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

IN THE MATTER OF:

[redacted]

Reg. No: 2012-2325
Case No: [redacted]
Issue: 2009/4031
Hearing Date
January 3, 2012
Saginaw County DHS

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

AMENDED HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon Claimant's request for a hearing. After due notice, a telephone hearing was held on January 3, 2012. Claimant personally appeared and testified.

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional medical evidence. The new evidence was forwarded to the State Hearing Review Team ("SHRT") for consideration. On March 19, 2012, the SHRT found Claimant was not disabled. This matter is now before the undersigned for a final decision.

ISSUE

Whether the Department of Human Services (the department) properly determined that Claimant was no longer disabled and denied her review application for Medical Assistance (MA-P) and State Disability Assistance (SDA) based upon medical improvement?

FINDINGS OF FACT

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

(1) Claimant was a Medical Assistance benefit recipient and her Medical Assistance case was scheduled for review in March, 2010. However, Claimant's case was not assigned to a worker until August, 2011. (Hearing Summary).

(2) On February 9, 2011, Claimant filed a Redetermination for Medical Assistance and State Disability Assistance benefits alleging continued disability.

(3) On September 23, 2011, the Medical Review Team denied Claimant's application indicating that Claimant was in noncompliance. (Department Exhibit A, pp 1-2).

(4) On September 29, 2011, the department sent Claimant notice that her MA and SDA benefits would be closed based upon medical improvement.

(5) On October 4, 2011, Claimant filed a request for a hearing to contest the department's negative action.

(6) On November 21, 2011, the State Hearing Review Team again denied Claimant's Redetermination indicating that the medical evidence of record does not document a mental/physical impairment(s) that significantly limits Claimant's ability to perform basic work activities. SDA was denied due to lack of severity.

(7) On October 10, 2010, Claimant saw her psychiatrist and stated that the Adderall helped not only with focus and concentration, but also with her energy level, motivation, and depression. She complained of anxiety persisting despite having Valium in her regimen. She denied drinking alcohol and current drug use. She reported compliance with medications. Her affect was sad and anxious, her thought processes were logical and her thought content was persecutory. Her insight and judgment were marginal. (Department Exhibit A, pp 25-28).

(8) On May 30, 2011, Claimant underwent an annual assessment at Community Mental Health. Claimant was currently in the action stage of her mental stability by evidence of her taking her prescribed medications and managing her symptoms. Claimant needs assistance with psychotropic medications and monitoring for side effects, and stressors. Claimant reported not having a good childhood. Assertive Community Treatment (ACT) will assist with monitoring her medication compliance. Claimant was cooperative and her speech was slurred. Her perceptions and mood were normal. Her judgment, insight and impulse control were fair. Claimant reported an extensive treatment history dating back to when she was 16 years old, with multiple suicide attempts. Claimant reported completing several inpatient and outpatient treatment programs. History of drug use included alcohol, marijuana, crack cocaine, and heroin. Diagnosis: Axis I: Bipolar II Disorder, Hypomania; Cocaine Abuse/Intoxication; Axis V: GAF=45.

(9) On August 3, 2011, Claimant underwent a Mental Residual Functional Capacity Assessment. Regarding her Understanding and Memory, Claimant was markedly limited in her ability to understand and remember detailed instructions. Under Sustained Concentration and Persistence, Claimant was markedly limited in her ability to carry out detailed instructions, to maintain attention and concentration for extended periods, to work in coordination with or proximity to others without being distracted by them, and to complete a normal workday and worksheet without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods. Under Social Interaction, Claimant was markedly limited in her ability to accept instructions and respond appropriately to criticism from supervisors, and to get along with co-workers or peers without distracting them or exhibiting behavioral extremes. Claimant's mental status was agitated, irritable and abrasive. She began by saying that none of her medications work. Throughout the session she indicated that she does not take her medications when she uses drugs and stated that this will not affect her medications if she uses sporadically. Her inconsistencies were highly suspicious and her reporting psychotic symptoms need to be investigated to determine whether they are secondary to her mental illness or active substance abuse. Her thought process was concrete. Her speech was slurred but comprehensible. Her mood was agitated, with blunted affect. She denied suicidal/homicidal ideation. She reported auditory hallucinations. Paranoia was noted. She had poor focus, concentration, and memory. Her judgment and insight were marginal. Diagnosis: Axis 1: Bipolar II Disorder, hypomania; Attention Deficit Disorder; Cocaine Dependence; Axis V: 45. (Department Exhibit A, pp 17-24).

(10) On September 1, 2011, Claimant reported to her ACT case worker that she had been taking all her prescribed medications, with no noted side effects. Claimant received medications which she took in front of staff. She reported she had some triggers to use substances within the past few days, but did not use. She is currently in the action stage of her mental stability.

(11) On September 13, 2011, Claimant's ACT case worker met her at her home. Claimant came out to the car and indicated she had just had an argument with her boy friend and he had asked her to leave. Claimant's case worker asked if she felt safe and Claimant said no. Her case worker instructed Claimant to get her things and she would be taken somewhere that she felt safe. Claimant said she would go tomorrow because she had to get all of her nice things because someone might come in and wear them. Claimant was encouraged to focus on her safety, versus her material possessions, and that if she felt that her life was in danger, she could seek shelter. Claimant said that she did not feel her life was in

danger and she would remain in the home. Claimant's boyfriend called Claimant on her cell phone and apologized for his behavior and wanted Claimant to come back into the house. Claimant started smiling and ended the call. Claimant then said, "I can take the knife back inside." The case worker asked, "What knife?" Claimant pulled a knife out of her purse, smiling. The case worker attempted to retrieve the knife, but Claimant refused stating her boy friend would miss his knife and become upset. The case worker asked Claimant if she could go inside with her and watch her put the knife away. Claimant said no, that her boy friend did not want her case worker in the house today. Claimant said that she would call her case worker at the office as soon as she returned the knife. Claimant reviewed her medications with her case worker and was monitored setting up medications.

(12) On September 14, 2011, Claimant's ACT case worker met with Claimant at her home. Claimant was doing well. She was well dressed and groomed and oriented to time place and person. She was pleasant and calm. She was excited about the possibility of having her own apartment. She had the necessary paperwork and forms that were requested for the leasing agent. Claimant disclosed information regarding her criminal history, employment, and financial history. She was shown the possible apartment by the leasing agent and was notified that she would be informed if she was chosen.

(13) On September 15, 2011, Claimant's ACT case worker gave Claimant medications for the next few days. Claimant's mood and affect were within normal limits. Her speech was slightly slurred. Her hygiene and grooming were good. Claimant and her case worker discussed occurrences Claimant had reported involving her boy friend and her possible unsafe living situation. Claimant stated that everything was all right. Claimant was looking forward to moving to a place of her own and felt that this might help her relationship with her boy friend.

(14) On September 21, 2011, Claimant's ACT case worker met with Claimant who was just returning from the ER for some female issues for which she received a referral to see a specialist. Claimant had good news about the apartment she had applied for. The landlord had called her back and she may be getting it. Her case worker helped Claimant set up her medications.

(15) On September 27, 2011, Claimant saw her ACT case worker who noted Claimant's mood and affect were appropriate. Clamant remained consistent as she was transported home. Claimant is in the action stage of change for goal to maintain mental stability, taking medications as prescribed and not presenting with any increase in symptoms or side effects at this time.

(16) On October 12, 2011, ACT case worker met with Client in her home. Claimant was happy and excited to be living in her new apartment. Her mood and affect were elevated. At times, her speech was loud, but clear. The apartment was very nice and she had it furnished and decorated nicely. She was given affirmations for making positive progress and moving to live independently. She told the ACT team member that she has not been using any drugs since last week before she moved out of her boyfriend's house. The ACT team member filled Claimant's medicine planner.

(17) On October 18, 2011, the ACT case worker met Claimant in her home. Claimant was alert and oriented to person, place and time, presenting with pleasant mood and affect. Claimant's new apartment remains clean and neat. Claimant reports that her boyfriend continues to come over frequently to visit, and she asks him to leave if they have a disagreement. The case manager assisted Claimant with setting up her medications. Claimant did not appear to be using any substances, and agreed to attend the IDDT meeting. Claimant reported that the IDDT meetings continue to be helpful to her, because of the opportunities to talk and process her stressors.

(18) On October 19, 2011, the ACT case worker met Claimant in her home. Claimant's mood and affect were appropriate. Claimant remained consistent as her case manager assisted her with medication monitoring. Claimant remained talkative and pleasant throughout the contact discussing relationship problems, taking pride in her apartment, and her reasons to remain sober.

(19) On October 25, 2011, Claimant's ACT case manager met with her in her home. Claimant was not doing very well. Her hygiene was good and her apartment was very neat. Claimant indicated that she had an increase in stressors. She stated that she had had an argument with her boyfriend several days ago and she has not seen him since. Claimant is not sure if he has done something to himself and she was worried. She stated that she would not make if he did not show up soon. Her case manager discussed a safety plan with her and she indicated that she had no current thoughts of harming herself or others today. Coping skills and ways to manage symptoms were also discussed. Claimant said that she had been visiting with her neighbor on a daily basis. Although Claimant did say that she felt isolated in her apartment and wished she could increase her community involvement, but has a lack of transportation. Claimant was informed of the public transit system and her case manager transported her into the community today to assist with her social supports. After returning to Claimant's apartment, Claimant indicated that she had plans

of visiting with her neighbor to make dinner together. Claimant was informed of her scheduled doctor's appointment for tomorrow.

(20) On October 26, 2011, Claimant saw her psychiatrist. Claimant was depressed and irritable. Claimant's speech was slurred and her gait ataxic. She appeared to be using drugs but denied using. She has thoughts of overdosing, but denies that she will do it and entered into a crisis plan.

(21) On October 26, 2011, Claimant's case manager met with Claimant after her visit with the psychiatrist to discuss the doctor's report of Claimant verbalizing suicidal statements and ideations of overdosing on her pills. Claimant reported that she had been having stressors with her boyfriend, and was stressed waiting for a package to arrive to help her fix her cell phone. The case manager and nurse discussed the importance of addressing Claimant's safety, by offering Claimant placement at crisis residential. The case manager called crisis residential and was informed that open admission would not be available until the following day. The case manager and Claimant completed a safety plan for Claimant to take with her and was informed her follow-up contact would be in her home the following day.

(22) On October 27, 2011, Claimant's case manager met with Claimant in her home. Claimant indicated she felt much better than yesterday due to utilizing her coping skills and relying on natural supports. Claimant stated that she had adhered properly to her medications and had refrained from substances as well. Claimant denied any suicidal ideations. She indicated that she spent time with a neighbor for the most part since yesterday and most of the night. Claimant was provided with positive affirmations for utilizing natural supports to assist with managing her symptoms and avoiding substances. After discussing ways to continue to avoid substances and lifestyle changes, Claimant was in a much better mood. Claimant has plans of contacting her children and visiting with her grandchildren. Claimant reviewed her medications with the case manager and was monitored setting up medications.

(23) On November 2, 2011, Claimant's case manager met with her in her home. Claimant's mood and affect were flat. Claimant discussed relationship problems and became tearful as she stated she had spent time with her boyfriend and he took some things from her. Claimant was assisted with medication monitoring. Claimant denied any suicidal ideation or intent and was encouraged to discuss coping skills.

(24) On November 7, 2011, Claimant's case manager met with her in her apartment. Claimant was well dressed and groomed, her apartment was neat and clean. She was preparing dinner with a friend. She was

provided with positive affirmations for remaining substance free. Claimant reported that she was planning on attending group. Claimant discussed family relations and how she plans to have her children and grandchildren over this evening for dinner.

(25) On November 8, 2011, Claimant's case manager met with her after group. Claimant was in good spirits. She indicated that group went very well for her today. She said that she participated in group discussion. Claimant verbalized how group really provides her with an opportunity to release her fears of relapsing. She reviewed her medications and was monitored setting up medications.

(26) On November 16, 2011, Claimant was examined by a gynecologist, on a referral from her primary physician. The gynecologist noted Claimant answered questions appropriately, but had limited eye contact and was very slow to process the question and then subsequently the answer. Claimant's exam findings were consistent with a significant amount of pelvic organ prolapse, cystocele, rectocele and uterine prolapse. An endometrial biopsy was recommended.

(27) On November 17, 2011, Claimant was transported by her case manager to complete an application for a holiday gift card at the Salvation Army. Claimant's mood and affect were appropriate. She displayed agitation and communicated inappropriately on the drive to the Salvation Army. Claimant was thankful for the ride back to her apartment. Her case manager observed Claimant set up her medication planner and noted no medication errors. Claimant demonstrated stable activities of daily living and medication adherence.

(28) On November 22, 2011, Claimant's case worker met with Claimant in her home. Claimant was well dressed and groomed. Her mood and affect were both flat. Claimant reported adhering to her medication regime without any problems today. She reported no current substance abuse at this time. Claimant indicated that she wishes to have random drug testing if possible. Claimant indicated that she is having some difficulty processing her feelings today that are related to her past. Claimant discussed her childhood at length, indicating that her mother mentally and physically abused her as a child. Processed coping skills with Claimant and discussed upcoming therapy sessions with ACT staff.

(29) On November 23, 2011, Claimant's case worker met with her in her home. Claimant's mood and affect were cheerful and pleasant. Thoughts and speech were clear. She was dressed nicely. Her case worker filled her medication box. Claimant asked her case worker if she would take her to her daughter's house. Claimant is planning on spending the holiday there. During the conversation, Claimant was very upbeat in her outlook and

reported that she is staying sober. Claimant has been consistently attending the IDDT group as part of her recovery plan.

(30) On December 1, 2011, Claimant met with her case worker at the ACT office. Her gait was unsteady, and her speech was slurred. Her hygiene was good. Her mood and affect were both appropriate. She indicated that she has been adhering to her medication regimen. After reviewing her medications with her case worker, Claimant was assisted with her medication set up. Claimant reported no substance abuse today. She indicated that she would like to have random drug screens completed.

(31) On December 7, 2011, Claimant's case manager met Claimant in her boyfriend's home, to assist her with her medication planner. Claimant was alert and oriented, presenting with a positive mood and affect. Claimant was nicely dressed and stated that she was feeling generally well today. Claimant was observed setting up her medications and reminded of her scheduled contact with the ACT nurse tomorrow for her scheduled injection.

(32) On December 13, 2011, Claimant met with her case manager in her home. Claimant's mood and affect were appropriate. She remained consistent as her case manager assisted her with medication monitoring. Claimant discussed problems with her daughter and them moving in for a couple of days due to not having any electricity. Claimant remained talkative and pleasant throughout the contact also discussing being denied SSDI benefits and the possibility of losing state disability benefits.

(33) On December 14, 2011, Claimant met her case manager at the office. Her mood and affect were appropriate, her hygiene was good. She reported increased stressors and depression related to family relations. Claimant indicated that there was a possibility that her children would be moving in with her on a temporary basis as well as her grandchildren. Claimant processed coping skills and discussed ways to manage her symptoms. She reported refraining from substances. Claimant reviewed her medications with worker and was monitored with medication set up.

(34) On December 22, 2011, Claimant's case manager met with her in her home. Claimant's mood and affect were appropriate. Claimant was assisted with medication monitoring. Claimant denied any current use of substances, and discussed participating in random drug screens. Claimant discussed reasons to remain sober and wanting to be able to spend more time with her children in hopes to have the younger children back in her care. Claimant was talkative and pleasant throughout the contact as she discussed coping skills and problems with phone service.

(35) On December 28, 2011, Claimant's case manager met with her in her home and assisted Claimant with setting up her medications. Claimant was slightly nervous, stating she has been experiencing visual hallucinations and vivid dreams. Claimant stated that she has been under a lot of stress recently, due to possible loss of monthly assistance. Claimant demonstrated she is in precontemplation of how she will manage this loss of income, as she stated she may choose to prostitute herself to earn extra money. The case worker assisted Claimant in exploring and reviewing safety risks of this plan, to help her review and explore other alternatives to prostitution.

(36) On January 3, 2012, Claimant went to the ACT office to meet with her case manager. Her case manager assisted Claimant with setting up her medication planner. Claimant was bright and pleasant, reporting she was able to schedule a review through her DHS worker regarding the ongoing status of state assistance. Claimant counted her medications accurately and correctly and denied any substance or alcohol use today.

(37) On January 4, 2012, Claimant saw a new psychologist. She reported she was concerned over the mention of drug use in her chart at her last appointment. Claimant stated that she has not been using cocaine since March of 2011. She stated her slurred speech was a medication side effect. Claimant did not feel well. She notes paranoia but keeps it to herself. She reported feeling that life is not worthwhile and having felt like that for years. She stated that she has struggled with chronic suicidal thoughts for years. Claimant was tearful and distraught over her continued symptoms. She reported paranoia. She was frustrated that substance abuse seemed to be mentioned in her chart. Her thinking was suspicious and she had a tendency to misinterpret things. She reported that she did not feel safe in her own apartment. Despite medication, she had a residual hyper vigilance that she relates to prior threats made against her in the past. Her insight was fair at best. Diagnosis: Axis I: Bipolar II Disorder, Hypomania; Attention Deficit/Hyperactivity Disorder; Cocaine Dependence; Axis V: GAF=45.

(38) On January 4, 2012, after Claimant saw the psychiatrist, Claimant met with her case manager. Orders were received to stop the Adderall and decrease the dosage of Abilify and Elavil. Claimant was educated regarding the changes in her medications. Claimant was very focused on the fact that she may be losing her case assistance and her only viable option would be to move back in her with her boyfriend.

(39) On January 5, 2012, Claimant's case manager met with her in her home. Claimant's mood and affect were appropriate. Claimant was assisted with medication monitoring. Claimant discussed changes in medications and hopes to decrease slurring speech. Claimant also reported falling down

the stairs the night before and hurting her leg. Claimant had no visual scrapes or bruising. Claimant was encouraged to follow up with her primary care provider and go to the emergency room if pain persisted.

(40) On January 10, 2012, Claimant's case manager met with her at her apartment. Claimant's mood and affect were appropriate. She remained consistent as her case manager assisted with her medication monitoring. Claimant declined to attend group stating she had no clean clothes. Claimant expressed concerns about upcoming surgery and going to see a specialist.

(41) On January 17, 2012, Claimant's case manager met with her in her home. Claimant was alert and oriented, but her mental status was flat with a detached affect. Claimant reported she had been sleeping most of the day, but it was questionable that she may have been using as her speech was slurred and she appeared off balance. However, Claimant denied using any substances at this time. Claimant reported that her cousin had recently died and she was feeling down in the dumps. Her case manager assisted her with setting up her medications, and by observing and helping her count her doses. Claimant reported having a decrease in energy since her Adderal had been discontinued, but did not ask for the medication to be resumed.

(42) On January 24, 2012, Claimant's case manager met with her in her home. Claimant's mood and affect were flat. Claimant was assisted with medication monitoring. Claimant reporting feeling that no one cared because individual therapy still had not been scheduled, so she does not care anymore. Claimant denied suicidal or homicidal ideation at this time. When offered the option to talk about what was bothering her, Claimant declined. Claimant denied substance use and was encouraged to discuss coping skills.

(43) Claimant was receiving Medicaid and State Disability Assistance at the time of this review.

(44) Claimant alleges as disabling impairments bipolar disorder and attention deficit disorder (ADD).

(45) Claimant is a [redacted] woman whose birth date is [redacted] Claimant is 5' 4" tall and weighs 250 pounds. Claimant completed the ninth grade.

(46) Claimant last worked in June, 2009 as a cashier.

CONCLUSIONS OF LAW

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. The Department of Human Services (DHS or 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 the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the MA program pursuant to MCL 400.10, *et seq.*, and MCL 400.105. Department policies are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

Pursuant to the federal regulations at 20 CFR 416.994, once a client is determined eligible for disability benefits, the eligibility for such benefits must be reviewed periodically. Before determining that a client is no longer eligible for disability benefits, the agency must establish that there has been a medical improvement of the client's impairment that is related to the client's ability to work. 20 CFR 416.994(b)(5).

> To assure that disability reviews are carried out in a uniform manner, that a decision of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop disability benefits are made objectively, neutrally, and are fully documented, we will follow specific steps in reviewing the question of whether your disability continues. Our review may cease and benefits may be continued at any point if we determine there is sufficient evidence to find that you are still unable to engage in substantial gainful activity. 20 CFR 416.994(b)(5).

The first questions asks:

> (i) Are you engaging in substantial gainful activity? If you are (and any applicable trial work period has been completed), we will find disability to have ended (see paragraph (b)(3)(v) of this section).

Claimant is not disqualified from this step because she has not engaged in substantial gainful activity at any time relevant to this matter. Furthermore, the evidence on the record fails to establish that Claimant has a severe impairment which meets or equals a listed impairment found at 20 CFR 404, Subpart P, Appendix 1. Therefore, the analysis continues. 20 CF 416.994(b)(5)(ii).

The next step asks the question if there has been medical improvement.

> Medical improvement is any decrease in the medical severity of your impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be based on changes (improvement) in the symptoms, signs and/or laboratory findings associated with your impairment(s). 20 CFR 416.994(b)(1)(i).
>
> If there is a decrease in medical severity as shown by the symptoms, signs and laboratory findings, we then must determine if it is related to your ability to do work. In paragraph (b)(1)(iv) of this section, we explain the relationship between medical severity and limitation on functional capacity to do basic work activities (or residual functional capacity) and how changes in medical severity can affect your residual functional capacity. In determining whether medical improvement that has occurred is related to your ability to do work, we will assess your residual functional capacity (in accordance with paragraph (b)(1)(iv) of this section) based on the current severity of the impairment(s) which was present at your last favorable medical decision. 20 CFR 416.994(b)(2)(ii).

The State Hearing Review Team upheld the denial of SDA and MA benefits on the basis that Claimant's medical condition has improved. Claimant was approved for SDA and MA benefits after being diagnosed with bipolar disorder. Pursuant to the federal regulations, at medical review, the agency has the burden of not only proving Claimant's medical condition has improved, but that the improvement relates to the client's ability to do basic work activities. The agency has the burden of establishing that Claimant is currently capable of doing basic work activities based on objective medical evidence from qualified medical sources. 20 CFR 416.994(b)(5).

In this case, the agency has not met its burden of proof. The agency has provided no evidence that indicates Claimant's medical condition has improved. In addition, the agency provided no objective medical evidence from qualified medical sources that show Claimant is currently capable of doing basic work activities. Accordingly, the agency's SDA and MA eligibility determination cannot be upheld at this time.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the department erred in proposing to close claimant's MA case based upon a finding of improvement at review.

Accordingly, the department's action is REVERSED, and this case is returned to the local office for benefit continuation as long as all other eligibility criteria are met, with

Claimant's next mandatory medical review scheduled in April, 2014 (unless she is approved eligible for Social Security disability benefits by that time).

It is SO ORDERED.

/s/
Vicki L. Armstrong
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: 4/9/12

Date Mailed: 4/9/12

NOTICE: Administrative Hearings 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. Administrative Hearings 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.

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the mailing 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.

VLA/ds