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: August 26, 2016
MAHS Docket No.: 16-007468
Agency No.: [redacted]
Petitioner: [redacted]

**ADMINISTRATIVE LAW JUDGE: Alice C. Elkin**

## 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 July 7, 2016, from Detroit, Michigan. Petitioner appeared and represented himself. The Department of Health and Human Services (Department) was represented by [redacted], Hearing Facilitator.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. A DHS-49D, Psychiatric/Psychological Examination Report, and DHS-49E, Mental Residual Functional Capacity Assessment, completed and signed by Petitioner's psychiatrist at [redacted] was received and marked into evidence as Exhibit E. The record closed on August 5, 2016, and the matter is now before the undersigned for a final determination based on the evidence presented.

## ISSUE

Did the Department properly determine that Petitioner was not disabled for purposes of continued State Disability Assistance (SDA) benefit program eligibility?

## 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 recipient of SDA benefits based on a Hearing Decision issued January 15, 2014 by Administrative Law Judge (ALJ) Jonathan W. Owens. In his decision, ALJ Owens ordered the Department to review Petitioner's medical condition for ongoing SDA eligibility in January 2015. (Exhibit D.)

2. In April 2016, Petitioner's updated medical packet was forwarded to the Disability Determination Service (DDS)/Medical Review Team (MRT) for review of his ongoing eligibility for SDA benefits.

3. On May 11, 2016, DDS/MRT found Petitioner no longer disabled (Exhibit A, pp. 15-63).

4. On May 17, 2016, the Department sent Petitioner a Notice of Case Action notifying him that his SDA case would close effective July 1, 2016 because, in relevant part, he was not disabled (Exhibit A, pp. 4-5, 11-14).

5. On May 25, 2016, the Department received Petitioner's timely written request for hearing concerning the closure of his SDA case (Exhibit A, pp. 2-3).

6. Petitioner alleged disabling impairment due lower back pain due to degenerative disc disease (DDD); arm pain; titanium plate in neck; bipolar disorder; and depression.

7. At the time of hearing, Petitioner was [redacted] years old with a [redacted] birth date; he is [redacted] in height and weighs about [redacted] pounds.

8. Petitioner has a [redacted].

9. Petitioner has an employment history of work as an assembly line worker.

10. Petitioner has a pending disability claim with the Social Security Administration (Exhibit C).

## 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 disabled person is eligible for SDA. BEM 261 (July 2014), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment lasting, or expected to last, at least ninety days which meets federal SSI disability standards,

meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Once an individual has been found disabled, continued entitlement to benefits based on a disability is periodically reviewed in accordance with the medical improvement review standard in order to make a current determination or decision as to whether disability remains. 20 CFR 416.993(a); 20 CFR 416.994(a). If the individual is not engaged in substantial gainful activity (SGA), the trier of fact must apply an 8 step sequential evaluation in evaluating whether an individual's disability continues. 20 CFR 416.994. The review may cease and benefits may be continued at any point if there is sufficient evidence to find that the individual is still unable to engage in SGA. 20 CFR 416.994(b)(5).

In this case, Petitioner has not engaged in SGA at any time since he became eligible for SDA. Therefore, his disability must be assessed to determine whether it continues. The eight-step evaluation applied to determine whether an individual has a continuing disability is as follows:

> **Step 1.** If the individual has an impairment or combination of impairments which meets or equals the severity of an impairment listed in 20 CFR Appendix 1 of subpart P of part 404, the disability will be found to continue. 20 CFR 416.994(b)(5)(i).
>
> **Step 2.** If a listing is not met or equaled, it must be determined whether there has been medical improvement as defined in 20 CFR 416.994(b)(1)(i) and shown by a decrease in medical severity. If there has been a decrease in medical severity, Step 3 is considered. If there has been no decrease in medical severity, there has been no medical improvement unless an exception in Step 4 applies. 20 CFR 416.994(b)(5)(ii).
>
> **Step 3.** If there has been medical improvement, it must be determined whether this improvement is related to the individual's ability to do work in accordance with 20 CFR 416.994(b)(1)(i) through (b)(1)(iv); *i.e.*, there an increase in the individual's residual functional capacity (RFC) based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to the individual's ability to do work, the analysis proceeds to Step 4. If medical improvement *is* related to the individual's ability to do work, the analysis proceeds to Step 5. 20 CFR 416.994(b)(5)(iii).
>
> **Step 4.** If it was found at Step 2 that there was no medical improvement or at Step 3 that the medical improvement is not related to the individual's ability to work, the exceptions in 20 CFR 416.994(b)(3) and (b)(4) are considered. If none of them apply, the disability will be found to continue.

If an exception from the first group of exceptions to medical improvement applies, the analysis proceeds to Step 5. If an exception from the second group of exceptions to medical improvement applies, the disability is found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process. 20 CFR 416.994(b)(5)(iv).

**Step 5.** If medical improvement is shown to be related to an individual's ability to do work or if one of the first group of exceptions to medical improvement applies, **all** the individual's current impairments in combination are considered to determine whether they are severe in light of 20 CFR 416.921. This determination considers all the individual's current impairments and the impact of the combination of these impairments on the individual's ability to function. If the RFC assessment in Step 3 shows significant limitation of the individual's ability to do basic work activities, the analysis proceeds to Step 6. When the evidence shows that all the individual's current impairments in combination do not significantly limit the individual's physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature and the individual will no longer be considered to be disabled. 20 CFR 416.994(b)(5)(v).

**Step 6.** If the individual's impairment(s) is severe, the individual's current ability to do substantial gainful activity is assessed in accordance with 20 CFR 416.960; i.e., the individual's RFC based on all current impairments is assessed to determine whether the individual can still do work done in the past. If so, disability will be found to have ended. 20 CFR 416.994(b)(5)(vi).

**Step 7.** If the individual is not able to do work done in the past, the individual's ability to do other work given the RFC assessment made under Step 6 and the individual's age, education, and past work experience is assessed (unless an exception in 20 CFR 416.994(b)(5)(viii) applies). If the individual can do work done in the past, the disability has ended. If the individual cannot, the disability continues. 20 CFR 416.994(b)(5)(vii).

**Step 8.** Step 8 may apply if the evidence in the individual's file is insufficient to make a finding under Step 6 about whether the individual can perform past relevant work. If the individual can adjust to other work based solely on age, education, and RFC, the individual is no longer disabled, and no finding about the individual's capacity to do past relevant work under Step 6 is required. If the individual may be unable to adjust to other work or if 20 CFR 416.962 may apply, the individual's claim is assessed under Step 6 to determine whether the individual can perform past relevant work. 20 CFR 416.994(b)(5)(viii).

**Step One**

Step 1 in determining whether an individual's disability has ended 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 with no further analysis required.

In this case, Petitioner alleges disabling impairments due to DDD; arm pain; titanium plate in neck; bipolar disorder; and depression. The medical record presented was reviewed and is briefly summarized below.

Petitioner participated in physical therapy from [redacted] to [redacted]. (Exhibit B, pp. 294-309, 412-414, 434 400.) On [redacted] he went to the emergency department complaining of back pain. It was noted that he could stand on toes and heels without difficulty and was ambulating in the room on the doctor's arrival. (Exhibit A, p. 268-270.)

Petitioner had ongoing treatment for neck and back pain from [redacted] to [redacted]. A [redacted] lumbar spine x-ray showed a slight progression of degenerative changes at L3-L4 with associated minimal posterolisthesis of L3 over L4. A [redacted] lumbar spine MRI showed significant intervertebral disc space narrowing and endplate signal changes at L3-4; additional multilevel disc degeneration with intervertebral disc space narrowing and endplate degenerative changes; L3-4 disc bulging with superimposed right paracentral disc extrusion and mild right foraminal narrowing; multilevel disc protrusions without foraminal narrowing; and mild L4-5 and L5-S1 and facet arthropathy. An [redacted] lumbar spine MRI showed L3-4 disc degeneration, intervertebral disc space narrowing, and endplate degenerative changes; multilevel disc bulging without spinal canal stenosis; L3-4 right paracentral disc protrusion that might slightly displace the intraspinal L4 nerve root posteriorly; and multilevel facet arthropathy. Petitioner had injections to treat his lower back on [redacted]; [redacted]; [redacted]; and [redacted]; and [redacted]; he had an injection to his bilateral trapezius in the cervical paraspinals on [redacted]. (Exhibit B, pp. 336-393, 476-533.)

On [redacted], Petitioner underwent an anterior cervical discectomy of C4-5 and C5-6 with decompression of the thecal sac and nerve roots at C4-5, C5-6 and anterior and posterior instrumentation C4 to C6 with plate and screws to address his C4-5 and C5-6 radiculopathy due to HNP (herniated nucleus pulposus) bilaterally, worse on the right resulting in neck pain and radiculopathy of the right side. (Exhibit B, pp. 315-320, 5-460.) At on [redacted] follow-up visit, Petitioner reported that the pain in his neck was better since surgery and manageable with medications. (Exhibit B, pp. 363-368.)

On [redacted], Petitioner was examined at the orthopedic clinic complaining of numbness from his right shoulder down to his elbow following the [redacted] anterior cervical decompression and fusion surgery. The doctor believed the symptoms were consistent with cervical disc pathology, but proposed cortisone injections to rule out

shoulder versus cervical spine pathology, noting that Petitioner did have some glenohumeral joint arthritis. (Exhibit A, pp. 324-326, 464-466.)

Petitioner continued to complain of neck pain at his [redacted]; [redacted]; and [redacted] office visits. As of his [redacted] office visit, he continued to complain of pain in his neck and low back, worse at times with radiation into his right arm but no radiation into his legs. He described pain as worse with movement, standing, and sitting and improved by medication. Petitioner described the low back pain as more severe than his neck pain. A physical examination of Petitioner's cervical spine showed normal range of motion; paraspinal muscle strength and tone within normal limits; and negative Sperling's test. An examination of his lumbosacral spine showed normal range of motion; paraspinal muscle strength and tone within normal limits; straight leg raise test negative bilaterally; negative FABER on the right; and positive facet loading bilaterally. There was decreased strength in the right upper extremity, and normal strength in the left upper extremity, and normal range of motion in the right lower extremity and left lower extremity. (Exhibit B, pp. 386-391, 514-533.)

From [redacted] to [redacted] Petitioner was hospitalized complaining of chest pain. Vital signs were stable and within normal limits; physical exam was unremarkable; no acute abnormalities were appreciated; EKG showed no acute ischemia; lab work showed no acute process; and imaging was within normal limits. Stress test results were negative or ischemia. (Exhibit B, pp. 271-284, 415-428.)

On [redacted], Petitioner went to the emergency department complaining of upper abdominal pain, dysphasia, nausea, and vomiting. He was treated and released but returned later that day and was hospitalized from [redacted] to [redacted]. At the emergency department, he denied having any medical conditions other than diabetes, hypertension, and previous surgical history of appendectomy. He admitted marijuana and alcohol use, with daily marijuana use and drinking three 12 ounce beers daily for the past three months. It was noted on examination that Petitioner had visible tremors and exhibited signs of withdrawal. It was also noted that his musculoskeletal range of motion and muscle strength was "okay" and all extremities and his range of motion in the back was normal. His discharge diagnosis was hiatal hernia with gastroesophageal reflux, erosive esophagitis, alcohol withdrawal, alcohol abuse, and marijuana use. He was discharged in stable condition, advised to quit alcohol and marijuana use, and referred to outpatient alcohol abuse programs. (Exhibit B, pp. 150-197, 536-603.)

On [redacted], Petitioner underwent a physical examination with an independent medical examiner at the Department's request. Petitioner reported to the doctor reconstructive surgery of the cervical spine and ongoing chronic neck pain, right shoulder pain, diabetes, DDD of the lumbar spine, hypertension, and mental illness. His hypertension and diabetes was controlled by medication although his blood pressure was low on exam. He was being seen by pain management for his right shoulder pain and chronic low back pain for which he had received injections and was wearing a back

brace. An operative report dated [redacted] showed on anterior spinal fusion involving C4 through C6. The doctor observed that Petitioner had normal range of motion of the back and joints except as follows: his flexion of the lumbar spine was 75° (normal is 0 to 90°) and his forward flexion of the right and left hip was 50° (normal is 0 to 100°). His straight leg raise was 90° while seated and 50° while lying. The doctor noted that Petitioner had no limitation on current abilities but complained of pain with sitting, standing, bending, and stooping. He was able to walk on heels and toes and tandem walk, and his gait was stable and within normal limits. He wore a back brace. (Exhibit B, pp. 250-258, 401-409.)

On [redacted], Petitioner went to the emergency department complaining of chest pain with atypical features. It was noted that Petitioner was presenting with alcohol intoxication. Petitioner admitted drinking three 12 ounce beers and two shots the previous day; he also admitted to marijuana use three times weekly. A chest x-ray showed no acute cardiopulmonary process. A stress echocardiogram (ECG) was normal with an ejection fraction of 60%. Petitioner was evaluated by cardiology who indicated that he should take 81 mg aspirin daily and follow up on an outpatient basis. He was sent home with a prescription for Librium and advised that he could not consume alcohol with that medication. (Exhibit B, pp. 198-239, 604-645.)

On [redacted], Petitioner underwent on adult mental status evaluation at the Department's request. Petitioner reported to the evaluating psychologist that he was extremely depressed, had a breakdown a couple weeks earlier, resulting in a week long hospitalization. He reported having hallucinations in seeing TV shows on the wall. He also reported feeling suicidal and wanted to be admitted into a psychiatric unit. He alleged he was going to a mental health facility but was terminated when he had troubles with transportation. He was looking to get back into treatment. The psychologist observed that Petitioner was in adequate, overt contact with reality, with no evidence of an overt thought disorder, and generally answered questions in a logical, goal-directed fashion. The psychologist made the following observation;

> Based on today's examination, [Petitioner] demonstrated difficulty in concentration as evidenced by performance on calculation tasks. He displayed moderate strength in immediate memory and ability to pay attention, as well as, short-term memory. He would appear capable of engaging in work type activities of a relatively simple type and should be able to remember and execute 2 or 3 step repetitive procedure with no independent judgment or decision making required.

The psychologist concluded that Petitioner had major depression, recurrent, moderate to severe with psychotic features and his prognosis was fair. Based on Petitioner's difficulties performing calculation tasks, he concluded that Petitioner was not capable of managing his own benefit funds. (Exhibit B, pp. 244-248, 395-399.)

Petitioner's [redacted] mental health discharge noted a primary diagnosis of mood disorder and secondary diagnoses of major depressive disorder, recurrent and alcohol, nicotine, and cannabis dependence. (Exhibit B, pp. 330, 470.) He reengaged in mental health treatment on [redacted] and was diagnosed with a primary diagnosis of bipolar affective disorder, mixed, unspecified and a secondary diagnosis of alcohol, cannabis and tobacco use dependence. As of [redacted], he denied any current suicidal or homicidal ideations or audio/visual hallucinations. He reported partial medication compliance. He was prescribed Lamictal and Seroquel (Exhibit 1.)

On [redacted], Petitioner's psychiatrist since [redacted] completed a DHS-49D, psychiatric/psychological evaluation, indicating that Petitioner was diagnosed with bipolar I disorder, mixed, and polysubstance use and was assigned a global assessment of functioning (GAF) score of 45. The doctor noted that Petitioner was oriented to person place and time and cooperative and had spontaneous speech, depressed mood, a linear/concrete thought process, intact insight/judgment, and no hallucinations. His fund of knowledge was adequate, and while his emotional reactions tended to be appropriate to the setting, he had mixed bipolar episodes resulting in observed agitation. He had a history of violent behavior in the past. (Exhibit E.)

The psychiatrist also completed a DHS-49E, mental residual functional capacity assessment, on [redacted] regarding Petitioner's mental impairments and how they affected his activities. The psychiatrist concluded that Petitioner had **no, or no significant,** limitations regarding his ability to understand and remember one or two-step instructions; carry out simple one or two step instructions; perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; ask simple questions or request assistance; and travel in unfamiliar places or use public transportation. The psychiatrist concluded that Petitioner had **moderate** limitations regarding his ability to remember locations and work-like procedures; understand and remember detailed instructions; carry out detailed instructions; sustain an ordinary routine without supervision; work in coordination with or proximity of others without being distracted by them; interact appropriately with the general public; accept instructions and respond appropriately to criticisms from supervisors; get along with co-workers or peers without distracting them or exhibiting behavioral extremes; and maintain socially appropriate behavior and adhere to basic standards of neatness and cleanliness. The psychiatrist concluded that Petitioner had **moderate to marked** limitations regarding his ability to complete a normal workday and worksheet without interruptions from psychologically based symptoms and perform at a consistent pace without an unreasonable number and length of rest periods; respond appropriately to change in the work setting; and be aware of normal hazards and take appropriate precautions. The psychiatrist concluded that Petitioner had **marked** limitations regarding his ability to maintain attention and concentration for extended periods; make simple work-related decision; and set realistic goals or make plans independently of others. (Exhibit E.)
Based on the medical evidence presented in this case, listings 1.02 (major dysfunction of a joint), 1.04 (disorders of the spine), 12.04 (affective disorders), 12.06 (anxiety-related disorders), and 12.09 (substance addiction disorders) were considered. The medical

evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, a disability is not continuing under Step 1 of the analysis, and the analysis proceeds to Step 2.

**Step Two**

If the impairment(s) does not meet or equal a Listing under Step 1, then Step 2 requires a determination of whether there has been medical improvement as defined in 20 CFR 416.994(b)(1). 20 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). For purposes of determining whether medical improvement has occurred, the current medical severity of the impairment(s) present at the time of the most recent favorable medical decision that found the individual disabled, or continued to be disabled, is compared to the medical severity of that impairment(s) at the time of the favorable decision. 20 CFR 416.994(b)(1)(vii). If there is medical improvement, the analysis proceeds to Step 3, and if there is no medical improvement, the analysis proceeds to Step 4. 20 CFR 416.994(b)(5)(ii).

In this case, in the January 15, 2014 Hearing Decision, ALJ Owens concluded that Petitioner had exertional limitations resulting from his back pain, DDD and chronic pancreatitis limiting him to less than sedentary activities with significant restriction on his ability to bend, stoop, squat, stand and sit.

The current medical evidence showed that Petitioner had ongoing treatment for neck and back pain from [redacted] to [redacted]. Petitioner had cervical fusion surgery on [redacted] but subsequently complained of neck pain and pain radiating into his right arm. An [redacted] lumbar spine MRI did not show any substantial improvement over the [redacted] lumbar spine MRI. Petitioner had continuing injections to treat his lower back on [redacted]; [redacted]; [redacted]; and [redacted]; and [redacted], and an injection to his bilateral trapezius in the cervical paraspinals on [redacted] but continued to complain of back and neck pain. At the [redacted] physical examination where Petitioner was examined by an independent medical examiner at the Department's request, the doctor observed that Petitioner's flexion of the lumbar spine was 75° (normal is 0 to 90°), his forward flexion of the right and left hip was 50° (normal is 0 to 100°), and his straight leg raise was 90° while seated and 50° while lying. The doctor observed that Petitioner's gait was stable and he could heel, toe, and tandem walk, but he complained of pain with sitting, standing, bending, and stooping. He was able to walk on heels and toes and tandem walk and his gait was stable and within normal limits. He wore a back brace.

Additionally, ALJ Owens found that Petitioner had nonexertional limitations due to his diagnosis of major depression and anxiety disorder with a global assessment of

functioning (GAF) score of 40 that, according to a consulting physician, resulted in Petitioner having difficulty understanding, retaining, and following simple instructions.

In the current review, Petitioner's psychiatrist diagnosed Petitioner as of [redacted] with bipolar I disorder, mixed, polysubstance use and assigned him a GAF score of 45. Both Petitioner's psychiatrist and the independent psychologist who evaluated Petitioner concluded that Petitioner would be able to remember and execute simple one and two-step instructions.

The evidence presented was sufficient to establish that Petitioner had a medical improvement in his condition since the January 15, 2014 Hearing Decision. Because there is evidence of medical improvement, the analysis proceeds to Step 3. 20 CFR 416.994(b)(5)(ii).

**Step Three**

If there has been medical improvement, it must be determined whether there is an increase in the individual's residual functional capacity (RFC) based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to the individual's ability to do work, the analysis proceeds to Step 4. If medical improvement *is* related to the individual's ability to do work, the analysis proceeds to Step 5. 20 CFR 416.994(b)(5)(iii).

In this case, Petitioner continues to complain of limitations in his ability to stand, sit, walk and lift, and the evidence presented does not establish that Petitioner's medical improvement would result in an increased exertional RFC from that presented in the January 15, 2014 Hearing Decision. While both Petitioner's psychiatrist and the independent medical examiner concluded that Petitioner was able to engage in simple one- and two-step procedures, they both also concluded that Petitioner had difficulty in concentration. Petitioner's psychiatrist noted that Petitioner was markedly limited in his ability to make simple work-related decisions and respond appropriately to change in the work setting and to complete a normal workday and worksheet without interruptions from psychologically-based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods. The independent psychologist's diagnosis indicated that Petitioner had psychotic features. This evidence indicates that any improvement in Petitioner's mental condition did not lead to an increased nonexertional RFC from that reflected in the January 15, 2014 Hearing Decision. Because Petitioner's medical improvement is not related to his ability to do work, the analysis proceeds to Step 4.

**Step Four**

When it is found at Step 3 that the medical improvement is not related to the individual's ability to work, Step 4 requires an assessment of whether one of the exceptions in 20 CFR 416.994(b)(3) or (b)(4) applies. 20 CFR 416.994(b)(5)(iv). If no exception is applicable, disability is found to continue. *Id.*

The first group of exceptions to medical improvement (i.e., when disability can be found to have ended even though medical improvement has not occurred) found in 20 CFR 416.994(b)(3) applies when any of the following exist:

(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; or
(iv) Substantial evidence demonstrates that any prior disability decision was in error.

In this case, the Department did not present any evidence establishing that, since Petitioner had been approved for SDA benefits to the time of the medical review, one of the above first set of exceptions to medical improvement applied to Petitioner's situation.

The second group of exceptions to medical improvement found in 20 CFR 416.994(b)(4) applies when any of the following exist:

(i) A prior determination was fraudulently obtained;
(ii) The individual failed to cooperate in providing requested medical documents or participating in requested examinations;
(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.

If an exception from the second group listed above is applicable, a determination that the individual's disability has ended is made. 20 CFR 416.994(b)(5)(iv). While the record indicates that there was a lapse in Petitioner's participation in mental health treatment, the Department did not present evidence that his ongoing participation was expected to restore his ability to engage in substantial gainful activity. Therefore, the Department has failed to establish that any of the listed exceptions in the second group of exceptions to medical improvement apply to Petitioner's case.

Because the evidence presented does not show that any medical improvement related to Petitioner's ability to do work or that any exception under either group of exceptions at Step 4 applies, Petitioner is found to have a continuing disability for purposes of SDA.

Notwithstanding the conclusion that the medical evidence shows that Petitioner has a continuing disability, 42 USC 423(d)(2)(C) of the Social Security Act provides that an

individual is not considered disabled if alcoholism or drug addiction is a contributing factor material to the determination that the individual is disabled. Because there was evidence in the medical record of Petitioner's cannabinoid and alcohol use, 20 CFR 416.935(a) requires a determination of whether drug addiction or alcoholism (DAA) is a contributing factor material to the determination of disability.

The key factor in determining whether DAA is a contributing factor material to the determination of disability is whether the client would be disabled if he or she stopped using drugs or alcohol. 20 CFR 416.935(b)(1). This requires consideration of whether the current disability determination would remain if the client stopped using drugs or alcohol. 20 CFR 416.935(b)(2). If the remaining limitations would not be disabling, the DAA is a contributing factor material to the determination of disability. 20 CFR 416.935(b)(2)(i). If the remaining limitations are disabling, the individual is disabled independent of the DAA and, as such, the individual's DAA is not a contributing factor material to the determination of disability. 20 CFR 416.935(b)(2)(ii).

While Petitioner testified that his drug and alcohol use made his depression worse and his psychiatric diagnoses includes polysubstance abuse, there is no evidence in this case to suggest that Petitioner's mental impairments would be resolved if he stopped using cannabinoids or alcohol. Therefore, Petitioner's marijuana and alcohol use is not a contributing factor material to the determination that he is disabled.

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Petitioner has continuing disability for purposes of the SDA benefit program. Therefore, Petitioner's SDA eligibility continues and the Department did not act in accordance with Department policy when it closed his SDA case.

## 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 THE ORDER WAS ISSUED:

1. Reinstate Petitioner's SDA case effective July 1, 2016;

2. Determine if all the other non-medical criteria are satisfied and notify Petitioner of its determination;

3. Supplement Petitioner for lost benefits, if any, that Petitioner was entitled to receive if otherwise eligible and qualified from July 1, 2016 ongoing;

4. Review Petitioner's continued eligibility in February 2017.

ACE/tlf

**Alice C. Elkin**
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]

**Via Electronic Mail:**

[redacted]