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

IN THE MATTER OF:

[redacted]
[redacted].
[redacted]

Reg. No.: 2013-55044
Issue Nos.: 2009, 4009
Case No.: [redacted]
Hearing Date: November 27, 2013
DHS County: Wayne County (19)

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

HEARING DECISION

Following Claimant's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on November 27, 2013, from Detroit, Michigan. Participants on behalf of Claimant included the Claimant. The Claimant's Authorized Hearing Representative, [redacted] of Community Care Services also appeared on her behalf. [redacted], the Claimant's mother, also appeared as a witness. Participants on behalf of the Department of Human Services (Department) included [redacted] [redacted], Eligibility Specialist.

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of the Medical Assistance (MA-P) benefit program 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. On October 3, 2011, the Claimant submitted an application for public assistance seeking MA-P and SDA.

2. On March 7, 2013, the Medical Review Team ("MRT") found the Claimant not disabled. (Exhibit 1)

3. The Department notified the Claimant of the MRT determination on June 5, 2013.

4. On June 17, 2013, the Department received the Claimant's written request for hearing.

5. On August 16, 2013 October 1, 2013, the State Hearing Review Team ("SHRT") found the Claimant not disabled. (Exhibit 2)

6. An Interim Order was issued October 31, 2013. The new evidence was submitted to the State Hearing Review Team on February 21, 2014.

7. On May 5, 2014, the State Hearing Review Team found the Claimant not disabled.

8. The Claimant alleges physical disabling impairments due to central pain syndrome, asthma, obstructive sleep apnea, carpal tunnel syndrome both sides EMG documented, genital herpes, facet hypertrophy of lumbar region, degenerative cervical disc, morbid obesity(hundred pounds over ideal weight BMI greater than 40), fibromyalgia, abdominal pain, constipation chronic venous insufficiency, Duane's syndrome, migraine, neck pain, and fatigue.

9. The Claimant has alleged mental disabling impairments due to major depressive disorder and a GAF score of 49.

10. At the time of hearing, the Claimant was [redacted] years old with an [redacted] birth date. The Claimant is now [redacted] of age. Claimant is 5' in height; and weighed 255 pounds.

11. The Claimant has past employment doing medical billing and cashiering.

12. The Claimant's impairments have lasted or are expected to last for 12 months duration or more.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by the Title XIX of the Social Security Act, 42 USC 1396-1396w-5, and is implemented by 42 CFR 400.200 to 1008.59. The Department of Human Services (formerly known as the Family Independence Agency) administers the MA program pursuant to MCL 400.10 and MCL 400.105.

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program purusant 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 Supplemental Security Income (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.

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 (e.g., 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 to 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 impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3 to Step 4. 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 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

As outlined above, the first step looks at the individual's current work activity. In the record presented, the Claimant is not involved in substantial gainful activity 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 mean 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 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).

The Claimant alleges physical disabling impairments due to central pain syndrome, asthma, obstructive sleep apnea, carpal tunnel syndrome both sides EMG documented, genital herpes, facet hypertrophy of lumbar region, degenerative cervical disc, morbid obesity(hundred pounds over ideal weight BMI greater than 40), fibromyalgia, abdominal pain, constipation chronic venous insufficiency, Duane's syndrome, migraine, neck pain, and fatigue.

The Claimant has alleged mental disabling impairments due to major depressive disorder, chronic and a GAF score of 49.

A summary of the Claimant's Medical evidence follows.

A Medical Examination Report was completed on December 16, 2013 by the Claimant's family practice physician. This doctor has seen her since November 2011. The exam notes burning pain, headache, fatigue and depression. In the general comments section blunted affect and limited speech are noted. Abduction of the bilateral eyes to lateral gaze and upward gaze difficult. Noted weakness in distal lower extremities. Appears depressed. The Claimant's condition was noted as stable, and limitations were imposed which were expected to last more than 90 days. The Claimant's lifting was restricted to never for less than 10 pounds. The Claimant was evaluated as unable to stand or walk less than two hours in an eight hour workday and sitting less than six hours in an eight hour workday. Assistive devices were occasionally necessary with use of cane noted. The Claimant was evaluated as incapable of simple grasping, reaching, pushing and pulling, and fine manipulating with either hand or either arm and no operation of foot controls. The medical findings note that these were subjective limitations. The mental limitations were sustained concentration, following simple directions and social

interactions. The Claimant does receive assistance with cooking cleaning and light housework from her mother.

The Claimant is seen every two months regarding her medical condition by the [redacted] hospital and her doctor. The exam problem list notes central pain syndrome, asthma, obstructive sleep apnea, carpal tunnel syndrome both sides, EMG documented, genital herpes, facet hypertrophy of lumbar region, degenerative cervical disc, morbid obesity (hundred pounds over ideal weight BMI greater than 40), fibromyalgia, abdominal pain, constipation, chronic venous insufficiency, depression, Duane's syndrome, migraine, neck pain, and fatigue. This doctor has seen the Claimant since September 2012.

A CAT scan of the neck was completed October 25, 2013. The impression was scattered facet arthropathy of the cervical spine with ossification of the posterior longitudinal ligament from C4 through C6 six levels. Multiple bilateral sub mandibular jugular chain and also all chain nodes the largest of which measures 1 cm.

The Claimant was tested for sleep apnea on November 22, 2013. The interpretation was that the CPAP settings during the testing treated the patient's obstructive sleep apnea during NREM and REM sleep. An upper extremity deep venous thrombosis test was performed on July 13, 2013. The impression was no evidence of deep vein thrombosis cannot rule out deep vein thrombosis in the radial vein due to small vessel size. This test was conducted due to complaints by the Claimant of right upper extremity and lower extremity paresthesia and heaviness.

A Mental Residual Functional Capacity examination was completed on December 9, 2013 by the Claimant's treating Doctor. The Claimant was markedly limited in understanding and memory in all categories; the Claimant was markedly limited in sustained concentration and persistence in all areas, except for the ability to work in coordination with or proximity to others without being distracted and to make simple work related decisions. As regards social interaction, the Claimant was markedly limited in four categories and moderately limited in the ability to ask simple questions and get along with coworkers or peers without distracting them. The Claimant as regards adaptation was markedly limited in all categories except for the ability to be aware of normal hazards and take appropriate precautions. The notes indicate that the client displays poor insight and judgment, she has difficulty in conducting herself in public settings without her mother's assistance. Very few activities are done independently and she has not worked since 2009. At the time a psychiatric evaluation was also done and the Claimant's GAF score was 49, the diagnosis was major depressive disorder recurrent, severe, without psychotic features.

A psychiatric evaluation was conducted on February 26, 2013 at which time the Claimant complained of severe depression and hopelessness and helplessness. The notes indicate the Claimant gets dressed only 2 to 3 times a week. She denied hallucinations and delusions. The Claimant presented with good grooming, her speech was soft and fluency fair. The Claimant did not appear to respond to internal stimuli, thought process was logical, mood was depressed, affect was appropriate to mood. The Claimant denied any suicidal ideation and her insight was limited, and judgment was rated as fair. During testing, immediate recall was diminished, recent memory was effected, no objects out of five were remembered after five minutes. Her math was incorrect and when asked to state the five largest cities in the United States she noted Massachusetts and California. The Claimant was unable to interpret sayings she was given. The examiner concluded that Claimant had significant difficulty in caring for her basic needs. Intelligence and ability to abstract seem somewhat impaired. It is not clear what her IQ is, but she certainly had difficulty processing information. The diagnosis was Major Depressive Disorder recurrent without psychosis. The GAF score was 49. The report noted that the patient continues to need help caring for her basic needs and this fact raises the question of whether or not she should be living alone.

The Claimant was seen for psychiatric treatment on November 13, 2013, at that time she presented with her mother. The notes indicated she was still having severe depression and that her [redacted] had been increased. At the time, the patient would not make eye contact and spoke softly and slowly. The Claimant had decreased motor function. Claimant's affect was reported as flat and constricted, with a note that the patient appeared catatonic. The patient denied suicidal ideation or wanting to harm self. The GAF score was 49.

The Claimant was seen also on November 4, 2013. At that time her mood was depressed, movement of body was painfully slow, facial expression flat, minimal eye contact, verbal responses are delayed and required several questions repeated. The Claimant reports spending most of her time in bed. The Claimant was seen on October 18, 2013, notes indicate patient did not make eye contact. Claimant had laryngitis affect was flat. Claimant was seen October 14, 2013, and presented with very slow movements, very limited affect in facial expression, very slow reactions or responses to directions. At that time, the Claimant related that she had thoughts of wanting to cut herself and making a suicide attempt but did not do so. The Claimant was seen on September 17, 2013, at which time the Claimant admitted she felt angry, expressed pain from herniated discs and fibromyalgia, slept all day and all night. She has had passing thoughts of suicide. The Claimant was seen August 20, 2013 for a psych progress note. At time of this meeting, the Claimant had good eye contact full range of mood and no suicidal ideations.

A psychiatric progress note was completed June 18, 2013. At that time the Claimant was worse as regards her depression with thoughts of cutting herself with the knife due to being turned down for cash assistance. She did not cut herself but picked up the knife. Claimant expressed problems with concentration, hopelessness and anger. Her affect was blunted and controlled with some sadness. The GAF score was 49. The Claimant also was seen for a therapy session on May 10, 2013, at which time she presented as very somber depressed facial expression and mood and spends time sleeping, attempting to avoid feeling the pain of her fibromyalgia.

A psychiatric progress note and exam was conducted on March 26, 2014. The Claimant spoke very slowly and moved very slowly. Her medications were changed to a new drug to assist her with depression. The mental status examination noted Claimant spoke very slowly but had grossly intact associations. Feelings were very blunted as were responses; no hallucinations or delusions.

A psychiatric evaluation was performed on February 26, 2013, and it was the initial evaluation performed by her community health doctor. The exam notes indicate grooming was good, attitude cooperative, and did not appear to respond to internal stimuli. Her thought process was logical, her mood was depressed, her affect was appropriate to mood. Her sleep, energy level and appetite were within normal limits. There was no evidence of suicidal ideation. The Claimant was oriented to person and place and her memory was intact, her insight was limited, judgment impaired and insight limited. The diagnosis was major depressive disorder the GAF score was 49.

On September 11, 2012, the Claimant was seen by her primary care Doctor. The impression and plan was chronic pain syndrome. On September 19, 2012, a physical exam was completed and the Claimant's BMI was 52. Extra ocular movements were noted as abnormal, and decreased abduction of bilateral lines. An EMG evaluation on July 6, 2012 noted left carpal tunnel syndrome. No evidence of neuropathy. There was a MRI of the lumbar spine January 4, 2012, noting mild to minimal lumbar spondylolisthesis, increase from June 2009 without focal disc protrusion or herniation of the canal or central stenosis. At the time of the exam, the Claimant had reported imbalance.

The Claimant was also seen by the Department of Rheumatology on September 25, 2012. During the exam, the Claimant was evaluated due to joint and extremity pain/swelling. At the time of the examination, the Claimant had left arm and leg swelling and weakness and fatigue of the right side. The summary noted bilateral carpal tunnel based on positive phalens and ultrasound. Left sided limb pain/swelling, no underlying autoimmune or inflammatory etiology found after an extensive evaluation, continue monitoring.

The Claimant was seen by a neurologist on July 28, 2012. At that time she was fully evaluated. In summary she was found to have insufficient vitamin D, noted left carpal tunnel syndrome to be treated with the left wrist splint. The recommendation was that she attend physical therapy. She had extensive evaluation without specific etiology identified including by rheumatology and in the spine clinic. The rheumatologist opined that a large portion of her pain is likely related to central pain syndrome. Fibromyalgia would be considered by some to be encompassed by this term. No other neurologic disease or other neurologic workup is consistent with any other diagnosis. It remains a significant possibility that the degenerative disease of her spine, and perhaps of her joints could be part of the cause of her pain. Her EMG was not consistent with myopathy. A conservative therapeutic approach was recommended. At the time it is noted that she has failed physical therapy. The patient was strongly advised to maintain increased physical activity and stretching. The Claimant was also on two excellent neuropathic pain medicines. Should the outline of therapy fail, another option would be to attend the fibromyalgia seminar offered through rheumatology. Focusing on mood would be important and undergoing counseling or psychiatric care, perhaps even being seen by a pain psychologists could be of benefit.

A nerve conduction study was completed on July 9, 2012. The interpretation notes abnormal examination, evidence of mild left median mono neuropathy at wrist without active denervation. There is also evidence of a very mild median mono neuropathy at right wrist which may be residual from her previous history of carpal tunnel syndrome and carpal tunnel surgery. No evidence of generalized polyneuropathy or myopathy to explain patient's symptoms.

On October 8, 2013, the Claimant was seen and given a physical examination at the rheumatology clinic. At the time of the evaluation, fibromyalgia tender points were present in 18 of 18 tender areas. The assessment noted that the Claimant had an underlying pattern of inflammatory disease very unspecific. She was found having fibromyalgia during last appointments and excluded specific autoimmune diseases such as lupus, and others; nevertheless, given the chronic anemia highly probable of chronic disease, chronic fatigue should be explored. The diagnosis was fibromyalgia, obesity and depression.

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 objective medical evidence establishing that she does have some physical limitations on her ability to perform basic work activities. Accordingly, the Claimant has an impairment, or combination thereof, that has more than a *de minimis* 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.

Listing 12.04 was also examined in light of the Claimant's diagnosis for Major Depressive Disorder, recurrent severe without psychosis. The listing provides:

12.04 ***Affective disorders***: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:

a. Anhedonia or pervasive loss of interest in almost all activities; or

b. Appetite disturbance with change in weight; or

c. Sleep disturbance; or

d. Psychomotor agitation or retardation; or

e. Decreased energy; or

f. Feelings of guilt or worthlessness; or

g. Difficulty concentrating or thinking; or

h. Thoughts of suicide; or

i. Hallucinations, delusions, or paranoid thinking; or

2. Manic syndrome characterized by at least three of the following:

a. Hyperactivity; or

b. Pressure of speech; or

c. Flight of ideas; or

d. Inflated self-esteem; or

e. Decreased need for sleep; or

f. Easy distractibility; or

g. Involvement in activities that have a high probability of painful consequences which are not recognized; or

h. Hallucinations, delusions or paranoid thinking; or …

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.

A review of the Claimant's medical evidence provided by psychiatric evaluations from the Claimant's treating psychiatrist summarized above was reviewed to determine whether listing 12.04, affective disorders has been demonstrated. Particular weight was given to both the Mental Residual Functional Capacity Assessment performed and several prior examinations summarized above. The Claimant has treated consistently with little improvement. Without question, the Mental Residual Functional Capacity Assessment establishes that the Claimant has severe marked limitations in abilities necessary to sustain gainful employment. With respect to Listing 12.04, A, depressive syndrome which requires meeting for at least four medically documented and persistent symptoms, which in Claimant's case include, difficulty concentrating or thinking, decreased energy, thoughts of suicide and anhedonia with pervasive loss of interest, feelings of guilt and worthlessness and thoughts of suicide. Therefore 12.04 A is satifisfied.

Listing 12.04 also requires that functional capacities for daily living and social functioning, concentration persistence and pace or decompensation, at least two of which categories must be demonstrated. In the Claimant's case, the Mental Residual Functional Capacity Assessment demonstrates marked limitations in sustained

concentration persistence and pace, understanding and memory, social interaction, and adaptation the specifics of which are fully outlined above.

Also considered was the behavior the Claimant exhibited and which was observed by the undersigned at the telephone hearing conducted in this matter. The Claimant's was extremely slow in answering questions posed to her, questions required repeating and problems with concentration were exhibited. The Claimant presented as subdued and quiet and slow in response to the point the hearing took approximately one and a half hours. These same traits and characteristics were documented and confirmed by her psychiatric examiners notes and treating family practice doctor's notes.

Based on the evaluation of Claimant's treating psychiatrist, it is determined that deference must be given to this evaluation as the Claimant has been seen for some time. The evaluations and medical opinions of a "treating "physician is "controlling" if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record. 20 CFR§ 404.1527(d)(2), Deference was given by the undersigned to objective medical testing and clinical observations of the Claimant's treating physician.

Therefore, it is determined based upon the objective medical evidence and a review of the entire record, that the Claimant is found disabled, at Step 3 with no further analysis required.

As the Claimant has been found disabled for medical assistance based on disability she is also deemed disabled for the State Disability Assistance program.

DECISION AND ORDER

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

Accordingly, it is ORDERED:

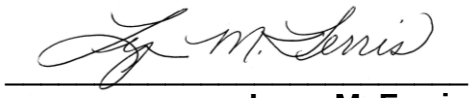
The Department's determination is REVERSED

☒ THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE OF MAILING OF THIS DECISION AND ORDER:

1. The Department is ORDERED to initiate a review of the application dated October 3, 2011 for MA-P and SDA, if not done previously, to determine Claimant's non-medical eligibility.

2. The Department shall issue a supplement to the Claimant for SDA benefits which the Claimant was otherwise entitled to receive in accordance with Department Policy.

3. A review of this case shall be set for June 2015.



Lynn M. Ferris
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: June 4, 2014

Date Mailed: June 5, 2014

NOTICE OF APPEAL: The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely Request for Rehearing or Reconsideration was made, within 30 days of the receipt date of the Decision and Order of Reconsideration or Rehearing Decision.

Michigan Administrative Hearing System (MAHS) may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. MAHS will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request (60 days for FAP cases).

A Request for Rehearing or Reconsideration may be granted when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion;
- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the client;
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The Department, AHR or the Claimant must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date the hearing decision is mailed.

The written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

If submitted by mail, the written request must be addressed as follows:

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

LMF/tm

cc: [redacted]