 20 CFR 416.920(a)(4) If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4) If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from step three to step four.

20 CFR 416.920(a)(4); 20 CFR 416.945 Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1) An individual's residual functional capacity assessment is evaluated at both steps four and five. 20 CFR 416.920(a)(4) In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv) In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a) An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a) The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6)

In addition to the above, when evaluating mental impairments, a special technique is utilized. 20 CFR 416.920a(a) First, an individual's pertinent symptoms, signs, and laboratory findings are evaluated to determine whether a medically determinable mental impairment exists. 20 CFR 416.920a(b)(1) When a medically determinable mental impairment is established, the symptoms, signs and laboratory findings that substantiate the impairment are documented to include the individual's significant history, laboratory findings, and functional limitations. 20 CFR 416.920a(e)(2) Functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. *Id.;* 20 CFR 416.920a(c)(2) Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality is considered. 20 CFR 416.920a(c)(1) In addition, four broad functional areas

(activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of functional limitation. 20 CFR 416.920a(c)(3) The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4) A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. *Id.* The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. *Id.*

After the degree of functional limitation is determined, the severity of the mental impairment is determined. 20 CFR 416.920a(d) If severe, a determination of whether the impairment meets or is the equivalent of a listed mental disorder. 20 CFR 416.920a(d)(2) If the severe mental impairment does not meet (or equal) a listed impairment, an individual's residual functional capacity is assessed. 20 CFR 416.920a(d)(3)

As outlined above, the first step looks at the individual's current work activity. An individual is not disabled regardless of the medical condition, age, education, and work experience, if the individual is working and the work is a substantial, gainful activity. 20 CFR 416.920(a)(4)(i) In the record presented, the Claimant is not involved in substantial gainful activity therefore is not ineligible for disability under Step 1.

The severity of the Claimant's alleged impairment(s) is considered under Step 2. The Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b) An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR

916.920(a)(4)(ii); 20 CFR 916.920(c) Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b) Examples include:

1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

5. Responding appropriately to supervision, co-workers and usual work situations; and

6. Dealing with changes in a routine work setting.

Id. The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985) An impairment qualifies as non-severe only if, regardless of a claimant's age, education, or work experience, the impairment would not affect the claimant's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985)

In the present case, the Claimant alleges physical and mental disability due to chronic back, neck, shoulder, and knee, lumbar disc herniation, headaches, dizziness, closed head injury, post-traumatic stress disorder, depression, and neurological deficits.

By way of background, the Claimant was involved in two motor vehicle accidents; one on [redacted] and the other on [redacted]. In support of his claim, older records resulting from the [redacted] accident were submitted to include a MRI report of the cervical spine which found multi-level disc herniations with foraminal encroachment; a MRI of the left

shoulder which documented a partial tear from the joint surface of the rotator cuff post prior reconstructive surgery with deformity of the anterior glenoid labrum as well as osteoarthritic degenerative changes.

On , the Claimant attended a consultative examination. X-rays documented a previous surgical repair and AC joint arthrosis and type II acromion. Spurring was seen inferiorly on the lumeral head with some post degenerative changes. The MRI confirmed a partial tear of the undersurface of the rotator cuff with some attrition at the anterior glenoid. Ultimately, the Claimant was found to have post left shoulder trauma with cuff tear with some new instability and acromioclavicular joint arthropathy; right shoulder pain; and bilateral hand and upper extremity discomfort.

On , the Claimant presented for a follow-up appointment with continued complaints of left should pain and weakness. After review of x-rays and MRI report, arthroscopy was recommended.

On , the Claimant was treated for left shoulder pain and weakness. The Claimant's previously scheduled surgery was cancelled. The physical examination showed positive signs for impingement with pain in the AC joint. The MRI revealed a partial tear of the rotator cuff with some anterior capsular thickening. AC joint damage was noted. X-rays documented type III acromion with AC joint arthrosis. The Claimant was diagnosed with persistent shoulder pain with instability and cuff tear with acromioclavicular joint damage. Surgery was recommended.

On , a disability certificate was completed by a physician on behalf of the Claimant finding him disabled from employment, housework, and caring for self, for the period from October 2007 through August 2008 (estimated).

On [redacted], a Medical Examination Report was completed on behalf of the Claimant. The current diagnosis was listed as disc herniation confirmed through a positive MRI. The Claimant was occasionally able to lift/carry less than 5 pounds and was unable to reach, push, and/or pull with either upper extremity. The Claimant was able to perform simple grasping and fine manipulation with both hands/arms however the he was unable to meet his daily needs in the home. No further limitations were noted.

On [redacted] [redacted], the Claimant was a pedestrian who was hit by a motor vehicle. The Claimant was admitted to the hospital with multiple right knee fractures. A CT of the brain revealed soft tissue swelling in the left frontal region. A CT of the right knee revealed a displaced fracture involving the posterior aspect of the lateral tibial plateau and a small avulsion fracture from the posterior aspect of the medial tibial plateau. The discharge summary was not submitted however it appears, based on the objective medical records, that the Claimant was discharged on or about [redacted] [redacted].

On [redacted], the Claimant attended a follow-up examination documented a fracture of the lateral tibial plateau with depression of the articular surface; avulsion fracture involving the medial tibial plateau; and joint effusion with considerable soft tissue swelling. Ultimately, the Claimant was diagnosed with polytrauma; lateral tibial plateau fracture; disc joint disruption with cervical spine facet joint sprain; and neck/shoulder/back trauma.

On [redacted], a MRI of the Claimant's right knee was performed which documented failure extensive injury to the knee joint to include subchondral fracturing and ACL and medial meniscus tears.

On ██████████, a MRI of the lumbar spine was performed which revealed bilateral herniation of the disc at L4-L5, right greater than left with facet hypertrophy and foraminal stenosis, and broad based right posterolateral herniation at L5-S1.

On ██████████, the Claimant attended a Department ordered evaluation. The examination found the Claimant recovering from the ██████ █ pedestrian/MVA accident. The Claimant was found to have osteoarthritis and spinal disorder noting multiple problems requiring assistive device for effective ambulation. The multiple fractures were also documented with corresponding range of motion limitations. The Claimant's clinical need for a walking aid was also noted.

On ██████████, the Claimant attended a follow-up appointment which documented a perineural cyst involving the sleeve of the S1 root on the right with early onset desiccation, L5-S1 disc joint with neurocompressive herniation, and a broad-based annular bulge at L4-5. The MRI of the right knee revealed polytrauma with lateral tibial plateau fracture secondary to neck/back/shoulder trauma.

On ██████████, a cervical spine MRI was performed which revealed an annular bulge at C3-4, C5-6, and C6-7 with indentation of the thecal sac and contact with the anterior aspect of the cord at C3-4. Developmental narrowing of the AP diameter of the central canal.

On ██████████, the Claimant attended a follow-up examination. The physical examination documented "great tenderness globally" with pain about the knee with a limited range of motion. In review of the MRI, a questionable fissure in the lateral meniscus was revealed with suggestion of an impaction injury at the medial femoral condyle. Ultimately, the Claimant was diagnosed with a questionable meniscal tear with a possible "bucket handle

component." The Claimant was prescribed treatment to include a course of physical therapy on the knee, noting that arthroscopy surgery may be considered.

On December 10, 2008, the Claimant's physician completed a disability certificate finding the Claimant disabled from September 7, 2008 through January 7, 2009.

On January 5, 2009, a Medical Examination Report was completed on behalf of the Claimant. The current diagnoses were listed as lumbar disc herniation (MRI), closed head injury, and right knee fractures. The physical examination was positive for spasms with a reduced range of motion. The Claimant was limited to occasionally lifting/carrying less than 5 pounds; standing and/or walking less than 2 hours during an 8-hour workday with sitting limited to less than 6 hours during the same time period. The Claimant was required to use an assistive device for ambulation with the inability to perform repetitive actions involving reaching, pushing, and pulling with his upper extremities. The Claimant was unable to perform repetitive action with his feet/legs. The Claimant was able to perform simple grasping and fine manipulation with his right hand/arm. Mental limitations were noted regarding the Claimant's comprehension and memory. The Claimant was determined to be unable to meet the activities necessary for daily living.

On this same date, the disability certificate was completed finding the Claimant disabled through February 2009.

On [redacted], the Claimant attended a follow-up evaluation. X-rays found no instability, deformity, malalignment, or obvious fractures. Previous MRI's were requested for review. The Claimant was found to have cervical, thoracic, and lumbar pain; cervical and lumbar radiculopathy; and cervical and lumbar discogenic pain.

On [redacted], the Claimant attended a follow-up evaluation. The Claimant was referred to an additional month of physical therapy noting the need for surgical repair of the right knee. The physician opined that the Claimant was unable to engage in employment due to musculoskeletal impairments.

On February 18, 2009, the Claimant's physician completed a disability certificate certifying the continuation of the Claimant's disability through March of 2009.

On [redacted], the Claimant attended a follow-up evaluation with virtually the same diagnoses from the February evaluation.

On [redacted], the Claimant attended a Department ordered evaluation. The physical examination found muscle strength 3-/5 in the right knee noting the Claimant's ability to stand as fair. Based on the examination, the physician opined that the Claimant would be unable to engage in employment due to limitations in walking, carrying, pushing, pulling, climbing stair, ropes, ladders, and/or scaffolding. The need for a walking aid was clinically necessary to reduce pain and prevent from falling.

On [redacted], the Claimant attended a psychotherapy evaluation. The Claimant was found to have post-traumatic disorder due to pain as a result of the two motor vehicle accidents. The Global Assessment Functioning ("GAF") was 50.

In May of 2009, the Claimant attended a follow-up appointment. The Claimant's multiple fractures involving the right knee requiring surgical intervention was documented. The Claimant was found unable, from a musculoskeletal perspective, to safely participate in any activity due to his limited ambulation; difficulty with standing, sitting, and neck movements, as well as stress/strain on the upper extremities. Household assistance/replacement services were

required as well as attendant care. The physician opined that the Claimant was disabled from working.

On [redacted], the Claimant attended a follow-up appointment. The physical examination, which was limited to the Claimant's knee, found the right knee compromised by about one third. Again, the Claimant's ability to engage in activity from a musculoskeletal perspective was extremely limited noting the Claimant was disabled from employment.

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the Claimant has presented medical evidence establishing that he does have some physical limitations on his ability to perform basic work activities. The medical evidence has established that the Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, the Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The Claimant has alleged physical disabling impairment(s) due to chronic back, neck, shoulder, and knee, lumbar disc herniation, headaches, dizziness, and closed head injury.

Listing 1.00 defines musculoskeletal system impairments. Disorders of the musculoskeletal system may result from hereditary, congenital, or acquired pathologic processes. 1.00A Impairments may result from infectious, inflammatory, or degenerative processes, traumatic or developmental events, or neoplastic, vascular, or toxic/metabolic diseases. 1.00A

Regardless of the cause(s) of a musculoskeletal impairment, functional loss for purposes of these listings is defined as the inability to ambulate effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment, or the inability to perform fine and gross movements effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment. 11.00B2a Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. 1.00B2b(1) Ineffective ambulation is defined generally as having insufficient lower extremity function to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities. (Listing 1.05C is an exception to this general definition because the individual has the use of only one upper extremity due to amputation of a hand.) *Id.* To ambulate effectively, individuals must be capable of sustaining a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living. 1.00B2b(2) They must have the ability to travel without companion assistance to and from a place of employment or school. . . . *Id.* When an individual's impairment involves a lower extremity uses a hand-held assistive device, such as a cane, crutch or walker, the medical basis for use of the device should be documented. 1.00J4 The requirement to use a hand-held assistive device may also impact an individual's functional capacity by virtue of the fact that one or both upper extremities are not available for such activities as lifting, carrying, pushing, and pulling. *Id.* The inability to perform fine and gross movements effectively means an extreme loss of function of both upper extremities. 11.00B2c

Categories of Musculoskeletal include:

1.02 Major dysfunction of a joint(s) due to any cause: Characterized by gross anatomical deformity (e.g.

subluxation, contracture, bony or fibrous ankylosis, instability) and chronic joint pain and stiffness with signs of limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With:

A. Involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in inability to ambulate effectively as defined in 1.00B2b; or

B. Involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, wrist, hand), resulting in inability to perform fine and gross movements effectively a defined in 1.00B2c

* * *

1.04 Disorders of the spine (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the cauda equine) or spinal cord. With:

A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine); or

B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours; or

C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b. (see above definition)

In order to meet a musculoskeletal listing, the impairment must present a major dysfunction resulting in the inability to ambulate effectively. The Claimant's back, neck, knee, and shoulder pain is supported by medical documentation, as well as his inability to ambulate

effectively without assistance. Furthermore, the record documents multi-level disc herniation with encroachment; shoulder tears; knee fractures and tears; as well as weakness, pain, and reduced range of motion. These same records establish that the Claimant is restricted to, in essence, less than sedentary work. Ultimately, it is found that the Claimant's impairments meets, or is the equivalent thereof, a listed impairment within 1.00, specifically, 1.02, thus he is found disabled at Step 3 with no further analysis required.

The State Disability Assistance ("SDA") program, which provides financial assistance for disabled persons, was established by 2004 PA 344. DHS administers the SDA program purusant to MCL 400.10 et seq. and Michigan Administrative Code ("MAC R") 400.3151 – 400.3180. Department policies are found in PAM, PEM, and PRM. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal SSI disability standards for at least ninety days. Receipt of SSI or RSDI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness (MA-P) automatically qualifies an individual as disabled for purposes of the SDA program.

In this case, the Claimant is found disabled for purposes of the Medical Assistance ("MA-P") program, therefore the Claimant's is found disabled for purposes of continued SDA benefits.

DECISION AND ORDER

The Administrative Law Judge, based upon the findings of fact and conclusions of law, finds the Claimant disabled for purposes of the Medical Assistance program and the State Disability Assistance program.

It is ORDERED:

1. The Department's determination is REVERSED.

2. The Department shall initiate review of the July 17, 2008 application to determine if all other non-medical criteria are met and inform the Claimant of the determination.

3. The Department shall supplement the Claimant any lost benefits he was entitled to receive if otherwise eligible and qualified in accordance with department policy.

4. The Department shall review the Claimant's continued eligibility in October 2010 in accordance with department policy.

Colleen M. Mamelka
Administrative Law Judge
For Ishmael Ahmed, Director
Department of Human Services

Date Signed: _09/23/09______

Date Mailed: _09/23/09______

NOTICE: Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

The Claimant may appeal the Decision and Order to the Circuit within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt date of the rehearing decision.

CMM/jlg

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