RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

Date Mailed: May 27, 2016
MAHS Docket No.: 16-004004
Agency No.:
Petitioner:

ADMINISTRATIVE LAW JUDGE: Vicki Armstrong

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; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on May 4, 2016, from Lansing, Michigan. Petitioner and his mother, , personally appeared and testified. Petitioner's Exhibits 1-35 were admitted.

The Department of Health and Human Services (Department) was represented by Assistance Payment Supervisor . testified as a witness on behalf of the Department. Department Exhibit A, pages 1-195 was admitted.

The record closed at the conclusion of the hearing.

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit program based upon medical improvement?

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 receiving SDA at all times pertinent to this case.

2. In December 2015, Petitioner timely submitted a Redetermination for SDA benefits alleging continuing disability.

3. On March 2, 2016, the Medical Review Team (MRT) denied Petitioner's continuing SDA benefits. (Dept Ex. A, pp 7-13).

4. On March 8, 2016, the Department mailed Petitioner a Notice of Case Action, informing Petitioner the SDA benefits would close effective April 1, 2016. (Dept Ex. A, pp 3-6).

5. On March 17, 2016, Petitioner submitted a Request for Hearing to the Department contesting the Department's actions.

6. On [redacted], Petitioner was admitted to the hospital for loop ileostomy surgery. His last surgery on [redacted] was a completion proctectomy with ileoanal J-pouch anastomosis with diverting loop ileostomy. The rectal biopsy did not show active ulcerative colitis. (Dept. Exh. A, p 115).

7. On [redacted], Petitioner followed up at the [redacted] concerning his ulcerative colitis. Petitioner has a history of ulcerative colitis status post total colectomy in July 2014, who developed mesenteric vein thrombosis on [redacted]. He completed systemic anticoagulation with Coumadin in April 2015 and was using anticoagulation postoperatively with no recurrent clotting events. On [redacted], he underwent completion proctectomy with ileoanal J-pouch anastomosis and diverting loop ileostomy. During the examination, he had some serious discharge from his abdominal wound. He agreed with continued prophylactic anticoagulation. (Dept. Exh. A, pp 116-119).

8. On [redacted], during a scheduled follow-up with his primary care physician, Petitioner was diagnosed with left sided colitis with other complication, opioid dependence with opioid-induced sleep disorder and obesity due to excess calories. His past medical history included anxiety, insomnia, chronic colitis, pancreatitis, hypertension and gastroesophageal reflux disease (GERD). (Petitioner Exhibits 5-8).

9. On [redacted], following Petitioner's complaints of a left-sided headache and elevated white blood cell count, a CT Brain without contrast was performed. The results when compared to an [redacted] CT showed an abnormal hyperdensity involving the left sigmoid and straight sinuses and also involving an extraaxial vein lateral to the left temporal lobe with findings compatible with venous thrombosis. There was also a small hyperdense focus in the subcortical white matter in the left cerebral hemisphere as described above near the junction of the occipital lobe with the temporal lobe. A small cortical hemorrhage was suspected. There was no gross mass lesion or obvious evidence of acute CVA. (Petitioner Exh. 2-3).

10. On [redacted], Petitioner presented to the emergency department with a headache. A CTA of head showed filling defects extending from the left transverse into the left jugular vein, compatible with dural venous sinus thrombosis. He was admitted to neurosurgery inpatient for monitoring until he could be started on long-

term anticoagulation. His neurological examination remain unchanged, with bilateral hyperreflexia being the only abnormal finding. For his headaches, he received 1000 mg acetaminophen, 15 mg PO morphine and 5 mg oxycodone. However, his headaches remained unchanged in severity. He was transitioned to 30 mg morphine prior to discharge, which represented an increase from his previous IV and oral combined regimen. He was also given one shot of 250 mg caffeine-benzoate. He was discharged on in fair condition. (Dept. Exh. A, pp 122-141).

11. On , Petitioner presented to the emergency department with numbness. His past medical history was significant for cerebral venous sinus thrombosis, ulcerative colitis and Clostridium difficile infection status post colectomy, which was complicated by superior mesenteric and portal vein thrombosis, who was presenting with facial weakness, numbness and tingling. Preliminary OSH head CT indicated a slightly increased size of ellipsoid high attenuation area in the left temporoparietal area likely representing hemorrhagic venous infarct with no new areas of hemorrhage. Neurology was consulted due to Petitioner's worsening symptoms despite treatment for his thrombosis and his history of venous sinus infarcts. Petitioner was admitted for a suspected transient ischemic attack (TIA) given his history of hypercoagulability. He was monitored in the stroke unit during which he had several episodes of right sided paresthesias. He was discharged in stable condition on and instructed to follow-up in the cerebrovascular clinic. (Dept. Exh. A, pp 141-163).

12. On , Petitioner followed up with his primary care physician concerning his MRI arthrogram of his right shoulder. Petitioner was diagnosed with right shoulder labral tear and humeral head subluxation. (Petitioner Exh. 1).

13. On , Petitioner saw his primary care physician post cerebral vascular accident (CVA). Petitioner reported he was still having headaches. He also reported fatigue, trouble sleeping and diarrhea. Petitioner's current diagnoses included: acute upper respiratory infection (URI), anxiety, weakness, chronic colitis, cough, GERD, headache, status post CVA, hypertension, insomnia, obesity, narcotic drug use, pancreatitis, shoulder pain, sinusitis and tachycardia. Petitioner still using anticoagulants. (Petitioner Exh. 24-28).

14. On , Petitioner followed up with his primary care physician complaining of chronic colitis and GERD. Petitioner was diagnosed with photo phobia, insomnia, phonophobia and hypercoagulopthy. The physician noted that Petition had a history of CVA due to hypercoagulability state of unknown etiology and he was continuing to experience symptoms. Petitioner reported weakness, fatigue, visual problems, photophobia, visual disturbances, sinus pain, diarrhea, heartburn, neck pain, joint pain, muscle pain, decreased range of motion, anxiety, depression, and sleep problems. The physician noted Petitioner was cooperative but his mood and affect were apathetic, calm, depressed and labile. He was diagnosed with chronic colitis, GERD, photophobia, insomnia, phonophobia and

hypercoagulopathy. The physician indicated that Petitioner's course was worsening. Surgery for GERD was recommended. (Petitioner Exh. 29-34).

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Health and Human Services Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

Pursuant to the federal regulations at 20 CFR 416.994, once a client is determined eligible for disability benefits, the eligibility for such benefits must be reviewed periodically. Before determining that a client is no longer eligible for disability benefits, the agency must establish that there has been a medical improvement of the client's impairment that is related to the client's ability to work. 20 CFR 416.994(b)(5).

> To assure that disability reviews are carried out in a uniform manner, that a decision of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop disability benefits are made objectively, neutrally, and are fully documented, we will follow specific steps in reviewing the question of whether your disability continues. Our review may cease and benefits may be continued at any point if we determine there is sufficient evidence to find that you are still unable to engage in substantial gainful activity. 20 CFR 416.994(b)(5).

The first question asks:

> (i) Are you engaging in substantial gainful activity? If you are (and any applicable trial work period has been completed), we will find disability to have ended (see paragraph (b)(3)(v) of this section).

Petitioner is not disqualified from this step because he has not engaged in substantial gainful activity at any time relevant to this matter. Furthermore, the evidence on the record fails to establish that Petitioner has a severe impairment which meets or equals a

listed impairment found at 20 CFR 404, Subpart P, Appendix 1. Therefore, the analysis continues. 20 CF 416.994(b)(5)(ii).

The next step asks the question if there has been medical improvement. Medical improvement is any decrease in the medical severity of your impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be based on changes (improvement) in the symptoms, signs and/or laboratory findings associated with your impairment(s). 20 CFR 416.994(b)(1)(i).

If there is a decrease in medical severity as shown by the symptoms, signs and laboratory findings, we then must determine if it is related to your ability to do work. In paragraph (b)(1)(iv) of this section, we explain the relationship between medical severity and limitation on functional capacity to do basic work activities (or residual functional capacity) and how changes in medical severity can affect your residual functional capacity. In determining whether medical improvement that has occurred is related to your ability to do work, we will assess your residual functional capacity (in accordance with paragraph (b)(1)(iv) of this section) based on the current severity of the impairment(s) which was present at your last favorable medical decision. 20 CFR 416.994(b)(2)(ii).

Petitioner credibly testified that he has to use the bathroom every two hours, which affects his sleep. He stated that the bright lights hurt his eyes, and he is unable to watch television due to the flickering lights. He reported that since his stroke, he has problems with depth perception and no longer drives. He also stated that his balance and coordination are off. He is also sensitive to noise. The Departmental representative credibly testified that she had to dim the lights for the hearing, and that Petitioner appeared anxious and concerned throughout.

In this case, Petitioner underwent surgery in June 2015 for a completion proctectomy with ileoanal J-pouch anastomosis and diverting loop ileostomy. He also had follow-up loop ileostomy surgery in September 2015. During a scheduled appointment with his primary care physician in October 2015, Petitioner was diagnosed with left sided colitis. He was hospitalized [redacted] through [redacted] for a dural venous sinus thrombosis. He was then readmitted the following day on [redacted] due to suffering a transient ischemic attack and remained hospitalized until [redacted]

As a result, the Department has not met its burden of proof. The Department has provided no evidence that indicates Petitioner's medical conditions have improved or that any improvement relates to his ability to do basic work activities. The agency provided no objective medical evidence from qualified medical sources that show Petitioner is currently capable of doing basic work activities. Accordingly, the agency's Disability Medicaid eligibility determination cannot be upheld at this time.

DECISION AND ORDER

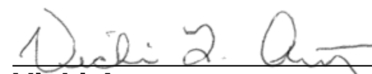
Accordingly, the Department's determination is **REVERSED**.

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE OF MAILING OF THIS DECISION AND ORDER:

1. Reinstate Petitioner's SDA back to the date of denial and issue any retroactive SDA benefits he may otherwise be entitled to receive, as long as he meets the remaining financial and non-financial eligibility factors.

2. Redetermine Petitioner's SDA eligibility in March, 2017.

It is SO ORDERED.



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Vicki Armstrong
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

430 Barfield Drive
Hastings, MI
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