RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: June 17, 2016
MAHS Docket No.: 16-005598
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, an in-person hearing was held on May 25, 2016, from Detroit, Michigan. Petitioner appeared and was unrepresented. [redacted] Petitioner's case manager from a mental health treatment agency, testified on behalf of Petitioner. 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. 4-11).

4. On [redacted], MDHHS terminated Petitioner's eligibility for SDA benefits, effective February 2016, and mailed a Notice of Case Action (Exhibit 1, pp. 14-15) 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).

Petitioner's hearing request indicated he had an authorized hearing representative (AHR). The AHR did not appear for the hearing. Petitioner verbally waived his right to representation and the hearing was conducted accordingly.

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.

Mental health provider treatment plan meeting notes (Exhibit 1, pp. 75-84) dated [redacted], were presented. Goals included case management, peer support, medication reviews, health services, and securing housing.

Handwritten psychiatrist office visit notes (Exhibit 1, pp. 94-95, 142-145) dated [redacted], were presented. Most of the notes were not legible. An Axis I diagnosis of major depressive disorder (recurrent) was stated. A GAF of 40 was noted. A guarded prognosis was given.

Physician office visit notes (Exhibit 1, pp. 52-54) dated [redacted], were presented. It was noted Petitioner presented for follow-up of back pain. Petitioner reported Norco fails to provide adequate relief. Assessments of scoliosis, lumbar spinal stenosis, and degenerative disc disease were noted. Prescriptions included Flexeril, Motrin, Wellbutrin, MiraLax, and Fionase.

Psychiatric progress notes (Exhibit 1, pp. 97-99) dated [redacted] were presented. Petitioner reported doing well with medications. Seroquel and Wellbutrin were prescribed.

Physician office visit notes (Exhibit 1, pp. 49-51) dated [redacted], were presented. It was noted Petitioner had an unspecified difficulty with following-up with pain clinic treatment.

A letter from the testifying case manager (Exhibit 1, p. 148) dated [redacted], was presented. The letter stated Petitioner was an ongoing patient diagnosed with major depressive disorder (recurrent, severe, and with psychotic features).

A physician letter (Exhibit 1, p. 146) dated [redacted], was presented. It was stated Petitioner was treated for chronic back pain, degenerative disc disease, thoracic spine scoliosis, vitamin D deficiency, constipation, and lumbar radiculopathy.

Psychiatric progress notes (Exhibit 1, pp. 100-102) dated [redacted], were presented. Petitioner reported recurring visions of dead family and friends. Seroquel and Wellbutrin were prescribed.

Physician office visit notes (Exhibit 1, pp. 39-43) dated [redacted], were presented. It was noted Petitioner reported non-radiating moderate back pain (pain level 8/10), ongoing for 2-3 years. Petitioner's request for Tylenol #4 was denied. Referrals to orthopedics, PT, and pain management were noted.

Psychiatric progress notes (Exhibit 1, pp. 103-105) dated [redacted], were presented. Back pain, restless sleep and grief from the passing of a friend was reported by Petitioner. Seroquel and Wellbutrin were continued.

An internal medicine examination report (Exhibit 1, pp. 128-136) dated [redacted], was presented. The report was noted as completed by a consultative physician. Petitioner reported complaints of back pain and constipation, ongoing for 2 years. Petitioner was noted as having a right-sided limp. Tandem walk, toe walk, and heel walk were noted as slowly performed. Reduced ranges of motion were noted in Petitioner's lumbar flexion (80°- normal 90°) and bilateral hip forward flexion (50°- normal 100°). It was noted that Petitioner was able to perform all 23 listed work-related activities which included sitting, standing, lifting, carrying, stooping, bending, and reaching, though most were performed with pain. The examiner stated that clinical evidence supported a need for a cane.

A mental status examination report (Exhibit 1, pp.138-142) dated [redacted], was presented. The report was noted as completed by a consultative licensed psychologist. The following mental health symptoms were reported by Petitioner: poor comprehension, illiteracy, and audio hallucinations. Noted observations of Petitioner made by the consultative examiner include the following: adequate contact with reality, logical stream of mental activity, and paranoid thought content. Diagnoses of

schizoaffective disorder and prolonged grief reaction were noted. A fair prognosis was noted.

Psychiatric progress notes (Exhibit 1, pp. 106-109) dated [redacted], were presented. Complaints of audio hallucinations were noted. Seroquel and Wellbutrin were continued.

Physician office visit notes (Exhibit 1, pp. 44-48) dated [redacted], were presented. Ongoing treatment for back pain was noted. Views of Petitioner's spine were ordered.

Psychiatric progress notes (Exhibit 1, pp. 110-114) dated [redacted], were presented. Petitioner reported ongoing grief with his daughter's death from 3 years earlier. Seroquel and Wellbutrin were continued.

Psychiatric progress notes (Exhibit 1, pp. 115-118) dated [redacted], were presented. It was noted Petitioner reported hallucinations of mumbling and smoky clouds. Petitioner reported sleeping and eating well. Seroquel and Wellbutrin were continued.

An annual biopsychosocial assessment from a treating mental health agency (Exhibit 1, pp. 59-74) dated [redacted], was presented. It was noted Petitioner reported he "was not right" and needed help. It was noted Petitioner's daughter was murdered one year earlier. Petitioner reported symptoms of grief, panic attacks, anxiety, isolative behaviors, paranoia, mood swings, sleep disturbance, and decreased appetite. Petitioner was noted to be a poor historian. An Axis I diagnosis of major depressive disorder (severe with psychosis) was noted. Petitioner's GAF as of [redacted], was 43.

Mental health provider treatment plan meeting notes (Exhibit 1, pp. 85-94) dated [redacted], were presented. Ongoing goals included case management, peer support, medication reviews, health services, and securing housing.

Psychiatric progress notes (Exhibit 1, pp. 119-123) dated [redacted], were presented. It was noted Petitioner reported audio hallucinations of his father. Petitioner reported sleeping and eating well. Seroquel and Wellbutrin were continued.

A physician letter (Exhibit A) dated [redacted], was presented. Diagnoses of L5-S1 disc tear, multilevel facet joint arthritis, L2-L4 slipped disc, gout, arthritis, and left hip pain with tear were stated. It was noted Petitioner's medical history included a gunshot wound to his right leg.

Petitioner testified he was shot in the right leg, near his ankle, 6 years earlier. Petitioner testified the bullet was surgically removed but he still has ongoing pain.

Petitioner testified his legs suffer from arthritis. Petitioner testified he has recurring "gouch" (i.e. cramps) in his legs. Petitioner testified he attends PT, which somewhat helps.

Petitioner testified he has back pain, in part, related to a back injury from when he was approximately 21 years old. Petitioner testified he had a long fall where significant amounts of broken glass became lodged in his back.

Petitioner testified he has hemorrhoids which affect his ability to stand. Treatment for hemorrhoids was not verified.

Petitioner testified he can only walk ½ a block, with his cane, before back and leg pain prevent further walking. Petitioner testified he always uses his cane and did not think he could walk without it. Petitioner reported that similar problems prevent standing for more than 10-15 minutes. Petitioner testified sitting is restricted to 25 minutes before his legs, back, and hip grow numb.

Petitioner testified he can bathe himself, though he sometimes needs help getting into the bathtub. Petitioner testified dressing is difficult when he is unable to bend his leg. Petitioner testified he tries to clean up his room, but is limited in other housework.

Petitioner testified he has anger problems and depression. Petitioner blamed much of his problems on grief. Petitioner testified several persons close to him have died (e.g. daughter, daughter's mother, and ex-girlfriend's child). Petitioner testified he lacks focus. Petitioner testified he has recurring visual hallucinations of his daughter. Petitioner testified he hears voices "all the time" and every day. Petitioner testified that hallucinations "take him off his track" and make it difficult for him to focus. Petitioner also testified he is illiterate.

A listing for joint dysfunction (Listing 1.02) was considered based on Petitioner's complaints of knee and hip pain. The listing was rejected due to an absence of objective medical evidence (e.g. radiology reports) supporting a finding that Petitioner is unable to ambulate effectively.

A listing for spinal disorders (Listing 1.04) was considered based on Petitioner's lumbar complaints. This listing was also rejected due to an absence of objective medical evidence establishing a spinal disorder resulting in a compromised nerve root and/or an inability to ambulate effectively.

Listings for psychotic disorders (Listing 12.03) and affective disorders (Listing 12.04) were considered based on provided diagnoses. Presented evidence was suggestive that Petitioner had marked restrictions in social functioning and concentration. Despite presented evidence, there were some unanswered questions concerning Petitioner's treatment history.

For example, it was curious that Petitioner appeared to have a lengthy mental health treatment history, yet Petitioner reported constant disruption from hallucinations. Generally, hallucinations are reasonably controllable with medication.

It is plausible that Petitioner is so grief-stricken from the death of loved ones, no medications can control his hallucinations. If that was the case, therapy records should be presented to document Petitioner's progress, or lack of it. No therapy records were presented.

Ongoing marked restrictions are consistent with at least a history of one psychiatric hospitalization. No psychiatric hospitalizations were verified or alleged.

Based on presented evidence, it is found Petitioner failed to establish meeting an SSA listing. 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).

MDHHS testimony indicated Petitioner was deemed disabled in June 2015. MDHHS did not present any documentary evidence of the original finding of disability.

Without the original medical packet supporting the disability finding, a finding that no medical evidence occurred is appropriate. It should also be noted that presented evidence was not particularly indicative of medical improvement. It is found MDHHS failed to establish medical improvement and the analysis may proceed 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 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]