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.: 15-019685
Issue No.: 4009
Agency Case No.: [redacted]
Hearing Date: January 6, 2016
County: Wayne (18)

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 6, 2016, from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], medical contact worker.

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] a Disability Determination Explanation (Exhibit 1, pp. 1-17) determined that Petitioner was not a disabled individual for purposes of Social Security Administration eligibility.

4. On [redacted] MDHHS terminated Petitioner's eligibility for SDA benefits, effective November 2015, and mailed a Notice of Case Action (Exhibit 1, pp. 588-591) 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).

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 (7/2014), 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 dated following the original finding of disability.

A Hearing Decision dated [redacted] (Exhibit 1, pp. 18-26, pp. 59-67) was presented. The presiding administrative law judge found Petitioner was disabled. An accompanying analysis did not clearly identify the basis for the finding, however, Petitioner's combined breathing difficulties and psychological impairments appeared to be the primary basis. Cited evidentiary support included the following: a Residual Functional Capacity Assessment form a non-physician indicating Petitioner had many marked restrictions; moderately severe breathing difficulties; diagnoses of depression, bipolar disorder, and PTSD; and a GAF of 50. All documents following [redacted], will be considered in the first step analysis.

Various cardiology treatment and testing documents (Exhibit 1, pp. 251-326) were presented. The documents ranged from the month of June 2014 through August 2015. Regular complaints of dyspnea and chest pain were noted. On [redacted], it was noted stress testing showed no ischemia, an echocardiogram showed normal left ventricular function, and a carotid ultrasound showed no stenosis.

Physician office visit notes (Exhibit 1, pp. 396-401) dated [redacted] were presented. Complaints of dyspnea, coughing, and chest pain were noted. Active

medications included Promethazine, Diazepam, Ciproflaxacin, Metformin, Ventrolin, Qvar, and several others.

Physician office visit notes (Exhibit 1, pp. 362-363, 402-404) dated [redacted], were presented. It was noted Petitioner presented to discuss laboratory results. Assessments of diabetes, costochondritis, paresthesia, and hyperlipidemia were noted. Various medications were prescribed.

Physician office visit notes (Exhibit 1, pp. 358-359, 405-407) dated [redacted] were presented. It was noted Petitioner complained of acute bronchitis. Medications for COPD, paresthesia, and costochondritis were noted as prescribed.

Physician office visit notes (Exhibit 1, pp. 356-357, 408-410) dated [redacted], were presented. It was noted Petitioner reported muscle pain, chest pain, and rib pain. Various medications were prescribed. Iodisine and and other medication were prescribed.

Physician office visit notes (Exhibit 1, pp. 354-355, 411-413) dated [redacted], were presented. It was noted Petitioner complained of chest pain.

Hospital emergency room documents (Exhibit 1, pp. 389-392) dated [redacted], were presented. It was noted that Petitioner presented with complaints of chest pain and cough. A CT report of Petitioner's thorax (Exhibit 1, p. 372, 376) indicated an impression of no evidence of acute intrathoracic process was noted.

Physician office visit notes (Exhibit 1, pp. 414-417) dated [redacted], were presented. A complaint of ear pain was noted.

Physician office visit notes (Exhibit 1, pp. 352-353) dated [redacted] were presented. It was noted Petitioner complained of ear pain and chest tightness.

Physician office visit notes (Exhibit 1, pp. 349-350, 418-420) dated [redacted], were presented. Ongoing asthma and COPD treatment was noted. Petitioner's muscle strength was noted to be 5/5. It was noted previous glove and stocking spasms have stopped.

Physician office visit notes (Exhibit 1, pp. 346-348, 421-423) dated [redacted], were presented. It was noted that Petitioner reported anxiety over the death of her sister. A lingering cough from bacterial pneumonia was noted. It was noted Petitioner's chest pain was 75% improved with prescription of Indosine, though some pain persists.

Physician office visit notes (Exhibit 1, p. 342-345, 425-426) dated [redacted], were presented. It was noted that Petitioner reported ongoing dyspnea, chest pain, and upper abdominal pain. A right leg muscle spasm was noted. An assessment of atypical chest

pain and tachycardia were noted. A referral to cardiology was noted. An x-ray of Petitioner's sternum indicated no fracture (see Exhibit 1, p. 371)

Hospital emergency room documents (Exhibit 1, pp. 224-239) dated S[redacted], [redacted] were presented. It was noted that Petitioner with severe claudication. It was noted Petitioner underwent an angiogram which discovered luminal irregularities of the left common iliac and left eternal iliac arteries. An impression of peripheral artery disease and microvascular dysfunction was noted. It was noted that Petitioner received various medications (e.g. fentanyl) and was discharged.

Physician office visit notes (Exhibit A, pp. 1-2) dated [redacted] were presented. It was noted that Petitioner presented for asthmatic bronchitis. Active medications of Zithromax, prednisone, simvastatin, Ventolin , and Qvar were noted.

Petitioner testified she has a history of COPD, bronchitis, and asthma which cause her ongoing breathing difficulties. Petitioner testified she thinks her lungs are undeveloped, in part, due to her mother's heroin addiction. Petitioner testified she quit smoking 5 years ago but she still can walk no more than 15 steps without gasping for breath; Petitioner's specialist testified she agreed with the stated restriction based on her first-hand observations of Petitioner. Petitioner testified she utilizes three different inhalers multiple times per day. As an example of how her life has changed, Petitioner testified she used to run and swim, but she no longer can do either. Petitioner testified she went to urgent care on [redacted], where she received steroid shots, medications, and breathing treatments. Petitioner testified her doctor wants to prescribe a breathing treatment machine. Petitioner also testified she utilizes a cane.

Petitioner testified she does not clean because cleaning chemicals exacerbate breathing difficulties. Petitioner indicated she does laundry but keeps her loads light; Petitioner also testified she sometimes needs help removing clothes from the washing machine.

A listing for chronic pulmonary insufficiency (Listing 3.02) was considered based on Petitioner's complaints of dyspnea. The listing was rejected due to a lack of respiratory testing evidence.

Most of Petitioner's testimony centered around her mental health. Psychiatric treatment records were presented.

Psychiatric progress notes (Exhibit 1, pp. 475-477) dated [redacted], were presented. Petitioner's GAF was noted to be 53.

Psychiatric progress notes (Exhibit 1, pp. 472-474) dated [redacted], were presented. Prescribed medications included Benadryl, Buspar, Risperdal, Topamax, and Zoloft. A GAF of 53 was noted. Axis I diagnoses of bipolar disorder I (most recent episode manic with psychosis) and PTSD were noted. Symptoms included nightmares,

“exploding” at others, being unable to ride elevators or escalators, and mild paranoia. A history of being a victim of sexual abuse and domestic violence was noted.

An Update Assessment (Exhibit 1, pp. 435-451) dated [redacted] was presented. The assessment was completed by a social worker. It was noted Petitioner was generally independent but she also got help from her sister for dyslexia. Mental status examination assessments included orientation x4, intact memory, alert, good judgment, unremarkable thought content, hallucinations of dead mother, obsessive thought process, unremarkable speech, and unremarkable affect. It was noted Petitioner completed daily activities independently. A long history of psychological trauma was noted. A psychiatric assessment noted bipolar disorder and PTSD diagnoses. Petitioner’s GAF was noted to be 44.

Mental health treatment agency counseling notes (Exhibit 1, pp. 435-451) dated [redacted], were presented. It was noted Petitioner read, talked on the phone, did crossword puzzles, and crafts. Petitioner reported being unable to jet-ski. Various treatment goals were noted.

Mental health treatment agency counseling notes (Exhibit 1, pp. 433-434) dated [redacted], were presented. Difficulties in dealing with sister’s recent death were noted.

Psychiatric progress notes (Exhibit 1, pp. 333-335) dated [redacted], were presented. It was noted Petitioner looked anxious but had a stable mood. A GAF of 54 was noted.

Mental health treatment agency counseling notes (Exhibit 1, pp. 431-432) dated [redacted], were presented. It was noted Petitioner discussed emotional triggers and grieving the death of her sister.

Mental health agency progress notes (Exhibit 1, pp. 331-332) dated [redacted], were presented. It was noted Petitioner discussed how to sort out her feelings about her sister’s death.

Psychiatric progress notes (Exhibit 1, pp. 327-330) dated [redacted], were presented. Prescribed medications included Benadryl, Brintellix, BuSpar, Rosperdol, Topamax, and Zoloft.

A mental status examination report (Exhibit 1, pp. 240-244) dated [redacted], was presented. The report was noted as completed by a consultative psychiatrist. Petitioner reported nervousness, crying spells, and discomfort around people. Petitioner indicated she needs mental health treatment but was worried about being around other people. Noted observations of Petitioner made by the consultative examiner include the following: adequate contact with reality, talkative, depressed mood, average attention, average persistence, and average concentration. It was noted Petitioner could not manage her own funds due to poor math skills. A diagnosis of PTSD was noted. The consulting psychiatrist concluded Petitioner had moderate restrictions in relating to

others. The examiner concluded Petitioner had moderate impairments in understanding, remembering, and carrying out tasks. Petitioner was concluded to be capable of performing simple tasks. Petitioner was found to have moderate impairments to maintaining attention and persistence.

Petitioner testified she has a long history of being victimized by abuse. Petitioner testified she was raped and held at gunpoint for 3 days. Petitioner testified she was present at the [redacted], where three of her friends lost their lives. Petitioner testified she is fearful of crowds and has great anxiety. Petitioner testified her uncle usually shops for her because she is afraid of crowds, though she stated she may try to shop by herself during slower store times. Petitioner testified she is afraid all of the time. Petitioner testified her anxiety worsened following the death of her sister (approximately 10 months ago). Petitioner testified she has panic attacks "every day just about." As an example, Petitioner testified she waited in the parking lot for 20 minutes on the day of the hearing, before she ran into the building when she saw her specialist. Petitioner's specialist testified Petitioner exhibited similar fears in the past. Petitioner testified she has been under psychiatric care for 10 years but still has ongoing symptoms. Petitioner testified she typically sees her therapist twice per week and her psychiatrist monthly. Petitioner testified her fears prevent her from driving.

Claimant's most prominent impairment appears to be 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.

Petitioner testimony and presented documents established a history of symptoms including hallucinations, decreased energy, anhedonia, concentration difficulties, and paranoia. It is found Petitioner meets Part A of the above listing. The analysis will proceed to determine if Petitioner meets Part B of the affective disorder listing.

It is notable that Petitioner was specifically diagnosed with bipolar disorder I. Bipolar disorder I is understood to be cause manic-depressive symptoms. A diagnosis of bipolar disorder I is not definitive evidence of marked restrictions, however, it is more consistent with meeting listing requirements than a diagnosis of bipolar disorder II.

Based on presented documents, Petitioner's most recent GAF was 54. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF within the range of 51-60 is representative of someone with moderate symptoms or any moderate difficulty in social, occupational, or school functioning. Moderate restrictions are not indicative of meeting listing requirements. Other evidence was more supportive.

Though Petitioner's psychiatrist did not provide a GAF indicative of marked restrictions, he provided an opinion of Petitioner's work capacity on the same date. Petitioner's psychiatrist stated Petitioner was unable to work because her symptoms impair her daily living activities (see Exhibit 1, p. 474). The statement is indicative of marked restrictions.

Similarly, a consultative psychiatrist determined Petitioner had numerous moderate restrictions. The same psychiatrist determined Petitioner had "significant" impairments in withstanding stress and pressure of day-to-day work. The statements were generally consistent with finding Petitioner had marked restrictions in concentration and social interactions.

The month after Petitioner's psychiatrist assessed Petitioner's GAF to be 44, Petitioner's social worker assessed Petitioner's GAF to be 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)." Such a GAF is indicative of meeting listing requirements.

Petitioner indicated she lacks the concentration and ability to be around people to perform any employment. Based on presented evidence, it is found Petitioner has marked social function and concentration restrictions. Accordingly, Petitioner is disabled and it is found 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 perform the following actions within 10 days of the date of mailing of this decision:

(1) redetermine Claimant's SDA benefit eligibility, effective November 2015, subject to the finding that Claimant is a disabled individual;
(2) initiate a supplement for any benefits not issued as a result of the improper application denial; and
(3) 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: **1/29/2016**

Date Mailed: **1/29/2016**

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]