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

IN THE MATTER OF:

Reg. No.:	15-004422
Issue No.:	4009
Case No.:	
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, 2013, from Detroit, Michigan. Participants included the above-named Claimant. Participants on behalf of the Department of Human Services (DHS) included , Medical Contact Worker.

ISSUE

The issue is whether DHS properly terminated Claimant's eligibility for State Disability Assistance (SDA) 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. Claimant was an ongoing SDA benefit recipient.

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

3. On , the Medical Review Team (MRT) determined that Claimant was not a disabled individual for purposes of SDA eligibility (see Exhibits 1-2).

4. On , DHS terminated Claimant's eligibility for SDA benefits, effective, April 2015, and mailed a Notice of Case Action (Exhibits 70-72) informing Claimant of the termination.

5. On [redacted], Claimant requested a hearing disputing the termination of SDA benefits.

6. As of the date of the administrative hearing, Claimant was a 44-year-old female with a height of 5'1" and weight of 139 pounds.

7. Claimant's highest education year completed was the 12th grade.

8. Claimant alleged disability based on knee arthritis, asthma, fibromyalgia, osteoarthritis, bipolar disorder, and chronic pain.

CONCLUSIONS OF LAW

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

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 (July 2014), p. 1.

A person is disabled for SDA purposes if he/she:

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

Generally, state agencies such as 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. The definition of SDA disability is identical except that only a three month period of disability is required.

Substantial gainful activity 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. BEM 260 (July 2014), p. 10. 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*.

Once an individual has been found disabled for purposes of MA benefits, continued entitlement is periodically reviewed in order to make a current determination or decision as to whether disability remains in accordance with the medical improvement review standard. 20 CFR 416.993(a); 20 CFR 416.994. Claimant was previously certified by the DHS Medical Review Team (MRT) as unable to work for at least 90 days. At Claimant's most recent SDA benefit redetermination, DHS determined that Claimant was no longer disabled.

In evaluating a claim for ongoing disability benefits, federal regulations require a sequential evaluation process be utilized. 20 CFR 416.994(b)(5). The review may cease and benefits continued if sufficient evidence supports a finding that an individual is still unable to engage in substantial gainful activity. *Id.* Prior to deciding if an individual's disability has ended, the department will develop, along with the Claimant's cooperation, a complete medical history covering at least the 12 months preceding the date the individual signed a request seeking continuing disability benefits. 20 CFR 416.993(b). The department may order a consultative examination to determine whether or not the disability continues. 20 CFR 416.993(c).

The below described evaluation process is applicable for clients that have not worked during a period of disability benefit eligibility. There was no evidence suggesting that Claimant received any wages since receiving disability benefits.

The first step in the analysis in determining the status of a claimant's disability requires the trier of fact to consider the severity of the impairment(s) and whether it meets or equals a listed impairment in Appendix 1 of subpart P of part 404 of Chapter 20. 20 CFR 416.994(b)(5)(i). If a listing is met, an individual's disability is found to continue and no further analysis is required. This consideration requires a summary and analysis of presented documents.

A Psychiatric Evaluation (Exhibits 26-28; 32-34) dated [redacted] was presented. This was the only presented document that pre-dated Claimant's favorable hearing decision. It was noted that Claimant reported episodes of mania involving symptoms of anxiety, panic attacks, worrying, and suicidal thoughts. Claimant reported that she wore earplugs because excessive noise triggers bipolar episodes. Observations and assessments of Claimant included the following: good eye contact, tangential thought process, hyper-verbal speech, and orientation x3. It was noted that Claimant was evasive on whether she had suicidal thoughts. An Axis I diagnosis of bipolar disorder was noted. Claimant's GAF was noted to be 55. A plan to continue Lamictal and Klonopin was noted.

A Hearing Decision (Exhibits 62-69) dated [redacted] from the Michigan Administrative Hearing System (MAHS). The MAHS administrative law judge found that Claimant was disabled. The only medical evidence cited was a psychiatric evaluation dated [redacted] and a Mental Residual Functional Capacity Assessment (MRFCA). Information from the psychiatric evaluation was not detailed. Claimant's MRFCA was noted to find Claimant markedly restricted in approximately 15/20 of the form's listed abilities.

Psychiatrist medical review notes (Exhibits 47-52) dated [redacted] were presented. It was noted that Claimant presented with an anxious mood. Claimant reported immense pain in her back and knees. Claimant reported that her meds were helping and were not causing side effects.

Audiological test results (Exhibits 53-54) dated [redacted] were presented. It was noted that Claimant had moderate-to-severe hearing loss in her right ear. Mild-to-severe hearing loss in Claimant's left ear was also noted. A recommendation of hearing aids was noted.

Rheumatologist notes (Exhibit 55) dated [redacted] were presented. It was noted that Claimant appeared for fibromyalgia and knee osteoarthritis treatment. Active medications included Neurontin, Lamictal, tramadol, ProAir, Klonopin, and loratadine.

Psychiatrist medical review notes (Exhibits 41-45) dated [redacted] were presented. It was noted that Claimant reported feeling well and denied hallucinations. It was noted that Claimant was stable and tolerating her meds well.

Psychiatrist medical review notes (Exhibits 35-40) dated [redacted] were presented. It was noted that Claimant denied any concerns other than "a lot of pain from fibromyalgia." Noted assessments of Claimant included the following: limited insight, limited judgment, unremarkable perception, good memory, normal speech, and goal directed thought process. A diagnosis of bipolar disorder was noted.

A Medication Log Summary (Exhibits 29; 56) dated [redacted] was presented. Claimant's current medications were noted to be Clonazepam and Seroquel.

A Mental Residual Functional Capacity Assessment (Exhibits 30-31) dated [redacted] was presented. The assessment was noted as completed by a treating psychiatrist. 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". 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
- Working in coordination or proximity to other without being distracting
- Completing a normal workday without psychological symptom interruption
- Maintaining socially appropriate behavior and adhering to general cleanliness standards
- Responding appropriately to changes in the work setting
- Traveling to unfamiliar places including use of public transportation
- Setting realistic goals or making plans independently of others.

Claimant presented a document from a rehabilitation service (Exhibits A1) dated September 15, 2014. It was noted that Clamant was scheduled for range of motion and strengthening rehabilitation, three times per week for an unspecified period.

A physician statement (Exhibit A2) dated [redacted] stated that Claimant was referred for physical therapy to treat knee osteoarthritis. Claimant's active medications included the following: Lamictal, loratidine, Klonopin, ProAir, Qvar, tramadol, Neurontin, Seroquel, and Claratin.

A mental status examination report (Exhibits 3-7) dated [redacted] was presented. The report was noted as completed by a consultative licensed psychologist. It was noted that Claimant reported severe mood swings and difficulty with stress. A reported history of hallucinations was noted. Claimant reported a history of unspecified hospitalizations and ongoing attendance at outpatient psychiatric treatment since 2012. Current medications included Klonopin and Seroquel. Claimant reported that she is manic in the morning. The consultative psychologist noted that Claimant displayed logical and goal directed stream of mental activity. A diagnosis of bipolar disorder (moderate) was noted. A fair prognosis was noted. Claimant was deemed capable of managing her own funds.

An internal medicine examination report (Exhibits 8-16) dated [redacted] was presented. The report was noted as completed by a consultative physician. Claimant reported the following medical problems: asthma, high blood pressure, angina, headaches, irritable bowel syndrome, mental illness, fibromyalgia, chronic knee pain, back pain (since 2007), and shoulder pain. Claimant's current medications included hydrocortisone cream, loratadine, Neurontin, Ultram, Proair, Qvar, Klonopin, and Seroquel. Ongoing dyspnea was reported. It was noted that Claimant did not use her 4 prong cane during a physical examination. Reduced range of motion was noted in Claimant's lumbar flexion and hip forward flexion. Impressions of the following were noted: asthma, HTN, chest pain, chronic headaches, mental illness, knee and back pain. It was noted that Claimant was able to perform 23 different work-related activities (e.g. sitting, standing, lifting, carrying, stooping, bending, and reaching), but most with pain.

Physician office visit notes (Exhibits A8-A9) dated [redacted] were presented. It was noted that Claimant reported unspecified bowel-related complaints. Claimant's celiac profile was noted to be normal. An assessment of acid reflux was noted.

A hospital letter (Exhibit A7) dated [redacted] was presented. It was noted that Claimant had an appointment with a dermatologist.

Discharge instructions (Exhibits A10-A12) from an encounter dated [redacted] were presented. Generic instructions for chronic pain and acid reflux were provided. Treatment details were not provided.

An optometrist letter (Exhibit A6) dated [redacted] was presented. The letter verified that Claimant underwent sphere testing; physician analysis was not provided.

Claimant testified that she has sensitive eyes and that her vision is deteriorating. Claimant testified that she just saw an eye doctor who diagnosed her with cataracts and "extremely dry eyes".

Claimant testified that she has severe eczema. Claimant testified that her skin breaks out if she is exposed to the sun. Claimant described herself as "hyper-allergic" to the sun.

Claimant testified she can stand 10 minutes without a cane before her knees buckle. Claimant testified that she can lift/carry 10-15 pounds for short distances. Claimant estimated she can sit for 30 minutes before needing to walk around for 5-10 minutes. Claimant thinks she can sit 35 minutes after that. Claimant says neck pain, lower thigh pain, foot pain, and back pain each limit her activities. Claimant testified that she uses a cane for ambulation.

Claimant testified that she needs a bath rail to get in and out of her tub, but that she can bathe without human assistance. Claimant testified she can dress herself. Claimant testified that she can clean, but only in 30 minute periods. Claimant testified that she can do her own laundry, but she uses a shopping cart to transport clothes. Claimant testified that she received help with shopping from a shopping service. Claimant testified that she does not drive, primarily because she worries about her medication side effects.

Claimant presented ample evidence of various physical and mental restrictions. The analysis will first consider whether Claimant meets any mental listings.

Claimant testified that she sees a psychiatrist and a therapist, each once per month. Claimant states she sometimes attends mental health group therapy. Presented records verified ongoing treatment for bipolar disorder, an affective disorder.

Claimant's most prominent impairment appears to be bipolar disorder. Bipolar disorder is an affective disorder covered by Listing 12.04 which reads as follows:

> **12.04 *Affective disorders***: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation. The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.
>
> A. Medically documented persistence, either continuous or intermittent, of one of the following:
> 1. Depressive syndrome characterized by at least four of the following:
>   - a. Anhedonia or pervasive loss of interest in almost all activities; or
>   - b. Appetite disturbance with change in weight; or
>   - c. Sleep disturbance; or
>   - d. Psychomotor agitation or retardation; or
>   - e. Decreased energy; or
>   - f. Feelings of guilt or worthlessness; or
>   - g. Difficulty concentrating or thinking; or
>   - h. Thoughts of suicide; or
>   - I. Hallucinations, delusions, or paranoid thinking
>
> OR
> 2. Manic syndrome characterized by at least three of the following:
>   - a. Hyperactivity; or
>   - b. Pressure of speech; or
>   - c. Flight of ideas; or
>   - d. Inflated self-esteem; or
>   - e. Decreased need for sleep; or
>   - f. Easy distractibility; or
>   - g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
>   - h. Hallucinations, delusions or paranoid thinking
>
> OR
> 3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);
>
> AND
> B. Resulting in at least two of the following:
>   - 1. Marked restriction of activities of daily living; or
>   - 2. Marked difficulties in maintaining social functioning; or
>   - 3. Marked difficulties in maintaining concentration, persistence, or pace; or
>   - 4. Repeated episodes of decompensation, each of extended duration

OR
C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

Presented treatment records and testimony established that Claimant reports ongoing difficulties with pressured speech, racing thoughts, and difficulty with concentration. It is found that Claimant meets Part B of the listing.

Claimant's psychiatrist opined that Claimant has marked restrictions involving concentration and social interactions. The stated restrictions were consistent with presented treatment documents. Most notable was the MRFCA which stated that Clamant was markedly restricted in universally required job-related abilities, e.g. completing a workday without psychological symptoms, socializing with others, maintaining concentration…). A consultative examination presented no particular conflicting opinions to the statements of Claimant's treating psychiatrist. It is found that Claimant meets Part B of the listing for affective disorders.

Based on presented evidence, it is found that Claimant meets Listing 12.04 and is a disabled individual. Accordingly, it is found that MDHHS improperly terminated Claimant's SDA eligibility.

DECISION AND ORDER

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

(1) redetermine Claimant's SDA benefit eligibility, effective April 2015, subject to the finding that Claimant is a disabled individual;
(2) initiate a supplement for any benefits not issued as a result of the improper application denial; and
(3) 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 MDHHS are **REVERSED**.

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

Date Signed: **6/11/2015**

Date Mailed: **6/11/2015**

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: