STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: March 10, 2017
MAHS Docket No.: 16-007561-RECON
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

Following Petitioner'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; and Mich Admin Code, R 792.11002. After due notice, an in-person hearing was held on January 11, 2017, from Detroit, Michigan. Petitioner appeared and was represented by [redacted]. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], hearing facilitator.

ISSUE

The issue is whether MDHHS properly denied Petitioner's State Disability Assistance (SDA) eligibility for the reason that Petitioner 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 [redacted], Petitioner applied for SDA benefits.

2. Petitioner's only basis for SDA benefits was as a disabled individual.

3. On [redacted], the Disability Determination Service (DDS) determined that Petitioner was not a disabled individual (see Exhibit 3, pp. 1-6).

4. On [redacted], MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action informing Petitioner of the denial.

5. On [redacted], Petitioner requested a hearing disputing the denial of SDA benefits (see Exhibit 4, pp. 2-3) and Medical Assistance eligibility.

6. On [redacted], an administrative hearing decision found Petitioner was not disabled and affirmed the denial of Petitioner's SDA application.

7. In November 2016, the Social Security Administration issued a "final" determination that Petitioner was not disabled.

8. On [redacted], the Michigan Administrative Hearing System issued an Order Vacating Decision and Order Granting Rehearing.

9. On [redacted], a rehearing was held concerning Petitioner's SDA application denial.

10. During the hearing, Petitioner and MDHHS waived the right to receive a timely hearing decision.

11. During the hearing, the record was extended 30 days to allow Petitioner to submit psychiatric records since July 2016, pain specialist records since July 2016, and cancer treatment records documenting complaints of fatigue.

12. On [redacted], and [redacted], Petitioner submitted various documents (Exhibits N, O, P, Q, R, S, and T), some of which were outside the scope of the order that extended the record.

13. As of the date of the administrative hearing, Petitioner was a [redacted]-year-old [redacted].

14. As of the date of the administrative hearing, Petitioner did not have employment earnings amounting to substantial gainful activity.

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

16. Petitioner has a history of unskilled employment, with no known transferrable job skills.

17. Beginning December 2016, Petitioner had restrictions related to medication side effects, foot pain, right knee pain, left arm dysfunction, back pain, diabetes mellitus (DM), and anxiety, which would prevent the performance of most types of employment.

18. MDHHS did not present evidence of employment within Petitioner's capabilities.

19. Petitioner withdrew the hearing request concerning MA benefits.

CONCLUSIONS OF LAW

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. MDHHS (formerly known as the Family Independence Agency) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k. MDHHS policies are contained in the Bridges Administrative Manual (BAM), Bridges Eligibility Manual (BEM), and Reference Tables Manual (RFT).

Petitioner requested a hearing, in part, to dispute MA benefits. Petitioner's AHR (during the initial hearing) indicated there was no ongoing dispute concerning MA benefits. Petitioner's hearing request will be partially dismissed.

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. MDHHS administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. MDHHS policies for SDA are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

Petitioner requested a hearing to dispute the denial of a SDA application. Petitioner claimed an inability to work for 90 days due to mental and/or physical disabilities. MDHHS did not present a Notice of Case Action but it was not disputed that the denial was based on a determination that Petitioner was not disabled. A finding of disability from the date of Petitioner's SDA application is precluded because of a finding made by SSA.

[For SDA benefits,] SSA's final determination that a client is not disabled/blind supersedes MRT's certification. BAM 815 (January 2016) p. 1. If a client's previous DDS and/or SSA medical determination was not approved, the client has to prove a new or worsening condition in order to start the medical determination process again. *Id*., p. 7.

It was not disputed Petitioner applied for disability benefits from SSA in 2014. Petitioner testimony conceded she was denied SSA benefits following an administrative hearing. It was not disputed that Petitioner did not appeal the hearing decision and reapplied for SSA benefits on December 16, 2016. Petitioner testified that SSA denied her claim of disability "shortly before" her application date. It was not disputed that the hearing decision found Petitioner to not be disabled.

Presented evidence was highly suggestive that SSA issued a "final" determination that Petitioner was not disabled as of November 2016. The evidence was consistent with presented medical records and a previously issued administrative hearing decision. The

circumstances justify applying the SSA determination that Petitioner is not disabled to Petitioner's claim of SDA eligibility. It is found Petitioner is denied disability from the date of SDA application through November 2016. At this point, a discussion of administrative hearing jurisdiction is apropos.

Generally, administrative hearing jurisdiction is limited to whether MDHHS took a proper or improper case action. Under this interpretation of administrative hearing jurisdiction, a finding that Petitioner was not disabled through November 2016 affirms the MDHHS determination and no further analysis is necessary. An alternative philosophy of administrative hearing jurisdiction exists.

In administrative hearings when ongoing disability is disputed, jurisdiction can be interpreted to extend through the date of hearing. Such an interpretation of jurisdiction would presumably be ideally suited for cases when an extended time period since the date of application exists between the date of application denial through date of close of record and disability could be established for some period following application denial.

In the present case, nearly one year of time elapsed between the date of MDHHS denial and the date of record closing. Presented evidence was suggestive of possible disability following the denial of SDA benefits. These considerations are supportive in evaluating Petitioner's claim of disability beyond November 2016. One other consideration supports a broad interpretation of administrative hearing jurisdiction.

Applying a strict interpretation of administrative hearing jurisdiction results in Petitioner having to reapply for SDA benefits. Such an outcome is not unjust, however, it would be inefficient.

Another application would require a new analysis requiring extensive further analysis of the same hundreds of documents. The undersigned has already invested dozens of hours evaluating Petitioner's claim of disability. A summary and analysis of hundreds of Petitioner's medical records has already been undertaken. In the interest of efficiency, a broad interpretation of administrative hearing jurisdiction is appropriate. Thus, the analysis will proceed to determine if Petitioner established disability after November 2016.

A procedural aspect should be noted. An Interim Order Extending the Record was issued following a second administrative hearing. The order allowed Petitioner to submit psychiatric records since July 2016, pain specialist records since July 2016, and cancer treatment records documenting complaints of fatigue. The dates within the order were based on Petitioner's AHR's statements that already submitted records were complete through July 2016. As a cautionary measure for Petitioner, the order allowed submissions from July 2016 as well as subsequent months.

In response to the order, Petitioner's AHR submitted various records (Exhibit N, O, P, Q, R, S, and T). Medical center treatment documents from June 2016 (Exhibit P, pp. 1-

43), psychological therapy documents from June 2016 and earlier (Exhibit O, pp. 1-16), and treatment for urinary frequency, sore throat, and abdominal pain (Exhibit P, pp. 44-130) were not considered because they were outside the scope of the order.

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (July 2015), p. 4. The goal of the SDA program is to provide financial assistance to meet a disabled person's basic personal and shelter needs. *Id*. To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older. BEM 261 (January 2012), p. 1. A person is disabled for SDA purposes if he/she:

- receives other specified disability-related benefits or services, see Other Benefits or Services below, or
- resides in a qualified Special Living Arrangement facility, or
- is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability; or
- is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS).

Id.

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 [90 days for SDA eligibility]. 20 CFR 416.905.

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. The 2016 monthly income limit considered SGA for non-blind individuals is $1,130.00.

Petitioner credibly denied performing current employment; no evidence was submitted to contradict Petitioner's testimony. Based on the presented evidence, it is found that Petitioner is not performing SGA. Accordingly, the disability analysis may proceed to the second step.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the durational 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 petitioners 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 requirements are 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 Petitioner'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.

A physician letter (Exhibit 1, p. 64; Exhibit 4, p. 7; Exhibit G, p. 7) dated [redacted], was presented. Diagnoses of DM (type 2), HTN, and hyperlipidemia were noted.

A cancer center physician letter (Exhibit 1, p. 63; Exhibit 4, p. 8) dated [redacted], was presented. It was stated Petitioner was an ongoing breast cancer patient. It was stated Petitioner would take Tamoxifen daily for five years.

A Comprehensive Biopsychosocial Assessment (Exhibit 1, pp. 52-59) dated [redacted], from a mental health treatment agency was presented. The assessment was signed by a social worker. Petitioner reported stress from physical problems, including ongoing treatment for breast cancer. Reported symptoms included crying spells, sleeping difficulty, loss of pleasure in activities, lack of motivation, excessive worrying, and mood swings. Petitioner's job loss in April 2014 was noted to be a contributing depression factor. No psychiatric hospitalizations from the past were noted. The following observations of Petitioner were noted: neatly dressed, no physical abnormalities, normal speech, cooperative, orientation x3, normal attention, highly emotional, tearful, and depressed mood. Memory, judgment, and insight were noted to be intact. Childhood sexual abuse was noted. A treatment plan to reduce depression symptoms and increase coping skills through case management, peer support, and psychiatric appointments was noted.

A Psychiatric Evaluation (Exhibit 1, p. 60-62) dated [redacted], was presented. The evaluation was completed by a treating psychiatrist. Petitioner reported panic attacks, ongoing for years. Petitioner reported she sought treatment for them in the emergency room. Petitioner reported her anxiety/depression was stable until she recently was diagnosed with breast cancer. Petitioner reported that "I'm all by myself" and that she felt she was a burden to her two adult children. Mental examination assessments included the following: average judgment, average insight, grossly intact recent memory, sad mood, and orientation x3. Axis I diagnoses of major depressive disorder (recurrent) and anxiety disorder were noted. Petitioner's GAF was 55. A guarded prognosis was noted. A plan to start Zoloft and BuSpar was noted.

Primary care physician treatment notes (Exhibit A, p. 1) dated [redacted], were presented. A refill for insulin was indicated.

Primary care physician treatment notes (Exhibit A, pp. 2-4) dated [redacted], were presented. Treatment for a yeast infection was noted.

Primary care physician treatment notes (Exhibit A, pp. 5-13) dated [redacted], were presented. Primary treatment for nasal congestion and a sore throat were noted. A diabetic foot exam was normal.

Social worker notes from a treating mental health agency (Exhibit B, pp. 15-16) dated [redacted], were presented. Petitioner denied anger problems though she stated she felt justified in using domestic violence against a boyfriend when he says unspecified things to her.

Primary care physician treatment notes (Exhibit A, pp. 14-25) dated [redacted], were presented. A complaint of right knee pain was noted. Petitioner also complained of headaches, body aches, joint pain, and fatigue; Petitioner speculated the problems were related to breast cancer medication side effects. DM was noted as poorly controlled as evidenced by Petitioner's last A1C of 9.1%; DM medication was increased. It was noted Petitioner failed to bring in blood sugar records; an emphasis on logging blood sugar level was noted. A diagnosis of patellofemoral syndrome was noted; Petitioner was given exercises to perform at home. It was noted Petitioner's request for a handicap sticker was denied.

Social worker notes from a treating mental health agency (Exhibit B, pp. 22-23) dated [redacted], were presented. Petitioner reported her father helped her too much and gave her a sense of entitlement, which she still feels.

Social worker notes from a treating mental health agency (Exhibit B, pp. 26-27) dated [redacted], were presented. Petitioner reported having "chemo brain" due to Tamoxifen.

Breast cancer treatment documents (Exhibit 2, pp. 27-32), dated [redacted] were presented. A stable left breast mammogram was noted. Possibly benign calcifications were indicated.

A letter from a mental health treatment agency (Exhibit 1, p. 45-47; Exhibit 4 pp. 4-6) dated [redacted], was presented. The letter was signed by a social worker who stated Petitioner was an ongoing patient. Petitioner was noted to be treatment compliant.

Primary care physician treatment notes (Exhibit A, pp. 26-39) dated [redacted], were presented. It was noted Petitioner's previous right knee pain resolved, although increased left knee pain was reported. It was noted Petitioner was not following a healthy diet or regularly checking her blood sugar. Petitioner reported headaches and sinus congestion have resolved. Ongoing fatigue was reported; fatigue was noted likely due to multiple factors including poor sleep habits and lack of exercise. Exercise instructions for patellofemoral syndrome were provided.

Primary care physician treatment notes (Exhibit A, pp. 40-54) dated [redacted], were presented. Complaints of left knee dysfunction was noted. Petitioner reported knee sometimes "gives out" causing near falls. Petitioner's morbid obesity was noted. A left knee exam indicated a full range of motion and full muscle strength. A positive

McMurray's test was indicated. A plan of x-rays and physical therapy was noted. Complaints of a rash was noted; ointment was prescribed. A complaint of urinary frequency (worsened after Petitioner ate a candy bar) was noted; a diagnosis of glucosuria was noted.

Breast cancer treatment documents (Exhibit 2, pp. 23-26) dated [redacted], were presented. Petitioner complaints of left-sided discomfort, shooting pains in her arms, left knee pain. It was noted Petitioner was to undergo physical therapy for her knee. Petitioner was encouraged to follow-up with her primary care physician for her complaints.

Social worker notes from a treating mental health agency (Exhibit B, pp. 50-51) dated [redacted], were presented. It was noted Petitioner ran out of medication and was unaware of a script telephone help line.

Mental health agency medication review notes (Exhibit B, pp. 53-54) dated [redacted], were presented. Zoloft and BuSpar were prescribed. Restrictions to associations, judgment, insight, and anxiety were deemed "mild". It was noted Petitioner had "none" concerning musculoskeletal, sleep, thought content, attention, and memory restrictions.

Primary care physician treatment notes (Exhibit A, pp. 55-71) dated [redacted], were presented. A complaint of right foot pain and swelling, ongoing for 3-4 days, was noted. A diagnosis of plantar fasciitis of the right foot was provided. Acetaminophen-codeine was prescribed. Various home treatment tips for plantar fasciitis were provided. It was noted that x-rays showed no factures though degenerative changes in the first toe were noted (see Exhibit 1, pp. 72-73).

Breast cancer treatment documents (Exhibit 2, pp. 20-22), dated [redacted], were presented. It was noted Petitioner completed radiation therapy in August 2015. It was noted there was no evidence of cancer recurrence.

Breast cancer treatment documents (Exhibit 2, pp. 13-19), dated [redacted], were presented. It was noted Petitioner recently completed radiation therapy and was currently treated with Tamoxifen. Increased right breast calcifications were noted. A biopsy was planned.

A right ankle MRI report (Exhibit E, pp. 12-13; Exhibit G pp. 12-13) dated [redacted], was presented. A primary impression of normal appearing peroneal tendons was noted. A partial tear of a ligament and retrocalcaneal bursitis were also stated.

Breast cancer treatment documents (Exhibit 2, pp. 6-7, 9-12, 44-45) dated [redacted], were presented. It was noted Petitioner underwent a biopsy of right breast calcifications.

Breast cancer treatment documents (Exhibit 2, p. 8) dated [redacted], were presented. Biopsy findings were found to be benign.

An internal medicine examination report (Exhibit 1, pp. 39-44) dated [redacted], was presented. The report was noted as completed by a consultative physician. Petitioner reported a history of DM, depression, right ankle tendonitis, and breast cancer. Petitioner reported symptoms of fatigue, headaches, insomnia, joint pain, joint stiffness, and walking difficulty. It was noted she took Tamoxifen to treat breast cancer. Physical examination findings were unremarkable other than Petitioner was morbidly obese and some loss of eyesight (20/50 in worst eye). Gait and posture were normal. It was noted there was no evidence of retinopathy or peripheral neuropathy. It was noted there was no evidence of hypertensive heart disease. No reduced ranges of motion were noted. It was noted that Petitioner was able to perform all 23 listed work-related activities which included sitting, standing, lifting, carrying, stooping, bending, and reaching.

Social worker notes from a treating mental health agency (Exhibit B, pp. 82-83) dated [redacted], were presented. It was noted Petitioner appeared to be in the "action stage" based on her willingness to pursue resources.

A Person Centered Plan of Service- Update (Exhibit B, pp. 1a-7a) dated [redacted], [redacted] was presented. Petitioner's listed goals included obtaining affordable diabetic supplies, pursuing disability, seeking affordable housing, and attending therapy appointments.

Primary care physician treatment notes (Exhibit A, pp. 76-83) dated [redacted], were presented. Petitioner reported memory difficulties since beginning Tamoxifen. Assessments of stable HTN and poorly controlled DM were stated.

Primary care physician treatment notes (Exhibit A, pp. 90-101) dated [redacted], were presented. Petitioner reported memory difficulties since beginning Tamoxifen. Petitioner reported difficulty with allergies. Assessments included stable HTN, relatively stable anxiety, inadequately controlled DM, seasonal allergies, obesity, and chronic right foot pain.

Social worker notes from a treating mental health agency (Exhibit B, pp. 122-123) dated [redacted], were presented. It was noted Petitioner reported hopelessness, depression, and anxiety. Petitioner was noted to be in the "action stage" as she was exploring ways to reduce barriers.

Physician office visit notes (Exhibit D, pp. 2-4) dated [redacted], were presented. A complaint of 7/10 right knee pain was reported. Prescribed medications included Novolog, tamoxifen, Prevacid, Zoloft, Zantac, Nasonex, and glipizide. Petitioner's weight was noted to be 268 pounds.

Social worker notes from a treating mental health agency (Exhibit B, pp. 127-128) dated [redacted], were presented. It was noted Petitioner reported ongoing symptoms of anxiety, racing thoughts, panic attacks, mood swings, insomnia, and feeling overwhelmed.

A Person Centered Plan of Service- Annual (Exhibit B, pp. 8a-15a) dated [redacted], [redacted] was presented. Petitioner reported needing help dealing with anxiety and anger issues. Petitioner reported she gets stressed, particularly concerning lack of income.

Physician office visit notes (Exhibit D, p. 13) dated [redacted], were presented. Petitioner reported 8/10 right foot pain. An MRI was noted as recently obtained, though findings were not stated. It was stated Petitioner had severe flatfoot on the right side. An assessment of probable stage II PTTD was noted.

Social worker notes from a treating mental health agency (Exhibit B, pp. 132-133) dated [redacted], were presented. It was noted Petitioner reported ongoing symptoms of anxiety.

A Psychiatric Evaluation (Exhibit B, pp, 135-137) dated [redacted], from a treating psychiatrist was presented. It was noted Petitioner's case was closed after she forgot to attend several appointments. Petitioner blamed her forgetfulness on her chemo medication. Petitioner reported persistent panic attacks, crying spells, and fatigue. Mental status examination assessments included orientation x3, no delusions, sad and tearful mood, average judgment, and average insight. Diagnosis of major depressive disorder and anxiety disorder were stated. A fair prognosis was given. Cymbalta was prescribed.

Medication review notes (Exhibit B, pp. 144-145) dated [redacted], from Petitioner's psychiatrist were presented. Tramadol was prescribed and Alprazolam dosage was increased.

Hospital documents (Exhibit 1, pp. E, pp. 2-11, pp. 14-16) from an admission dated [redacted], were presented. It was noted that Petitioner presented with complaints of dizziness, anxiety, and right-sided chest pain. Active range of motion and full strength was noted in all extremities. Various medications were provided. An ECG was noted to be normal. Chest radiology was noted to be normal. Stress testing results included 60% ejection fraction, no reversible ischemia, and normal ventricular function. Petitioner was discharged on [redacted].

Social worker notes from a treating mental health agency (Exhibit B, pp. 147-148) dated [redacted], were presented. It was noted Petitioner reported she experienced intense panic and anxiety.

Social worker notes from a treating mental health agency (Exhibit B, pp. 149-151) dated [redacted], were presented. It was noted Petitioner was feeling better after recent cardiac testing was negative.

Physician office visit notes (Exhibit D, pp. 5-7) dated [redacted], were presented. A complaint of 10/10 right knee pain was stated. Treatment details were not apparent.

Physician office visit notes (Exhibit D, p. 1, 12) dated [redacted], were presented. A diagnosis of stage II posterior tibial tendon dysfunction (PTTD) of the right ankle was noted. Subtalar joint tenderness and severe right-sided flatfoot was noted. A positive heel-rise test was indicated.

Social worker notes from a treating mental health agency (Exhibit B, pp. 153) dated [redacted], were presented. It was noted Petitioner reported ongoing severe panic attacks.

Physician office visit notes (Exhibit D, pp. 8-11) dated [redacted], were presented. A complaint of hand pain, including loss of strength and “snapping” of the left hand was stated. Treatment details were not apparent.

Medication review notes (Exhibit B, pp. 155-156) dated [redacted], from Petitioner’s psychiatrist were presented. “Moderate” restrictions related to anxiety, sleep, and attention were noted. Mild judgment impairment was noted. Memory or insight restrictions were “none”.

Petitioner presented physician office visit notes (Exhibit Q, pp. 1-2) dated [redacted]. It was noted Petitioner expressed concern over an armpit nodule. The nodule was described by the physician as “small.” An impression of a cyst that was “amenable to resection” was stated. Later-dated documents (see Exhibit Q, pp. 3-11) indicated the cyst was “low potential for malignancy” (see Exhibit Q, p. 6. A plan for surgery on [redacted], was noted (see Exhibit Q, p. 8).

A letter from a social worker from Petitioner’s mental health treatment agency (Exhibit G, p. 1) dated [redacted], was presented. It was noted Petitioner received ongoing treatment for depression and anxiety.

A lumbar spine MRI report (Exhibit J, pp. 1-2) dated [redacted], was presented. An impression of L3-L4 disc desiccation with small disc protrusion was stated. Mild bilateral facet arthropathy at L4-L5 and L5-S1 was stated. A congenitally narrow central canal due to mild epidural lipomatosis was stated. A large pelvic cyst was indicated; further study was recommended.

Social worker progress notes (Exhibit O, pp. 17-18) dated [redacted], were presented. Ongoing complaints of anxiety, depression, memory loss, and panic attacks were noted.

Psychiatrist progress notes (Exhibit O, pp. 19-20) dated [redacted], were presented. It was noted Petitioner "has not had any panic attacks." Petitioner reported anxiety will improve when her finances improve. Cymbalta, trazodone, and alprazolam were continued.

Social worker progress notes (Exhibit O, pp. 23-24) dated [redacted], were presented. Ongoing complaints of anxiety, depression, memory loss, and panic attacks were noted.

Social worker progress notes (Exhibit O, pp. 26-27) dated [redacted], were presented. Ongoing complaints of anxiety and depression were noted.

Various cancer treatment records (Exhibit 2, pp. 33-43 Exhibit C, pp. 1-249; Exhibit H pp. 1-11) were presented. The records were not notable other than being consistent with below-cited records and indicating increased complaints of fatigue by Petitioner in 2016.

Various mental health treatment notes including therapist notes and medication reviews (Exhibit B, pp. 1-157). The notes ranged from January 2015 through May 2016. Missed appointments, phone calls, and scheduling of appointments were regularly documented.

Medical center office visit notes (Exhibit N, pp. 7-9) dated [redacted], were presented. It was noted Petitioner complained of back pain (9/10), ongoing for 5 years. It was noted that a mass showed up on an MRI, which was being followed by Respondent's primary care physician. Medication refills were provided.

Psychiatrist medication review notes (Exhibit O, pp. 41-42) dated [redacted], were presented. Petitioner reported decreased anxiety. It was noted Petitioner was hired for employment at a grocery store (Petitioner did not mention employment during the hearing). Petitioner expressed concern about having a panic attack at work.

Petitioner presented an oncologist letter (Exhibit K, p. 1) dated [redacted]. The letter stated Petitioner was taking Tamoxifen daily, and would continue to do so for 3 more years. The letter stated Petitioner experiences "significant fatigue as a result of her treatment with tamoxifen, along with other side effects."

Medical center office visit notes (Exhibit N, pp. 1-3) dated [redacted], were presented. It was noted Petitioner complained of back pain, ongoing for 5 years. It was noted Petitioner had no range of motion restrictions in back. It was noted Petitioner was not interested in back injections. Norco was refilled.

Psychiatrist medication review notes (Exhibit O, pp. 41-42) dated [redacted], were presented. Petitioner reported accepting a new job, but not working due to back pain "and other issues." Petitioner reported sleep difficulty Petitioner stated she stays up

until 3 a.m. sometimes, and wakes up at 7:00 a.m. Petitioner reported she will try taking Cymbalta in the evening because she believes it makes her tired.

Social worker progress notes (Exhibit O, pp. 70-71) dated [redacted], were presented. Ongoing lethargy and depression complaints were noted.

Physician office visit notes (Exhibit Q, pp. 8-11) dated [redacted], were presented. It was noted Petitioner was counseled for surgery on a cyst. A complaint of urinary frequency was noted. It was noted a urinary tract infection was possible and that a urine culture would be evaluated.

Medical center office visit notes (Exhibit N, pp. 4-6) dated [redacted], were presented. It was noted Petitioner complained of back pain. It was noted Petitioner had no range of motion restrictions in back. It was noted Petitioner was not interested in back injections. Norco was refilled.

Petitioner presented a document from her treating cancer clinic (Exhibit K, p. 2). An appointment for salpingo-oophorectomy surgery on [redacted], was noted. Petitioner testified the purpose of surgery is to remove a blood-filled cyst from her spine.

Petitioner testified she is regularly fatigued due to Tamoxifen. Petitioner testified she lies down 4 times daily. Petitioner testified she takes 2-3 hour naps twice per day. Petitioner testified she spends the rest of her days attending medical appointments, watching television, and caring for her disabled adult child.

Petitioner testified she lost 30 pounds over the last 2 years. Petitioner was told she needs to lose more weight.

Petitioner testified she wears a brace on her right knee. Petitioner testified she has arthritis in both knees.

Petitioner testified she cannot raise her arm past her shoulder. Petitioner testified her oncologist and pain specialist restricted her to lifting/carrying of 5 pounds. Petitioner testified she also has carpal-tunnel syndrome in her left hand. Petitioner testified that she has “sticky fingers” which limits her finger function.

Petitioner testified she has a history of 10-15 psychiatric-related hospitalizations Petitioner testified she was last hospitalized in April 2016 when she went because of tachycardia. Petitioner testified she was also hospitalized in March 2016. Petitioner testified she has anxiety “all the time.” Petitioner testified her last panic attack occurred 5 days before the hearing. Petitioner testified her attacks feel like a heart attack and leave her gasping for air. Petitioner testified medications (Xanax, Cymbalta and a third medication) help to keep her stable.

Petitioner testified her medications cause her to feel sluggish and “out of it.” Petitioner testified she has “chemo brain” and memory loss from her cancer medication.

Petitioner testified knee and back pain restrict her to walking for less than 15 minutes, standing for less than 5 minutes, and sitting of 30 minutes. Petitioner testified she cannot walk more than 2 stairs due to knee pain. Petitioner testified she does not use a walking-assistance device.

Petitioner testified her showering is limited because of standing restrictions. Petitioner testified she is unable to vacuum due to back pain. Petitioner testified she is unable to wash dishes due to grasping difficulties. Petitioner testified she is unable to do laundry due to difficulty with stairs. Petitioner testified she cannot shop for herself.

Petitioner alleged ambulation and lifting/carrying restrictions, in part due to “severe” right ankle tendonitis. Abnormal right ankle radiology and treatment of right ankle dysfunction was verified. Patellofemoral disorder, lumbar spine disorder, and plantar fasciitis treatment were also verified. Treatment history sufficiently verified degrees of ambulation, lifting/carrying, and/or standing restriction

Petitioner alleged restrictions related to anxiety. Complaints and treatment for anxiety were verified. Presented evidence sufficiently implied a degree of social functioning and/or concentration and persistence restrictions.

Petitioner testimony conceded her cancer is in remission, however, she alleged disability, in part, due to side effects of necessary chemotherapy medication. Petitioner alleged the medication causes a degree of fatigue and/or “chemo brain.” Presented records verified a need to take the medication and some degree of fatigue and concentration restrictions can be inferred.

Petitioner testified she is limited in use of her left arm. Petitioner blamed the dysfunction on cancer surgery which removed lymph nodes from her arm area.

Presented medical records generally verified a medical treatment history with Petitioner’s general allegations of restrictions. The treatment history was established to last since at least December 2016. Accordingly, it is found that Petitioner established having a severe impairment and the disability analysis may proceed to Step 3.

The third step of the sequential analysis requires determining whether the Petitioner’s impairment, or combination of impairments, is listed in 20 CFR Part 404, Subpart P, appendix 1. 20 CFR 416.920 (a)(4)(iii). If a petitioner’s impairments are listed and deemed to meet the durational requirement, then the petitioner is deemed disabled. If the impairment is unlisted or impairments do not meet listing level requirements, then the analysis proceeds to the next step.

A listing for joint dysfunction (Listing 1.02) was considered based on Petitioner's complaints of knee pain. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively.

A listing for spinal disorders (Listing 1.04) was considered based on Petitioner's lumbar complaints. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root.

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

A listing for anxiety-related disorders (Listing 12.06) was considered based on a diagnosis of an anxiety disorder. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Petitioner had a complete inability to function outside of the home.

A listing for breast cancer (Listing 13.10) was considered based on Petitioner's medical history. The listing was rejected due to a lack of evidence of ongoing carcinoma.

It is found that Petitioner's treatment history failed to establish meeting (or equaling) a SSA listing. The finding is consistent with hearing statements of Petitioner's AHR that Petitioner's circumstances do not meet any SSA listings. Accordingly, the disability analysis may proceed to the fourth step.

The fourth step in analyzing a disability claim requires an assessment of the Petitioner'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 petitioner 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.

Petitioner testified she worked as a part-time cashier in 2005 and 2011. Client also worked as a part-time customer service representative at an airport in 2008-2009. Neither job will be considered in the analysis because it is presumed the employment did not amount to SGA earnings.

Petitioner testified she worked from 2007-2014 as a security guard. Petitioner testified her duties including patrolling job sites (sometimes in a vehicle and sometimes on foot) and corresponding with clients.

Petitioner testified she worked a nursing assistant from 2001-2007. Petitioner testified her duties included changing beds and dressing patients.

Petitioner testimony implied she was not capable of the standing, ambulation and/or concentration required to perform previous employment. For purposes of this decision, Petitioner's testimony will be accepted. It is found Petitioner is unable to perform past and relevant employment. Accordingly, the analysis may proceed to the final step.

In the fifth step in the process, the individual's RFC in conjunction with his or her age, education, and work experience, are considered to determine whether the individual can engage in any other substantial gainful work which exists in the national economy. SSR 83-10. While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). To determine the physical demands (i.e. exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967.

Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b) Even though weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are

additionally limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.*

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.*

Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.*

Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands are considered non-exertional. 20 CFR 416.969a(a). Examples of non-exertional limitations include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (e.g. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i)-(vi) If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2)

The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.* In using the rules of Appendix 2, an individual's circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, is compared to the pertinent rule(s).

Given Petitioner's age, education and employment history a determination of disability is dependent on Petitioner's ability to perform sedentary employment. For sedentary employment, periods of standing or walking should generally total no more than about 2 hours of an 8-hour workday. Social Security Rule 83-10.

Physician statements of restriction were provided. SSR 96-2p states that if a treating source's medical opinion is well-supported and not inconsistent with the other substantial evidence in the case record, it must be given controlling weight (i.e. it must be adopted). Treating source opinions cannot be discounted unless the Administrative

Law Judge provides good reasons for discounting the opinion. *Rogers v. Commissioner,* 486 F. 3d 234 (6th Cir. 2007)*; Bowen v Commissioner.*

A letter from a treating oncologist (Exhibit G, p. 6) dated [redacted], was presented. It was stated Petitioner was unable to return to work "at this time" due to severe fatigue from radiation and chemotherapy side effects.

Subsequent treatment records verified Petitioner was no longer on radiation treatment after August 2014. Petitioner did not apply for SDA benefits until [redacted]. Thus, a physician statement advising Petitioner could not work as of August 2014 is not found to be insightful evidence of Petitioner's abilities as of December 2016.

A Mental Impairment Questionnaire (Exhibit G, pp. 2-7) dated [redacted], was presented. The assessment was completed by a social worker from a treating mental health agency. Petitioner's GAF was stated to be 55. Petitioner was assessed to have marked concentration and social functioning difficulties. Moderate daily living restrictions were stated. It was opined that Petitioner's impairments would cause her to be absent more than 4 days per month from employment.

The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF within the range of 51-60 is representative of someone with moderate symptoms or any moderate difficulty in social, occupational, or school functioning. Generally a GAF of 55 is not consistent with marked concentration and social restrictions. This consideration lessens the source's credibility. More problematic for Petitioner is that a social worker is not an acceptable medical source.

SSR 06-03p provides guidance on what SSA accepts as "acceptable medical sources". Licensed physicians and licensed or certified psychologists are acceptable medical sources. Nurse practitioners and social workers are not "acceptable medical sources". SSR 06-03p goes on to state why the distinction between medical sources and non-medical sources is important.

> First, we need evidence from "acceptable medical sources" to establish the existence of a medically determinable impairment. Second, only "acceptable medical sources" can give us medical opinions. Third, only "acceptable medical sources" can be considered treating sources, as defined in 20 CFR 404.1502 and 416.902, whose medical opinions may be entitled to controlling weight.

Petitioner's AHR contended that being 4 days or more absent per month is indicative of disability. The contention is logical, however, the statement of Petitioner's likely work absences did not come from an acceptable medical source. Thus, the statement will be disregarded.

A Medical Source Statement of Ability to Do Work-Related Activities (Physical) (Exhibit F, pp. 1-7) dated [redacted] was presented. The assessment was completed by

Petitioner's treating orthopedic physician. A total lifting/carrying restriction was stated. Petitioner was restricted to performing the following activities: 30 minutes of sitting, 5-10 minutes of standing, and 10 minutes of walking; the same restrictions applied to an 8 hour workday. It was stated Petitioner did not require a cane to ambulate. Petitioner was totally restricted form using left hand to perform reaching, pushing/pulling, handling, feeling, or fingering. Petitioner was restricted to occasional performance of the same activities with her right hand. Petitioner was restricted to occasional performance of operating foot controls. Petitioner was totally restricted form kneeling, crouching, crawling, stooping, climbing stairs, and climbing ladders. Petitioner was deemed incapable of shopping, traveling without a companion, walking a block at a reasonable pace, using public transportation, or climbing a few stairs using a handrail, or sorting or handling paper/files. The stated basis of restrictions was posterior tibial tendon dysfunction of the right foot.

Presented evidence did not verify the occurrence of actual functional capacity testing. The absence of such testing renders the statements to be less credible than those made following such testing.

It was curious that Petitioner's single period capabilities matched her capabilities for an 8 hour workday. To accept the physician's statement would require accepting that Petitioner required 24 hours of rest before repeating 10 minutes of standing or ambulation, or 30 minutes of sitting. Such a restriction is theoretically possible, however, it is unlikely given presented evidence.

Petitioner's physician imposed a total lifting/carrying restriction, stated Petitioner could not walk even a block at a reasonable pace, and stated Petitioner could not climb stairs with a handrail. The stated restrictions would be more consistent with a person requiring a cane or a walker; Petitioner's physician indicated no such need. This consideration supports the stated restrictions were exaggerated.

The only stated basis for restriction was right foot dysfunction. It is not understood how right foot dysfunction would limit Petitioner to sitting for 30 minutes or impact Petitioner's ability to handle paper/files.

Sitting restrictions could be justified by lumbar spine dysfunction. Presented radiology verified a "small" disc protrusion, "mild" facet arthropathy, and "mild" lipomatosis. The descriptions of "mild" and "small" are not indicative of significant sitting restrictions. Also notable was the absence of stenosis as a diagnosis. It is plausible that a pelvic cyst increased lumbar pain, however, such a conclusion would be speculative.

Restrictions to pushing/pulling, reaching, and other hand/arm movements could be justified to Petitioner's left arm due to the removal of lymph nodes. There was no treatment history justifying the same restrictions to Petitioner's right (also her dominant) hand/arm.

It is found the statements of restriction by Petitioner's orthopedic physician were not persuasive. More realistic restrictions can be inferred from presented evidence.

Grade II PTTD was listed as a diagnosis. The diagnosis is consistent with flat-footedness. The diagnosis, along with knee dysfunction would reasonably limit Petitioner to employment no more exertional than sedentary employment. The evidence must be further evaluated to determine if Petitioner is capable of all types of sedentary employment.

Petitioner presented multiple Mental Impairment Medical Source Statements (Exhibit R, pp. 2-7; Exhibit T pp. 1-6) dated [redacted]. One of the statements listed signatures from a social worker and behavioral center physician. A second statement listed a second physician's signature. It was noted Petitioner attended regular case management, individual therapy, and psychiatric sessions. A GAF was not provided. Listed symptoms included weight change, sleep disturbance, mood disturbance, emotional liability, recurrent panic attacks, time or place disorientation, social withdrawal or isolation, decreased energy, concentration difficulty, generalized persistent anxiety, and persistent irrational fears. Prescribed medications included Alprazolam and Cymbalta. In response to a question asking if Petitioner's impairments would cause her to be absent from work, checkmarks were placed at 1, 2, 3, 3+ times per month. Petitioner was deemed to have poor or no ability to maintain regular attendance and punctuality, completing a normal workday without interruption from symptoms, perform at a reasonable pace without unreasonable rest periods. Petitioner was deemed to have fair ability to maintain attention for 2 hour segments, respond appropriately to work setting changes, deal with normal work stress, and taking public transportation. Petitioner was deemed to have moderate restriction of ADLs. Petitioner was deemed to have "marked" social function deficiencies. Petitioner was deemed to have "continual" episodes of decompensation in work or work like settings. Petitioner was deemed to have "frequent" concentration difficulties resulting in failures to complete tasks.

Generally, marked restrictions in abilities to maintain attendance and punctuality, working at a reasonable pace, and completing a workday without psychological interruption are indicative of an inability to perform any employment. This consideration supports a finding that Petitioner is disabled.

It is debatable whether Petitioner's non-exertional impairments, by themselves, justify a finding that Petitioner is unable to perform any employment. The combination of Petitioner's exertional and non-exertional restrictions render the probability of Petitioner maintaining any employment to be improbable. MDHHS did not provide evidence of employment available to Petitioner given her various restrictions.

It is found Petitioner is a disabled individual as of December 2016. It cannot be stated that MDHHS erred by denying Petitioner's application on [redacted], though the finding does justify processing of Petitioner's SDA eligibility from December 2016. The below order reflects that MDHHS are "reversed", though it is acknowledged to be an

inaccurate representation because MDHHS had no responsibility to make such a finding.

DECISION AND ORDER

The administrative law judge, based upon the above findings of fact and conclusions of law, finds that Petitioner withdrew the hearing request concerning MA benefits. Petitioner's hearing request is **PARTIALLY DISMISSED**.

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that MDHHS properly denied Petitioner's SDA benefit eligibility through November 2016, based on a determination that Petitioner is not disabled. The actions taken by MDHHS are **PARTIALLY AFFIRMED**.

The administrative law judge, based upon the above findings of fact and conclusions of law, finds that Petitioner is disabled as of December 2016. It is ordered that MDHHS begin to perform the following actions within 10 days of the date of mailing of this decision:

(1) reinstate Petitioner's SDA benefit application dated [redacted];
(2) evaluate Petitioner's eligibility subject to the finding that Petitioner is a disabled individual **AS OF DECEMBER 2016**;
(3) initiate a supplement for any benefits not issued as a result of the application denial; and
(4) schedule a review of benefits in one year from the date of this administrative decision, if Petitioner is found eligible for future benefits.

The actions taken by MDHHS are **REVERSED**.

CG/hw

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

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; 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

DHHS

[redacted]

Counsel for Petitioner

[redacted]

Petitioner

[redacted]