STATE OF MICHIGAN

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

IN THE MATTER OF:

[redacted]

Reg No.: 2014 29236
Issue No.: 2009
Case No.: [redacted]
Hearing Date: June 25, 2014
Wayne County DHS (15)

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 three-way telephone hearing was held on June 25, 2014, from Detroit, Michigan. Participants on behalf of Claimant included the Claimant, and the Claimant's Authorized Hearing Representative, [redacted], who appeared on Claimant's behalf. Participants on behalf of the Department of Human Services (Department) included [redacted], Medical Contact Worker.

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of the Medical Assistance ("MA-P") 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 April 11, 2013, the Claimant submitted an application for public assistance seeking MA-P and retro MA-P for March 2013.

2. On March 26, 2013, the Medical Review Team ("MRT") found the Claimant not disabled. (Exhibit 1)

3. The Department notified the Claimant of the MRT determination on November 26, 2013.

4. On February 20, 2014, the Department received the Claimant's AHR's timely written request for hearing.

5. On May 1, 2014, the State Hearing Review Team ("SHRT") found the Claimant not disabled. Exhibit 2

6. The Claimant alleged mental disabling impairment(s) due to Bipolar disorder with depression and schizophrenia and psychosis. The Claimant also alleged panic attacks.

7. The Claimant has alleged physical disabling impairments which include hyperlipidemia, and difficulty with pain due to left ankle fracture with permanent screws and metal hardware. The Claimant uses a cane to walk and cannot bear weight on her left foot. The Claimant also alleges carpal tunnel syndrome in both hands.

8. At the time of hearing, the Claimant was [redacted] years old with an [redacted] birth date. The Claimant is 5'6.5" feet tall in height; and weighed 152.

9. The Claimant has a high school education, attended some college and trade school, and did not obtain a college degree. The Claimant's work experience since 2001 has involved working in auto assembly plants and parts manufacturing. Claimant also worked in quality control for the auto companies involving technical management of processes. The Claimant last worked in August 2013, in an auto factory using sealer guns weighing 35 pounds to seal automobiles. The Claimant has lost her last several jobs due to the hospital admissions for psychiatric psychosis.

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 (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 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.

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-relate 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 applicants 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) An individual is not disabled regardless of the medical condition, age, education, and work experience, if the individual is working and the work is a substantial, gainful activity. 20 CFR 416.920(a) (4) (i) Substantial gainful activity means work that involves doing significant and productive physical or mental duties and is done (or intended) for pay or profit. 20 CFR 416.910(a) (b) Substantial gainful activity is work activity that is both substantial and gainful. 20 CFR 416.972 Work may be substantial even if it is done on a part-time basis or if an individual does less, with less responsibility, and gets paid less than prior employment. 20 CFR 416.972(a) Gainful work activity is work activity that is done for pay or profit. 20 CFR 416.972(b)

In addition to the above, when evaluating mental impairments, a special technique is utilized. 20 CFR 416.920(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; 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 alleged mental disabling impairment(s) due to bipolar disorder with depression, schizophrenia and psychosis. The Claimant also alleged panic attacks.

The Claimant has alleged physical disabling impairments due to hyperlipidemia, and difficulty with pain due to left ankle fracture with permanent screws and metal hardware. The Claimant uses a cane to walk and cannot bear weight on her left foot. The Claimant also alleges carpal tunnel syndrome in both hands.

A summary of Claimant's medical evidence follows.

On January 12, 2014, the Claimant was seen for a neurological problem in the emergency facility for her right arm which was shaking uncontrollably. A CT of the head was taken and was negative.

The Claimant was seen for an office visit on January 10, 2014. A tremor at the time in bilateral hands was noted. The Claimant was wearing a boot on her left ankle. An orthopedic and neurological consult was ordered.

The Claimant was seen on February 12, 2014 for a tremor with in her right hand and was examined for her left ankle. The Claimant was wearing an ortho boot at the time of the examination. The tremor in her hands was reported as getting worse.

The Claimant's reported history of mental health treatment included [redacted] and other community health clinics ongoing. On April 29, 2014, the Claimant was given an assessment screening by the [redacted], a community mental health organization. The examination noted the Claimant's appearance to be within normal limits, she had an unsteady gait, and was cooperative. Speech, communication and affect were all within normal limits. Her appetite was reported as fair, as was her sleep. Her mood was noted as sad and depressed. At the time, there were no hallucinations

noted, and the Claimant was well oriented to person, her memory was intact as was her judgment, attention and concentration was rated as fair. No drug or alcohol abuse was reported. At the time of the evaluation, the Claimant's GAF score was 55 and the diagnosis was bipolar disorder and psychotic disorder both to be ruled out. At the time, the Claimant was evaluated, she was still having intense psychiatric signs and symptoms consistent with serious mental illness. It was determined that it was a medical necessity for Claimant to have services to address her symptomology and that her disability and its duration were expected to last six months or longer. Her intellectual impairment was not affected. Relationships were noted as severely affected, her activities of daily living were severely affected as was her self-direction, personal hygiene, work and support system. At the time, the interpretive summary noted that the Claimant had been seeing a therapist at the [redacted] but wanted also to see a psychiatrist. The Claimant reported having depression due to lack of employment after an ankle injury. Her hallucinations are controlled with medications.

The Claimant was seen by a doctor on July 2, 2014, due to ankle pain in the left ankle due to prior fracture and repair in September 2013. At that time, it was reported that the hardware had to be removed. At the time, the Claimant still had a cast on her ankle. Claimant was provided pain medication. At the examination, the Claimant was encouraged to lose weight and to begin a regular exercise program.

The Claimant was seen on February 20, 2013 for a psychiatric evaluation. At the time, she had normal ambulatory status and was alert, oriented and fully verbal. At the time of the evaluation, the Claimant stated she was feeling that she was being followed by two gentlemen who were coworkers. She denied all suicidal thoughts. The Claimant presented voluntarily for a psychiatric evaluation no significant history of drug or alcohol use or violent behavior; the records also noted no current history of hallucinations or delusional thoughts. At the time, the Claimant presented she had a disheveled look with poor habitus. Quite loose thought associations were noted with a number of paranoid thoughts. The diagnosis was schizophrenia and paranoid disorder. After the examination, the Claimant was admitted to the hospital.

The Claimant was seen in the emergency room on August 6, 2013. At the time, the Claimant was complaining of ankle pain and paranoia, reporting that she believes someone from work is trying to get her. The report notes that the Claimant jumped out of the second story window of a hotel room and broke her left ankle and leg. Claimant reported jumping out the window because she thought someone was trying to kill her at the hotel where she was staying because of breaking up with her boyfriend. The Claimant reported that she heard a knock on the door and jumped out the window after calling the front desk to have them call police. On examination, the notes indicate that the patient answered all questions correctly was alert and oriented X3, and seems to have some delusional thinking. Tenderness to palpation was noted diffusely to the left

ankle with significant swelling and abrasions. Her mood and affect was noted as normal; her behavior was normal for judgment and thought was normal. The Claimant was admitted to the hospital for a psychiatric follow-up. At the time of admission, the Claimant did receive sedation so that a reset of the left ankle could be performed. The Claimant was admitted due to psychosis for a two-week stay.

While in the hospital, the Claimant denied any suicidal thoughts or attempts. During a psychiatric interview, the Claimant admitted to hearing voices, which were described as talking and denied any visual hallucinations. The examiner noted speech as low toned with reduced spontaneity. Mood was dysphoric and affect labile. Thought process was linear with decreased production. Contents reflect ideas of helplessness and hopelessness. Insight and judgment was fair. As of August 21, 2013, the Claimant had made slow but steady progress, psychotic features had remitted, and were ok. Claimant was provided with supportive and insight oriented therapy. The Claimant was discharged to out patient care.

The Claimant was seen by her orthopedic surgeon on December 16, 2013. At that time, the Claimant was complaining of pain post revision open reduction, internal fixation of her left tibial Pilon and fibula fracture. The treatment notes that the Claimant had revision to her original surgery because she walked on it. There was no pain or purulence noted. At that time, the Claimant was required to maintain non-weight bearing. An x-ray of the ankle noted that no evidence of fracture of the hardware had occurred and the hardware had maintained its position.

The Claimant was seen for an office visit in November 2013. At the time, the Claimant reported a resting right unilateral tremor for the last three weeks. Claimant was concerned that it might be due to her medications. No loss of sensation, numbness or parathesias was noted. An examination was performed and the Claimant denied difficulty with concentration, poor balance, headaches, disturbance in coordination, numbness, inability to speak, falling down, tingling brief paralysis, visual disturbances, seizures, weakness, sensation of room spinning or memory loss. The neurologic exam noted no focal deficits, cranial nerves were grossly intact within normal sensation, reflexes, coordination, muscle strength and tone. The examiner concluded there was no sign of focal neurological deficit. At the time of the examination, the Claimant was noted as alert, cooperative, normal mood and affect with normal attention span and concentration.

On October 4, 2013, the Claimant was seen for an office visit at her then community health network. At the time, she was given a depression assessment with nine questions that would elicit whether or not she was having emotional problems to which she answered not at all. Claimant was seen for a medication refill. The impression was depression fatigue and the medications were refilled.

Claimant was seen on November 4, 2013 for follow-up post left tibial Pilon open reduction and internal fixation. At the time, the examiner noted loss of reduction status post left tibial Pilon open reduction due to walking on the ankle. At that time, it was determined that the Claimant would have to undergo another operation to fix the revision of the open reduction. The hardware was confirmed to have failed after x-rays.

In October 2013, the Claimant was seen for an office visit, at which time she confirmed she was attempting to stay off her left ankle but was concerned about losing her job. At the time, an x-ray showed markedly comminuted and displaced intra-articular tibial metaphyseal fracture. It also noted internal fixation of the lateral fragment with the transverse screw, internal fixation of fibular fracture and placement of external stabilization hardware.

The Claimant was admitted to the hospital on March 20, 2013. At the time of the admission, the Claimant was admitted for psychiatric reasons due to acute psychosis. The patient presented with very paranoid behavior. The admission notes indicate that the Claimant had been previously admitted to Havenwhyck in August 2012 for a three-week stay. Throughout her stay, Claimant was treated for her psychosis and notes indicate that she remained suspicious, heard voices but the voices were less intense. As of March 25, 2013, the notes indicate she was much improved, denied suicidal ideation and wished to be released to return to work. The GAF on discharge was 40. The diagnosis was acute psychosis with paranoid features. The Claimant was prescribed [redacted]. The intake notes note that the Claimant's insight and judgment were poor and that the Claimant had been having paranoid delusions of people following her. On admission, the GAF was 20.

In September 2012, the Claimant was seen at the [redacted] facility after her admission to [redacted] in August 2012 due to a petition. The Claimant had a 3-week stay at the facility. The admission was noted in the psychological assessment conducted on September 17, 2012. At the time of her admission, the Claimant was working and stated she noticed or believed that people started to follow her and knew her whereabouts, so she checked herself into the hospital. She also reported that she had had extreme sleep loss at the time. The evaluator noted that the Claimant suffered from sleeplessness and could not concentrate, was hearing things, seeing things, had compulsive obsessive behavior and obsessive constant thoughts. The Claimant was prescribed [redacted] a psychotropic medication. At the time, the Claimant denied any thoughts of self-harm. No drug or alcohol abuse was noted or reported.

Much of the September 2012 examination indicated that the Claimant's behavior and attitudes, speech, mood, thought content and process, as well as orientation were within

normal limits. Memory and judgment were intact. The Assessment noted that the Claimant stated that she still feels that the things that caused her to be hospitalized actually did happen to her. Claimant worked in the automotive industry at the time with very high tech audio components, and that there are others who could try to sabotage her job situation to gain information. She spoke more than once of some woman accusing her of being a man because she looks so much like her father. The examiner concluded that despite her denial of delusions, it is apparent that they still continue. It is possible that these are fixed. Most of the time the Claimant made complete sense. The assessment of risk noted that the consumer (Claimant) appears to have fixed delusions about others talking about her. The examiner noted that Claimant's cognitive functioning was of concern such that the belief of others talking about her could lead to aggressive behavior towards others if she believes others are discussing her. The Claimant was noted as requiring medication assistance and community support.

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 some objective medical evidence establishing that she does have some mental and 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. The Claimant asserts mental disabling impairments due to bipolar disorder, with depression, schizophrenia and psychosis. The Claimant also alleged panic attacks.

Listing 12.03 was reviewed as regards the alleged mental impairments, it requires the following be met.

Listing 12.03 Schizophrenic, paranoid and other psychotic disorders characterized by the onset of psychotic features with deterioration from a previous level of functioning.
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.

The Listing was carefully reviewed and it is determined for the reasons set for below that the Claimant meets listing 12.03 A1 and B 1, 2 and 3 which requires:

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

1. Delusions or hallucinations; or

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;

In this case, the record reveals ongoing treatment for Bipolar Disorder, depression, schizophrenia and prescribed drug treatment with [redacted]. The record presented presents a middle-aged individual who has been hospitalized three times since 2012 due to psychiatric problems with the last reported hospitalization of 5-day stay. The Claimant credibly testified that she suffers from hearing voices and believes that people are out to get her. This belief system caused her to leap from a hotel window as she believed she was in fear of harm. No facts were discovered which would have indicated that she was in fact placed in harm's way at the time she jumped from window. As a result of jumping from the window, she shattered her left ankle and was also psychiatrically admitted to the hospital, at the time repair on her ankle in psychiatric treatment. She was also admitted in August 2012 and August 2013. These admissions are set forth in the medical summary above. The Claimant continues with her therapy but did credibly testify to great fear causing panic attacks, she suffers from appetite inconsistency, lack of concentration and conintues to take psychtropic medications with respect to hearing voices. The Claimant has not been able to keep her last several jobs due to her psychosis.

The Claimant has treated for several years with no significant change or improvement, demonstrated by her several admissions for psychiatric problems arising from her psychosis and hearing voices. Her current treatment noted that the delusions that she harbors from time to time may indeed be fixed.

Overall, based on the testimony of the Claimant, and the independent medical evidence presented, it is determined that the Claimant has met the Listing 12.03 A1 and B 1-3 or its medical equivalent. It is determined that the Claimant exhibited recurrent symptoms associated with her psychosis and has at least 3 hospitalizations for mental illness associated with his mental impairments which are a sign of marked distress.

The records and evaluations of the Claimant indicate that the Claimant will need continuing treatment.

Ultimately, based on the medical evidence, the Claimant's impairment(s) meets, or is the medical equivalent of, a listed impairment within 12.00, specifically 12.03 A1 and B 1-3. Accordingly, the Claimant is found disabled at Step 3 with no further analysis required.

In this case, the Claimant is found disabled for purposes of the MA-P program;

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Claimant disabled for purposes of the MA-P and/or SDA benefit program.

Accordingly, the Department's determination is REVERSED.

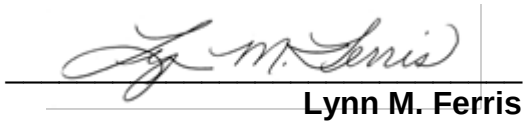
THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE OF MAILING OF THIS DECISION AND ORDER:

Accordingly, It is ORDERED:

1. The Department's determination is REVERSED.

2. The Department shall initiate processing of the April 11, 2013 application for MA-P and retro application to March 2013 to determine the Claimant's eligibility and determine if all other non-medical criteria are met, and inform the Claimant and the Claimant's AHR of the determination in accordance with Department policy.

3. The Department shall review the Claimant's continued eligibility in September 2015 in accordance with Department policy.



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

Date Signed: September 17, 2014

Date Mailed: September 17, 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]