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

IN THE MATTER OF:

[redacted]

Reg. No.: 2014-18381
Issue No.: 2009
Case No.: [redacted]
Hearing Date: May 29, 2014
County: Monroe

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

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; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10. After due notice, an in-person hearing was held on May 29, 2014, from Monroe, Michigan. Participants included the above-named Claimant. [redacted] of Michigan testified and appeared as Claimant's authorized hearing representative (AHR) / legal counsel. Participants on behalf of the Department of Human Services (DHS) included [redacted], Medical Contact Worker.

ISSUE

The issue is whether DHS properly terminated Claimant's eligibility for Medical Assistance (MA) for the reason that Claimant is not a disabled individual.

FINDINGS OF FACT

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

1. Claimant was an ongoing MA benefit recipient.

2. Claimant's only basis for MA benefits was as a disabled individual.

3. On [redacted], the Medical Review Team (MRT) determined that Claimant was not a disabled individual for purposes of MA eligibility (see Exhibits 11-12).

4. On [redacted] DHS terminated Claimant's eligibility for MA benefits, effective 1/2014, and mailed a Notice of Case Action (Exhibits 5-10) informing Claimant of the termination.

5. On [redacted], Claimant requested a hearing disputing the termination of MA benefits.

6. On [redacted] the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual, in part, by reliance on a Disability Determination Explanation which determined that Claimant did not have a severe impairment.

7. During the hearing, Claimant waived the right to receive a timely hearing decision.

8. During the hearing, Claimant and DHS waived any objections to allow the admission of additional documents considered and forwarded by SHRT.

9. On [redacted], Claimant submitted additional documents (Exhibits A1-A14).

10. On [redacted], an updated hearing packet was forwarded to SHRT and an Interim Order Extending the Record for Review by State Hearing Review Team was subsequently issued which extended the record 90 days from the date of hearing.

11. On [redacted] SHRT determined that Claimant was not a disabled individual, in part, by determining that Claimant can perform past relevant employment.

12. On [redacted], MAHS received the updated SHRT decision and hearing packet.

13. As of the date of the administrative hearing, Claimant was a 25-year-old male with a height of 6'0'' and weight of 160 pounds.

14. Claimant has no relevant history of alcohol or drug abuse.

15. Claimant's highest education year completed was the 12th grade.

16. Claimant alleged disability based on anxiety and panic disorders.

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. Department policies are contained in the Department of Human Services

Bridges Administrative Manual (BAM) and Department of Human Services Bridges Eligibility Manual (BEM) and Department of Human Services Reference Tables Manual (RFT).

The Medicaid program is comprised of several sub-programs which fall under one of two categories; one category is FIP-related and the second category is SSI-related. BEM 105 (10/2010), p. 1. To receive MA under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled. *Id*. Families with dependent children, caretaker relatives of dependent children, persons under age 21 and pregnant, or recently pregnant, women receive MA under FIP-related categories. *Id*. AMP is an MA program available to persons not eligible for Medicaid through the SSI-related or FIP-related categories though DHS does always offer the program to applicants. It was not disputed that Claimant's only potential category for Medicaid eligibility would be as a disabled individual.

Disability for purposes of MA benefits is established if one of the following circumstances applies:

- by death (for the month of death);
- the applicant receives Supplemental Security Income (SSI) benefits;
- SSI benefits were recently terminated due to financial factors;
- the applicant receives Retirement Survivors and Disability Insurance (RSDI) on the basis of being disabled; or
- RSDI eligibility is established following denial of the MA benefit application (under certain circumstances).
  BEM 260 (7/2012) pp. 1-2

There was no evidence that any of the above circumstances apply to Claimant. Accordingly, Claimant may not be considered for Medicaid eligibility without undergoing a medical review process which determines whether Claimant is a disabled individual. *Id*., p. 2.

Generally, state agencies such as DHS must use the same definition of SSI disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally defined as the inability to do any substantial gainful activity (SGA) 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 functionally identical definition of disability is found under DHS regulations. BEM 260 (7/2012), p. 8.

Substantial gainful activity means a person does the following:

- Performs significant duties, and
- Does them for a reasonable length of time, and
- Does a job normally done for pay or profit. *Id*., p. 9.

Significant duties are duties used to do a job or run a business. *Id*. They must also have a degree of economic value. *Id*. The ability to run a household or take care of oneself does not, on its own, constitute substantial gainful activity. *Id*.

The person claiming a physical or mental disability has the burden to establish a disability 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).

The analysis of Claimant's MA benefit eligibility depends on whether Claimant was an applicant or an ongoing recipient. Once an individual has been found disabled for purposes of MA benefits, continued entitlement is periodically reviewed in order to make a current determination or decision as to whether disability remains in accordance with the medical improvement review standard. 20 CFR 416.993(a); 20 CFR 416.994.

In evaluating a claim for ongoing MA benefits, federal regulations require a sequential evaluation process be utilized. 20 CFR 416.994(b)(5). The review may cease and benefits continued if sufficient evidence supports a finding that an individual is still unable to engage in substantial gainful activity. *Id.* Prior to deciding if an individual's disability has ended, the department will develop, along with the Claimant's cooperation, a complete medical history covering at least the 12 months preceding the date the individual signed a request seeking continuing disability benefits. 20 CFR 416.993(b). The department may order a consultative examination to determine whether or not the disability continues. 20 CFR 416.993(c).

The below described evaluation process is applicable for clients that have not worked during a period of disability benefit eligibility. There was no evidence that Claimant received any wages since receiving disability benefits.

The first step in the analysis in determining the status of a claimant's disability requires the trier of fact to consider the severity of the impairment(s) and whether it meets or equals a listed impairment in Appendix 1 of subpart P of part 404 of Chapter 20. 20 CFR 416.994(b)(5)(i). If a listing is met, an individual's disability is found to continue and no further analysis is required. This consideration requires a summary and analysis of presented medical documents.

Various progress noted from a treating nurse practitioner (Exhibits 39-44) were presented. The notes were from the following dates: [redacted] It was regularly noted that Claimant's mood was stable, had normal speech, and regularly slept 8 hours. It was regularly noted that Claimant received refills of Seroquel which was reported by Claimant to be the only thing that keeps his mood stable.

A Mental Residual Functional Capacity Assessment (Exhibits 29-30) dated [redacted] was presented. The form was completed by a treating nurse practitioner. This form lists 20

different work-related activities among four areas: understanding and memory, sustained concentration and persistence, social interaction and adaptation. It was noted that Claimant had no significant limitations in understanding and memory. Marked restrictions were noted in the following abilities:

- Working in coordination or proximity to other without being distracting
- Completing a normal workday without psychological symptom interruption
- Interacting appropriately with the general public
- Asking simple questions or requesting assistance
- Accepting instructions and responding appropriately to criticism
- Getting along with others without exhibiting behavioral extremes
- Maintaining socially appropriate behavior and adhering to general cleanliness standards
- Traveling to unfamiliar places including use of public transportation
- Setting realistic goals or making plans independently of others.

A Psychiatric Psychological Examination Report (Exhibits 26-28) dated [redacted] was presented. The form was completed by a treating nurse practitioner with an approximate 4 year history of treating Claimant. A history of anxiety attacks was noted. It was noted that Claimant has not worked at any job for some time. Noted observations included well groomed, orientation x4, good focus, and fair-to-good long-term-memory. It was noted that Claimant functions well when at home. An Axis I diagnosis of bipolar disorder was noted. Claimant's GAF was noted to be 62; Claimant's GAF from last year was noted to be 60.

Treatment documents (Exhibits 45-47) dated [redacted] from Claimant's treating physician were presented. It was noted that Claimant reported for his annual exam. It was noted that Claimant had daily panic attacks and decreased energy. It was noted that Claimant reported sleeping 8 hours every day. Diagnoses of bipolar disorder and anxiety were noted. A plan to continue Seroquel was noted.

A Medical Examination Report (Exhibits 23-25) dated [redacted] was presented. The form was completed by a physician with an approximate 10 year history of treating Claimant. Noted diagnoses were bipolar disorder and anxiety. Seroquel was the only noted current medication. An impression was given that Claimant's condition was stable. It was noted that Claimant can meet household needs. It was noted that Claimant had limitations in sustaining concentration and social interactions.

A Psychological Medical Report (Exhibits 15-18) dated [redacted] was presented. The report was completed by a consultative licensed psychologist. It was noted that Claimant reported lifelong anxiety. It was noted that Claimant's anxiety increased following the death of his sister. It was noted that from the age of 16-20, Claimant drank and smoked marijuana. It was noted that Claimant reported that he quit several jobs due to stress and anxiety. It was noted that Claimant reported that he does well with routine, but not unfamiliar places. It was noted that Claimant had a girlfriend of 5 years, with whom he felt very comfortable. Notable observations of Claimant included the following: avoiding eye contact, intact reality, logical and normal speech, orientation x3,

and average intelligence. Diagnoses of social anxiety disorder, major depressive disorder (mild and chronic), and ADHD were noted. A fair prognosis was noted.

A Biopsychosocial Assessment (Exhibits A9-A13) dated [redacted] was presented. The assessment was completed by a treating social worker. It was noted that Claimant reported ongoing depression and anxiety.

A Psychiatric Evaluation (Exhibits A7-A8) dated [redacted] was presented. The evaluation was completed by a treating psychiatrist with an unknown treating history. It was noted that Claimant reported sleeping and eating okay. It was noted that Claimant reported doing well on Seroquel. It was noted that Claimant denied anxiety or panic symptoms. An Axis I diagnosis of bipolar disorder was noted. Claimant's GAF was noted to be 50.

A handwritten Progress Note (Exhibit A2) dated [redacted] was presented. The note was completed by a treating social worker. It was noted that Claimant reported two panic attacks in the previous week. It was noted that Claimant likes to travel. It was noted that Claimant had very few interests and low motivation.

A Psychiatric Follow-Up (Exhibit A6) dated [redacted] was presented. It was noted that Claimant denied being depressed. A plan to continue Seroquel was noted.

A handwritten Progress Note (Exhibit A1) dated [redacted] was presented. The note was completed by a treating social worker. It was noted that Claimant went to the emergency room for unspecified reasons. It was noted that Claimant was encouraged to leave his house more often.

A Psychiatric follow-up (Exhibit A5) dated [redacted] was presented. It was noted that Claimant continued to smoke; smoking cessation counseling was noted as provided. It was noted that Claimant denied being depressed. A plan to continue Seroquel was noted.

> **12.06** ***Anxiety-related disorders***: In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders. 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 both A and C are satisfied.
>
> A. Medically documented findings of at least one of the following:
> 1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:
> a. Motor tension; or
> b. Autonomic hyperactivity; or
> c. Apprehensive expectation; or
> d. Vigilance and scanning; or

2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or
3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or
4. Recurrent obsessions or compulsions which are a source of marked distress; or
5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;

AND

B. Resulting in at least two of the following:
1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration.

OR

C. Resulting in complete inability to function independently outside the area of one's home.

Claimant provided proof of recent GAF scores of 62 and 50. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF within the range of 61-70 is representative of a person with “Some mild symptoms OR some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.” Claimant’s GAF of 62 was not indicative of marked restrictions.

A GAF within the range of 41-50 is representative of a person with “serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g. no friends, unable to keep a job).” A GAF of 50 is at the high functioning level of a person with marked restrictions. The GAF of 50 is suggestive of marked restrictions.

A treating nurse practitioner listed that Claimant had numerous marked restrictions in performing basic work activities. SSA 06-03p provides guidance on what SSA accepts as “acceptable medical sources”.

Licensed physicians and licensed or certified psychologists are acceptable medical sources. Nurse practitioners and social workers are not “acceptable medical sources”. SSA 06-03p goes on to state why the distinction between medical sources and non-medical sources is important.

> First, we need evidence from “acceptable medical sources” to establish the existence of a medically determinable impairment. Second, only “acceptable medical sources” can give us medical opinions. Third, only “acceptable medical

> sources" can be considered treating sources, as defined in 20 CFR 404.1502 and 416.902, whose medical opinions may be entitled to controlling weight.

Restrictions from Claimant's nurse practitioner will not be completely disregarded. The restrictions will carry less weight because they were not provided by an acceptable medical source.

Claimant testified that his has attempted psychological techniques, but to no avail. Claimant testified that he has panic attacks every time that he leaves the house. Claimant testified that he throws up every time that he has a panic attack.

Claimant's testimony should have been documented in counseling records. No counseling records were presented. It is important to learn not only what symptoms that Claimant experiences, but what attempts he is making to overcome his symptoms. The absence of counseling records makes it difficult to verify Claimant's symptoms and efforts in overcoming them. The absence of counseling records also makes it difficult to chart Claimant progress and to determine a prognosis. A fair prognosis was noted by a consultative examiner.

A fair prognosis is suggestive that Claimant will make progress in reducing the effects of psychological symptoms. The prognosis is also not particularly indicative of marked restrictions. Overall, the evidence failed to verify that Claimant has marked restrictions that amount to SSA listing levels.

A listing for affective disorder (Listing 12.04) was considered based on diagnoses of depression. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Claimant required a highly supportive living arrangement, suffered repeated episodes of decompensation or that the residual disease process resulted in a marginal adjustment so that even a slight increase in mental demands would cause decompensation.

Claimant's testimony suggested that the residual disease process resulted in a marginal adjustment so that even a slight increase in mental demands would cause decompensation. Claimant's testimony is purely speculative. Medical records verified that Claimant has not attempted any recent employment. Claimant testified that he has not attempted any employment since 2010. The absence of counseling records makes it extremely difficult to presume that a slight increase in demands would cause decompensation.

Based on the presented evidence, it is found that Claimant does not meet a SSA listing. Accordingly, the analysis may proceed to step two.

The second step of the analysis considers whether medical improvement occurred. CFR 416.994(b)(5)(ii). Medical improvement is defined as any decrease in the medical severity of the impairment(s) which was present at the time of the most favorable

medical decision that the individual was disabled or continues to be disabled. 20 CFR 416.994(b)(1)(i).

Claimant's testified that he experiences panic attacks whenever he leaves his house. Claimant testified that he cannot hold a job because of anxiety.

Medical records well established that Claimant's anxiety started (or increased exponentially) beginning with the death of his sister. Claimant was not a witness to her death but clearly developed psychological problems. Claimant's anxiety began approximately 10 years ago. Claimant essentially claims a general lack of improvement despite the passage of 10 years since his sister's death and four years of psychological treatment. The analysis will begin with a summary of the relevant submitted medical documentation from Claimant's original medical packet.

Hospital documents (Exhibits 80-122) from 10/2009 were presented. A discharge diagnosis of allergic mouth reaction was noted.

Various mental health treatment documents (Exhibits 123-134) were presented. The documents were from 2009-2010. The documents verified ongoing treatment for anxiety.

A Psychiatric Psychological Examination Report (Exhibits 65-67) dated [redacted] was presented. The form was completed by a treating psychiatrist with an approximate 2 ½ year history of treating Claimant. It was noted that Claimant reported anxiety attacks. Claimant's GAF was noted to be 60.

A mental status examination report (Exhibits 58-61) dated [redacted] was presented. The report was completed by a consultative licensed psychologist. It was noted that Claimant began experiencing anxiety at the age of 15, right after his sister was killed in a motor vehicle accident. It was noted that Claimant took Seroquel to manage anxiety but that he still has daily panic attacks. Claimant's GAF was noted to be 45-50. A fair-to-guarded prognosis was noted.

The first page of a Mental Residual Functional Capacity Assessment (Exhibit 68) was presented. The second page, which lists 13 of 20 work-related abilities and signature information, was not provided. The form will be ignored due to the unknown source for the information on the form.

A SHRT decision (Exhibit 50) approving Claimant for disability benefits was presented. The decision was dated [redacted]. SHRT cited a consultative examination which determined that Claimant was incapable of performing even simple and repetitive tasks and treating source opinion which stated that Claimant had multiple marked restrictions in concentration, social interaction, and adaptability.

A prognosis of fair is improvement from fair-to guarded. Claimant's GAFs were slightly higher in more recently submitted documentation. The evidence was suggestive that Claimant's condition has improved. Accordingly, the analysis may proceed to step three.

The third step of the analysis considers medical improvement and its effect on the ability to perform SGA. Medical improvement is not related to the ability to work if there has been a decrease in the severity of the impairment(s) present at the time of the most recent favorable medical decision, but *no* increase in functional capacity to do basic work activities. 20 CFR 416.994(b)(1)(ii). If there has been any medical improvement, but it is not related to the ability to do work and none of the exceptions applies, benefits will be continued. *Id*. If medical improvement is related to the ability to do work, the process moves to step five.

Claimant saw a consultative examiner when he originally applied for MA benefits and shortly before DHS terminated Claimant's MA eligibility.

The most notable difference between Claimant's original documentation and recent documentation was that a consultative examiner did not state that Claimant was incapable of performing employment. The first examiner stated that Claimant had difficulty leaving his home and would not likely be able to sustain concentration or attention to work activities (see Exhibit 60). A recent examining psychologist noted that Claimant may benefit from using a job coach and that Claimant struggles with details due to anxiety. Struggling with details and benefitting from a job coach is significant improvement from not likely being able to sustain concentration or attention. Other than generally unsupported statements of marked restrictions from a non-medical source, the evidence was supportive in finding that Claimant's improvement was related to the ability to perform employment. It is found that Claimant has improvement related to the ability to work and the analysis may skip to step five.

Step five of the analysis considers whether all the current impairments in combination are severe. 20 CFR 416.994(b)(5)(v). When the evidence shows that all current impairments in combination do not significantly limit physical or mental abilities to do basic work activities, these impairments will not be considered severe and the claimant will not be considered disabled. *Id*. If the impairments are considered severe, the analysis moves to step six. *Id*.

The impairments must significantly limit a person's basic work activities. 20 CFR 416.921 (a). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921 (b). Examples of basic work activities include:

- physical functions (e.g. walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling)
- capacities for seeing, hearing, and speaking, understanding; carrying out, and remembering simple instructions
- use of judgment
- responding appropriately to supervision, co-workers and usual work situations; and/or

- dealing with changes in a routine work setting. (*Id*.)

Generally, federal courts have imposed a de minimus standard upon claimants to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v Bowen,* 880 F2d 860, 862 (6th Cir. 1988). Similarly, Social Security Ruling 85-28 has been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirement is intended "to do no more than screen out groundless claims." *McDonald v. Secretary of Health and Human Servs.*, 795 F.2d 1118, 1124 (1st Cir. 1986).

Sufficient medical evidence was presented to establish that anxiety impairs Claimant's ability to concentrate, maintain persistence, adapt and interact socially. Accordingly, the analysis may proceed to step six.

The sixth step in analyzing a disability claim requires an assessment of the Claimant's RFC and past relevant employment. 20 CFR 416.994(b)(5)(vi). An individual is not disabled if it is determined that a claimant can perform past relevant work. *Id*.

Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

Claimant testified that he worked for 3 months unloading trucks for a delivery service. Claimant also testified that he performed physical labor involving stacking pallets. Claimant stated that his job lasted a "couple months".

Claimant conceded that he has no physical obstacles to performing employment. Thus, Claimant is indisputably physically capable of performing past employment.

It is appreciated that Claimant requires ongoing daily doses of Seroquel in order to maintain a level of normalcy. If Claimant had no access to Seroquel, it would likely be found that Claimant was disabled because he could not function without it. Claimant should have ongoing access to his medications due to recent federal and state changes. Thus, access to medication is not a factor in the analysis.

Presented medical records adequately verified that Claimant has anxiety which would make any work difficult. The records are also suggestive that Clamant would function best in physical work involving a minimum of customer service and work that is familiar to Claimant; Claimant's past employment is just such employment. It is found that Claimant is capable of performing past relevant employment. Accordingly, Claimant is not a disabled individual and it is found that DHS properly terminated Claimant's MA eligibility.

It should be noted that Claimant is on his second SSA application following an unfavorable administrative hearing decision. This decision is consistent with Claimant's previous denial of SSA benefits.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that DHS properly terminated Claimant's MA benefit eligibility effective 1/2014, based on a determination that Claimant is not disabled. The actions taken by DHS are **AFFIRMED**.

Christian Gardocki
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: 8/27/2014

Date Mailed: 8/27/2014

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

CG/hw

cc: [redacted]