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.: 15-022982
Issue No.: 4009
Agency Case No.: [redacted]
Hearing Date: February 8, 2016
County: Wayne (17)

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 February 8, 2016, from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], hearing facilitator.

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 an unspecified date, the Medical Review Team (MRT) determined that Petitioner was not a disabled individual for purposes of SDA eligibility (see Exhibit 1, p. 5).

4. On [redacted], MDHHS terminated Petitioner's eligibility for SDA benefits, effective December 2015, and mailed a Notice of Case Action (Exhibit 1, pp. 312-313) informing Petitioner of the termination.

5. On [redacted], Petitioner requested a hearing disputing the termination of SDA benefits (see Exhibit 1, pp. 2-3).

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 (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 (July 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.

A portion of a foot specialist physician letter (Exhibit 1, p. 277) dated [redacted], was presented. An assessment of hallux valgus (left foot) and left hammertoe deformity at 2, 3, and 4 were noted.

Various foot specialist office visit notes (Exhibit 1, pp. 278-286) were presented. The documents ranged from May 2014 through October 2014. Ongoing foot pain (ranging from 5-8/10) was reported by Petitioner. Related complaints included difficulty sleeping (due to pain) and hip pain.

Urgent care visit notes (Exhibit A, pp. 11-13) dated [redacted], were presented. It was noted Petitioner injured her right index finger at work. Petitioner reported swelling, decreased range of motion, and pain.

Physician office visit notes (Exhibit A, p. 8) dated [redacted], were presented. It was noted that Petitioner presented for right finger treatment. Petitioner reported the finger was injured about a month earlier after a piece of equipment landed on it. Petitioner reported she was diagnosed with a fracture after going to urgent care. It was noted x-rays indicated subacute bony mallet with bridging bone across the fracture

region (see Exhibit A, p. 15). It was noted the bone healed in displaced position. A recommendation of full-time stack splinting for 2 weeks was noted.

Physician office visit notes (Exhibit A, p. 9) dated [redacted], were presented. It was noted that Petitioner presented for right index finger treatment. Petitioner reported the finger was mildly sore and stiff. It was noted Petitioner returned to work with a 5 pound weight restriction. A plan of two weeks of splinting during employment and at night was noted. Petitioner was to not splint the remainder of her time so she could work on range of motion.

Foot specialist office visit notes (Exhibit 1, p. 287) dated [redacted], were presented. It was noted Petitioner appeared for surgical documentation.

Physician office visit notes (Exhibit A, p. 10) dated [redacted], were presented. It was noted that Petitioner presented for right index finger treatment. Petitioner reported improved finger range of motion and mild tenderness. It was noted x-rays demonstrated a well-healed fracture (see Exhibit A, p. 14). It was noted Petitioner had no work restrictions.

An Operative Report (Exhibit 1, pp. 299-301) dated [redacted] was presented. Pre-operative and post-operative diagnoses of left hallux valgus, left 2nd hammertoe deformity, and extensor tendon contractions of left 2-5 digits were noted. It was noted Petitioner underwent a bunionectomy, arthroplasty of the left 2nd digit, and extensor tenotomies of left 2-5 digits. Discharge instructions (Exhibit 1, pp. 302-303) indicated no weight bearing for 24 hours.

Foot specialist office visit notes (Exhibit 1, p. 288) dated [redacted], were presented. It was noted Petitioner appeared for surgical documents. A pain level of 10/10 was reported. Left foot x-rays (see Exhibit 1, pp. 297-298) were noted to be “good.”

Foot specialist office visit notes (Exhibit 1, p. 276) dated [redacted], were presented. It was noted Petitioner reported ongoing foot pain (5-6/10). An examination was noted to show progress.

Foot specialist office visit notes (Exhibit 1, p. 269) dated [redacted], were presented. It was noted Petitioner reported ongoing foot pain (3-4/10). Petitioner’s dressing was changed.

A document intended for Petitioner’s employer (Exhibit 1, pp. 69-70) dated [redacted] was presented. The document was presumably completed by Petitioner’s surgeon though the heath care provider signature was not legible. It was noted Petitioner underwent a bunionectomy on [redacted]. The stated probable duration of condition was 12 weeks.

Foot specialist office visit notes (Exhibit 1, p. 270) dated [redacted], were presented. It was noted Petitioner reported ongoing foot pain and discomfort. The appointment was noted to be Petitioner's 5th one following surgery.

A Medical Examination Report (Exhibit 1, pp. 31-33. 49-51) was presented. The form was completed by a podiatrist with an approximate 1 year history of treating Petitioner. A signature date was not stated, however, Petitioner's most recent examination was indicated to be [redacted]. Petitioner's physician listed diagnoses of s/p left foot bunionectomy and hammertoe. Tylenol #3 was listed as the only current medication. 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 stated. Petitioner's physician stated Petitioner had various lifting/carrying and standing/walking limitation(s) which were not expected to last 90 days. It was noted Petitioner would be reevaluated on [redacted]. It was noted x-rays dated [redacted], [redacted] showed Petitioner was positive for left foot lymphedema.

Foot specialist office visit notes (Exhibit 1, p. 271) dated [redacted], were presented. It was noted Petitioner presented for her 12th post-op visit. Ongoing pain (3/10) was reported. It was noted 3rd and 4th left hammertoe surgery was scheduled for [redacted]

Foot specialist office visit notes (Exhibit 1, p. 272) dated [redacted], were presented. It was noted Petitioner reported ongoing pain (4/10). It was noted Petitioner reported ongoing swelling prevented wearing of a shoe. Petitioner reported she constantly ices and elevates her foot to prevent swelling.

Foot specialist office visit notes (Exhibit 1, p. 273) dated [redacted], were presented. It was noted Petitioner reported ongoing pain (3/10). It was noted x-rays were positive for a left fifth digit fracture.

An internal medicine examination report (Exhibit 1, pp. 52-59) dated [redacted], was presented. The report was noted as completed by a consultative physician. Petitioner reported complaints of frozen shoulders, COPD, left foot surgeries, and CTS. It was noted Petitioner had a long history of waitressing which may have contributed to shoulder problems. Petitioner reported a medical history including a cervical spine fusion; Petitioner reported she gets spasms and muscle tenderness though her neck is overall stable. Notable physical examination findings included the following: antalgic gait, second and third toe deformities, and standing difficulties. Tandem walk and squatting were noted as difficult due to left foot pain. "Significant" reduced ranges of motion were noted in Petitioner's shoulders and left foot. A 20 minute standing restriction was noted. Pushing, pulling, and carrying were noted to be restricted to 30 pounds or less. The examiner stated that clinical evidence supported a need for a cane. The examining physician stated Petitioner had "significant limitations" to working.

Foot specialist office visit notes (Exhibit 1, p. 274) dated [redacted], were presented. It was noted Petitioner reported unchanged pain. It was noted an examination revealed “slow process.”

Foot specialist office visit notes (Exhibit 1, p. 275) dated [redacted], were presented. It was noted Petitioner reported ongoing pain (4/10).

A left shoulder MRI report (Exhibit 1, pp. 187-188, 235-236) dated [redacted] was presented. An impression of a full thickness tear of a tendon was noted. Associated mild atrophy of the supraspinatus tendon was noted. Osteoarthritis and tendonitis were also noted.

An internal medicine examination report (Exhibit 1, pp. 258-264) dated [redacted], was presented. The report was noted as completed by a consultative physician. Petitioner reported complaints of COPD, left foot pain, and left shoulder pain. It was noted Petitioner reported to be a pack per day smoker who recently cut her tobacco intake in half. Petitioner reported no emergency room treatments due to breathing difficulties. Petitioner’s COPD was described by the examiner as mild. Petitioner reported her January 2015 foot surgery did little to reduce her pain. Petitioner reported a recent cortisone injection in her foot relieved her pain, but only temporarily. Petitioner reported left shoulder pain due to a rotator cuff tear. It was noted Petitioner displayed a mild-to-moderate left side limp. Mild-to-moderate left shoulder tenderness causing marked restrictions was noted. It was noted Petitioner was unable to squat. Reduced ranges of motion were noted in Petitioner’s cervical spine, bilateral shoulders, left ankle, and bilateral knees.

A foot specialist letter (Exhibit A, p. 3) dated [redacted], was presented. Diagnoses of adhesions on left foot (first metatarsal interphalangeal joint) and hammer digit deformity (2nd, 3rd, and 4th left digits) were noted. It was noted the next treatment would be proposed hammertoe repair and adhesiotomy surgery.

A prescription (Exhibit A, p. 5) dated [redacted], was presented. The script was for Lyrica (75 mg).

An appointment notice (Exhibit A, p. 6) dated [redacted] was presented. The appointment was stated to be with an orthopedic surgeon concerning Petitioner’s shoulder.

Various eye institute and hospital documents (Exhibit 1, pp. 238-248, 253-256) from 2015 were presented. Petitioner testified she had cataract surgery performed in October 2015 and has no continuing visual restrictions.

Petitioner testified she broke her right index finger in November 2014. Petitioner testified the finger improperly healed. Petitioner testified she is unable to bend her finger. Petitioner testified the restriction affects her typing ability though she was unable to

state how fast she can currently type. Petitioner testified she struggles with buttons because of her finger.

Petitioner testified she has ongoing problems with her left foot. Petitioner testified that pre-surgery, her 2nd toe was on top of her big toe. Petitioner testified surgery did not alleviate her problems. Petitioner testified she has to regularly elevate and ice her foot to avoid swelling. Petitioner testified she still utilized a surgical shoe.

Petitioner testified she has a torn rotator cuff in her left shoulder. Petitioner testified the tear may be related to frozen shoulder syndrome. Petitioner testified she is unable to lift her arm above her shoulder. Petitioner testified she has an appointment to see a surgeon.

Petitioner testified she has COPD. Petitioner testified she still smokes cigarettes but reduced her intake to 5 cigarettes per day.

Petitioner estimated she can walk one block before foot pain prevents further walking. Petitioner testified she has no sitting restrictions as long as she can ice and elevate her foot.

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

A listing for visual acuity (Listing 2.02) was considered based on cataract treatment history. This listing was rejected due to a failure to establish a corrected eyesight of worse than 20/200 in Petitioner's best eye.

A listing for chronic pulmonary insufficiency (Listing 3.02) was considered based on a diagnosis for COPD. The listing was rejected due to a lack of respiratory testing evidence.

It is found Petitioner failed to meet a SSA listing. Accordingly, the analysis proceeds 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, 310-311). The document verified MRT approved Petitioner for SDA on [redacted]. A redetermination for September 2015 was noted.

Presumably, the MRT approval of disability expected Petitioner's toe surgery from January 2015 to improve Petitioner's condition. All presented post-surgical documents tended to demonstrate the opposite. From the month of Petitioner's surgery through August 2015, Petitioner reported ongoing foot pain. Petitioner's complaint was consistent with foot specialist documents which regularly noted Petitioner's complaint of pain. The complaint of pain was consistent with a need for follow-up surgery which was verified. The complaint was also consistent with a consultative examiner statement of reduced foot ranges of motion and an ongoing limp.

In addition to Petitioner's toe/foot problems, Petitioner also established serious ongoing problems with her left shoulder. A consultative examiner described Petitioner's shoulder range of motion as "significantly" reduced.

It is found MDHHS failed to establish medical improvement. Accordingly, the analysis proceeds directly 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 claimant 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 claimant is deemed not disabled if it is established that the claimant can engage is substantial gainful activity. If no exception applies, then the claimant's disability is established.

The second group of exceptions allow a finding that a claimant 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. It is found that Petitioner is still a disabled individual. Accordingly, it is found 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 December 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

Christian Gardocki
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Signed: **MARCH 1, 2016**

Date Mailed: M**ARCH 1,** 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]