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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-006934
Issue No.: 4009
Case No.: [redacted]
Hearing Date: June 10, 2015
County: Wayne (15)

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 June 10, 2015, from Detroit, Michigan. Participants included the above-named Claimant. [redacted], [redacted] appeared as Claimant's authorized hearing representative (AHR). Participants on behalf of the Michigan Department of Health and Human Services (MDHHS) included [redacted], medical contact worker.

ISSUE

The issue is whether MDHHS 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 (see Exhibits 2-4).

4. On [redacted], MDHHS denied Claimant's application for SDA benefits and mailed a Notice of Case Action 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 44-year-old female with a height of 5'5" and weight of 111 pounds.

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

8. Claimant obtained a Bachelor of Administration degree from a university.

9. Claimant has a history of semi-skilled employment, with no known transferrable job skills.

10. Claimant alleged disability based on restrictions related to diagnoses of neuropathy, radiculopathy, and gait disturbance.

CONCLUSIONS OF LAW

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. MDHHS administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. MDHHS 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 (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 MDHHS 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 Medical Assistance 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 minimis 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.

Claimant reported that she was diagnosed with scoliosis in 1983 (see Exhibit 24). Claimant testified that she underwent a corrective rod placement surgery which improved her upper and mid-back curvature. Claimant testified that scoliosis still causes her lower back pain.

Neurologist office visit notes (Exhibits 47-48; A15) dated [redacted] were presented. It was noted that Claimant reported painful bilateral foot numbness radiating to her ankles. Bilateral hand weakness was also reported. Reduced strength (4/5) was noted in Claimant's deltoid and triceps. Claimant's complaints were noted to have a peripheral etiology.

A cervical spine MRI report (Exhibits 54-55) dated [redacted] was presented. Disc herniations were noted at C3-C4, C4-C5, C5-C6, C6-C7, and C7-T1. An impression noted that the herniations encroach Claimant's anterior epidural spaces at C3-C4 and C4-C5. Bilateral neural foraminal narrowing at C5-C6 was noted. Mild lordotic curve reversal was noted.

An EMG report (Exhibits 51-53) dated [redacted] was presented. It was noted that there was electro-diagnostic evidence of mild right L4-L5 and left L4 radiculopathy.

Neurologist office visit notes (Exhibits 49-50; A18) dated [redacted] were presented. It was noted that Claimant reported ongoing foot numbness and back pain. A low dose of Norco was prescribed.

Physician office visit notes (Exhibits A2-A3) dated [redacted] were presented. It was noted that Claimant presented with complaints of numbness and back pain. An assessment of peripheral neuropathy was noted; a routine venipuncture was noted as scheduled. Assessments of abdominal pain LFT elevation were also noted.

A lumbar MRI report (Exhibits 56-57) dated [redacted] was presented. Disc herniations at L3-L4, L4-L5, and L5-S1 were noted. Stenosis was noted to be absent, but asymmetric left neural foramen encroachment was noted.

Neurosurgery clinic office visit notes (Exhibits 58-60) dated [redacted] were presented. It was noted that Claimant presented with complaints of neck and back pain. It was noted that Claimant smoked and drank daily. An assessment of spondylosis was noted.

Physician office visit notes (Exhibits A9-A14) dated [redacted] were presented. Complaints of hair loss and sexual dysfunction were noted. A plan of increased water intake and vitamins to address hair loss was noted. It was noted that Claimant has fallen 5 times. Claimant reported that increased dosage of Lyrica was helping with neuropathy.

A thoracic spine CT report (Exhibits 45-46) dated [redacted] was presented. An impression of severe scoliotic curvature throughout Claimant's spine was noted. It was noted that stabilization clips were present. Stenosis, fracture, and vertebral heights were noted to be normal. A pancreatic cyst was also noted.

An abdominal ultrasound report (Exhibit 44) dated [redacted] was presented. An impression of a cystic pancreatic mass and gallstones was noted.

Physician office visit notes (Exhibits 37-40; A16-A17) dated [redacted] were presented. Assessments of chronic lumbar radiculopathy, abdominal pain, gallstones, emesis, alcohol dependence, and peripheral neuropathy were noted. Claimant's current

medications included Tylenol-Codeine #3, Lyrica, Xanax, Tylenol Extra Strength, and Ambien. A cane was noted as prescribed on [redacted].

A Medical Examination Report (Exhibits 10-12) dated [redacted] was presented. The form was completed by an internal medicine physician with an approximate 7 month history of treating Claimant. Claimant's physician listed diagnoses of chronic lumbar radiculopathy, peripheral neuropathy, depression, cervical spondylosis with angulation at C4-C5, and scoliosis. An impression was given that Claimant's condition was deteriorating. It was noted that Claimant required assistance with cooking, hair, and laundry (because Claimant could not walk down stairs). It was noted that Claimant needed surgery to remove gallstones. Physical examination findings included the following: gait disturbance, walks with a cane, and abdominal tenderness. Claimant's physician also opined that Claimant had restrictions with memory, following simple instructions, and writing (due to nerve damage).

Gastroenterologist office visit notes (Exhibits 13-15) dated [redacted] were presented. It was noted that Claimant reported ongoing abdominal pain. It was noted that Claimant continued daily alcohol consumption. Claimant's weight was noted to be 102 pounds. A history of alcohol abuse was noted. It was noted that Claimant reported a 40-pound weight loss over the past 2-3 years, in part, due to abdominal pain. It was noted that previous radiology verified a pancreatic cyst. A plan of an ultrasound, pain management, and nutrition advice was noted.

A mental status examination report (Exhibits 17-21) dated [redacted] was presented. The report was noted as completed by a consultative psychologist. It was noted that Claimant took Ambien and Xanax for unspecified diagnoses. It was noted that Claimant reported drinking 2 glasses of wine every other day. Claimant reported symptoms of irritability and anhedonia. Claimant reported feeling depressed because of financial difficulties and physical problems preventing her from working. Noted observations of Claimant made by the consultative examiner included logical stream of mental activity, adequate contact with reality, and orientation x3. An Axis I diagnosis of Adjustment Disorder was noted. Claimant's GAF was noted to be 55. A fair prognosis was noted. The examiner concluded that Claimant appeared capable of performing work involving moderate-to-higher complexity. The examiner concluded that Claimant retains good judgment and decision making. The examiner concluded that Claimant displayed strength in memory and the ability to pay attention.

An internal medicine examination report (Exhibits 24-31) dated [redacted] was presented. The report was noted as completed by a consultative physician. Claimant's complaints included the following: depression, scoliosis, chronic back pain, and peripheral neuropathy. Physical examination findings noted "extreme curvature" of Claimant's spine, primarily to the right with obvious deformity in the thoracic and lumbar areas. Neurological abnormalities were not noted. It was noted that Claimant brought a cane but did not use it for during the examination. Tandem walk, heel walk, and toe walk were noted as slowly performed. A positive straight-leg-raising test was noted. A

slight limp to the right was noted. Reduced ranges of motions were noted in Claimant's lumbar flexion (80°- normal 90°), bilateral shoulder abduction (140°- normal 150°), bilateral forward elevation (140°- normal 150°), hip forward flexion (50°- normal 100°). Notable physical examination findings included the following: It was noted that Claimant was able to perform all 23 listed work-related activities which included sitting, standing, lifting, carrying, stooping, bending, and reaching, though most were performed with pain.

An ultrasound report (Exhibits A19-A20) dated [redacted] was presented. An impression of an increasing cyst noted to presumably be a pseudocyst was noted.

A mammogram report (Exhibit A21-A22) dated [redacted] was presented. A right breast mass was noted. A biopsy recommendation was noted.

Physician office visit notes (Exhibits A5-A8) dated [redacted] were presented. A recent fall at home was noted.

Claimant testified that she has ongoing abdominal pain. Claimant testified that recent physician encounters led her to believe that she may need surgery to have the pseudocyst removed or that she will need an abdominal stent so fluid can be more easily removed. Claimant testified that she takes Creon to treat her pseudocyst. Claimant's testimony was consistent with presented medical records.

Claimant testified that she has ongoing hand and foot paresthesia from neuropathy. Claimant testified that her neuropathy was not diabetic related. Claimant testified that she is unable to type because of hand numbness. Claimant's testimony was consistent with presented medical records.

Claimant testified that she has had feelings of depression since 2007. Claimant testified that she experiences recurring panic attacks and crying spells. Claimant testified that she does not see a psychiatrist but that she takes anti-depressant medication. Claimant's testimony was consistent with presented records.

Claimant testified that she has ongoing back pain which affects her ability to sit, stand, lift/carry, and ambulate. Claimant estimated that she can only lift up to 5 pounds. Claimant testified that she is unable to climb stairs. Claimant testified that she will soon see an orthopedic physician for treatment of back pain. Claimant testified that she attended physical therapy for a few weeks in September 2014; Claimant testified that she had to stop due to back, leg, and neck pain. Claimant's testimony was consistent with presented records which established various cervical and lumbar spinal abnormalities.

MDHHS testimony was also supportive of restrictions. MDHHS testified that Claimant was observed to use a cane in the past. MDHHS also testified that Claimant appeared very uncomfortable while sitting in the hearing.

Presented evidence established that Claimant is restricted in lifting/carrying, ambulation, sitting, daily activity performance, concentration, and repetitive arm and leg movements. All restrictions have or can be expected to last longer 90 days. 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.

Claimant alleged that she is disabled, in part, due to peripheral neuropathy. Peripheral neuropathy is covered by 11.14 which reads (in combination with Listing 11.04B:

> **11.14** ***Peripheral neuropathies***. With disorganization of motor function characterized by significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C), in spite of prescribed treatment.

Claimant testified that MDHHS pays for her to have a chore provider 4-5 days per week. Claimant testified that her provider helps her with housework, cleaning, cooking, shopping, and laundry. Claimant testified that she will go shopping with her provider if the store provides scooters. Claimant testified that she also sometimes has difficulty with dressing (e.g. buttoning her shirt, putting on socks, and putting on shoes) due to neuropathy. Claimant also testified that she does not drive due to limb numbness.

On a Medical Examination Report, Claimant's physician restricted Claimant to less than 6 hours of sitting over an 8-hour workday and less than 2 hours of standing and/or walking over an 8-hour workday. Claimant's physician restricted her to occasional lifting/carrying of less than 10 pounds, never more. Claimant was not restricted in performing repetitive actions though it was noted that Clamant had difficulty with driving due to foot numbness.

Claimant testified that she has used a cane since May 2014. Claimant testified that she has a history of falls, though it is uncertain if Claimant's falls happened with cane usage. Claimant's testimony suggested that her falls are likely a result of neuropathy and gait disturbance of an unknown etiology. Claimant's testimony was consistent with presented records.

Medical records established numerous medical problems which adversely affect Claimant's daily life. It is debatable whether Claimant's neuropathy treatment history supports a finding that Claimant experiences sustained disturbance to her gait or her ability to perform fine and gross movements. Neuropathy treatment history factored with

cervical and lumbar problems, abdominal pain from a pseudocyst are much more supportive of a finding that Claimant meets the above-cited listing. A need for a cane, a history of falls, and reliance on chore services each support that Claimant has sustained gait disturbance. Based on the presented records, it is found that Claimant meets Listing 11.14.

Consideration was given to evaluating the materiality of Claimant's ongoing alcohol usage to the disability finding. Claimant's medical history verified a history of alcohol abuse. An active diagnosis of alcohol dependence was verified. Claimant testified that she still drinks 2-3 times per week.

Despite Claimant's ongoing alcohol use, medical records were not particularly suggestive that Claimant's alcohol use is a significantly affects Claimant's ability to ambulate. It is found that Claimant's alcohol use is immaterial to Claimant's inability to ambulate effectively. Accordingly, Claimant is a disabled individual.

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) 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 MDHHS are **REVERSED**.

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

Date Signed: **6/18/2015**

Date Mailed: **6/18/2015**

CG / cl

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: