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: September 29, 2016
MAHS Docket No.: 16-010924
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 September 6, 2016, from Detroit, Michigan. Petitioner appeared and was unrepresented. [redacted], Petitioner's son, testified on behalf of Petitioner. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], medical contact worker.

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, in part, based on a Disability Determination Explanation (Exhibit 1, pp. 2-16).

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.

6. As of the date of the administrative hearing, Petitioner was a 44-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 alleged disability based on restrictions related to a stroke.

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).

Prior to a substantive analysis of Petitioner's hearing request, it should be noted that Petitioner noted special arrangements in order to participate in the hearing; specifically, Petitioner stated she had slurred speech. Petitioner testified that she spoke slowly and that patience would need to be given to her to finish her speech. The hearing was completed without any complaints by Petitioner concerning a lack of patience provided to her.

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. 358-359) July 18, 2016,

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.

Cardiology testing documents (Exhibit 1, pp. 317-318) dated [redacted], were presented. Petitioner's ejection fraction was noted to be 60-65%. A "technically adequate study" was noted.

Hospital documents (Exhibit 1, pp. 247-314, 333-337) from an admission dated [redacted], were presented. It was noted that Petitioner presented with complaints of right-sided weakness, ongoing for 2 days. It was noted Petitioner was unable to speak due to aphasia. It was noted an MRI of Petitioner's head was consistent with a stroke; a stroke workup was noted to be otherwise negative other than hyperlipidemia and elevated hemoglobin levels. Discharge documentation indicated Petitioner's stroke was likely

caused by uncontrolled HTN. It was noted Petitioner underwent “aggressive” physical therapy during her admission. A discharge diagnosis of acute left-sided stroke with hemiparesis, aphasia, and facial droop was noted. A discharge date of [redacted], [redacted] was noted.

Rehabilitation center documents (Exhibit 1, pp. 215-239) from an admission dated [redacted], were presented. It was noted Petitioner was admitted for the purpose of improving function. It was noted Petitioner made “very good functional progress” from physical therapy. It was noted Petitioner needed maximal assistance with lower extremity at admission and progressed to a modified independent level. It was noted Petitioner required modified assistance with transferring, and progressed to an independent level. It was noted Petitioner’s ambulation capabilities progressed from a short distance to 250 feet. Improved strength and endurance were indicated. It was noted Petitioner had minimal cognitive deficits. A date of discharge of [redacted], was stated.

Neurologist office visit notes (Exhibit 1, pp. 171-174. 188-191) dated [redacted], were presented. It was noted that Petitioner recently completed physical therapy, was attending occupational therapy, and awaiting speech therapy. It was noted Petitioner was prescribed a cane, though she reported not wanting to use it. It was noted Petitioner could independently perform most ADLs, though difficulties with writing and feeding herself were indicated. Severe pain in the right shoulder, elbow, and hand were reported. Muscle strength of 4/5 in the right upper extremity and 4+/5 in the right lower extremity were indicated. 1/4 bilateral ankle reflexes were noted. A wide-based gait was noted. A quad cane was prescribed to Petitioner for the purpose of improving stability. An increase in Gabapentin was recommended.

Neurologist office visit notes (Exhibit 1, pp. 168-170) dated [redacted], were presented. It was noted that Petitioner’s medical history included DM, hyperlipidemia, sleep apnea, and diabetic neuropathy. It was noted Petitioner experienced a stroke in October 2015; subsequently performed radiology demonstrated infarct. Ongoing complaints of walking difficulty (with recurring falls when no cane was used), slurred speech, right shoulder pain, and a headache (ongoing for 1 week). A plan of physical and occupational therapy was indicated. Various medications were adjusted and/or prescribed.

A medical examination report (Exhibit 1, pp. 176-184) dated [redacted], was presented. The report was completed by a consultative physician. Petitioner reported complaints of right-sided weakness, cognitive deficits, and speech deficits. It was noted Petitioner was unable to perform tandem gait, stand on heels, or stand on toes. Reduced muscle strength (4/5) throughout Petitioner’s right side was noted. It was stated Petitioner utilized a 4-point cane during the examination. Stated diagnoses included stroke resulting in right-sided weakness and speech deficit, balance deficit (secondary to stroke), HTN, DM, and asthma.

A speech and language assessment report (Exhibit 1, pp. 153-160) dated [redacted] was presented. The report was completed by a consultative speech therapist. It was noted tests results were thought to accurately reflect Petitioner's communication. Petitioner was able to intelligibly pronounce single words at a 90% rate, conversation of a known context at 80%, and conversation of an unknown context at 75%. Petitioner's speech was noted to be slow and labored. Petitioner's conversation and syntax were noted to be functional, though it was noted listeners had to be patient to allow Petitioner to finish her words. An impression of moderate dysarthria was noted. Moderate impact on general tasks, household tasks, interpersonal interactions, reacting in emergencies, and being left alone at home were noted. A guarded prognosis was indicated.

A mental status examination report (Exhibit 1, pp. 162-165) dated [redacted], was presented. The report was completed by a consultative psychiatrist. Petitioner reported various physical ailments, sleeping difficulty, poor appetite, crying spells, and excessive emotion. It was noted Petitioner was emotional during the examination and displayed slight right-sided facial drooping, slurring of speech, and dragging of the right leg. A diagnosis of depressive disorder was noted. A fair-to guarded prognosis was indicated. It was noted Petitioner could benefit from therapy and support services.

A lumbar spine MRI report (Exhibit A, p. 1) dated [redacted], was presented. It was noted there was no evidence of a herniated disc, fracture, or stenosis.

A thoracic spine MRI report (Exhibit A, pp. 2-3) dated [redacted], was presented. It was noted there was no evidence of a herniated disc, fracture, or stenosis.

A cervical spine MRI report (Exhibit A, p. 5) dated [redacted], was presented. Impressions of C5-C6 herniation and abnormal spinal straightening were indicated.

An MRI report of Petitioner's left shoulder (Exhibit 1, p. 6) dated [redacted], was presented. Impressions of tendinopathy and minimal joint effusion were indicated.

An MRI report of Petitioner's right shoulder (Exhibit 1, pp. 7-8) dated [redacted], was presented. Impressions of tendinopathy and degenerative signal were noted.

Petitioner testified she still has slurred speech from her stroke. She testified she saw a speech therapist in May 2016 but had to stop her appointments because of health insurance limitations.

Petitioner testified she has difficulty with ambulation, in part, because her right leg "keeps giving out." Petitioner testified she still has right arm pain and she plans to see a specialist about the problem. Petitioner testified her strength is affected as she drops items at least twice per day.

Petitioner testified she needs a walker but her insurance is not yet willing to cover the cost. Petitioner testified she limits her ambulation because she is afraid of falling.

Petitioner testified she can only stand 5-10 minutes before her leg feels weak. Petitioner was unable to state what sitting restrictions she has, though she stated she spends most days lying down, and that her legs will stiffen if she sits too long. Petitioner testified she is restricted to lifting 5 pounds or less. Petitioner testified she can ascend stairs, but requires a railing.

Petitioner testified she independently showers, but paces herself when she does. Petitioner testified she independently dresses herself, by learning how to do so with just her left hand. Petitioner testified she does not perform housework or laundry. Petitioner testified she goes shopping with her mother; she testified she can hold onto a cart for 15-20 minutes before needing a rest.

Presented medical records generally verified a medical treatment history consistent with Petitioner's allegations of restrictions. 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.

Petitioner's most prominent restrictions appear to be stroke-related. The relevant SSA listing for nervous system dysfunction due to a stroke is Listing 11.04 which reads as follows:

> **11.04** ***Central nervous system vascular accident****.*
> With one of the following more than *3* months post-vascular accident
> A. Sensory or motor aphasia resulting in ineffective speech or communication; or
> B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

Presented records verified Petitioner possesses less than ideal speech despite the passage of several months since experiencing a stroke. Speech therapy records indicated listeners have to be patient in understanding Petitioner. Though Petitioner's speech is far from ideal, it cannot be stated that her speech is ineffective in communication.

Presented records also verified Petitioner has right-sided weakness since her stroke. Though loss of muscle strength was verified, it cannot be stated that the loss of strength (4/5 generally) is consistent with significant persistent disorganization.

It is found Petitioner does not meet the requirements of Listing 11.04. Consideration will be given to whether Petitioner's condition functionally meets the requirements of the listing by rendering Petitioner to be essentially unemployable.

On a medical examination report dated [redacted], a consultative physician provided various statements of restrictions. The physician opined Petitioner could walk at least 1 hour during a workday. The examiner opined Petitioner could stand at least 2 hours during an 8 hour workday. The examiner opined Petitioner had no sitting restrictions. The examiner opined Petitioner could not lift/carry more than 5 pounds. The examiner stated Petitioner's speech deficit allowed for occasional communication within the workplace. It was noted Petitioner should not be expected to drive. The report was indicative that Petitioner might be capable of some types of sit-down jobs, though she would be restricted in communication. The report was somewhat indicative that Petitioner may be realistically unemployable.

On [redacted], a speech therapist states Petitioner had "severe restrictions" to education, employment, and traveling alone. Generally, a "severe" employment restriction is indicative of being unable to realistically performing employment.

On [redacted], a consultative examiner stated Petitioner "would have difficulty in functioning in any work situation." The statement is indicative that Petitioner is not realistically employable.

It is found Petitioner's combination of speech difficulty, right-sided weakness, and some loss of cognitive function renders her to be functionally unemployable. Accordingly, Petitioner functionally meets the SSA listing for strokes, and therefore, is a disabled individual. Accordingly, it is found MDHHS improperly denied Petitioner's SDA application by failing to find Petitioner to be disabled.

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]