RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

Date Mailed: March 24, 2017
MAHS Docket No.: 16-011236
Agency No.:
Petitioner:

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 . Petitioner appeared and was represented by of . The Michigan Department of Health and Human Services (MDHHS) was represented by , 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 , Petitioner applied for SDA benefits (see Exhibit 2, pp. 3-26).

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

3. On an unspecified date, Disability Determination Services determined that Petitioner was not a disabled individual.

4. On , 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. 1-2).

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], an administrative hearing decision was issued which found that MDHHS properly denied Petitioner's SDA application.

10. On [redacted], following an appeal by Petitioner, the Michigan Administrative Hearing System granted Petitioner's request for rehearing.

11. On [redacted], a second administrative hearing was held.

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

13. Petitioner has various problems causing severe impairments.

14. Petitioner's severe impairments preclude performance of past employment.

15. Petitioner's severe impairments preclude performance of any employment.

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 90 days due to mental and/or physical disabilities. MDHHS presented a Notice of Case Action (Exhibit 3, pp. 253-259) dated [redacted] verifying Petitioner's application was denied based on a determination that Petitioner was not disabled.

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

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

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

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

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person

is statutorily blind or not. The 2016 monthly income limit considered SGA for non-blind individuals is $[redacted].

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

Physician office visit notes (Exhibit S) dated [REDACTED], were presented. Active problems included stable depression, epileptic seizures, stable high blood pressure, and osteoarthritis. Paxil was prescribed for syncope episodes. It was noted Petitioner was not taking any other medications.

Neurologist office visit notes (Exhibit 7, pp. 6-9) dated [REDACTED], were presented. Petitioner complained of vertigo, spells, staring-off seizures, 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 to her pacemaker. 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 provided functionally identical information.

Physician office visit notes (Exhibit 8, pp. 11-14) dated [REDACTED], were presented. It was noted that Petitioner reported occasional "mild" chest pain (2/10), ongoing for 1-4 weeks. A plan of pacemaker reprogramming was noted. A diagnosis of epilepsy (without status epilepticus and not intractable) was noted.

Internist office visit notes (Exhibit T) dated [REDACTED], were presented. A complaint of chest pain was noted. It was noted that recurrent syncope episodes were suspicious for "severe" neurocardiogenic syncope.

Cardiologist office visit notes (Exhibit 3, pp. 97-99, 107-109, Exhibit P) dated [REDACTED] were presented. It was noted that Petitioner was a new patient who reported ongoing episodes of vibration and pulsation at the site of pacemaker, along with a burning and choking/nausea sensation. Normal ejection fraction was noted. It was noted Petitioner had not had syncope episodes; syncope was noted to be resolved. A plan of pacemaker interrogation was noted (see Exhibit O for corresponding report of interrogation).

Cardiologist office visit notes (Exhibit 3, pp. 93-96, 103-106, Exhibit Q) 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. It was noted Petitioner was unable to tolerate beta blocker treatment. A plan of therapy with calcium channel blockers was noted. Assessments included syncope (no recurrence), cardiac arrhythmia, HTN, seizure, and cerebral aneurysm. A follow-up in 3 months was noted.

A Mental Residual Functional Capacity Assessment (Exhibit 1, pp. 217-251) dated ███ ████, was presented. The assessment was signed by a licensed psychologist as part of Petitioner's SSA claim of disability. Moderate limitations to understanding and remembering information, carrying out detailed instructions, maintaining attention, interacting with the public, getting along with coworkers, and responding to changes were noted. A history of outpatient treatment and alcohol dependence was noted. Insight was noted to be fair. Petitioner was deemed capable of performing simple (1-4 steps) and repetitive work requiring low-stress interactions.

Hospital emergency room documents (Exhibit 5, pp. 1-20, Exhibit 6, pp. 2-31, Exhibit U) dated ██████████, were presented. It was noted that Petitioner presented with complaints of chest pain, palpitations, and vomiting. Tenderness to palpation was noted on Petitioner's left side of her chest. It was noted a stress test was not indicative of ischemia; normal left ventricular wall motion and a 56% EF were also noted. Petitioner was given medication and discharged. An impression of atypical chest pain was noted.

Cardiologist Summary of Care documents (Exhibit V) dated ███████████, were presented. It was noted that ongoing recurrent syncope was suspicious for severe neurocardiogenic syncope. Conservative treatment was recommended. Specific recommendations included slow positional changes, adequate hydration, stress management, and support stockings. Paxil was prescribed.

Physician office visit notes (Exhibit 8, pp. 6-16) dated ███████████, were presented. It was noted that Petitioner reported mid-back pain related to a fall from █ days earlier. Petitioner reported the fall happened during a syncope episode. It was noted Petitioner declined medication, a steroid shot, and/or physical therapy. Cyclobenzaprine was prescribed.

Cardiovascular physician Summary of Care notes (Exhibit X) was presented. An office visit report dated █████████████, noted prescriptions for cyclobenzaprine and midodrine.

Cardiovascular visit notes (Exhibit Y) dated ████████████, were presented. Petitioner's blood pressure was noted to be 118/72.

Petitioner testified she was in a motor vehicle accident several years earlier. Petitioner testified seizures began shortly thereafter. Petitioner testified she had a lengthy period from ███ without seizures, but they restarted following ███ brain surgery. Petitioner's testimony was consistent with a diagnosis of focal epilepsy.

Petitioner testified she was hospitalized for ■ weeks in ■. 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 testified her electrophysiologist diagnosed her with neurocardiogenic syncope (aka vasovagal syncope). Petitioner testified her doctor told she might “outgrow” the diagnosis. The diagnosis is understood to cause a loss of consciousness due to low blood pressure and/or poor blood flow to the brain.

Petitioner testified she started taking Midodrine in ■. Petitioner testified the medication “very slightly” helps. Petitioner testified she’s had about 5-6 syncope episodes in ■ Petitioner testified she was unable to start the medication sooner because of difficulty controlling blood pressure. Presumably, a side effect of the medication is an increase in blood pressure because Petitioner testified she has to check her blood pressure before taking the medication.

Presented evidence verified Petitioner has a pacemaker. Petitioner testified the pacemaker has been off for “a couple months.” Petitioner testified she will soon have to decide if she will allow the pacemaker to be replaced. Petitioner testified she sees her cardiologist every 3 months for check-ups.

A diagnosis of PSVT was indicated based on pacemaker testing. Syncope episodes are a potential symptom of the diagnosis.

Petitioner testified she was diagnosed with bipolar disorder and anxiety. Petitioner testified she saw a therapist approximately 6-8 months earlier, but stopped due to a lack of transportation.

Petitioner testified she deals with a degree of lumbar pain. Petitioner testified physical therapy was recommended. The testimony is consistent with a diagnosis of osteoarthritis.

Presented records provided little insight into back and/or joint problems. A diagnosis of osteoarthritis was verified. No radiology was presented. No treatment other than medication was verified. A treatment for back pain was documented following a fall, but the incident was not indicative of chronic problems.

Petitioner testified her abilities change from day-to-day. Petitioner described at least half of the past 30 days as “bad” and no more than a quarter as “good” days. As an example, Petitioner testified the previous Monday was terrible due to a drop in blood pressure. Petitioner testified physical exertion is particularly difficult on such days. Petitioner testified her bad days are increasing since her pacemaker was shut-down.

Petitioner testified she does not require a walking-assistance device to ambulate. Petitioner testified her walking is limited to 5-6 blocks (on a good day), less than a block

on a bad day. Petitioner testified she can stand from 0-15 minutes before dizziness or pain prevent further standing. Petitioner testified she has no sitting restrictions other than a need to sometimes stand.

Petitioner testified she is able to bathe and dress herself without notable difficulty. Petitioner testified she can do housework on her better days. Petitioner testified she can do laundry, though she stated her laundry loads are small. Petitioner testified she can go shopping on her better days.

During the hearing, Petitioner was asked about the possibility of performing office work (e.g. typing, computer work, telephone, filing…). Petitioner's stated she is unable to type (not due to physical restrictions) and has no experience. Petitioner's response is not relevant to the analysis. Petitioner also suggested that transportation would be an obstacle.

Petitioner testified she has been on a total driving restriction since [redacted]. During the hearing, Petitioner was asked if public transportation was a reasonable alternative; Petitioner testified the bus stop is "quite the walk." Petitioner's conditions could preclude use of public transportation if walking and/or weather would aggravate Petitioner's condition; such a possibility is reasonable, but not certain.

Presented treatment history was consistent with degrees of various exertional and non-exertional restrictions to Petitioner's performance of basic work activities. The treatment history was established to have lasted at least 90 days, and at least since Petitioner's date of SDA application. 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.

A prominent impairment for Petitioner is 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.

Presented records did not establish a “detailed description of a seizure pattern.” The absence of such a history automatically renders Petitioner unable to meet listing requirements.

Petitioner also complained of chronic syncope episodes. The most apparent cause is related to vasovagal/neurocardiogenic syncope which is most closely aligned to SSA listing 4.05 which reads as follows:

> ***4.05 Recurrent arrhythmias,*** not related to reversible causes, such as electrolyte abnormalities or digitalis glycoside or antiarrhythmic drug toxicity, resulting in uncontrolled (see 4.00A3f), recurrent (see 4.00A3c) episodes of cardiac syncope or near syncope (see 4.00F3b), despite prescribed treatment (see 4.00B3 if there is no prescribed treatment), and documented by resting or ambulatory (Holter) electrocardiography, or by other appropriate medically acceptable testing, coincident with the occurrence of syncope or near syncope (see 4.00F3c).

Petitioner’s cardiac treatment history appears complicated. Petitioner has a pacemaker which apparently does not function. A non-functioning pacemaker seems concerning, though Petitioner testimony and treatment records indicated regular monitoring is needed, but a new pacemaker may not be needed. A need for cardiac monitoring is not particularly indicative of meeting SSA listing requirements.

Petitioner testified she suffers recurrent syncope. Petitioner testimony estimated she passed out “uncountable” times over the past year. Petitioner testimony clarified the count is over 100 times. Petitioner testified the episodes last from 30 seconds to 5 minutes. Petitioner testified she has to worry about injuring herself if she falls during a syncope episode; Petitioner testified she fell the week before the hearing and hit a wall during an episode. Petitioner testified the episodes are fatiguing. Petitioner testified her physicians advised her to lie down after an episode; Petitioner testified she tries to rest for an hour whenever she has a syncope episode. Petitioner’s testimony was highly indicative of recurrent and uncontrolled syncope which meet listing requirements.

In ██████, a cardiologist specifically stated that Petitioner had no episodes of syncope, vertigo, or seizures. The statement is highly indicative that whatever episodes Petitioner had, were resolved.

A fall in ██████ caused by a syncope episode was documented. The incident is indicative that syncope is a recurring problem.

Petitioner’s cardiologist eventually acknowledged Petitioner’s claims of seizures by later diagnosing Petitioner with “severe” neurocardiogenic syncope. Generally, any “severe” diagnosis is indicative of disability. A “severe” diagnosis of syncope could reasonably produce the numerous syncope episodes alleged by Petitioner. Such an inference is somewhat contradicted by the recommendation of conservative treatment. One

subsequent cardiologist visit was documented, however, the record provided no insight into the severity of Petitioner's condition. The cardiologist later expressed some opinion on the severity of Petitioner's condition.

A Return To Work Form (Exhibit R) dated [redacted], was presented. Petitioner's cardiologist stated Petitioner was evaluated and not able to drive. It was also noted Petitioner was unable to work from [redacted], until "to be determined." The document appears to signify an increased concern for Petitioner's health. Given Petitioner's various conditions, an inference of uncontrolled and recurrent syncope episodes is reasonable.

It is found that Petitioner meets the requirements for recurrent arrhythmia. Accordingly, Petitioner is disabled and it is found that MDHHS improperly denied Petitioner's SDA application.

DECISION AND ORDER

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

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

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

CG/hw

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

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

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

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

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

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

DHHS

Counsel for Petitioner

Petitioner