RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

MIKE ZIMMER
DIRECTOR

[redacted]

Date Mailed: April 19, 2016
MAHS Docket No.: 16-000725
Agency No.: [redacted]

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 March 9, 2016, from Detroit, Michigan. Petitioner appeared and was unrepresented. [redacted], Client's mother, testified on behalf of Petitioner. The Michigan Department of Health and Human Services (MDHHS) was represented by [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. 1-7).

4. On [redacted], MDHHS terminated Petitioner's eligibility for SDA benefits, effective February 2016, and mailed a Notice of Case Action (Exhibit 1, pp. 301-304) 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 (July 2015), p. 5. 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 2015), p. 1. A person is disabled for SDA purposes if he [or she]:

- Receives other specified disability-related benefits or services…, 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., pp. 1-2.

Generally, state agencies such as MDDHS must use the same definition of disability as used under SSI regulations (see 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. MDHHS adopted a functionally identical definition of disability (see BEM 260 (July 2015, p. 10)). The definition of SDA disability is identical except that only a 90 day 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 2015), 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. It was not disputed that Petitioner was an ongoing SDA recipient whose benefits were terminated by MDHHS.

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.

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.

An MRI report of Petitioner's cervical spine (Exhibit 1, p. 83) dated [redacted], was presented. Mild bilateral foraminal narrowing was noted at C3-C4. Marked bilateral foraminal narrowing (caused by facet arthropathy) and spinal cord flattening was noted at C4-C5. Moderate foraminal narrowing was noted at C5-C6. An impression of multilevel degenerative changes were noted.

An MRI report of Petitioner's lumbar spine (Exhibit 1, pp. 84-85) dated [redacted], was presented. Marrow edema was noted at L1 and L3. Moderate facet arthropathy was noted at L3-L4, L4-L5, and L5-S1. A follow-up MRI was planned in 6 weeks.

A whole body bone scan report (Exhibit 1, p. 86) dated [redacted] was presented. Increased activity was noted at L1-L3 vertebral bodies. Increased activity at Petitioner's left knee and left wrist were noted to likely indicate degenerative/arthritic changes. Increased activity at the right anterior first rib was noted to likely reflect costal cartilage calcification.

Hospital documents (Exhibit 1, pp. 79-82) from an admission dated [redacted], were presented. It was noted that Petitioner presented with complaints of fever, gait

disturbance and intractable back pain. A history of severe back pain was noted. An MRI was noted to show bone marrow edema. It was noted Petitioner underwent a kyphoplasty. It was noted Petitioner smoked while in the hospital. A discharge date of [redacted], was noted. It was noted Petitioner received medications until the time she could see a pain specialist.

Hospital documents (Exhibit 1, pp. 9-78) from an admission dated [redacted], were presented. It was noted that Petitioner presented as unresponsive and with renal dysfunction. It was noted Petitioner apparently took too much morphine, Percocet, and over-the counter sleeping aids. It was noted Petitioner was not suicidal and she denied attempting suicide. A history of anxiety and panic attacks was noted. Chest and kidney radiology were unremarkable. An impression of cholelithiasis was noted following a CT of Petitioner's abdomen; osteopenia with kyphoplasty changes were also noted. A mental status examination noted Petitioner had a depressed mood, full insight, and full judgment. An Axis I diagnoses of major depression, panic disorder, and PTSD were noted. Petitioner's GAF was 51-60. Cymbalta was started and Xanax and Wellbutrin were noted as continued. Outpatient follow-up was recommended. A discharge date of [redacted], was noted.

Physician office visit notes (Exhibit 1, pp. 111-116) dated [redacted], were presented. It was noted Petitioner reported feeling better over the last 2 weeks. Various medications were prescribed.

Physician office visit notes (Exhibit 1, pp. 109-110) dated [redacted], were presented. Ongoing treatment for anxiety was noted.

Physician office visit notes (Exhibit 1, pp. 106-108) dated [redacted], were presented. Treatment for anxiety was noted. Reported symptoms included feeling depressed, difficulty falling asleep, feeling lethargic, and difficulty with concentration. Xanax was noted as refilled. A recommendation of pain clinic follow-up was noted for a complaint of back pain.

Hospital emergency room documents (Exhibit 1, pp. 90-101) dated [redacted] were presented. It was noted Petitioner presented with complaints of lower back pain. A whole body bone scan report was noted to show no new area of increased activity; interval decreased intensity was noted to possibly reflect postsurgical changes. An MRI of Petitioner's lumbar was noted to show mild stenosis and facet arthrosis at L3-L4. A disc bulge at L4-L5 was noted to contribute to minimal stenosis. A left paracentral bulge was noted to cause severe left neural foraminal stenosis with L5 nerve root impingement. Effacement of the L5 nerve roots was also noted. An impression of multilevel degenerative disc disease and redemonstration of L1 and L3 kyphoplasty with residual edema was noted.

A mental status examination report (Exhibit 1, pp.119-123) dated [redacted], was presented. The report was noted as completed by a limited licensed psychologist and cosigned by a licensed psychologist. Petitioner reported ongoing depression and

anxiety. Petitioner's quality and frequency of ADLs were reported as "marginal" due to pain. Mental status examination findings included the following: responds well to positive criticism, cooperative, motivated, responsive, good eye contact, logical thought process, appropriate communication, good contact with reality, and mildly depressed mood. It was noted Petitioner did not appear to exaggerate symptoms. Diagnoses of depression secondary to medical condition, panic disorder, and social anxiety were noted. Fair judgment and fair insight were noted. Petitioner's attention was noted to be normal. A fair prognosis was noted.

Physician office visit notes (Exhibit A, p. 2) dated [redacted], were presented. A complaint of headaches was noted. Butalbital was noted as prescribed.

Petitioner testified she has a mass on her right shoulder. Petitioner testified the mass restricts her right arm function. As an example, Petitioner testified if she writes a single sentence, her hand cramps and she is in pain for at least 12 hours. Petitioner also testified her right hand is weak and she drops items due to weakness. Petitioner testified she would be unable to type because of her right arm dysfunction. Petitioner estimated her lifting is restricted to 10 pounds due to her arm difficulties. Petitioner testified her arm hurts when she is just standing.

Petitioner testified she can walk for 5 minutes before she becomes tired and/or her arm pain prevents further walking. Petitioner testified she is restricted to 15-20 minutes of sitting (though Petitioner stated this after sitting for 48 minutes during the hearing). Petitioner testified when she sits, she has to lean to the side because resting against her back is painful.

Petitioner testified she was diagnosed with COPD. Petitioner testified she reduced her cigarette intake to 4-5 cigarettes per day. Petitioner testified she breathes fine and that COPD does not restrict her ability to work. Petitioner and her mother testified Petitioner spends a lot of time in bed.

Petitioner testified she struggles with ADLs. Petitioner testified she will go 2-3 weeks without showering. Petitioner testified part of the reason is she cannot raise her right arm long enough to wash her hair. Petitioner testified she wears the same clothes for several days because it is painful to change clothes. Petitioner testified she is unable to help her mother (with whom she lives) with cleaning because of pain.

Petitioner testified she does not see a psychiatrist, though she also conceded that she should. Petitioner testified she last saw her psychiatrist "awhile" ago. Petitioner testified she was diagnosed with PTSD since the death of her spouse. Petitioner testified she experiences panic attacks a "couple times per month".

Petitioner's most prominent impairment appears to be back pain. Spinal disorders are covered by Listing 1.04 which reads:

> **1.04** ***Disorders of the spine*** (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the cauda equina) or the spinal cord. With:
> A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine);
> OR
> B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours;
> OR
> C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b.

Looking at Part C, the inability to ambulate effectively is a requirement. SSA defines this as follows:

> Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. Ineffective ambulation is defined generally as having insufficient lower extremity functioning (see 1.00J) to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities.

Petitioner testified the kyphoplasty she underwent in May 2015 provided some relief in her back pain. Petitioner testified she still has ongoing pain with her upper body due to inverted discs which were not addressed by the surgery. Petitioner testified she has not seen her surgeon since undergoing the kyphoplasty. Petitioner testified she attends pain clinic appointments for continued treatment. Petitioner testified her physician provides her with pain medications but she complained that her physician fails to address the underlying problem. Petitioner’s testimony was consistent with presented records.

Radiology from October 2015 verified ongoing lumbar stenosis, facet arthropathy, a disc bulge, and nerve root impingement. Most notably, left neural foraminal stenosis was “severe” at L5. Generally, severe stenosis is indicative of pain that causes symptoms meeting SSA listing requirements.

It is also notable that Petitioner also has untreated cervical spine abnormalities. Most notably, marked foraminal narrowing and spinal cord flattening were verified by

radiology from January 2015. “Marked” foraminal narrowing is also consistent with spinal pain symptoms which meet listing requirements. When factored in combination with other cervical spinal problems (e.g. moderate foraminal narrowing at C5-C6), lumbar stenosis, arm weakness, and other arthritic changes, muscle weakness and radiating pain can be inferred.

It should be noted that the record was extended for 30 days to allow Petitioner to submit updated neurologist documents. Neurologist documents could have verified neural dysfunction such as sensory loss and/or loss of reflex. Petitioner submitted no documents despite the record extension.

Despite Petitioner’s failure to submit neurologist documents, presented documentation sufficiently verified disabling spinal dysfunction. The spinal dysfunction was persistent despite a kyphoplasty, which appeared to resolve only a small portion of Petitioner’s spinal dysfunction.

It is found Petitioner meets the listing for spinal dysfunction, and therefore, is a disabled individual. Accordingly, 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 begin to perform the following actions within 10 days of the date of mailing of this decision:

(1) reinstate Petitioner’s SDA eligibility, effective February 2016;
(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**.

CG/hw

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

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; 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

DHHS

[redacted]

Petitioner

[redacted]