STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

[redacted]

Reg No.: 2012-41828
Issue No.: 2009
Case No.: [redacted]
Hearing Date: June 4, 2012
Wayne County DHS (43)

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 hearing was held in Highland Park, Michigan on Monday, June 4, 2012. The Claimant appeared and testified. The Claimant was represented by [redacted], Inc. Participating on behalf of the Department of Human Services ("Department") was [redacted].

During the hearing, the Claimant waived the time period for the issuance of this decision, in order to allow for the submission of additional medical evidence. The records were received, reviewed, and forwarded to the State Hearing Review Team ('SHRT") for consideration. On October 11, 2012, this office received the SHRT determination which found the Claimant not disabled. This matter is now before the undersigned for a final decision.

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of the Medical Assistance ("MA-P") benefit 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 MA-P benefits on March 18, 2008, retroactive to January 2008. (Exhibit 1, pp. 13 – 24)

2. On February 6, 2008, the Medical Review Team ("MRT") found the Claimant not disabled. (Exhibit 1, pp. 65, 66)

3. On July 29, 2008, the Department sent an Eligibility Notice to the Claimant informing him that he was found not disabled. (Exhibit 1, p. 3)

4. On July 30, 2008, the Department received the Claimant's written request for hearing. (Exhibit 1, p. 1b)

5. As a result of a Settlement Order dated August 26, 2009 (Reg No. 2008-27452) the Department sent a currently dated denial notice regarding the March 2008 application to the Authorized Hearing Representative ("AHR") on May 27, 2011.

6. On June 13, 2011, the Department received the AHR written request for hearing. (Exhibit 2)

7. On May 7th and October 5, 2012, the SHRT found the Claimant not disabled. (Exhibit 3).

8. The Claimant alleged physical disabling impairments due to weakness, shortness of breath, high blood pressure, vomiting, bleeding ulcers, gallstones, seizure disorder, arthritis, and brain hematoma (2008).

9. The Claimant has not alleged any mental disabling impairment(s).

10. At the time of hearing, the Claimant was 53 years old with an [redacted] birth date; was 5'5" in height; and weighed 130 pounds.

11. The Claimant has the equivalent of a high school education with an employment history over the last 15 years of working part-time doing landscaping.

CONCLUSIONS OF LAW

As a preliminary matter, an issue of whether a timely hearing request was received by the Department was discussed. In going through the chronology of events, the evidence ultimately shows that the AHR received the denial notice in May 2011 and timely requested a hearing in June 2011. Accordingly, the Request for Hearing is timely.

The Medical Assistance 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, formerly known as the Family Independence Agency, pursuant to MCL 400.10 *et seq.* and MCL 400.105. Department policies are found in the Bridges Administrative Manual ("BAM"), the Bridges Eligibility Manual ("BEM"), and the Bridges Reference Tables ("RFT").

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-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CFR 416.913. 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 416.927.

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 applicant 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 416.945(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).

As outlined above, the first step looks at the individual's current work activity. In the record presented, the Claimant is not involved in substantial gainful activity therefore is not ineligible for disability benefits 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 416.920(a)(4)(ii); 20 CFR 416.920(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 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921(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 disability due to weakness, shortness of breath, high blood pressure, vomiting, bleeding ulcers, gallstones, seizure disorder, arthritis, and brain hematoma (2008).

In support of his claim, records from 2007 were submitted with document treatment/diagnoses of partial small bowel obstruction.

On January 2, 2008, the Claimant was admitted to the hospital status post assault with a headache and mental status changes. A CT of the head revealed a right-sided subdural hematoma. The Claimant was taken to surgery for an emergent craniotomy. The Claimant was discharged on January 17th in stable condition.

On January 23, 2009, an MRI of the abdomen revealed mild proximal narrowing likely secondary to stenosis of the celiac axis.

There were no medical records for 2010.

On March 18, 2011, a CT of the cervical spine found minimal degenerative changes of the cervical spine, old communited fracture of the nasal bone, and deviation of the anterior septum to the right. A CT of the brain was unremarkable.

On March 26, 2011, an x-ray of the left wrist revealed impacted, communited fracture of the distal radius with minimal dorsal displacement and fracture of the tip of the ulnar styloid.

On April 14, 2011, x-rays of the left writes revealed a redemonstration of a colles fracture of the distal radius and of a minimally displaced fracture of the ulnar styloid with near anatomic alignment, without significant interval callus formation.

On April 19, 2011, the Claimant was admitted to the hospital after falling down the stairs while intoxicated, injuring his face. This was the Claimant's second event of this nature in recent weeks noting the previous fracture of the upper extremity. A CT of the face revealed acute fractures of the left orbital floor and anterior wall of the maxillary sinus with hemosinus, acute on chronic fractures of the nasal bones, and large soft tissue hematoma of the left cheek. Remaining imaging studies were unremarkable. The Claimant was discharged on April 22nd.

On June 25, 2011, an x-ray of the pelvis found no acute fracture of dislocation. A CT of the cervical spine revealed no acute fracture of dislocation and mild to moderate degenerative changes at multiple levels with degenerative facet hypertrophy. A CT of the head found no acute intracranial bleed noting old fractures of the nasal bones and left maxillary sinus, old stable lacunar infarcts, and status post right frontoparietal craniotomy with a stable post-surgical changes.

On July 13, 2011, a CT of the head revealed no acute intracranial abnormality and a likely old nasal bone fractures. An x-ray of the pelvis revealed no visualized acute fracture.

On August 30, 2011, the Claimant sought treatment for chest pain after falling and hitting his ribs on a railing. The Claimant was treated and discharged with the diagnoses of left rib fracture and small hemothorax. Surgical intervention was not needed.

On January 31, 2012, the Claimant was admitted to the hospital with complaints of abdominal pain associated with nausea and vomiting. The Claimant was treated and discharged on February 5th in stable condition.

On February 1, 2012, an esophagogastroduodenoscopy ("EGD") revealed a small hiatal hernia, mild esophagitis, linear gastric ulcers, and gastric atrophy.

On May 12, 2012, the Claimant presented to the hospital after being assaulted. A CT of the head revealed right craniotomy post-surgical changes without acute intracranial abnormality and prior nasal bone fracture, paranasal sinus disease, and right mastoid air cell opacification. A CT of the cervical spine found no acute fractures or dislocation, multi-level degenerative disc disease of the cervical spine, particularly with severe right foraminal stenosis at C2-3 and severe bilateral neuroforaminal stenosis at C5-6, and partially opacified right mastoid air cells.

On June 8, 2012, a consultative examination was attempted; however, it was not completed because the Claimant was severely medicated and unable to communicate with the doctor.

On June 10, 2012, the Claimant was treated in the emergency room after found unconscious on the side of a road. The physical examination was limited by the effects of drug/alcohol, noting an altered mental state. A CT of the head was stable and without evidence of acute intracranial process. Chest x-rays showed stable heart size and mediastinal contours with mild right basilar linear atelectasis and right posterior thoracotomy defect. The admitting diagnosis was alcohol withdrawal syndrome and

polysubstance abuse. The Claimant was treated and discharged with the diagnoses of inhalation injury and elevated blood pressure.

On June 30, 2012, the Claimant was diagnosed with alcohol withdrawal.

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, prior to the January 2008 application, the evidence shows treatment for partial small bowel obstruction. In January 2008, the evidence shows that the Claimant either fell or was assaulted resulting in a subdural hematoma requiring a craniotomy. After the discharge in 2008, there was no further treatment until January 2009. After that treatment, there was no treatment until March 2011. In 2011, the evidence shows treatment for injuries sustained while intoxicated. Importantly, there was no evidence to show treatment for any conditions that were alleged on the March 2008 application (retroactive to January 2008). Importantly, a CT of the head in July 2011 revealed no acute intracranial abnormality and likely old nasal bone fractures. Similarly, CT of the head in 2012 was essentially unremarkable. Since the 2008 application, and mainly in 2012, new evidence shows that the Claimant suffers with some musculoskeletal issues, not previously alleged, along with, again, treatment for alcohol/drug related injuries. Ultimately, in consideration of the conditions alleged at the time of application, noting no treatment for any head-related impairment until April 2011 (which related to a fall down the stairs while intoxicated over 3 years later) the evidence does not establish that the impairment(s) as alleged in 2008 have lasted continuously for a period of 12 months or longer. Accordingly, the Claimant's impairment(s) were not severe and fail to meet the durational requirement. Accordingly, the Claimant is found not disabled at Step 2 with no further analysis required.

Assuming *arguendo,* step 3 of the sequential analysis was required. At this step, 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 evidence confirms treatment/diagnoses of partial bowel obstruction, subdural hematoma status post craniotomy (2008) without complications, mild proximal narrowing of the abdomen, fractured wrist/hand/face, elevated blood pressure, inhalation injury, mild esophagitis, gastric ulcers, hiatral hernia, gastric atrophy, degenerative disc disease of cervical spine with severe right foraminal stenosis at C2-3, and severe bilateral neuroforaminal stenosis at C5-6.

Listing 1.00 (musculoskeletal system), Listing 3.00 (respiratory system), Listing 4.00 (cardiovascular system), Listing 5.00 (digestive disorders), and Listing 11.00 (neurological disorders) would be considered in light of the objective medical evidence. There were no objective findings of major joint dysfunction, unhealed fracture, nerve root impingement, or evidence to show that the Claimant was unable to ambulate effectively and/or perform fine/gross motor functions; ongoing treatment for persistent,

recurrent, and/or uncontrolled (while on prescribed treatment) cardiovascular impairment or end organ damage resulting from the Claimant's hypertension. There was no evidence to meet the intent and severity requirement necessary to meet a respiratory, digestive, and/or neurological impairment nor does the evidence show that the Claimant symptoms persist despite prescribed treatment or that the Claimant has very serious limitations in her ability to independently initiate, sustain, or complete activities of daily living. Although the objective medical records established some physical impairments, these records do not meet the intent and severity requirements of a listing, or its equivalent. Accordingly, the Claimant would not be found disabled, or not disabled, at Step 3; therefore, the Claimant's eligibility under Step 4 would be considered. 20 CFR 416.905(a).

Before considering the fourth step in the sequential analysis, a determination of the individual's residual functional capacity ("RFC") is made. 20 CFR 416.945. An individual's RFC is the most he/she can still do on a sustained basis despite the limitations from the impairment(s). *Id.* The total limiting effects of all the impairments, to include those that are not severe, are considered. 20 CFR 416.945(e).

To determine the physical demands (exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967. Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b). Even though 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. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additionally limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id*. Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.* Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.* Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id.*

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands (exertional requirements, i.e. sitting, standing, walking, lifting, carrying, pushing, or pulling) are considered nonexertional. 20 CFR 416.969a(a). In considering whether an individual can perform past relevant work, a comparison of the individual's residual functional capacity with the demands of past relevant work. *Id.* If an individual can no longer do past relevant work the same residual functional capacity assessment along with an individual's age, education, and work experience is considered to determine whether an individual can adjust to other work which exists in the national economy. *Id.* Examples of non-exertional limitations or restrictions include difficulty to function due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2). The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.*

In this case, the evidence confirms treatment/diagnoses of partial bowel obstruction, subdural hematoma status post craniotomy (2008) without complications, mild proximal narrowing of the abdomen, fractured wrist/hand/face, elevated blood pressure, inhalation injury, mild esophagitis, gastric ulcers, hiatral hernia, gastric atrophy, degenerative disc disease of cervical spine with severe right foraminal stenosis at C2-3, and severe bilateral neuroforaminal stenosis at C5-6. The Claimant testified that he is able to walk short distances; grip/grasp with some problems; sit for 2 hours; lift/carry approximately 15 pounds; stand for about 10 or 15 minutes; and is able to bend but not squat. The objective medical evidence does not contain any restrictions. After review of the entire record and considering the Claimant's testimony, it would be found, at this point, that the Claimant maintains the residual functional capacity to perform at least unskilled, limited, sedentary work as defined by 20 CFR 416.967(a). Limitations being the alternation between sitting and standing at will.

The fourth step in analyzing a disability claim requires an assessment of the Claimant's residual functional capacity ("RFC") and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if he/she can perform past relevant work. *Id*.; 20 CFR 416.960(b)(3). Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age,

education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3).

The Claimant's employment over the last 15 years consists of part-time work in lawn cutting. In consideration of the Claimant's testimony and Occupational Code, the prior employment is classified as unskilled medium work. If the impairment or combination of impairments does not limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. 20 CFR 416.920. As noted above, the objective evidence contains does not contain any restrictions that would preclude prior work; however, in light of the entire record and the Claimant's RFC (see above), the Claimant would be found unable to perform past relevant work. As such, the Claimant would not be found disabled, or not disabled, at Step 4.

If Step 5 were necessary, an assessment of the Claimant's residual functional capacity and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v). At the time of hearing, the Claimant was 53 years old and, thus, considered to be closely approaching advanced age for MA-P purposes. The Claimant has the equivalent of a high school education. Disability is found if an individual is unable to adjust to other work. *Id.* At this point in the analysis, the burden shifts from the Claimant to the Department to present proof that the Claimant has the residual capacity to substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

In this case, the evidence confirms treatment/diagnoses of partial bowel obstruction, subdural hematoma status post craniotomy (2008) without complications, mild proximal narrowing of the abdomen, fractured wrist/hand/face, elevated blood pressure, inhalation injury, mild esophagitis, gastric ulcers, hiatral hernia, gastric atrophy, degenerative disc disease of cervical spine with severe right foraminal stenosis at C2-3, and severe bilateral neuroforaminal stenosis at C5-6. The Claimant testified that he was able to perform activity comparable to sedentary work. As previously noted, the objective medical evidence does not contain any restrictions. In light of the foregoing, it would be found that the Claimant maintains the residual functional capacity for work activities on a regular and continuing basis to meet the physical and mental demands required to perform at least sedentary work as defined in 20 CFR 416.967(a). After review of the entire record and in consideration of the Claimant's age, education, work

experience, RFC, and using the Medical-Vocational Guidelines [20 CFR 404, Subpart P, Appendix II] as a guide, specifically Rule 201.12, would direct a finding of disabled; however, because the evidence establishes alcohol/drug dependence noting several alcohol/drug induced injuries, a determination of whether the dependence/abuse is a contributing factor material to the finding of disability would be made. 20 CFR 416.935(a). A key factor in making this determination is whether the Claimant would still be found disabled if the Claimant stopped drinking. 20 CFR 416.935(b)(1). As detailed above, the evidence does not contain and physical and/or mental limitations. In removing the conditions/injuries associated with the Claimant's alcohol consumption, the remaining treatment/diagnoses mainly relate to neck pain; a condition not originally alleged in 2008. Accordingly, it would be found that the Claimant's continued alcohol dependence is a contributing factor material to the determination of disability. 20 CFR 416.935(b)(2)(i). In light of the foregoing, the Claimant would be found not disabled.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law finds the Claimant not disabled for purposes of the MA-P benefit programs.

Accordingly, it is ORDERED:

The Department's determination **is AFFIRMED**.

Colleen M. Mamelka
Administrative Law Judge
For Maura Corrigan, Director
Department of Human Services

Date Signed: October 26, 2012

Date Mailed: October 29, 2012

NOTICE: Michigan Administrative Hearing System (MAHS) 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. MAHS 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. (60 days for FAP cases)

The Claimant 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 date of the rehearing decision.

Claimant may request a rehearing or reconsideration for the following reasons:

- A rehearing **MAY** be granted if there is newly discovered evidence that could affect the outcome of the original hearing decision.
- A reconsideration **MAY** be granted for any of the following reasons:
  - misapplication of manual policy or law in the hearing decision,
  - typographical errors, mathematical error, or other obvious errors in the hearing decision that effect the substantial rights of the claimant:
  - the failure of the ALJ to address other relevant issues in the hearing decision.

Request must be submitted through the local DHS office or directly to MAHS by mail at

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P. O. Box 30639
Lansing, Michigan 48909-07322

CMM/tmm

cc: [redacted]