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

IN THE MATTER OF:

[redacted]

MAHS Reg. No.: 15-017934
Issue No.: 4009
Agency Case No.: [redacted]
Hearing Date: November 30, 2015
County: Wayne (15)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

Following Petitioner'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 November 30, 2015, from Detroit, Michigan. Petitioner appeared and was unrepresented. Cary Price, Petitioner's caretaker, testified on behalf of Petitioner. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], specialist, and [redacted], specialist.

ISSUE

The issue is whether MDHHS properly denied Petitioner's State Disability Assistance (SDA) eligibility for the reason that Petitioner 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 June 12, 2015, Petitioner applied for SDA benefits.

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

3. On August 6, 2015, the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibits 2-8).

4. On August 14, 2015, MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action informing Petitioner of the denial.

5. On October 2, 2015, Petitioner requested a hearing disputing the denial of SDA benefits.

6. On November 30, 2015, an administrative hearing was held.

7. During the hearing, the record was extended 7 days to allow Petitioner to submit psychiatric treatment records; MDHHS waived their right to object to the admission of the documents.

8. An Interim Order Extending the Record was subsequently mailed to both parties.

9. On December 7, 2015, Petitioner submitted additional documents.

10. As of the date of the administrative hearing, Petitioner was a 49-year-old female.

11. Petitioner has not earned substantial gainful activity since before the first month of benefits sought.

12. Petitioner's highest education year completed was the 12th grade (via equivalency degree).

13. Petitioner has a history of semi-skilled employment, with no transferrable job skills.

14. Petitioner alleged disability based on restrictions related to black-outs, bipolar disorder, left-sided weakness, back pain, leg pain, and neuropathy.

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 Petitioner. Accordingly, Petitioner may not be considered for SDA eligibility without undergoing a medical review process (see BAM 815) which determines whether Petitioner 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. SDA differs in that a 90 day period is required to establish 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 CFR 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.

Petitioner credibly denied performing any employment since the date of the SDA application; no evidence was submitted to contradict Petitioner's testimony. Based on the presented evidence, it is found that Petitioner 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 durational 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 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 Petitioners 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 requirements are 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 Petitioner'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.

Hospital emergency room documents (Exhibits 114-118) dated August 30, 2014, were presented. An active problem of morbid obesity was noted. Lab testing was performed.

Hospital documents (Exhibits 56-80; 119-126) from an admission dated September 11, 2014, were presented. It was noted that Petitioner presented with complaints of left-sided weakness and "slower than normal" speech. It was noted Petitioner's examination findings suggested left-sided hemiparesis was psychosomatic, though radiology was

ordered. A head CT and brain MRI were noted to be unremarkable. AN EKG was noted to show no evidence of acute ischemia or infarction. Carotid Doppler testing was noted to be normal. Vascular testing indicated carotid artery stenosis of less than 50%. A discharge diagnosis of hemiplegia was noted. A follow-up with a neurologist was scheduled. Discharge medications included atorvastatin, aspiring, and nifedipine. A discharge date of September 14, 2014, was noted.

Emergency room hospital documents (Exhibits 92-110; 136-139; 162-163) dated September 30, 2014, were presented. Complaints of slurred speech and left-sided weakness were noted. It was noted Petitioner had not yet followed-up with a neurologist. An impression of no acute cardiopulmonary process was noted following chest x-rays. An impression of no acute intracranial process was noted following a head CT. On October 1, 2014, Petitioner's speech was noted to have returned back to normal. "No diagnosis specified" was noted. A follow-up appointment to a psychiatrist/neurologist was noted.

Various hospital documents (Exhibits 141-158) from October 2014 were presented. Petitioner testified she spent 20 days in a nursing home during October 2014. It was noted that Petitioner presented with complaints of slurred speech and left-sided weakness. It was noted that a neurologist diagnosed Petitioner with TIA and Petitioner was admitted for physical therapy, occupational therapy, and speech therapy. A discharge diagnosis of TIA was noted. At discharge, Petitioner was noted to be back to baseline. It was noted Petitioner could transfer from chair to bed with minimal assistance.

Hospital documents (Exhibits 16-23; 27-45; 81-91) from an admission dated January 3, 2015, were presented. It was noted that Petitioner presented with complaints of headaches and speaking difficulty. It was noted Petitioner's complaints date back to August 2014. A previous diagnosis of conversion disorder secondary to multiple hospital visits was noted. Petitioner's headache and HTN were noted to have responded well to medication. A CT of Petitioner's brain was noted to be negative. A discharge diagnosis of acute TIA was noted. A follow-up for psychotherapy was noted. Discharge medications included aspirin, acetaminophen-codeine, atorvastatin, nifedipine, and cyclobenzaprine. A discharge date of January 5, 2015, was noted.

Hospital emergency room documents (Exhibits 24-26; 46-55; 159-161) dated February 5, 2015, were presented. It was noted that Petitioner presented with complaints of chronic symptoms which included severe right-sided neck pain, left-sided weakness, headache, speaking difficulty, and walking difficulty. Symptoms were reported as ongoing for 5 days. A physician noted Petitioner was initially stuttering, but one minute later, Petitioner spoke fluently and held a logical conversation. It was noted that Petitioner received 2 Norcos for neck pain. It was noted Petitioner was previously prescribed muscle relaxers but she did not get the prescription filled. Noted discharge diagnoses included neck pain and spasm.

Hospital emergency room documents (Exhibits 111-113) dated March 10, 2015, were presented. Noted diagnoses included tremors and HTN.

A Medical Examination Report (Exhibits 13-15) dated June 30, 2015, was presented. The form was completed by an internal medicine physician with no history of treating Petitioner; Petitioner testified the form was completed by a newly-treating primary care physician. The physician listed diagnoses of HTN, hyperlipidemia, and syncope/TIA. No physical examination abnormalities were noted. An impression was given that Petitioner's condition was deteriorating. It was noted that Petitioner required assistance with laundry, grocery shopping, and housekeeping. Full range of motion was noted in physical examination findings.

Petitioner testified she was hospitalized from August 21, 2015 through August 24, 2015. No records were presented to verify Petitioner's testimony.

A Mental Impairment Questionnaire (Exhibits A1) dated September 24, 2015, was presented. The questionnaire was completed by a physician from a treating counseling agency. A treatment history since July 29, 2015, was noted. Petitioner was noted to be seen monthly. An Axis I diagnosis of bipolar disorder with psychogenic seizures was noted. Petitioner's GAF was noted to be 50. It was noted Petitioner partially responded to treatment, though she remains paranoid and socially avoidant. Prescribed medications included Abilify and Restoril. It was noted Petitioner had psychogenic seizures when stressed. Other symptoms included insomnia, paranoia, and irritability. A guarded prognosis was noted.

Petitioner testified she uses a caretaker for laundry and transportation. Petitioner also testified she has difficulty with grooming her hair because of difficulty in right hand/arm lifting. Petitioner testified her caregiver or daughter does her shopping for her. Petitioner indicated her left knee stiffens up after 20 minutes and prevents her from shopping. Petitioner says she has a walker. Petitioner testified she uses a walker 3 times per week. Petitioner testified she requires a caregiver twice per week. Petitioner testified she is restricted to 20 minute periods of walking though she has no sitting restrictions. Petitioner also testified her physician imposed a 5 pound lifting restriction.

Petitioner testified she has arthritis in her left knee. Petitioner's testimony blamed the pain on "bone on bone" spurs on her knee. Petitioner says she was told that surgery is not an option due to her young age. Petitioner also testified she has a pinched nerve in neck.

Petitioner presented no treatment records to verify knee pain. A single treatment for neck spasms was verified. Zero radiology of Petitioner's knees and/or neck was provided. Petitioner's physician did not list any diagnoses related to knee or neck pain. A need for a walking-assistance device was not established. A need for ADL assistance was indicated by a physician though no basis for the restriction was established. One treatment for neck pain is insufficient to establish a severe exertional impairment related

to neck and/or knee pain. It is found Petitioner failed to establish a severe exertional impairment

Petitioner testified she has recurring problems of tremors, head shaking, left-sided weakness, and slurred speech. Medical documents generally corroborated Petitioner's testimony.

Repeated radiological (CTs and MRIs) testing of Petitioner's brain consistently showed no abnormalities. An EKG was normal. Carotid Doppler testing was normal. There was zero evidence of any abnormal brain, heart, or vascular function. Even when Petitioner was diagnosed with a TIA and kept for 20 days, presented evidence was not strongly indicative that Petitioner had a stroke.

Petitioner testified her neurologist who told her the cause of her "mini strokes" was psychologically based. Most treatment documents support a conclusion that Petitioner's seizures have no physical basis.

Petitioner testified she thinks her recurring loss of speech and weakness has some physical origin though her testimony also conceded otherwise. Petitioner testified that stress is a trigger for her recurring symptoms. Petitioner says sexual abuse from her past may be contributing to seizures. Petitioner says she started seeing a therapist around June 2015 for weekly one-hour sessions. Petitioner's recurring stroke-like symptoms are a compelling impairment.

It is found that Petitioner established significant impairment to basic work activities for a period longer than 90 days. Accordingly, it is found that Petitioner established having a severe impairment and the disability analysis may proceed to Step 3.

The third step of the sequential analysis requires determining whether the Petitioner's impairment, or combination of impairments, is listed in 20 CFR Part 404, Subpart P, appendix 1. 20 CFR 416.920 (a)(4)(iii). If a Petitioner's impairments are listed and deemed to meet the durational requirement, then the Petitioner is deemed disabled. If the impairment is unlisted or impairments do not meet listing level requirements, then the analysis proceeds to the next step.

Petitioner's primary impairment was recurring seizures causing loss of speech and physical dysfunction. Presented evidence established the seizures were psychogenic. A primary diagnosis of bipolar disorder was established. 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.

Symptoms of paranoia, motor dysfunction, insomnia, and concentration difficulties were established. It is found that Petitioner meets Part A of the bipolar disorder listing.

The Mental Impairment Questionnaire dated September 24, 2015, included assessments of Petitioner's capability of performing various mental abilities. Petitioner was found "limited but satisfactory" in the following aptitudes: remembering work-like procedures, understanding short and simple instructions, carrying out simple instructions, making simple decisions, asking simple questions, responding appropriately to changes, dealing with normal work stress, being aware of hazards, and interacting with the public. Petitioner was found "seriously limited" in the following aptitudes: maintaining attention for 2 hour periods, maintaining regular attendance and punctuality, sustaining an ordinary routine, working in coordination with others, performing at a consistent pace, accepting instructions and responding to criticism, getting along with peers, and completing a normal workday without psychological interruption.

Generally, "serious" limitations in completing a workday, maintaining attendance and working with others are highly indicative of an inability to maintain any employment. The "serious" limitations could reasonably be equated to marked restrictions of concentration and social function. Given Petitioner's recurring seizure-like symptoms, the restrictions were reasonable.

It is found that Petitioner meets the bipolar disorder listing and is therefore a disabled individual. Accordingly, it is found that MDHHS improperly denied Petitioner's SDA application.

It should be noted that Petitioner presented only a very brief history of psychological treatment. Presented records established Petitioner began seeing a psychiatrist and/or therapist in late June 2015. The time it took for Petitioner to begin treatment is surprising when factoring she was told that her seizures were psychogenic as far back as September 2014. The brief treatment history creates two concerns.

First, it was considered that Petitioner was noncompliant in treatment history. The consideration was rejected due to the unique circumstances. It is not unreasonable for someone affected by seizures to stubbornly insist for several months that the seizures were neurologically-based.

Secondly, there is reason to believe that Petitioner's symptoms will lessen with therapy. Petitioner testified she had childhood trauma and that she hadn't discussed it for many years. It would be unsurprising for Petitioner's symptoms to significantly lessen after a few months of weekly therapy sessions. Such a conclusion is speculative as very little psychotherapy information was provided. Though the conclusion is speculative, it is consistent with Petitioner's testimony and presented evidence which indicated some improvement already. Once Petitioner's seizures can be controlled, it is reasonable for Petitioner to pursue employment. At this point in time, in 6 months, Petitioner will have been in therapy for nearly one year. Such a time is reasonable to review Petitioner's symptoms.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that MDHHS improperly denied Petitioner's application for SDA benefits. It is ordered that MDHHS perform the following actions within 10 days of the date of mailing of this decision:

(1) reinstate Petitioner's SDA benefit application dated June 12, 2015;
(2) evaluate Petitioner's eligibility subject to the finding that Petitioner 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 **SIX MONTHS** from the date of this administrative decision, if Petitioner 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: **12/21/2015**

Date Mailed: **12/21/2015**

CG/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]