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 21, 2016
MAHS Docket No.: 16-001911
Agency No.: [redacted]
Petitioner: [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 April 4, 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 [redacted], the Medical Review Team (MRT) determined that Petitioner was not a disabled individual for purposes of SDA eligibility (see Exhibit 1, pp. 5-11).

4. On [redacted], MDHHS terminated Petitioner's eligibility for SDA benefits, effective March 2016, and mailed a Notice of Case Action (Exhibit 1, pp. 189-190) informing Petitioner of the termination.

5. On [redacted], Petitioner requested a hearing disputing the termination of SDA benefits (see Exhibit 1, pp. 2-4).

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 benefits. MDHHS presented a Notice of Case (Exhibit 1, pp. 189-190) verifying the reason for termination was Petitioner was no longer considered disabled.

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.

It should be noted that at the hearing, Petitioner presented MDHHS with 33 pages of documents for the purpose of having the documents admitted as exhibits. The documents were admitted. The documents were to be faxed by MDHHS to the Michigan Administrative Hearing System after the hearing. MDHHS forwarded 35 pages of documents (and a fax cover sheet). Presumably, Petitioner wanted all pages to be admitted as exhibits and MDHHS had no objections. Thus, all 36 pages were admitted as exhibits.

A Medical Examination Report (Exhibit 1, pp. 150-152) dated [redacted], was presented. The form was completed by a rheumatologist with an approximate 6 month history of treating Petitioner. A diagnosis of possible lupus was noted. An impression was given that Petitioner's condition was stable. It was noted that Petitioner can meet household needs. It was noted that Petitioner did not need an assistive device for ambulation.

Internal medicine physician office visit notes (Exhibit 1, pp. 73-76) dated [redacted] were presented. It was noted Petitioner presented for thyroid treatment. An assessment of a right thyroid nodule was noted.

A thyroid ultrasound report (Exhibit 1, pp. 79-80) dated [redacted], was presented. An impression of a diffusely heterogeneous thyroid gland with no discrete thyroid nodule was noted.

Internal medicine physician office visit notes (Exhibit 1, pp. 70-72) dated [redacted], were presented. It was noted Petitioner presented to discuss diagnostic procedure results. The results and discussion of results were not apparent.

Physician office visit notes (Exhibit 1, pp. 128-129) dated [redacted] were presented. Treatment for a chronic non-healed thigh wound was noted. An assessment of folliculitis was noted.

Pathology notes (Exhibit 1, p. 131-132) dated [redacted], were presented. A diagnosis of chronic left thigh folliculitis was noted. The wound was excised (see Exhibit 1, pp. 133-135).

Internal medicine physician office visit notes (Exhibit 1, pp. 66-69) dated [redacted], were presented. It was noted Petitioner presented for follow-up for a thyroid disorder and for vitamin D deficiency medication. Medication for hypothyroidism and a vitamin D deficiency was prescribed.

An MRI report of Petitioner's lumbar (Exhibit 1, p. 88-89; A, pp. 27-28) dated [redacted], [redacted] was presented. An impression of left-side convexity scoliosis was noted. An impression of disc protrusions compressing the thecal sac were noted at L4-L5 and L5-S1. Moderate left-sided foraminal narrowing was noted at L5-S1.

Physician office visit notes (Exhibit 1, p. 82) dated [redacted], were presented. It was noted Petitioner was positive for bilateral straight-leg-raising. Lumbar tenderness and significant difficulty with transitional movements was noted. An MRI was planned.

Internal medicine physician notes (Exhibit 1, p. 65) dated [redacted], were presented. A plan for a thyroid ultrasound was noted.

A thyroid ultrasound report (Exhibit A, pp. 335-36) dated [redacted], was presented. Two nodules were noted; sonography was recommended for a short-term follow-up.

Physician office visit notes (Exhibit 1, p. 82) dated [redacted], were presented. It was noted a MRI indicated new disk pathology at L5-S1. An EMG was planned.

A lower extremity EMG examination (Exhibit 1, pp. 84-85; A, p. 29) dated [redacted] was presented. An impression of possible osteoarthritic changes in the lumbosacral spine were noted.

Internal medicine physician office visit notes (Exhibit 1, pp. 62-64) dated [redacted] were presented. It was noted Petitioner complained of mild tiredness. Full muscle strength was noted. Assessments of hypothyroidism due to Hashimoto's thyroiditis, vitamin D deficiency, and right thyroid nodule were noted.

Handwritten rheumatologist office visit notes (Exhibit A, p. 11) dated [redacted], were presented. Ongoing treatment for back pain, possible lupus, Hashimoto's disease, back pain, and depression was noted.

Physician office visit notes (Exhibit 1, p. 82) dated [redacted], were presented. It was noted an EMG showed activity consistent with spondylolisthesis and degenerative joint disease. A plan of physical therapy was noted. A cortisone injection was noted as given that day.

Internal medicine physician office visit notes (Exhibit 1, pp. 56-61) dated [redacted] were presented. It was noted Petitioner complained of tiredness, joint pain, and chronic back pain. Full muscle strength, full range of neck motion, enlarged thyroid were noted. Ongoing assessments of hypothyroidism due to Hashimoto's thyroiditis, goiter, vitamin D deficiency, and lupus were noted.

Handwritten rheumatologist office visit notes (Exhibit A, p. 10) dated [redacted] were presented. Ongoing treatment for back pain, possible lupus, Hashimoto's disease, back pain, and depression was noted.

Internal medicine physician notes (Exhibit 1, p. 57) dated [redacted], were presented. A plan for a thyroid ultrasound was noted.

A letter from Petitioner's rheumatologist (Exhibit A, p. 33) dated [redacted], was presented. It was noted ANA testing was positive. A history of treatment for Hashimoto's disease, lumbar spondylolisthesis, and cervicalgia was noted.

Handwritten rheumatologist office visit notes (Exhibit A, p. 9) dated [redacted], were presented. Ongoing treatment for back pain, possible lupus, Hashimoto's disease, back pain, and depression were noted.

Physical therapy documents (Exhibit A, pp. 5-7) dated [redacted], were presented. It was noted Petitioner reported ongoing neck pain, upper back pain, lower back pain, dizziness, and headaches. Reduced lumbar strength (4-/5) was noted. Reduced bilateral arm strength (4+/5) and reduced bilateral knee strength (4+/5) was noted. It was noted Petitioner was limited in ADLs.

Mental health agency notes (Exhibit A, p. 31) dated [redacted], were presented. The notes were unsigned. Diagnoses of major depressive disorder (recurrent and severe) and anxiety disorder were noted.

A Medical Examination Report (Exhibit A, pp. 2-4) dated [redacted], was presented. The form was completed by a rheumatologist with an approximate 21 month history of treating Petitioner. Petitioner's physician listed diagnoses of L5-S1 disc protrusion and possible lupus. 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 included back and joint tenderness.

A cervical spine MRI report (Exhibit A, p. 34) dated [redacted] was presented. An impression of grade I retrolisthesis from C5-C7 was noted. Thecal sac compression from disc bulges was noted from C2-C6. Stenosis was noted as absent.

Petitioner testified she slipped and fell in 2012. Petitioner's testimony was consistent with presented treatment documents which also referenced a slip and fall injury from 2012. Petitioner testified she has herniated discs and back pain related to the fall. Petitioner testified she is in need of a spinal fusion, however, her auto-immune diagnosis makes her a risky surgery candidate. Petitioner testimony estimated she's had 10 lumbar injections which have done little to reduce pain.

Petitioner testified she's had 4 surgeries on her left shoulder. Petitioner testified she thinks she has bursitis.

Petitioner testified she's had multiple cortisone injections in her right elbow. Petitioner testified she was diagnosed with synovitis. Petitioner testified physical therapy on her neck reduced her right elbow pain. Petitioner testified she believes that her neck injuries are causing her hands to feel numb. Petitioner testimony expressed doubt at her capability of typing at a professional level due to hand numbness. Petitioner also thought her lumbar pain was related to foot numbness she experiences. Petitioner testified she is currently in physical therapy and it is worsening her hand numbness.

Petitioner testified she sees a psychiatrist every 6 weeks and a counselor monthly. Petitioner testified she has difficulty dealing with stress. Petitioner testified her psychological symptoms include shakiness, anxiety, and crying spells. Petitioner expressed doubt about having the concentration to perform past jobs (such as medical receptionist, banquet server, and front desk reception).

Petitioner testified she sees a physician for thyroid nodule treatment. Petitioner testified her thyroid problems make her easily fatigued.

Petitioner testified she has vocal cord nodules. Petitioner testified she can get hoarse because of the problem.

Petitioner testified she may have to sit down to rest after a shower. Petitioner testified she can dress herself though she may have difficulty with putting on her shoes. Petitioner testified she performs only light housework; she testified she could not scrub

floors or tubs because it is too physically taxing. Petitioner testified she can drive. Petitioner testified she can do laundry but cannot carry baskets.

Petitioner estimated she can walk two blocks before her back and knee pain prevent further walking. Petitioner testified she can walk 30 minutes before her back hurts. Petitioner testified she could sit for 30-60 minute periods before her feet get numb. Petitioner testified she has to repeatedly change positions when sitting and may need to lie down for periods of the day. Petitioner testimony conceded she does not use a cane or walker.

A listing for joint dysfunction (Listing 1.02) was considered based on Petitioner's various joint problems. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively. Consideration was given that Petitioner was unable to perform fine and gross movement with multiple upper extremities based on Petitioner's rheumatologist restrictions dated [redacted]. Though restrictions to both upper extremities were noted, right-sided restrictions were insufficiently documented to justify restrictions.

A listing for spinal disorders (Listing 1.04) was considered based on Petitioner's lumbar complaints. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root and/or Petitioner is unable to ambulate effectively.

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.

A listing for anxiety-related disorders (Listing 12.06) was considered based on Petitioner's treating physician's diagnosis of an anxiety disorder. 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 had a complete inability to function outside of the home.

It is found Petitioner failed to establish meeting any SSA listings. 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). To evaluate medical improvement, the original finding of disability and related records must be considered.

MDHHS presented an administrative hearing decision (Exhibit 1, pp. 160-168) dated [redacted]. The authoring ALJ concluded Petitioner was unable to perform a full range of sedentary employment and that MDHHS failed to provide vocational evidence to establish a sufficient number of job were available for Petitioner to perform. The basis for the finding was not clear.

The authoring ALJ wrote the above finding was justified based on a "careful review of the Claimant's medical record" and Petitioner's testimony from the hearing. The ALJ did not cite one specific medical document or Petitioner statement in supporting the conclusions. Medical records purportedly considered by the ALJ will be considered in evaluating Petitioner's medical improvement.

Various medical documents from 2012 and earlier (Exhibit 1, pp. 95-100, 103-120), were presented. Treatment from a slip and fall and complaint of back, leg, neck, and arm pain were noted.

An Electrodiagnostic Report (Exhibit 1, p. 94, 147) dated [redacted], was presented. It was noted Petitioner complained of bilateral hand numbness, bilateral forearm numbness, low back pain, and bilateral leg pain. An impression of a normal upper extremity study was noted. An impression of evidence of bilateral L5-S1 radiculitis in Petitioner's legs was noted. A recommendation of conservative treatment involving NSAIDs and PT was noted.

An MRI report of Petitioner's lumbar (Exhibit 1, p. 92-93, 138-139) dated [redacted] was presented. Suggestion of a pars defect at L5 and disc herniations at L3-L4 and L4-L5 were noted.

A cervical spine MRI report (Exhibit 1, pp. 90-91, 136-137) dated [redacted], was performed in response to a complaint of neck pain and stiffness. An impression of mild osteophytes and disc protrusion was noted at C6-C7.

Physician office visit notes (Exhibit 1, p. 83) dated [redacted], were presented. It was noted Petitioner complained of neck, lumbar, right elbow, and left shoulder pain. Left shoulder crepitus with motion was noted. Right elbow tenderness was noted. Multiple lumbar disc protrusions were noted. A diagnosis of right elbow tendonitis was noted. It was noted Petitioner received a right elbow cortisone injection.

Physician office visit notes (Exhibit 1, p. 83) dated [redacted], were presented. It was noted that Petitioner underwent left lumbar transforaminal steroid injection. It was noted Petitioner received a left shoulder cortisone injection. A previous injection in Petitioner's right elbow was noted to briefly reduce Petitioner's pain.

Physician office visit notes (Exhibit 1, pp. 141-142) dated [redacted], were presented. It was noted Petitioner underwent left lumbar transforaminal steroid injection.

Physician office visit notes (Exhibit 1, pp. 143-144) dated [redacted], were presented. It was noted Petitioner underwent lumbar bilateral facet injections.

Physician office visit notes (Exhibit 1, pp. 145-146) dated [redacted], were presented. It was noted Petitioner underwent left lumbar transforaminal steroid injection.

Physician office visit notes (Exhibit 1, pp. 148-149) dated [redacted], were presented. It was noted Petitioner complained of back pain and depression. Tramadol and Citalopram were prescribed.

A mental status report (Exhibit 1, pp.154-158) dated [redacted], was presented. The report was noted as completed by a consultative licensed psychologist and a limited licensed psychologist. Petitioner reported symptoms of sleep disturbances, anxiety, and tearfulness. It was noted Petitioner previously had to end counseling due to health insurance problems. Notable mental examination findings included the following: cooperative, not exaggerating, serious and downcast mood, logical and goal oriented, and orientation x3. An impression of persistent depressive disorder, with mild intermittent major depressive disorders was noted. A fair prognosis was noted.

Physician office visit notes (Exhibit 1, p. 83) dated [redacted], were presented. It was noted that Petitioner complained of hip pain. It was noted a hip x-ray indicated at least mild degenerative changes.

An MRI report of Petitioner's right elbow (Exhibit 1, pp. 86-87) dated [redacted], was presented. An impression of significant sprain or tear of ligament and small joint effusion was noted.

Physician office visit notes (Exhibit 1, p. 82) dated [redacted] were presented. It was noted a recent right elbow MRI did not show a definite mass. It was noted Petitioner may have synovitis secondary to lupus.

Handwritten physician office visit notes (Exhibit 1, p. 159) dated [redacted], were presented. Petitioner reported ongoing pain related to a 2012 fall.

Generally, all of Petitioner's conditions were unchanged or worsened. Various treatments (medications, injections, physical therapy…) were attempted but no improvement was apparent. This conclusion is consistent based on treatment records and radiology. The finding is also consistent with a comparison of restrictions from petitioner's rheumatologist.

On a Medical Examination Report dated [redacted], Petitioner's rheumatologist 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, less than 2 hours of standing and/or walking, and less than 6 hours of sitting. Petitioner was restricted to occasional lifting/carrying of less than 10 pounds, never 10 pounds or more. Petitioner's physician opined that Petitioner was restricted from performing

repetitive pushing/pulling. In response to a question asking for the stated basis for restrictions, Petitioner's physician cited polyarthralgias.

On a Medical Examination Report dated [redacted], Petitioner's rheumatologist 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: less than 2 hours of standing and/or walking, and less than 6 hours of sitting. Petitioner was restricted to occasional lifting/carrying of less than 10 pounds, never 10 pounds or more. Petitioner's physician opined that Petitioner was restricted from performing the following repetitive actions with hands or arms: bilateral simple grasping, bilateral pushing/pulling, and bilateral fine manipulating; bilateral operation of foot/leg control was also noted to be restricted. Petitioner's physician cited hand and back pain as basis to support restrictions.

It is found Petitioner has experienced no 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 March 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]