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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-005224
Issue No.: 4009
Case No.: [redacted]
Hearing Date: May 13, 2015
County: Wayne (49)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

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; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10. After due notice, a telephone hearing was held on May 13, 2015, from Detroit, Michigan. Participants included the above-named Claimant. Participants on behalf of the Department of Health and Human Services (DHHS) included [redacted], specialist.

ISSUE

The issue is whether DHHS properly denied Claimant's State Disability Assistance (SDA) eligibility for the reason that Claimant is not a disabled individual.

FINDINGS OF FACT

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

1. On [redacted], Claimant applied for SDA benefits.
2. Claimant's only basis for SDA benefits was as a disabled individual.
3. On [redacted], the Medical Review Team (MRT) determined that Claimant was not a disabled individual.
4. On [redacted], DHHS denied Claimant's application for SDA benefits and mailed a Notice of Case Action (Exhibits 145-147) informing Claimant of the denial.
5. On [redacted], Claimant requested a hearing disputing the denial of SDA benefits.

6. As of the date of the administrative hearing, Claimant was a 35 year old female.

7. Claimant has not earned substantial gainful activity since before the first month of benefits sought.

8. Claimant alleged disability based on restrictions related to diagnoses of osteoarthritis, depression, body pains, acid reflux, and left arm weakness related to an aneurysm.

CONCLUSIONS OF LAW

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

Prior to a substantive analysis of Claimant's hearing request, it should be noted that Claimant noted special arrangements in order to participate in the hearing. At the outset of the hearing, Claimant was asked what special arrangements or accommodations that she required. Claimant testified that she required no special arrangements and the hearing was conducted accordingly.

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (January 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 (January 2012), p. 1.A person is disabled for SDA purposes if he/she:

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

Id.

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 DHHS 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.

SGA means a person does the following: performs significant duties, does them for a reasonable length of time, and does a job normally done for pay or profit. *Id*., p. 9. Significant duties are duties used to do a job or run a business. *Id*. They must also have a degree of economic value. *Id*. The ability to run a household or take care of oneself does not, on its own, constitute SGA. *Id*.

The person claiming a physical or mental disability has the burden to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 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. The 2014 monthly income limit considered SGA for non-blind individuals is $1,070.

Claimant credibly denied performing any employment since the date of the SDA 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 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 12 month durational period is applicable to MA benefits; as noted above, SDA eligibility requires only a 90 day duration of disability.

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 presented medical documentation.

A Psychiatric Evaluation (Exhibits 11- 17) dated [redacted] was presented. The evaluation was completed by a newly-treating nurse practitioner and co-signed by a newly treating psychiatrist. It was noted that Claimant reported depression symptoms since having an aneurysm in 2005. It was noted that Claimant was without depression medication for a year and a half. Claimant's psychiatrist noted the following assessments of Claimant: unremarkable appearance, unremarkable speech, unremarkable affect, anxious and tearful mood, unremarkable interview behavior, unremarkable thought process, unremarkable perception, unremarkable cognition, difficulties with recent and immediate memory, fair insight, and fair judgment. A diagnosis of major depressive disorder was noted. Claimant's GAF was 50. Referrals for outpatient and case management services were noted.

Rheumatologist office visit notes (Exhibits 32-35; 73-90) dated [redacted] were

presented. It was noted that Claimant complained of joint pain. Physical examination findings included knee joint tenderness, crepitus, and painful ranges of motion. No neurological abnormalities were noted. Claimant's muscle strength was noted to be 5/5. Assessments of osteoarthritis, abnormal CPK testing, and generalized pain were noted.

Physician office visit notes (Exhibits 123-125) dated [redacted] were presented. It was noted that Claimant reported increased urination, left earache, and headache.

A Mental Residual Functional Capacity Assessment (Exhibits 12-13) dated [redacted], [redacted] was presented. The assessment was noted as completed by a treating psychiatrist with no prior history of treating Claimant. This form lists 20 different work-related activities among four areas: understanding and memory, sustained concentration and persistence, social interaction and adaptation. A therapist or physician rates the patient's ability to perform each of the 20 abilities as either "not significantly limited", "moderately limited", "markedly limited" or "no evidence of limitation". Claimant was found moderately limited in 12/20 abilities, which included understanding simple directions, carrying out simple directions, and maintaining regular attendance. It was noted that Claimant was markedly restricted in the following abilities:

- Understanding and remembering detailed instructions
- Carrying out detailed instructions
- Maintaining concentration for extended periods
- Completing a normal workday without psychological symptom interruption

Physician office visit notes (Exhibit 122) dated [redacted] were presented. It was noted that Claimant reported ongoing stomach pain. Treatment details were not provided.

Physician office visit notes (Exhibits 36-40) dated [redacted] were presented. It was noted that Claimant complained of chronic abdominal pain, ongoing for 2 years. A diagnosis of GERD was noted.

Pathology documents (Exhibits 101-102) dated [redacted] were presented. A normal epigastric examination was noted.

Physician office visit notes (Exhibits 95-96; 119-121) dated [redacted] were presented. Complaints of body pain, recurring fever, night sweats, and heartburn were noted. It was noted that recent laboratory results identified causes for Claimant's chronic pain; a diagnosis of a collagen vascular disease was noted; lupus was ruled-out as a diagnosis.

Hospital documents (Exhibits 41-43; 45-50; 59-60) from an encounter dated [redacted], [redacted] were presented. It was noted that Claimant presented with complaints of a headache, ongoing for 6 days. Claimant was treated with Norco and IV fluids. It was noted that Claimant felt feeling better after taking a nap. A discharge diagnosis of resolved acute cephalgia was noted.

Rheumatologist office visit notes (Exhibit 91) dated [redacted] were presented. It was noted that Claimant complained of weakness, fatigue, and joint pain, ongoing for one week. A recent pain clinic referral was noted. Treatment details were not included.

Physician office visit notes (Exhibits 97-100; 116-118) dated [redacted] were presented. It was noted that Claimant presented for auto-immune disease follow-up. Claimant reported a recent flare-up that lasted one week. Reported symptoms included fatigue, total muscle body weakness, lightheadedness, and loss of appetite. It was noted that Claimant reported that Tylenol #4s were not helping her pain level. A referral to a pain management clinic was noted.

A Medical Examination Report (Exhibits 3-5) dated [redacted] was presented. The form was completed by an internal medicine physician with an unstated history of treating Claimant. Claimant's physician listed diagnoses of fibromyalgia, plantar fasciitis, asthma, gastritis, autoimmunity syndrome, osteoarthritis of the knees, and hemiparesis from a CVA. An impression was given that Claimant's condition was stable. It was noted that Claimant can meet household needs. Physical examination findings included the following: morbid obesity, knee crepitus, left-sided hemiparesis (3/5 strength), and difficulty with complex ambulatory maneuvering. Claimant's physician opined that Claimant was restricted as follows over an eight-hour workday, less than 2 hours of standing and/or walking, and less than 6 hours of sitting. Claimant was restricted to occasional lifting/carrying of 10 pounds or less. Claimant's physician opined that Claimant was restricted from performing the following repetitive actions: reaching, pushing/pulling, and operating foot controls. Stated opinions were noted to be based upon limited knee range of motions and an autoimmune disease diagnosis.

Physician office visit notes (Exhibits 114-115) dated [redacted] were presented. It was noted that Claimant complained of vaginal discharge following unprotected sex. An assessment of vaginitis was noted.

Rheumatologist office visit notes (61-70) dated [redacted] were presented. It was noted that Claimant complained of daily moderate left knee pain. Claimant's gait was noted to be normal. Claimant reported pain exacerbation factors included walking and standing. Moderate pain, with motion, was noted along the medial aspect of Claimant's left knee. An assessment of osteoarthritis was noted. An impression of torn medial meniscus was noted. An MRI was ordered. Active medications included the following: Neurontin, Paxil, Tylenol-Codeine, among others.

A radiology report (Exhibit 105-106) dated [redacted] was presented. An impression of no significant finding was noted following views of Claimant's left knee.

A radiology report (Exhibit 107-108) dated [redacted] was presented. An impression of no significant findings was noted following views of Claimant's cervical spine, though "tiny spur projects" were noted at C5.

A radiology report (Exhibit 109-110) dated [redacted] was presented. An impression of mild degenerative changes and hypertrophic facet changes were noted following views of Claimant's lumbar spine.

Hospital documents (Exhibits 51-58; 103-104) from an admission dated [redacted] were presented. It was noted that Claimant presented with complaints of right knee pain. It was noted that Claimant twisted her right knee after she was accidentally pushed. An impression of small joint effusion was noted following right knee radiology.

Physician office visit notes (Exhibits 92-94; 111-113) dated [redacted] were presented. It was noted that Claimant reported knee pain, ongoing for 4 days, after wrestling with her significant other. Active medications included the following: Promethazine, Voltaren, Prednisone, Zantac, Meloxicam, Cymbalta, and prenatal vitamins. It was noted that Claimant was an active smoker. Tenderness on palpation and pain on flexion in Claimant's knee was noted. A plan to follow-up in one month was noted.

A mental status examination report (Exhibits 133-135) dated [redacted] was presented. The report was noted as completed by a consultative psychologist. A history of outpatient psychiatric treatment was noted as reported by Claimant. An adequate contact with reality was noted. A diagnosis of depression secondary to general medical condition was noted. Claimant's GAF was noted as 55. A fair prognosis was noted.

An internal medicine examination report (Exhibits 136-144) dated [redacted] was presented. The report was noted as completed by a consultative physician. Reported complaints included the following: asthma, stroke, high cholesterol, depression, arthritis, collagen vascular disorder, auto-immune disorder, chronic headaches, and fibromyalgia. Claimant reported that she took Norco 7.5, Mobic 7.5, Tylenol #4, Zantac, Cymbalta and 20 other medications. It was noted that Claimant was slow in tandem walk, heel walk, and toe walk. Reduced lumbar and hip flexion motions were noted. It was noted that Claimant could stand and climb stairs, but both with pain. Restrictions to Claimant's sitting, bending, stooping abilities were not noted. The examining physician's noted impression repeated Claimant's complaints.

Medical records verified that Claimant has difficulties with acid reflux. Claimant testimony conceded that she has no work restrictions related to acid reflux.

Claimant testified that she attends mental health therapy and psychiatric appointments, each twice per month. Claimant testimony conceded that her depression is controlled with medication. Psychiatric treatment records were not presented though some psychiatric restrictions were verified.

A consultative examiner opined that Claimant's physical problems adversely impact her functioning abilities. A treating physician stated that Claimant is markedly restricted in

performing multiple work-related activities requiring concentration. Presented documents sufficiently established some degree of attention and concentration deficits.

Claimant testified that she had an aneurysm in 2003. Claimant testified that she still has residual left arm weakness from the aneurysm. Aneurysm treatment records were not presented, though a CVA was regularly noted in Claimant's treatment records. Claimant's physician also noted repetitive left-sided restrictions, presumably due to ongoing left arm dysfunction.

Claimant is right-handed. Claimant testified that her left arm dysfunction does not restrict her ability to write or type. Left arm restrictions would reduce Claimant's ability to lift and carry. Other two-arm functions (e.g. dressing) would also be problematic, though Claimant's physician did not cite that Claimant requires assistance. It is found that Claimant established a severe impairment related to left-arm weakness.

Claimant testified that she can stand 15-20 minutes "at most" due to leg pain. Claimant testified she can sit for maybe 1-2 hours; Claimant testified that she has to get up for "just a few minutes" before resuming sitting for 1-2 hours. Claimant testified that she "cannot lift that much."

Claimant testified that she has standing and lifting/carrying restrictions. Treatment for and diagnoses of knee osteoarthritis, lumbar pain, fibromyalgia, and collagen-vascular disease were verified. Claimant testified that she is restricted in lifting/carrying and ambulation because of each. Claimant testified that periodic flare-up severely reduce her abilities to lift/carry, ambulate, and sit.
Claimant's testimony was consistent with presented medical records.

It is found that Claimant has work-related restrictions expected to last longer than 90 days. Accordingly, it is found that Claimant established having a severe impairment and the disability analysis may proceed to Step 3.

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.

> ***14.07 Immune deficiency disorders, excluding HIV infection.*** As described in 14.00E. With:
> **A.** One or more of the following infections. The infection(s) must either be resistant to treatment or require hospitalization or intravenous treatment three or more times in a 12-month period.
> 1. Sepsis; or
> 2. Meningitis; or
> 3. Pneumonia; or

4. Septic arthritis; or
5. Endocarditis; or
6. Sinusitis documented by appropriate medically acceptable imaging.

OR

B. Stem cell transplantation as described under 14.00E3. Consider under a disability until at least 12 months from the date of transplantation. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

OR

C. Repeated manifestations of an immune deficiency disorder, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.
2. Limitation in maintaining social function.
3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

SSA goes on to define what is required by "repeated manifestations." Listing 14.00 states the following:

> As used in these listings, "repeated" means that the manifestations occur on an average of three times a year, or once every 4 months, each lasting 2 weeks or more; or the manifestations do not last for 2 weeks but occur substantially more frequently than three times in a year or once every 4 months; or they occur less frequently than an average of three times a year or once every 4 months but last substantially longer than 2 weeks.

Collagen-vascular disorder is understood to be an incurable auto-immune disease whereby the body's immune system attacks body tissue. Flare-ups are understood to occur and vary with the individual.

Claimant testified that she has monthly flare-ups of collagen-vascular disorder. Claimant estimated that she is unable to function approximately 3 days per month. Claimant testified that she must use a cane whenever she attempts ambulation during a period of flare-up. Claimant testified that she sometimes has longer flare-ups; for example, Claimant testified that she had a 2 ½ week long flare-up approximately a month before the hearing. Claimant testified that she had to cease her voluntary attendance with a Michigan Works! Agency because of her most recent flare-up.

Presented records verified that Claimant had a week long flare-up in August 2014. Presented records verified that Claimant receives relatively strong narcotic pain medication (e.g. Norco) for her daily living. Presented records also verified that Claimant has significant concentration difficulties due to her daily pain level. Claimant's testimony of flare-ups was credible and reasonably consistent with presented records.

It is found that flare-ups from collagen-vascular disorder cause Claimant to have marked restrictions in daily activities and persistence. Accordingly, it is found that Claimant is a disabled individual by meeting meets SSA listing 14.07 (c). It is further found that DHHS improperly denied Claimant's SDA application.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that DHHS improperly denied Claimant's application for SDA benefits. It is ordered that DHHS:

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

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

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

Date Signed: **5/20/2015**

Date Mailed: **5/20/2015**

CG / hw

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 48909-8139

cc: [redacted]