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: September 1, 2016
MAHS Docket No.: 16-007565
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 August 4, 2016, from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], specialist.

ISSUE

The issue is whether MDHHS properly denied Petitioner's State Disability Assistance (SDA) eligibility for the reason that Petitioner is not a disabled individual.

FINDINGS OF FACT

The administrative law judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On [redacted], Petitioner applied for SDA benefits.

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

3. On an unspecified date, the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibit 1, p. 4), in part, based on a Disability Determination Explanation (Exhibit 1, pp. 5-30).

4. On [redacted], MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action informing Petitioner of the denial.

5. On [redacted], Petitioner requested a hearing disputing the denial of SDA benefits (see Exhibit 1, pp. 2-3).

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

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

8. Petitioner's highest education year completed was the 12th grade (via general equivalency degree).

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

10. Petitioner alleged disability based on restrictions related to fibromyalgia, depression, carpal tunnel syndrome (CTS), systemic lupus erythematosus (SLE), hypertension (HTN), and diabetes mellitus (DM).

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).

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (July 2015), p. 4. The goal of the SDA program is to provide financial assistance to meet a disabled person's basic personal and shelter needs. *Id*. To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older. BEM 261 (January 2012), p. 1. A person is disabled for SDA purposes if he/she:

- receives other specified disability-related benefits or services, see Other Benefits or Services below, or
- resides in a qualified Special Living Arrangement facility, or
- is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability; or
- is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS).

Id.

Petitioner requested a hearing to dispute the denial of a SDA application. Petitioner claimed an inability to work for 90 days due to mental and/or physical disabilities. MDHHS presented a Notice of Case Action (Exhibit 1, pp. 336-338) dated [redacted], verifying Petitioner's application was denied based on a determination that Petitioner was not disabled.

Generally, state agencies such as MDHHS must use the same definition of SSI disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally defined as the inability to do any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months [90 days for SDA eligibility]. 20 CFR 416.905.

SGA means a person does the following: performs significant duties, does them for a reasonable length of time, and does a job normally done for pay or profit. *Id*., p. 9. Significant duties are duties used to do a job or run a business. *Id*. They must also have a degree of economic value. *Id*. The ability to run a household or take care of oneself does not, on its own, constitute SGA. *Id*.

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

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

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

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

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

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

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

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

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

Various physician treatment records (Exhibit 1, pp. 249-257, 333-335) from January 2014 through April 2014 were presented. Ongoing DM treatment was noted.

Handwritten physician office visit documents (Exhibit 1, p. 243) dated [redacted], were presented. Diagnoses of DM and anxiety were indicated.

Diabetes testing results (Exhibit 1, p. 238-239, 244-245, 330-332) dated [redacted], [redacted] were presented. An A1c of 6.8 was noted.

Handwritten physician office visit documents (Exhibit 1, p. 242) dated [redacted] [redacted] were presented. A diagnosis of DM was noted.

Hospital emergency room documents (Exhibit 1, pp. 323-329) dated [redacted], [redacted] were presented. It was noted that Petitioner presented with complaints of body pain. Treatment details were not apparent. Generic discharge instructions for fibromyalgia were provided.

Handwritten rheumatologist office visit notes (Exhibit 1, p. 277) dated [redacted], [redacted] were presented. It was noted Petitioner reported back, shoulder, and neck pain. Physical examination notes indicated joint stiffness. It was noted lupus and fibromyalgia were diagnosed in 2010.

Handwritten physician office visit documents (Exhibit 1, p. 241) dated [redacted], [redacted] were presented. A diagnosis of acute bronchitis was indicated.

Handwritten physician office visit documents (Exhibit 1, p. 240) dated [redacted], were presented. Upper respiratory infection treatment was indicated.

Handwritten rheumatologist office visit notes (Exhibit 1, p. 276 dated [redacted], were presented. It was noted Petitioner reported back, shoulder, and neck pain. Physical examination noted indicated joint tenderness and shoulder stiffness. Ongoing assessments of SLE and fibromyalgia were indicated.

Handwritten rheumatologist office visit notes (Exhibit 1, p. 275) dated [redacted], were presented. It was noted Petitioner reported no change. Ongoing assessments of SLE and fibromyalgia were indicated.

Handwritten physician office visit documents (Exhibit 1, p. 235) dated [redacted], were presented. A diagnosis of DM was indicated.

Handwritten physician office visit documents (Exhibit 1, p. 232) dated [redacted], were presented. Diagnosis of DM and HTN were indicated.

Handwritten physician office visit documents (Exhibit 1, p. 234) dated [redacted], were presented. A diagnosis of acute bronchitis was indicated.

Diabetes testing results (Exhibit 1, p. 233) dated [redacted], were presented. An A1c of 4.3. was indicated.

A Psychiatric Evaluation (Exhibit 1, pp. 149-156, 215-222) dated [redacted], was presented. Petitioner reported she lives with chronic joint pain due to lupus and fibromyalgia. Petitioner reported a lengthy history of feeling depressed, however, recently diagnosed medical conditions worsened her symptoms. Petitioner reported feeling sad all day. Other reported symptoms include crying spells, poor sleep, severe anxiety, easily taken off-task, racing thoughts, constant worrying, and irritability. Mental status examination assessments included depressed mood, labile affect, normal speech, normal motor activity, intact memory, and impaired attention. An Axis I diagnosis of mood disorder was noted. Petitioner's GAF was 40. Prescribed

medications included Seroquel, Ativan, Latuda, and Lexapro. A moderate-to-severe psychiatric impairment was indicated. It was noted chronic medical problems exacerbate Petitioner's psyche.

Mental health treatment documents (Exhibit 1, pp. 140-148, 206-214) dated [redacted], [redacted] were presented. The documents were completed by a nurse practitioner. Petitioner reported she is tolerating medications well. Depression, anxiety, and panic attacks were ongoing and "significant." Medications were adjusted.

Handwritten rheumatologist office visit notes (Exhibit 1, p. 274) dated [redacted], were presented. It was noted Petitioner reported increased muscle pain in upper back and shoulders. Right hand pain (9/10) was noted. Right knee pain and morning stiffness was indicated. Various medications were prescribed.

Mental health treatment documents (Exhibit 1, pp. 133-139, 199-205) dated [redacted], [redacted] were presented. The documents were completed by a nurse practitioner. Petitioner reported decreased mood swings, no crying spells, and improved sleep. Ativan was discontinued. Petitioner also reported right hand and foot tingling and numbness; follow-up with Petitioner's physician was recommended.

Hospital emergency room documents (Exhibit 1, pp. 310-321) dated [redacted], were presented. It was noted that Petitioner complained of intermittent right arm pain, ongoing for 4 days. Treatment details were not apparent. Generic discharge instructions for a pinched cervical spine nerve were provided.

Handwritten rheumatologist office visit notes (Exhibit 1, p. 272) dated [redacted], were presented. It was noted Petitioner reported poorly controlled pain (10/10). Plaquenil, MTX, folic acid, and Norco were prescribed for lupus. Lyrica was prescribed for fibromyalgia. Prednisone was prescribed for right-sided CTS.

Handwritten physician office visit documents (Exhibit 1, p. 231) dated [redacted], were presented. Diagnosis of DM and HTN were indicated.

Mental health treatment documents (Exhibit 1, pp. 126-132, 192-198) dated [redacted] were presented. The documents were completed by a nurse practitioner. Petitioner reported stress after her 15 y/o ran away from home. Medications were continued.

Handwritten physician office visit documents (Exhibit 1, p. 229) dated [redacted] were presented. Venereal disease testing was indicated (see Exhibit 1, pp. 227-228).

Mental health treatment documents (Exhibit 1, pp. 118-125, 184-191) dated [redacted], were presented. The documents were completed by a nurse practitioner. Petitioner reported her sleeping pattern is better and that her son is displaying improved

behavior. Petitioner reported symptoms of anxiety and poor impulse control. Lexapro was increased.

Handwritten rheumatologist office visit notes (Exhibit 1, p. 270) dated [redacted], [redacted] were presented. It was noted Petitioner "feels fine." Ongoing SLE and fibromyalgia assessments were noted.

Handwritten physician office visit documents (Exhibit 1, p. 225) dated [redacted], were presented. DM treatment was noted.

Mental health treatment documents (Exhibit 1, pp. 112-117, 178-183) dated [redacted] 2015, were presented. The documents were completed by a nurse practitioner. Petitioner reported various family difficulties including her son who was in a gang. Medications were continued.

Diabetes testing documents (Exhibit 1, p. 226) dated [redacted], were presented. An A1C of 6.9 was noted.

Mental health treatment documents (Exhibit 1, pp. 106-111, 172-177) dated [redacted], were presented. The documents were completed by a nurse practitioner. Petitioner reported improved sleeping patterns. Medications were continued.

Handwritten rheumatologist office visit notes (Exhibit 1, p. 267) dated [redacted], [redacted] were presented. Joint pain in hands and bones was indicated. HTN was noted to be stable. Ongoing assessments of lupus and fibromyalgia were indicated.

Hospital emergency room documents (Exhibit 1, pp. 292-304) dated [redacted], were presented. It was noted that Petitioner presented with complaints of a headache (8/10), and upper abdominal pain ongoing for 3 days. It was noted Petitioner received pain medication which reduced headache pain to 4/10 and decreased abdominal pain. Petitioner was prescribed pain medication and discharged.

Mental health treatment documents (Exhibit 1, pp. 100-105, 166-171) dated [redacted], [redacted] were presented. The documents were completed by a nurse practitioner. Petitioner reported doing well. Medications were continued.

Handwritten rheumatologist office visit notes (Exhibit 1, p. 265) dated [redacted], were presented. Diffuse joint pain (7-8/10) and headaches were reported. It was noted Petitioner reported Flexeril was not working. Diagnoses of lupus, fibromyalgia, and bilateral CTS were indicated.

Mental health treatment documents (Exhibit 1, pp. 92-99, 158-165) dated [redacted], [redacted] were presented. The documents were completed by a nurse practitioner. Petitioner reported feeling depressed after a denial of SSI benefits and the death of a relative. Medications were continued.

Petitioner testified her DM is uncontrollable. Petitioner testified she has lost 20-40 pounds since being diagnosed in 2014. Petitioner testified she has not been diagnosed with neuropathy. Petitioner testified her HTN medications were recently increased.

Petitioner testimony alleged bilateral CTS and/or lupus causes restrictions in hand function. For example, Petitioner testified she used to braid hair, but can no longer do so due to hand cramping and swelling.

Petitioner testified she was diagnosed with fibromyalgia and lupus in 2010 after blood testing. Petitioner testified lupus and fibromyalgia affect her daily life. Petitioner testified her bones, knees, hips, calves and head ache. Petitioner testified her muscles ache and tingle.

Petitioner testified lupus causes face rash and her hair to fall out. Petitioner testified one of her medications causes mouth sores.

Petitioner alleged she has psychological symptoms of mood swings, crying spells, anger control, panic attacks, and racing thoughts. Petitioner testified seeing a psychiatrist the last 2 years has “somewhat” helped. Petitioner testified she sometimes will “shut-down.”

Presented medical records generally verified a medical treatment history consistent with a degree of restrictions to ambulation, lifting/carrying, concentration, and performance of activities of daily living (ADLs). The treatment history was established to have lasted at least 90 days and at least since Petitioner’s date of SDA application. Accordingly, it is found that Petitioner established having a severe impairment and the disability analysis may proceed to Step 3.

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

Claimant’s most prominent impairment appears to be lupus. Lupus is covered by Listing 14.02 which reads as follows:

> ***14.02 Systemic lupus erythematosus.*** As described in 14.00D1. With:
> **A.** Involvement of two or more organs/body systems, with:
> 1. One of the organs/body systems involved to at least a moderate level of severity; and
> 2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).
> OR

B. Repeated manifestations of SLE, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:
1. Limitation of activities of daily living.
2. Limitation in maintaining social functioning.
3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

Petitioner testified she does not require a walking assistance device. Petitioner testified she can only walk for 15 minutes before losing her breath. Petitioner testified she can only stand for 20 minutes. Petitioner testified she has to shift her position after sitting for 30-35 minutes. Petitioner testified her lifting/carrying is restricted though she can lift a gallon of milk. Petitioner testified she can write, but not for an unspecified long period.

Petitioner testified she sometimes needs help getting in and out of her shower. Petitioner testified she requires assistance with putting on her shoes and shirt. Petitioner testified she is unable to clean, cook, shop, or do laundry; Petitioner testified she has a state-paid housekeeper who completes these duties for her.

Petitioner testified she has good days and bad days. Petitioner estimated she may have 2 good days per week. Petitioner testified she struggles just to get out of bed on bad days.

Petitioner testified she has two children, a [redacted] year-old and an [redacted] year-old. Petitioner testified she takes them to the movies “every now and then” and sometimes attends their sports games.

Petitioner’s testimony was indicative of meeting Part B of the above listing. Medical evidence was mixed in support for Petitioner’s testimony.

Restrictions based on lupus and fibromyalgia are difficult to verify. Neither diagnoses was confirmed by presented testing documents, however a rheumatologist repeatedly cited the diagnoses. It was also verified Petitioner regularly reported complaints consistent with the diagnoses’ symptoms. Presented records tended to verify changes in medication were not particularly beneficial in reducing Petitioner’s pain. This evidence was supportive for finding Petitioner has severe fatigue and malaise markedly restricting her daily activities and persistence.

Petitioner’s job history is not particularly insightful into Petitioner’s condition. Petitioner’s only reported employment was self-employment as a hair stylist. Petitioner reported to her nurse practitioner that medical conditions have caused her to discontinue hair styling, however, the evidence is not the strongest of confirmations that Petitioner is unable to perform daily activities.

As of the date of hearing, Petitioner was only [redacted] years of age. Generally, lupus is not expected to markedly restrict daily function of a person so relatively young. The same is

also generally true for a person diagnosed with fibromyalgia. When factoring the combination of diagnoses, along with CTS, it is reasonable that Petitioner is markedly restricted in daily activities and/or concentration.

It is found that Petitioner meets the listing for lupus, in part, due to exacerbating diagnoses of fibromyalgia and CTS. Accordingly, it is found Petitioner is disabled and that MDHHS improperly denied Petitioner's SDA application.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that MDHHS improperly denied Petitioner's application for SDA benefits. It is ordered that MDHHS begin to perform the following actions within 10 days of the date of mailing of this decision:

(1) reinstate Petitioner's SDA benefit application dated [redacted];
(2) evaluate Petitioner's eligibility subject to the finding that Petitioner is a disabled individual;
(3) initiate a supplement for any benefits not issued as a result of the improper application denial; and
(4) schedule a review of benefits in one year from the date of this administrative decision, if Petitioner is found eligible for future benefits.

The actions taken by MDHHS are **REVERSED**.

CG/hw

Christian Gardocki
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

DHHS

[redacted]

Petitioner

[redacted]