STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF:

[redacted],

Appellant

_____/

Docket No. 2012-5578 CMH
Case No. 32003661

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ), pursuant to M.C.L. § 400.9 and 42 C.F.R. § 431.200 *et seq*., upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted].[1] Attorney [redacted] appeared on behalf of Appellant. [redacted], [redacted], [redacted], and [redacted] testified as witnesses for Appellant. [redacted], Manager of Due Process, appeared on behalf of the [redacted] County Community Mental Health (CMH). [redacted], [redacted], and [redacted] appeared as witnesses for the CMH.

ISSUE

Did the CMH properly deny Appellant's request for 80 hours of respite care services per month and instead authorize 40 hours of such services per month?

FINDINGS OF FACT

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

1. Appellant is an [redacted] year-old girl who has been diagnosed with, among other things, Post-traumatic stress disorder, Reactive attachment disorder, Obsessive–compulsive disorder, and a severe emotional disorder. (Exhibit 3, pages 1, 15; Testimony of [redacted]).

2. The CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.

[1] Appellant's hearing was consolidated with the hearings for her sister [redacted] (Docket No. 2012-9365) and her brother [redacted] (Docket No. 2012-5577).

3. In early [redacted], Appellant was receiving 60 hours of respite care services per month through the CMH. (Exhibit 3, page 16; Testimony of Erin Werth).

4. Appellant then requested 80 hours of respite care services. (Exhibit 3, page 3; Testimony of [redacted]).

5. Before allowing Appellant to make the request for increased respite hours, the CMH improperly required that she terminate her plan of service early. (Exhibit 3, pages 12-14; Testimony of [redacted]).

6. A Respite Assessment form was completed on [redacted]. (Exhibit 3, pages 2-6).

7. Based on the assessment and the scoring tool used by the CMH, the CMH authorized 32 hours of respite care per month. (Exhibit 8, page 14-a; Testimony of [redacted]).

8. Appellant subsequently appealed the CMH's decision and, on [redacted], Administrative Law Judge (ALJ) [redacted] reversed the CMH's decision and ordered: "The Department shall REINSTATE the Appellant's Respite grant that was in effect on [redacted], and shall REASSESS the Appellant's request for increased RESPITE in a face to face meeting within 30-days receipt of this Decision and Order or as soon as might reasonably be scheduled between the parties, thereafter." (Exhibit 1, pages 15-22).

9. On [redacted], the date it received ALJ [redacted] decision, the CMH authorized a month of services at the previous level, *i.e.* 60 respite hours a month.

10. On [redacted], a new respite assessment form was completed and Appellant again requested 80 hours of respite care per month. The respite assessment form was completed during a face-to-face meeting between Appellant's mother and Clinical Therapist [redacted]. (Exhibit 3, pages 31-35).

11. Based on the assessment and the scoring tool used by the CMH, the CMH authorized 40 hours of respite care per month. (Testimony of [redacted]).

12. On [redacted], the CMH sent notice to Appellant notifying her that the request for 80 hours per month of respite was denied, but that 40 hours of respite per month were approved effective [redacted]. (Exhibit 3, pages 36-38).

13. The Michigan Administrative Hearing System (MAHS) received Appellant's request for hearing on [redacted].

CONCLUSIONS OF LAW

As a preliminary matter, Appellant argues that an earlier decision by ALJ [redacted] controls this case. As discussed above, Appellant was at one time receiving 60 respite hours per month and requested an increase to 80 respite hours per month. In response to that request, the CMH authorized 32 respite care hours per month. Appellant appealed and her case was assigned to ALJ [redacted].

This ALJ would also note that, before allowing Appellant to make the request for increased respite hours, the CMH improperly required that she terminate her plan of service early and it treated her request as a new request. Accordingly, while her appeal before ALJ [redacted] was pending, Appellant was limited to 32 hours of respite care hours rather than the 60 she should have been receiving according to policy.

On [redacted], ALJ [redacted] reversed the CMH's decision and ordered:

> The Department shall REINSTATE the Appellant's Respite grant that was in effect on [redacted], and shall REASSESS the Appellant's request for increased RESPITE in a face to face meeting within 30-days receipt of this Decision and Order or as soon as might reasonably be scheduled between the parties, thereafter.

On [redacted], the date it received ALJ [redacted]'s decision, the CMH authorized a month of services at the previous level, *i.e.* 60 respite hours a month.

On [redacted], a new respite assessment form was completed and Appellant again requested 80 hours of respite care per month. The respite assessment form was completed during a face-to-face meeting between Appellant's mother and Clinical Therapist [redacted]. [redacted] subsequently sent the form to the CMH, where it was scored by Care Coordinator [redacted]. After scoring the respite assessment form, [redacted] authorized 40 respite care hours per month.

Appellant's attorney now argues that the CMH violated ALJ [redacted]'s decision by (1) failing to reinstate Appellant's respite hours on the date of the decision; (2) failing to assess Appellant's request in a face-to-face meeting between Appellant, Appellant's mother and the person actually authorizing the respite hours; and (3) by reducing Appellant's respite hours below the amount ALJ [redacted] ordered reinstated. With respect to that third argument, it is the position of Appellant that the CMH was limited to reviewing the request for *increased* respite hours and that, even if it chose not to increase the hours, the CMH was prohibited from authorizing less than 60 respite care hours per month.

This Administrative Law Judge finds that, to the extent Appellant is challenging the implementation of ALJ [redacted]'s decision, this ALJ does not have jurisdiction over

Appellant's claims. Moreover, with respect to Appellant's claim that ALJ [redacted] limited any new authorization of respite hours to a minimum of 60 hours per month, this ALJ rejects that argument. ALJ [redacted] was simply ordering that another assessment of Appellant's request for increased respite hours be completed and was not ordering that Appellant should receive at least 60 hours of respite care per month in perpetuity.

With respect to this case, this ALJ would note that the Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> (42 C.F.R. § 430.0)

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> (42 C.F.R. § 430.10)

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection(s) of this section) (other

> than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…
>
> (42 U.S.C. § 1396n(b))

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

The Medicaid Provider Manual (MPM), Mental Health/Substance Abuse Section, articulates the relevant policy and, with respect to respite care services, it states:

> **17.3.J. RESPITE CARE SERVICES**
>
> Services that are provided to assist in maintaining a goal of living in a natural community home by temporarily relieving the **unpaid** primary caregiver (e.g., family members and/or adult family foster care providers) and is provided during those portions of the day when the caregivers are not being paid to provide care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite should be decided during person-centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.
>
> *(*MPM, Mental Health and Substance Abuse Section, October 1, 2011, page 118*)*

However, Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not waive the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 C.F.R. § 440.230. The MPM also describes the criteria the CMH must apply before Medicaid can pay for outpatient mental health benefits:

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
- Documented in the individual plan of service.

(MPM, Mental Health and Substance Abuse Section, October 1, 2011, page 13)

In addition to requiring medical necessity, the MPM also states that B3 supports and services, such as respite care services, are not intended to meet every minute of need, in particular when parents of children without disabilities would be expected to be providing care:

> Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of

> minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDCH encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.
>
> *(*MPM, Mental Health and Substance Abuse Section, October 1, 2011, page 105*)*

Here, applying the relevant policy and facts in this case, the CMH's decision to deny the request for 80 hours of respite care services per month and only authorize of 40 hours of respite care services per month must be sustained as it is reflective of the need for assistance and provides Appellant's caregivers with significant, temporary relief.

CMH witness [redacted], Utilization Management Care Coordinator, testified in this case regarding the process for assessment and allocation of respite hours used by the CMH. According to [redacted], the MDCH does not provide a screening tool for respite care and the CMH has therefore developed its own tool that is only used in [redacted] County. [redacted] was part of the team that developed the scoring tool.

[redacted] testified that, as part of the assessment and allocation process, staff from Child and Family Services meets with the client and others in order to fill out the respite assessment form. However, in conducting the respite assessment, the staff members that complete the respite assessments are not given the scoring tool so they cannot manipulate the answers on the assessment or affect the number of respite hours to be approved. Subsequently, the Utilization Management section of the CMH receives a request for authorization, along with the respite assessment form, and Utilization Management Coordinators apply a scoring tool and assign respite hours based on the respite assessment form. The scorer does not have any face-to-face contact with the client. When scoring the form, the scorer can also look at the amount of respite hours previously authorized if appropriate. An example of such a situation given by [redacted] was when there is a significant change in the number of hours requested.

[redacted] also testified that the scoring tool was changed in the past year in part because the CMH was an outlier in awarding respite hours and the old scoring tool was deemed too subjective. However, it is still possible to get the maximum 96 hours of respite care services through the new scoring tool and [redacted] testified that, in her professional opinion, the scoring tool now being used by the CMH accurately reflects the client's needs for respite services. [redacted] also asserted that respite services are to provide a temporary break for an unpaid caregiver and are not intended to be provided on a continuous or daily basis.

[redacted] further testified regarding other specific changes made from the earlier scoring tool to the one used in the assessment at issue here. For example, the starting point of 20 hours of respite care per month under the prior scoring tool has been eliminated in order to accurately reflect need. Another change was to clarify the behavioral section in order to remove the subjectivity from the scoring and achieve more accurate and uniform scoring within their department.

With respect to the availability of caregivers, definitions and language were added. However, the maximum number of hours (6) that could be awarded for this factor remained the same. The hours that could be allocated due to the condition of caretaker also remained the same.

Regarding nighttime interventions, a client can now only be awarded a maximum of 4 respite hours a month, whereas he could receive 6 hours under the previous tool. According to [redacted], the change was due to a change in policy in the Children's Waiver Program.

[redacted] testified that, with respect to the behavioral/emotional section of the scoring tool, a client could receive up to 30 hours under either scoring tool. However, given issues with the different credentials of staff members and subjective judgments, the new scoring tool clarified the most common behaviors into 9 categories. Moreover, according to [redacted], a behavior plan was necessary to receive the full 30 hours under either scoring tool.

[redacted] further testified that, while the number of respite hours that could be assigned for factors such as mobility, oral care, eating, bathing, toileting and dressing remained the same, more choices were added to allow for greater clarification. Also, the CMH added a new category for dietary needs and replaced hair care with grooming, which also encompasses more tasks.

As stated by [redacted], the new scoring tool also distinguishes between the need for medication administration by age because it is still a parent's duty to administer medication to children. Only a need for medication administration with clients over the age of 18 justifies respite hours. [redacted] also stated that a client can receive 2 respite hours a month due to non-verbal communication and 3 hours a month if the client requires extensive prompting and encouragement to participate in things.

[redacted] further testified that the narrative sections of the respite assessment form are reviewed and taken into consideration when allocating hours. If anything in the narrative justifies additional respite hours, then the scorer could contact the scorer's supervisor and have additional hours awarded. The scoring tool allows for 13 such discretionary hours.

With respect to Appellant's score in this case, Care Coordinator [redacted] testified that she calculated Appellant's respite hours from the respite assessment form.

According to [redacted], Appellant was awarded 4 respite hours per month because both of Appellant's caregivers work or are in school full-time or part-time. [redacted] also testified that Appellant was awarded 2 hours because her mother's medical conditions interfere with her care and 2 respite hours because there are 1-2 interventions per night and the time required to complete the intervention(s) is 1 hour or less.

[redacted] further testified that Appellant was awarded 2 respite hours per month because she is verbally abusive daily, 3 respite hours because she is physically abusive to others daily, 2 respite hours because she is physically abusive to herself weekly, 3 respite hours because she engages in the destruction or disruption of property daily, 1 respite hour because she has daily temper tantrums, and 2 respite hours because she wanders daily.[2]

[redacted] also testified that Appellant was awarded 3 respite hours per month because she requires assistance with for self care-oral care, 3 respite hours because she requires assistance with self care-bathing, 2 respite hours because Appellant requires reminding for self care-toileting, and 2 respite hours because Appellant requires reminding for self care-dressing.

As stated in [redacted]' testimony, Appellant was also awarded 3 respite hours per month because she requires extensive prompting and encouragement in the area of participation and 6 respite hours because of her other clinical needs, which included Appellant being suspended from school for stealing.

Overall, Appellant was therefore awarded 40 hours of respite care per month instead of the 80 hours she requested. For the reasons discussed below, this Administrative Law Judge finds that the CMH's decision should be sustained.

In response to the above testimony and evidence, Appellant's attorney raised arguments generally challenging the use of the scoring tool by the CMH. For example, Appellant's attorney argues that the use of the respite assessment scoring tool violates the MPM because it does not satisfy the "person-centered planning" requirement of the MPM. As provided in the MPM, "[d]ecisions about the methods and amounts of respite should be decided during person-centered planning." (MPM, Mental Health and Substance Abuse Section, October 1, 2011, page 118). However, while the MPM is replete with references to person-centered planning, that concept is not expressly described and Appellant does not elaborate on why the requirement is not met in this case. At one point, the MPM does provide

> Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others during the person-centered

[2] The box for a behavioral plan was checked on the respite assessment form and, if such a plan was in place, Appellant would be awarded an additional 10 respite care hours. (Exhibit 3, page 34). However, [redacted] did not allocate those hours because she could not locate such a plan. Subsequent testimony by [redacted] and [redacted] confirmed that, while Appellant is in the process of getting a behavioral plan, no plan was in place at the time of the CMH's decision.

> planning process and identified in the plan of service must meet the medical necessity criteria contained in this chapter, be appropriate to the individual's needs, and meet the standards herein. A person-centered planning process that meets the standards of the Person-centered Planning Practice Guideline attached to the MDCH/PIHP contract must be used in selecting services and supports with mental health program beneficiaries who have mental illness, serious emotional disturbance, or developmental disabilities.
>
> (MPM, Mental Health and Substance Abuse Section, October 1, 2011, page 4)

Similarly, those guidelines also focus on letting the individual directing the planning process, with a focus on what he/she wants and needs, and awarding services on an individualized basis. While those choices and preferences are not always granted, they are considered and respected. (Person-Centered Planning Revised Practice Guideline, October 2002). Here, while the CMH used the same scoring tool it uses with every client, it also applied that tool to Appellant's individual circumstances while also considering her request for respite services. Additionally, [redacted] expressly testified and explained why it would not be feasible to determine respite hours at the exact time the person-centered plan is developed. Accordingly, Appellant's argument that the use of the scoring tool means that services are not decided during the person-centered planning must be rejected.

Appellant also appears to argue that the CMH violated the MPM by improperly denying or basing services on preset limits. The MPM does provide that a "PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services." (MPM, Mental Health and Substance Abuse Section, October 1, 2011, page 14). However, the CMH did not deny any services because of preset limits. [redacted] specifically testified that, depending on the facts in an individual case, a client could score anywhere from 0 to 96 hours of respite care hours per month and an examination of the scoring tool also reveals that 96 hours is obtainable. "The maximum monthly respite allocation is 96 hours" (MPM, Mental Health and Substance Abuse Section, October 1, 2011, page 74), but that limit is set by the MPM.

Appellant further argues that the use of the scoring tool is improper because the person filling out form does not know what is important while the person scoring the form never meets with the client face-to-face. However, no such requirement is found in the Medicaid Provider Manual. Moreover, [redacted] testified that, given the number of clients involved, face-to-face meetings between the clients and scorers are not possible. [redacted] also testified that the CMH trains the staff filling out the respite assessment forms on how to complete those forms. To the extent Appellant argues that the respite assessment form in this case was incomplete, that argument will be addressed below. Appellant's general argument that the use of the scoring tool is improper must be rejected.

In addition to the general objections to the scoring tool used by the CMH, Appellant also challenges the specific application of the scoring tool to her case. For example, Appellant's mother testified that Appellant's respite hours have been reduced from previous years despite the fact that her behavior is actually worsening. Specifically, Erin Werth testified that Appellant has been engaging in high-risk and aggressive behavior. Appellant's mother also testified that Appellant will often target her bad behavior toward Appellant's mother. Additionally, Appellant has been violent toward her younger siblings and increased her amount of rage and property destruction. According to Appellant's mother, the increase in bad behavior has meant that she must spend more time with Appellant and that it takes much work to manage Appellant's behavior.

However, the mere fact that an Appellant may receive less respite hours despite worsening behavior is not dispositive in this case. [redacted] testified that the CMH developed the new scoring tool in part because the old respite assessment process was awarding 20 hours of respite care automatically and was an outlier with respect to the hours awarded by other agencies, which suggests that the previous assessment process was awarding too many respite hours and was not based on medical necessity. The ultimate question remains whether the denied hours were medically necessary and the burden still remains on Appellant to demonstrate by a preponderance of the evidence that, in this case, the CMH erred in allocating the amount of respite hours.

Appellant first attempts to meet that burden by arguing that the CMH should have awarded some of the possible discretionary hours. As described above, while the scoring tool allows for 13 hours of respite care hours to be awarded for discretionary reasons, only 6 such hours were awarded in this case. Those 6 hours were based on the section of the narrative that noted Appellant had been caught stealing and was suspended from school.

Appellant's attorney first argues that the presence of multiple kids with special needs in home justifies an award of additional respite hours. It is undisputed that two of Appellant's siblings have special needs and exhibit behavioral issues. Moreover, as described by [redacted], the siblings feed off each other's behavior in a vicious cycle and Appellant has been violent toward her siblings. Psychologist [redacted] also testified that, given the interactions among the children, the whole problem they present is greater than the sum of their individual problems. However, the respite assessment form specifically addresses and accounts for some of the interaction between Appellant and her siblings. For example, as described above, the CMH awarded respite hours because Appellant is verbally and physically abusive to others daily. Moreover, other activities that may stem from Appellant's relationship with her siblings, such as temper tantrums, destruction of property or self physical abuse, were also accounted for and lead to respite hours. Appellant's mother fails to describe any behavior between the siblings that was not accounted for and, consequently, the CMH properly found that the presence of multiple kids with special needs in home did not justify an award of additional respite hours.

Appellant's mother further challenges some of the specific, identified factors of the scoring tool. For example, she testified that, while the respite assessment form provides that there are only 1-2 nighttime interventions per night and the time required to complete the intervention(s) is less than 1 hour, the interventions actually take much longer than 1 hour. The narrative for that section also provides that Appellant "rages" at bedtime and may get up to steal things or kick holes in the wall before her parents get up and the calm the house down. (Exhibit 3, page 33). However, Appellant's mother does not recall what she said exactly and, given the detailed narrative, it appears that nighttime interventions were discussed without Appellant's mother stating that the interventions took over an hour.

Appellant's mother further testified that Appellant should have been awarded some respite care hours because of her need for assistance with eating. According to [redacted], Appellant actually reminders and prompting while she is eating or she will eat too fast and lick her plate. Again, however, Appellant's mother does not recall if she mentioned this information during the respite assessment and she has therefore failed to meet her burden of proof.

Finally, Appellant's mother testified that, while the respite assessment form did not find that Appellant required total physical assistance with grooming, Appellant must be significantly monitored and watched while she is brushing her teeth. Nevertheless, as pointed out by the CMH's representative, brushing teeth is covered by the self care-oral care factor and Appellant is already receiving respite hours due to needing assistance in that area.

Appellant bears the burden of proving by a preponderance of evidence that there was medical necessity for the additional hours of respite requested. Here, Appellant did not meet that burden of proof. The CMH adequately explained what led to the calculation of Appellant's respite hours and why those respite hours are medically necessary. It also provided evidence that it adhered to the relevant regulations and state policy by not authorizing respite other than to provide temporary relief for Appellant's parents. Appellant's representatives argues that Appellant's needs have only worsened and that the CMH failed to take into account all of her needs, but this Administrative Law Judge finds those arguments to be unpersuasive for the reasons stated above. The CMH took into account all of the relevant factors and properly assessed Appellant for respite care hours.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly authorized 40 hours of respite care per month based on the information available at the time of its decision.

IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

Steven J. Kibit
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 1/12/2012

***** NOTICE *****

The Michigan Administrative Hearing System may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.