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: December 8, 2016
MAHS Docket No.: 16-011236
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 September 7, 2016. The hearing was conducted by Administrative Law Judge Robert Chavez. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], hearing facilitator.

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 (see Exhibit 1, pp. 3-26).

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.

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. On [redacted], an administrative hearing was held.

7. During the hearing, Petitioner and MDHHS waived the right to receive a timely hearing decision.

8. During the hearing, the record was extended 60 days to allow Petitioner to submit various medical records; an Interim Order Extending the Record was subsequently mailed to both parties.

9. On [redacted], Petitioner submitted additional documents (Exhibit 5, pp. 1-31, Exhibit 6 pp. 2-3, Exhibit 7 pp. 1-11, Exhibit 8, pp. 1-34).

10. As of the date of the administrative hearing, Petitioner was a 46-year-old female.

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

12. Petitioner's highest education year completed was the 12th grade.

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

14. Petitioner alleged disability based on restrictions related to recurring syncope episodes.

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 3, pp. 253-259) dated July 26, 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.

Physician office visit notes (Exhibit 8, pp. 15-19) dated [redacted], were presented. It was noted that Petitioner reported insomnia, ongoing for a month.

Decreased range of motion in Petitioner's lumbar was noted. Diagnoses included benign HTN, osteoarthritis, epilepsy which was managed by a neurologist, depression which was managed by a psychiatrist, and osteoarthritis. Motrin was prescribed for osteoarthritis.

Neurologist office visit notes (Exhibit 7, pp. 6-9) dated [redacted], were presented. Petitioner complained of vertigo, spells of staring-off, headaches, and bilateral arm tingling and numbness. A recent EEG was noted to reveal wave activity suggestive of a focal epilepsy. A neurological examination indicated no notable findings. It was noted Petitioner was unable to undergo a brain MRI due pacemaker placement. A plan of discontinuing Klonopin and starting Zonegran was noted. It was noted vestibular therapy was discussed, though Petitioner lacked transportation and reported she could not attend. A neurologist letter (Exhibit 7, pp. 10-11) of the same date repeated the information from the office visit notes.

Physician office visit notes (Exhibit 8, pp. 11-14) dated [redacted], were presented. It was noted that Petitioner reported occasional "mild" chest pain, ongoing for 1-4 weeks. A plan of pacemaker reprogramming was noted.

Cardiologist office visit notes (Exhibit 3, pp. 97-99, 107-109) dated [redacted], were presented. It was noted that Petitioner reported ongoing episodes of vibration and pulsation at the site of pacemaker, along with a burning and choking/nausea sensation. It was noted Petitioner had not had syncope episodes. A plan of having pacemaker interrogated was noted. Syncope was noted to be resolved.

Cardiologist office visit notes (Exhibit 3, pp. 93-96, 103-106) dated [redacted] were presented. It was noted that Petitioner reported ongoing episodes of vibration and pulsation at the site of pacemaker. Petitioner also reported palpitations, a burning sensation, and nausea. Petitioner's ejection fraction was noted to be normal. It was noted a heart catheterization showed no significant coronary artery disease. Pacemaker interrogation (see Exhibit 3, pp. 111-202) was noted to demonstrate paroxysmal supraventricular tachycardia (PSVT) with a heart rate of up to 200 beats per minute. A plan of therapy with calcium channel blockers was noted. A follow-up in 3 months was noted.

Hospital emergency room documents (Exhibit 5, pp. 1-20) dated [redacted], were presented. It was noted that Petitioner presented with complaints of chest pain, palpitations, and vomiting. It was noted a stress test was not indicative of ischemia. Petitioner was given medication and discharged. An impression of atypical chest pain was noted. Presumably, this was Petitioner's last hospital encounter as she testified she was last hospitalized in early August 2016.

Physician office visit notes (Exhibit 8, pp. 6-16) dated [redacted], were presented. It was noted that Petitioner reported mid-back pain related to a recent fall. It was noted

Petitioner declined medication, a steroid shot, and/or physical therapy. Cyclobenzaprine was prescribed.

Petitioner testified she had traumatic brain injury in 2003. Petitioner testified seizures began shortly thereafter. Petitioner testified she had a lengthy period without seizures, but they restarted following 2015 brain surgery.

Petitioner testified she was hospitalized for 2 weeks in August 2015. Petitioner testified she was diagnosed with a cerebral aneurysm. Petitioner testified she underwent a craniotomy. Petitioner testified the treatment included implantation of a pacemaker.

Petitioner alleged restrictions, in part, due to back pain. Petitioner testified back pain limits her sitting to an unspecified degree. One medical appointment noted restricted lumbar range of motion. Another appointment noted a recent fall causing mid-back pain. Lumbar radiology was absent. Back pain treatment (other than prescribing Motrin) was absent. In fact, Petitioner apparently declined therapies which might have reduced restrictions; this is indicative of minimal restrictions. Presented evidence failed to establish severe restrictions related to back pain.

Petitioner alleged disability, in part, due to daily seizures. Petitioner testified she last had a seizure on morning of hearing. Petitioner testified her seizure causes her eyes to "do weird things." Petitioner testified she is unaware of any triggers, though she gets light-headed with exertion.

Petitioner testified her physicians are unsure what is causing her to "pass out." Petitioner testified triggers include overexertion. Petitioner testified she will be seeing an electrophysiologist to hopefully discover a diagnosis. Petitioner testified she thinks it may be caused by neurocardiogenic syncope.

Petitioner testified she passed out on [redacted]. Petitioner testified she saw a physician, though she stated nothing was done to help her due to the unknown cause of seizures.

Petitioner testified previously prescribed anti-seizure medications did not help. Petitioner testified she currently takes Paxil for her seizures.

Presented evidence suggested a degree of restrictions related to syncope. Minimally, Petitioner would be precluded from activities involving driving. Petitioner would also be restricted from performing employment particularly dangerous for a person with a history of epilepsy (e.g. operating heavy machinery, working at heights, working near open water…).

Petitioner testified she has recurring feelings of chest "jumping" and "pulsating" resulting in a "shocky felling." Petitioner testified her pacemaker has been reset and tweaked but has not reduced the syncope episodes Petitioner testified her pacemaker is currently

set for 30 beats per minute. Petitioner testified the setting is “extremely low” and causes her to be constantly fatigued. Petitioner testified her pacemaker problems are unable to be duplicated. Petitioner does not know if syncope episodes are related to pacemaker malfunction.

Petitioner’s testimony was not insincere, though it was not well verified. Presented medical records verified a need for pacemaker reprogramming which was performed. Presented records did not verify a need for a new pacemaker. The most recently verified testing demonstrated PSVT which could cause some degree of work restriction such as preclusion from heavy exertion. A follow-up in 3 months (which was not verified) is not indicative of additional restrictions.

Petitioner testified she is unable to drive. Petitioner testified taking out the trash makes her light-headed if it is heavy; she testified her neighbor helps with the trash. Petitioner testified she is unable to do yard work; for example, she testified she tried to mow the lawn and was unable to finish due to light-headedness.

Presented medical records sufficiently verified a degree of restriction to basic work activities due to syncope episodes. 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 impairment appears to be focal epilepsy. Petitioner’s reported seizures are most closely associated with Listing 11.03 which reads:

> **11.03 Epilepsy -** nonconvulsive epilepsy (petit mal, psychomotor, or focal), documented by detailed description of a typical seizure pattern including all associated phenomena, occurring more frequently than once weekly in spite of at least 3 months of prescribed treatment. With alteration of awareness or loss of consciousness and transient postictal manifestations of unconventional behavior or significant interference with activity during the day.

Petitioner alleged she has seizures every day. Petitioner’s testimony was not consistent with presented records.

Presented records did not establish a “detailed description of a seizure pattern.” The absence of such a history decreases the credibility of Petitioner’s claims of daily seizures.

Petitioner’s testimony that she has daily seizures appeared to be contradicted by her cardiologist. At an office visit dated [redacted], Petitioner’s cardiologist specifically stated Petitioner did not have syncope, near syncope, or vertigo. (see Exhibit 3, p. 93); no subsequent syncope episodes appeared to be documented within presented records.

A finding that Petitioner does not have daily syncope episodes is consistent with a lengthy period of not seeing a neurologist. Petitioner testified she last saw neurologist in April 2016, approximately 5 months before the hearing. Petitioner’s lack of treatment over the 5 months before the hearing is not indicative of significant interference with daily activities.

A listing for joint dysfunction (Listing 1.02) was considered based on a diagnosis of joint pain from arthritis. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively.

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.

Cardiac-related listings (Listing 4.00) were considered based on Petitioner’s cardiac treatment history. Petitioner failed to meet any cardiac listings.

It is found that Petitioner failed to establish meeting (or equaling) an SSA listing. Accordingly, the analysis moves to the fourth step.

The fourth step in analyzing a disability claim requires an assessment of the Petitioner’s residual functional capacity (RFC) and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if it is determined that a petitioner can perform past relevant work. *Id*.

Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

Petitioner testified she last worked as a phlebotomist on [redacted]. Petitioner testified she had worked as a phlebotomist for 2 years. Petitioner testified her duties involved drawing blood and processing the blood. Petitioner testified her job required her to lift supplies weighing up to 10 pounds. Petitioner testified she was sometimes expected to lift patients who fainted.

Petitioner testified she worked as a bartender for 15 years. Petitioner testified her job sometimes required her to move kegs of beer.

Petitioner testified she cannot perform either of past her jobs because of daily syncope episodes. Petitioner's testimony was generally unsupported for the reasons stated in the third step of the analysis.

Petitioner's syncope episode history would preclude from jobs involving driving, or other employment particularly dangerous for persons with a seizure history. Neither bartending nor phlebotomist are jobs which would increase Petitioner's danger. It is notable that even if such jobs would be deemed to be dangerous (perhaps because the of working with needles and glasses), Petitioner would be not disabled under Medical Vocational Rule 201.21 based on her high school education, 46 year age, and sedentary employment (at minimum) capabilities.

It is found Petitioner is capable of performing past employment. Accordingly, the denial of Petitioner's SDA application was proper.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that MDHHS properly denied Petitioner's SDA benefit application dated [redacted], based on a determination that Petitioner is not disabled. The actions taken by MDHHS are **AFFIRMED**.

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]