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: November 21, 2016
MAHS Docket No.: 16-012634
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 [redacted], from Sandusky, Michigan. Petitioner appeared and was unrepresented. [redacted] Petitioner's sister, and [redacted], Petitioner's counselor from [redacted] County Mental Health, testified on behalf of Petitioner. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], specialist.

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. 17-23).

4. On [redacted], MDHHS terminated Petitioner's eligibility for SDA benefits, effective [redacted], and mailed a Notice of Case Action informing Petitioner of the termination.

5. On [redacted], Petitioner requested a hearing disputing the termination of SDA benefits (see Exhibit 1, p. 12).

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. 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.

MDHHS presented a Notice of Case Action (Exhibit 1, pp. 10-11). The written notice stated Petitioner was no longer eligible to receive SDA due to a determination that Petitioner was no longer disabled. Petitioner did not assert any other basis for receiving SDA benefits. Thus, the only issue to be determined is if MDHHS properly determined Petitioner to no longer be 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.

Petitioner presented various psychiatric treatment and physical health documents. A summary of documents will begin with presented psychiatric treatment documents.

A portion of Petitioner's psychiatric history was summarized in presented documents (see Exhibit 1, pp. 120-122). It was noted that in [redacted] Petitioner found her husband's dead body. In [redacted] Petitioner went to the emergency room to report she was raped. It was noted the attending physician admitted Petitioner for schizoaffective disorder. A history of 3 psychiatric hospital admissions within 40 days was noted. It was noted Petitioner reported recurring flashbacks of being raped; it was also implied that police officers and a physician thought Petitioner's reports of rape were not believable.

An Individual Plan of Service Periodic Review (Exhibit 1, pp. 108-111) dated [redacted], was presented. Petitioner reported doing well. It was noted Petitioner reported she did not need to continue therapy following psychiatric hospitalization.

Mental health agency medication review office visit notes (Exhibit 1, pp. 94-95) dated [redacted], were presented. It was noted Petitioner reported wanting to discontinue Abilify Maintena injections. Mental health examination notes were unremarkable. It was noted Petitioner was psychiatrically hospitalized in [redacted] after Petitioner reported depression, paranoia, and an alleged gang rape (which seemed to be a hallucination). A psychiatric hospitalization in [redacted] was also noted after Petitioner reported paranoia. Abilify was prescribed.

Mental health agency medication review office visit notes (Exhibit 1, pp. 92-93) dated [redacted], were presented. It was noted Petitioner reported feeling better with medications. Improved sleep and thoughts were noted. Mental health examination notes were unremarkable. Medications were noted as continued without changes.

Mental health agency medication review office visit notes (Exhibit 1, pp. 90-91) dated [redacted], were presented. It was noted Petitioner reported a stable mood, though she struggled with chronic pain. Mental health examination notes were unremarkable. Medications were noted as continued without changes.

An Individual Plan of Service Periodic Review (Exhibit 1, pp. 105-107) dated [redacted] was presented. Petitioner reported an unstable residence for the past months.

Counseling notes (Exhibit 1, p. 145) dated [redacted], were presented. It was noted Petitioner reported that she thought a family was trying to poison her. Ongoing struggles with paranoia were noted.

Mental health agency medication review office visit notes (Exhibit 1, pp. 88-89) dated [redacted], were presented. It was noted Petitioner reported “doing fairly well” at home. Abilify was increased.

Counseling notes (Exhibit 1, p. 145) dated [redacted], were presented. It was noted Petitioner reported decreased paranoia following a medication increase.

Counseling notes (Exhibit 1, p. 143) dated [redacted], were presented. It was noted Petitioner reported to her doctor that she could not work because of anxiety and racing thoughts.

Counseling notes (Exhibit 1, p. 143) dated [redacted], were presented. It was noted Petitioner reported decreased paranoia. Petitioner reported her feelings were hurt by social media post about her by her daughter and daughter’s step-mother.

An Individual Plan of Service Periodic Review (Exhibit 1, pp. 100-104) dated [redacted] was presented. Goals of stabilizing mood and stabilizing emotions. Petitioner reported ongoing stress concerning an ex-husband.

Counseling notes (Exhibit 1, p. 142) dated [redacted], were presented. It was noted Petitioner used a coping skill to deal with anxiety.

Mental health agency medication review office visit notes (Exhibit 1, pp. 83-84) dated [redacted], were presented. It was noted Petitioner reported less irritability and feeling better after Ativan was increased. Mental health examination notes were unremarkable. Medications were noted as continued without changes.

Mental health agency medication review office visit notes (Exhibit 1, pp. 83-84) dated [redacted] were presented. It was noted Petitioner reported arthritis pain. Increased mood swings were reported. Mental health examination notes were unremarkable. Medications were noted as continued without changes.

An annual mental health assessment (Exhibit 1, pp. 112-125) dated [redacted] was presented. The report was completed by a counselor. It was noted Petitioner "improved greatly" over the previous year. Petitioner reported flashbacks of her boyfriend drugging her, raping her, and trying to set her on fire. It was noted Petitioner was able to independently complete all ADLs except transportation and paying bills. A history of delusions was indicated, though Petitioner denied having them. Petitioner's GAF was noted elsewhere in presented documents to be 85.

Counseling notes (Exhibit 1, p. 133) dated [redacted], were presented. It was noted Petitioner discussed her boyfriend.

Counseling notes (Exhibit 1, pp. 126-132) dated [redacted], were presented. It was noted Petitioner admitted memories of rape could be delusions stemming from mental illness. It was noted Petitioner had no education desires and was pursuing disability benefits.

Mental health agency medication review office visit notes (Exhibit 1, pp. 79-80) dated [redacted], were presented. It was noted Petitioner reported jaw pain. Mental health examination notes were unremarkable. Abilify and Ativan were increased; Ambien was continued at past dosage.

Mental health agency medication review office visit notes (Exhibit 1, pp. 76-77) dated [redacted] were presented. It was noted Petitioner reported increased anxiousness, which was noted as possibly related to an upcoming surgery. Mental health examination notes were unremarkable other than an anxious mood. Medications were noted as continued.

An Individual Plan of Service Periodic Review (Exhibit 1, pp. 96-99) dated [redacted] was presented. Ongoing complaints about health, pain, and Petitioner's boyfriend were reported. Goals included continuing therapy attendance and medication reviews. Petitioner was noted to be fixated on her physical health.

Mental health agency medication review office visit notes (Exhibit 1, pp. 74-75) dated [redacted], were presented. It was noted Petitioner reported an anxious mood. Hallucinations were noted as denied. Mental health examination notes were unremarkable. It was noted Petitioner was "doing well psychiatrically" and no medication changes were made.

Mental health agency medication review office visit notes (Exhibit 1, pp. 72-73) dated [redacted], were presented. It was noted Petitioner reported an anxious mood. Hallucinations were noted as denied. Medications were noted as continued without changes.

Counseling notes (Exhibit 1, p. 133, 170) dated [redacted], were presented. It was noted Petitioner reported she is confident she has cancer and that it will spread after an upcoming surgery.

Counseling notes (Exhibit 1, p. 132, 169) dated [redacted], were presented. It was noted Petitioner reported relief after "they found nothing" in an exploratory abdominal surgery.

Mental health agency medication review office visit notes (Exhibit 1, pp. 161-162) dated [redacted] were presented. It was noted Petitioner reported worry over gastrointestinal symptoms. Ongoing health concerns were reported. Medications were noted as continued without changes.

Counseling notes (Exhibit 1, p. 167) dated [redacted], were presented. It was noted Petitioner reported she was sure she had some blockage due to high cholesterol.

Counseling notes (Exhibit 1, p. 167) dated [redacted], were presented. It was noted Petitioner reported she fought with her boyfriend over her allegation that he drugged and raped her.

Mental health agency medication review office visit notes (Exhibit 1, pp. 159-160) dated [redacted] were presented. It was noted Petitioner reported feeling overwhelmed, increased paranoia, and increased stress. Abilify was increased to 30mg per day.

Counseling notes (Exhibit 1, p. 166) dated [redacted] were presented. It was noted Petitioner reported dissatisfaction over living in a camper. Petitioner reported increased paranoia when trying to sleep.

Counseling notes (Exhibit 1, p. 165) dated [redacted] were presented. It was noted Petitioner reported she does not feel like she belongs anywhere. Ongoing paranoid thoughts were reported.

Petitioner also presented physical health treatment documents. A summary of the documents follows.

A thoracic spine MRI report (Exhibit 1, pp. 175-176, 175-176) dated [redacted], was presented. An impression of T3-T4, T5-T6, and T7-T8 disk protrusions were noted. Minimal spinal cord flattening at T5-T6 was noted. Facet hypertrophy at T10-T11, without cord compression, was noted.

Physician office visit notes (Exhibit 1, pp. 60-64) dated [redacted] were presented. It was noted Petitioner presented for an annual physical. Occasional dyspnea was reported. It was noted Petitioner reduced cigarette intake to 4-5 per day. An increase in walking was noted. Assessments included HTN, COPD, degenerative disc disease, tobacco abuse, arthritis, and chronic back pain. Neurontin and naproxen were prescribed for back pain.

Physician office visit notes (Exhibit 1, pp. 58-59) dated [redacted], were presented. It was noted Petitioner presented for a Pap smear.

Physician office visit notes (Exhibit 1, pp. 56-57) dated [redacted], were presented. It was noted Petitioner presented for mole removal. Low blood pressure was noted.

Physician office visit notes (Exhibit 1, pp. 54-55) dated [redacted], were presented. It was noted Petitioner reported bumps on her legs and recurring skin breakouts. Medication was prescribed.

Physician office visit notes (Exhibit 1, pp. 50-53) dated [redacted], were presented. It was noted Petitioner reported bumps on her legs. It was noted knee pain was suspected to be caused by calcium deposit. An x-ray of Petitioner's knees was planned.

A right knee radiology report (Exhibit 1, p. 66) dated [redacted], was presented. "Very mild" degenerative spurring was noted.

A left knee radiology report (Exhibit 1, p. 67) dated [redacted], was presented. "Very mild" degenerative spurring was noted.

Physician office visit notes (Exhibit 1, pp. 47-49) dated [redacted], were presented. It was noted that Petitioner reported back and leg pain which disturbs her sleep. It was noted Neurontin was refilled after Petitioner reported she has been out for several months. A recommendation for Petitioner to see a treating pain clinic for back pain was noted.

A chest radiology report (Exhibit 1, p. 65) dated [redacted], was presented. An impression of mild COPD was noted.

Physician office visit notes (Exhibit 1, pp. 45-46) dated [redacted], were presented. It was noted that Petitioner reported improved breathing since completing medication course. Petitioner reported that her lungs "shut-down" in cold weather.

Ongoing fatigue was noted as reported. HTN was noted to be stable. Various medications were prescribed.

Spinal specialist office visit notes (Exhibit 1, pp. 177-187) dated [redacted], were presented. It was noted Petitioner had not been seen since [redacted]. It was noted Petitioner complained of lumbar pain (6/10 at its lowest; 9/10 at worst) shooting through her legs, ongoing for 1 month. Recurring headaches (2-3 times per week) were reported; stress was reported as a trigger.

Physician office visit notes (Exhibit 1, pp. 42-44) dated [redacted], were presented. It was noted that Petitioner reported "doing a little bit better" with COPD after Qvar dosage increased. An assessment of anxiety was noted to be related to life stressors. Assessments of COPD, lumbar pain, tobacco abuse, HTN, fatigue, and alopecia were also noted.

Spinal specialist office visit notes (Exhibit 1, pp. 188-196) dated [redacted], were presented. It was noted Petitioner reported CTS pain ranging from 2/10 -7/10. Petitioner underwent a CTS injection. A diagnosis of chronic pain syndrome was indicated, in part, based on drug testing revealing long-term use of opiate analgesics.

Spinal specialist office visit notes (Exhibit 1, pp. 197-200) dated [redacted], were presented. It was noted Petitioner reported CTS pain ranging from 2/10 -8/10. Petitioner underwent a CTS injection.

Physician office visit notes (Exhibit 1, pp. 40-41) dated [redacted], were presented. It was noted that Petitioner reported congestion and a sore throat. A diagnosis of left otitis media was noted. Medication was prescribed.

Physician office visit notes (Exhibit 1, pp. 38-39) dated [redacted], were presented. It was noted that Petitioner presented for a follow-up for left ear pain. The condition was noted to be resolved.

Spinal specialist office visit notes (Exhibit 1, pp. 201-204) dated [redacted], were presented. It was noted Petitioner underwent urine testing. A diagnosis of chronic pain syndrome was indicated, in part, based on long-term use of opiate analgesics.

Physician office visit notes (Exhibit 1, pp. 36-37) dated [redacted], were presented. It was noted Petitioner had 2 abrasions in her mouth area. The abrasions were noted to be likely related to wearing of dentures. Assessments of COPD, nicotine dependence, and acute pharyngitis were also noted.

Physician office visit notes (Exhibit 1, pp. 34-35) dated [redacted], were presented. It was noted that Petitioner complained of neck pain. It was noted Petitioner was recently riding a 4 wheeler with her boyfriend when they hit a snow drift causing her to be thrown from the vehicle after it flipped. A physical examination noted neck

tenderness to palpation; a full range of neck motion was noted. Respondent was given Naproxen. Going to the ER for further evaluation was recommended.

Spinal specialist office visit notes (Exhibit 1, pp. 205-208, 221-224) dated [redacted] were presented. It was noted Petitioner underwent urine testing. A diagnosis of chronic pain syndrome was indicated, in part, based on long-term use of opiate analgesics.

Spinal specialist office visit notes (Exhibit 1, pp. 209-212, 225-228) dated [redacted], were presented. It was noted Petitioner underwent urine testing. A diagnosis of chronic pain syndrome was indicated, in part, based on long-term use of opiate analgesics.

Spinal specialist office visit notes (Exhibit 1, pp. 229-237) dated [redacted], were presented. It was noted Petitioner reported constant lumbar pain (5/10 - 8/10); pain was noted to interfere with ADLs. Reported triggers included prolonged standing, walking, and sitting. Petitioner also reported constant neck pain (5/10 - 8/10) radiating to both arms. Petitioner also reported recurring headaches, thoracic spine pain, and bilateral hand pain. Decreased cervical and lumbar spine ranges of motion were noted. A straight-leg-raising test was noted to be positive for right and left side. Tinel's sign was noted to be positive bilaterally. Diagnoses of chronic pain syndrome, cervicalalgia, lower back pain, thoracic spine pain, CTS, and spondylosis were noted. Naproxen and Zanaflex were noted as ongoing medications. Percocet was prescribed for thoracic spine pain. MRIs were ordered. Continued wearing of CTS braces was recommended.

Spinal specialist office visit notes (Exhibit 1, pp. 242-246) dated [redacted], were presented. It was noted Petitioner reported CTS pain ranging from 2/10 - 9/10. Petitioner underwent a CTS injection.

Spinal specialist office visit notes (Exhibit 1, pp. 213-216, 238-241) dated [redacted] were presented. It was noted Petitioner underwent urine testing. A diagnosis of chronic pain syndrome was indicated, in part, based on long-term use of opiate analgesics.

A lumbar spine MRI report (Exhibit 1, pp. 263-264) dated [redacted], was presented. An impression of L4-L5 mild central canal stenosis, moderate left-sided neural foraminal stenosis, and mild-to-moderate right-sided neural foraminal stenosis was indicated.

A cervical spine MRI report (Exhibit 1, pp. 265-266) dated [redacted], was presented. An impression of a stable cervical spine ([redacted]) was noted. Moderate right-sided foraminal stenosis with hypertrophy was noted at C2-C3. Moderate left-sided neural foraminal stenosis was noted at C3-C4. Other "mild" abnormalities were noted throughout Petitioner's spine.

Spinal specialist office visit notes (Exhibit 1, pp. 247-254) dated [redacted], were presented. It was noted a thoracic spine MRI was normal (see Exhibit 1, pp 261-262). It was noted a cervical spine MRI demonstrated multi-level degenerative disc disease;

epidural injections were noted as planned. It was noted a lumbar spine MRI demonstrated a L4-L5 disc bulge with left-sided neural foramen narrowing. A plan of injections was noted.

Spinal specialist office visit notes (Exhibit 1, pp. 255-260; Exhibit A, pp. 1-5) dated [redacted], were presented. It was noted electrodiagnostic testing demonstrated moderate right-sided and mild left-sided CTS.

Spinal specialist office visit notes (Exhibit A, pp. 6-10) dated [redacted], were presented. It was noted electrodiagnostic testing demonstrated right-sided lumbosacral radiculopathy at L5-S1.

Petitioner testified she has seen a psychiatrist since [redacted] The time appears to be shortly after Petitioner reported she found her husband to be dead. Petitioner testified she was psychiatrically hospitalized twice in [redacted] (for 10 and 12 day periods). Petitioner testified she has regular episodes (3-4 times per week) of paranoia. As an example, Petitioner thinks the government is "out to get her." Petitioner testified she sees a counselor weekly and a psychiatrist on a monthly basis. Petitioner testified her current medications include Klonopin, Cymbalta, Ambien, and Abilify.

Petitioner's sister testified she has seen little improvement her sister's mental health. As an example, Petitioner's sister testified that during a recent shopping trip with her sister, Petitioner abruptly left the store due to anxiety.

Petitioner's counselor testified she treated Petitioner for the past [redacted] years. Petitioner's counselor testified Petitioner still reports anxiety in public, depression "severe" anxiety and paranoia. As an example of Petitioner's paranoia, Petitioner reported having multiple cancers though there is no apparent medical support.

Petitioner's counselor expressed doubt if Petitioner could maintain any job due to paranoia and/or somatic disorder. The testimony would have been better supported had Petitioner had a recent history of unsuccessfully attempting employment. Petitioner testified she has not tried to find employment since [redacted]

Petitioner testified she has ongoing neck pain, lumbar pain, and hand pain. Petitioner testified she underwent PT for 6 weeks for her pains, but it did little to alleviate pain. Petitioner's sister testified Petitioner often drops items.

Petitioner testified her legs sometimes feel numb causing her to sometimes use a cane. Petitioner estimated this occurs 3-4 times per week.

Petitioner testified she can only walk 10 minutes before she has to rest due to back and/or leg pain. Petitioner testified she sometimes wears a back brace. Petitioner testified she can stand 15 minutes before her back hurts. Petitioner testified she can

only sit for 10-15 minutes before needing a standing break. Petitioner testified her physician limited her to lifting/carrying of 5 pounds.

Petitioner testified she can independently shower. Petitioner testified she sometimes needs assistance with putting on shoes, presumably due to difficulty with bending. Petitioner testified she does light laundry, but cannot sweep or vacuum. Petitioner testified she can drive. Petitioner testified she can shop for 15-20 minute periods.

A listing for joint dysfunction (Listing 1.02) was considered based on Petitioner's complaints of hand pain. The listing was rejected due to a failure to establish that Petitioner is 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 lumbar 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 due to a lack of respiratory testing evidence.

A listing for schizophrenic disorder (Listing 12.02) was considered based on diagnoses of schizoaffective 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 required a highly supportive living arrangement, suffered repeated episodes of decompensation, or that the residual disease process resulted in a marginal adjustment so that even a slight increase in mental demands would cause decompensation. The most notable evidence factored in the consideration was Petitioner's GAF score of 85 which is indicative of minimal or absent psychological restrictions.

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 testimony that Petitioner was approved for disability based on an MRT decision in [redacted]. Consideration was given to finding that Petitioner had medically improved based on an absence of psychiatric hospitalizations since Petitioner's disability approval; ultimately, such a finding is rejected.

MDHHS failed to present any of Petitioner's medical documents to support disability. Such documentation should not only be required for an analysis of medical improvement, but the evidence is also insightful into Petitioner's current restrictions. In the absence of medical documents supporting the original finding of disability, it is found MDHHS failed to establish medical improvement and the analysis may proceed directly to the fourth step.

Step 4 of the analysis considers whether any exceptions apply to a previous finding that no medical improvement occurred or that the improvement did not relate to an increase in RFC. 20 CFR 416.994(b)(5)(iv). If medical improvement related to the ability to work has not occurred and no exception applies, then benefits will continue. CFR 416.994(b). Step 4 of the disability analysis lists two sets of exceptions.

The first group of exceptions allow a finding that a claimant is not disabled even when medical improvement had not occurred 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 [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 no less than twelve months from the date of this administrative decision, if Petitioner is found eligible for future benefits.

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

CG/hw

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

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

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

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

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

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

DHHS

[redacted]

Petitioner

[redacted]