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: July 21, 2017
MAHS Docket No.: 17-005965
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, a telephone hearing was held on from Detroit, Michigan. Petitioner appeared and was unrepresented. , Petitioner's sister, testified on behalf of Petitioner. 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 1, pp. 12-40).

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

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

4. On , MDHHS denied Petitioner's application for SDA benefits.

5. On , Petitioner requested a hearing disputing the denial of SDA benefits (see Exhibit 1, pp. 4-5).

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

7. As of the date of the administrative hearing, Petitioner was a 42-year-old female.

8. Petitioner has various symptoms and marked concentration and social interaction restrictions due to psychological disorders.

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).

Petitioner's hearing request checked a dispute concerning Family Independence Program (FIP) benefits. Petitioner testified a dispute of cash assistance based on disability (i.e. SDA) was intended. MDHHS was not confused by Petitioner's error and prepared for an SDA dispute. MDHHS had no objections to proceeding with a hearing to resolve the SDA dispute and the hearing was conducted accordingly.

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 1, pp. 10-11)) dated [REDACTED], verifying Petitioner's application was denied based on a determination that Petitioner was not disabled.

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (April 2017), 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 (April 2017), p. 1. A person is disabled for SDA purposes if he or she meets any of the following criteria:

- Receives other specified disability-related benefits or services….
- Resides in a qualified Special Living Arrangement (SLA) facility.
- Is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability.
- Is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS)...

Id., pp. 1-2.

When the person does not meet one of the [above] criteria, [MDHHS is to] follow the instructions in BAM 815, Medical Determination and Disability Determination Service

(DDS), Steps for Medical Determination Applications. *Id*., p. 4. The DDS will gather and review the medical evidence and either certify or deny the disability claim based on the medical evidence. *Id*. The review of medical evidence is primarily outlined by federal law.

[State agencies] must use the same definition of disability as used under SSI… 42 C.F.R. § 435.540(a). [Federal] law defines disability as the inability to do any substantial gainful activity 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 C.F.R. § 416.905(a).

MDHHS adopted a functionally identical definition of disability (see BEM 260 (July 2015), p. 10). The same definition applies to SDA, though SDA eligibility factors only a 90-day period of disability.

In general, you have to prove… that you are blind or disabled. 20 C.F.R. § 416.912(a). You must inform [SSA] about or submit all evidence known… that relates to whether or not you are blind or disabled. *Id*. Evidence includes, but is not limited to objective medical evidence e.g. medical signs and laboratory findings), evidence from other medical sources (e.g. medical history and opinions), and non-medical statements about symptoms (e.g. testimony) (see *Id*.).

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

The first step in the process considers a person's current work activity (see 20 C.F.R. §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 ████████.

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*.

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.

At the second step, [SSA will] consider the medical severity of your impairment(s). 20 C.F.R. §416.920 (a)(4)(ii). If you do not have a severe medically determinable physical

or mental impairment that meets the duration requirement in § 416.909, or a combination of impairments that is severe and meets the duration requirement, [SSA] will find that you are not disabled. *Id*.

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, SSR 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 (see 20 C.F.R. § 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 and Petitioner's testimony.

Neurologist office visit notes (Exhibit 1, p. 90) dated , were presented. It was noted Petitioner presented for follow-up. Petitioner was noted as not in acute distress. Lamictal was prescribed to help stabilize Petitioner's mood. A follow-up in 3 months was planned.

Psychiatrist office visit notes (Exhibit 1, pp. 113-114) dated , were presented. Petitioner reported long-term depression, worse over the past 8 years. Reported symptoms included racing thoughts, limited sleep (3-4 hours), irritability (including throwing items), erratic mood, panic attacks, and excessive worrying. Depression was reportedly diagnosed when Petitioner was 16. An assessment of bipolar disorder (Type 2) was noted. Petitioner's GAF was 60.

Psychiatrist office visit notes (Exhibit 1, p. 112) dated , were presented. Petitioner reported increased anxiety, hypersensitivity to noises, and limited sleep (4 hours). Medications were updated and follow-up in 2 weeks was planned.

Psychiatrist office visit notes (Exhibit 1, p. 111) dated , were presented. Petitioner reported increased depression, crying spells, and limited sleep (3 hours) due to body pain. Medications were updated and follow-up in one month was planned.

Hospital emergency room documents (Exhibit 1, pp. 175-197) dated [REDACTED], were presented. It was noted that Petitioner presented with complaints of vomiting, finger tingling, and leg tingling. An EKG was negative. Zofran and Ativan were prescribed. Generic discharge instructions for vomiting, anxiety, and narcotic medications were issued.

Hospital emergency room documents (Exhibit 1, pp. 152-174) dated [REDACTED], were presented. It was noted that Petitioner presented with complaints of chest palpitations and right arm pain with tingling. Chest radiology was unremarkable. An EKG was negative. Toradol and prednisone were prescribed. Generic discharge instructions for neck pain, paresthesia, and anxiety were issued.

Neurology office visit notes (Exhibit 1, p. 91) dated [REDACTED], were presented. Petitioner complained of severe neck pain and tingling radiating to right arm. A steroid injection from a month earlier reportedly caused Petitioner to have left foot pain. A recent EMG was indicative of C7 radiculopathy; a follow-up EMG was planned. Anti-inflammatory medication was prescribed.

Psychiatrist office visit notes (Exhibit 1, p. 110) dated [REDACTED], were presented. Petitioner reported 2 recent emergency room encounters due to panic attacks. Medications were updated and follow-up in 2 weeks was planned.

A cervical spine MRI report (Exhibit 1, pp. 150-151) dated [REDACTED], was presented. Cervical spine spondylosis with moderate foraminal narrowing at C4-C5 and C6-C7 was noted.

Neurology office visit notes (Exhibit 1, p. 92) dated [REDACTED], were presented. Ongoing neck and arm pain was reported. An EMG of the right arm was normal (see Exhibit 1, p. 93). Cervical spine MRI findings were noted to be “mild” and surgery was not recommended. Zanaflex was prescribed.

Psychiatrist office visit notes (Exhibit 1, p. 109) dated [REDACTED], were presented. Petitioner reported sleep of 4 hours per night (due to back pain) and dizziness. A stable mood was noted. Medications were updated and follow-up in one month was planned.

Neurology office visit notes (Exhibit 1, p. 95) dated [REDACTED], were presented. Petitioner reported increased pain, including in her left shoulder, left calf, and right wrist. Fatigue was also reported. Fibromyalgia was suspected, though sleep apnea was stated as a contributing factor to fatigue. An anti-depressant was recommended for pain.

Psychiatrist office visit notes (Exhibit 1, p. 108) dated [REDACTED] were presented. Petitioner reported sleep of 4-5 hours per night, increased eating, irritability, and anhedonia. Petitioner ceased meds 2 months earlier for unspecified reasons. Medications were updated and follow-up in one month was planned.

Neurology office visit notes (Exhibit 1, p. 95) dated , were presented. Petitioner reported ongoing pain. It was noted Petitioner stopped taking pain medications based on her psychiatrist's recommendations. Physical activity was recommended.

Psychiatrist office visit notes (Exhibit 1, p. 107) dated were presented. Petitioner reported sleep of 4 hours per night, impatience, irritability, racing thoughts and other "OCD-like" symptoms. Medications were updated and follow-up in 3 weeks was planned.

Psychiatrist office visit notes (Exhibit 1, p. 106) dated , were presented. Petitioner reported her mother died 4 days earlier. It was noted Petitioner's sisters would not allow her mother to have a blood transfusion that might have saved her mother's life. Petitioner reported a lack of sleep and anger related to the death of her mother. Medications were updated.

Psychiatrist office visit notes (Exhibit 1, p. 105) dated, were presented. Petitioner reported racing thoughts which limit sleep to 2-3 hours; increased nightmares since her mother's passing were also reported. Chronic anger, sadness, and concentration difficulties were noted. Medications were updated and follow-up in 2 weeks was planned.

Psychiatrist office visit notes (Exhibit 1, p.104) dated, were presented. Petitioner reported racing thoughts which limit sleep to 3-4 hours. Depression and panic attacks (lasting several minutes) were also reported. Various meds were continued.

Neurology office visit notes (Exhibit 1, p. 96) dated were presented. Petitioner reported body pain and weakness. A Doppler study was noted to be negative. Strength was noted to be 5-/5. A recommendation of weight loss and exercise was noted. Baclofen was prescribed.

A Physical Residual Functional Capacity Assessment (Exhibit 1, pp. 45-52) dated , was presented. The assessment was illegibly signed. It is assumed that the assessment was completed by Petitioner's neurologist (partially based on legible signature letters and partially based on Petitioner being examined on the same date by her neurologist). The stated basis for assessments were uncited medical records. Assessments of Petitioner included occasional lifting of 20 pounds, frequent ability to lift/carry 10 pounds, standing or walking less than 2 hours in an 8-hour workday, and pushing and/or pulling of less than 40 pounds. Stated support for restrictions included diagnoses of fibromyalgia, cervical radiculopathy, and possible myopathy. Petitioner was totally restricted from crawling, crouching, and kneeling; support for assessments was muscle pain, a history of falling, and medication side effects. Limited reaching was noted due to shoulder pain. Other than ambulation restrictions, Petitioner's neurologist's statements were consistent with an ability to perform sedentary employment.

Psychiatrist office visit notes (Exhibit 1, p. 103) dated , were presented. Petitioner reported a “mostly stable” mood and no side effects other than some abdominal pain. Various meds were continued.

Psychiatrist office visit notes (Exhibit 1, p. 102) dated were presented. Petitioner reported racing thoughts, irritable and depressed mood, anhedonia, insomnia, and lethargy. Lamictal dosages were increased. Lamictal, Neurontin, and Ativan were continued.

A Physical Residual Functional Capacity Assessment (Exhibit 1, pp. 118-125) dated , was presented. The assessment was signed by a “single decisionmaker” as part of Petitioner’s SSA claim of disability. The stated basis for assessments were various neurologist treatment records, a consultative examination report, and hospital record form . Stated restrictions included occasional lifting of 50 pounds, frequent ability to lift/carry 25 pounds, standing or sitting about 6 hours in an 8-hour workday. Limited pushing/pulling and overhead reaching was noted due to cervical spine fusion. The assessment were not insightful because they did not come from an acceptable medical source (see 20 C.F.R. §416.913).

An internal medicine examination report (Exhibit 1, pp. 77-85) dated , was presented. The report was noted as completed by a consultative physician. Notable physical examination findings included the following: normal gait, able to stand tiptoed and on heels, full weight-bearing on both legs, normal cervical spine lordosis, normal lumbar lordosis, normal muscle strength, and normal reflexes. Various cervical spine and lumbar motion ranges were restricted; knee flexion was also limited. The examining physician opined that Petitioner could perform her customary activities and occupational duties without restrictions.

Petitioner testified she injured her neck in while performing required gun training for her employment as a prison guard. Petitioner testified a C4-C5 fusion in did not resolve her neck pain. Petitioner testified she eventually continued her employment but was limited to light duties.

Petitioner testified she does not utilize a walking aide. Petitioner testified she can walk for 10 minutes and stand for 10-20 minutes before back pain prevents further activity. Petitioner estimated she could sit for 30-45 minutes before arising. Petitioner testified she can lift/carry approximately 20 pounds. Petitioner testified her neck and arms sometimes feel fine, but sometimes feel unbearably achy.

Petitioner testified she relies on a railing to shower. Petitioner testified she will not change clothes if she is in pain. Petitioner testified she can sometimes perform laundry (presumably when not in pain). Petitioner testified she is unable to shop in crowded stores. Petitioner testified she does not have a vehicle and has no public transportation near her home.

Petitioner testified she has lumbar dysfunction. Petitioner testified she thinks the pain is related to her sciatic nerve. Petitioner testified she takes gabapentin for her pain. Petitioner testified neither injections nor physical therapy reduced her pain.

Petitioner testified she has seen a psychiatrist since [redacted] Petitioner testified she has no history of psychiatric hospitalizations or suicide attempts. Petitioner testified ongoing psychological symptoms include difficulty sleeping, anxiety, difficulty with people, crying spells, anger problems and sadness.

Various records indicated that Petitioner blames family members for her mother's death due to their refusal, for religious reasons, to allow her mother to have a blood transfusion. Petitioner testified her psychiatric problems worsened since her mother passed in [redacted]

Presented medical records generally verified a medical treatment history consistent with standing and lifting/carrying restrictions due to lumbar pain and neurological pain. Presented records also generally verified degrees of concentration and social interaction restrictions. Petitioner's 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.

At the third step, [SSA will] also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals… listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, [SSA] will find that you are disabled. 20 C.F.R. § 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 (see 20 C.F.R. § 416.920 (d)). If your impairment(s) does not meet or equal a listed impairment, [SSA] will assess and make a finding about your residual functional capacity based on all the relevant medical and other evidence in your case record…. 20 C.F.R. § 416.920 (e).

Petitioner's primary basis for disability was based on anxiety. The relevant listing for anxiety disorders reads as follows:

> **12.06 Anxiety and obsessive-compulsive disorders (see 12.00B5), satisfied by A and B, or A and C:**
>
> A. Medical documentation of the requirements of paragraph 1, 2, or 3:
>
> 1. Anxiety disorder, characterized by <u>three</u> or more of the following;
>   a. Restlessness;
>   b. Easily fatigued;
>   c. Difficulty concentrating;
>   d. Irritability;
>   e. Muscle tension; or
>   f. Sleep disturbance.
> 2. Panic disorder or agoraphobia, characterized by <u>one</u> or both:

  a. Panic attacks followed by a persistent concern or worry about additional panic attacks or their consequences; or
  b. Disproportionate fear or anxiety about at least two different situations (for example, using public transportation, being in a crowd, being in a line, being outside of your home, being in open spaces).
3. Obsessive-compulsive disorder, characterized by one or both:
  a. Involuntary, time-consuming preoccupation with intrusive, unwanted thoughts; or
  b. Repetitive behaviors aimed at reducing anxiety.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):
  1. Understand, remember, or apply information (see 12.00E1).
  2. Interact with others (see 12.00E2).
  3. Concentrate, persist, or maintain pace (see 12.00E3).
  4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is "serious and persistent;" that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:
  1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and
  2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

Petitioner's most recently documented psychiatric treatment noted complaints of racing thoughts, irritability, anhedonia, insomnia, and lethargy. The complaints were regularly noted throughout Petitioner's treatment history. The evidence was sufficient to meet Part A of the anxiety disorder listing. A consideration of whether Petitioner meets Part B of the listing will factor multiple psychological assessments.

A Psychiatric Review Technique and Mental Residual Functional Capacity Assessment (Exhibit 1, pp. 126-144) dated [redacted], were presented. The documents were signed by a licensed psychologist as part of Petitioner's SSA claim of disability. Moderate restrictions to understanding, interaction, concentration, and adaptability were noted. Petitioner was deemed to have no significant restrictions in following simple directions, carrying-out simple instructions, making simple decisions, or in completing a normal workday without psychological disruption.

No specific support justifying the assessments was provided. A case cannot be decided in reliance on a medical opinion without some reasonable support for the opinion (see SSR 96-2p). Other assessments from treating sources were much better supported.

A Mental Residual Functional Capacity Assessment (Exhibit 1, pp. 59-61, 218-220) dated [redacted], was presented. The assessment was completed by Petitioner's psychiatrist. Petitioner was assessed as having no restriction to remembering simple instructions or remembering work-like procedures. The following marked concentration and persistence restrictions were noted: carrying out detailed instructions, maintaining concentration for extended periods, performing activities within a schedule while maintaining punctuality and attendance, sustaining an ordinary routine without supervision, working in coordination with others, and completing a normal workday without interruption from psychological symptom. Petitioner was deemed to also have marked restrictions in accepting instructions and responding to criticism, getting along with coworkers, responding appropriately to workplace changes, and setting realistic goals. It was noted that Petitioner tried antidepressant agents which may have caused a "malignant state" of bipolar disorder.

A Mental Residual Functional Capacity Assessment (Exhibit 1, pp. 6-9; Exhibit A, pp. 1-4) dated [redacted], was presented. The assessment was completed by a social worker following a meeting on [redacted] [redacted] [redacted]. Marked restrictions to understanding and memory included remembering locations and work-like procedures, understanding and remembering detailed instructions, and understanding and remembering simple instructions. The following marked concentration and persistence restrictions were noted: carrying out detailed or simple instructions, maintaining concentration for extended periods, performing activities within a schedule while maintaining punctuality and attendance, sustaining an ordinary routine without supervision, working in coordination with others, making simple work-related decisions, and completing a normal workday without interruption from psychological symptom. Marked restrictions were also noted concerning responding appropriately to workplace changes, setting realistic goals, getting along with others without behavioral extremes, accepting instructions while responding appropriately, and accepting criticism. Statements supporting the assessment included the circumstances of the death of Petitioner's mother and her physical health problems.

Presented assessments of marked concentration and social interaction restrictions were supported by detailed information of Petitioner's treatment history. The assessments were generally consistent with Petitioner's treatment history. It is found that Petitioner has marked concentration and social interaction restrictions which meet the listing for anxiety disorders

It is found Petitioner meets the listing for anxiety disorders. Accordingly, Petitioner is disabled and it is found that MDHHS improperly denied Petitioner's application for SDA benefits.

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 ;
(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

Petitioner