

**STATE OF MICHIGAN**  
**MICHIGAN ADMINISTRATIVE HEARING SYSTEM**  
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**  
P. O. Box 30763, Lansing, MI 48909  
(877) 833-0870; Fax (517) 373-4147

**IN THE MATTER OF:**

**Docket No. 2014-31211 CMH**

██████████

██████████

██████████

Appellant

\_\_\_\_\_ /

**DECISION AND ORDER**

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, and upon a request for a hearing filed on behalf of the minor Appellant.

After due notice, a hearing was held on ██████████, Appellant's mother, appeared and testified on Appellant's behalf. ██████████ Due Process Hearings Coordinator and attorney, represented Respondent ██████████ County Community Mental Health Authority (██████████). ██████████ a Clinical Psychologist at ██████████), and ██████████ a Clinical Analyst at the ██████████ testified as witnesses for Respondent.

**ISSUE**

Did the ██████████ properly deny Appellant's request for inpatient psychiatric hospitalization?

**FINDINGS OF FACT**

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

1. ██████████ is under contract with the Michigan Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH's service area.
2. In turn, ██████████ contracts with service providers, such as ██████████. (Testimony of ██████████)
3. Appellant is an ██████ year-old male who has been diagnosed with Autism Spectrum Disorder; Attention Deficit Hyperactivity Disorder; Oppositional Defiant Disorder; and a Learning Disorder, NOS. (Petitioner's Exhibit 1, page 8; Respondent's Exhibit B, page 14).

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4. Due to those conditions and their effect on his behavior, Appellant is on a number of medications, including Seroquel, Ritalin, Clonidine, and Melatonin. (Petitioner's Exhibit 1, pages 7-9).
5. Petitioner has been on those medications for years, in increasing amounts, and he has reached the maximum dosage for his age or size on some of the medications. (Petitioner's Exhibit 1, pages 7-9; Testimony of Appellant's representative).
6. On ██████████, Appellant's representative requested inpatient psychiatric hospitalization through ██████████ on Appellant's behalf. (Testimony of Appellant's representative).
7. The inpatient psychiatric hospitalization was to be for the purpose of weaning Appellant off his current medications; washing those medications out of his system; and assessing him for future treatment, including new medications. (Petitioner's Exhibit 1, pages 1-9; Testimony of Appellant's representative).
8. Appellant's representative brought three written recommendations from medical providers with her when making the request. (Petitioner's Exhibit 1, pages 7-9; Testimony of Appellant's representative).
9. In one of those recommendations, Appellant's psychologist stated that she recommends that Appellant "be admitted for observation in order to be monitored while washed out from his medication" and that she would recommend a "wash out period to be implemented in a secure and organized matter [sic] in order for [Appellant] to be monitored closely." (Petitioner's Exhibit 1, page 7).
10. Appellant's psychologist also wrote a wash out would be an opportunity for Appellant's family and medical professionals to start on a new basis, which would be a good option as Appellant is only █ years-old, and that "[w]hile washed out, his behaviors need to be monitored closely." (Petitioner's Exhibit 1, page 7).
11. In another letter, the Medical Director for the ██████████ ██████████ wrote that due to the harmful effects of Appellant's medications if taken long term and the difficulties in managing his many medications, the Director was recommending the inpatient hospitalization for the wash out. (Petitioner's Exhibit 1, page 8).
12. The Director also indicated that the process is "extremely necessary for [Appellant's] future and overall wellbeing." (Petitioner's Exhibit 1, page 8).

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13. In the third letter, Appellant's neurologist wrote that she supported "admission to ██████████ inpatient psychiatric facility so his medications may be weaned off and he may start afresh. I believe this is in his best interest." (Petitioner's Exhibit 1, page 9).
14. Staff at ██████████ reviewed the request, observed Appellant, and discussed the request with their contact within the ██████████. (Respondent's Exhibit A, pages 1-16; Testimony of ██████████; Testimony of ██████████)
15. They determined that, given the available information, inpatient psychiatric hospitalization was not medically necessary at that time and, to the extent Appellant's circumstances changed in the future, due to the wash out or any other reason, he could request services as needed. (Testimony of ██████████ Testimony of ██████████).
16. On ██████████ and ██████████ sent Appellant written notice that the request for inpatient psychiatric hospitalization was denied on the basis that the requested service was not medically necessary and Appellant did not need inpatient psychiatry at the time. (Respondent's Exhibit A, pages 1-2).
17. In addition to notifying Appellant of the right to request a Medicaid Fair Hearing, the notice of denial also stated that Appellant could request a second opinion from a staff person at ██████████ and see another doctor within ██████████ hours. (Respondent's Exhibit A, page 1).
18. On ██████████, the Michigan Administrative Hearing System (MAHS) receiving the request for hearing filed in this case. (Petitioner's Exhibit 1, pages 1-9).

**CONCLUSIONS OF LAW**

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides

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eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.

*42 CFR 430.0*

The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

*42 CFR 430.10*

Moreover, Section 1915(b) of the Social Security Act provides:

The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection(s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State...

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

Among the services that [REDACTED] can provide as part of the waiver are inpatient psychiatric hospital admissions and, with respect to such services, the applicable version of Medicaid Provider Manual (MPM) states:

**SECTION 8 – INPATIENT PSYCHIATRIC HOSPITAL ADMISSIONS**

The PIHP is responsible to manage and pay for Medicaid mental health services in community-based psychiatric inpatient units for all Medicaid beneficiaries who reside

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within the service area covered by the PIHP. This means that the PIHP is responsible for timely screening and authorization/certification of requests for admission, notice and provision of several opinions, and continuing stay for inpatient services, defined as follows:

- **Screening** means the PIHP has been notified of the beneficiary and has been provided enough information to make a determination of the most appropriate services. The screening may be provided on-site, face-to-face by PIHP personnel, or over the telephone.
- **Authorization/certification** means that the PIHP has screened the beneficiary and has approved the services requested. Telephone screening must be followed-up by the written certification.

PIHP responsibilities include:

- Pre-admission screening to determine whether alternative services are appropriate and available. Severity of Illness and Intensity of Service clinical criteria will be used for such pre-screening. Inpatient pre-screening services must be available 24-hours-a-day, seven-days-a-week.
- Provision of notice regarding rights to a second opinion in the case of denials.
- Coordination with substance abuse treatment providers, when appropriate.
- Provision of, or referral to and linkage with, alternative services, when appropriate.
- Communication with the treating and/or referring provider.
- Communication with the primary care physician or health plan.

- Planning in conjunction with hospital personnel for the beneficiary's after-care services.

In most instances, the beneficiary will receive services in a community-based psychiatric unit in the PIHP service area where he resides. There may be instances when a PIHP is responsible for a resident that they have placed into a community program in another county or state. In these cases, the responsible PIHP, i.e., the one managing the case, is responsible for authorizing admission and/or continuing stay.

If a beneficiary experiences psychiatric crisis in another county, the PIHP in that county should provide crisis intervention/services as needed and contact the PIHP for the county of the beneficiary's residence for disposition.

### **8.1 ADMISSIONS**

The PIHPs will make authorization and approval decisions for these services according to Level of Care guidelines established by MDCH and appearing in this section. All admission and continuing stay responsibilities and procedures must be conducted in accordance with the terms of the contract between the hospital and the PIHP.

\* \* \*

### **8.2 APPEALS**

PIHPs will make authorization and approval decisions for services according to Level of Care guidelines. If the hospital disagrees with the decision of the PIHP, regarding either admission authorization/approval or the number of authorized days of care, the hospital may appeal to the PIHP according to the terms of its contract with the PIHP. If the hospital does not have a contract or agreement with the PIHP, any appeals by the hospital will be conducted through the usual and customary procedures that the PIHP employs in its contracts with other enrolled hospital providers.

If a beneficiary or his legal representative disagrees with a PIHP decision related to admission authorization/approval or approved days of care, he may request a reconsideration and second opinion from the PIHP. If the PIHP's initial

decision is upheld, the beneficiary has further redress through the Medicaid fair hearing process. Medicaid beneficiaries can request the Medicaid fair hearing without going through local review processes.

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## **8.5 ELIGIBILITY CRITERIA**

### **8.5.A. INPATIENT PSYCHIATRIC AND PARTIAL HOSPITALIZATION SERVICES**

Medicaid requires that hospitals providing inpatient psychiatric services or partial hospitalization services obtain authorization and certification of the need for admission and continuing stay from PIHPs. A PIHP reviewer determines authorization and certification by applying criteria outlined in this document. The hospital or attending physician may request a reconsideration of adverse authorization/certification determinations made by the initial PIHP reviewer.

The criteria described below employ the concepts of Severity of Illness (SI) and Intensity of Service (IS) to assist reviewers in determinations regarding whether a particular care setting or service intensity is appropriately matched to the beneficiary's current condition.

- Severity of Illness (SI) refers to the nature and severity of the signs, symptoms, functional impairments and risk potential related to the beneficiary's psychiatric disorder.
- Intensity of Service (IS) refers to the setting of care, to the types and frequency of needed services and supports, and to the degree of restrictiveness necessary to safely and effectively treat the beneficiary.

Medicaid coverage for inpatient psychiatric services is limited to beneficiaries with a current primary psychiatric diagnosis, as described in the criteria

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below. It is recognized that some beneficiaries will have other conditions or disorders (e.g., developmental disabilities or substance abuse) that coexist with a psychiatric disturbance. In regard to developmental disabilities, if a person with developmental disabilities presents with signs or symptoms of a significant, serious, concomitant mental illness, the mental illness will take precedence for purposes of care and placement decisions, and the beneficiary may be authorized/certified for inpatient psychiatric care under these guidelines.

For beneficiaries who present with psychiatric symptoms associated with current active substance abuse, it may be difficult to determine whether symptoms exhibited are due to a primary mental illness or represent a substance-induced disorder, and to make an informed level of care placement decision. A beneficiary exhibiting a psychiatric disturbance in the context of current active substance use or intoxication may require acute detoxification services before an accurate assessment of the need for psychiatric inpatient services can be made. In these situations, the hospital and the PIHP must confer to determine the appropriate location (acute medical setting or psychiatric unit) for the detoxification services.

The crucial consideration in initial placement decisions for a beneficiary with psychiatric symptoms associated with current active substance abuse is whether the beneficiary's immediate treatment needs are primarily medical or psychiatric. If the beneficiary's primary need is medical (e.g., life-threatening substance-induced toxic conditions requiring acute medical care and detoxification), then detoxification in an acute medical setting (presuming the beneficiary's condition meets previously published acute care detoxification criteria) is indicated. If the beneficiary's primary need is psychiatric care (the person meets the SI/IS criteria for inpatient psychiatric care), they should be admitted to the psychiatric unit and acute medical detoxification provided in that setting.

Hospitals are reminded that they must obtain PIHP admission authorization and certification for all admissions to a distinct part psychiatric unit or freestanding psychiatric hospital.

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**8.5.C. INPATIENT ADMISSION CRITERIA:  
CHILDREN THROUGH AGE 21**

Inpatient psychiatric care may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based on the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the table below:

<b>Diagnosis</b>	The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM Axis I, or ICD diagnosis (not including V Codes).
<b>Severity of Illness</b> (signs, symptoms, functional impairments and risk potential)	At least <b>one</b> of the following manifestations is present:  •Severe Psychiatric Signs and Symptoms  ➤ Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) - severe enough to cause disordered and/or

	<p>bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.</p> <ul style="list-style-type: none"><li>➤ Disorientation, impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.</li><li>➤ Severe anxiety, phobic symptoms or agitation, or ruminative/obsessive behavior that has failed, or is deemed unlikely, to respond to less intensive levels of care and has resulted in substantial current dysfunction.</li></ul> <p>▪Disruptions of Self-Care and Independent Functioning</p> <ul style="list-style-type: none"><li>➤ Beneficiary is unable to maintain adequate nutrition or self care due to a severe psychiatric disorder.</li><li>➤ The beneficiary exhibits significant inability to attend to age-appropriate responsibilities, and there has been a serious deterioration/impairment of interpersonal, familial, and/or educational functioning due to an acute psychiatric disorder or severe developmental disturbance.</li></ul> <p>▪Harm to Self</p> <ul style="list-style-type: none"><li>➤ A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, or impulsivity.</li></ul>
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	<ul style="list-style-type: none"><li>➤ There is a specific plan to harm self with clear intent and/or lethal potential.</li><li>➤ There is self-harm ideation or threats without a plan, which are considered serious due to impulsivity, current impairment or a history of prior attempts.</li><li>➤ There is current behavior or recent history of self-mutilation, severe impulsivity, significant risk-taking or other self-endangering behavior.</li><li>➤ There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations.</li><li>➤ There is a recent history of drug ingestion with a strong suspicion of intentional overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.</li></ul> <p>▪Harm to Others</p> <ul style="list-style-type: none"><li>➤ Serious assaultive behavior has occurred and there is a clear risk of escalation or repetition of this behavior in the near future.</li><li>➤ There is expressed intention to harm others and a plan and means to carry it out; the level of impulse control is non existent or impaired.</li><li>➤ There has been significant</li></ul>
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	<p>destructive behavior toward property that endangers others, such as setting fires.</p> <ul style="list-style-type: none"><li>➤ The person has experienced severe side effects from using therapeutic psychotropic medications.</li></ul> <p>▪Drug/Medication Complications or Coexisting General Medical Condition Requiring Care</p> <ul style="list-style-type: none"><li>➤ The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or reinitiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved.</li><li>➤ There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the coexisting general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care.</li></ul> <p><b>Special Consideration: Concomitant Substance Abuse</b> - The underlying psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represents the primary reason observation and treatment are necessary in the hospital setting.</p>
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<b>Intensity of Service</b>	<p>The person meets the intensity of service requirements if inpatient services are considered medically necessary and if the person requires at least one of the following:</p> <ul style="list-style-type: none"><li>▪Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications.</li><li>▪Close and continuous skilled medical observation is needed due to otherwise unmanageable side effects of psychotropic medications.</li><li>▪Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur.</li><li>▪A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.</li></ul>
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*MPM, January 1, 2014 version  
Mental Health/Substance Abuse Chapter, pages 43-48*

Moreover, while inpatient psychiatric hospitalization may be a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services for which they are eligible and services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. See 42 CFR 440.230.

Regarding medical necessity in general, the applicable version of the MPM states:

### **2.5 MEDICAL NECESSITY CRITERIA**

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

### **2.5.A. MEDICAL NECESSITY CRITERIA**

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

### **2.5.B. DETERMINATION CRITERIA**

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant

qualifications who have evaluated the beneficiary;

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

**2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP**

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

#### **2.5.D. PIHP DECISIONS**

Using criteria for medical necessity, a PIHP may:

- Deny services:
  - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
  - that are experimental or investigational in nature; or
  - for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

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A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

*MPM, January 1, 2014 version*  
*Mental Health/Substance Abuse Chapter, pages 12-14*

Here, as discussed above, Appellant's representative requested inpatient psychiatric hospitalization for Appellant for the purpose of weaning Appellant off his current medications; washing those medications out of his system; and assessing him for future treatment, including new medications. In support of that request, Appellant's representative also provided three letters of recommendation from medical personnel who have treated Appellant.

After reviewing that request, [REDACTED] denied it. As described by Respondent's witnesses, it was determined that, given the available information, inpatient psychiatric hospitalization was not medically necessary at that time and, to the extent Appellant's circumstances changed in the future, due to the wash out or any other reason, he could request services as needed.

Appellant bears the burden of proving by the preponderance of the evidence that [REDACTED] erred in denying the request.

Given the evidence and applicable policies in this case, Appellant has failed to meet that burden of proof and the denial must be affirmed. Per policy, services must be medically necessary and provided in the least restrictive, most integrated setting appropriate to the beneficiary's needs.

Moreover, with respect to the specific criteria for inpatient psychiatric hospitalization for children through age 21, the above policy identifies certain manifestations regarding the severity of illness factor, including where:

The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or reinitiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved.

*MPM, January 1, 2014 version*  
*Mental Health/Substance Abuse Chapter, page 50*

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Similarly, the intensity of service factor in the above policy states in part:

The person meets the intensity of service requirements if inpatient services are considered medically necessary and if the person requires at least one of the following:

- Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications.

*MPM, January 1, 2014 version*  
*Mental Health/Substance Abuse Chapter, page 51*

Here, there has been no showing of the needs required by the above policy. The letters from Appellant's doctors indicated a need for the wash out and describe why the wash out is to take place, but they do not explain why the wash out needs to take place in an inpatient facility or why it cannot be accomplished in a less restrictive setting or at a lower level of care. Similarly, while Appellant's representative described a number of scenarios where problems with the wash out could potentially require additional services and/or hospitalization, the potential scenarios have not occurred and the submitted documentation does not reflect such concerns or a need for inpatient psychiatric hospitalization.

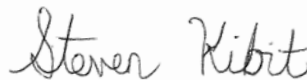
Accordingly, given the available information, [REDACTED] properly denied Appellant's request for inpatient psychiatric hospitalization.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the [REDACTED] properly denied the request for inpatient psychiatric hospitalization.

**IT IS THEREFORE ORDERED** that:

The [REDACTED] decision is **AFFIRMED**.



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Steven J. Kibit  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

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SK/db

cc:

[REDACTED]

**\*\*\* NOTICE \*\*\***

The Michigan Administrative Hearing System may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant 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 was made, within 30 days of the receipt of the rehearing decision.