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: December 29, 2016
MAHS Docket No.: 16-015210
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 [redacted] Michigan. Petitioner appeared and was unrepresented. [redacted], Petitioner's mother, 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 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 3, pp. 1-11).

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.

6. Petitioner has ongoing (for longer than 3 months) spinal and/or neurological dysfunction causing balance difficulties when walking.

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 an SDA application. Petitioner claimed an inability to work for longer than 90 days due to mental and/or physical disabilities. It was not disputed that MDHHS denied Petitioner's application on [redacted], following 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.

Hospital emergency room documents (Exhibit 1, pp. 165-170, 181-186) dated [redacted] were presented. It was noted that Petitioner presented with complaints of unsteady gait and tremors, ongoing for a month. Petitioner was noted as [redacted] into an alcohol rehabilitation. Petitioner reported going no longer than 1-2 days in the past [redacted] years without drinking alcohol. Intact motor sensation and strength were noted. It was noted Petitioner improved following replacement of magnesium. A brain MRI was planned.

A brain MRI report (Exhibit 1, pp. 209-210) dated [redacted], was presented. An impression of no ischemic changes and mild ventriculomegaly was noted. Increased T2 signal intensity was also noted; possible explanations included HTN, diabetes, or demyelinating disease. Follow-up was recommended.

Medical clinic documents (Exhibit 1, p. 171, 187-188) dated [redacted], were presented. A lumbar puncture was recommended for the purpose of evaluation of a demyelinating condition.

Hospital emergency room documents (Exhibit 1, pp. 172-175, 189-202, 211-212) dated [redacted] were presented. It was noted that Petitioner presented for a lumbar puncture. Some inflammation was noted, though there was no infectious process.

Hospital emergency room documents (Exhibit 1, pp. 175-180, 203-207, 213) dated [redacted], were presented. It was noted that Petitioner presented with complaints of worsening dizziness, unsteady gait, and walking difficulty (with many falls). It was noted Petitioner had no difficulties with performing daily living activities. It was noted Petitioner continued to drink alcohol. It was noted Petitioner was supposed to be taking 3 medications to control his HTN but he has not taken them for over a year. A

loss of 150 pounds was reported over the past year. It was noted MRI findings could be caused by small vessel disease (given HTN history) or demyelinating disease. Gait dysfunction was noted to be possibly caused by lower neuropathy (caused by ETOH abuse). A cervical spine MRI was ordered. A chest x-ray was negative.

MRI reports of Petitioner's brain, cervical spine, and thoracic spine (Exhibit 1, pp. 214-221) dated [redacted], were presented. The reports were completed in response to continuing complaints of gait dysfunction. Increased T2/FLAIR signal hyper-intensity and slightly increased white matter were noted. Signal changes in the cervical spine were noted. An impression of findings suggestive of a chronic demyelinating process was noted.

A CT report of the thorax (Exhibit 1, pp. 221-222) dated [redacted], was presented. Findings including an enlarged liver.

A letter from Petitioner's neurologist (Exhibit 1, p. 48, 224; Exhibit 2, p. 33) dated [redacted], was presented. The letter was based on blood test results (Exhibit 1, pp. 49-51, 225-226; Exhibit 2, pp. 34-35). It was noted that Petitioner's Vitamin B1 level was low, and this was "likely" due to alcohol abuse. It was further stated that low Vitamin B1 was a cause of neuropathy. It was also noted that elevated proteins in Petitioner's blood contributed to neuropathy; liver disease, was noted as a cause of protein elevation. Recommendations to see a blood and liver doctor were noted. A prescription for thiamine was provided. An EEG was recommended and instructions for testing were provided (see Exhibit 1, pp. 54-55; Exhibit 2, pp. 30-31).

A mental status examination report (Exhibit 1, pp.147-152) dated [redacted], was presented. The report was completed by a consultative licensed psychologist and a limited licensed psychologist. Petitioner's reported history included a [redacted] car accident, a prison sentence from [redacted], a diagnosis of PTSD from the car accident, and alcohol consumption of at least a pint per day. Petitioner reported sleeping [redacted] hours per day due to medications. Observations included Petitioner smelling of alcohol. It was noted Petitioner's lack of effort in the examination rendered it impossible to get an accurate assessment of cognitive function. The examiner opined Petitioner could perform employment involving simple 2-3 step directions. Diagnoses included chronic alcohol abuse and antisocial personality disorder.

An internal medicine examination report (Exhibit 1, pp. 153-160) dated [redacted], was presented. The report was noted as completed by a consultative physician. Petitioner reported symptoms of body pain, progressive function decline, and headache. It was observed Petitioner ambulated slowly, was off-balance, and used a cane. Muscle strength was noted to be 5/5 throughout all extremities. Reflexes were noted to be absent in all extremities. It was noted Petitioner was unable to tandem walk, toe walk, and heel walk. Petitioner's gait was described as "very slow" and shuffling. Petitioner was noted as unable to stoop, bend, carry, push, pull, or squat. Cervical spine range of motion was limited to 10° for all motions. All lumbar spine ranges of motion were noted

to be less than 10°. An impression of significant debility with chronic demyelinating process and setting-in of alcoholism was noted; HTN, alcohol abuse, and tobacco abuse were also noted.

An MRI of Petitioner's lumbar spine (Exhibit A, pp. 13-14) dated [redacted], was presented. Findings were noted to be significantly degraded by motion. Impressions included "no convincing signal abnormality" within the spine. Bilateral pars defect with minimal anterolisthesis was noted at L5. L5 nerve root compression was noted followed by a statement that there was disc abutment but not nerve root compression. Boilerplate language noted that 8 in 10 persons have disk degeneration, 6 in 10 have a bulging disk, and 3 in 10 have a disc protrusion; it was also noted that many persons with these diagnoses are pain-free.

Internal medicine office visit summary notes (Exhibit A, pp. 1-5) [redacted], were presented. It was noted Petitioner appeared for back pain treatment. A diagnosis of chronic midline low back pain with right-sided sciatica was noted. Alcohol abuse and cirrhosis were also noted diagnoses. Acetaminophen-codeine, Duloxetine, furosemide, potassium chloride, and spironolactone were prescribed. Petitioner was referred to physical therapy and a pain clinic (see Exhibit A, pp. 9-12).

Petitioner testified he's experienced regular grand mal seizures since [redacted]. Petitioner testified the seizures typically occur when he is near stairs or the dark. Petitioner's testimony of seizures implied some type of psychological cause of seizures. Though neurological dysfunction was verified, treatment for grand mal seizures was not apparent within presented records.

Petitioner's mother expressed concern over Petitioner's weight loss. Petitioner testified he has no lost weight over the past year. Petitioner's mother clarified her son's weight was higher in the past. A stable weight for over a year is not particularly indicative of weight loss relevant to a disability finding. More importantly, there was no apparent concern by any treating physician concerning loss of weight. Petitioner's height during a consultative physical examination was noted to be [redacted]"; his weight was [redacted] The result is A BMI of [redacted] which is borderline obese is not indicative of a disabling weight. These considerations supports rejecting Petitioner's weight as relevant.

Presented medical records generally verified some type of neurological dysfunction and spinal abnormality causing restrictions to Petitioner's leg and back function. 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 appears to be without a definitive diagnosis concerning his documented ambulation difficulties. The combination of verified spinal and neurological abnormalities were suggestive of a spinal neurological disorder. The most relevant SSA listing justifies a finding of disability by the following:

> **11.08 Spinal cord disorders**, characterized by A, B, or C:
> A. Complete loss of function, as described in 11.00M2, persisting for 3 consecutive months after the disorder (see 11.00M4).
> OR
> B. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities persisting for 3 consecutive months after the disorder (see 11.00M4).
> OR
> C. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a) and in one of the following areas of mental functioning, both persisting for 3 consecutive months after the disorder (see 11.00M4):
> 1. Understanding, remembering, or applying information (see 11.00G3b(i)); or
> 2. Interacting with others (see 11.00G3b(ii)); or
> 3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or
> 4. Adapting or managing oneself (see 11.00G3b(iv)).

Petitioner testified he uses a walker for ambulation. Petitioner testified he has relied on a walker for the previous 2 months. Petitioner testified he can only walk 50 feet (with his walker) before back pain and fatigue prevent further walking. Petitioner testified stairs are particularly difficult and that he “scoots” on stairs. Petitioner testimony estimated he has fallen 20 times on stairs.

Petitioner testified he can only stand 1-2 minutes before his legs are swollen. Petitioner testified back pain prevents sitting of longer than 5 minutes.

Petitioner testified he needs assistance with bathing from his mother. Petitioner testified he sometimes needs help with putting on his socks, shoes, and pants. Petitioner testified he contributes no cleaning to his mother’s household- not even putting away his own dishes. Petitioner testified he can “slightly” drive (5-10 minutes only). Petitioner testified he does not shop because of his walking difficulties. Petitioner’s mother testified she has to give her son body rubs thrice per day to help him relieve his pain.

Petitioner’s testimony was highly indicative of severe disability. Radiological and neurological findings were indicative of restrictions consistent with Petitioner’s testimony.

A degree of nerve root compression was found in spinal radiology. A physical examination noted significant loss of cervical and lumbar range of motion. The findings were consistent with severe ambulation difficulties.

Presented documentation noted a loss of reflexes in all of Petitioner's extremities. Neurological testing verified abnormal signals which were indicative of demyelinating disease. Again, the findings were consistent with severe ambulation difficulties.

It is found that Petitioner sufficiently meets the SSA listing for 11.08(B). Typically, meeting a SSA listing concludes the disability analysis. Petitioner's lifestyle raises presents obstacles to a disability finding.

Claimants have the burden of proof to establish disability. SSR 13-2p. When drug and/or alcohol abuse (DAA) is applicable, SSA applies the steps of the sequential evaluation a second time to determine whether the claimant would be disabled if he or she were not using drugs or alcohol. *Id.* It is a longstanding SSA policy that the claimant continues to have the burden of proving disability throughout the DAA materiality analysis. *Id.* Noted considerations made by SSA concerning drug materiality include the following:

- Does the claimant have DAA?
- Is the claimant disabled considering all impairments, including DAA?
- Is DAA the only impairment?
- Is the other impairment disabling by itself while the claimant is dependent upon or abusing drugs and/or alcohol?
- Does the DAA cause or affect the claimant's medically determinable impairments?
- Would the other impairments improve to the point of non-disability in the absence of DAA

Petitioner testified he has cirrhosis. Petitioner testified that he was told it can be corrected, but he would have to stop drinking alcohol first.

Petitioner testified he continues to drink a pint of alcohol a day. The testimony was consistent with multiple diagnoses of alcohol abuse. Presented evidence was not indicative that cirrhosis and/or liver dysfunction notably contributes to Petitioner's ongoing physical restrictions.

If the finding of disability was based on Petitioner's liver dysfunction, Petitioner's continued alcohol abuse would surely be material to the disability finding. The finding of disability was based solely on spinal and/or neurological dysfunction. Though Petitioner is surely not helping his neurological and spinal function by continued alcohol abuse, it cannot be stated that his neurological and spinal condition would be improved if Petitioner became sober.

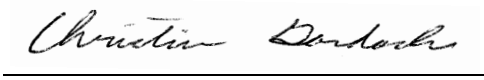
It is found Petitioner's alcohol abuse is not material to the finding of disability. Accordingly, Petitioner is disabled and the denial of Petitioner's SDA application is found to be improper.

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]