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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-012886
Issue No.: 2009
Case No.: [redacted]
Hearing Date: September 2, 2015
County: Wayne (17)

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, a telephone hearing was held on September 2, 2015, from Detroit, Michigan. Participants included the above-named Claimant. [redacted] Claimant's mother testified on behalf of Claimant. [redacted] testified and appeared as Claimant's authorized hearing representative (AHR). Participants on behalf of the Michigan Department of Health and Human Services (MDHHS) included [redacted], medical contact worker.

ISSUE

The issue is whether MDHHS properly denied Claimant's Medical Assistance (MA) eligibility 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. On March 3, 2014, Claimant applied for MA benefits.

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

3. On October 30, 2014, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 3-4).

4. On June 24, 2015, MDHHS denied Claimant's application for MA benefits and mailed a written notice informing Claimant of the denial.

5. On July 9, 2015, Claimant's AHR requested a hearing disputing the denial of MA benefits.

6. As of the date of the administrative hearing, Claimant was a 29-year-old male.

7. Claimant has not earned substantial gainful activity since before the first month of benefits sought.

8. Claimant's highest education year completed was the 11th grade.

9. Claimant has a history of unskilled employment, with no known transferrable job skills.

10. Claimant alleged disability based on restrictions related to various neurological problems including seizures and memory loss.

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 Bridges Administrative Manual (BAM), Bridges Eligibility Manual (BEM), and Reference Tables Manual (RFT).

Prior to a substantive analysis of Claimant's hearing request, it should be noted that Claimant's AHR noted special arrangements in order to participate in the hearing; specifically, a 3-way telephone hearing was requested. Claimant's AHR's request was granted and the hearing was conducted accordingly.

Claimant requested a hearing to dispute the denial of an MA application from March 2014. MDHHS presented testimony that Clamant was eligible for Healthy Michigan Plan benefits since April 2014. Claimant's AHR's testimony conceded that Medicaid benefits are only currently needed for March 2014.

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*. 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 MDHHS 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 MDHHS regulations. BEM 260 (7/2012), p. 8.

SGA means a person does the following: performs significant duties, 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 SGA. *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 CFR 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).

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled. 20 CFR 416.920. If there is no finding of disability or lack of disability at each step, the process moves to the next step. 20 CFR 416.920 (a)(4).

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person is statutorily blind or not. "Current" work activity is interpreted to include all time since the date of application. The 2014 monthly income limit considered SGA for non-blind individuals is $1,070.

Claimant credibly denied performing any employment since the date of the MA application; no evidence was submitted to contradict Claimant's testimony. Based on the presented evidence, it is found that Claimant is not performing SGA and has not performed SGA since the date of MA application. Accordingly, the disability analysis may proceed to step two.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the 12 month duration requirement. 20 CFR 416.920 (a)(4)(ii). The impairments may be combined to meet the severity requirement. If a severe impairment is not found, then a person is deemed not disabled. *Id*.

The impairments must significantly limit a person's basic work activities. 20 CFR 416.920 (a)(5)(c). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. *Id.* 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.

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).

SSA specifically notes that age, education, and work experience are not considered at the second step of the disability analysis. 20 CFR 416.920 (5)(c). In determining whether Claimant's impairments amount to a severe impairment, all other relevant evidence may be considered. The analysis will begin with a summary of presented medical documentation.

Hospital documents (Exhibits 20-85; 100-161; B2-B27; B56-B63) from an admission dated March 2, 2014, were presented. It was noted that Claimant was brought to the hospital after being unresponsive. It was noted that Claimant overdosed on an unspecified medication; Claimant testified he only abused pain medications (per Exhibit 78, abused medications included Xanax and Vicodin). A long history of drug abuse was noted (see Exhibit 48). A recent history of severe weight loss (30 pounds over an unspecified short period) was noted (see Exhibit 55). Initial problems were low hemoglobin which was treated with a blood transfusion. Claimant had a 103.8° fever at admission. Claimant was intubated and placed on a ventilator. It was noted that Claimant was septic. It was noted that Claimant's heart was enlarged and an echocardiogram showed endocarditis due to an aortic root abscess. On March 5, 2014, Claimant was noted to be comatose. It was noted that Claimant underwent an emergency aortic valve replacement on March 8, 2014; a fair-to-guarded prognosis for returning to modified independent level of function was noted. On March 13, 2014, it was noted that Clamant was in critical condition due to gastrointestinal bleeding. Claimant then had dental abscesses removed; valvular and mitral valve abscesses were also discovered. Claimant was noted as performing well post-surgically, though he showed signs of confusion. An MRI of Claimant's head demonstrated enlargement of an aneurysm which led to Claimant undergoing a craniotomy. On April 2, 2014, Clamant complained of generalized weakness and persistent headache (see Exhibit B1). On April 18, 2014, a stable brain MRI was noted (compared to previous day's exam), though some indication of an evolving aneurysm was also indicated. On April 29, 2014, it was noted that Claimant was previously discharged for rehabilitative services and that he was doing well post-operatively. It was noted that a brain MRI demonstrated suspicion for empyema, a new small abscess, and worsening edema; follow-up was recommended. Claimant was discharged on April 22, 2014, in "good" condition." Noted discharge diagnoses included drug abuse, anemia, gastrointestinal bleeding, sepsis, brain abscess aneurysm, aortic valve endocarditis, and dental abscesses.

Neurosurgeon office visit notes (Exhibits C1-C2) dated May 6, 2014, were presented. It was noted that Claimant reported left hand tingling and numbness. Musculoskeletal physical examination findings were normal. Left-sided pronator drift was noted. A brain MRI was recommended.

Hospital emergency room documents (Exhibits B28-B30) dated May 15, 2014, were presented. It was noted that Claimant presented with complaints of paresthesias and headaches, ongoing for one day. Treatment was not apparent.

Hospital emergency room documents (Exhibits B31-B33) dated May 17, 2014, were presented. It was noted that Claimant presented with complaints of mild general illness. An impression of Fentanyl withdrawal was noted.

Hospital emergency room documents (Exhibits B34-B55) dated May 18, 2014, were presented. It was noted that Claimant presented with complaints of pain, rapid breathing, increased sleep, and drug withdrawal. A physical examination indicated no neurological abnormalities. A drug screening noted Claimant was positive for barbiturates, benzo, and marijuana. An impression was given that Clamant has a narcotic dependency. A brain MRI from the previous day was noted to indicate 2 aneurysms. A follow-up in 3 months with neurosurgery was recommended.

Hospital emergency room documents (Exhibits B64-B84) dated July 20, 2014, were presented. It was noted that Claimant presented for a cranioplasty consultation. It was noted that Claimant reported complaints of headache and numbness along previous brain surgery incision site. A physical examination noted no neurological abnormalities. A brain MRI noted no evidence of aneurysm though a re-demonstration of abnormal signals was noted; an impression of a normal brain MRI was noted. It was noted that Claimant would undergo a cranioplasty that week. A plan to increase pain medications was noted.

Hospital emergency room documents (Exhibits B85-B91) dated July 29, 2014, were presented. It was noted that Claimant presented with complaints of a seizure and recurrent headache (reported pain level 8/10), currently ongoing for 2 days. Claimant reported taking 2 Norco that day though Claimant's brother reported Claimant took 10-15 pills. It was noted that Claimant's family found empty bottles of Vicodin in Claimant's room even though the family was dispensing pain medication. It was noted that Claimant was worried about an upcoming surgery. Claimant was treated with pain and anxiety medication.

Hospital emergency room documents (Exhibits B92-B116) dated August 6, 2014, were presented. It was noted that Claimant presented for replacement of a bone flap stemming from previous brain surgery. Discharge documents noted Claimant was discharged in fair condition following surgical reopening of craniotomy and repositioning of bone flap. Various medications were provided at discharge.

Hospital emergency room documents (Exhibits B117-B136) dated August 16, 2014, were presented. It was noted that Claimant presented with head swelling, ongoing for 4 days. It was noted that Claimant's sutures prematurely disengaged. Cultures were noted to be infected with strep parasanguinis (see Exhibit C14) which led to a 6 week regimen of antibiotics. It was noted that Claimant was recently treated for a seizure; it was also noted that the seizure was likely caused by a missed dosage of Keppra. A physical examination noted no neurological abnormalities. It was noted that excess brain fluid was removed. Post-surgery, Claimant reported "some headache." A prescription for Keflex was prescribed.

Hospital emergency room documents (Exhibits B137-B161) dated August 23, 2014, were presented. It was noted that Claimant was brought after sitting in the shower and "not behaving very well"; misbehaving specifics were not apparent. Claimant reported a severe headache and generalized weakness. A CT of Claimant's head was performed. The CT was noted to "appear stable." (compared to previous MRI dated August 18, 2014) other than decreased subdural hyper-dense mixed fluid collection; A history of congestive heart failure (now improved) was noted. A plan to consult neurological and psychiatric units was noted. A plan to reduce Lopressor (to improve light-headedness) and administer IV fluids was noted. Current medications included the following: Lipitor, Colace, Doxycycline, Pepcid, Heparin, Keppra, Lopressor, and Zoloft. A physical examination noted no neurological abnormalities. Following blood testing, impressions of hypogonadism and gynecomastia were noted.

Neurosurgeon office visit notes (Exhibits C14-C25) dated September 3, 2014, were presented. It was noted that Claimant's surgical wound opened up for a second time and that Claimant was positive for MRSE. A recommendation of bone flap removal was noted; Claimant refused the recommendation and opted for antibiotic treatment. Claimant's head wound was cleaned and covered.

Hospital emergency room documents (Exhibits B162-B173) dated September 14, 2014, were presented. It was noted that Claimant reported severe headache pain. Admission notes indicated that part of Claimant's cranial scar was not healing. It was noted that Clamant was advised to have an unspecified surgery "after the lab was taken out", but Claimant refused, resulting in scalp flap infection. A plan of antibiotics was noted.

Hospital emergency room documents (Exhibits B174-B179) dated September 25, 2014, were presented. It was noted that Claimant reported ear ringing and headache, ongoing for one week. A physical examination noted no neurological abnormalities. Normal mood, normal affect, normal judgment, and normal thought content were noted. A diagnosis of vancomycin toxicity was noted, though it was later noted that infectious disease specialists thought otherwise. "No diagnosis" was ultimately indicated.

Hospital emergency room documents (Exhibits 16-19) dated December 15, 2014, were presented. It was noted that Claimant presented with complaints of a seizure. A CT of Claimant's brain was noted as performed. Levetiracetam was noted as a continued medication. Generic discharge instructions for recurrent seizures were provided.

A physician letter (Exhibit 15) dated December 30, 2014, was presented. The letter stated that Claimant was unable to drive, until further notice, due to seizures.

Hospital emergency room documents (Exhibits B180-B181) dated February 3, 2015, were presented. It was noted that Claimant was treated for breakthrough seizure and headache. A prescription for Topamax was provided.

Presented evidence established an eventful medical history. Claimant testified he's had 13 major surgeries since March 2013. Claimant and his mother testified that Claimant has ongoing difficulties with seizures and headaches. Claimant's and his mother's testimony was consistent with presented treatment documents.

It is found that Claimant established significant impairment to basic work activities for a period longer than 12 months. Accordingly, it is found that Claimant established having a severe impairment and the disability analysis may proceed to Step 3.

The third step of the sequential analysis requires a determination whether the Claimant'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 Claimant's impairments are listed and deemed to meet the 12 month requirement, then the claimant is deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step.

Claimant's most prominent impairment appears to be ongoing seizures. SSA provides two different listings related to epilepsy; the listing read as follows:

> **11.02 Epilepsy** - convulsive epilepsy, (grand mal or psychomotor), documented by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once a month, in spite of at least 3 months of prescribed treatment. With:
>
> A. Daytime episodes (loss of consciousness and convulsive seizures) or
>
> B. Nocturnal episodes manifesting residuals which interfere significantly with activity during the day.
>
> **11.03 Epilepsy -** nonconvulsive epilepsy (petit mal, psychomotor, or focal), documented by detailed description of a typical seizure pattern including all associated phenomena, occurring more frequently than once weekly in spite of at least 3 months of prescribed treatment. With alteration of awareness or loss of consciousness and transient postictal manifestations of unconventional behavior or significant interference with activity during the day.

Claimant testified he has grand mal seizures which include "bad convulsions." Claimant estimated the seizures occur 1-2 times per month. Claimant testified he also experiences smaller seizures which occur 1-2 times per week. Claimant testified the smaller seizures precipitate 20 minute periods of confusion. Claimant testified that seizures cause symptoms of migraine headaches, light-headedness, and temporary right-eye blindness. Claimant stated his headaches are constant. Claimant testified he takes 1000 mg of Keppra (a known anti-seizure medication) and Topamax (a known anti-seizure and headache relief mediation).

Claimant's mother testified Claimant has grand mal seizures monthly- an improvement from the 1-2 seizures/month he previously had. She testified that seizures began in

October 2014. Claimant's mom testified her son also experiences petty mal seizures where he "zones out" and stares into space; she estimated the seizures last a few minutes. She estimated the smaller seizures occur twice per week. She also reported that her son shows symptoms of behavior changes, fidgetiness, anxiousness, fatigue and tiredness lasting 3-4 days.

Claimant's mother also testified that her son is forgetful. As an example, Claimant's mother testified that her son has gotten lost when he goes for walks near his house. She also testified that her son needs assistance with reading. Claimant's mother testified her son's personality has changed dramatically since his March 2014 hospitalization. She suspected it may have something to do with the 5 different cranial surgeries he has undergone.

Claimant and his mother's testimony concerning seizures was consistent and credible. It was not well verified.

Emergency room treatment for a seizure from February 2015 was verified. Very little treatment information was presented. It is not known what caused Claimant's seizure. A cause of seizure is relevant because Claimant has a history of prescription drug abuse which appeared to be a substantial contributor to Claimant's initial hospitalization. There is also at least one seizure treatment noted to be caused by a missed Keppra dosage.

Labeling the treatment as a "breakthrough seizure" is indicative that noncompliance was not an issue. A breakthrough seizure, by definition, occurs despite medication compliance. Thus, Claimant's February 2014 seizure appears to be not related to noncompliance.

A breakthrough seizure, by definition, is also a seizure that is unexpected and sudden. Only one treatment for a breakthrough seizure was verified. This consideration is suggestive that Claimant's history of seizures is not as severe as indicated by testimony.

Seizure treatment from July 2014 was presented. Treatment documents were highly suggestive that Claimant took an excess of pain medication before having a seizure. This appears to be the likeliest cause of seizure, similar to Claimant's initial hospitalization from March 2014.

The best evidence of seizures would be abnormal brain radiology. Despite multiple MRIs and scans, presented radiology was not established to be indicative of seizures. Other forms of seizure testing (e.g. an electrocephalogram (EEG)) also was not presented.

Claimant testified he sees a physician monthly. It is presumed that Claimant sees his primary care physician because Claimant conceded that he is not regularly treated by a neurologist. It is not appreciated how Claimant could allege neurological dysfunction in

the form of grand mal seizures, petty mal seizures, headaches, and confusion, yet not pursue a medical specialist's treatment. During the hearing, neither Claimant nor his mother adequately explained the failure to pursue neurological treatment.

Also notable was the consistent absence of neurological abnormalities in physical examinations. Claimant's physical examinations consistently noted normal reflexes (2/4), orientation x3, grossly intact cranial nerves, fluent speech, 5/5 muscle strength, intact sensation, no Hoffman's sign, and no Tromner's sign.

A pronator drift was noted in one physical examination in May 2014. This is understood to be a sign of an upper motor neurological disorder. The sign was not apparent in subsequent examinations; thus, it seems to be an isolated symptom rather than evidence of ongoing neurological problems.

A listing for organic mental disorder (Listing 12.02) was considered based on Claimant extensive medical history involving brain surgeries. The listing was rejected due to the absences of psychiatric testing, marked limitations, and/or a documented history of an organic disorder lasting 2 years.

It is found that Claimant failed to establish meeting a SSA listing. Accordingly, the analysis moves to step four.

The fourth step in analyzing a disability claim requires an assessment of the Claimant's residual functional capacity (RFC) and past relevant employment. 20 CFR 416.920(a)(4)(iv). 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 he had various full-time jobs working with his family. Claimant testified that he recalled working as a cashier at a gas station. Claimant also testified that he worked at a gym selling memberships. Claimant and his mother testified that Claimant's seizures, headaches, and confusion would prevent Claimant from performing any employment.

In the third step analysis, it was found that Claimant failed to establish a frequency of seizures sufficient to meet SSA listing levels. Claimant's recurring seizures would prevent Claimant from driving, working at heights, working near open water, and

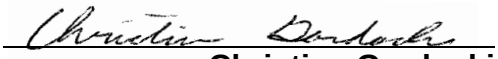
operating heavy machinery. Claimant's seizure frequency would not appear to preclude the performance of gas station cashier or gym membership salesman.

Claimant complained of regular headaches, and some treatment and medication was verified. There was insufficient evidence that Claimant's headaches are so frequent or severe that he is unable to work if he complies with medication. It is appreciated that Claimant's medical history is complicated and that numerous treatments involving brain function were verified; however, brain radiology was consistently normal and no mental health treatment suggested a brain disorder.

Based on presented evidence, it is found that Claimant is capable of performing past relevant employment. Accordingly, Claimant is not disabled and it is found that MDHHS properly denied Claimant's MA application.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that MDHHS properly denied Claimant's MA benefit application dated March 13, 2014, based on a determination that Claimant is not disabled. The actions taken by MDHHS are **AFFIRMED**.



Christian Gardocki
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Signed: **9/8/2015**

Date Mailed: **9/8/2015**

GC/tm

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]