STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

[redacted]

Reg. No: 2009-12560
2010-31788
Issue No: 2009
Case No: [redacted]
Load No:
Hearing Date:
April 28, 2009
Wayne County DHS

ADMINISTRATIVE LAW JUDGE: Landis Y. Lain

RECONSIDERATION DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon claimant's request for a hearing. After due notice, a telephone hearing was held on April 28, 2009. Claimant personally appeared and testified. Claimant was represented at the hearing by [redacted]

ISSUE

Did the Department of Human Services (the department) properly deny claimant's application for Medical Assistance (MA-P) and retroactive Medical Assistance (retro MA-P)?

FINDINGS OF FACT

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

(1) On January 18, 2008, claimant filed an application for Medical Assistance and retroactive Medical Assistance for the months of October, November, and December 2007.

(2) On August 20, 2008, the Medical Review Team denied claimant's application stating that claimant could perform other work.

(3) On August 20, 2008, the department caseworker sent claimant notice that her application was denied.

(4) On November 21, 2008, claimant filed a request for a hearing to contest the department's negative action.

(5) On February 26, 2009, the State Hearing Review Team again denied claimant's application stating that t here was insufficient evidence and that the claimant's representative indicated that claimant was approved for SSI disability effective August 2005, which is correct. However, the claimant is not currently in paym ent status and has a current S SI disabilit y claim pending in the DDS. T here is an August 2008 exam in t he file but page 4 of the exam, which was the actual object ive finding, is not in the file (page 62 was missing). Please obtain the mi ssing page of the exam and return to SHRT. Also, please obtain any updated medical and psychiatric records from August 2008 to current.

(6) The hearing was held on April 28, 2009. At the hearing, claimant waived the time periods and requested to submit additional medical information.

(7) Additional medical information was submitted and sent to the State Hearing Review Team on April 29, 2009.

(8) On May 8, 2009, the St ate Hearing Review Team again denied claimant's application stating that claimant is capable of performing past work. Her past work was as a maid and was light work.

(9) Claimant is a 53-year-old woman whose birth date is [redacted] Claimant is 5' 2" tall and weighs 135 pounds. Claimant recently gained 15 pounds. Claimant is able to read and wr ite and does have b asic math skills.

(10) Claimant last worked 1996 at [redacted] in the gourmet section making cookies. Claimant als o worked in factory work and had a car accident around 1996 and her husband currently supports her.

(11) Claimant alleges as disabling impairments: heart problems, cardio obstructive pulmonar y diseas e, arthri tis, shortness of breath, herpes keratitis, asthma, psoriasis, herni ated disc, degenerative hip disease, and depression.

(12) On June 4, 2009, Ad ministrative Law Judge Lan dis Y. Lain, affir med the department's denial of clai mant's application for M edical Ass istance and Retroactive Medical Assistance benefits.

(13) Claimant's representative filed an appeal with the T hird Jud icial Circuit Court.

(14) On March 12, 2010, pursuant to a stipulation bet ween the Assistant Attorney General and Claimant's repres entative, the Circuit Court signed an order r emanding the case back to the Administrative Law Ju dge wit h

the order to allow claimant to submit additional medical information from August 2008 - June 1, 2009, for reconsideration and a new hearing decision.

(15) The additional medical information was submitted and sent to the State hearing Review team for further review on August 18, 2010.

(16) On August 20, 2010, the State hearing Review Team again denied claimant's application stating that claimant is capable of performing her past work as a maid and stating that the additional information does not significantly or materially alter the previous recommended decision.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the MA program 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).

Pursuant to Federal Rule 42 CFR 435.540, the Department of Human Services uses the federal Supplemental Security Income (SSI) policy in determining eligibility for disability under the Medical Assistance program. Under SSI, 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 set order is used to determine disability. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience is reviewed. If there is a finding that an individual is disabled or not disabled at any point in the review, there will be no further evaluation. 20 CFR 416.920.

If an individual is working and the work is substantial gainful activity, the individual is not disabled regardless of the medical condition, education and work experience. 20 CFR 416.920(c).

If the impairment or combination of impairments do not significantly limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. Age, education and work experience will not be considered. 20 CFR 416.920.

Statements about pain or other symptoms do not alone establish disability. There must be medical signs and laboratory findings which demonstrate a medical impairment.... 20 CFR 416.929(a).

> ...Medical reports should include –
>
> (1) Medical history.
>
> (2) Clinical findings (such as the results of physical or mental status examinations);
>
> (3) Laboratory findings (such as blood pressure, X-rays);
>
> (4) Diagnosis (statement of disease or injury based on its signs and symptoms).... 20 CFR 416.913(b).

In determining disability under the law, the ability to work is measured. An individual's functional capacity for doing basic work activities is evaluated. If an individual has the ability to perform basic work activities without significant limitations, he or she is not considered disabled. 20 CFR 416.994(b)(1)(iv).

> Basic work activities are the abilities and aptitudes necessary to do most jobs.
>
> Examples of these 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. 20 CFR 416.921(b).

Medical findings must allow a determination of (1) the nature and limiting effects of your impairment(s) for any period in question; (2) the probable duration of the impairment; and (3) the residual functional capacity to do work-related physical and mental activities. 20 CFR 416.913(d).

Medical evidence may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of the impairment(s), including your symptoms, diagnosis and prognosis, what an individual can do despite impairment(s), and the physical or mental restrictions. 20 CFR 416.927(a)(2).

All of the evidence relevant to the claim, including medical opinions, is reviewed and findings are made. 20 CFR 416.927(c).

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability.... 20 CFR 416.927(e).

A statement by a medical source finding that an individual is "disabled" or "unable to work" does not mean that disability exists for the purposes of the program. 20 CFR 416.927(e).

When determining disability, the federal regulations require that several considerations be analyzed in sequential order. If disability can be ruled out at any step, analysis of the next step is not required. These steps are:

1. Does the client perform Substantial Gainful Activity (SGA)? If yes, the client is ineligible for MA. If no, the analysis continues to Step 2. 20 CFR 416.920(b).

2. Does the client have a severe impairment that has lasted or is expected to last 12 months or more or result in death? If no, the client is ineligible for MA. If yes, the analysis continues to Step 3. 20 CFR 416.920(c).

3. Does the impairment appear on a special listing of impairments or are the client's symptoms, signs, and laboratory findings at least equivalent in severity to the set of medical findings specified for the listed impairment? If no, the analysis continues to Step 4. If yes, MA is approved. 20 CFR 416.290(d).

4. Can the client do the former work that he/she performed within the last 15 years? If yes, the client is ineligible for MA. If no, the analysis continues to Step 5. 20 CFR 416.920(e).

5. Does the client have the Residual Functional Capacity (RFC) to perform other work according to the guidelines set forth at 20 CFR 404, Subpart P, Appendix 2, Sections 200.00-

204.00? If yes, the analysis ends and the client is ineligible for MA. If no, MA is approved. 20 CFR 416.920(f).

At Step 1, claimant is not engaged in substantial gainful activity and has not worked since 1996. Claimant is not disqualified from receiving disability at Step 1.

The objective medical evidence on the record indicates that an internal medical examination of July 16, 2008, indicates that upon physical examination claimant was age 52 and her height was 5' 2" tall. Her weight was 129 pounds and her blood pressure was 90/60; her temperature was 98 degrees Fahrenheit; pulse 76 per minute and regular and respiration 18 per minute and regular. Her HEENT: Her sclera, PERRLA normal. No nystagmus. Fundi normal. Ears clear. She had dentures on the upper jaw and loss of several teeth in the lower jaw. Her neck was supple and the thyroid was not enlarged. No lymphadenopathy. Jugular venous pressure was normal. Carotid arterial pulsations are normal. No carotid bruit. In the chest, her cardiac and liver dullness are obliterated. (Patient has a thin chest wall.) Her CVS: PMI is normal in position and character. Heart sounds are normal. No murmur, no gallop rhythm. Her abdomen was soft with no organomegaly or tenderness. Bowel sounds are normal. Her skin shows a well-healed surgical scar in the abdomen. No rash or pigmentation. No ulceration or gangrene. Extremities: no cyanosis, clubbing, edema or lymphadenopathy. No calf muscle tenderness. Homan's sign was negative. Peripheral pulsations are 1+ all over. In the spine: the claimant could stand erect without support. There was no loss of lumbar lordosis. There was no tenderness of paraspinals muscle spasm. All movements of the lumbar spine were painful and flexion of the hip was restricted to 80 degrees and there was tenderness over the upper and lower lumbar spine. Straight leg raising test was 45 degrees on the right and 80 degrees on both side. Claimant complained of pain over the lower part of the back during this procedure. Bones and joints: there was crepitance in both knee joints. All movement of both knee joints was painful but there was no limitation of movement. There was no pain, swelling, limitation of movements or crepitance in any other joints. Grip was good in both hands (5/5) tested manually. Muscle power is good in all the extremities. There is no wasting of muscles around the joints. Gait and stance are normal. The claimant had difficulty walking tiptoe, tandem gait and on the heel because of the pain in the knee joint and lumbar spine. Claimant cannot squat more than 40 percent due to the pain in the knee joint and the lumbar spine. Claimant can get on and off the examination couch from the supine position. Can dress, undress and write legibly. In her nervous system: her higher functions – she was oriented to time, place and person. Speech was normal. Memory was fairly good. Claimant could remember day, date, month, year and names of the Presidents. Cranial nerves II through XII were normal. Power, tone and sensations were normal. Deep tendon reflexes are 2+ and equal bilaterally. Plantars were flexor bilaterally. Romberg's sign is negative. Cerebellar functions are normal. Gait was normal.

Claimant had no evidence of emphysema or cor pulmonale. Claimant was not breathless on normal physical exertion. Claimant alleged a history of migraine headaches, but had no abnormal physical findings detected during the examination related to that problem. Claimant is status post coronary arterial bypass surgery.

Claimant had chest pain which was not suggestive of angina pectoris. She had tenderness over the sternal area, suggestive that the chest pain was due to fibromyositis. Alleged history of gastroesophageal reflux disease (GERD) is well controlled with present regimen. Osteoarthritis of the lumbar spine and the knee joint. Claimant has some functional limitations from it. Panic attacks and anxiety state. Claimant also has a history of chronic polysubstance abuse. Her memory is good. She was in fair grooming and hygiene. She responded fairly well to the examination situation. (Pages 61-63)

On April 30, 2008, claimant came to the emergency room and upon physical examination it revealed a friendly, adult female who was awake oriented and alert. She was afebrile. The pulse rate was 78 beats per minute and regular. Blood pressure was 108/74. Jugular venous distention. Hepatojugular reflex was negative. No cervical bruits. Heart examination revealed regular rhythm, normal S1 and S2, no S3 and no S4. No pericardial rub. The claimant does have some tenderness over the pericardium and costochondral junction. Lung examination revealed scattered rhonchi. The abdomen was soft without hepatosplenomegaly. There was mild tenderness in the right upper quadrant. The extremities showed no pedal edema. The claimant was still smoking about five cigarettes per day. (Page 144) Exam on February 20, 2008, indicates that claimant was a middle-aged white female who appeared her stated age. She was a little bit guarded but more cooperative. She spoke in a clear voice. Responses were relevant and appropriate. Mood was depressed. She was mildly anxious. Affect was appropriate. Thought process was goal-oriented. No evidence of any formal thought disorder. She did not have any suicidal or homicidal ideas at present. Cognitive functions are intact on gross examination. Insight was fair. Operational judgment and impulse control seemed adequate. (Page 76) An April 30, 2008, medical document indicates that the plan and recommendation stated that claimant's pains are atypical. The claimant has some tenderness over the costochondral junction and also over the sternum. She has been a chronic smoker and coughs quite a bit. It is possible that all of this pain which she is having may be partly related to her chronic cough. Also, the claimant has chronic anxiety and gets frequent anxiety induced chest pain for about a year at least. From a cardiac standpoint, she appears to be quite stable. No myocardial infarction. No cardiac arrhythmia. No congestive heart failure. The impression is that claimant had chronic chest pain with acute exacerbation. Arteriosclerotic heart disease status post aortocoronary bypass graft and chronic obstructive pulmonary disease with a history of chronic smoking and degenerative joint disease. (Page 145)

Emergency room visit January 4, 2008, indicates that claimant was afebrile, vital signs were reviewed. Claimant had a normal pulse, normal blood pressure, normal respiratory rate and was alert and oriented x3. Claimant did appear uncomfortable or to be in mild pain distress. Claimant's ears were normal to inspection. Her nose examination was normal. Her breath sounds were normal and she had no respiratory distress. She had some tenderness anteriorly and bilaterally. Claimant had normal heart sounds with no murmurs and normal S1 and S2. PMI was normal to palpation. Pedal pulses were normal. Neurologically, her GCS was 15, no focal motor deficits, focal sensory deficits, speech was normal, and memory was normal. Her head was atraumatic. Eyes were

normal to inspection. Pupils were equal, round and reactive to light. Extraocular muscles were intact. Her neck had normal range of motion. No meningeal signs. Her cervical spine was non-tender. Her abdomen was non-tender with no masses and the bowel sounds were normal, no distention, or peritoneal signs. Her upper extremity inspection was normal. Her lower extremity inspection was normal. No edema. Her skin was warm. Her skin was dry and her skin was normal color. No adenopathy in the neck and she was oriented x3 with normal affect, insight and concentration. Claimant's care was discussed and she was told that she would not be getting any narcotics; she refused any further evaluation and was very belligerent and abusive to the doctor and staff. Claimant threatened to sue the doctor and hospital. Claimant continued to be verbally abusive to the staff and did not cooperate well when discharging her. (Pages 190-192) The doctor indicated that claimant was exhibiting narcotic seeking behavior and insisted on leaving without further testing when she was told they would not give her any narcotics. (Page 199) This Administrative Law Judge did consider the newly submitted evidence when making this decision.

For the record, the Social Security Administration did conclude that claimant was not disabled prior to August 21, 2005, but became disabled on that date and continued to be disabled through November 21, 2006. Claimant received only a partially favorable decision on that date. However, a check of an SOLQ shows that claimant is not in payment status and was terminated under T51 code, which indicates System generated termination (no payment previously made). Claimant has a current application pending with the Social Security Administration.

At Step 2, claimant has the burden of proof of establishing that she has a severely restrictive physical or mental impairment that has lasted or is expected to last for the duration of at least 12 months. There is insufficient objective clinical medical evidence in the record that claimant continues to suffer a severely restrictive physical or mental impairment. Claimant has reports of pain in multiple areas of her body; however, there are no corresponding clinical findings that support the reports of symptoms and limitations made by the claimant. There is no medical finding that claimant has any muscle atrophy or trauma, abnormality or injury that is consistent with a deteriorating condition. In short, claimant has restricted herself from tasks associated with occupational functioning based upon her reports of pain (symptoms) rather than medical findings. Reported symptoms are an insufficient basis upon which a finding that claimant has met the evidentiary burden of proof can be made. This Administrative Law Judge finds that the medical record is insufficient to establish that claimant has a severely restrictive physical impairment. She is disqualified at Step 2.

There is insufficient evidence indicating claimant suffers mental limitations resulting from her reportedly depressed state. There is no mental residual functional capacity assessment in the record. The evidentiary record is insufficient to find claimant suffers a severely restrictive mental impairment. Claimant did testify that she does continue to smoke ten cigarettes per day when her doctor has told her to quit and she is not in a smoking cessation program. Claimant is not in compliance with her treatment program.

If an individual fails to follow prescribed tr eatment which would be expect ed to restor e their ability to engage in substantial gainful activity without good cause, there will not be a finding of disability.... 20 CFR 416.994(b)(4)(iv).

Claimant does have a history of alcohol and marijuana abuse as well as cocaine abus e and the m edical records indic ate that clai mant did c ontinue to smoke marijuana even though c laimant testified that that she stopped smoking approximately 20 years ago . Claimant's testimony and the medical recor ds are inconsis tent. This Administrative Law Judge finds that claimant has failed to m eet her burden of proof at Step 2. Claim ant must be denied benefits at this step bas ed upon her failure t o meet the evidentiary burden.

If claimant had not been denied at Step 2, the analys is would proceed to Step 3 where the medical evidence of claimant 's condition does not give rise to a finding that sh e would meet a statutory listing in the code of federal regulations.

If claimant had not already been denied at Step 2, this Administrative Law Judge would have to deny her again at Step 4 based u pon her ability to perform her past relevant work. Cla imant's pas t relevant work was light work. Claimant was a gourmet cookie maker and stated that she left her job be cause s he had a disagreement with the manager, not because she had s ome medical problems. This Administrative Law Judge finds that claimant could work in a delicatessen or a gourmet section as a cook or as a salesperson even with her im pairments. Thus, if claim ant had not already been denied at Step 2, she would be denied again at Step 4.

The Administrative Law Judge will co ntinue to proceed through the sequentia l evaluation process to determine whether or not claimant has the residual functional capacity to perform some other less strenuous tasks than in her prior jobs.

At Step 5, the burden of proof shifts to the department to establish that claimant does not have residual functional capacity.

The residual functional capac ity is what an individual can do desp ite limitations. All impairments will be co nsidered in addition to abilit y to meet certai n demands of jobs in the national economy. Physic al demands, m ental demands, sensor y requirements and other functions will be evaluated.... 20 CFR 416.945(a).

To determine the physical demands (exertional requir ements) of work in the national economy, we class ify jobs as sedentary, light, medium and heavy . These terms have the same meaning as they have in the *Dictionary of Occupational Titles* , publis hed by the Department of Labor... 20 CFR 416.967.

Sedentary work. Sedentary wor k involves lifting no more t han 10 pounds at a time and occasionally lifting or carrying articles lik e docket files, ledgers, and small tools. Although a sedentary job is defined as one whic h involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if

walking and standing are required occasionally and other sedentary criteria are met. 20 CFR 416.967(a).

Light work. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls.... 20 CFR 416.967(b).

Claimant has submitted insufficient objective medical evidence that she lacks the residual functional capacity to perform some other less strenuous tasks than in her prior employment or that she is physically unable to do light or sedentary tasks if demanded of her. Claimant testified that she does live with her husband and she has a driver's license and that she drives one time per week to her doctors or psychiatric evaluation and she drives about three miles. Claimant testified that she does cook one time per week and cooks things like meat, potatoes and vegetables. Claimant testified that she does grocery one time per month and needs help with some reaching and lifting. Claimant testified that she does do the dishes and dust and that her hobby is watching television approximately eight hours per day. Claimant did testify that her asthma is controlled with her inhaler and she hasn't had a full asthma attack for approximately two years. Claimant testified that she had bypass surgery around [redacted] Claimant testified that she can walk a half a block with a cane, and that she can stand for 15 minutes at a time and sit for 5 minutes at a time. Claimant testified that she can shower and dress, tie her shoes but not touch her toes. Claimant testified that the heaviest weight she can carry is 5 to 10 pounds and that she is right handed and has some muscle damage in her hands from her heart surgery. Claimant testified that her level of pain on a scale from 1 to 10 without medication is a 10 and with medication is a 6. Claimant did testify that she continues to smoke ten cigarettes per day and that in a typical day she gets up and uses the bathroom, puts coffee on and watches television. She gets up and straightens up and then she sits on the couch mostly or sits on the porch and she stated that she can have sex but not too often.

Claimant's activities of daily living do not appear to be very limited and she should be able to perform light or sedentary work even with her impairments. Claimant has failed to provide the necessary objective medical evidence to establish that she has a severe impairment of combination of impairments which prevent her from performing any level of work for a period of 12 months. The claimant's testimony as to her limitations indicates that she should be able to perform light or sedentary work. She is disqualified from receiving disability at Step 4 and Step 5.

The Federal Regulations at 20 CFR 404.1535 speak to the determination of whether Drug Addiction and Alcoholism (DAA) is material to a person's disability and when benefits will or will not be approved. The regulations require the disability analysis be completed prior to a determination of whether a person's drug and alcohol use is material. It is only when a person meets the disability criterion, as set forth in the regulations, that the issue of materiality becomes relevant. In such cases, the

regulations require a sixth step to determine the materiality of DAA to a person's disability.

When the record contains evidence of DAA, a determination must be made whether or not the person would continue to be disabled if the individual stopped using drugs or alcohol. The trier of fact must determine what, if any, of the physical or mental limitations would remain if the person were to stop the use of the drugs or alcohol and whether any of these remaining limitations would be disabling.

Claimant's testimony and the information contained in the file indicate that claimant has a history of alcohol and tobacco abuse as well as drug abuse. After a careful review of the credible and substantial evidence on the whole record, this Administrative Law Judge finds that even if claimant did meet the disability criteria for Steps 1-5, she would not meet the statutory definition under the DAA legislation because her substance abuse is material to her alleged impairments and alleged disability.

Claimant testified on the record that she does have depression.

For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph (B) of the listings for mental disorders (descriptions of restrictions of activities of daily living, social functioning; concentration, persistence, or pace; and ability to tolerate increased mental demands associated with competitive work).... 20 CFR, Part 404, Subpart P, App. 1, 12.00(C).

There is insufficient objective medical/psychiatric evidence contained in the file of depression or a cognitive dysfunction that is so severe that it would prevent claimant from working at any job. In addition, based upon claimant's medical reports, it is document that she had heavy use of alcohol as well as cocaine use and tobacco use which would have contributed to her physical and any alleged mental problems. Claimant was oriented to time, person and place during the hearing. Claimant was able to answer all the questions at the hearing and was responsive to the questions. Claimant's complaints of pain, while profound and credible, are out of proportion to the objective medical evidence contained in the file as it relates to claimant's ability to perform work. Claimant did testify that she does receive some relief from her pain medication. Therefore, this Administrative Law Judge finds that the objective medical evidence on the record does not establish that claimant has no residual functional capacity. Claimant is disqualified from receiving disability at Step 5 based upon the fact that she has not established by objective medical evidence that she cannot perform light or sedentary work even with her impairments.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the department has appropriately established on the record that it was acting in compliance with department policy when it denied claimant's application

for Medical Assistance and retroactive M edical Assistance benefits. The claimant should be able to perform a wide range of light or sedentary work even with her impairments. The cl aimant should be able to perform her past work even with her impairments. The department has establis hed its case by a preponderance of the evidence.

Accordingly, the department's decision is AFFIRMED.

/s/
Landis Y. Lain
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: September 28, 2010

Date Mailed: September 29, 2010

NOTICE: Administrative Hearings may or der a rehearing or reconsideration on either its own motion or at t he request of a party wit hin 30 days of the ma iling date of this Decision and Order. Administrative Hear ings will not orde r a rehearing or reconsideration on the Department's mo tion where the final decis ion cannot be implemented within 90 days of the filing of the original request.

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the mailing of the Decis ion and Order or, if a ti mely request for rehearing was made, within 30 days of the receipt date of the rehearing decision.

LYL/alc

cc: [redacted]