RICK SNYDER
GOVERNOR

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

MIKE ZIMMER
DIRECTOR

Date Mailed: April 26, 2016
MAHS Docket No.: 16-001248
Agency No.:
Petitioner:

**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 30, 2016, from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by , hearing facilitator.

## ISSUE

The issue is whether MDHHS properly denied 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. On , Petitioner applied for SDA benefits.

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

3. On  the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 1-7).

4. On , MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action (Exhibit 1, pp. 111-113) informing Petitioner of the denial.

5. On [redacted], Petitioner requested a hearing disputing the denial of SDA benefits (see Exhibit 1, pp. 114-115).

6. As of the date of the administrative hearing, Petitioner was a 38-year-old female.

7. As of the date of the administrative hearing, Petitioner did not have employment earnings amounting to substantial gainful activity.

8. Petitioner's highest education year completed was the 12th grade.

9. Petitioner has a history of unskilled employment, with no known transferrable job skills.

10. Petitioner alleged disability based on restrictions related to epilepsy and various mental health restrictions.

## 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's hearing request stated a dispute concerning a denial of SDA eligibility. A Notice of Case Action verified Petitioner's application was denied based on a determination that Petitioner was not disabled.

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 (1/2012), 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.*

There was no evidence that any of the above circumstances apply to Petitioner. Accordingly, Petitioner may not be considered for SDA eligibility without undergoing a medical review process (see BAM 815) which determines whether Petitioner is a disabled individual. *Id.*, p. 3.

Generally, state agencies such as MDHHS 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. SDA differs in that a 90 day period is required to establish disability.

SGA 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. *Id.*, p. 9. 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 SGA. *Id.*

The person claiming a physical or mental disability has the burden to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CFR 413.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a).

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled. 20 CFR 416.920. If there is no finding of disability or lack of disability at each step, the process moves to the next step. 20 CFR 416.920 (a)(4).

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person is statutorily blind or not. The 2016 monthly income limit considered SGA for non-blind individuals is $1,130.00.

Petitioner credibly denied performing current employment; no evidence was submitted to contradict Petitioner's testimony. Based on the presented evidence, it is found that Petitioner is not performing SGA. Accordingly, the disability analysis may proceed to the second step.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the durational requirement. 20 CFR 416.920 (a)(4)(ii). The impairments may be combined to meet the severity requirement. If a severe impairment is not found, then a person is deemed not disabled. *Id.*

The impairments must significantly limit a person's basic work activities. 20 CFR 416.920 (a)(5)(c). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. *Id.* Examples of basic work activities include:

- physical functions (e.g. walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling)
- capacities for seeing, hearing, and speaking, understanding; carrying out, and remembering simple instructions
- use of judgment
- responding appropriately to supervision, co-workers and usual work situations; and/or
- dealing with changes in a routine work setting.

Generally, federal courts have imposed a de minimus standard upon petitioners to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v Bowen,* 880 F2d 860, 862 (6th Cir. 1988). Similarly, Social Security Ruling 85-28 has been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirements are intended "to do no more than screen out groundless claims." *McDonald v. Secretary of Health and Human Servs.*, 795 F.2d 1118, 1124 (1st Cir. 1986).

SSA specifically notes that age, education, and work experience are not considered at the second step of the disability analysis. 20 CFR 416.920 (5)(c). In determining whether Petitioner's impairments amount to a severe impairment, all other relevant evidence may be considered. The analysis will begin with a summary of presented medical documentation.

Physician office visit notes (Exhibit A, pp. 8-9) dated [redacted], were presented. A diagnosis of seizure disorder was noted.

A pelvis ultrasound report (Exhibit 1, pp. 86-89) dated [redacted], was presented. An impression of "likely fibroids" was noted.

Gynecologist office visit notes (Exhibit 1, pp. 90-91) dated [redacted], were presented. Diagnoses of enlarged uterus and heavy menstruation were noted.

Physician office visit notes (Exhibit 1, pp. 92-93) dated [redacted], were presented. Diagnoses of seizure disorder, uterine fibroids, and thyromegaly were noted.

Physician office visit notes (Exhibit 1, pp. 94-95) dated [redacted], were presented. Diagnoses of right knee swelling and thyromegaly were noted. Knee x-rays were noted as planned.

Gynecologist office visit notes (Exhibit 1, pp. 96-101, 104-107) dated [redacted], were presented. Ongoing diagnoses of enlarged uterus, painful menstruation, and heavy menstruation were noted. Additional diagnoses of irregular periods and abnormal maternal glucose tolerance were noted. Birth control device instructions were provided.

Physician office visit notes (Exhibit A, pp. 10-11) dated [redacted], were presented. Diagnoses of hyponatremia, acute kidney injury, and fatigue were noted.

Various mental health treatment agency documents (Exhibit 1, pp. 59-81) from June 2015 were presented. A treatment plan, health assessment, and progress notes were included. It was noted Petitioner sought to control her anger and get her life “back on track.”

Neurologist office visit notes (Exhibit 1, pp. 108-109), dated [redacted], were presented. A diagnosis of seizures was noted. A follow-up in 3 months was scheduled.

A Psychiatric Evaluation (Exhibit 1, pp. 55-58, 82-85) dated [redacted] from a newly treating psychiatrist was presented. Petitioner reported a history of seizures and depression. Reported symptoms included crying spells, mood swings, low energy, nervousness, helplessness, anhedonia, and difficulty sleeping. It was noted Petitioner was frustrated with sometimes having to be watched like a child. It was noted Petitioner drank alcohol and smoked marijuana. Petitioner reported that seizures began in 2012. Petitioner reported her last seizure was in May 2015. Mental status assessments were all noted as unremarkable other than impaired memory. An Axis I diagnosis of major depressive disorder (recurrent) was noted. Petitioner’s GAF was noted to be 50.

A Medical Examination Report (Exhibit 1, pp. 12-14) dated [redacted], was presented. The form was completed by a neurologist with an approximate 23 month history of treating Petitioner. Diagnoses of focal epilepsy and recurrent seizures were 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. Petitioner’s neurologist stated Petitioner had various limitation(s) expected to last 90 days. Petitioner’s neurologist opined that Petitioner was restricted to about 2 hours of standing and/or walking. No sitting restrictions were indicated. A restriction of lifting/carrying 50 pounds or more was noted. Petitioner was restricted to occasional lifting/carrying of 25 pounds or less. Petitioner was deemed capable of frequent lifting/carrying of 10 pounds or less. No repetitive action restrictions were noted. In response to a question asking for the stated basis for restrictions, Petitioner’s neurologist stated Petitioner had seizures every 2-3 months and that Petitioner’s seizures were unpredictable.

Mental health therapist notes (Exhibit 1, pp. 48-49) dated [redacted], were presented. It was noted Petitioner reported having a seizure the previous evening. It was noted Petitioner appeared for the purpose of having MDHHS documents completed.

A treatment plan (Exhibit 1, pp. 50-52) dated [redacted], was presented. The plan was completed by a treating mental health therapist. Goals of controlling anger and depression, smoking cessation, and maintaining better physical health were noted.

A Psychiatric/Psychological Examination Report (Exhibit 1, pp 15-17) dated [redacted] was presented. The form was completed by a treating psychiatrist. Petitioner was noted to be emotionally unstable. Rage, frustration, anger, anxiety, confusion, depression, fatigue, irregular sleep pattern, and sadness were noted as symptoms. An Axis I diagnosis of major depressive disorder (recurrent and severe) was noted. Petitioner's GAF was noted to be 40.

Mental health therapist notes (Exhibit 1, pp. 46-47) dated [redacted], were presented. It was noted Petitioner reported having a seizure the previous evening.

Mental health treatment agency notes (Exhibit 1, pp. 35-40) dated [redacted], were presented. Prescribed medications included Ativan and Celexa.

Internal physician office visit notes (Exhibit 1, pp. 44-45) dated [redacted], were presented. It was noted Vitamin D3 was newly prescribed.

A letter from a non-physician from Petitioner's treating mental health agency (Exhibit A, pp. 5-6) dated March 29, 2016, was presented. The letter provided no new information concerning Petitioner's mental health claims.

An undated letter (Exhibit A, p. 7) from a treating neurologist was presented. It was noted Petitioner suffered breakthrough seizures every 2-3 months despite ongoing treatment. Confusion, unresponsiveness, and loss of time/memory were noted as seizure characteristics. The physician noted support for Petitioner's disability application.

Petitioner testified she has ongoing seizures. Petitioner testified she shakes and may stare if she has a seizure. Petitioner testified she fell down stairs and experienced urinary incontinence with past seizures. Petitioner's mother testified it is not always clear when Petitioner is having a seizure.

Petitioner testified she was recently diagnosed with epilepsy by her neurologist. Petitioner testified she last had a seizure in February 2016. Petitioner estimated she had 7-8 seizures during 2015. Petitioner also testified she has not driven since February 2012 because of seizure-related restrictions.

Petitioner testified she takes Keppra and Trileptal to control her seizures. Petitioner testified the medications render her dizzy and forgetful.

Petitioner also testified she is unable to perform past employment of child care because she might drop a child if she had a seizure. Petitioner testified she has pursued employment over the last 2 years; Petitioner testimony suspected that employers do not offer her employment because of potential liability if Petitioner had a seizure during work.

Presented evidence sufficiently verified Petitioner has ongoing psychological and physical restrictions which restrict the performance of basic work activities. The restrictions were established to have been ongoing for longer than 90 days. Accordingly, it is found that Petitioner established having a severe impairment and the disability analysis may proceed to Step 3.

The third step of the sequential analysis requires determining whether the Petitioner's impairment, or combination of impairments, is listed in 20 CFR Part 404, Subpart P, appendix 1. 20 CFR 416.920 (a)(4)(iii). If a petitioner's impairments are listed and deemed to meet the durational requirement, then the petitioner is deemed disabled. If the impairment is unlisted or impairments do not meet listing level requirements, then the analysis proceeds to the next step.

Petitioner's most apparent exertional impairment is epilepsy. A listing for non-convulsive epilepsy (Listing 11.03) was considered. The listing was rejected due to a failure to provide detailed seizure history. Petitioner's seizure frequency also does not exceed listing requirements.

Petitioner also alleged restrictions based on depression. Depression 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 testified she began seeing a psychiatrist in June 2015. Petitioner testified she experiences symptoms of mood swings, social isolation, and anger. Petitioner testified she tries to block suicidal thoughts. Petitioner testified she attempts stress relief techniques learned in therapy (e.g. listening to affirmations and ocean sounds).

Symptoms of suicidal ideation, concentration difficulty, sleep problems, and decreased energy were documented. Petitioner sufficiently meets Part A of the affective disorder listing.

Evidence did not support that Petitioner meets Part C. Evidence was mixed concerning whether Petitioner meets Part B of the affective disorder listing.

On a Medical Examination Report dated [redacted], Petitioner's neurologist stated Petitioner was limited in comprehension, memory, sustained concentration, following simple directions, reading/writing, and social interactions. Petitioner's neurologist noted all of the following the restrictions applied "immediately after" seizures for an unspecified period. Petitioner's neurologist's statements were not compelling as most persons experiencing seizures will have comparable symptoms. It would be more concerning if Petitioner experiences these symptoms between seizures. Petitioner's neurologist did not address Petitioner's abilities between seizures. Performance restrictions of 6-7 times per year for a few minutes is not deemed to qualify as marked restrictions.

Petitioner's GAF was 50 as of the beginning of July 2015. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that 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)." Petitioner's GAF was consistent with having marked functional restrictions.

By the end of July 2015, Petitioner's GAF was 40. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF within the range of 31-40 is described as "some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood." A GAF of 40 is consistent with meeting Part B affective disorder listing requirements.

The provided GAFs were not exceptionally consistent with Petitioner's symptoms, though it cannot be concluded that the GAFs were inconsistent with symptoms. Petitioner has not attempted suicide, not had any psychiatric hallucinations, and has no hallucinations; generally, these are significant indicators of a low functioning level. Though Petitioner's symptoms are relatively less impactful than other symptoms, they could be so severe that Petitioner struggles with everyday life.

A Mental Residual Functional Capacity Assessment (Exhibit 1, pp. 18-19) dated [redacted], was presented. The assessment was noted as completed by a treating psychiatrist. This form lists 20 different work-related activities among four areas: understanding and memory, sustained concentration and persistence, social interaction and adaptation. Petitioner was found to be markedly limited in all 20 of the abilities listed on the form, which included:

- Remembering locations and other work-like procedures
- Understanding and remembering 1 or 2-step directions

- Understanding and remembering detailed instructions
- Carrying out simple 1-2 step directions.
- Carrying out detailed instructions
- Maintaining concentration for extended periods
- Performing activities within a schedule and maintaining attendance and punctuality
- Sustaining an ordinary routine without supervision
- Working in coordination or proximity to other without being distracting
- Making simple work-related decisions
- Completing a normal workday without psychological symptom interruption
- Interacting appropriately with the general public
- Asking simple questions or requesting assistance
- Accepting instructions and responding appropriately to criticism
- Getting along with others without exhibiting behavioral extremes
- Maintaining socially appropriate behavior and adhering to general cleanliness standards
- Responding appropriately to changes in the work setting
- Being aware of normal hazards and taking appropriate precautions
- Traveling to unfamiliar places including use of public transportation
- Setting realistic goals or making plans independently of others.

A statement that Petitioner is markedly restricted in every work ability is completely unsupported by presented evidence. For example, presented treatment records could not justify an inference that Petitioner cannot understand or carry-out simple directions. The checking of all 20 abilities is more indicative that Petitioner's psychiatrist failed to take the time to thoughtfully complete the form rather than insightful information on Petitioner's abilities. The statements of restriction are deemed to be unreliable.

Because of the overstatements of Petitioner's work-related abilities, consideration was given to finding Petitioner's psychiatrist overstated everything. The consideration was disregarded because an independent examiner also provided statements that are consistent with marked restrictions to concentration and social function.

A mental status examination report (Exhibit 1, pp. 31-34) dated [redacted], was presented. The report was noted as completed by a consultative psychiatrist. The following mental health symptoms were reported by Petitioner: depression, social isolation, appetite fluctuation, crying spells, hearing voices, paranoia, and insomnia. Noted observations of Petitioner made by the consultative examiner include the following: adequate grooming, very emotional including crying, marginal contact with reality, and spontaneous stream of mental activity. It was noted Petitioner had difficulties with immediate memory. The examiner opined that Petitioner was not able to function on a fully sustained basis. Diagnoses of major depressive disorder, nicotine disorder, and cannabis disorder were noted. A guarded prognosis was noted. A recommendation of continuing treatment and support services was noted.

A statement that Petitioner was not able to function on a fully sustained basis is indicative of marked restrictions to concentration and social function. The statements were compelling because they tended to corroborate questionable treating psychiatrist statements. It is found Petitioner meets Part B of the affective disorder listing.

It is found Petitioner meets the listing for affective disorders and, therefore, is a disabled individual. Accordingly, it is found MDHHS improperly denied Petitioner's SDA application.

It should be noted that a finding of disability is not binding in perpetuity. Petitioner's seizure disorder, as it is, is insufficient to establish disability. It is very reasonably possible that Petitioner's seizures will lessen further in the future. It is also reasonably possible that Petitioner's mental health will improve with further therapies. A guarded prognosis is suggestive of obstacles, though not insurmountable ones. It is hopeful that Petitioner has medical improvement before her annual redetermination.

## DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that MDHHS improperly denied Petitioner's application 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 benefit application dated ██████████;
(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 one year 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**

**Petitioner**