STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: August 31, 2016
MAHS Docket No.: 16-008811
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned administrative law judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10; and Mich Admin Code, R 792.11002. After due notice, a telephone hearing was held on July 27, 2016, from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], medical contact worker.

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. 2-8)

4. On [redacted], MDHHS terminated Petitioner's eligibility for SDA benefits , effective August 2016, and mailed a Notice of Case Action (Exhibit 1, pp. 345-348) informing Petitioner of the termination.

5. On [redacted], Petitioner requested a hearing disputing the termination of SDA benefits (see Exhibit 1, pp. 349-350).

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 checked a dispute concerning Family Independence Program (FIP) benefits. Petitioner testified a dispute of cash assistance based on disability (i.e. SDA) was intended. MDHHS was not confused by Petitioner's error and prepared for the hearing to defend a termination of Petitioner's SDA eligibility. The hearing was conducted, without objection, to determine if MDHHS properly terminated Petitioner's SDA eligibility.

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 based on a determination that Petitioner was not disabled.

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.

A CT cervical spine report (Exhibit 1, pp. 163-164) dated [redacted] was presented. "Mild" degenerative changes were indicated. No significant canal stenosis was indicated.

A CT cervical spine report (Exhibit 1, pp. 165) dated [redacted], was presented. "Mild" degenerative disc disease and disc bulging was indicated.

An abdominal CT report (Exhibit 1, pp. 59-60, 67-68) dated [redacted], was presented. A benign kidney cyst was noted. It was noted that no follow-up was needed. Additional treatment records (Exhibit 1, pp. 65-66) from the prior week for the same problem were also presented.

Neurologist office visit documents (Exhibit 1, pp. 86-89) dated [redacted], were presented. It was noted Petitioner underwent a greater occipital nerve block.

Neurologist office visit documents (Exhibit 1, pp. 90-93) dated [redacted], were presented. It was noted Petitioner underwent drug screening due to chronic use of prescription analgesics. Active diagnoses included fibromyalgia, CTS, and migraine headaches.

Handwritten physician office visit notes (Exhibit 1, p. 70) dated [redacted], were presented. Diagnoses of fibromyalgia, GERD, and sleep apnea were legible.

Hospital emergency room documents (Exhibit 1, pp. 56-58) dated [redacted], were presented. Petitioner complained of right ear pain. A diagnosis of otitis media was noted. Petitioner was directed to follow-up with his physician.

Neurologist office visit documents (Exhibit 1, pp. 94-101) dated [redacted], were presented. It was noted Petitioner complained of neck pain, ongoing for years, ranging in pain from 1-5/10. Reported pain triggers included physical activity, bending, and lifting. Petitioner also reported recurring headaches and bilateral knee joint pain. Examination findings included decreased cervical spine ranges of motion, right knee grinding and crepitus with decreased flexion, left knee crepitus and decreased extension, and normal muscle strength in all extremities. It was noted recent drug testing was consistent with Petitioner's prescribed medications. It was noted Petitioner underwent a Toradol injection. It was noted Petitioner's lumbar pain was "quite tolerable" at that time. Petitioner's cervical spine was noted to be less severe than previous times. It was noted joint pains did not affect Petitioner's daily activities.

Hospital emergency room documents (Exhibit 1, pp. 51-55) dated [redacted], were presented. Petitioner reported right buttock pain after a slip and fall. Petitioner was discharged with anti-inflammatory medication and muscle relaxers.

Hospital emergency room documents (Exhibit 1, pp. 41-49) dated [redacted], were presented. It was noted that Petitioner presented immediately following a motor vehicle accident. Petitioner reported he went home but later experienced muscle aches (8/10). An impression of minimal ventral spondylosis was noted following lumbar radiology. An impression of lumbar, cervical, and thoracic spinal strain was stated. Ibuprofen was prescribed.

Handwritten physician office visit notes (Exhibit 1, p. 71) dated [redacted], were presented. Diagnoses of fibromyalgia and COPD were legible.

Handwritten physician office visit notes (Exhibit 1, p. 73) dated [redacted], were presented. Diagnoses of hyperlipidemia and anxiety were legible.

Hospital emergency room notes (Exhibit 1, pp. 32-35) dated [redacted], were presented. It was noted that Petitioner presented immediately following a motor vehicle accident. Petitioner reported he was a passenger in a vehicle which was struck on his side by another vehicle. A flare-up of back pain was reported. Physical examination notes indicated full strength, tenderness throughout his spine, and grossly intact

neurology. Brain, thoracic spine, and pelvis radiology was negative. A more prominent osteophytic spur formation was noted in Petitioner's lumbar spine. Cyclobenzaprine was prescribed.

Neurologist office visit documents (Exhibit 1, pp. 102-109) dated [redacted], were presented. It was noted Petitioner reported ongoing neck pain (6-10/10) radiating to right arm. Rest, physical therapy, and heat application were noted to be pain relievers. Ongoing lumbar pain (5-10/10) was reported. Joint pain, headaches, abdominal pain, hearing loss, anxiety, and drowsiness was also reported. It was noted Petitioner underwent a Toradol injection. Norco was prescribed.

Handwritten physician office visit notes (Exhibit 1, p. 75) dated [redacted], were presented. Diagnoses of fibromyalgia and chronic pain were legible.

Neurologist office visit documents (Exhibit 1, pp. 110-117) dated [redacted], were presented. It was noted Petitioner underwent EMG testing. An impression of mild bilateral CTS was noted.

Physician office visit notes (Exhibit 1, pp. 79-80) dated [redacted], were presented. Assessments of anxiety and insomnia were noted. Various medications were refilled and prescribed.

Neurologist office visit documents (Exhibit 1, pp. 118-121) dated [redacted], were presented. It was noted Petitioner underwent drug screening; results were not apparent.

Physician office visit notes (Exhibit 1, pp. 76-78) dated [redacted], were presented. It was noted that Petitioner reported lethargy, dyspnea when walking, muscle aches, joint pain, weakness, frequent headaches, restless legs, depression, and anxiety. Assessments of erectile dysfunction and chronic depression were noted. Various medications were refilled and prescribed.

Neurologist office visit documents (Exhibit 1, pp. 122-125) dated [redacted], were presented. It was noted Petitioner underwent drug screening; results were not apparent. A diagnosis of chronic pain syndrome was noted.

Neurologist office visit documents (Exhibit 1, pp. 126-130) dated [redacted], were presented. It was noted Petitioner underwent L4-L5 epidural injection.

Physician office visit notes (Exhibit 1, pp. 23-25) dated [redacted], were presented. It was noted that Petitioner presented for COPD treatment. Petitioner reported he smoked ½ pack per day. A 17 pound weight loss was indicated. It was noted Petitioner's FEV1 improved to 91% of predicted value (from 75% of predicted); Tudorza was credited for Petitioner's respiratory improvement.

Neurologist office visit documents (Exhibit 1, pp. 131-134) dated [redacted], were presented. It was noted Petitioner underwent drug screening; results were not apparent. A diagnosis of chronic pain syndrome was noted.

Neurologist office visit documents (Exhibit 1, pp. 135-139) dated [redacted], were presented. It was noted Petitioner underwent a lumbar epidural injection to address a complaint of lumbar pain radiating to his right leg. A previous injection was noted to produce 80% improvement.

Neurologist office visit documents (Exhibit 1, pp. 140-147) dated [redacted], were presented. It was noted Petitioner reported ongoing neck pain, worse with activity. It was noted Petitioner also reported lumbar pain (though it was elsewhere noted to be resolved). Complaints of joint pain and recurring headaches were noted. It was noted nerve conduction testing of Petitioner's lower extremities was normal; it was noted testing could not rule out lumbosacral radiculopathy. Physical examination findings included severe trigger point tenderness of the neck, decreased cervical spine ranges of motion, positive Tinel's sign on left and right, bilateral knee crepitus, and lumbar tenderness. It was noted Petitioner underwent a Toradol injection. A plan to repeat a nerve block to address headaches was noted. A plan of trigger point injections to address neck pain was noted. Carpal tunnel injections were also planned.

Neurologist office visit documents (Exhibit 1, pp. 148-152) dated [redacted], were presented. It was noted Petitioner underwent a cervical spine epidural injection.

Neurologist office visit documents (Exhibit 1, pp. 153-157) dated [redacted], were presented. It was noted Petitioner underwent a carpal tunnel injection.

Neurologist office visit documents (Exhibit 1, pp. 158-162) dated [redacted], were presented. It was noted Petitioner underwent trigger point injections.

Petitioner testified he is restricted to walking a ½ block before losing his breath. Petitioner testified he is limited in standing due to 10 minutes because of lumbar pain. Petitioner testified lumbar pain restricts his sitting to 20-30 minute periods. Petitioner testified he is unable to lift/carry more than 10 pounds. Petitioner testified he uses a prescribed cane to assist with ambulation.

Petitioner testified he can shower and dress himself without difficulties. Petitioner testified he can wash dishes while sitting, but he cannot vacuum or sweep. Petitioner testified he can do laundry but cannot carry laundry down stairs. Petitioner testified he shops, but relies on a scooter and needs help to reach high shelves. Petitioner testified he can drive.

Petitioner testified trigger point testing from 2014 verified his fibromyalgia diagnosis. Petitioner testimony implied fibromyalgia causes general body pain.

Petitioner testified COPD causes him to require the use of 2 inhalers, one to open bronchial tubes, and one to be used as a rescue inhaler. Petitioner also testified he requires daily breathing treatments.

Petitioner testified he has CTS in both wrists. Petitioner testified surgery on his right wrist did not reduce pain, but was helpful in reducing numbness. Petitioner testified he gets annual injections to combat CTS. Petitioner testified CTS has caused his typing ability to decrease from 60 words per minute down to about 5 words per minute.

A listing for joint dysfunction (Listing 1.02) was considered based on Petitioner's complaints of joint pain. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively or unable to perform fine and gross movements with both upper extremities.

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

A listing for chronic pulmonary insufficiency (Listing 3.02) was considered based on Petitioner's complaints of dyspnea. The listing was rejected as presented respiratory testing failed to meet listing standards.

A listing for anxiety-related disorders (Listing 12.06) was considered based on Petitioner's treating physician's diagnosis of an anxiety disorder. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Petitioner had a complete inability to function outside of the home.

It is found Petitioner failed to establish meeting any SSA listings. Accordingly, the analysis may proceed to the second step.

The second step of the analysis considers whether medical improvement occurred. CFR 416.994(b)(5)(ii). Medical improvement is defined as any decrease in the medical severity of the impairment(s) which was present at the time of the most favorable medical decision that the individual was disabled or continues to be disabled. 20 CFR 416.994(b)(1)(i).

MDHHS presented an administrative hearing decision (Exhibit 1, pp. 325-334) from a hearing conducted on [redacted]. The presiding administrative law judge determined Petitioner to be disabled, for purposes of SDA eligibility, in part, based on a finding that Petitioner is restricted to sedentary employment and application of Medical-Vocational Rule 201.12. The decision cited various medical documents which were presented by MDHHS.

Hospital documents (Exhibit 1, pp. 306-318) dated [redacted], were presented. It was noted Petitioner underwent a colonoscopy. An assessment of a sigmoid colon polyp was noted.

A left wrist x-ray report (Exhibit 1, p. 305) dated [redacted], was presented. An impression of generalized soft tissue swelling was noted.

Physician office visit notes (Exhibit 1, pp. 262-266; 274-276) dated [redacted], were presented. It was noted that Petitioner presented to establish care. Assessment of polyarthralgia, left-sided CTS, hyperlipidemia, snoring, headache, heartburn, chronic cough, and tobacco abuse were noted. A surgical history of right carpal-tunnel release form [redacted] was noted. Blood work (see Exhibit 1, pp. 277-278, 289-290) was ordered.

Rheumatologist office visit notes (Exhibit 1, pp. 205-206, 280-288, 294-299) dated [redacted], were presented. It was noted Petitioner complained of a lifelong body pain, worse in the last 2 years. Assessments of fibromyalgia, CTS, osteoarthritis, and cephalgia were noted. Neurontin was prescribed. A referral to a neurologist for treatment of chronic pain syndrome was noted.

Physician office visit notes (Exhibit 1, pp. 267-270) dated [redacted], were presented. It was noted that Petitioner complained of a stubbed toe; x-rays were negative. Petitioner complained of recurring cough; a referral to a pulmonologist was noted. Medication was given for heartburn. A referral to a sleep specialist was given in response to complaints of sleep apnea and headaches. A referral to a bone and joint specialist was given concerning fibromyalgia.

Pulmonologist office visit notes (Exhibit 1, pp. 253-261) dated [redacted], were presented. It was noted Petitioner complained of coughing, exertional dyspnea (worse after walking 5-6 blocks), and daily wheezing. Assessments included chronic bronchitis, sleep apnea, nicotine addiction, and GERD. Spirometry testing indicated a post-bronchodilator FVC of 4.37 (92% of predicted) and FEV1 post-bronchodilator of 3.25 (88% of predicted),

Various hospital documents (Exhibit 1, pp. 214-246) dated [redacted], were presented. Petitioner underwent a gastroscopy on [redacted]. Diagnoses of chronic GERD and mild gastric disorder were noted.

Rheumatologist office visit notes (Exhibit 1, pp. 204, 279, 293) dated [redacted], were presented. It was noted Petitioner complained of general body pain. It was noted Neurontin “dramatically” improved pain though continuing neck pain was reported.

Physician office visit notes (Exhibit 1, pp. 271-273) dated [redacted], were presented. It was noted that Petitioner complained of headaches; Topamax was prescribed. Petitioner reported “intense” left wrist pain; radiology was ordered.

Sleep study documents (Exhibit 1, pp. 248-249) dated [redacted], were presented. A plan of CPAP treatment was noted.

Rheumatologist office visit notes (Exhibit 1, pp. 203) dated [redacted], were presented. It was noted Petitioner presented for follow-up of fibromyalgia. Petitioner reported Neurontin has helped reduce pain level to 5/10.

Rheumatologist office visit notes (Exhibit 1, pp. 201-202) dated [redacted], were presented. It was noted Petitioner presented for follow-up of fibromyalgia. Ongoing active problems included osteoarthritis, CAD, sleep apnea, and COPD. It was noted Neurontin was helping, but Petitioner reported recent shoulder and neck pain (8/10). It was noted Petitioner underwent an injection of Kenalog into each intrascapular trigger point. A plan of continuing Neurontin was noted. Blood work was ordered.

A Physical Residual Functional Capacity Assessment (Exhibit 1, pp. 9-16) dated [redacted], was presented. The assessment was completed by a physician associated with SSA. It was stated Petitioner was capable of standing/walking for 6 hours in an 8 hour workday. An ability to stand and/or walk for 6 hours over an 8 hour workday is indicative of medical improvement. The basis for the assessment was not particularly persuasive.

The basis for assessments was a lack of new information since an ALJ decision (presumably from an ALJ determining Petitioner's SSA benefit eligibility) determining Petitioner was capable of performing light employment, full muscle strength, continued smoking, normal gait, and improved spirometry testing.

Normal gait and full strength are factors in a person's ability to ambulate, however, other evidence did not appear to be considered. Consistent neck range of motion restrictions was verified. Recurring neck and knee pain was regularly reported. A need for multiple pain injections was verified. Fibromyalgia, a fairly intrusive diagnosis, was verified. These considerations were not indicative of medical improvement.

A previous administrative decision from the SSA was not presented. Thus, it cannot be determined what change, if any, occurred form a previous SSA decision.

The improvement in Petitioner's respiratory testing was cited as further support of improvement. It was noted Petitioner's FEV1 improved from 75% to 91%. It is not known when Petitioner's FEV1 was 75% of expected value as presented records only verified a modest 3% FEV1 increase over a period of about 1½ years. The slight increase is not particularly indicative notable medical improvement.

Consideration was given to finding medical improvement based on apparent improvement of lumbar pain. This consideration was rejected as lumbar pain did not appear to be a basis for the original finding of disability.

The original finding of disability appeared to be based on body pain, mildly restricted breathing, and other conditions (GERD, osteoarthritis, left-sided CTS, and sleep apnea). More current documentation was not particularly indicative of any notable improvements in Petitioner's condition.

It is found MDHHS failed to establish medical improvement. Accordingly, the analysis may proceed 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 if it is established that the claimant can engage is substantial gainful activity. 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)(1)(3)

The second group of exceptions also allow a finding that a claimant is not disabled when medical improvement has not occurred. The exceptions do not require a showing that a claimant can engage is substantial activity. 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 August 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**.

Christian Gardocki

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]