STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2010-13192 CMH

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9, following the Appellant's request for a hearing.

After due notice, a hearing was held . The Appellant is a minor and was represented by her mother, .

, Assistant Corporation Counsel, appeared on behalf of the an agency contracted with the Michigan Department of Community Health to provide Medicaid-funded community mental health supports and services (hereafter, 'Department'). Also appearing on behalf of the Department was , Manager, Access Center.

ISSUE

Has the Department appropriately denied the Appellant's request for Medicaid-funded inpatient psychiatric treatment?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant is a who resides with her family in

2. The Appellant resides in the geographical service area.

3. The Appellant has been involved with the [redacted] Juvenile justice system and at all times pertinent to this decision, was residing in a youth home.

4. On [redacted], the Appellant's mother telephoned the [redacted] requesting inpatient psychiatric services be provided to her daughter. The Appellant has had at least three (3) prior in patient psychiatric admissions within the last two (2) years.

5. The Appellant's mother is requesting inpatient psychiatric hospitalization for the Appellant to address her mental health needs and behaviors.

6. The Appellant was transported to the local hospital for psychiatric evaluation, in cooperation with the [redacted] center.

7. The evaluation was commenced [redacted], however, no plan of care or needs assessment was completed at that time.

8. A needs assessment and level of care was to be completed on or about [redacted] On [redacted], an incident report was generated detailing another incident at the detention center. The Appellant assaulted a staff person who was thereafter transported to the hospital.

9. The Appellant's needs were documented as:

> (the Appellant) is in need of 24 hour supervision due to the fact that she is experiencing command auditory hallucinations which tell her "hurt & kill herself & others". (She) is in need of stabilization, having her medications evaluated & adjusted. Ongoing psychiatric services are needed to monitor (her) psychotropic medications. Daily monitoring needs to be available to provide the assurance that (she) is being observed as well as the efficacy of the medications prescribed her. The medications currently being prescribed are not effective in ameliorating the auditory hallucinations which (she) is continuing to experience. Therapeutic interventions (individual and family therapy) need to be available several times a week. She clearly needs work in controlling her anger and impulses. However, prior to any psychotherapy, there is the necessity to correctly diagnose and explore the nature of (her) psychotic symptoms, and medicate properly. Crisis intervention needs to be available on a 24-hour basis. An OT assessment is highly recommended in order to rule out any sensory impairments. A complete psychiatric

> evaluation is also recommended to identify the level of emotional impairment/trauma which is driving her intense rages.

10. The Needs Assessment was received and noted, the writer of the case notes in evidence apparently agreeing with the recommendations as evidenced by the following statements:

> Writer received notice the consumer's needs assessment was completed. Writer noted the following recommendations. Traditional out-patient therapy as well as in-home program are not able to address the severity of the Appellant's issues and behaviors, nor are they able to provide the level of safety needed at this time. An in-home program should be explored once the above concerns have been addressed an it is considered safe to have her return home.
>
> A referral to [redacted] was considered and was to be discussed with [redacted].

11. Following a telephone call to [redacted], the writer of the notes in evidence stated:

> Writer discussed this case with [redacted]. It was discussed that since consumer has had 3 IP hosps at HOH medications and diagnosis need to be clarified by a second party/opinion. [redacted] were discussed as options. Writer called consumers mother to discuss the plan and she stated that she can handle consumer and that she would be agreeable to the plan and that she would be agreeable to consumer coming home with home based services. Writer spoke to New Dimensions therapist, [redacted] and she stated that consumer was kicked out of [redacted] due to her attack on staff. Writer informed [redacted] of the plan to have consumer evaluated in an acute care setting and possible home based services if necessary. She reported that she does not know if court will release her but stated that another look at her would be a good idea. She also stated that [redacted] is handling the case as consumer is in the general population at this time. Writer called [redacted] and he was agreeable to recommendations. He reported, as did [redacted], that consumer may have initially had auditory hallucinations but now maybe more behavioral

> than MI as she seems to be using the excuse of auditory/visual hallucinations to act out.

12. The next entry is on [redacted], stating access screening placed in denial tray for denial of state hospitalization as consumer does not meet criteria for services requested.

13. No axis I diagnosis is provided in evidence.

14. The Appellant's mother agreed with in–home placement of the Appellant in [redacted].

15. The CMH sent Notice of denial of inpatient psychiatric hospitalization in [redacted].

16. New, additional charges were filed following the [redacted], psychiatric evaluation, resulting in continuing detention of the Appellant at the [redacted].

17. As of the hearing date, the Appellant is still in the custody of the [redacted] detention center in [redacted].

18. The Appellant's mother requested a formal, administrative hearing [redacted].

CONCLUSIONS OF LAW

The Medical Assistance Program 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…

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 operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) HSW. MCCMHSP contracts with the Michigan Department of Community Health to provide Medicaid State Plan Specialty Supports and Services.

The Code of Federal Regulations at *42 CFR 440.230* states that Medicaid beneficiaries are only entitled to medically necessary **Medicaid-covered** services, provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service.

The Medicaid Provider Manual, Mental Health/Substance Abuse chapter provides a listing of the Medicaid covered services MCCMHSP may provide. With regard to "covered services," Section 3 states, in pertinent part, as follows:

> **Section 3 - Covered Services**
>
> The Mental Health Specialty Services and Supports program is limited to the state plan services listed in this section, the services described in the Habilitation/Supports Waiver for Persons with Developmental Disabilities Section of this chapter,

and the additional/B3 services described in the Additional Mental Health Services (B3s) section of this chapter. The PIHP is not responsible for providing state plan covered services that MDCH has designated another agency to provide (refer to other chapters in this manual for additional information, including the Chapters on Medicaid Health Plans, Home Health, Hospice, Pharmacy and Ambulance), nor is the PIHP responsible for providing the Children's Waiver Services described in this chapter. However, it is expected that the PIHP will assist beneficiaries in accessing these other Medicaid services.

Inpatient psychiatric hospital treatment Services are Medicaid-covered services. The Medicaid Provider Manual, Mental Health/Substance Abuse chapter, details the eligibility requirements for this service:

SECTION 8 – INPATIENT PSYCHIATRIC HOSPITAL ADMISSIONS

The PIHP is responsible to manage and pay for Medicaid mental health services in community-based psychiatric inpatient units for all Medicaid beneficiaries who reside within the service area covered by the PIHP. This means that the PIHP is responsible for timely screening and authorization/certification of requests for admission, notice and provision of several opinions, and continuing stay for inpatient services, defined as follows:

 Screening means the PIHP has been notified of the beneficiary and has been provided enough information to make a determination of the most appropriate services. The screening may be provided on-site, face-to-face by PIHP personnel, or over the telephone.

 Authorization/certification means that the PIHP has screened the beneficiary and has approved the services requested. Telephone screening must be followed-up by the written certification. PIHP responsibilities include:

- Pre-admission screening to determine whether alternative services are appropriate and available. Severity of Illness and Intensity of Service clinical criteria will be used for such pre-screening. Inpatient pre-screening services must be available 24-hours-a-day, seven-days-a-week.
- Provision of notice regarding rights to a second opinion in the case of denials.
- Coordination with substance abuse treatment providers, when appropriate.
- Provision of, or referral to and linkage with, alternative services, when appropriate.

- Communication with the treating and/or referring provider.
- Communication with the primary care physician or health plan.
- Planning in conjunction with hospital personnel for the beneficiary's after-care services. In most instances, the beneficiary will receive services in a community-based psychiatric unit in the PIHP service area where he resides. There may be instances when a PIHP is responsible for a resident that they have placed into a community program in another county or state. In these cases, the responsible PIHP, i.e., the one managing the case, is responsible for authorizing admission and/or continuing stay. If a beneficiary experiences psychiatric crisis in another county, the PIHP in that county should provide crisis intervention/services as needed and contact the PIHP for the county of the beneficiary's residence for disposition.

8.1 ADMISSIONS

The PIHPs will make authorization and approval decisions for these services according to Level of Care guidelines established by MDCH and appearing in this section. All admission and continuing stay responsibilities and procedures must be conducted in accordance with the terms of the contract between the hospital and the PIHP.

8.2 APPEALS

PIHPs will make authorization and approval decisions for services according to Level of Care guidelines. If the hospital disagrees with the decision of the PIHP, regarding either admission authorization/approval or the number of authorized days of care, the hospital may appeal to the PIHP according to the terms of its contract with the PIHP. If the hospital does not have a contract or agreement with the PIHP, any appeals by the hospital will be conducted through the usual and customary procedures that the PIHP employs in its contracts with other enrolled hospital providers. If a beneficiary or his legal representative disagrees with a PIHP decision related to admission authorization/approval or approved days of care, he may request a reconsideration and second opinion from the PIHP. If the PIHP's initial decision is upheld, the beneficiary has further redress through the Medicaid fair hearing process. Medicaid beneficiaries can request the Medicaid fair hearing without going through local review processes.

8.5 ELIGIBILITY CRITERIA

8.5.A. INPATIENT PSYCHIATRIC AND PARTIAL HOSPITALIZATION SERVICES

Medicaid requires that hospitals providing inpatient psychiatric services or partial hospitalization services obtain authorization and certification of the need for admission and continuing stay from PIHPs. A PIHP reviewer determines authorization and certification by applying criteria outlined in this document. The hospital or attending physician may request a reconsideration of adverse authorization/certification determinations made by the initial PIHP reviewer. The criteria described below employ the concepts of Severity of Illness (SI) and Intensity of Service (IS) to assist reviewers in determinations regarding whether a particular care setting or service intensity is appropriately matched to the beneficiary's current condition.

- Severity of Illness (SI) refers to the nature and severity of the signs, symptoms, functional impairments and risk potential related to the beneficiary's psychiatric disorder.
- Intensity of Service (IS) refers to the setting of care, to the types and frequency of needed services and supports, and to the degree of restrictiveness necessary to safely and effectively treat the beneficiary. Medicaid coverage for inpatient psychiatric services is limited to beneficiaries with a current primary psychiatric diagnosis, as described in the criteria below. It is recognized that some beneficiaries will have other conditions or disorders (e.g., developmental disabilities or substance abuse) that co-exist with a psychiatric disturbance. In regard to developmental disabilities, if a person with developmental disabilities presents with signs or symptoms of a significant, serious, concomitant mental illness, the mental illness will take precedence for purposes of care and placement decisions, and the beneficiary may be authorized/certified for inpatient psychiatric care under these guidelines.

For beneficiaries who present with psychiatric symptoms associated with current active substance abuse, it may be difficult to determine whether symptoms exhibited are due to a primary mental illness or represent a substance-induced disorder, and to make an informed level of care placement decision. A beneficiary exhibiting a psychiatric disturbance in the context of current active substance use or intoxication may require acute detoxification services before an accurate assessment of the need for psychiatric inpatient services can be made. In these situations, the hospital and the PIHP must confer to determine the appropriate location (acute medical setting or psychiatric unit) for the detoxification services.

The crucial consideration in initial placement decisions for a beneficiary with psychiatric symptoms associated with current active substance abuse is whether the beneficiary's immediate treatment needs are primarily medical or

psychiatric. If the beneficiary's primary need is medical (e.g., life-threatening substance-induced toxic conditions requiring acute medical care and detoxification), then detoxification in an acute medical setting (presuming the beneficiary's condition meets previously published acute care detoxification criteria) is indicated. If the beneficiary's primary need is psychiatric care (the person meets the SI/IS criteria for inpatient psychiatric care), they should be admitted to the psychiatric unit and acute medical detoxification provided in that setting. Hospitals are reminded that they must obtain PIHP admission authorization and certification for all admissions to a distinct part psychiatric unit or freestanding psychiatric hospital.

8.5.C. INPATIENT ADMISSION CRITERIA: CHILDREN THROUGH AGE 21

Inpatient psychiatric care may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based on the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective. Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care. The individual must meet all three criteria outlined in the table below:

Diagnosis The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM Axis I, or ICD diagnosis (not including V Codes).

Severity of Illness (signs, symptoms, functional impairments and risk potential) At least **one** of the following manifestations is present:

- Severe Psychiatric Signs and Symptoms
- Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) - severe enough to cause disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.
- Disorientation, impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.

 Severe anxiety, phobic symptoms or agitation, or ruminative/obsessive behavior that has failed, or is deemed unlikely, to respond to less intensive levels of care and has resulted in substantial current dysfunction.
 Disruptions of Self-Care and Independent Functioning
 Beneficiary is unable to maintain adequate nutrition or self care due to a severe psychiatric disorder.
 The beneficiary exhibits significant inability to attend to age-appropriate responsibilities, and there has been a serious deterioration/impairment of interpersonal, familial, and/or educational functioning due to an acute psychiatric disorder or severe developmental disturbance.
 Harm to Self
 A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, or impulsivity.
 There is a specific plan to harm self with clear intent and/or lethal potential.
 There is self-harm ideation or threats without a plan, which are considered serious due to impulsivity, current impairment or a history of prior attempts.
 There is current behavior or recent history of self-mutilation, severe impulsivity, significant risk-taking or other self-endangering behavior.
 There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations.
 There is a recent history of drug ingestion with a strong suspicion of intentional overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.
 Harm to Others
 Serious assaultive behavior has occurred and there is a clear risk of escalation or repetition of this behavior in the near future.
 There is expressed intention to harm others and a plan and means to carry it out;
the level of impulse control is non-existent or impaired.
 There has been significant destructive behavior toward property that endangers others, such as setting fires.
 The person has experienced severe side effects from using therapeutic psychotropic medications.
 Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care

 The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or reinitiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved.
 There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the co-existing general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care.

Special Consideration: Concomitant Substance Abuse - The underlying psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represents the primary reason observation and treatment are necessary in the hospital setting. **Intensity of Service** The person meets the intensity of service requirements if inpatient services are considered medically necessary and if the person requires at least **one** of the following:

 Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications.
 Close and continuous skilled medical observation is needed due to otherwise unmanageable side effects of psychotropic medications.
 Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur.
 A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.

Version Mental Health/Substance Abuse
Date: April 1, 2010 Page 48

The Appellant's mother is requesting residential placement at an inpatient psychiatric facility. With the agreement of the juvenile court, the Appellant was transferred to a local hospital where an evaluation took place. The notes in evidence indicate the assessment

was scheduled for [redacted]. A Needs Assessment and Level of Care was to be completed and provided by another mental health professional according to the notes in evidence. On [redacted], clinical information from the hospital was received and sent on to another mental health professional who was completing a Level of Care Assessment. Nothing further is noted until [redacted], when an incident report from the [redacted] is forwarded and referenced in the case notes. The incident report indicates the Appellant physically attacked a staff member, causing the staffer to have to seek treatment at the emergency room. Charges were eventually brought. The notes in evidence indicate the Appellant experienced auditory hallucinations telling her to hurt others.

The [redacted], Need Assessment indicate the Appellant is in need of structured environment with 24 hour supervision due to the fact hat she is experiencing command auditory hallucinations which tell her "hurt & kill herself & others" She is in need of stabilization, having her medications monitored, evaluated and adjusted and ongoing psychiatric services are needed to monitor her psychotropic medications. Her current medications were not effective at monitoring her auditory hallucinations. There was priority placed on a need to monitor her psychotic symptoms and medication management over psychotherapy at that time. It was stated crisis intervention was needed on a 24 hour on-going basis. The recommendations explicitly stated "traditional out-patient therapy, as well as in-home programs are not able to address the severity of (the Appellant's) issues & behaviors, nor are they able to provide the level of safety needed at this time. An in-home program should be explored once the above concerns have been addressed and it is considered safe to have (the Appellant) return home" The writer of those notes agreed with the recommendations as written until [redacted], when she spoke with [redacted]. Following that contact, it was written that because the Appellant had already had three (3) inpatient hospitalizations within the last two (2) years her diagnosis and medications should be evaluated by a second party. The Appellant's mother agreed to have the Appellant at home with home based services. Another contact with psychologist at the detention center stated the Appellant may have had hallucinations when she first arrived, however, there as some concern that she may have behavioral issues, more than issues caused or controlled by auditory hallucinations. On [redacted], it was stated on the note that the consumer does not meet criteria for services requested. It was electronically designated as [redacted].

The Appellant's mother did not present any evidence that the Appellant met the in patient criteria for hospitalization on [redacted]; however, the evaluation process appeared to take place over several weeks according to the documentation in evidence. A denial notice is not dated until [redacted], although the request for services was made [redacted] This ALJ will not confine the evaluation of evidence to that noted for [redacted], given that the evaluation was a process that took place over several weeks and was not an on-the-spot emergency evaluation, as evidenced by the delay in decision making. When evaluating the evidence of record, this ALJ sees good evidence the Appellant met the criteria for in-patient hospitalization according to the notes of [redacted]. The recommendation was made for placement at [redacted] and the

criteria was met according to the evaluation at that time. Specifically, it was stated the Appellant met the severity of illness and intensity of service criteria. The notes in evidence do not explicitly reveal her diagnosis. This was not disclosed by the CMH at hearing, nor found by this ALJ in the documentation presented. However, the Appellant has three (3) prior in-patient admissions within the last two (2) years, thus presumably has a qualifying Axis I diagnosis. The severity of illness criteria also appears to be met. It states, again:

> □ Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) - severe enough to cause disordered and/or bizarre behavior.

This criteria is met by the evidence of record that the Appellant was suffering hallucinations and command auditory hallucinations, her eyes rolled to the back of her head and she began quivering.

The Intensity of service criteria appears to be met by the stated need to monitor her medications, make changes because they are not controlling her hallucinations and her assaultive conduct. She sent another person to the emergency room for medication treatment as a result of her assault. The criteria is restated below:

> □ Harm to Others
> □ Serious assaultive behavior has occurred and there is a clear risk of escalation or repetition of this behavior in the near future.
> □ There is expressed intention to harm others and a plan and means to carry it out; the level of impulse control is non-existent or impaired.
> □ Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications

This ALJ finds there is good evidence the Appellant may have met the criteria at some time during the evaluation process despite the apparent concern she is acting out at times and may falsely report experiencing hallucinations at times. There is evidence of record she meets all three (3) criteria set forth above. However, given the length of time it took to arrange, begin and complete the evaluation, the Appellant's mental status was essentially a moving target. It is a full month between the request for evaluation and denial notice.

Moreover, this ALJ has a deep concern over the apparent disregard for the safety needs of the Appellant, her family, and the community with the plan to return her home without obvious success in stabilizing her conduct. Safety is explicitly addressed in the criteria for in patient treatment. There is evidence of safety risks and in fact, ongoing assaultive conduct being engaged in. The CMH failed to explicitly address how in home treatment

could effectively address safety concerns. There is no substantial evidence supporting the conclusion at the end the notes simply stating the Appellant does not meet the criteria for services sought.

After review of the services authorized by the Medicaid Provider Manual, admission criteria and uncontested evidence of the Appellant's mental status during [redacted] and [redacted], this ALJ does not concur with the [redacted] that she did not meet the criteria for in patient placement and treatment due to the significant evidence she met the criteria in the manual.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I find that, the evidentiary record is sufficient to support a finding the Appellant met all three (3) of criteria necessary to be admitted for in patient psychiatric treatment. The decision of the [redacted] is hereby REVERSED. [redacted] is hereby ordered to conduct another evaluation for in patient psychiatric hospitalization.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 4/9/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules for the Department of Community Health will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court 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 of the rehearing decision.