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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-011697
Issue No.: 4009
Case No.: [redacted]
Hearing Date: August 17, 2015
County: Wayne (18)

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 August 17, 2015, from Detroit, Michigan. Participants included the above-named Claimant. [redacted], Claimant's friend, testified on behalf of Claimant. Participants on behalf of the Michigan Department of Health and Human Services (MDHHS) included [redacted] hearings facilitator.

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 May 6, 2015, Claimant applied for SDA benefits.

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

3. On June 19, 2015, the Medical Review Team (MRT) determined that Claimant was not a disabled individual.

4. On June 24, 2015, MDHHS denied Claimant's application for SDA benefits and mailed a Notice of Case Action (Exhibits 233-234) informing Claimant of the denial.

5. On July 6, 2015, Claimant requested a hearing disputing the denial of SDA benefits (see Exhibit 235).

6. As of the date of the administrative hearing, Claimant was a 38-year-old female.

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

8. Claimant's highest education year completed was the 8th grade.

9. Claimant has a history of zero full-time employment from the past 15 years.

10. Claimant alleged disability based on restrictions related to diagnoses of back pain, carpal-tunnel syndrome (CTS), and mental health issues.

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 2015 monthly income limit considered SGA for non-blind individuals is $1,090.

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 2.

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 disability duration of 90 days.

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 psychiatrist letter (Exhibit 190) dated September 24, 2012, was presented. An approximate 2 year treatment history with Claimant was noted. A diagnosis of Bipolar disorder I (mixed, severe, and without psychotic features) was noted. It was noted that Claimant had severe manic-depressive disturbances which caused marked impairment to occupational functioning and in social interactions. Noted symptoms included mood swings, lack of energy, and severe euphoric hyperactivity.

Five medical center office visit documents (Exhibits 11-24) from May 2014, were presented. Treatment for an acute kidney injury, hypothyroidism, hair loss, and lumbar pain was noted.

A CT report of Claimant's abdomen (Exhibits 54-55; 188) dated May 12, 2014, was presented. An impression of no evidence of renal calculi was noted.

Medical center office visit documents (Exhibits 25-27) dated June 5, 2014, were presented. A diagnosis of bilateral CTS ("much better on the left"), ongoing for 1 month, was noted. A positive left-sided Tinel's test was noted. A prescription of Gabapentin was noted.

Medical center office visit documents (Exhibits 28-30) dated July 7, 2014, were presented. A complaint of back pain, ongoing for several years was noted. A plan to evaluate Claimant for drug abuse/over-utilization was noted.

Hospital documents (Exhibits 180-185) dated July 17, 2014, were presented. Generic instructions for urinary tract infection and ankle pain were noted.

Medical center office visit documents (Exhibits 31-33) dated July 17, 2014, were presented. It was noted that Claimant reported being unconscious for one hour the previous day. It was noted that Claimant underwent lab work.

An x-ray report of Claimant's left hip (Exhibit 186) dated July 19, 2014, was presented. A normal examination was noted.

Medical center office visit documents (Exhibits 34-36) dated July 25, 2014, were presented. It was noted that Claimant reported abdominal pain, ongoing for 4 days. A diagnosis of a urinary tract infection was noted. Various medications were prescribed.

A Medical Examination Report (Exhibits 177-179) dated July 25, 2014, was presented. The form was completed by an internal medicine physician with an approximate 4-year history of treating Claimant. It was noted that MRIs indicated spondylosis, disc displacement, and recent degenerative changes in Claimant's lumbar. It was noted that Claimant was limited in sustaining concentration and following simple directions due to diagnoses of bipolar disorder and anxiety. It was noted that Clamant was not emotionally stable.

Medical center office visit documents (Exhibits 37-39) dated July 30, 2014, were presented. It was noted that Claimant presented with complaints of memory loss and confusion. The symptom was noted as resolved.

Medical center office visit documents (Exhibits 42-45) dated August 13, 2014, were presented. It was noted that Claimant presented with a complaint of daily hypothyroidism episodes. Various medications were prescribed.

Hospital physician office visit documents (Exhibits 66-67) dated August 28, 2014, were presented. A complaint of lumbar pain radiating to Claimant's right leg was noted. Physical examination findings noted full muscle strength. An assessment of lumbar disk displacement, L5 spondylosis, and lumbar radiculitis was noted. A plan of steroid injections was noted.

Medical center office visit documents (Exhibits 46-48) dated September 10, 2014, were presented. It was noted that reported thinking disturbance and attention difficulties; reported symptoms were noted to be alleviated with medication. Diagnoses of altered mental status, bipolar disorder, and depression were noted.

Medical center office visit documents (Exhibits 49-51) dated October 8, 2014, were presented. It was noted that reported thinking disturbances and attention difficulties; reported symptoms were noted to be alleviated with medication. It was noted that Claimant appeared to be “doctor shopping” and that she was advised to obtain all mental health prescriptions from a psychiatrist.

A letter from a medical center (Exhibit 10) dated October 13, 2014, was presented. The letter was authored by two staff members of the medical center. It was alleged that Claimant attempted to seek medication from multiple physicians and forged prescriptions. It was noted that Clamant was barred from further treatment.

Physician office visit notes (Exhibits 75-81) dated December 11, 2014, were presented. It was noted that Claimant reported anxiety, ongoing back pain (7/10 without treatment; 4/10 with treatment). Claimant’s anxiety symptoms were noted to be controlled by medication. A plan of prescribing Xanax and Wellbutrin was noted for Claimant’s anxiety. It was noted that Claimant was prescribed Norco and referred for long-term pain management for her back pain. A complaint of thyroid problems was also noted; Levothyroxine was noted as prescribed.

Physician office visit notes (Exhibits 82-88) dated December 26, 2014, were presented. A complaint of constipation, ongoing for 10 days was noted. Claimant was prescribed lactulose and MiraLax and given diet information. A complaint of intermittent and severe hand pain, ongoing for 10 years was noted. Hand weakness was noted to be negative. A plan to start Lyrica for CTS was noted.

Physician office visit notes (Exhibits 89-96) dated January 6, 2015, were presented. A complaint of anxiety and left hand pain was noted. Mild pain was noted with left-hand motion. Lyrica dosage was noted to be increased. Claimant was referred to a psychiatrist for anxiety treatment.

Physician office visit notes (Exhibits 97-104) dated February 9, 2015, were presented. Treatment for anxiety, left-hand pain, and thyroid disorder was noted. It was noted that Claimant’s anxiety was improved and controlled with medication; a switch from Xanax to Klonopin was noted. Left-wrist pain was noted to be 5/10 and controlled. A refill of meds was noted for thyroid treatment.

Physician office visit notes (Exhibits 105-114) dated February 12, 2015, were presented. Irregular menses was noted. It was also noted that Claimant was a heavy tobacco smoker. Smoking cessation counseling was provided.

A Psychiatric/Psychological Examination Report (Exhibits 170-172; 227-228) from an examination dated March 5, 2015, was presented. The assessment was noted as completed by a treating psychiatrist and limited licensed psychologist with an approximate 4 month history of treating Claimant. It was noted that Claimant was crying due to difficulty in finding housing. It was noted that Claimant was in ongoing treatment for an unspecified addiction; Claimant was noted to be 1.5 years clean. Prescribed medications included Adderall, Klonopin, and Wellbutrin. An Axis I diagnosis of bipolar disorder I was noted. Claimant's GAF was noted to be 40-42.

Physician office visit notes (Exhibits 115-124) dated March 26, 2015, were presented. It was noted that Claimant complained of ongoing back pain. It was noted that Claimant was taking illicit drugs while on narcotics. It was noted that Claimant denied using different pharmacies to obtain narcotics though Claimant's records indicated otherwise. It was noted that Claimant also smoked marijuana to treat her pain. It was noted that a previous MRI of Claimant's spine indicated a disc protrusion, but no stenosis.

Physician office visit notes (Exhibits 125-136) dated April 23, 2015, were presented. It was noted that Claimant sought an increase of Norco from 7.5 to 10 to treat worsening back pain and CTS. Claimant's request was granted though she was warned not to abuse medication.

Hospital documents (Exhibits 151-152; 154; 220-226) dated May 18, 2015, were presented. It was noted that Claimant complained of hand pain. It was noted that Claimant reported needing Norco until she could see her physician which would not occur sooner than May 30, 2015.

Physician office visit notes (Exhibits 137-147) dated May 21, 2015, were presented. It was noted that Claimant presented for a refill of Norco medications. A check of Claimant's pharmacy history indicated that Claimant was recently treated for CTS and that she subsequently filled prescriptions for 20 tablets of Norco and Xanax. It was noted that Norco 10s control Claimant's pain well. It was noted that Claimant was positive for methadone and marijuana (see Exhibits 148-149). It was noted that Claimant's substance contract was ended that day due to Claimant story inconsistencies concerning pain medication.

Claimant testified she has seen a psychiatrist for last 15 years. Claimant testified her current psychiatrist has treated her for 1 ½ years. Claimant testified she has also seen a therapist for the past 1 ½ years. Claimant testified that her history includes the loss of custody of her daughter. Claimant testified she has a history of drug abuse though she is 4 years clean of heroin and 9 years clean from cocaine.

Claimant testified she spends most of her days watching television. Claimant testified she sometimes performs light cleaning.

Claimant testified she tried holding a job as a cleaner in 2014. Claimant testified she was often late and was eventually fired. Claimant blamed the problem on depression.

Claimant testimony estimated she is depressed 5 out of 7 days in a week. Claimant testified that her moods are up and down and that her bad moods are severely bad. Claimant testified she sometimes does not feel like doing anything. Claimant testified medication and therapy helps her function though ongoing problems persist. Claimant testified she is not mentally capable of holding a job. Claimant testified she is not responsible enough to take her own medication and gets help from a family friend.

Claimant testified she has 3 deteriorating discs and stenosis in her lumbar. Claimant testified that she is currently trying epidural injections and will start physical therapy soon. Claimant testified she has difficulty with cleaning when her back hurts. Claimant testified she can do laundry but restricts the weight of her clothes load.

Claimant testified she can only walk 5-10 minutes due to tailbone pain. Claimant estimated she was equally limited in her standing. Claimant testified that she can sit for 20 minutes and would require standing breaks of 5-10 minutes before returning to sitting. Claimant testimony conceded she does not use any walking assistance devices.

Claimant testified she has CTS in both hands. Claimant testified that she had surgery on her right hand. Claimant expects to have surgery on her left hand in a few weeks. Claimant testified her right hand pain is gone but she needs to rebuild hand strength.

Claimant's history of prescription drug abuse is problematic. Claimant was caught attempting to illegally obtain pain medication in the very most recent verified treatment. As a result, Claimant's overall credibility is essentially meaningless. The analysis may still consider disability based on verified treatment and medical sources.

Presented evidence verified lumbar treatment which would reasonably limit Claimant's ability to walk, stand, lift/carry, and sit. It is found Claimant established severe exertional impairments.

Claimant was diagnosed with bipolar disorder I. Such a diagnosis is appropriate for a medical history involving at least one manic or manic/depressive episode. Generally, it is a more severe and debilitating disorder than bipolar II. The diagnosis, along with Claimant's treatment history, was sufficient to infer various restrictions affect Claimant's concentration, social skills, and daily activities.

It is found that Claimant established significant impairment to basic work activities for a period 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.

Claimant's primary impairment was 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.

A Mental Residual Functional Capacity Assessment (Exhibits 168-169; 229; 232) from an examination dated March 5, 2015, was presented. The assessment was noted as completed by a treating psychiatrist and limited licensed psychologist. It was noted that Claimant was markedly restricted in the following abilities:

- Remembering locations and other work-like procedures
- Understanding and remembering detailed instructions
- Carrying out detailed instructions
- Maintaining concentration for extended periods
- Performing activities within a schedule and maintaining attendance and punctuality
- Sustaining an ordinary routine without supervision
- Working in coordination or proximity to other without being distracting
- Completing a normal workday without psychological symptom interruption
- Accepting instructions and responding appropriately to criticism
- Getting along with others without exhibiting behavioral extremes
- 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.

The above-stated restrictions were consistent with Claimant’s mental health history. The restrictions were highly indicative of marked concentration, daily activity, and social restrictions.

Claimant's GAF was noted to be 40-42 as of March 2015. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF within the range of 41-50 is representative of a person with "serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g. no friends, unable to keep a job)." A GAF score of 31-40 is described as "some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood." Claimant's GAF is highly consistent with marked functioning restrictions.

Based on presented records, it is found that Claimant meets the listing for affective disorders. Accordingly, Claimant is a disabled individual and it is found that MDHHS erred in denying Claimant's SDA application.

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 May 6, 2015;
(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 if Claimant is found eligible for 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: **8/31/2015**

Date Mailed: **8/31/2015**

GC/tm

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

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

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

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

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

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

Attention: MAHS Rehearing/Reconsideration Request

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

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

cc: [redacted]