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

IN THE MATTER OF:

[redacted]

Reg. No.: 14-013814
Issue No.: 2009
Case No.: [redacted]
Hearing Date: January 07, 2015
County: WAYNE-DISTRICT 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, three-way telephone hearing was held on January 7, 2015, from Detroit, Michigan. Participants on behalf of Claimant included the Claimant. A witness, [redacted], also appeared. [redacted] appeared as the Claimant's Authorized Hearing Representative. Participants on behalf of the Department of Health and Human Services (Department) included [redacted], Medical Contact Worker.

ISSUE

Whether the Department properly determined that Claimant was not disabled for purposes of the Medical Assistance (MA) and/or State Disability Assistance (SDA) benefit programs?

FINDINGS OF FACT

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

1. The Claimant's AHR filed an application for Medical Assistance [redacted] and retro Medical Assistance for December 2012.

2. On [redacted], the Medical Review Team denied the application finding the Claimant not disabled.

3. On [redacted], the Department sent a Notice of Case Action to the Claimant denying the application.

4. The Claimant's AHR requested a timely hearing on [redacted].

5. At the time of the hearing the Claimant was 46 years of age with a [redacted]. The Claimant was 4' 11" tall and weighed 140.

6. The Claimant completed the 8th grade and was expelled from school due to fighting and anger outbursts and behavioral problems. The Claimant has no relevant substantial gainful employment history. The Claimant described that she could read a little, but could not read a newspaper. The claimant could not perform multiplication and division.

7. Interim Orders were issued on [redacted] and [redacted], for the submission of additional medical records.

8. The Claimant has alleged physical disabling impairments which include coronary artery disease with multiple stenting, hypertension, diabetes mellitus and low back pain.

9. Claimant has alleged mental disabling impairments including schizoaffective disorder, depression, and most recently, bipolar disorder.

10. On [redacted], the Social Security Administration (SSA) denied Claimant's application for Social Security benefits after finding that she was not disabled.

11. The Claimant did not file an appeal of the [redacted]3 SSA decision within 60 days of the [redacted] unfavorable decision.

12. At the hearing the Claimant's AHR advised that Claimant filed a new application for Social Security Benefits on [redacted], which is pending a hearing. Claimant's AHR further advised that the Claimant's representative before SSA in the current application, a division of the AHR [redacted] had not asked for a reopening of the [redacted] denial of the unfavorable decision as of the hearing date [redacted] of the instant matter.

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

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Human Services Reference Tables Manual (RFT).

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No.

111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Department of Human Services) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

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). A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

Individuals seeking disability-related MA must apply with SSA for Supplemental Security Income (SSI) or Retirement Survivors and Disability Income (RSDI) benefits. BEM 270 (October 2013), pp 2-3. If a client is denied SSI (or disability-based RSDI) by an SSA administrative law judge based on the judge's finding that the client is not disabled, the client must request an appeals council review within 60 days of the administrative law judge's SSI hearing decision date. BEM 271 (July 2013), pp. 8-9. Once SSA's determination that disability or blindness does not exist for SSI is final, the Department must close the client's MA case if the following conditions are established: (i) the determination was made after 1/1/90, **and** (ii) either no further appeals may be made at SSA or the client failed to file an appeal at any step within SSA's 60-day limit; **and** (iii) the client is **not** claiming either a totally different disabling condition than the condition SSA based its determination on, or an additional impairment(s), change, or deterioration in his/her condition that SSA has reviewed and made a determination on yet. BEM 271, p. 10.

As a preliminary matter the issue of whether the Claimant's current application is precluded by the failure of the Claimant to appeal the Decision of the Social Security Administration (SSA) denying Claimant's application on August 17, 2013 must be addressed. Neither the Department, nor the AHR provided any information as regards the SSA ALJ's Decision, the time periods covered, the disabling impairments alleged or the medical evidence relied upon which would inform or support a dismissal of the current March 28, 2013 application. Therefore the undersigned will proceed to determine whether the Claimant is disabled as of the application and retro application seeking coverage to December 2012.

MA-P and SDA benefits are available to disabled individuals. BEM 105 (January 2014), p. 1; BEM 260 (July 260); BEM 261 (July 2013), p. 1. In order to receive MA benefits based upon disability, Claimant must be disabled as defined in Title XVI of the Social Security Act. 20 CFR 416.901. Disability for MA purposes 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).

In order to determine whether or not an individual is disabled, federal regulations require application of a five-step sequential evaluation process. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider (1) whether the individual is engaged in substantial gainful activity; (2) whether the individual's impairment is severe; (3) whether the impairment and its duration meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) whether the individual has the residual functional capacity to perform past relevant work; and (5) whether the individual has the residual functional capacity and vocational factors (based on age, education and work experience) to 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)

In general, the individual has the responsibility 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, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. 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(d).

Step One

As outlined above, the first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is substantial gainful activity (SGA), then the individual must be considered as not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Claimant at the time of the hearing was not engaged in SGA activity during the period for which assistance might be available. Therefore, Claimant is not ineligible under step 1 and the analysis continues to step 2.

Step Two

Under step 2, the severity of an individual's alleged impairment(s) is considered. If the individual does not have a severe medically determinable physical or mental impairment

that meets the duration requirement, or a combination of impairments that is severe and meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 12 months. 20 CFR 416.922.

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 416.920(a)(4)(ii); 20 CFR 416.920(c). 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); see also *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921(b). Examples include (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. CFR 416.921(b).

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. A disability claim obviously lacking in medical merit may be dismissed. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may 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). However, under the *de minimus* standard applied at step 2, an impairment is not severe only if it is a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs* at 862.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). In the present case the Claimant has alleged both physical and mental disabling impairments.

Claimant alleges physical disabling impairments which include coronary artery disease with multiple stenting, hypertension, diabetes mellitus and low back pain.

Claimant also alleges mental disabling impairments which include schizoaffective disorder, depression, and most recently, bipolar disorder.

A summary of the medical evidence follows.

The Claimant has received treatment for her mental impairments as demonstrated by medical evidence provided at the hearing. Records as early as 2007 document a consistent history of mental illness since early teens with several suicide attempts, although none recent. By medical history, the Claimant has been psychiatrically

hospitalized twice; the last time in 2012 “when she was about to kill somebody”. Exhibit 1, p.200

An intake interview at the Northeast Guidance Center on [redacted] noted auditory/visual hallucinations, anger, agitation, isolation from others, crying spells, disrupted sleep with insomnia, depression, and impairment in social occupation areas of functioning.

The Claimant treats consistently at the [redacted] and underwent a formal treatment plan review covering 6 months on [redacted]. The Clamant was seen for evaluation by her treating psychiatrist, whose notes indicate she requested more medication for hearing of voices with complaints of mood swings. The Claimant’s affect was noted as constricted and memory was noted as vague. Notes indicate that patient still hears some harm commands and notes she almost went to jail last night due to a fight with her cousin. Attention and concentration was within normal limits, judgment and impulse control were adequate, noted suicidal ideation. The diagnosis was schizophrenia, paranoid type, secondary Bipolar I disorder, most recent episode mixed severe with psych. Problems related to social environment and other psychosocial and environmental problems were noted. The GAF score was 40. The date of the evaluation was [redacted]. A diagnostic summary was also included which noted that schizophrenia onset at age 23. Also noted was that Claimant hears voices that tell her to hurt herself and others or that she is worthless, with visual hallucination of deceased aunt who was physically abusive. The Claimant’s medical records notes her avoidance of people as a stressor to her anxiety and ongoing anger issues causing her to isolate in her home and avoidance of going out. The Claimant has treated consistently with this mental health provider throughout 2014. Claimant Exhibit B

Claimant was evaluated by her psychiatrist on [redacted]. At the time of the exam, the Claimant had problems with depression, anger control, stress and having thoughts of suicide. Exam notes indicated poor memory, and visual and auditory hallucinations with harm commands and her mother telling her she is no good and unwanted. Claimant expressed hopelessness in trying to get herself together. Suicidal thoughts were reported every other day and homicidal thoughts when she sees others. The Diagnosis was schizophrenia, paranoid type, secondary Bipolar I disorder, most recent episode mixed severe with psych. Problems related to social environment and other psychosocial and environmental problems were noted. The GAF score was 40.

The Claimant’s GAF score in December 2009 was 45, in 2007 it was 42 and has stayed consistently at 45 despite treatment at this previous mental health care provider. See also medical records of prior treatment, Exhibit 1 pps. 252, 263, 269, 274, 281, 288, 291, 314, 330, 333, 343-344, 346, 351,361, 369, 368, 376, 378, 381, 383, 393, 399, 405, 411, 440, 442, 476, 480 and 509.
The Claimant’s current GAF score from her treating psychiatrist is 40. Throughout mental health treatment, the Claimant presents hopelessness, depression, paranoia,

anger and hearing voices to which she responds, with increased anxiety due to her health concerns and does not leave the house, avoiding contact with people other than immediate family members.

A consultative mental status exam was conducted on [redacted] At that exam the Claimant was reported to have no transportation, no insurance and did not know who would see her for treatment. Claimant reported isolating herself staying at home as much as possible. At the exam Claimant reported hearing voices, visual hallucinations and a history of abuse. The Claimant expressed feelings of others plotting against her and tried to kill herself four times, attempting to smother herself. At the exam, the Claimant felt sad and angry, and depressed. The Claimant felt suicidal and had thoughts of taking somebody else's life. The Diagnosis was schizoaffective disorder, cannabis abuse, and antisocial personality disorder with a GAF score of 51. The Claimant was noted as unable to manage her funds. Exhibit 1, pp. 201-202

The 2010 assessment contained in the medical records is offered to demonstrate an ongoing history and pattern of serious mental impairment. A comprehensive assessment was made of Claimants' psychiatric treatment records from [redacted] in January 2010. The Claimant presented as depressed and irritable and was homeless. Her children were living with friends and relatives. The Claimant refused to seek emergency shelter and emergency room treatment due to feeling sick. The symptoms described by Claimant were verbal aggression, depressed mood, decreased energy, hopelessness, worthlessness, insomnia, irritability, anger, hallucinations, stoped taking medications, disruption of thought process/content, emotional/physical / sexual trauma and guilt. The notes indicate the Claimant acts with verbal aggression and verbal threatening of people. The Claimant expressed hopelessness and "wished she wasn't here". The claimant reported that despite threats, she has not harmed others or herself. The Claimant continues to take her medication but does not see the good in it. The review notes that Claimant had no stable personal relationships except with her children. Her children were being raised by relatives. Claimant's functioning related to various subjects were rated as follows, relationship to family, Marked Impairment; job/ school performance, Severe Impairment; friend peer relationships, Severe Impairment; hobbies/interests/play activities, Severe Impairment; physical health, Severe Impairment; ADL's, Severe Impairment; sleeping habits, Marked Impairment; sexual functioning, Marked Impairment; ability to concentrate, Moderate Impairment; ability to control temper, Serious Impairment. The Claimant was prescribed trazadone, Geodon, and Paxil. No substance or alcohol abuse was noted. A diagnosis of schizoaffective disorder, paranoid personality disorder, GAF of 45 and noted problems to social environment. At the time of this assessment the Claimant was being cared for by her daughter, who was her home help provider.

A medication review was conducted on [redacted]. The doctor's notes indicated that the Claimant presented with mood lability, depression, command hallucinations, irritable, anxious, blunted affect, though speech logical. Claimant reported thoughts of

suicide. Claimant was advised due to lack of insurance the treating agency could not provide medications. Overall health status was fair.

While hospitalized for abdominal pain in July 2014, the Claimant was not allowed to leave the hospital due to threats of daily suicide, description of a recent suicide attempt and belligerent behaviors. The Claimant was advised that she could not leave without a psychiatric exam and a room sitter was assigned.

As early as [redacted] the Claimant had an abnormal EKG with sinus bradycardia and sinus arrhythmia.

In December 2014, the Claimant underwent another stenting at OM1 described as critical coronary artery disease and a 4 day hospital stay. The Claimant's LVEF was 45%. The current ejection fraction is 60%.

The Claimant was seen for a follow up exam [redacted]. Her diagnosis were diabetes mellitus, benign hypertension, coronary artery disease, lower back pain, spondylosis with radiculopathy, urinary incontinence and diabetic poly neuropathy.

The Claimant's general practice treating doctor completed a DHS 49 dated [redacted] The diagnosis was hypertension, diabetes 2, COPD, degenerative joint disease, back pain, multiple cardiac stents and osteoarthritis. The exam noted irregular rhythm, murmur, and palpitations. Musculoskeletal examination noted limited range of motion, muscle spasm, tenderness. The notes also indicate abnormal reflexes and gait. Schizophrenia was also noted. The Doctor imposed limitations expecting to last 90 or more and limited the Claimant to lifting occasionally 10 pounds, standing or walking less than 2 hours in an 8 hour workday. Use of hands arms was limited regarding pushing/pulling. The Claimant could not operate foot controls with the right leg. The medical findings supporting the limitations listed cardiac stents X2, osteoarthritis and hypertension. The Doctor also observed the Claimant had limitations with sustained concentration and following simple directions basing his opinion on history of schizophrenia. The Doctor also noted Claimant needed a home aid.

The Claimant was seen for angina and on admission, received a coronary angiography with stenting in February 2014.

On [redacted], the Claimant was hospitalized with unstable angina with stenting of the mid LAD with 90% stenosis and was at the site of a prior stent. After stenting the impressions were severe In-Stent Restenosis involving the LAD. The LVEF was 40%.
The Claimant was admitted to the hospital on September 10, 2013 with constant sharp chest pain. Medication noncompliance was noted secondary to lack of insurance. At the time of her admission, due to cardiology, the condition was serious.

A history of procedures performed due to coronary artery disease include, left cardiac catheterization (2011), coronary angioplasty, 2010, two insertions of drug eluting coronary artery stents percutaneous transluminal coronary angioplasty, insertion of drug eluting coronary artery stents 2010 and stent insertion in 2009. In a 2012 admission the Claimant's confirmed conditions were acute ischemic heart disease, depression, diabetes mellitus, hypertension and schizophrenia. At the time of the 2012 admission the Claimant received another stent.

An MRI of the lumbar spine was presented on [redacted]. The impression was multilevel hypertrophic facet arthropathy, most prominent at L4-L5 causing mild bilateral mild neural forminal stenosis. There was also a shallow disc bulge at L4-L5 which mildly effaces the thecal sac. The cauda aquina nerve root demonstrated as normal without thickening or clumping.

At the hearing, the Claimant demonstrated several behavior traits including having emotional difficulty after an hour long hearing, and when leaving she was crying. The Claimant credibly testified that she has sleep disturbance, sometimes sleeping only 2 hours a day, has crying spells daily, and that she is hostile and "goes at people " who irritate or upset her. The Claimant indicated that the previous weekend she was almost arrested for assaultive behavior with a knife followed by suicidal ideation. The Claimant continues to hear voices and see shadows. The Claimant does not watch TV, but enjoys coloring. The Claimant also said she would have trouble taking the bus as well as shopping due to her anger issues and irritability (suggesting she might hurt somebody). She avoids contact with persons outside her family and isolates herself to her room. Also noteworthy, at the end of the telephone hearing the Department representative present notes the Claimant sat hunched over for most of the hearing and became frustrated, agitated and disturbed at times as well as left crying because the hearing lasted over an hour.

As summarized above, Claimant has presented medical evidence establishing that she does have some mental limitations on her ability to perform basic work activities. In consideration of the de minimis standard necessary to establish a severe impairment under step 2, the foregoing medical evidence is sufficient to establish that Claimant suffers from severe impairments as a result of his mental condition that have lasted or are expected to last for a continuous period of not less than 12 months. Therefore, Claimant has satisfied the requirements under step 2, and the analysis will proceed to step 3.

Step Three

Step 3 of the sequential analysis of a disability claim requires a determination if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920(a)(4)(iii). If an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

Based on the objective medical evidence presented of the diagnosed mental disorders of mood disorder and paranoid schizophrenia, Listing 12.00, which encompasses adult mental disorders, particularly Listing 12.03 (schizophrenic, paranoid and other psychotic disorders) was reviewed. The Listing requires the following conditions be met or their medical equivalent:

> **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.
>
> A. Medically documented persistence, either continuous or intermittent, of one or more of the following:
>
> 1. Delusions or hallucinations; or
>
> 2. Catatonic or other grossly disorganized behavior; or
>
> 3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:
>
> a. Blunt affect; or
>
> b. Flat affect; or
>
> c. Inappropriate affect;
>
> OR
>
> 4. Emotional withdrawal and/or isolation;
>
> 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;

After a review of the medical evidence presented and Claimant's testimony it is determined that the Claimant meets listing 12.03 A 1, 3a and 4 and B 1 and 2 or its medical equivalent. As the listing is deemed satisfied, it is determined that the listing is met with no further analysis required and it is determined that Claimant is disabled at Step 3, with no further analysis required.

Finally, it is also determined that based upon current testimony, the Claimant no longer smokes and drinks (only on holidays) with marijuana use diminished. Therefore, it is determined that neither drugs nor alcohol are material.

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 benefit program.

DECISION AND ORDER

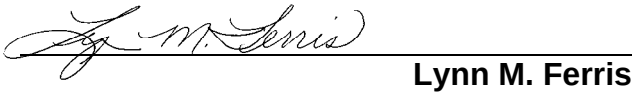
Accordingly, the Department's determination is **REVERSED**.

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:

1. The Department shall re register and process the Claimant MA-P application dated [redacted], and retro MA-P application for December 2012 to determine the Claimant's non medical eligibility.

2. The Department shall advise the Claimant and the Claimant's AHR as of the MA-P coverage effective date.

3. The Department shall complete a review of this matter in August 2016.



Lynn M. Ferris
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Signed: **8/31/2015**

Date Mailed: **8/31/2015**

LMF / hw

NOTICE OF APPEAL: A party may appeal this Hearing Decision in the circuit court in the county in which he/she resides, or the circuit court in Ingham County, within 30 days of the receipt date.

A party may request a rehearing or reconsideration of this Hearing Decision from the Michigan Administrative Hearing System (MAHS) within 30 days of the mailing date of this Hearing Decision, or MAHS may order a rehearing or reconsideration on its own motion.

MAHS may grant a party's Request for Rehearing or Reconsideration 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 party requesting a rehearing or reconsideration 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 this Hearing Decision is mailed.

A written request may be faxed or mailed to MAHS. If submitted by fax, 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 48909-8139

cc: [redacted]