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.: 15-019217
Issue No.: 4009
Agency Case No.: [redacted]
Hearing Date: January 28, 2016
County: Mason

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; and Mich Admin Code, R 792.11002. After due notice, a telephone hearing was held on January 28, 2016, from Detroit, Michigan. Petitioner appeared and was represented by [redacted] Petitioner's father. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted] supervisor, and [redacted], specialist.

ISSUE

The issue is whether MDHHS properly terminated 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. Petitioner was an ongoing SDA benefit recipient.

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

3. On [redacted], the Medical Review Team (MRT) determined that Petitioner was not a disabled individual for purposes of SDA eligibility (see Exhibit 1, pp. 5-6).

4. On [redacted], MDHHS terminated Petitioner's eligibility for SDA benefits, effective November 2015, and mailed a Notice of Case Action (Exhibit 1, pp. 1-3) informing Petitioner of the termination.

5. On [redacted], Petitioner requested a hearing disputing the termination of SDA benefits.

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).

Petitioner requested a hearing to dispute a termination of SDA eligibility. MDHHS presented a Notice of Case Action (Exhibit 1, pp. 1-3) which stated Petitioner was deemed to be no longer disabled.

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (January 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 (July 2014), 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.

Generally, state agencies such as MDDHS 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. The definition of SDA disability is identical except that only a three month period of disability is required.

Substantial gainful activity 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. BEM 260 (7/2014), p. 10. 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 substantial gainful activity. *Id*.

Once an individual has been found disabled for purposes of disability-related benefits, continued entitlement 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. Petitioner was previously certified by the MRT as unable to work for at least 90 days. At Petitioner's most recent SDA benefit redetermination, MDDHS determined that Petitioner was no longer disabled.

In evaluating a claim for ongoing disability benefits, federal regulations require a sequential evaluation process be utilized. 20 CFR 416.994(b)(5). The review may cease and benefits continued if sufficient evidence supports a finding that an individual is still unable to engage in substantial gainful activity. *Id.* Prior to deciding if an individual's disability has ended, the department will develop, along with the petitioner's cooperation, a complete medical history covering at least the 12 months preceding the date the individual signed a request seeking continuing disability benefits. 20 CFR 416.993(b). The department may order a consultative examination to determine whether or not the disability continues. 20 CFR 416.993(c).

The below-described evaluation process is applicable for clients that have not worked during a period of disability benefit eligibility. There was no evidence suggesting that Petitioner received any wages since receiving disability benefits; thus, the analysis may commence.

The first step in the analysis in determining the status of a petitioner's disability 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 and no further analysis is required. This consideration requires a summary and analysis of presented medical documents.

Various physician office visit notes from 2001 through 2011 (Exhibit 1, pp. 111-140, 166-174, 215-221, 232-238) were presented. Various treatments for left eye pain, headaches, nausea, abdominal pain, chronic back pain, dental pain, left toe pain, left knee pain, chronic foot pain, diarrhea, chest pain, and IBS.

A left knee MRI (Exhibit 1, p. 78) dated [redacted], was presented. Chronic femoral condylar concavities were noted. A questionable small meniscus tear was also noted.

A lumbar spine study report (Exhibit 1, p. 74) dated [redacted], was presented. It was noted the exam was very similar to a 2002 exam (see Exhibit 1, p. 82). "Only mild osteoarthritic changes" were noted.

An operative note (Exhibit 1, pp. 109-110) dated [redacted], was presented. Pre-operative and post-operative diagnoses of left inguinal hernia were noted. It was noted

Petitioner underwent repair of hernia with excision of lipoma of the cord; a ProLIte mesh was noted as inserted.

Physician office visit notes (Exhibit 1, pp. 106-108) dated [redacted], were presented. It was noted that Petitioner presented with a complaint of pain above his left eye. Diazepam was noted as prescribed.

Physician office visit notes (Exhibit 1, pp. 103-105) dated [redacted], were presented. It was noted that Petitioner presented with a complaint of eye pain and headache (intermittent for a year, worse over the last 5 days). Prednisone was noted as prescribed.

An MRI brain report (Exhibit 1, pp. 67-68) dated [redacted], was presented. The MRI was noted to have been performed in response to Petitioner's complaints of headaches. An impression of very mild ethmoid sinusitis was noted. A 3mm cyst was also noted.

Medical center documents (Exhibit 1, pp. 156-157) dated [redacted], were presented. It was noted Petitioner reported intermittent headaches over the past year.

A sleep study report (Exhibit 1, pp. 150-151) dated [redacted], was presented. It was noted Petitioner reported excessive daytime somnolence and snoring. A conclusion of mild obstructive sleep apnea was noted.

Medical center documents (Exhibit 1, pp. 152-155) dated [redacted], were presented. It was noted Petitioner reported constipation and rectal pain for 24 hours. A history of fissures was noted. Medication was prescribed and a high fiber diet was recommended.

Physician office visit notes (Exhibit 1, pp. 146-149) dated [redacted], were presented. It was noted that Petitioner presented with a complaint of malaise, fever, and body pain. An impression of pharyngitis was noted.

Physician office visit notes (Exhibit 1, pp. 141-145) dated [redacted], were presented. It was noted that Petitioner presented with a complaint of stomach bug and cough. An impression of non-critical findings were noted following chest and head x-rays.

Medical center and hospital documents (Exhibit 1, pp. 160-164, 193-196, 209-214) dated [redacted], were presented. It was noted Petitioner presented with a complaint of chest pain. It was noted Petitioner appeared earlier that day with the same complaint but left against medical advice. A chest x-ray was noted to be negative. It was noted an EKG was negative. Petitioner received a nitroglycerin drip. A discharge diagnosis of acute chest pain was noted.

Cardiologist testing and treatment documents (Exhibit 1, pp. 86-91, 158-159) dated [redacted], was presented. Mild decreased perfusion on stress imaging involving left ventricle was noted. Petitioner's ejection fraction was noted to be 65%. It was noted Petitioner showed shortness of breath but no chest pain during the stress test.

Operative notes (Exhibit 1, pp 206-208) dated [redacted] were presented. It was noted Petitioner underwent a selective left and right angiogram. A left heart catheterization and ventriculogram were also performed.

Medical center treatment documents (Exhibit 1, pp. 201-204) dated [redacted], were presented. A complaint of scratchy throat, earaches, and diarrhea were noted. Medications of ondansetron and amoxicillin were noted as prescribed.

Medical center treatment documents (Exhibit 1, pp. 197-200) dated [redacted], were presented. A complaint of neck pain, ongoing for several years was noted. Pain medication was prescribed.

Hospital emergency room documents (Exhibit 1, pp. 189-192) dated [redacted], were presented. It was noted that Petitioner presented with neck pain following a fall down stairs. Pain medication was prescribed and Petitioner was discharged.

Orthopedist office visit notes (Exhibit 1, pp. 49-50) dated [redacted], were presented. It was noted that Petitioner received ongoing treatment for neck pain and headaches, ongoing for 30 years. A complaint of thigh pain was also noted. It was noted Petitioner had no neurological problems to explain thigh pain. An impression of early neural cord compression was noted.

Orthopedist office visit notes (Exhibit 1, pp. 51-54, 242-246) dated [redacted], were presented. Motor strength of 4/5 was noted in Petitioner's deltoids, biceps, triceps, wrist extension, grip, and intrinsics. It was noted a cervical spine MRI demonstrated congenital narrowing throughout the cervical spine. "Severe" stenosis and cord compression were noted (along with disc bulges) at C3-C6. 10 degrees of lordosis was noted from C2-C7. It was noted Petitioner's complaints were consistent with myelopathy. It was noted Petitioner would best be treated with a laminoplasty.

Orthopedist office visit notes (Exhibit 1, pp. 55-58, 100-102, 239-241) dated [redacted], were presented. Ongoing Petitioner difficulties included neck pain radiating to Petitioner's shoulders and spine, hand dexterity difficulties, and gait instability. Petitioner's grip strength was 4-/5. It was noted a spinal fusion was considered but not recommended, in part, due to Petitioner's young age and the high risk for developing adjacent issues.

An operative report (Exhibit 1, pp. 59-60, 97-99) dated [redacted] was presented. It was noted Petitioner underwent a cervical laminoplasty C3-C7. A pre-operative and post-operative diagnosis of multi-level cervical stenosis with myelopathy was noted.

Petitioner testified 2 plates, 17 screws, a rod, and a bone were each inserted into his neck. The operation was performed during a hospital admission starting [redacted] (see Exhibit 1, pp. 179-188). A discharge date of [redacted], was noted.

Orthopedist office visit notes (Exhibit 1, pp. 61-62) dated [redacted], were presented. It was noted Petitioner reported "doing quite well." It was noted Petitioner reported the "vast majority" of upper and lower extremity symptoms have resolved. It was noted Petitioner took Norco every 4 hours. A 2-3 week follow-up was noted as planned.

Hospital emergency room documents (Exhibit 1, pp. 175-178) dated [redacted], were presented. It was noted that Petitioner presented after falling on his head and shoulder. Petitioner reported concern that the fall affected his recent neck surgery. A recommendation to see his surgeon was noted.

A Medical Examination Report (Exhibit 1, pp. 24-26) dated [redacted]5, was presented. The form was completed by a family practice physician with an approximate 13 year history of treating Petitioner. Petitioner's physician listed diagnoses of s/p cervical laminoplasty for multiple level stenosis, migraine cephalalgia, anxiety, depression, myelopathy, and GERD. An impression was given that Petitioner's condition was stable. It was noted that Petitioner can meet household needs. A need for a walking-assistance device was not indicated. Physical examination findings noted decreased back and neck range of motion. Petitioner's primary care physician stated Petitioner had various limitation(s) expected to last 90 days. The physician opined that Petitioner was restricted as follows over an eight-hour workday, 2 hours of standing. Petitioner was restricted from all lifting/carrying of 10 pounds or more. Petitioner's physician opined that Petitioner was restricted from performing the following repetitive actions: bilateral simple grasping, bilateral reaching, bilateral pushing/pulling, bilateral fine manipulating, and bilateral foot/leg control operation. Petitioner's physician cited Petitioner's post-surgical status and need for a cervical collar as the basis for restrictions. Petitioner's physician also cited Petitioner to be limited in comprehension and reading/writing due to anxiety, depression, and dyslexia.

A letter from a treating orthopedist (Exhibit 1, p. 42, 46, 66) dated [redacted], was presented. Petitioner's orthopedist noted Petitioner's "advanced" degeneration and cervical myelopathy preclude Petitioner's continuation of employment involving heavy lifting.

A Medical Examination Report (Exhibit 1, pp. 43-45, 63-65) dated [redacted], was presented. The form was completed by a treating orthopedic surgeon with an approximate 3 month history of treating Petitioner. Petitioner's physician listed diagnoses of cervical stenosis with myelopathy. Strength was noted to be 5/5. An impression was given that Petitioner's condition was improving. It was noted that Petitioner can meet household needs. A need for a walking-assistance device was not indicated. Petitioner's orthopedic surgeon stated Petitioner had various limitation(s)

expected to last 90 days. Standing and sitting restrictions were not listed. A repetitive restriction of bilateral pushing/pulling was noted. A restriction of no lifting of 50 pounds was noted. It was also noted Petitioner could frequently lift/carry less than 10 pounds. A statement of Petitioner's ability to lift/carry 10-50 pounds was not stated. A 3 month restriction from lifting/carrying more than 10 pounds was also noted. Petitioner's physician cited congenital cervical stenosis, advanced cervical disease degeneration, and myelopathy as support for restrictions.

Orthopedist office visit notes (Exhibit 1, pp. 47-48) dated [redacted], were presented. It was noted Petitioner reported left hand ulnar numbness and thigh pain. Motor strength was 5/5 in all tested area, except for 4/5 intrinsics strength. A CT scan from the hospital was noted to not show traumatic injury. It was noted Petitioner's pre-operative symptoms "improved significantly." A 2 week follow-up was planned.

Petitioner testified he has bipolar disorder and anger control difficulties. Petitioner testified he sees a counselor every week. Petitioner testified he has dyslexia and can barely read.

Petitioner alleged ongoing problems, in part due to lumbar problems. Petitioner testimony implied the problem is related to a spinal fracture from some unspecified time in the past.

Petitioner testified he uses a cane all of the time. Petitioner testified the cane helps with severe right foot drop, ongoing for 5 years. Petitioner testified his foot drop cannot be surgically corrected. Petitioner speculated that foot drop was caused by nerve damage in his right hand.

Petitioner testified he is restricted to walking 1 block due to back pain. Petitioner testified he could stand for 30 minutes. Petitioner estimated he could sit 30 minutes before his lower back grew stiff; Petitioner testified he could return to sitting after 10 minutes of standing. Petitioner testified his orthopedic surgeon imposed a permanent 10 pound lifting/carrying restriction (this statement conflicted with a presented Medical Examination Report). Petitioner testified he was told heavier lifting could cause his neck to be severely reinjured.

Petitioner testified he limits his showers to 5 minutes due to standing difficulties. Petitioner testified he dresses himself, but has to sit to put on his pants. Petitioner testified he can do laundry but he does not carry more than 10 pounds. Petitioner testified he shops, but brings his father to help carry groceries. Petitioner testified he can drive.

A listing for joint dysfunction (Listing 1.02) was considered based on Petitioner's complaints of knee pain. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively.

A listing for spinal disorders (Listing 1.04) was considered based on Petitioner's cervical spine surgical history. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root.

A listing for sleep apnea (Listing 3.10) was considered. The listing was rejected due to a failure to meet the requirements of Listings 3.09 or 12.02.

Cardiac-related listings (Listing 4.00) were considered based on Petitioner's cardiac treatment history. Petitioner failed to meet any cardiac listings.

Digestive disorder listings (Listings 5.00) were considered based on a history of IBS. Petitioner presented insufficient evidence that any digestive disorder listing was met.

A listing for affective disorder (Listing 12.04) was considered based on diagnoses of depression. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Petitioner required a highly supportive living arrangement, suffered repeated episodes of decompensation or that the residual disease process resulted in a marginal adjustment so that even a slight increase in mental demands would cause decompensation.

It is found Petitioner failed to establish meeting a SSA listing. Accordingly, the analysis may proceed to the second step.

The second step of the analysis considers whether medical improvement occurred. 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).

A Medical-Social Eligibility Certification (Exhibit 1, pp. 22-23). The document verified MRT approved Petitioner for SDA on [redacted]

Petitioner testimony conceded he has medically improved since undergoing a laminectomy in January 2015. The testimony was consistent with presented documentation. Despite Petitioner's concession, MDHHS has a substantial obstacle in establishing medical improvement.

MDHHS cited Petitioner's laminectomy and subsequent treatment documents as support for terminating Petitioner's SDA eligibility. The documents MDHHS cited as support to terminate SDA eligibility were all submitted before the original finding of disability. Presumably, MDHHS considered the same documents in supporting the disability claim as they are using to terminate Petitioner's disability. MDHHS presented zero medical documentation dated following the original determination of disability.

Due to the total absence of records following the original finding of disability, it is found MDHHS failed to establish Petitioner underwent medical improvement and the analysis may directly proceed to the fourth step.

Step 4 of the analysis considers whether any exceptions apply to a previous finding that no medical improvement occurred or that the improvement did not relate to an increase in RFC. 20 CFR 416.994(b)(5)(iv). If medical improvement related to the ability to work has not occurred and no exception applies, then benefits will continue. CFR 416.994(b). Step 4 of the disability analysis lists two sets of exceptions.

The first group of exceptions allow a finding that a petitioner is not disabled even when medical improvement had not occurred. The exceptions are:

(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.
20 CFR 416.994(b)(4)

If an exception from the first group of exception applies, then the petitioner is deemed not disabled if it is established that the Petitioner can engage is substantial gainful activity. If no exception applies, then the petitioner's disability is established.

The second group of exceptions allow a finding that a petitioner is not disabled irrespective of whether medical improvement occurred. The exceptions are:

(i) A prior determination was fraudulently obtained;
(ii) The individual failed to cooperate;
(iii) The individual cannot be located;
(iv) The prescribed treatment that was expected to restore the individual's ability to engage in substantial gainful activity was not followed.
20 CFR 416.994(b)(4)

There was no evidence that any of the above exceptions are applicable. Accordingly, it is found Petitioner is still a disabled individual and that MDHHS improperly terminated Petitioner's SDA eligibility.

DECISION AND ORDER

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

(1) reinstate Petitioner's SDA eligibility, effective November 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 no less than twelve 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: **FEBRUARY 29, 2016**

Date Mailed: **FEBRUARY 29, 2016**

CG / hw

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 copy of the claim or application for appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Hearing Decision from 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]