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

IN THE MATTER OF:

[redacted]

Reg. No.: 20148114
Issue No(s).: 2009; 4009
Case No.: [redacted]
Hearing Date: February 27, 2014
County: Kent 41 (00)

ADMINISTRATIVE LAW JUDGE: Robert J. Chavez

HEARING DECISION

Following Claimant's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on February 27, 2014, from Detroit, Michigan. Participants on behalf of Claimant included [redacted]. Participants on behalf of the Department of Human Services (Department) included [redacted], APS, [redacted] ES, and [redacted] Analyst.

ISSUE

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

FINDINGS OF FACT

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

1. Claimant applied for MA-P and SDA on April 20, 2012.

2. On July 11, 2012, claimant was approved for SDA benefits, and denied MA-P benefits.

3. The Department proceeded to incorrectly open both SDA and MA-P benefits for the claimant, though claimant had not been approved for MA-P by the Medical Review Team (MRT).

4. On May 30, 2013, it was discovered that claimant had been incorrectly approved for MA-P benefits and that claimant was overdue for an SDA medical review; claimant was sent a medical packet to start the medical review process.

5. MA-P benefits were not closed at this time.

6. On June 10, 2013, the Department had claimant file a new application for MA-P and SDA benefits.

7. On July 30, 2013, all medical evidence was forwarded to MRT.

8. Claimant was [redacted] years old during the time of the MRT decisions and case closure.

9. Claimant has a limited education.

10. Claimant is not currently working.

11. Claimant has a work history consisting of machine operator, hi-lo driver, and die setter.

12. These jobs were worked at the heavy exertional levels, and required extensive carrying, lifting, and standing.

13. Claimant has a medical history of degenerative disc disease, diabetes, and neuropathy.

14. An MRI conducted in March, 2012, notes a large disc extrusion at the L4-5 level with significant nerve root compression.

15. In April, 2012 claimant underwent a disc fusion at the L4-5 level.

16. Treatment notes from 2013 noted post-lumbar laminectomy syndrome, with right-sided pain; more recent pain management notes showed that pain control injections were only 50% effective for three days.

17. An independent examination conducted in September, 2013 gave claimant less than sedentary limitations, and noted decreased range of lumbar motion, a need for a cane, decreased strength in the lower right extremity, and intact sensation and reflexes.

18. Claimant testified to inability to stand for extended periods of time, frequent spinal pain injections, radiating pain, numbness, and lifting restrictions.

19. Claimant is unable to perform some activities of daily living.

20. On September 16, 2013, the Medical Review Team denied MA-P, SDA, and retroactive MA-P, stating that claimant could perform other work.

21. On September 24, 2013, claimant was sent a notice of case action.

22. On October 16, 2013, claimant filed for hearing.

23. On January 8, 2014, the State Hearing Review Team denied MA-P, and SDA, citing medical improvement.

24. On February 27, 2014, a hearing was held before the Administrative Law Judge.

25. The record was extended for the submission of additional evidence.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by the Title XIX of the Social Security Act, 42 USC 1396-1396w-5, and is implemented by 42 CFR 400.200 to 1008.59. The Department of Human Services (formerly known as the Family Independence Agency) administers the MA program pursuant to MCL 400.10 and MCL 400.105.

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program purusant to MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. Department policies are found in BAM, BEM, and RFT. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

The procedural history of this case is quite complex, and the undersigned must first make a determination as to whether there is jurisdiction to hear the various issues raised.

Claimant was originally approved for SDA benefits, and denied MA-P benefits, in 2012. However, the agency erred in reading the MRT determination and approved claimant for both SDA and MA-P benefits.

This continued until May, 2013, when the error was realized. However, instead of immediately closing claimant's MA-P benefits as an error, the Department proceeded to have claimant file a completely new application for SDA and MA-P. MRT reviewed the submitted records with regard to this new application, denied both programs, and the agency subsequently closed both SDA and MA-P in September, 2013.

With regard to the MA-P program, the undersigned believes there is jurisdiction to hear the case. While DHS committed an Agency Error in keeping claimant's MA-P benefits open, even after it was obvious that they should close, claimant did file a new application in June, 2013. This new application is wholly separate from claimant's SDA medical improvement review, and must thus be reviewed under a different review standard appropriate for a new application, and not medical improvement.

The Department was correct to close claimant's MA-P case; disability had been denied in 2012, and the case had been opened in an obvious Agency Error. Per policy in BAM 705, this error may not be recouped.

However, claimant filed a new application for benefits in June, 2013. This application was required to be legally processed, and a disability determination made. The agency met this obligation, and processed the disability portion appropriately. Benefits for the previous MA-P closed in November, 2013. It is that disability determination that the undersigned reviews in this decision.

It should be noted that the notice of case action filed on September 24, 2013 stated that MA-P was closing as of November 1, 2013, and made no reference to the application filed in June, 2013, and a subsequent denial of that application. While it would be legally permissible to hold that this notice only closed the MA-P benefits that should have never been open in the first place, and failed to address the June, 2013 MA-P application for benefits, the undersigned will hold this as a typo for the sake of simplicity, as all parties believed that the case in question involved MA-P benefits, and more specifically, the MRT determination from September, 2013. The more pertinent information is that the reason cited on the notice was a lack of disability; whether this lack of disability referred to the original 2012 application or the more recent June 2013 application is a distinction without a difference. As such, all evidence that was considered pending is deemed relevant to the determination and entered into the evidence record.

However, because MA-P benefits should have never opened in the first place, the June, 2013 application for MA-P is best viewed as a new application for benefits, and must therefore be reviewed under the 5 step disability review, rather than the more lenient 8 step medical improvement review standard.

Therefore, in this decision, the undersigned will address the application for MA-P benefits made on June 10, 2013, and the SDA review conducted by MRT for medical improvement, and the negative determination made in those cases with regard to disability in September, 2013.

Federal regulations require that the Department use the same operative definition of the term "disabled" as is used by the Social Security Administration for Supplemental Security Income (SSI) under Title XVI of the Social Security Act. 42 CFR 435.540(a).

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

This is determined by a five step sequential evaluation process where current work activity, the severity and duration of the impairment(s), statutory listings of medical impairments, residual functional capacity, and vocational factors (i.e., age, education, and work experience) are considered. These factors are always considered in order according to the five step sequential evaluation, and when a determination can be made at any step as to the claimant's disability status, no analysis of subsequent steps are necessary. 20 CFR 416.920

The first step that must be considered is whether the claimant is still partaking in Substantial Gainful Activity (SGA). 20 CFR 416.920(b). To be considered disabled, a person must be unable to engage in SGA. A person who is earning more than a certain monthly amount (net of impairment-related work expenses) is ordinarily considered to be engaging in SGA. The amount of monthly earnings considered as SGA depends on the nature of a person's disability; the Social Security Act specifies a higher SGA amount for statutorily blind individuals and a lower SGA amount for non-blind individuals. Both SGA amounts increase with increases in the national average wage index. The monthly SGA amount for statutorily blind individuals for 2013 is $1,740. For non-blind individuals, the monthly SGA amount for 2013 is $1040.

In the current case, the undersigned holds that the competent material evidence shows that claimant is not engaging in SGA and therefore passes the first step.

The second step that must be considered is whether or not the claimant has a severe impairment. A severe impairment is an impairment expected to last 12 months or more (or result in death), which significantly limits an individual's physical or mental ability to perform basic work activities. The term "basic work activities" means the abilities and aptitudes necessary to do most jobs. Examples of these include:

(1) Physical functions such as walking, 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. 20 CFR 416.921(b).

The purpose of the second step in the sequential evaluation process is to screen out claims lacking in medical merit. *Higgs v. Bowen* 880 F2d 860, 862 (6th Cir, 1988). As a result, the Department may only screen out claims at this level which are "totally groundless" solely from a medical standpoint. This is a *de minimus* standard in the disability determination that the court may use only to disregard trifling matters. As a rule, any impairment that can reasonably be expected to significantly impair basic activities is enough to meet this standard.

In the current case, claimant has presented competent material evidence of a severe impairment that meets durational requirements. Claimant therefore passes the second step.

In the third step of the sequential evaluation, we must determine if the claimant's impairment is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. This is, generally speaking, an objective standard; either claimant's impairment is listed in this appendix, or it is not. However, at this step, a ruling against the claimant does not direct a finding of "not disabled"; if the claimant's impairment does not meet or equal a listing found in Appendix 1, the sequential evaluation process must continue on to step four.

The Administrative Law Judge finds that the claimant's medical records do not contain medical evidence of an impairment that meets or equals a listed impairment.

In making this determination, the undersigned has considered all applicable listings. Claimant has not provided evidence required to find disability at this step. The medical evidence presented does not support a finding of disability at this step.

Therefore, the claimant cannot be found to be disabled at this step, based upon medical evidence alone. 20 CFR 416.920(d). We must thus proceed to the next steps, and evaluate claimant's vocational factors.

Evaluation under the disability regulations requires careful consideration of whether the claimant can do past relevant work (PRW), which is our step four, and if not, whether they can reasonably be expected to make vocational adjustments to other work, which is our step five. When the individual's residual functional capacity (RFC) precludes meeting the physical and mental demands of PRW, consideration of all facts of the case will lead to a finding that:

1) The individual has the functional and vocational capacity to for other work, considering the individual's age, education and work experience, and that jobs which the individual could perform exist in significant numbers in the national economy, or

2) The extent of work that the claimant can do, functionally and vocationally, is too narrow to sustain a finding of the ability to engage in SGA. SSR 86-8.

Given that the severity of the impairment must be the basis for a finding of disability, steps four and five of the sequential evaluation process must begin with an assessment of the claimant's functional limitations and capacities. After the RFC assessment is made, we must determine whether the individual retains the capacity to perform PRW. Following that, an evaluation of the claimant's age, education and work experience and training will be made to determine if the claimant retains the capacity to participate in SGA.

RFC is an assessment of an individual's ability to do sustained work-related physical and mental activities in a work setting on a regular and continuing basis—meaning 8 hours a day, 5 days a week, or an equivalent work schedule. RFC assessments may only consider functional limitations and restrictions that result from a claimant's medically determinable impairment, including the impact from related symptoms. It is important to note that RFC is not a measure of the least an individual can do despite their limitations, but rather, the most. Furthermore, medical impairments and symptoms, including pain, are not intrinsically exertional or nonexertional; the functional limitations caused by medical impairments and symptoms are placed into the exertional and nonexertional categories. SSR 96-8p, 20 CFR 416.945 (a).

However, our RFC evaluations must necessarily differ between steps four and five. At step four of the evaluation process, RFC must not be expressed initially in terms of the step five exertional categories of "sedentary", "light", "medium", "heavy", and "very heavy" work because the first consideration in step four is whether the claimant can do PRW as they actually performed it. Such exertional categories are useful to determine whether a claimant can perform at their PRW as is normally performed in the national economy, but this is generally not useful for a step four determination because particular occupations may not require all of the exertional and nonexertional demands necessary to do a full range of work at a given exertional level. SSR 96-8p.

Therefore, at this step, it is important to assess the claimant's RFC on a function-by-function basis, based upon all the relevant evidence of an individual's ability to do work related activities. Only at step 5 can we consider the claimant's exertional category.

An RFC assessment must be based on all relevant evidence in the case record, such as medical history, laboratory findings, the effects of treatments (including limitations or restrictions imposed by the mechanics of treatment), reports of daily activities, lay evidence, recorded observations, medical treating source statements, effects of symptoms (including pain) that are reasonably attributed to the impairment, and evidence from attempts to work. SSR 96-8p.

RFC assessments must also address both the remaining exertional and nonexertional capacities of the claimant. Exertional capacity addresses an individual's limitations and restrictions of physical strength, and the claimant's ability to perform everyday activities such as sitting, standing, walking, lifting, carrying, pushing and pulling; each activity must be considered separately. Nonexertional capacity considers all work-related limitations and restrictions that do not depend on an individual's physical strength, such

as the ability to stoop, climb, reach, handle, communicate and understand and remember instructions.

Symptom, such as pain, are neither exertional or nonexertional limitations; however such symptoms can often affect the capacity to perform activities as contemplated above and thus, can cause exertional or nonexertional limitations. SSR 96-8.

In the current case, claimant has presented competent material evidence that they are unable to perform past relevant work or have no past relevant work, and therefore passes the fourth step. The lifting and standing requirements from claimant's past relevant work, as well as documented increases in pain with activity, prevent claimant from participating in their past relevant work.

In the fifth step of the sequential consideration of a disability claim, the Administrative Law Judge must determine if the claimant's impairment(s) prevents claimant from doing other work. 20 CFR 416.920(f). This determination is based upon the claimant's:

(1) residual functional capacity defined simply as "what can you still do despite you limitations?" 20 CFR 416.945;

(2) age, education, and work experience, 20 CFR 416.963-.965; and

(3) the kinds of work which exist in significant numbers in the national economy which the claimant could perform despite his/her limitations. 20 CFR 416.966.

See *Felton v DSS* 161 Mich. App 690, 696 (1987).

At step five, RFC must be expressed in terms of, or related to, the exertional categories when the adjudicator determines whether there is other work that the individual can do. However, in order for an individual to do a full range of work at a given exertional level, such as sedentary, the individual must be able to perform substantially all of the exertional and nonexertional functions required at that level. SSR 96-8p. The individual has the burden of proving that they are disabled and of raising any issue bearing on that determination or decision. SSR 86-8.

If the remaining physical and mental capacities are consistent with meeting the physical and mental demands of a significant number of jobs in the national economy, and the claimant has the vocational capabilities (considering age, education and past work experience) to make an adjustment to work different from that performed in the past, it shall be determined that the claimant is not disabled. However, if the claimant's physical, mental and vocational capacities do not allow the individual to adjust to work different from that performed in the past, it shall be determined at this step that the claimant is disabled. SSR 86-8.

For the purpose of determining the exertional requirements of work in the national economy, jobs are classified as “sedentary”, “light”, “medium”, “heavy”, and “very heavy”. These terms have the same meaning as are used in the *Dictionary of Occupational Titles*. In order to evaluate the claimant’s skills and to help determine the existence in the national economy of work the claimant is able to do, occupations are classified as unskilled, semiskilled and skilled. SSR 86-8.

These aspects are tied together through use of the rules established in Appendix 2 to Subpart P of the regulations (*20 CR 404, Appendix 2 to Subpart P, Section 200-204 et. seq*) to make a determination as to disability. They reflect the analysis of the various vocational factors (i.e., age, education, and work experience) in combination with the individual's residual functional capacity (used to determine his or her maximum sustained work capability for sedentary, light, medium, heavy, or very heavy work) in evaluating the individual's ability to engage in substantial gainful activity in other than his or her vocationally relevant past work. Where the findings of fact made with respect to a particular individual's vocational factors and residual functional capacity coincide with all of the criteria of a particular rule, the rule directs a conclusion as to whether the individual is or is not disabled. 20 CFR 404, Subpart P, Appendix 2, Rule 200.00(a).

In the application of the rules, the individual's residual functional capacity, age, education, and work experience must first be determined. The correct disability decision (i.e., on the issue of ability to engage in substantial gainful activity) is found by then locating the individual's specific vocational profile. Since the rules are predicated on an individual's having an impairment which manifests itself by limitations in meeting the strength requirements of jobs, they may not be fully applicable where the nature of an individual's impairment does not result in such limitations, e.g., certain mental, sensory, or skin impairments. 20 CFR 404, Subpart P, Appendix 2, Rule 200.00(c)-200.00(d).

In the evaluation of disability where the individual has solely a nonexertional type of impairment, determination as to whether disability exists shall be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations. The rules do not direct factual conclusions of disabled or not disabled for individuals with solely nonexertional types of impairments. 20 CFR 404, Subpart P, Appendix 2, Rule 200.00(e)(1).

However, where an individual has an impairment or combination of impairments resulting in both strength limitations and nonexertional limitations, the rules are considered in determining first whether a finding of disabled may be possible based on the strength limitations alone; if not, the rule(s) reflecting the individual's maximum residual strength capabilities, age, education, and work experience provide a framework for consideration of how much the individual's work capability is further diminished in terms of any types of jobs that would be contraindicated by the nonexertional limitations. Furthermore, when there are combinations of nonexertional and exertional limitations which cannot be wholly determined under the rules, full consideration must be given to all of the relevant facts in the case in accordance with the definitions and discussions of

each factor in the appropriate sections of the regulations, which will provide insight into the adjudicative weight to be accorded each factor.

Claimant was [redacted] years old at the relevant times of this application, with a limited education and a heavy, skilled work history. The undersigned holds that the competent material evidence provided shows that claimant's exertional impairments render claimant unable to perform work at the sedentary level.

An independent examination conducted in September, 2013 finds claimant is restricted to less than sedentary limitations. While the undersigned found claimant's credibility to be suspect during several points of his testimony, this examination, as well as treating source statements and objective medical testing show the extent of claimant's limitations. The independent source does not substantially contradict treating source records, and could is reasonable in light of claimant's diagnoses. Therefore, the undersigned gives this evaluation full weight. No other statement of residual functional capacity exists in the medical record.

Claimant's treating and independent sources indicate that claimant does not have the RFC to perform work at the sedentary level; this is consistent with an inability to perform at the sedentary level.

Therefore, after careful review of claimant's medical records and the Administrative Law Judge's personal interaction with claimant at the hearing, 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 2, Section 201.00(h). See Social Security Ruling 83-10; *Wilson v Heckler*, 743 F2d 216 (1986).

The Department has failed to provide vocational evidence which establishes that claimant has the residual functional capacity for substantial gainful activity and that, given claimant's age, education, and work experience, there are significant numbers of jobs in the national economy which the claimant could perform despite claimant's limitations. Accordingly, this Administrative Law Judge concludes that claimant is disabled for the purposes of the MA program.

With regard to the SDA program, claimant's approval for SDA benefits in 2012 and the subsequent continuing benefits requires an evaluation under the medical improvement standard, and not the initial review standard, regardless of the application filed in June, 2013. Therefore, even though MA-P was evaluated under the 5 step initial disability determination process, SDA benefits must be evaluated under the 8 step medical improvement determination process.

Once an individual has been determined to be disabled for the purposes of disability benefits, continued entitlement to benefits must be periodically reviewed. 20 CFR 416.994. In evaluating whether disability continues, the Administrative Law Judge must follow a sequential evaluation process, not unlike the initial disability evaluation, in

which current work activities, severity of impairment, and the possibility of medical improvement and its relationship to the individual's work ability is assessed. Review ceases and benefits continue if there is substantial evidence to find that the individual is unable to engage in substantial gainful activity (SGA). 20 CFR 416.994(b)(5)

In determining the continuation of disability, an eight step process is followed. First, there must be a determination of whether the claimant is engaging in SGA. Second, the undersigned will determine whether the claimant has an impairment which meets or equals the severity of a listed impairment. This is followed by a determination of whether there has been medical improvement. If there has been medical improvement, a determination of whether the medical improvement is related to the claimant's ability to work must be made. If there has been no medical improvement, the undersigned will consider whether any exceptions apply if the claimant has made no medical improvement. If there has been medical improvement and the improvement is related to claimant's ability to work, a determination of whether the impairment is severe will be made. For the seventh step, the undersigned will assess a claimant's current ability to engage in SGA. Finally, the claimant will be judged according to their capacity to perform any other work, given the claimant's age, education, and past work experience. 20 CFR 416.994(b)(5)(i-viii).

The first step that must be considered is whether the claimant is still partaking in Substantial Gainful Activity (SGA). 20 CFR 416.994(b)(5)(i). To be considered disabled, a person must be unable to engage in SGA. A person who is earning more than a certain monthly amount (net of impairment-related work expenses) is ordinarily considered to be engaging in SGA. The amount of monthly earnings considered as SGA depends on the nature of a person's disability; the Social Security Act specifies a higher SGA amount for statutorily blind individuals and a lower SGA amount for non-blind individuals. Both SGA amounts increase with increases in the national average wage index. The monthly SGA amount for statutorily blind individuals for 2013 is $1,740. For non-blind individuals, the monthly SGA amount for 2013 is $1040.

In the current case, claimant has testified that they are not working, and the Department has presented no evidence or allegations that claimant is engaging in SGA. Therefore, the Administrative Law Judge finds that the claimant is not engaging in SGA, and thus passes the first step of the sequential evaluation process.

In the second step of the sequential evaluation, we must determine if the claimant's impairment is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. This is, generally speaking, an objective standard; either claimant's impairment is listed in this appendix, or it is not. However, at this step, a ruling against the claimant does not direct a finding of "not disabled"; if the claimant's impairment does not meet or equal a listing found in Appendix 1, the sequential evaluation process must continue on to step three.

The Administrative Law Judge finds that the claimant's medical records do not contain medical evidence of an impairment that meets or equals a listed impairment. We therefore proceed to the next step.

In this step, the undersigned must determine whether there has been medical improvement as defined in 20 CFR 416.994(b)(1)(i). 20 CFR 416.994 (b)(5)(iii). Medical improvement is defined as any decrease in the medical severity of the impairment which was present at the time of the most recent favorable medical decision that the claimant was disabled or continues to be disabled. A determination that there has been a decrease in the medical severity must be based on improvement in the symptoms, signs, and/or laboratory findings associated with claimant's impairment. If there has been medical improvement as shown by a decrease in the medical severity, the undersigned must proceed to step 4, as discussed above. If there has been no decrease in severity, and thus no medical improvement, step 4 is skipped, and the undersigned will proceed to step 5.

In the current case, the Department has failed to meet its burden of proof in showing medical improvement, shown by a decrease in medical severity. The medical evidence presented does not indicate an improvement or a decrease in medical severity. While newer records show that claimant is post a lumbar fusion at the L4-5 level, claimant was post lumbar fusion when initially approved as well. Current medical records show no particular decrease in pain, and, as discussed above, claimant has been given less than sedentary restrictions by an independent source. Regardless, current medical records only consist of a few documents that don't show any particular change since the initial approval in July, 2012. As the Department has the burden of proof in showing medical improvement, a lack of medical records showing significant medical improvement must therefore be held against the Department, and the undersigned must hold that the Department has failed to make its case.

The Administrative Law Judge will not find actual medical improvement without adequate submitted medical records actually showing significant improvement, nor will the Administrative Law Judge infer improvement from a lack of medical evidence, when the Department has the burden of proof in showing improvement.

The Department has the burden of proof to show actual improvement. There are no findings that show claimant is capable of work related activities. Therefore, as the medical records cannot be said to show improvement, the Department has not met its burden of proof in showing improvement, and the undersigned will continue to step 5.

If there has been no medical improvement or it is found that the medical improvement is not related to your ability to work, the Administrative Law Judge must consider whether any of the exceptions in 20 CFR 416.994(b)(3) and (4) apply. If no exceptions apply, disability will be found to continue. If one of the first group of exceptions to medical improvement applies, the sequential process continues. If an exception from the second group of exceptions to medical improvement applies, disability will be found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process. 20 CFR 416.994(b)(5)(v).

The law provides for certain limited situations when disability can be found to have ended even though medical improvement has not occurred, if the claimant can engage in substantial gainful activity. These exceptions to medical improvement are intended to provide a way of finding that a person is no longer disabled in those limited situations where, even though there has been no decrease in severity of the impairment(s), evidence shows that the person should no longer be considered disabled or never should have been considered disabled. If one of these exceptions applies, it must also be shown that, taking all current impairment(s) into account, not just those that existed at the time of the most recent favorable medical decision, you are now able to engage in substantial gainful activity before disability can be found to have ended. 20 CFR 416.994(b)(3).

The first group of exceptions, found in 20 CFR 416.994(b)(3), are as follows:

(i) Substantial evidence shows that you are the beneficiary of advances in medical or vocational therapy or technology (related to your ability to work);

(ii) Substantial evidence shows that you have undergone vocational therapy (related to your ability to work);

(iii) Substantial evidence shows that based on new or improved diagnostic or evaluative techniques your impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision;

(iv) Substantial evidence demonstrates that any prior disability decision was in error. This exception to medical improvement based on error is considered if substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) demonstrates that a prior determination was in error. A prior determination will be found in error only if:

(A) Substantial evidence shows on its face that the decision in question should not have been made (e.g., the evidence in your file such as pulmonary function study values was misread or an adjudicative standard such as a listing in appendix 1 of subpart P of part 404 of this chapter or a medical/vocational rule in appendix 2 of subpart P of part 404 of this chapter was misapplied), or;

(B) At the time of the prior evaluation, required and material evidence of the severity of your impairment(s) was missing. That evidence becomes available upon review, and substantial evidence demonstrates that had such evidence been present at the time of the prior determination, disability would not have been found, or;

(C) Substantial evidence which is new evidence which relates to the prior determination (of allowance or continuance) refutes the conclusions that were based upon the prior evidence (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that had the new evidence,

(which relates to the prior determination) been considered at the time of the prior decision, the claim would not have been allowed or continued. **A substitution of current judgment for that used in the prior favorable decision will not be the basis for applying this exception.**

In examining the record, the undersigned finds that no exceptions of the first group apply.

In addition to the first group of exceptions to medical improvement, the following exceptions may result in a determination that the claimant is no longer disabled. In these situations, the decision will be made without a determination that the claimant has medically improved or can engage in substantial gainful activity. 20 CFR 416.994(b)(4). The second group of exceptions to medical improvement, found at 20 CFR 416.994(b)(4), are as follows:

i) A prior determination or decision was fraudulently obtained;

ii) Claimant did not cooperate;

iii) Claimant is unable to be located;

iv) Claimant failed to follow prescribed treatment which would be expected to restore the ability to engage in substantial gainful activity.

The undersigned has considered the record and finds no evidence that the claimant meets any of these exceptions.

Therefore, as no exceptions apply, disability must be found to continue. 20 CFR 416.994(b)(5)(v). As claimant is found disabled at this step, no further evaluation is needed, and the undersigned declines to do so. Finally, as disability must be found to continue, the Department was in error when in closed claimant's SDA benefit case for medical improvement.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Claimant ☒ disabled for purposes of the MA and/or SDA benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is ☒ REVERSED.

☒ THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE OF MAILING OF THIS DECISION AND ORDER:

1. The Department is ORDERED to process claimant's MA-P application of June 10, 2013 and award all benefits that claimant is entitled to receive under the appropriate regulations; claimant is considered disabled for the purposes of the MA-P program retroactive to March, 2013.

2. The Department is ORDERED to remove all negative actions against claimant's SDA benefit case.

3. The failure to close claimant's MA-P case until November, 2013 is considered Agency Error, and per policy in BAM 705, may not be recouped.

4. A review of this case is to be conducted in January, 2015.

Robert J. Chavez
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: August 27, 2014

Date Mailed: August 27, 2014

NOTICE OF APPEAL: The claimant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely Request for Rehearing or Reconsideration was made, within 30 days of the receipt date of the Decision and Order of Reconsideration or Rehearing Decision.

Michigan Administrative Hearing System (MAHS) 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. MAHS 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 (60 days for FAP cases).

A Request for Rehearing or Reconsideration may be granted when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion;
- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the client;
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The Department, AHR or the claimant must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date the hearing decision is mailed.

The written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

If submitted by mail, the written request must be addressed as follows:

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

RJC/tm

cc: [redacted]