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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-009213
Issue No.: 4009
Case No.: [redacted]
Hearing Date: July 22, 2015
County: Van Buren

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

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 July 22, 2015, from Detroit, Michigan. Participants on behalf of Claimant included Claimant and [redacted], Claimant's wife. Participants on behalf of the Department of Health and Human Services (Department) included [redacted], Assistance Payment Supervisor.

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional records. The documents were received. The record closed on August 21, 2015, and the matter is now before the undersigned for a final determination.

ISSUE

Did the Department properly close Claimant's State Disability Assistance (SDA) benefit case based on its determination that Claimant was no longer disabled?

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 recipient of SDA benefits.

2. In December 2014, Claimant's updated medical packet was forwarded to the Medical Review Team (MRT) for review of his ongoing eligibility for SDA benefits based on allegations of neck, back and arm pain and toe amputation and pain.

3. On May 13, 2015, MRT found Claimant no longer disabled (Exhibit A, pp. 4-6).

4. On May 15, 2015, the Department sent Claimant a Benefit Notice notifying him that his SDA case closed effective December 31, 2014 because MRT had denied his claim (Exhibit A, pp. 2-3).

5. On June 4, 2015, the Department received Claimant's timely written request for hearing concerning the closure of his SDA case (Exhibit A, p. 1).

6. Claimant's application with the Social Security Administration continued to be pending as of the hearing date (Exhibit B).

7. Claimant alleged physical disabling impairment due to neck, back and arm pain and toe amputation and pain.

8. At the time of hearing, Claimant was [redacted] years old with a [redacted] birth date; he was [redacted]" in height and weighed about [redacted] pounds.

9. Claimant has a GED.

10. Claimant has an employment history of work as a line worker at three different factories.

CONCLUSIONS OF LAW

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

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 disabled person is eligible for SDA. BEM 261 (July 2014), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment lasting, or expected to last, at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Once an individual has been found disabled, continued entitlement to benefits based on a disability 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(a). If the individual is not engaged in substantial gainful activity, the trier of fact must apply an eight step sequential evaluation n evaluating whether an individual's disability continues. 20 CFR 416.994. The review may cease and benefits may be continued at any point if there is sufficient evidence to find that the individual is still unable to engage in substantial gainful activity. 20 CFR 416.994(b)(5). In this case, Claimant has not engaged in SGA at any time since he became eligible for SDA. Therefore, his disability must be assessed to determine whether it continues. The 8 steps for reviewing whether a disability continues are as follows:

> **Step 1.** Does the individual have an impairment or combination of impairments which meets or equals the severity of an impairment listed in 20 CFR Appendix 1 of subpart P of part 404? If so, the disability will be found to continue. 20 CFR 416.994(b)(5)(i).
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> **Step 2.** If not, has there been medical improvement as defined in paragraph (b)(1)(i) of 20 CFR 416.994? If there has been medical improvement as shown by a decrease in medical severity, go to Step 3. If there has been no decrease in medical severity, there has been no medical improvement unless an exception in Step 4 applies.
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> **Step 3.** If there has been medical improvement, is it related to the individual's ability to do work in accordance with 20 CFR 416.994(b)(1)(i) through (b)(1)(iv); *i.e.*, was there an increase in the individual's residual functional capacity (RFC) based on the impairment(s) that was present at the time of the most recent favorable medical determination? If medical improvement is *not* related to the individual's ability to do work, the analysis proceeds to Step 4. If medical improvement *is* related to the individual's ability to do work, the analysis proceeds to Step 5.
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> **Step 4.** If it was found at Step 2 that there was no medical improvement or at Step 3 that the medical improvement is not related to the individual's ability to work, the exceptions in 20 CFR 416.994(b)(3) and (b)(4) are considered. If none of them apply, the disability will be found to continue. If an exception from the first group of exceptions to medical improvement applies, the analysis proceeds to Step 5. If an exception from the second group of exceptions to medical improvement applies, the disability is found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process.
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> Step **5.** If medical improvement is shown to be related to an individual's ability to do work or if one of the first group of exceptions to medical improvement applies, **all** the individual's current impairments in combination are considered to determine whether they are severe in light of 20 CFR 416.921. This determination considers all the individual's current impairments and the impact of the combination of these impairments on the individual's ability to function. If the RFC assessment in Step 3 shows significant limitation of the individual's ability to do basic work activities, the analysis proceeds to Step 6. When the evidence shows that all the individual's current impairments in combination do not significantly limit the individual's physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature and the individual will no longer be considered to be disabled.
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> **Step 6.** If the individual's impairment(s) is severe, the individual's current ability to do substantial gainful activity is assessed in accordance with 20 CFR 416.960; i.e., the individual's RFC based on all current impairments is assessed to determine whether the

individual can still do work done in the past. If so, disability will be found to have ended.

Step 7. If the individual is not able to do work done in the past, the individual's ability to do other work given the RFC assessment made under Step 6 and the individual's age, education, and past work experience is assessed (unless an exception in 20 CFR 416.994(b)(5)(viii) applies). If the individual can, the disability has ended. If the individual cannot, the disability continues.

Step 8. Step 8 may apply if the evidence in the individual's file is insufficient to make a finding under Step 6 about whether the individual can perform past relevant work. If the individual can adjust to other work based solely on age, education, and RFC, the individual is no longer disabled, and no finding about the individual's capacity to do past relevant work under Step 6 is required. If the individual may be unable to adjust to other work or if 20 CFR 416.962 may apply, the individual's claim is assessed under Step 6 to determine whether the individual can perform past relevant work.

Step One

Step 1 in determining whether an individual's disability has ended 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 with no further analysis required.

In the present case, Claimant alleges a disability due to neck, back and arm pain and toe amputation and pain. In 1984, Claimant injured his left big toe in a lawn mower accident. He reported continuing issues concerning his toe with repeated surgeries and ongoing pain. The medical evidence presented at the hearing and in response to the interim order concerning the disabilities alleged by Claimant is briefly summarized below.

In February 2008, a portion of Claimant's left great toe, including neurovascular bundle fragments, was amputated (Exhibit A, pp. 29-30, 56).

On May 23, 2014, a bone scan of Claimant's great left toe was obtained in response to pain and swelling and previous amputation of the great toe at the IP (interphalangeal) joint. The bone scan showed possible osteomyelitis (bone infection) or fracture. A May 22, 2014 ultrasound of the left great toe showed cellulitis of the remaining stump and a very small fluid collection in the dorsal soft tissues midway between the skin and proximal phalanx that could represent localized edema or very small abscess (Exhibit D; Exhibit A, pp. 67-70).

A May 28, 2014 scan following recent surgery of the bony stump of the proximal phalanx of the great left toe showed a small area of mildly intense uptake along the distal tip of the remaining portion of the toe, likely a small amount of cellulitis likely related to recent surgical intervention involving that phalanx, rather than osteomyelitis (Exhibit D).

Notes from Claimant's July 7, 2014 office visit with his foot surgeon showed that Claimant had active dorsification and plantar flexion of motion of the left hallux stump, which was partially amputated at the level of the IP joint. The doctor noted that Claimant was very sensitive to even slight palpation at any spot on the left hallux and he guarded against touching of the area, tensing his left leg muscles so that he even shook a bit. A July 8, 2014 x-ray of Claimant's left foot was negative for fracture or evidence of osteomyelitis. However, the doctor noted the loss of the left hallux at the IP joint level and some bony exostosis dorsomedially as well as especially lateral to plantar laterally at the distal stump of the proximal phalanx. The doctor noted that Claimant reported using marijuana to alleviate his neck and toe pain (Exhibit A, pp. 71, 101-102, 123-124).

A September 25, 2014 CT of the cervical spine showed (i) no evidence of fracture, subluxation, or other acute bony abnormality, (ii) marked disc space narrowing at C5-6, posterior osteophytes and bilateral uncovertebral joint spurs at that level that narrowed the neural foramina, (iii) no significant narrowing of the AP canal diameter, (iv) moderate disc space narrowing at C4-5 and C6-7, (v) well-maintained vertebral body heights, and (vi) anterior osteophytes at multiple levels (Exhibit A, pp. 95-96, 120-121).

On May 2, 2015, Claimant was examined by a doctor at the Department's request. The doctor noted that Claimant walked with a mild limp on the left but did not use an assistive device. In his examination of Claimant, the doctor noted partial amputation of the left great toe and superficial skin ulceration but no surrounding erythema. The doctor concluded that Claimant had no nerve root impingement at the cervical spine but identified the following limitations in Claimant's range of motion of the cervical spine: flexion was 40 degrees (normal is 0 to 50 degrees), extension was 40 degrees (normal is 0 to 60 degrees), right lateral flexion was 35 degrees (normal is 0 to 45 degrees), left lateral flexion was 40 degrees (normal is 0 to 45 degrees), right rotation was 60 degrees (normal is 0 to 80 degrees), and left rotation was 60 degrees (normal is 0 to 80 degrees). He found that Claimant could get on and off the examination table without difficulty, heel and toe walk with moderate to severe difficulty, and squat with mild difficulty (Exhibit A, pp. 9-12).

On May 27, 2015, Claimant had surgery for partial excision of his left great toe consistent with exostosis (Exhibit D).

On August 5, 2015, Claimant's family practitioner completed a medical examination report, DHS-49, identifying no limitation but indicating in handwritten notes that she had not seen Claimant since a February 2014 exam. She attached notes from Claimant's office visits in February 2013 and February 2014. The office visit notes indicated that Claimant smoked marijuana and had a medical card for migraines and relaxation (Exhibit C; Exhibit A, pp. 104-107, 126-129).

On August 7, 2015, Claimant's foot surgeon completed a DHS-49 listing Claimant's diagnoses as chronic pain left great toe; status post partial left great toe amputation; and exostosis proximal phalanx. The doctor noted that Claimant used crutches in order

to walk. The doctor concluded that Claimant's condition was improving but he had physical limitations that were expected to last more than 90 days. Rather than identify the limitations, the doctor noted "see P.T. evaluation" and attached physical therapy records. The physical therapy records for July 24, 2015 showed that Claimant used crutches and had moderate pain or limitation in ambulation, work, and activities of daily living. The therapists noted that Claimant entirely avoided placing any weight on his left foot, had a significant antalgic gait and limp to compensate for avoiding weight bearing on the left, and his whole left leg shook with active range of motion. His prognosis was good (Exhibit D).

The medical evidence presented does **not** show that Claimant's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Listings 1.02 (major dysfunction of a joint), 1.04 (disorders of the spine), and 1.06 (fracture of the femur, tibia, pelvis or one or more of the tarsal bones) were considered. Because the medical evidence presented in this case was insufficient to meet or equal any of the listings considered, a disability is not continuing under Step 1 of the analysis, and the analysis proceeds to Step 2.

Step Two

If the impairment(s) does not meet or equal a Listing under Step 1, then Step 2 requires a determination of whether there has been medical improvement as defined in 20 CFR 416.994(b)(1). 20 CFR 416.994(b)(5)(ii). If there is medical improvement, the analysis proceeds to Step 3. If there is no medical improvement, the analysis proceeds to Step 4. 20 CFR 416.994(b)(5)(ii).

Medical improvement is defined as any decrease in the medical severity of the impairment(s) which was present at the time of the most favorable medical decision that the individual was disabled or continues to be disabled. 20 CFR 416.994(b)(1)(i). If no medical improvement found, and none of the exceptions listed below in Step 4 applies, then an individual's disability is found to continue.

In this case, the Department testified that Claimant had been initially approved for SDA by MRT or the State Hearing Review Team (SHRT) but failed to clearly identify what medical evidence was relied upon in the initial finding that Claimant was disabled. A review of the medical evidence presented fails to establish any medical improvement in Claimant's condition over the course of the last year and a-half. To the contrary, Claimant testified that, since enduring 10 surgeries on his toe following a 1984 lawn mowing accident, his left toe was recently entirely amputated and he was required to wear a walking boot and participate in physical therapy. The medical record shows that Claimant experienced ongoing pain in his left toe, that there were surgeries performed on the toe, the most recent on May 27, 2015 for partial excision of his left great toe consistent with exostosis (Exhibit D). Claimant's foot surgeon completed a DHS-49 on August 7, 2015, listing Claimant's diagnoses as chronic pain left great toe; status post partial left great toe amputation; and exostosis proximal phalanx. The doctor noted that Claimant used crutches in order to walk and, while his condition was improving, he had

physical limitations that were expected to last more than 90 days. The doctor referred to Claimant's physical therapy records to identify any limitations. The physical therapy records for July 24, 2015 showed that Claimant's prognosis was good but as of the office visit that day he used crutches; had moderate pain or limitation in ambulation, work, and activities of daily living; entirely avoided placing any weight on his left foot; had a significant antalgic gait and limp to compensate for avoiding weight bearing on the left; and his whole left leg shook with active range of motion (Exhibit D).

The May 2, 2015 consultative exam report also showed that Claimant walked with a mild limp on the left. At that time he did not use an assistive device but he reported to the consulting doctor that surgery on his toe was scheduled. While the examiner found that Claimant could get on and off the examination table without difficulty, heel and toe walk with moderate to severe difficulty, and squat with mild difficulty, these limitations applied to his condition prior to the toe amputation and it would be fair to conclude that even more significant limitations applied after the surgery, at least until he had the opportunity to heal. The examining doctor also concluded that Claimant had no nerve root impingement at the cervical spine but identified the following limitations in Claimant's range of motion of the cervical spine: flexion was 40 degrees (normal is 0 to 50 degrees), extension was 40 degrees (normal is 0 to 60 degrees), right lateral flexion was 35 degrees (normal is 0 to 45 degrees), left lateral flexion was 40 degrees (normal is 0 to 45 degrees), right rotation was 60 degrees (normal is 0 to 80 degrees), and left rotation was 60 degrees (normal is 0 to 80 degrees). (Exhibit A, pp. 9-12.) This evidence substantiated Claimant's testimony concerning his neck pain.

In the absence of any medical evidence establishing the medical evidence that MRT or SHRT relied upon in the earlier finding that Claimant was disabled, the Department has failed to substantiate a decrease in the medical severity of the impairment(s) which was present at the time of the most favorable medical decision by MRT/SHRT. Thus, the evidence does not support a finding that there was a medical improvement in Claimant's condition.

Step Four

When there is no medical improvement, an assessment of whether one of the exceptions in 20 CFR 416.994(b)(5)(iv) applies is required. If no exception is applicable, disability is found to continue. *Id.*

The first group of exceptions to medical improvement (i.e., when disability can be found to have ended even though medical improvement has not occurred) found in 20 CFR 416.994(b)(3) are as follows:

(i) Substantial evidence shows that the individual is the beneficiary of advances in medical or vocational therapy or technology (related to the ability to work);
(ii) Substantial evidence shows that the individual has undergone vocational therapy related to the ability to work;

(iii) Substantial evidence shows that based on new or improved diagnostic or evaluative techniques the impairment(s) is not as disabling as previously determined at the time of the most recent favorable decision;
(iv) Substantial evidence demonstrates that any prior disability decision was in error.

While there was evidence that Claimant was participating in physical therapy as of July 2015 and his prognosis was good, the Department did not present any evidence establishing that, from the date of review to the date of hearing, an exception under the first set of exceptions to medical improvement applied to Claimant's situation.

The second group of exceptions to medical improvement are found in 20 CFR 416.994(b)(4) and are as follows:

(i) A prior determination was fraudulently obtained;
(ii) The individual failed to cooperated;
(iii) The individual cannot be located;
(v) The prescribed treatment that was expected to restore the individual's ability to engage in substantial gainful activity was not followed.

If an exception from the second group listed above is applicable, a determination that the individual's disability has ended is made. 20 CFR 416.994(b)(5)(iv).

In this case, the Department has failed to establish that any of the listed exceptions in the second group of exceptions to medical improvement apply to Claimant's case. Although MRT concluded in the DHS-49A that Claimant failed to participate in ongoing treatment, there was no evidence presented in the medical file that Claimant was referred to, or failed to follow, any prescribed treatment that was expected to restore his ability to engage in substantial gainful activity**.**

Because the evidence presented does not show a medical improvement to Claimant's condition and no exception under either group of exceptions at Step 4 applies, the Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Claimant has a continuing disability for purposes of the SDA benefit program. Therefore, Claimant's SDA eligibility continues and the Department did not act in accordance with Department policy when it closed his SDA case.

DECISION AND ORDER

Accordingly, the Department's determination is REVERSED.

THE DEPARTMENT IS ORDERED TO BEGIN DOING 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. Reinstate Claimant's SDA case effective January 1, 2015;

2. Issue supplements to Claimant for any lost SDA benefits that he was entitled to receive from January 1, 2015 ongoing if otherwise eligible and qualified in accordance with Department policy;

3. Notify Claimant of its decision in writing; and

4. Review Claimant's continued SDA eligibility in January 2016 in accordance with Department policy.

Alice C. Elkin
Administrative Law Judge
for Nick Lyon, Director
epartment of Health and Human Services

Date Signed: **9/2/2015**

Date Mailed: **9/2/2015**

ACE / tlf

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]