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

IN THE MATTER OF

[redacted],

Docket No. 15-013994 CMH
15-013141 CMH
Case No. [redacted]

Appellant

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 upon Appellant's request for a hearing.

After due notice, a telephone hearing was held on [redacted]. Appellant appeared at the hearing. Appellant was represented by Attorney [redacted] (P[redacted]) and Attorney [redacted] (P[redacted]). [redacted]. Clinical Director; and [redacted], Independent Support Coordinator, appeared and testified on Appellant's behalf.

Attorney [redacted] (P[redacted]) represented Respondent [redacted] County Community Mental Health of Central Michigan (CMHCM or Department or Respondent). [redacted], Program Director; and [redacted], Utilization Manager, appeared as witnesses for the Department.

Exhibits Admitted: State's Exhibit A pages 1-14;
Appellant's Exhibits 1-7 (pages 17-78);
Stipulated Exhibit pages 79-589

ISSUE

Did the CMHCM properly calculate Appellant's Community Living Supports (CLS) hours?

FINDINGS OF FACT

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

1. Appellant is a Medicaid beneficiary.

2. Appellant is a [redacted] year old woman who receives support services through CMHCM and has for more than [redacted].

3. Appellant is diagnosed with Cognitive Impairment; Obsessive Compulsive disorder; Mood disorder; Depression; Tachycardia; Gastro Esophageal Reflux Disease; and Hypothyroidism.

4. CMHCM is under contract with the Department of Health and Human Services (DHHS) to provide Medicaid covered services to people who reside in the CMH service area.

5. Appellant's Medicaid Services include Targeted Case Management, Out-of-Home Non-Vocational Habilitation (HAB), Medication Review, supported Employment, non-emergency Transportation, and Comprehensive CLS Services.

6. On [redacted], CMHCM performed an annual person-centered planning (PCP meeting) and rendered no change in Appellant's CLS profile or medical condition, and approved her for CLS service hours.

7. The [redacted] Plan of Service was effective [redacted] to [redacted].

8. Appellant shares 60 hours a month of CLS support services with her roommate, [redacted] (Docket # 15-013142 CMH and #15-013997 CMH).

9. Appellant was receiving 100-179 units (25-44.75 hours per week) of Community Living Services per week as a result of her Individual Plan of Service (IPOS).

10. Appellant's services were increased temporarily because Appellant and her roommate became involved in a dangerous money laundering scheme which required police involvement.

11. Once the safety concerns were over, regular support and staffing was to be put back into place.

12. A billing error occurred regarding the temporarily approved CLS hours.

13. CMHCM's Program Director conducted a review of Appellant's case by reviewing all of the in Home Services Progress notes dated [redacted] through [redacted].

14. In [redacted], Appellant's Case Manager was instructed to reduce Appellant's shared Community Living Services to 64 units (16 hours) per week because she did not think that Appellant and her roommate needed the level of staffing they currently had.

15. On [redacted], LSSM, the CLS service provider, requested 843 units (210.75 hours) for services performed in [redacted].

16. On [redacted] CMHCM amended Appellant's authorized level of CLS services and reduced the units from 100-179 per week to 64 units per week in shared CLS staffing benefits.

17. On [redacted], CMHCM sent Appellant notice of the Reduction of the CLS services.

18. On [redacted], Appellant filed a request for a hearing with CMHCM to contest the reduction of CLS benefits.

19. On [redacted], Appellant's representative filed a request for a hearing to contest the Respondent's Negative Action (Docket # 15-013141 CMH).

20. On [redacted], CHMCM sent Appellant Notice of Service Hour Reduction effective [redacted].

21. On [redacted], Appellant's representative filed a second request for a hearing to contest the Respondent's Negative Action (Docket #15-013994 CMH); specifically the reduction of CLS services and the change in her Plan of Service.

22. On [redacted], an annual PCP meeting was held.

23. During the [redacted] annual PCP meeting it was determined that Appellant had a medical necessity for an increase of CLS Services in the amount of 200-240 units per week of CLS Services.

24. On [redacted], the Docket numbers were consolidated with the agreement of the parties and the consolidated hearing was held.

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 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*

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. CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. *See 42 CFR 440.230.*

The Medicaid Provider Manual provides, in pertinent part:

> **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; and
> - Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
> - For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
> - Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
> - Made within federal and state standards for timeliness; and
> - Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
> - 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; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- 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. (Emphasis added)

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;
- 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.

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.

Medicaid Provider Manual
Mental Health and Substance Abuse Chapter
January 1, 2014, pp 12-14

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Its states with regard to community living supports:

> **17.3.B. COMMUNITY LIVING SUPPORTS**
>
> Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).
>
> Coverage includes:
>
> - Assisting, reminding, observing, guiding and/or training in the following activities:
>
> - meal preparation
> - laundry
> - routine, seasonal, and heavy household care and maintenance
> - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
> - shopping for food and other necessities of daily living
>
> CLS services may not supplant state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance is needed, the beneficiary, with the help of the PIHP case manager or supports coordinator **must** request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. The PIHP case manager or supports coordinator must assist, if necessary, the beneficiary in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization amount, scope and duration of Home Help does not accurately reflect the beneficiary's needs based on findings of the DHS assessment.

- Staff assistance, support and/or training with activities such as:

  - money management
  - non-medical care (not requiring nurse or physician intervention)
  - socialization and relationship building
  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
  - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
  - attendance at medical appointments
  - acquiring or procuring goods, other than those listed under shopping, and nonmedical services

- Reminding, observing and/or monitoring of medication administration

- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan Personal Care services. Transportation to medical appointments is covered by Medicaid through DHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.

Medicaid Provider Manual
Mental Health and Substance Abuse Section
January 1, 2014, pp 113-114.

The *Medicaid Provider Manual, Mental Health/Substance Abuse, April 1, 2014, Pages 126 and 127,* states:

> 17.3.K. SKILL-BUILDING ASSISTANCE
>
> Skill-building assistance consists of activities identified in the individual plan of services and designed by a professional within his/her scope of practice that assist a beneficiary to increase his economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services provide knowledge and specialized skill development and/or support. Skill-building assistance may be provided in the beneficiary's residence or in community settings.
>
> Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for sheltered work services provided by Michigan Rehabilitation Services (MRS). Information must be updated when the beneficiary's MRS eligibility conditions change.
>
> Coverage includes:
>
> - Out-of-home adaptive skills training: Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and supports services, including:
>
> - Aides helping the beneficiary with his mobility, transferring, and personal hygiene functions at the various sites where adaptive skills training is provided in the community.
>
> - When necessary, helping the person to engage in the adaptive skills training activities (e.g., interpreting).
>
> Services must be furnished on a regularly scheduled basis (several hours a day, one or more days a week) as determined in the individual plan of services and should be coordinated with any physical, occupational, or speech therapies listed in the plan of supports and services. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.
>
> - Work preparatory services are aimed at preparing a beneficiary for paid or unpaid employment, but are not job task-oriented. They include teaching such concepts as attendance, task completion, problem solving, and safety. Work preparatory services are provided to people not able

to join the general workforce, or are unable to participate in a transitional sheltered workshop within one year (excluding supported employment programs).

- Activities included in these services are directed primarily at reaching habilitative goals (e.g., improving attention span and motor skills), not at teaching specific job skills. These services must be reflected in the beneficiary's person-centered plan and directed to habilitative or rehabilitative objectives rather than employment objectives.

- Transportation from the beneficiary's place of residence to the skill building assistance training, between skills training sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

- Services that would otherwise be available to the beneficiary.

CMH's Utilization Management Coordinator testified that her department considers requests for services and determines if those services are medically necessary. CMH's Utilization Management Coordinator testified that she sent out the Adequate Action Notice denying Appellant's request for Skill Building services after reviewing Appellant's Individual Plan of Service (IPOS), Psychosocial Assessment, and other records from Appellant's file.

CMHCM is mandated by federal regulation to perform an assessment for the Appellant to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services that are needed to reasonably achieve Appellant's goals. CMHCM is required to use a person centered planning process to identify medically necessary services and how those meets will be met.

The Michigan Mental Health Code explicitly states:

330.1712 Individualized written plan of services.

Sec. 712.

(1) The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the

commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan.

(2) If a recipient is not satisfied with his or her individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.

(3) An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 1996, Act 588, Imd. Eff. Jan. 21, 1997

In the instant case, Appellant's [redacted], Targeted Case Management meeting indicated that Appellant has natural supports in the form of her children, mother, brothers, sister, her friend, [redacted] and her roommate. Appellant works up to five days per week at the Arnold center. She works part time on the shop floor and at supported employment sites. She enjoys shopping with friends, spending time with her children and watching movies. She was to be referred to Michigan Rehabilitation Services to assist with employment services to find community based employment and to work on resume building, interview skills, completing applications for jobs on paper and a computer and tips on how to dress for an interview. The desired outcome for the future is for Appellant to:

- Be able to talk to and see all of her four kids (2 in [redacted], 2 in [redacted])
- Find a new job in the community
- Have her own house or apartment

- Feeling good and to be healthy
- Take a vacation to see kids.

Appellant had no risks in community safety. She needed assistance to coordinate her medical care needs and have someone be with her to help explain medical/health care information that she may not understand to first time explained to her by a health care professional. Her Community Integration and Supports include:

- Dial-a-ride provides public transportation to get her to and from work and appointments.
- [redacted] is appellant's payee. They assist with decision making and advocacy, as well as management of finances.
- [redacted] County DHHS provides reimbursement for transportation related to medical appointments
- Primary Health Care Physician.

CMHSP Provider Supports was to provide:

1. Verbal prompts/reminders and supervision to Appellant when taking medications as prescribed by her physician at the proper time with the proper dose.

2. Encourage, cue and prompt Appellant to participate in household chores. Provide assistance with cleaning, laundry, cooking. Home staff demonstrate and Appellant repeat household tasks. Assist appellant in creating a chore chart so that she and her roommate can take turns completing various household tasks.

3. Verbally prompt/remind Appellant of community safety, i.e., walking on the sidewalk, looking for cars, stranger danger, letting staff know where she was going if leaving the apartment alone and when expected back.

4. Verbally prompt/remind appellant of appropriate safe activities available to her and encourage her to participate with others.

5. Ensure that Appellant is at appointments, meetings, activities on time.

6. Verbally prompt and remind Appellant to keep money in a safe place, help her figure out if she has enough money to purchase items. Assist appellant by keeping track of finances or funds that her payee has given her. Help appellant record her finances in a log or notebook she keeps in a secure place of her choosing.

7. Provide or assist Appellant with transportation to and from activities, store, movies and doctors' appointments. Assist to provide transportation o events or functions in the community that promote community inclusion when

transportation is not available.

8. Remind appellant of healthy food choices; upcoming doctor's appointments; healthy activities. Guide and direct appellant to healthy foods. Assist with scheduling medical appointments and accompany her to help obtain information related to after care (with Appellant's consent).

9. Work with Appellant to develop a monthly activity calendar of things to do at home and in the community.

The CMHCM representative testified that the purpose of CLS is skill building and that CLS is not intended to meet all the needs of the beneficiary. Evidence on the record shows Appellant's one on one services have not changed. The reduction in services was for services that Appellant shares with her roommate. Appellant was receiving 240 hours of shared services with her roommate. The provider agency requested 210 additional hours for Appellant for the month of [redacted], which triggered the investigation of Appellant's CLS. The Program Director then reviewed the provider logs from [redacted] through [redacted] and determined that based on the notes contained in the provider logs, Appellant did not appear to need as many CLS hours. The Program Director determined that: Appellant was able to take public transportation. She rides the bus to and from work. She rides the bus to [redacted] to see her children. Her goals were being met. Staff would come to Appellant's home and services would already have been completed. Companionship is not a covered service for CLS. Appellant did not demonstrate a need for the services being provided, so there was no medical necessity for the services. Thus, Program Director directed the Supports Coordinator to reduce the CLS hours from 60 hours/240 units to 16 hours/64 units per week.

CMHCM contends that 16 hours of shared CLS per week is sufficient for Appellant to reach her objectives. Appellant has met her goals, could perform all of her activities of daily living or functioning, and her conduct reflects a lack of need for the level of CLS services. In short, additional hours of CLS would be ineffective as an intervention. CMH has the authority under Section 2.5 of the Medicaid Provider Manual to deny a requested service on the grounds that it would not be clinically effective. CMHCM also contends that there was a substantial over-utilization of approved CLS hours

Appellant's representative argues that Appellant has received services for over six years. A disruption of those services and a deviation from her Plan of Service will be detrimental to her. Appellant's representative further argues that the appropriate protocol was not followed to determine the amount of CLS hours needed based upon medical necessity. Lastly, the Appellant's representative argues that the service agency's request for an increase in CLS services should not have resulted in a reduction of services for an individual who is both Medicaid and functionally eligible for those services. The problem is with the provider's billing and documentation process. The Appellant should not be penalized for the billing errors of the service provider.

CMH has established by the necessary, competent and substantial evidence on the record that it was acting in compliance with Department policy when it determined that Appellant should not receive ***additional*** hours of Community Living Services when they were requested by the service provider. However, Medicaid Provider Manual explicitly states

> 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.

The [redacted] Plan of Service was effective [redacted] to [redacted]. While the Department would certainly have been within its discretion to reduce the CLS hours to 100 units (25 hours per week), to allow the Department's utilization unit to unilaterally reduce the hours set forth in the Individualized Plan of Service (IPOS) is to render the IPOS document worthless. The Person Centered Plan and Medical Necessity are the criteria set forth by the Medicaid Provider Manual as the criteria for determining the level of services to be provided on an individualized basis. There has been no evidence provided to this Administrative Law Judge that Appellant's medical condition has improved or that her diagnosis has changed since the implementation of the Person Centered Plan in [redacted]. It was also not made clear on the record just how many personal CLS hours Appellant is to receive to equal 100 units of CLS services or what percentage of the services should be shared. Currently, Appellant receives eight hours per month (32 units) in personal CLS services. 32 units plus 64 units = 96 units (24 hours per week) of combined shared and individual Community Living Services for Appellant which is four (4) units less than the minimum number of CLS units the Person Centered Plan had established for Appellant. There was no change in the amount of Personal CLS hours for Appellant, nor was there argument that Appellant failed the test for medical necessity eligibility for personal for CLS services. Finally, the Department failed to cite a policy, rule or law which allows the Department to disregard or circumvent the Person Centered Planning process when making a determination for eligibility for Community Living Services.

CMHCM has not established by the necessary, competent and substantial evidence on the record that it was acting in compliance with Department policy when it determined that Appellant's shared Community Living Service hours should be reduced based upon the Department's utilization unit's assessment. The Department's decision cannot be upheld under these circumstances.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMHCM did not properly reduce Appellant's shared CLS hours under the circumstances.

IT IS THEREFORE ORDERED that:

The CMHCM decision is **REVERSED**. The Department is **ORDERED** to reinstate Appellant's Community Living Services to the prior approved level as determined by the Person Centered Planning Process.

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

cc: [redacted]

LYL[redacted]

Date Signed: December 2, 2015

Date Mailed: December 3, 2015

***** 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.