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

IN THE MATTER OF:

[redacted]

Reg No.: 2012-10738
Issue No.: 2009, 4031
Case No.: [redacted]
Hearing Date: February 2, 2012
Oakland County DHS (03)

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 telephone hearing was conducted from Detroit, Michigan on Thursday, February 2, 2012. The Claimant appeared, along with [redacted], and testified. [redacted] appeared on behalf of the Department of Human Services ("Department").

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of the Medical Assistance ("MA-P") and State Disability Assistance ("SDA") 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 and SDA benefits on May 25, 2011.

2. On September 8, 2011, the Medical Review Team ("MRT") found the Claimant not disabled. (Exhibit 1, pp. 4, 5)

3. On September 13, 2011, the Department notified the Claimant of the MRT determination. (Exhibit 1, p. 2)

4. On or about September 28, 2011, the Department received the Claimant's timely written request for hearing.

5. On December 14, 2011, the State Hearing Review Team ("SHRT") found the Claimant not disabled. (Exhibit 2)

6. The Claimant alleged physical disabling impairments due to right eye blindness, oveitis disease with bilateral optic nerve edema, tinnitus, and headaches.

7. The Claimant alleged mental disabling impairments due to obsessive compulsive disorder ("OCD") and bipolar disorder.

8. At the time of hearing, the Claimant was [redacted] years old with a [redacted] birth date; was 5'8½" in height; and weighed approximately 145 pounds.

9. The Claimant is a high school graduate with some college and an employment history of work in an office and at fast food restaurants.

10. The Claimant's impairments have lasted, or are expected to last, continuously for a period of 12 months or longer.

CONCLUSIONS OF LAW

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 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). 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 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).

In addition to the above, when evaluating mental impairments, a special technique is utilized. 20 CFR 416.920a(a). First, an individual's pertinent symptoms, signs, and laboratory findings are evaluated to determine whether a medically determinable mental

impairment exists. 20 CFR 416.920a(b)(1). When a medically determinable mental impairment is established, the symptoms, signs and laboratory findings that substantiate the impairment are documented to include the individual's significant history, laboratory findings, and functional limitations. 20 CFR 416.920a(e)(2). Functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. *Id.;* 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality is considered. 20 CFR 416.920a(c)(1). In addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of functional limitation. 20 CFR 416.920a(c)(3). The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. *Id.* The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. *Id.*

After the degree of functional limitation is determined, the severity of the mental impairment is determined. 20 CFR 416.920a(d). If severe, a determination of whether the impairment meets or is the equivalent of a listed mental disorder is made. 20 CFR 416.920a(d)(2). If the severe mental impairment does not meet (or equal) a listed impairment, an individual's residual functional capacity is assessed. 20 CFR 416.920a(d)(3).

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 and, 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 916.920(a)(4)(ii); 20 CFR 916.920(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 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(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 right eye blindness, oveitis disease with bilateral optic nerve edema, tinnitus, headaches, OCD, and bipolar disorder. In support of her claim, some older records from as early as [redacted] were submitted which document treatment/diagnoses of depression, mood instability, poly cystic ovarian syndrome; bipolar II disorder, rapid cycling; impulse control disorder, and vaginal infections.

On [redacted] an audiological evaluation was performed which resulted in abnormal auditory brainstem response.

On [redacted] an MRI of the brain found mild white matter disease including a subcentimeter focus of abnormal T2/FLAIR hyperintensity and T1 hypointensity in the periventricular white matter of the right frontal lobe and prominent circumferential CSF signal in the optic nerve complex bilaterally.

On [redacted] the Claimant was diagnosed with bilateral optic nerve edema and posterior uveitis with optic nerve swelling. Chest x-rays revealed mild thoracolumbar scoliosis.

On [redacted] the Claimant was diagnosed with optic neuritis and tinnitus (not otherwise specified). X-rays bilaterally of the hands/feet were normal.

On [redacted] the Claimant was evaluated for her right posterior uveitis. The Claimant's condition had worsened despite high doses of steroid treatment. Continued treatment for infection and autoimmune disease was imposed.

On [redacted] the Claimant was evaluated for her right posterior uveitis. A CT scan was reviewed which showed patch and diffuse areas of ground-glass opacification in the periphery of the lungs. The diagnosis was posterior uveitis with ground-glass opacities.

On [redacted] an angiography was performed which was suggestive of infundibula dilation at carotid origins of posterior communicating arteries bilaterally without convincing evidence of saccular aneurysm formation.

On [redacted] the Claimant attended a pulmonary consultative examination after having an abnormal chest x-ray. A bronchoscopy with transbronchial biopsies looking for sarcoidosis and possible hypersensitivity pathology was recommended.

On [redacted] test results found vitreous (right eye) and lymphocytes, neutrophis, and histiocytes. These findings were consistent with inflammatory process; however, a low-grade lymphoma was not ruled out. Vitrectomy, membrane peeling, injection of intravitreal antibiotics and intravitreal antifjungal was performed without complication. The diagnosis was persistent uveitis with progressive vitreitis OD, mucular pucker OD.

On [redacted] the bronchoscopy showed mild chronic inflammation in the right lower lung lobe.

On [redacted] the Clamant sought treatment for right eye vision loss and swelling of the optic nerve in the left eye. Symptoms included rashes, skin sores, hearing ringing/loss, swelling in the feet/legs, headache, joint pain/swelling, and anxiety.

On [redacted] the Claimant attended an infectious disease appointment. The Claimant was found to have multiple systemic symptoms including edema and imaging changes of her optic nerves, lungs, and pericardial effusion. The fungal infection of the eye was concerning for a intravascular source and further testing was recommended to rule out the presence of blood stream infection.

On this same date, the Claimant attended an appointment at the Retina/Uveitis Service. The Ophthalmologist agreed with the diagnosis of probable endophthalmitis in the right eye noting severe pedal edema and the presence of obvious ascites fluid. The Claimant was scheduled for an urgent consult with infectious disease due to the possible fungal nidus (see above).

On [redacted] the Claimant was diagnosed with abnormal finding in the lung field, optic neuritis, and tinnitus.

On [redacted] the Claimant attended an initial evaluation due to her multiple medical conditions. Symptoms included weight change, headache, irregular heart beat, poor circulation, rapid heart rate, ankle swelling, vision changes, hearing loss, and ringing in ears. The assessment was right eye vision changes; anxiety/stress; history of drug abuse; polycystic ovarian disease; tinnitus; lung changes; peripheral edema; and abdominal swelling.

On [redacted] a CT of the abdomen revealed heterogeneous fatty infiltration of the liver and interval decrease in the previously seen ground-glass opacities in the visualized portions of the lung bases (most compatible with an improved infectious or inflammatory process).

On [redacted] an EKG was abnormal.

On [redacted] the Claimant attended a follow-up appointment for recent symptoms of right-sided vision loss, bilateral optic nerve edema, and peripheral edema.

On [redacted] the Claimant attended a follow-up appointment. Although some of the Claimant's symptoms had improved, the Claimant still showed significant optic disc swelling in the right eye and an increase in the optic disc swelling in the left eye.

On [redacted] the Claimant was diagnosed with progressive, extensive inflammation of the right eye and bilateral optic nerve edema, with no clear etiology. The Claimant's symptoms mirrored an autoimmune disease, similar to lupus. Visual acuity was 20/60 +1 on the right, and 20/20 on the left.

On [redacted] the Claimant was prescribed prednisone and a steroid-sparing agent along with immunosuppressive treatment for her bilateral optic nerve edema. On examination, visual acuity was correctable to 20/50-2OS and 20/20-1 OS. Intracular pressures were 16 mm Hg OD and 9 MM Hg OS. Disc edema in each eye was noted as well as a small amount of resolving old vitreous hemorrhage inferiorly in the right eye. A mild epiretinal membrane and an atropt hic scar involving the macula in the right eye caused a reduction in visual acuity.

On [redacted] a MRI/MRA of the brain revealed multifocal tiny signal alterations, mainly in cerebral white matter and bilateral transverse sinus irregularities/narrowing. There was no evidence of active-appearing venous occlusive disease. The results were "worrisome" for papilledema with some ocular distortion.

On [redacted] a fluoroscopically- guided lumbar puncture was performed without complication.

On [redacted] the Claim ant attended a follow- up appointment for bilateral disc edema in the setting of a prev ious fungal endophthalm itis. In summary, the Claimant had an idiopathic ps eudo-tumor cerebri which had g reatly improv ed with treatment. Visual acuity was 20/30 on the right and 20/20 on the left. Extraocular movements were full.

On [redacted] the Claimant's treating R heumatologist wrote a letter confirming treatment for right-sided posterior uveitis with extensive inflammation and bilateral optic nerve edema.

On [redacted] t he Claimant attended a co nsultative evaluation. Chest x-ray s revealed normal cardiac silhouet te noting permanent pacemaker and AICD placement . A spirometry was consistent with a mild rest rictive ventilatory deficit. The diagnos es were sarcoidos is affecting both lungs and heart (appropriately tr eated) and anxiety. From a physical standpoint, the Claimant was found able t o return to her prior occupation; however her anxiety issues may interfere. With tr eatment, the Claimant was found able to return to the workfo rce and was not disabled from all gainful employment.

On [redacted] the Claim ant attended a Psychiatric evaluation. The Claimant's mental ability to relate to others, co-workers, and superviso rs were within nor mal limits; the ability to understand, remember, and carry out simple tasks and to maintain her own schedule was within normal limits; however s he was lik ely to have intermittent episode s of anxiety and depr ession that may interfer e with her performance; the ability to maintain attention, concent ration, persistence and pace to perform routine tasks was markedly impaired during episodes of depressi on and anxiety; the ab ility to withstand stress and pressures associated with day -to-day work activity was markedly lim ited because of her mood disorder; and the Clai mant was found unable to manage benefit funds. The diagnosis was major depressive di sorder, recurrent, moderate. T he Global Assessment Functioning ("GAF") was 60 and the prognosis was guarded.

On [redacted] the Claimant's treati ng Rheum atologist wrot e a letter confirming treatment/diagnoses of right-sided uveitis with bilateral optic nerve edema resulting in complete v ision loss. The autoimmune di sease requires chronic immunosuppressive treatment, such that, without it, the Claimant's condition would worsen wit h potential blindness to the left eye.

On this same date, the Claim ant's treating Ophthalmologist wrote a letter confirming treatment for chronic panuveitis. The uveitis was noted as an ongoing disease requiring continued treatment/medication.

On [redacted] another treating Ophthalmologist wrote a letter confirming treatment for idiopathic intracranial hypertension resulting in pressure inside the head producing headaches, episodic visual loss, with potential permanent visual loss.

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the Claimant has presented medical evidence establishing that she does have some physical and mental limitations on her ability to perform basic work activities. The medical evidence has established that the Claimant has an impairment, or combination thereof, that has more than a *de minimus* effect on the Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, the Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, 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 Claimant has alleged physical and mental disabling impairments due to right eye blindness, uveitis disease with bilateral optic nerve edema, tinnitus, headaches, OCD, and bipolar disorder.

Listing 2.00 discusses special senses and speech. To meet this listing, remaining vision in the better eye after correction is 20/200 or less, or a showing of visual efficiency in the better eye of 20 percent or less after best correction. Here, the objective findings seemingly contradict the Claimant's testimony and letters from the treating physicians in that the most recent examination found the Claimant with 20/30 in the right eye, and 20/20 in the left. Conversely, the treating source wrote a letter stating that the Claimant had complete vision loss in her right eye with potential permanent left eye vision loss absent immunosuppressive treatment. The Claimant also testified the complete right eye vision loss. That being stated, the left eye, with treatment does not satisfy Listing 2.02 and/or 2.04.

Listing 4.00 defines cardiovascular impairment in part, as follows:

> . . . any disorder that affects the proper functioning of the heart or the circulatory system (that is, arteries, veins, capillaries, and the lymphatic drainage). The disorder can be congenital or acquired. Cardiovascular impairment results from one or more of four consequences of heart disease:
> (i) Chronic heart failure or ventricular dysfunction.
> (ii) Discomfort or pain due to myocardial ischemia, with or without necrosis of heart muscle.

(iii) Syncope, or near syncope, due to inadequate cerebral perfusion from any cardiac cause, such as obstruction of flow or disturbance in rhythm or conduction resulting in inadequate cardiac output.

(iv) Central cyanosis due to right-to-left shunt, reduced oxygen concentration in the arterial blood, or pulmonary vascular disease.

An uncontrolled impairment means one that does not adequately respond to the standard prescribed medical treatment. 4.00A3f. In a situation where an individual has not received ongoing treatment or have an ongoing relationship with the medical community despite the existence of a severe impairment, the disability evaluation is based on the current objective medical evidence. 4.00B3a. if an individual does not receive treatment, an impairment that meets the criteria of a listing cannot be established. *Id.*

In this case, the Claimant has a pacemaker and AICD placement. Recent x-rays [redacted] showed normal cardiac silhouette. Accordingly, the Claimant's cardiac impairments alone, do not meet the intent or severity requirements of a listing within 4.00.

Listing 12.00 discusses mental disorders. More specifically, to meet 12.06 (anxiety-related disorders), both A and B, or A and C must be 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.

In this case, the Claimant testified about t he impact on her daily living with respect to her OCD and anxiety. The psychiatric evaluation from [redacted] ound the Claimant able to relat e to others, co-worke rs, and supervisors within normal limits as was her ability to underst and, remember, and carry out simple tasks to include maintaining a schedule. The intermittent ep isodes of anxiety/depre ssion were found to likely interfere with her perfo rmance noting that during the episodes, the Claimant was markedly impaired. The Claim ant's abilit y to withstand the stress and pressures associated with day-to-day work activity was markedly limited. The consultativ e physical evaluation also noted that the Claimant's anxiety may interfere with gainful employment. Ultimately, based on the medical evidence al one, the Claima nt's mental impairments do not meet a Listing within 12.00.

Listing 14.00 discuss es autoimmune disorders. Extra-articular features of inflammatory arthritis ma y involve any body system to incl ude ophthalmologic such as uveitis. The inflammation or deformity mu st be persistent in one or more major peripheral joints resulting in the inab ility to ambulate effectively or the inab ility to perform fine and gross movements. Other symptoms in clude severe fatigue, fever, malaise, or involuntary weight loss resulting in marked limitations in activities of daily living, social functioning or in timely completing tasks. Outside of the diagnoses of uveitis and the ongoing

inflammatory process, the Claimant has not been diagnosed with arthritis. The Claimant testified that her symptoms are similar to those associated with lupus. To meet Listing 14.02 (systemic lupus erythematosus, "SLE"), involvement of two or more organs/body systems must be shown with at least a moderate level of severity and at least two symptoms or signs of severe fatigue, fever, malaise, or involuntary weight loss, or, the record must show repeated manifestions of SLE with at least two signs of symptoms which marked limit activities of daily living, social functioning, or in the ability to timely complete tasks.

Ultimately, the Claimant has presented several medical records from several doctors/specialists, some which are inconclusive, but confirm that the Claimant suffers from several severe and complicated impairments. Each impairment individually does not meet a specific listing; however, when considered collectively, it is found that at this point, the combination of the Claimant's impairments to include her mental state, is the medical equivalent of a listing. Accordingly, the Claimant is found disabled at Step 3 with no further analysis required.

The State Disability Assistance program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. Department policies are found in BAM, BEM, and RFT. A person is considered disabled for SDA purposes if the person has a physical or mental impairment which meets federal SSI disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness automatically qualifies an individual as disabled for purposes of the SDA program.

In this case, the Claimant is found disabled for purposes of the MA-P program; therefore, she is found disabled for purposes of SDA benefit program.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law finds the Claimant disabled for purposes of the MA-P benefit program.

Accordingly, It is ORDERED:

1. The Department's determination is REVERSED.

2. The Department shall initiate review of the May 25, 2011 application to determine if all other non-medical criteria are met and inform the Claimant of the determination in accordance with department policy.

3. The Department shall supplement for lo st benefits (if any) that the Claimant was entitled to receiv e if otherwise elig ible and qualified in acc ordance with department policy.

4. The Depar tment shall review the Clai mant's continued eligibility in March 2013 in accordance with department policy.

Colleen M. Mamelka

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

Date Signed: February 24, 2012

Date Mailed: February 24, 2012

NOTICE: Michigan Administrative Hearing Syst em (MAHS) may order a rehearing or reconsideration on either its own motion or at the request of a par ty within 30 days of the mailing date of this Dec ision and Order . MAHS will not order a rehearing or reconsideration on the Department's mo tion where the final decis ion cannot be implemented within 90 days of the filing of the original request. (60 days for FAP cases)

The Claimant may appeal the Decision and Order to C ircuit Court within 30 days of the receipt of the Dec ision and Order or, if a ti mely request for rehea ring 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 i s newly discovered evidence that co uld 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, math ematical error, or other obvious errors in the h earing 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
Re consideration/Rehearing Request
P. O. Box 30639
Lansing, Michigan 48909-07322

2012-10738/CMM

CMM/cl

cc: [redacted]