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

IN THE MATTER OF:

Reg. No.:	14-003106
Issue No.:	4001
Case No.:	
Hearing Date:	September 18,2014
County:	WAYNE-18 (TAYLOR)

ADMINISTRATIVE LAW JUDGE: Lynn Ferris

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 September 18, 2014, from Detroit, Michigan. Participants on behalf of Claimant included the Claimant. t, the Claimant's Authorized Hearing Representative (AHR), also appeared on behalf of the Claimant. Participants on behalf of the Department of Human Services (Department) included Contact Worker.

ISSUE

Whether the Department properly determined that Claimant was not disabled for purposes of the 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. On 12/10/13, Claimant applied for SDA benefits.

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

3. On 4/1/14, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 1-2).

4. On May 22, 2014, DHS denied Claimant's application for SDA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On May 28, 2014, Claimant requested a hearing disputing the denial of SDA benefits.

6. As of the date of the administrative hearing, Claimant was a 39-year old female with a height of 5'3'' and weight of 250 pounds (BMI 44.9).

7. Claimant has no known relevant history of alcohol or illegal substance abuse.

8. Claimant's highest education year completed was the 12th grade and community college with an Associate's Degree in business and a certified nurses assistant CNA certificate (expired).

9. Claimant alleged disability based on restrictions related to diagnoses of traumatic brain injury secondary to an automobile accident, Vertical heterophobia – vision, depression and anxiety, bilateral fibula fractures with right and left ankle pain, and headaches and dizziness.

10. The Claimant's impairments have lasted or are expected to last for a 12-month duration or more

CONCLUSIONS OF LAW

Department policies are contained in the Department of Human Services Bridges Administrative Manual (BAM), Department of Human Services Bridges Eligibility Manual (BEM), and Department of Human Services Reference Tables Manual (RFT).

The 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. The Department (formerly known as the Family Independence Agency) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

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 pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. 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.

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (1/2013), 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 (1/2012), 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.

There was no evidence that any of the above circumstances apply to Claimant. Accordingly, Claimant may not be considered for SDA eligibility without undergoing a medical review process (see BAM 815) which determines whether Claimant is a disabled individual. *Id*., p. 3.

Generally, state agencies such as DHS must use the same definition of SSI disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally defined as the inability to do any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905. As noted above, SDA eligibility is based on a 90-day period of disability.

Substantial gainful activity means a person does the following:

- Performs significant duties, and
- 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 substantial gainful activity. *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 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).

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

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

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

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

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

- physical functions (e.g. walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling);
- capacities for seeing, hearing, and speaking, understanding; carrying out, and remembering simple instructions;
- use of judgment;
- responding appropriately to supervision, co-workers and usual work situations; and/or
- dealing with changes in a routine work setting.

Generally, federal courts have imposed a de minimus standard upon Claimants to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v Bowen,* 880 F2d 860, 862 (6th Cir. 1988). Similarly, Social Security Ruling 85-28 has been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight

abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirement is intended "to do no more than screen out groundless claims." *McDonald v. Secretary of Health and Human Servs.*, 795 F.2d 1118, 1124 (1st Cir. 1986).

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

The Claimant has received vocational management therapy, and records were reviewed for May, June and July 2014, from her vocational therapist. The Claimant has received these services since at least September 2013. The most recent report dated July 17, 2014 indicates the following. Claimant was released to return to work with no restrictions effective March 11, 2014.

On July 17, 2014, the Claimant's doctor removed the restriction regarding no prolonged standing, but continued to restrict the Claimant to part-time work due to her closed head injury. The Claimant had suffered a bilateral ankle fracture injury. At the time, the Claimant was being assisted by the therapist for competitive job search for employment. The appointment with her doctor notes that the doctor thought the pain experienced by the Claimant was due to arthritic changes, were scar tissue, or possibly muscular pain from over compensation. After reviewing x-rays, the doctor noted part-time work, only due to closed head injury.

At a meeting on July 11, 2014 with the vocational therapist, her social worker noted her mental health as exceptionally well and her emotional regulator was good. She still needed to address her verbal impulsivity and to apply compensatory strategies. Claimant was given outpatient mental health resources. At the time, the Claimant was able to drive. At the meeting, the mental health services were closed out with the agreement of the Claimant. In addition, great strides were noted with the progress of her speech therapy and improvement with organizing in managing her life. Claimant has an active ongoing search for part-time work and is seen by a vocational rehabilitation specialist every two weeks for the purpose of job development and placement activities.

A progress report for vocational management was also provided for June 2014. At that time, the Claimant had been placed on restrictions by her primary care physician of no prolonged standing and no working more than four hours a day. The report notes Claimant continues to complain of leg pain and soreness. The therapist noted that the continuing restrictions with regard to standing have an impact on the type of jobs that can be pursued. The vocational therapist indicated a need to determine if there was a medical necessity for the standing restriction. The report notes that due to her closed

head injury she works better with fewer people where she is not overwhelmed with too many things at one time. She requires the opportunity to know the job before learning other duties.

A progress report for vocational management was also prepared by the vocational manager on May 15 2014. The report notes the Claimant was released to return to work with no restrictions effective March 11, 2014 by her orthopedic specialist who performed various surgeries associated with bilateral ankle fracture. The Claimant's primary care treating doctor however has placed restriction due to verbal complaints of the Claimant. The restrictions were not prolonged, standing and no working more than four hours a day. Claimant had continuing job search and location services, as well as speech therapy and social worker follow-up. At the meeting, the notes indicate the Claimant had applied for numerous jobs.

The Claimant's treating doctor provided treatment notes from an April 8, 2014 visit. The doctor had evaluated the Claimant for a traumatic brain injury sustained in a motor vehicle accident on May 16, 1988. The report notes Claimant has significant cognitive deficits that have been addressed through several therapies, including speech, vocational and counseling. The report notes injuries sustained resulting in fracture of the bilateral fibulae. This injury caused a distal right and proximal left fibula fracture that was treated with non-weight bearing. Report notes that the Claimant's gate is slowed and she has achiness with a lot of activity or standing. Currently, she would have difficulties with standing for greater than an hour. She would need to be able to alternately sit to stand as tolerated, and would probably consider a maximum of four hour shifts per day. The doctor notes that the injury was sustained due to the Claimant's impulsivity which has been present since or as a result of her traumatic brain injury. She has impulsively left previous jobs. She does not think through possible consequences to activity, and has poor planning skills. She has shown reduced attention to task. She is impulsive with her decisions and makes very quick judgments, which are the issues that are attempted to be addressed in her therapy. As another example of her cognitive impairments, the report notes that a volunteer position was secured for the Claimant for one hour or two times a week doing meal set up entrées for delivery, but because the room was hot, she quit her job without notice. The report further notes that she does not do well with long distance drives

A Medical Examination Report was completed on June 27, 2014 by the Claimant's orthopedic surgeon. The report notes based on x-ray findings of the left and right fibula fractures, that the Claimant was stable and that no limitations were imposed, and that the Claimant could meet her needs in the home. A progress note dated March 10, 2014 was also included with the medical records, at which time the Claimant reported with our complaints and was able to walk her dog and she at that time was requesting to return to work. The physical examination conducted noted full ankle range of motion with tibialis anterior and gastroc are intact. The impression was healed bilateral ankle fracture. The plan was weight bear as tolerated, return to full activities, and follow up as

needed. The Claimant was granted a full return to work without restrictions as of March 11, 2014. The exam notes also indicate that the pain level was reported as 1 out of 10.

In November 2013, the Claimant was seen by her orthopedic doctor who noted her x-rays that a right side transverse nondisplaced fibular fracture, on left side is a spiral oblique minimally displaced fibular fracture. Bilateral casts were applied. Claimant was to be non-weight bearing on left, transfer weight bearing on right. Follow-up in two weeks for x-rays of left ankle displacement. A follow up on Claimant's ankle in December 2013 noted stable Weber B fractured left ankle. At the time of this examination and a DHS 49 medical examination report indicated the Claimant needed full assistance with activities of daily living including cooking, cleaning, shopping, traveling etc., due to a short leg cast, pain and swelling.

On April 9, 2014, a medical examination report was completed by the Claimant's treating physician whose specialty is primary medicine and rehabilitation. The report's diagnosis notes traumatic brain injury and memory problems. With regard to mental restrictions comments, the report notes reduced memory, organization, planning and processing speed. The Claimant's condition was stable and was expected to last 90 days or more. Claimant was restricted from sitting to standing and walking less than 2 to 4 hours in an eight-hour workday. Otherwise, the Claimant had full use of her hands, arms, feet, and legs. The medical findings supporting the evaluation were left proximal and right distal fibular fractures, with arthritic changes of stiffness and achiness. The report noted mental limitations which included comprehension memory and sustained concentration. These limitations were based on a neuropsychological examination and testing performed in August 2013.

The Claimant was seen on July 26, 2013 for a neural visual progress evaluation. At the time of the exam the medical symptoms included dizziness, nausea, anxiety, headaches, unsteadiness with walking, sensitivity to light and difficulty with reading. Patient reported a 95% improvement with symptoms after prism glasses prescribed. Nocturnal headaches have ceased. The glasses have helped her feel surer of her body position and space. Noted changes included walking straighter, better eye contact, increased ability to concentrate, was anxiety with driving over – passes, ability to read more easily and computer screen more clearly. The diagnosis was vertical heterophoria and exophoria.

The Claimant was administered a neuropsychological evaluation on October 14, 2014. The testing was administered by a board certified neuropsychologist. The Claimant was administered the battery of testing. The test results regarding attention and concentration were summarized as being performed within the mild to moderately impaired to average range on attention and concentration tasks. It appeared the patient was better at visual versus auditory stimuli. The patient performed below average on the written portion of the symbol digit test and below average on the oral form of that test indicating mild slowing of speed of information processing abilities. The patient performed in the mild to moderately impaired range for both immediate and delayed

recall on the Verbal Paired Associates subtest. This finding indicated that the patient has marked difficulties when information that needs to be retained is unstructured. Verbal and nonverbal abilities as measured by testing showed full-scale IQ score to be 87 a score in the 10th percentile for age and education. The Claimant also performed in the 5th percentile for age and education on the visual constructional test requiring nonverbal reasoning. The overall perceptual reasoning score was at the 14th percentile for age and education. Academic abilities were assessed by performance on the Weschler individual achievement test which produced an overall reading of 21st percentile for age reading, recognition was 19th percentile, while comprehension was at 66 percentile for age. It appears that the patient's reading rate is quite slow. Numerical operations were performed at the 34th percentile for age. The diagnosis after testing was cognitive disorder, anxiety disorder, and depressive disorder with personality change due to traumatic brain injury. Axis III noted traumatic brain injury (severe). The exam noted that the neuropsychological evaluation which was conducted approximately 25 years, posted traumatic brain injury shows a mixture of cognitive strengths and weaknesses which can help explain the patient's difficulty maintaining employment. Additionally, behaviorally she has a number of difficulties which also negatively impact her ability as an employee. On current cognitive testing, deficits are noted in regard to attention and concentration, speed of information processing, verbal learning for unstructured material, visual memory (immediate and delayed), visual constructional abilities, verbal fluency, dis inhibition, and impulsivity. The patient also exhibits behavior changes related to the accident; has problems interpersonally, and at times has anxiety and depression. As the patient tries to present herself as not impaired, her cognitive deficits as well as behavioral changes would adversely affect her ability to perform competitively in a job, if her employer was not aware of her limitations. To the patient's credit, she has certainly persevered in regard to continuing to work on improving her skills and abilities.

Based on the outcome of the neuropsychological examination the examiner made the following recommendations: the patient should continue vocational therapies including speech, social work, counseling case management and vocational counseling. The patient will require much vocational support to be successful on the job, including job coaching. Patient would benefit from social skills training, including role-playing and videotape feedback as patient does not understand how she comes across to others. Patient has had suicidal ideation in the past and that should be monitored. Patient might benefit from a medication evaluation. There are areas where patient is receiving help from her parents such as major decision-making, as well as financial management. Patient most likely will require some level of assistance from an outside source. The patient should continue to receive case manager services.

The third step of the sequential analysis requires a determination whether the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920 (a)(4)(iii). If Claimant's impairments are listed and deemed to meet the 12 month requirement, then the Claimant is deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step. In this case,

Listing 12.02 Organic Mental Disorders was reviewed. Listing 12.02 requires: Psychological or behavioral abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities.

The required level of severity for this disorder is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied. After careful review of the requirements of the listing it is determined that the Claimant has met the requirements or the medical equivalent of listing as the medical records, her treating physician's evaluation, her perceived conduct at the hearing and job loss history and neuropsychological testing results substantiate memory impairment, perceptual or thinking disturbances and emotional lability, and B marked restrictions in maintaining concentration persistence and pace, as well as social functioning with a medically documented history of a chronic organic mental disorder of at least two years duration, which is caused more than a minimal limitation of the ability to do basic work activities.

As the Claimant has met the requirements of listing 12.02 or its medical equivalent, no further analysis with respect to step four and step five is required.

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 SDA benefit program.

DECISION AND ORDER

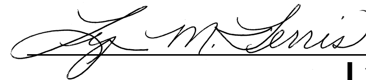
Accordingly, the Department's determination is REVERSED.

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 shall process the December 10, 2013 application for State Disability Assistance to determine nonfinancial eligibility.

2. The Department shall issue an SDA supplement to the Claimant for all benefits she is deemed otherwise eligible to receive in accordance with Department policy.

3. A review of this case shall be scheduled for October 2015.



Lynn Ferris
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: **10/23/2014**

Date Mailed: **10/23/2014**

LMF/tm

NOTICE OF APPEAL: A party may appeal this Hearing Decision in the circuit court in the county in which he/she resides, or the circuit court in Ingham County, within 30 days of the receipt date.

A party may request a rehearing or reconsideration of this Hearing Decision from the Michigan Administrative Hearing System (MAHS) within 30 days of the mailing date of this Hearing Decision, or MAHS may order a rehearing or reconsideration on its own motion.

MAHS may grant a party's Request for Rehearing or Reconsideration when one of the following exists:

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

The party requesting a rehearing or reconsideration must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date this Hearing Decision is mailed.

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

Attention: MAHS Rehearing/Reconsideration Request

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

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

cc: