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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-010991
Issue No.: 4009
Case No.: [redacted]
Hearing Date: August 10, 2015
County: Wayne (31)

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 10, 2015, from Detroit, Michigan. Participants included the above-named Claimant. 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 February 11, 2015, Claimant applied for SDA benefits.

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

3. On May 22, 2015, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 1-6).

4. On June 11, 2015, MDHHS denied Claimant's application for SDA benefits and mailed a Notice of Case Action (Exhibits 7-10) informing Claimant of the denial.

5. On June 22, 2015, Claimant requested a hearing disputing the denial of SDA benefits.

6. As of the date of the administrative hearing, Claimant was a 45 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 11th grade.

9. Claimant has a history of unskilled employment, with no transferrable job skills.

10. Claimant alleged disability based on restrictions related to chronic obstructive pulmonary disorder (COPD), back pain, shoulder pain, and hand pain related to carpal-tunnel syndrome (CTS).

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).

Claimant's hearing request noted a dispute of Family independence Program (FIP) (cash) benefits. FIP is an MDHHS program available to caretakers of minor children and pregnant women. Claimant testified that she only intended to dispute a denial of SDA benefits. MDHHS was not confused by Claimant's request to dispute FIP eligibility and was prepared to defend a denial of Claimant's SDA application denial. It is found that Claimant intended to dispute her SDA eligibility and the hearing was conducted accordingly.

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.

An electromyography report (Exhibits 36-38) dated October 25, 2013, was presented. It was noted that Claimant reported right-hand pain and a lumbar pain radiating to Claimant's right calf. Reduced dorsiflexion strength (4+/5) was noted. A conclusion of ulnar neuropathy across the right elbow was noted. Moderate right-sided ulnar neuropathy at Claimant's right wrist was noted. Decreased pinprick sensation was noted

in Claimant's right hand. A conclusion of an abnormal study was noted. It was noted that testing revealed mononeuropathy of the right wrist consistent with CTS and electrodiagnostic evidence of ulnar mononeuropathy across the right elbow. It was noted that there was no electrodiagnostic evidence of polyneuropathy affecting upper right or lower extremities. It was noted that findings do not correlate with Claimant's complaints of radiating lumbar pain.

A lumbar MRI report (Exhibits 34-35) dated July 7, 2014, was presented. An impression of mild degenerative changes without significant foraminal narrowing or stenosis was noted. Shallow disc protrusions were noted at L4-L5 and L5-S1.

A pulmonary function test report (Exhibits 28-30) dated July 16, 2014, was presented. The report included results from before and after use of a bronchodilator. Claimant's best forced vital capacity (FVC) was noted to be 2.60 (68% of predicted value). Claimant's best post-bronchodilator FEV1 was noted to be 1.90 (65% of predicted value). The following impressions were noted: mildly reduced FVC (unchanged by bronchodilator), mildly reduced total lung capacity, and mildly reduced diffusing capacity.

A Medical Examination Report (Exhibits 22-24) was presented. The form was completed by an internal medicine physician with an approximate 13 month history of treating Claimant. The form was undated but it was noted that Claimant was last examined on October 24, 2014. Claimant's physician listed diagnoses of COPD, HTN, back pain, CTS, depression, smoking, and vitamin D deficiency. Active medications were noted to include: Zoloft, nicotine patch, Losartan, Advair, valium, Norvasc, and Lipitor. A need for a cane, back brace, and right forearm splint was noted. An impression was given that Claimant's condition was stable. It was noted that Claimant reported a need for assistance with completing household needs. The physician noted that Claimant reported being unable to stand and/or walk more 2 hours, per 8 hour workday. Claimant was restricted to frequent lifting/carrying of less than 10 pounds, never 10 pounds or more. Claimant's physician opined that Claimant was restricted from performing the following repetitive actions: right-sided simple grasping, right-sided reaching, right-sided pushing pulling, and bilateral fine manipulation. In response to questions asking for the stated basis for restrictions and what laboratory or radiography was considered, Claimant's physician did not respond.

Neurologist office visit notes (Exhibits 31-33) dated December 8, 2014, were presented. It was noted that Claimant reported symptoms of lumbar degenerative disease (without radiculopathy) and increased shoulder pain. CTS was noted to be stable with use of a brace. A normal gait was noted. Reduced right knee reflex was noted. Tinel's sign was noted to be positive. Recommendations included continuance of Norco, Valium, and Motrin, and continued use of back brace.

A Medical Examination Report (Exhibits 25-27) dated February 20, 2015 was presented. The form was completed by a neurologist with an approximate 2 month

history of treating Claimant. Claimant's neurologist listed diagnoses of lumbar degenerative disease, CTS, and ulnar neuropathy. An impression was given that Claimant's condition was stable. It was noted that Claimant can meet household needs.

An internal medicine examination report (Exhibits 17-21) dated March 23, 2015 was presented. The report was noted as completed by a consultative physician. Claimant reported complaints of HTN ongoing for 7 years, dizzy spells, dyspnea with activity, lumbar pain radiating to right upper thigh area, CTS on the right side, and depression. It was noted that Claimant's right grip was "fairly good." Claimant's gait was noted to be normal. Restricted ranges of motion were noted throughout Claimant's lumbar and right wrist. The following conclusions were noted: HTN, history of COPD, tobacco abuse, chronic and recurrent lumbar pain, CTS of the right hand, depression, and anxiety.

An electromyography report (Exhibits 15-16; A1-A2) dated March 25, 2015, was presented. It was noted that Claimant reported pain and numbness in her left hand. Claimant's upper left muscle strength was noted to be 4/5. Decreased pinprick sensation was noted in Claimant's left hand. A conclusion of an abnormal study was noted. A neurologist noted that testing revealed marked mononeuropathy of the left wrist consistent with CTS and electrodiagnostic evidence of ulnar mononeuropathy across the left elbow. No electrodiagnostic evidence affecting the upper left extremity was noted.

A mental status examination report (Exhibits 11-14) dated April 30, 2015, was presented. The report was noted as completed by a consultative licensed psychologist. It was noted that Claimant reported difficulty in the initial phases of sleep. Noted observations of Claimant made by the consultative examiner included the following: appropriate dress and hygiene, good grooming, cooperative nature, spontaneous and goal-directed speech, no indication of delusions, no reported psychiatric hospitalizations, no reported suicide ideation, alert, and orientation x3. The examiner categorized Claimant to be "good" in the following abilities: social, ADLs, communication, relationships, social support, coping skills, frustration and behavior. The examiner opined that Claimant was restricted to performing simple, routine, repetitive, concrete, tangible tasks.

A prescription from Claimant's neurologist (Exhibit A4) dated May 11, 2015, was presented. A need for a rolling walker was noted.

A prescription from Claimant's neurologist (Exhibit A3) dated August 4, 2015, was presented. A need for left elbow brace and left wrist brace was noted.

Claimant testified that she has been depressed. Claimant testified that she restarted psychiatric 2 months ago after stopping treatment in January 2015. Therapy documents were not presented. It was verified that Claimant takes anti-depressant medication (Claimant's physician noted that Claimant takes Zoloft). Psychological restrictions were not stated by Claimant's physician. A presented consultative examination revealed no

severe impairments. It is found that Claimant failed to establish restrictions based on depression.

Claimant testified that she cannot walk even a half block with her walker before losing her breath. Claimant's testimony was not consistent with pulmonary functional testing which verified only mild abnormalities with her lung functioning. A finding of respiratory function restrictions is also hampered by Claimant's concession that she continues to smoke against medical advice, though Claimant testimony claimed that she significantly reduced her smoking. It is likely that Claimant has some breathing difficulties, but not to the extent alleged by Claimant.

Claimant testified that she has ambulation, lifting/carrying, and standing, and repetitive arm and hand movement restrictions. Claimant testified that neuropathy, CTS, and lumbar abnormalities contribute to her exertional restrictions. Claimant's testimony was consistent with her treatment history.

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 primary alleged impairment due to neuropathy. The listing most applicable to Claimant 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 she has difficulty with bending, opening lids, cleaning, and writing. Claimant testified that she cannot bend to put on socks and has to wear slip-on shoes. Claimant testified that cleaning her backside is very difficult due to arm pain. Claimant testified that she usually does not do her shopping. Claimant testified that she cannot walk downstairs to do her own laundry. Claimant testified that she has a friend who prepares food for Claimant. Claimant's difficulty with performing ADLs was generally consistent with meeting SSA listing requirements.

Restrictions alleged by Claimant seemed to involve a significant amount of lumbar pain. Documents verified that Claimant has a need for pain medication, however, lumbar radiology was not compelling. An absence of stenosis was noted in an MRI report. Mild

degenerative changes and shallow disc protrusions were noted, however, neither is particularly indicative of significant lumbar restrictions. Neurological testing found no explanation for Claimant's complaint of radiating lumbar pain.

On a Medical Examination Report dated February 20, 2015, Claimant's neurologist opined that Claimant was restricted as follows over an eight-hour workday, less than 2 hours of standing and/or walking, and less than 6 hours of sitting. Claimant was restricted to occasional lifting/carrying of 10 pounds or less, never 20 pounds or more. Claimant's physician opined that Claimant was restricted from performing any repetitive actions with her right hand or arm. An MRI and EMG were cited as radiological support for stated restrictions. Stated restrictions to Claimant's right arm were consistent with treatment and testing history. Claimant established persistent disorganization of her right arm.

Claimant's neurologist did not note left-sided restrictions on the Medical Examination Report, however, subsequent electromyography testing noted problems in Claimant's left arm that were similar to previously found right arm problems. The evidence was sufficient to establish disorganization of motor function affecting two of Claimant's extremities causing sustained disturbance of gross and dexterous movements. For good measure, a need for a walker and/or a cane was verified; this evidence was highly indicative that Claimant has some degree of gait disturbance as well. This evidence was less compelling as a normal gait was noted in multiple records and a need for a walker was not apparent outside of a prescription for the walker.

It is found that Claimant meets the listing for peripheral neuropathies. Accordingly, Claimant is a disabled individual and it is found that MDHHS improperly denied 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 February 11, 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 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: **8/11/2015**
Date Mailed: **8/11/2015**
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]