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

IN THE MATTER OF:

[redacted]

Reg. No.: 2013-3862
Issue No.: 2009; 4031
Case No.: [redacted]
Hearing Date: March 26, 2013
County: Wayne-76

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

HEARING DECISION

This matter is before the undersigned Administrative Law Judge upon Claimant's request for a hearing made pursuant to Michigan Compiled Laws 400.9 and 400.37, which govern the administrative hearing and appeal process. After due notice, a telephone hearing was commenced on March 26, 2013, from Lansing, Michigan. Claimant personally appeared and testified. Participants on behalf of the Department of Human Services (Department) included Eligibility Specialist [redacted] [redacted]

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional medical evidence. The new evidence was forwarded to the State Hearing Review Team ("SHRT") for consideration. On July 25, 2013, the SHRT found Claimant was not disabled. This matter is now before the undersigned for a final decision.

ISSUE

Whether the Department of Human Services (the department) properly denied Claimant's application for Medical Assistance (MA-P), Retro-MA and State Disability Assistance (SDA)?

FINDINGS OF FACT

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

(1) On June 6, 2012, Claimant filed an application for MA-P, Retro-MA and SDA benefits alleging disability.

(2) On September 6, 2012, the Medical Review Team (MRT) denied Claimant's application for MA-P, Retro-MA, and SDA were denied due to lack of duration. (Depart Ex. A, pp 4-5).

(3) On September 11, 2012, the department caseworker sent Claimant notice that her application was denied.

(4) On October 4, 2012, Claimant filed a request for a hearing to contest the department's negative action.

(5) On November 3, 2012, the State Hearing Review Team (SHRT) found Claimant was not disabled and retained the capacity to perform light work. (Depart Ex B, pp 1-2).

(6) Claimant has a history of hypertension, diabetes, herniated discs and depression.

(7) Claimant is a 47 year old woman whose birthday is [redacted]. Claimant is 5'3" tall and weighs 127 lbs. Claimant completed the ninth grade.

(8) Claimant had applied for Social Security disability benefits at the time of the hearing.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department, (DHS or department), pursuant to MCL 400.10 *et seq.* and MCL 400.105. Department policies are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM), and the Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. The Department of Human Services (DHS or department) administers the SDA program pursuant to MCL 400.10, *et seq.*, and Mich Admin Code, Rules 400.3151-400.3180. Department policies are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

Current legislative amendments to the Act delineate eligibility criteria as implemented by department policy set forth in program manuals. 2004 PA 344, Sec. 604, establishes the State Disability Assistance program. It reads in part:

> Sec. 604 (1). The department shall operate a state disability assistance program. Except as provided in subsection (3), persons eligible for this program shall include needy citizens of the United States or aliens exempt from the Supplemental Security Income citizenship requirement who are at least 18 years of age or emancipated minors meeting one or more of the following requirements:

> (b) A person with a physical or mental impairment which meets federal SSI disability standards, except that the minimum duration of the disability shall be 90 days. Substance abuse alone is not defined as a basis for eligibility.

Specifically, this Act provides minimal cash assistance to individuals with some type of severe, temporary disability which prevents him or her from engaging in substantial gainful work activity for at least ninety (90) days.

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a). The person claiming a physical or mental disability has the burden to establish it 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 CRF 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). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and, (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (e.g., age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945.

The regulations require that if disability can be ruled out at any step, analysis of the next step is not required. These steps are:

1. If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or your age, education, and work experience. 20 CFR 416.920(b). If no, the analysis continues to Step 2.

2. Does the client have a severe impairment that has lasted or is expected to last 12 months or more or result in death? If no, the client is ineligible for MA. If yes, the analysis continues to Step 3. 20 CFR 416.909(c).

3. Does the impairment appear on a special Listing of Impairments or are the client's symptoms, signs, and laboratory findings at least equivalent in severity to the set of medical findings specified for the listed impairment that meets the duration requirement? If no, the analysis continues to Step 4. If yes, MA is approved. 20 CFR 416.920(d).

4. Can the client do the former work that he/she performed within the last 15 years? If yes, the client is ineligible for MA. If no, the analysis continues to Step 5. Sections 200.00-204.00(f)?

5. Does the client have the Residual Functional Capacity (RFC) to perform other work according to the guidelines set forth at 20 CFR 404, Subpart P, Appendix 2, Sections 200.00-204.00? This step considers the residual functional capacity, age, education, and past work experience to see if the client can do other work. If yes, the analysis ends and the client is ineligible for MA. If no, MA is approved. 20 CFR 416.920(g).

At application Claimant has the burden of proof pursuant to:

> . . . You must provide medical evidence showing that you have an impairment(s) and how severe it is during the time you say that you are disabled. 20 CFR 416.912(c).

Federal regulations are very specific regarding the type of medical evidence required by claimant to establish statutory disability. The regulations essentially require laboratory or clinical medical reports that corroborate claimant's claims or claimant's physicians' statements regarding disability. These regulations state in part:

Medical reports should include --

(1) Medical history.

(2) Clinical findings (such as the results of physical or mental status examinations);

(3) Laboratory findings (such as ultrasounds, X-rays);

(4) Diagnosis (statement of disease or injury based on its signs and symptoms). 20 CFR 416.913(b).

Statements about your pain or other symptoms will not alone establish that you are disabled; there must be medical signs and laboratory findings which show that you have a medical impairment. 20 CFR 416.929(a). The medical evidence must be complete and detailed enough to allow us to make a determination about whether you are disabled or blind. 20 CFR 416.913(d).

Medical findings consist of symptoms, signs, and laboratory findings:

(a) **Symptoms** are your own description of your physical or mental impairment. Your statements alone are not enough to establish that there is a physical or mental impairment.

(b) **Signs** are anatomical, physiological, or psychological abnormalities which can be observed, apart from your statements (symptoms). Signs must be shown by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomena which indicate specific psychological abnormalities e.g., abnormalities of behavior, mood, thought, memory, orientation, development, or perception. They must also be shown by observable facts that can be medically described and evaluated.

(c) **Laboratory findings** are anatomical, physiological, or psychological phenomena which can be shown by the use of a medically acceptable laboratory diagnostic techniques. Some of these diagnostic techniques include chemical tests, electrophysiological studies (electrocardiogram, electroencephalogram, etc.), roentgenological studies (X-rays), and psychological tests. 20 CFR 416.928.

It must allow us to determine --

(1) The nature and limiting effe cts of your impairment(s) for any period in question;

(2) The probable duration of your impairment; and

(3) Your residual functional capac ity to do work-related physical and mental activities. 20 CFR 416.913(d).

Information from other sources may also help us to understand how your impairment(s) affects your ability to work. 20 CFR 416.913(e). You can only be found dis abled if you are unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a co ntinuous period of not less than 12 months. See 20 CF R 416.905. Your impairment must re sult from anatomical, physiologic al, or psychological abnormalities which are demons trable by medically acc eptable clinica l and laboratory diagnostic techniques. 20 CFR 416.927(a)(1).

Applying the sequential analys is herein, Claimant is not ine ligible at the first step as Claimant is not currently working. 20 CFR 416.920(b). The analysis continues.

As outlined above, the first step looks at the i ndividual's current work activity. In the record presented, Claimant is not involved in substantial gainful activity and testified that she has not worked since 1992. Theref ore, she is not dis qualified from receivin g disability benefits under Step 1.

The severity of the individ ual's alleged impairment(s) i s considered under Step 2. The individual bears the burden to present suffi cient objective medical evidenc e to substantiate the alleged disa bling impairments. In order to be considered disabled for MA purpos es, the impairment must be se vere. 20 CFR 916. 920(a)(4)(ii); 20 CFR 916.920(b). An impairment, or co mbination of impairments, is severe if it signific antly limits an in dividual's p hysical or mental ability to do basic wo rk activities re gardless of age, education and work exper ience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities means the abilities and aptitude s necessar y to do most jobs. 20 CFR 916.921(b). Examples include:

1. Physical functions such as walk ing, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

5. Responding appropriately to supervision, co-workers and usual work situations; and

6. Dealing with changes in a routine work setting. *Id.*

The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). An impairment qualifies as non-severe only if, regardless of a claimant's age, education, or work experience, the impairment would not affect the claimant's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985).

In the present case, Claimant alleges disability due to hypertension, diabetes, herniated discs and depression.

On December 12, 2011, Claimant underwent surgery for a septic right shoulder joint and bursa as well as a right shoulder soft tissue abscess. There was an infectious disease consultation based on her history of IV drug abuse, heroin dependency, and skin popping. Claimant stated that she had skin popped heroin into her right shoulder approximately 4-5 days before the surgery and following that episode she began to notice increasing pain and swelling in her right shoulder.

On May 29, 2012, Claimant presented to the emergency room after a car accident following by the ankle pain and swelling while she was riding a bicycle. Pain was in the left shoulder, hand and left ankle. She denied any loss of consciousness. She was admitted. An x-ray of the left ankle showed she had a trimalleolar type fracture. The CT scan of the left ankle showed a type 2 pylon fracture of the ankle. Claimant's medical history was notable for drug abuse which included heroin and crack cocaine, bronchitis and depression. No cardiac history symptoms. She did admit to snorting heroin about five to ten dollars' worth at a time on a daily basis for the last several years. She stated she was not using on the day of the accident. Except for the isolated orthopedic injury, she had no acute traumatic injury. A drug screen was positive for cocaine. On June 1, 2012, Claimant underwent an open reduction internal fixation of the left tibia and the application of a short leg cast. She was discharged with a walker on 6/4/12.

On August 27, 2012, Claimant saw her orthopedic surgeon for follow-up. Claimant was 12 weeks post status surgery and was doing reasonably well. She stated she had mild swelling in her ankle when walking for long periods of time, but otherwise feels great. She was in acute distress. Her incision was healing well. Her range of motion was decreased. There was mild edema about the left ankle and shin. The scar was well healed. She was nontender in the area of the fracture. The ankle motion was slightly

reduced. Her surgeon opined that she could bear weight as tolerated and begin physical therapy for gait, balance, and range of motion.

On August 31, 2012, Claimant saw her primary care physician complaining of left ankle and leg pain, and right shoulder pain. Her low back was doing well. Her physician noted she is basically the same. Her cervical spine has no tenderness to palpation and no restriction of motion. Her lumbar spine has mild tenderness with restriction of motion in forward flexion, extension, side bending left and right and with rotation left and right. Her right shoulder has restriction of motion in abduction. Her left ankle was tender with restriction of motion. Diagnosis: Status post motor vehicle accident; Lumbar strain improved; Left ankle strain; Left leg strain; and Right shoulder sprain. She was referred to physical therapy three times a week for four weeks. An MRI of her lumbar spine and right shoulder were ordered.

On September 19, 2012, an MRI of the Right Ankle without contrast revealed a bony fragmentation and regional abnormal bone marrow edema about the posterior talus which may reflect accessory ossicle with superimposed injury. There was also small fluid within the flexor hallucis longus tendon as it traverses posteriorly to the talus. The tendon itself appears intact. This may reflect tenosynovitis. The MRI of the Left Ankle showed a prominent osteochondritis dissecans lesion involving the mid aspect of the medial talar dome. There was an essentially nondisplaced incompletely healed transverse fracture through the lateral malleolus with adjacent bone marrow and subcutaneous edema. There was also avascular necrosis of the tarsal navicular bone and moderate to advanced degenerative changes of the talonavicular articulation.

On September 20, 2012, the MRI of the Cervical Spine without contrast showed the cervical spinal cord had normal signal and morphology. The cerebellar tonsils were in normal position. C2-C3, C3-C4, C4-C5 and C7-T1 were normal. At C5-C6 there was a 7mm central disc herniation that approximates the anterior ventral surface of the cervical cords. There was also bilateral neural foraminal narrowing with no canal stenosis. At C6-C7 there was an 8mm central disc herniation that encroaches on the anterior ventral surface of the cervical cord with mild bilateral neural foraminal narrowing. There were also noted some possible disc herniations in the upper thoracic spine specifically T3-T and T4-T5 on the left. The MRI of the Lumbar Spine without contrast revealed disc desiccation and diffuse disc bulging with facet changes at L3-L4, L4-L5 and L5-S1. There was no focal disc protrusion to suggest definite lumbar spine disc herniation. There was some possible compression deformity of the superior endplate of T11. The MRI examination of the Brain without contrast found no acute intracranial abnormal MR signal.

On September 29, 2012, Claimant saw her treating physician complaining of pain in the ankle, status post fracture with open reduction and internal fixation with metal plates and screws. Claimant had been in physical therapy three times a week the past several weeks. She also had a right shoulder injury and low back pain that was worse with activities of daily living, walking up and down the stairs and squatting. There were scars over the ankle. Some crepitus and swelling was also present. There was decreased

range of motion and decreased st rength against resistance. There was tenderness in the lumbar spine from L3 to S1 with guar ding. She had decreas ed range of motion and decreased strength against resistanc e. Straight leg rais ing caused back pain. She had decreased sensation at S1. The compressi on tests reproduced her neck pain from C3 to T1. There was decreased range of motion and decreased strength agains t resistance in paraspinal muscles. She has ce rvical ruptured discs at C5-C6 and C6-C7 confirmed by MRI. She also has lumbar degenerative disc disease from L3 to S 1 confirmed by MRI. Claimant wa s instructed to continue ph ysical therapy. She was to continue pain management with t he addition of epidural steroid injections to the cervical and lumbar spines. Household replacement serv ices were to be ordered, in addition to transportation to and from doctor' s visits. C are for her children and attendant care for herself for 8 hours a day 7 days a week was also recommended. The treating physician opined that Claimant was dis abled from bending, lifting, twisting, turning, pushing, pulling and squatting and would be re-evaluated in six weeks.

On October 27, 2012, Claimant followed up with her treating phy sician regarding her lower back, left shoulder and ankle pain. Claimant has attendant care eight hours a day seven days a week. Claimant stated s he gets diz zy and light headed. She stated she is sch eduled for right ankle surgery on 6/27/13. Clin ically, she was u nchanged. She had tenderness, guarding, decreased c ervical lordosis, decreased range of motion and decreased strength against resistance to the cervical and thor acic spines. Compression test reproduces her neck pain. The treating physician ordered continue d physical therapy, epidural steroid injectio ns, attendant care, household r eplacement services, care for her children and transpor tation to and from doctor vi sits. The physician opined that Claimant was disabled from bending, lif ting, twisting, turning, pushing, pulling and squatting and would be re-evaluated in six weeks.

On December 7, 2012, an MRI of the Ri ght Shoulder without contrast showed a complex partial-thickness tear of the distal rotator cuff te ndon near its attachment with regional abnormal bone marrow signal of t he superolateral humeral head near the attachment of the rotator cuff tendon. Cor relation with prior surgical intervention was recommended and reference to pr ior shoulder exam as surg ical change with possible reinjury could have this appearance. There was also ir regular na rrowing of glenohumeral relationship with grade 2 SLAP t ear of the glenoid labrum. In addition, there was AC joint degenerativ e irregularit y with downward type 2 sloping acromion contributing to encroachment on the distal supraspinatus.

On December 14, 2012, Claima nt followed up with her treati ng physician indicating she is feeling better and the phys ical therapy and medications are definitely helping. She also stated her ankle is bette r. Clinica lly she is imp roving. She has tenderness to palpation with restrictio n of motion in the lum bar spine in forward flexion, extension and with s ide bending left and right and rotation left and right. T he phys ician ordere d continued physical therapy, hous ehold replacement services and transportation to and from doctor visits. The physic ian opined that Claim ant was di sabled from bending, lifting, twisting, turning, pushing, pulling and squatting and would be re-evaluated in one month.

On January 4, 2013, Claimant was evaluated by the pain clinic. A review of her cervical MRI showed two herniated discs at level of C5-C6 and C6-C7 which are central to right paracentral. She also has facet joint changes. The lumbar MRI shows mostly facet joint changes with no critical stenosis or herniation. Lumbar range of motion is restricted for flexion and extension. She has positive facet loading maneuver on the right, negative on the left. Range of motion for the cervical spine is decreased for extension and right rotation. There is significant tenderness along the facet joints on the right side. Range of motion in the right shoulder is restricted. There is scarring and evidence of multiple previous surgeries. There is also evidence of left ankle surgery as well. Diagnosis: Right sided neck pain without radicular symptomology. The consulting physician opined that her pain is mostly coming from the facet joints because of the radiation to the occipital area, most probably from the C2-C3, C3-C4 and C4-C5 facet joints. She also has low back pain with no radicular symptomology, also most probably coming from the facet joints. A cervical/diagnostic/therapeutic medial branch block was discussed and recommended. She would also be a candidate for radiofrequency ablation to denervate the facet joint and give her longer-lasting pain relief.

On January 11, 2013, Claimant followed up with her treating physician, indicating she is feeling better and the physical therapy and medications are helping. Clinically she is improving. She has tenderness to palpation with restriction of motion in the lumbar spine in forward flexion, extension and with side bending left and right and rotation left and right. The physician ordered continued physical therapy, epidural steroid injections to the cervical spine, household replacement services and transportation to and from doctor visits. The physician opined that Claimant was disabled from bending, lifting, twisting, turning, pushing, pulling and squatting and would be re-evaluated in one month.

On January 29, 2013, Claimant underwent a mental status evaluation on behalf of the Disability Determination Service. Claimant stated she was hit by a car on 5/29/12 resulting in six screws, two bolts and a plate in her foot. She is afraid to cross the street since she was hit by a car. She said she dreams about it. She has been psychiatrically hospitalized at age 14 after taking some of her mother's medications. She was not trying to kill herself and was in the hospital for three weeks at that time. She denied drug or alcohol use, but medical records show a history of intravenous drug abuse and skin popping as well as a history of prior right lower extremity infection related to drug abuse. Claimant presented as being in adequate overt contract with reality, with no evidence of an overt thought disorder. She appeared to be an accurate historian, without evident tendency to exaggerate or minimize symptoms. Claimant states she sees spots and hears things now and then. She does not hear voice, but hears noises like tapping. She does feel others are plotting against her. She reported suicidal thoughts sometimes, but no history of attempts. She stated she gets messages from the radio and television. Claimant demonstrated moderately intact capacity to concentrate as evidenced by performance on calculational tasks and slight to moderate strengths in immediate memory and the capacity to pay attention, but significant problems with short term memory. She displayed concrete thinking and variability in terms of capacity for judgment and impulse control. She would appear capable of

engaging in work type activities of a simple nature, remembering and executing a two or three-step repetitive procedure on a sustained basis with little in the way of independent judgment or decision making required. Diagnosis: Axis I: Posttraumatic stress disorder (PTSD) secondary to injuries from being hit by car; History of IV drug abuse and skin popping, denied by Claimant; Axis II: No diagnosis; Axis IV: Single mother of eight children; Axis V: GAF=51. Prognosis is fair.

The second step of the analysis looks at a two-fold assessment of duration and severity. 20 CFR 416.920(c). This second step is a *de minimus* standard. Ruling any ambiguities in Claimant's favor, this Administrative Law Judge (ALJ) finds that Claimant meets both. The analysis continues.

The third step of the analysis looks at whether an individual meets or equals one of the Listings of Impairments. 20 CFR 416.920(d). Claimant does not. The analysis continues.

The fourth step of the analysis looks at the ability of the applicant to return to past relevant work. This step examines the physical and mental demands of the work done by Claimant in the past. 20 CFR 416.920(f). In this case, Claimant has a history of less than gainful employment. As such, there is no past work for Claimant to perform, nor are there past work skills to transfer to other work occupations. Accordingly, Step 5 of the sequential analysis is required.

The fifth and final step of the analysis applies the biographical data of the applicant to the Medical Vocational Grids to determine the residual functional capacity of the applicant to do other work. 20 CFR 416.920(g). See *Felton v DSS* 161 Mich. App 690, 696 (1987). Once Claimant reaches Step 5 in the sequential review process, Claimant has already established a *prima facie* case of disability. *Richardson v Secretary of Health and Human Services,* 735 F2d 962 (6th Cir, 1984). At that point, the burden of proof is on the state to prove by substantial evidence that Claimant has the residual functional capacity for substantial gainful activity.

After a careful review of the credible and substantial evidence on the whole record, this Administrative Law Judge finds that Claimant's exertional and non-exertional impairments render Claimant unable to engage in a full range of even sedentary work activities on a regular and continuing basis. 20 CFR 404, Subpart P. Appendix 11, Section 201.00(h). See Social Security Ruling 83-10; *Wilson v Heckler*, 743 F2d 216 (1986).

In this case, as of April 13, 2013, Claimant's treating physician had restricted her from driving in all circumstances and indicated on a Disability Certificate that Claimant is disabled from work, housework and driving through May 10, 2013. Her treating physician has completed monthly Disability Certificates since June 8, 2012. Her treating physician opined that Claimant is disabled based on her herniated discs and chronic pain. Because Claimant's treating physician's opinion is well supported by

medically acceptable clinical and laboratory diagnostic techniques, it has controlling weight. 20 CFR 404.1527(d)(2).

This evidence, as already noted, does rise to statutory disability. It is noted that at review Claimant's current medical records, if she has not already received a fully favorable decision from SSA, will be assessed as controlling with regards to continuing eligibility.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides the department erred in determining Claimant is not currently disabled for MA/Retro-MA and SDA eligibility purposes.

Accordingly, the department's decision is **REVERSED**, and it is ORDERED that:

1. The department shall process Claimant's June 6, 2012, MA/Retro-MA and SDA application, and shall award her all the benefits she may be entitled to receive, as long as she meets the remaining financial and non-financial eligibility factors.

2. The department shall review Claimant's medical condition for improvement in August, 2014, unless her Social Security Administration disability status is fully approved by that time.

3. The department shall obtain updated medical evidence from Claimant's treating physicians, physical therapists, pain clinic notes, etc. regarding her continued treatment, progress and prognosis at review.

It is SO ORDERED.

Vicki L. Armstrong
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: August 22, 2013

Date Mailed: August 23, 2013

NOTICE: Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative Hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the mailing of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt date of the rehearing decision.

Claimant may request a rehearing or reconsideration for the following reasons:

- A rehearing **MAY** be granted if there is newly discovered evidence that could affect the outcome of the original hearing decision.
- A reconsideration **MAY** be granted for any of the following reasons:

  - misapplication of manual policy or law in the hearing decision,
  - typographical errors, mathematical error, or other obvious errors in the hearing decision that effect the substantial rights of the claimant:
  - the failure of the ALJ to address other relevant issues in the hearing decision.

Request must be submitted through the local DHS office or directly to MAHS by mail at

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P. O. Box 30639
Lansing, Michigan 48909-07322

VLA/las

cc: [redacted]