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

IN THE MATTER OF:

[redacted]

Reg. No.: 201242385
Issue No.: 2009
Case No.: [redacted]
Hearing Date: June 20, 2012
County: Monroe DHS

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 following Claimant's request for a hearing. After due notice, an in-person hearing was held on June 20, 2012 from Monroe, Michigan. Participants included the above-named claimant. [redacted] testified and appeared as Claimant's authorized hearing representative. [redacted] testified on behalf of Claimant. Participants on behalf of Department of Human Services (DHS) included [redacted], Specialist.

ISSUE

The issue is whether DHS properly denied Claimant's application for Medical Assistance (MA) on the basis that Claimant is not a disabled individual.

FINDINGS OF FACT

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

1. On 12/20/11, Claimant applied for MA benefits including retroactive MA benefits (see Exhibits 15-16) from 10/2011.

2. Claimant's only basis for MA benefits was as a disabled individual.

3. On 3/9/12, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 1-2).

4. On 3/15/12, DHS denied Claimant's application for MA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On 3/27/12, Claimant requested a hearing disputing the denial of MA benefits.

6. On 5/12/12, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual (see Exhibits 896-897), in part, by application of Medical-Vocational Rule 202.21.

7. On 7/16/12, an administrative hearing was held.

8. Claimant presented new medical documents (Exhibits A1-A71) at the administrative hearing, which were forwarded to SHRT along with previously presented documents.

9. On 12/18/12, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual (see Exhibits B18-B19), in part, based on new medical documents (B1-B17) and by application of Medical-Vocational Rule 202.20.

10. As of the date of the administrative hearing, Claimant was a [redacted] year old female with a height of 5'4'' and weight of 207 pounds.

11. Claimant has no known relevant history of tobacco, alcohol or illegal substance abuse.

12. Claimant completed high school and subsequently obtained an associate's degree.

13. As of the date of the administrative hearing, Claimant had medical coverage through Monroe County (which covered some of Claimant's prescriptions).

14. Claimant alleged that she is disabled based on impairments and issues including: depression, anxiety, impaired vision, diabetes, hypertension, lower back pain, congestive heart failure, vertigo, nausea, neuropathy and migraine headaches.

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). DHS (formerly known as the Family Independence Agency) administers the MA program 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 Reference Tables Manual (RFT).

MA provides medical assistance to individuals and families who meet financial and nonfinancial eligibility factors. The goal of the MA program is to ensure that essential

health care services are made available to those who otherwise would not have financial resources to purchase them.

The Medicaid program is comprised of several sub-programs which fall under one of two categories; one category is FIP-related and the second category is SSI-related. BEM 105 at 1. To receive MA under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled. *Id*. Families with dependent children, caretaker relatives of dependent children, persons under age 21 and pregnant, or recently pregnant, women receive MA under FIP-related categories. *Id*. AMP is an MA program available to persons not eligible for Medicaid through the SSI-related or FIP-related categories though DHS does always offer the program to applicants. It was not disputed that Claimant's only potential category for Medicaid eligibility would be as a disabled individual.

Disability for purposes of MA benefits is established if one of the following circumstances applies (see BEM 260 at 1-2):

- by death (for the month of death);
- the applicant receives Supplemental Security Income (SSI) benefits;
- SSI benefits were recently terminated due to financial factors;
- the applicant receives Retirement Survivors and Disability Insurance (RSDI) on the basis of being disabled; or
- RSDI eligibility is established following denial of the MA benefit application (under certain circumstances).

There was no evidence that any of the above circumstances apply to Claimant. Accordingly, Claimant may not be considered for Medicaid eligibility without undergoing a medical review process which determines whether Claimant is a disabled individual. *Id*. at 2.

Generally, state agencies such as DHS must use the same definition of SSI disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally defined as the inability to do any substantial gainful activity (SGA) 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 functionally identical definition of disability is found under DHS regulations. BEM 260 at 8.

Substantial gainful activity means a person does the following:

- Performs significant duties, and
- Does them for a reasonable length of time, and
- Does a job normally done for pay or profit. *Id*. at 9.

Significant duties are duties used to do a job or run a business. *Id*. They must also have a degree of economic value. *Id*. The ability to run a household or take care of oneself does not, on its own, constitute substantial gainful activity. *Id*.

The person claiming a physical or mental disability has the burden to establish a disability 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 CRF 413.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a).

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled. 20 CFR 416.920. If there is no finding of disability or lack of disability at each step, the process moves to the next step. 20 CFR 416.920 (a)(4).

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person is statutorily blind or not. The 2011 income limit is $1000/month.

In the present case, Claimant denied having any employment since the date of the MA application; no evidence was submitted to contradict Claimant's testimony. Without ongoing employment, it can only be concluded that Claimant is not performing SGA. It is found that Claimant is not performing SGA; accordingly, the disability analysis may proceed to step two.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the 12 month duration requirement. 20 CFR 416.920 (a)(4)(ii). The impairments may be combined to meet the severity requirement. If a severe impairment is not found, then a person is deemed not disabled. *Id*.

The impairments must significantly limit a person's basic work activities. 20 CFR 416.920 (a)(5)(c). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. *Id.* Examples of basic work activities include:

- physical functions (e.g. walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling)
- capacities for seeing, hearing, and speaking, understanding; carrying out, and remembering simple instructions
- use of judgment
- responding appropriately to supervision, co-workers and usual work situations; and/or
- dealing with changes in a routine work setting.

Generally, federal courts have imposed a de minimus standard upon claimants to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v*

Bowen, 880 F2d 860, 862 (6th Cir. 1988). Similarly, Social Security Ruling 85-28 has been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirement is intended "to do no more than screen out groundless claims." *McDonald v. Secretary of Health and Human Servs.*, 795 F.2d 1118, 1124 (1st Cir. 1986).

SSA specifically notes that age, education, and work experience are not considered at the second step of the disability analysis. 20 CFR 416.920 (5)(c). In determining whether Claimant's impairments amount to a severe impairment, all other relevant evidence may be considered. The analysis will begin with the relevant submitted medical documentation.

A Medical Social Questionnaire (Exhibits 7-9) dated [redacted] completed by Claimant was presented. Claimant noted she has the following illnesses: diabetic retinopathy with bleeding cataracts, CHF, diabetes mellitus, anxiety, HTN, LBP, fatigue and hypercholesterolemia. Claimant noted that she had multiple hospital encounters in 2011.

Hospital records (Exhibits 293-306; 332-353; 452-459) were presented from 2009 and earlier. These documents were obsolete considering the large volume of more recent documents presented on behalf of Claimant. Claimant's complaints and hospital diagnoses from 2009 and prior included: nausea, urinary tract infection, finger tip laceration and rib pain.

Additional hospital records (Exhibits 365-407) were presented. The documents were either duplicate records, or contained lab, test and/or radiology information that is appropriate for doctors, not administrative law judges, to analyze.

Hospital records (Exhibits 288-290; 442-451) from a [redacted] encounter were presented. It was noted that Claimant presented with complaints of abdomen pain and leg swelling.

Hospital records (Exhibits 232-258) from a [redacted] admission were presented. It was noted that Claimant presented with complaints of chest pain, dizziness and cramping. A discharge diagnosis of hemorrhagic pelvic cyst was provided (see Exhibit 265). Following multiple radiology examinations, Claimant was given Vicodin for her pain prior to discharge.

Hospital records (Exhibits 232-258) from a [redacted] encounter were presented; Claimant was discharged on the same date. It was noted that Claimant presented with complaints of vomiting and nausea over the previous three days. A final diagnosis of gastroenteritis was provided.

Hospital records (Exhibits 228-231; 435-441) from an [redacted] encounter were presented. It was noted that Claimant presented with complaints of right shoulder pain after a fall. Radiography of Claimant's cervical spine led to an impression of moderate chronic disc space narrowing at C5-C6.

Hospital documents (Exhibits 429-434) dated [redacted] were presented. It was noted that Claimant presented with right foot pain after a hiking trip. It was noted that the pain was probably caused by Claimant's choice of hiking footwear.

Hospital documents (Exhibits 420-428) dated [redacted] were presented. It was noted that Claimant reported with pain in left hip and thigh after she fell when a laundry cart was pushed into her by her autistic son. Claimant also reported unusual vaginal bleeding. Diagnoses of left hip and thigh contusion and dysfunctional uterine bleeding were noted.

Hospital documents (Exhibits 415-419) dated [redacted] were presented. It was noted that Claimant reported falling in her bathtub and hurting her back, neck, arm and ankle. It was noted that a CT scan revealed disk space narrowing at C4-6 and bulging disks at multiple levels. It was noted that x-rays showed Claimant was negative for fracture. Diagnoses included post-traumatic headache and cervical radiculopathy.

Hospital documents (Exhibits 569-609) were presented stemming from a hospital admission dated [redacted]. It was noted that Claimant presented with atypical chest pain. It was noted that labs and an EKG were normal. It was noted that Claimant's chest pain was atypical for cardiac problems. A CT scan of Claimant's brain was unremarkable.

Hospital documents (Exhibits 538-568) were presented stemming from a hospital admission dated [redacted] It was noted that Claimant reported with chest pain and blackout spells. It was noted that a stress test was negative for ischemia.

Hospital documents (Exhibits 505-537) were presented stemming from a hospital admission dated [redacted]. It was noted that Claimant reported with atypical chest pain. Radiology of Claimant's chest led to an impression of borderline cardiomegaly.

Hospital documents (Exhibits 474-504) dated [redacted] were presented. It was noted that Claimant presented with complaints of chest pain, dizziness and shortness of breath. A cardiac diagnostic report noted single vessel coronary artery disease. It was noted that a lesion causing 70% stenosis was reduced to 0%. It was noted that Claimant was discharged on [redacted].

Hospital records (Exhibits 181-227) from a [redacted] admission were presented. The final hospital note was dated [redacted] (presumed to be the date of discharge). It was noted that Claimant presented with complaints of abdominal pain, nausea and vomiting. An initial diagnosis of dehydration and gastroenteritis were noted. It was noted that Claimant's blood sugar was elevated. It was noted that Claimant had neuropathy (see Exhibit 199). It was noted that an esophagogastroduodenoscopy was performed. An impression was

given of normal GE junction with mild non-erosive gastritis in the stomach (see Exhibit 204)

Hospital documents (Exhibits 408-414) dated [redacted] were presented. It was noted that Claimant presented with pain following a fall at work. Radiography was performed on Claimant's ankle; an impression of osteoarthritis with no fracture was noted. Radiography was performed on Claimant's knee; the exam was noted as normal.

Hospital records (Exhibits 308-309; 354-364) from an admission dated [redacted] were presented. It was noted that Claimant was discharged on [redacted]. It was not that Claimant had an allergic reaction to a bee sting. It was noted that Claimant's blood sugar was high (see Exhibit 361).

Hospital records (Exhibits 176-180) from an admission dated [redacted] were presented. It was noted that Claimant presented with a complaint of chest pain. Claimant took an exercise stress test. An impression was given that Claimant's test results were normal sub-maximal and that Claimant had moderate exercise tolerance.

Hospital records (Exhibits 37-175) were presented. It was noted that Claimant was hospitalized on [redacted] and discharged on [redacted] (see Exhibit 42). An initial diagnosis of mild pancreatitis was given (see Exhibit 60). A principal diagnosis of partial small bowel obstruction was subsequently noted; the diagnosis was confirmed by radiology (see Exhibit 76, 85 and 87). It was noted that Claimant presented with complaints of abdominal pain. It was noted that Claimant complained of fatigue (see Exhibit 56). It was noted that an exploratory laporatomy was performed. It was noted that Claimant was negative for deep vein thrombosis (see Exhibit 68). Radiology of Claimant's chest was performed on [redacted]; an impression was given of no CT evidence for acute pulmonary emboli and low lung volumes with mild dependent edema and dependent atelectasis.

Hospital records (Exhibits 21-36) dated [redacted] were presented. It was noted that Claimant was discharged on the same date. It was noted that Claimant presented with a complaints of nausea and vomiting. Discharge diagnoses of nausea and vomiting were provided. X-rays of Claimant's chest were unremarkable. X-rays of Claimant's abdomen noted "nonspecific gas pattern".

Hundreds of other documents (Exhibits 610-895) were presented. The various documents addressed numerous other emergency room visits and hospitalizations for Claimant, primarily from 2011.

A Medical Examination Report (Exhibits 3-4) dated [redacted] was completed by Claimant's treating physician. It was noted that the physician first treated Claimant on [redacted] and last examined Claimant on [redacted]. The physician provided diagnoses of a small bowel obstruction, hypertension and an illegible third diagnoses. It was noted that Claimant took 10 medications including Plavix and Novolog among others. An

impression was given that Claimant's condition was improving. It was noted that Claimant can meet household needs.

Hospital documents (A63-A71) from an emergency visit dated [redacted] were presented. It was noted that Claimant presented with complaints of vertigo. It was noted that prolonged standing was a precipitating factor.

Various physician notes (Exhibits A39-A62) from a treating physician were presented. It was noted on [redacted] that Claimant's diabetic macular disease was worsening. A history of diabetic neuropathy was noted. Various complaints from Claimant were noted including: dizziness, cough, breathing difficulties and chest pain.

Medical documents (Exhibits A12-A38) were presented. The documents range in date from [redacted] and concern Claimant's vision. It was noted on [redacted] that Claimant's right eye vision improved since an unspecified injection was made. It was noted on [redacted] that Claimant reported complained of blurry left eye vision; an assessment of macular puckering was noted.

Treatment documents (Exhibits A5-A7 from Claimant's treating psychologist were presented. The documents ranged in date from [redacted]. it was noted that Claimant's GAF was 40; a score of 31-40 is described as "some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood." A diagnosis of PTSD was noted. It was noted that Claimant had high anxiety and flashbacks.

A consultative examination report (Exhibits B1-B4) dated [redacted] was presented. It was noted that Claimant reported a history of hypertension, diabetes, abdominal pain, back pain and vertigo. It was noted that Claimant had a full range of motion in all examined areas, full strength and a normal gait. It was noted that Claimant's gait was slow and that Claimant appeared in pain.

A Psychiatric/Psychological Examination Report (Exhibits A1-A2) was presented. It was noted that the examiner first examined patient on [redacted] and last examined patient on [redacted]. It was noted that Claimant had difficulty with social functioning. It was noted that Claimant would function independently after leaving Fairview (a shelter). An Axis I diagnosis of post-traumatic stress disorder was noted. A GAF of 45 was noted. A GAF within the range of 41-50 is representative of a person with "serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g. no friends, unable to keep a job)."

A Mental Residual Functional Capacity Assessment (Exhibits A3-A4) dated [redacted] was completed by Claimant's treating physician. This form lists 20 different work-related activities among four areas: understanding and memory, sustained concentration and persistence, social interaction and adaptation. A therapist or physician rates the patient's ability to perform each of the 20 abilities as either "not significantly limited",

"moderately limited", "markedly limited" or "no evidence of limitation". Claimant was noted as markedly restricted in 7 of 9 concentration related abilities and 3 of 5 social abilities.

A consultative examination report (Exhibits BB5-B17) dated [redacted] was presented. Axis I diagnoses included: chronic PTSD, depression, generalized anxiety disorder and panic disorder. Claimant's GAF was 48. Claimant's prognosis was guarded. The examiner noted that she suspected that the pressure of employment would be a major factor in decompensation. Claimant was tested on the Wechsler Adult Intelligence Scale (WAIS-IV); Claimant's scores placed in low-average or average rankings. It was noted that Claimant was markedly restricted in: understanding and remembering complex instructions, carrying out complex instructions and making judgments on complex work decisions. Claimant was found moderately restricted in: understanding simple instructions, carrying-out simple instructions and making simple work-related decisions. Claimant was also markedly restricted in interacting appropriately with supervisors and coworkers. Claimant was found moderately restricted in responding to changes.

Claimant completed an Activities of Daily Living (Exhibits 10-14) dated [redacted]. Claimant noted she had trouble sleeping due to back pain. Claimant noted that she does her laundry and makes her bed but it is difficult for her to lift. Claimant noted that she does her own shopping. Claimant noted that she visits her family regularly.

Overall, hundreds of medical documents were presented in support of Claimant's various exertional impairments. It was established that Claimant suffers from degrees of: diabetes, hypertension, vision loss, neuropathy, cervical back pain, lumbar back pain and vertigo. Despite the litany of records presented in support of Claimant's physical problems, analysis of only Claimant's psychological problems will be undertaken at step two.

Claimant's treating psychologist established that Claimant is markedly restricted in the majority of work-related abilities involving social function and concentration. The restrictions were generally confirmed by a consultative examiner in 9/2012. The marked restrictions to Claimant's concentration and social functioning were sufficient to establish significant impairment to performing basic work activities.

Claimant's treating psychologist noted Claimant's restrictions as early as 5/2012. Claimant's guarded prognosis is suggestive that Claimant's restrictions are unlikely to change within 12 moths. Claimant's relatively small increase in GAF from 40 in 5/2012 to 45 in 9/2012 (or 48 in 9/2012 based on the consultative examiner's assessment) are also suggestive of incremental improvement; however, the improvement is supportive of Claimant having a significant psychological impairment lasting longer than 12 months.

Based on the presented evidence, it is found that Claimant established a significant impairment expected to last longer than 12 months. Thus Claimant established a severe impairment. Accordingly, the disability analysis may move to step three.

The third step of the sequential analysis requires a determination whether the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920 (a)(4)(iii). If Claimant's impairments are listed and deemed to meet the 12 month requirement, then the claimant is deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step.

There was no shortage of alleged impairments to consider at step three. The step three analysis will begin with Claimant's anxiety related to PTSD. Anxiety disorders are covered by SSA Listing 12.06 which reads:

> **12.06** ***Anxiety-related disorders***: In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders. The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in both A and C are satisfied.
>
> A. Medically documented findings of at least one of the following:
>
> 1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:
>
> a. Motor tension; or
>
> b. Autonomic hyperactivity; or
>
> c. Apprehensive expectation; or
>
> d. Vigilance and scanning; or
>
> 2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or
>
> 3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or
>
> 4. Recurrent obsessions or compulsions which are a source of marked distress; or
>
> 5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;
>
> AND
>
> B. Resulting in at least two of the following:
>
> 1. Marked restriction of activities of daily living; or
>
> 2. Marked difficulties in maintaining social functioning; or
>
> 3. Marked difficulties in maintaining concentration, persistence, or pace; or
>
> 4. Repeated episodes of decompensation, each of extended duration.
>
> OR
>
> C. Resulting in complete inability to function independently outside the area of one's home.

Starting with Part A of the listing, there was evidence that Claimant suffered from flashbacks of recurring abuse from a former spouse and a relative. The flashbacks were noted by Claimant's treating psychologist as a significant reason for Claimant's stress and anxiety. Part A of the listing for anxiety disorders was established.

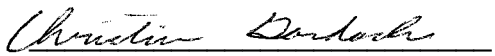
Looking at Part B, Claimant's treating psychologist and consultative examiner made comparable conclusions concerning Claimant's abilities. Both concluded that Claimant was markedly restricted in understanding and carrying-out complex instructions while Claimant was moderately restricted in performing simple instructions. The consultative examiner found Claimant only markedly limited in social function while Claimant's treating psychologist found Claimant markedly restricted in the majority of abilities related to social function. Though the consultative examiner found Claimant to be more capable socially than Claimant's treating therapist, the consultative examiner also concluded that it was suspected that the stress of employment would cause Claimant to decompensate. Potential decompensation due to the stress of employment is very consistent with a disabling condition. Based on the presented evidence, it was established that Claimant was markedly limited in social functioning and concentration. Based on the presented evidence, Claimant meets Parts A and B of the listing for anxiety disorders and is a disabled individual. Accordingly, the DHS denial of MA benefits was improper.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that DHS improperly denied Claimant's application for MA benefits. It is ordered that DHS:

(1) reinstate Claimant's MA benefit application dated 12/20/11 including retroactive MA benefits back to 10/2011
(2) evaluate Claimant's eligibility for MA benefits on the basis that Claimant is a disabled individual;
(3) supplement Claimant for any benefits not received as a result of the improper denial; and
(4) schedule a review of benefits in one year from the date of this administrative decision, if Claimant is found eligible for future MA benefits.

The actions taken by DHS are REVERSED.



Christian Gardocki
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: January 18, 2013

Date Mailed: January 18, 2013

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

CG/hw

cc: [redacted]