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: August 4, 2017
MAHS Docket No.: [redacted] 17-004465
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Jacquelyn A. McClinton

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; 42 CFR 431.200 to 431.250. After due notice, a telephone hearing was held on [redacted], from Detroit, Michigan. The Petitioner was represented by Petitioner. The Department of Health and Human Services (Department) was represented by [redacted] Medical Contact Worker.

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of continued eligibility for State Disability Assistance (SDA) benefits?

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. Petitioner was an ongoing recipient of SDA benefits.

2. On [redacted], a Hearing Decision was issued which concluded that Petitioner was disabled and eligible for SDA benefits. Disability Determination Services (DDS)/Medical Review Team (MRT) referred Petitioner's case for medical review in [redacted]

3. In an [redacted] review, DDS/MRT determined on [redacted] that Petitioner's condition had significantly improved and that a physical relating to new allegations found Petitioner able to perform light work. DDS/MRT concluded that Petitioner was no longer disabled.

4. On [redacted], the Department sent Petitioner a Notice of Case Action notifying her that her SDA case would close effective [redacted] because, among other things, she was not disabled.

5. On [redacted], the Department received Petitioner's timely written request for hearing concerning the closure of his SDA case.

6. Petitioner alleged disabling impairment due to depression; headaches; a shunt placed in her head; anxiety; and insomnia.

7. At the time of hearing, Petitioner was 40 years old with a [redacted] birth date; she is 5' 9" in height; and weighs about 222 pounds.

8. Petitioner completed the 11th grade and obtained a GED.

9. Petitioner has an employment history of work as a cashier.

10. Petitioner has a claim pending disability claim with the Social Security Administration.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Health and Human Services Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

A disabled person is eligible for SDA. BEM 261 (July 2014), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment lasting, or expected to last, at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Once an individual has been found disabled, continued entitlement to benefits based on a disability is periodically reviewed in accordance with the medical improvement review standard in order to make a current determination or decision as to whether disability remains. 20 CFR 416.993(a); 20 CFR 416.994(a). If the individual is not engaged in substantial gainful activity (SGA), the trier of fact must apply an eight-step sequential evaluation in evaluating whether an individual's disability continues. 20 CFR 416.994. The review may cease and benefits may be continued at any point if there is sufficient evidence to find that the individual is still unable to engage in SGA. 20 CFR 416.994(b)(5). In this case, Petitioner has not engaged in SGA at any time since she became eligible for SDA. Therefore, her disability must be assessed to determine whether it continues.

An eight-step evaluation is applied to determine whether an individual has a continuing disability:

> **Step 1.** If the individual has an impairment or combination of impairments which meets or equals the severity of an impairment listed in 20 CFR Appendix 1 of subpart P of part 404, the disability will be found to continue. 20 CFR 416.994(b)(5)(i).
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> **Step 2.** If a listing is not met or equaled, it must be determined whether there has been medical improvement as defined in paragraph (b)(1)(i) of 20 CFR 416.994 and shown by a decrease in medical severity. If there has been a decrease in medical severity, Step 3 is considered. If there has been no decrease in medical severity, there has been no medical improvement unless an exception in Step 4 applies. 20 CFR 416.994(b)(5)(ii).
>
> **Step 3.** If there has been medical improvement, it must be determined whether this improvement is related to the individual's ability to do work in accordance with 20 CFR 416.994(b)(1)(i) through (b)(1)(iv); *i.e.*, there was an increase in the individual's residual functional capacity (RFC) based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to the individual's ability to do work, the analysis proceeds to Step 4. If medical improvement *is* related to the individual's ability to do work, the analysis proceeds to Step 5. 20 CFR 416.994(b)(5)(iii).
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> **Step 4.** If it was found at Step 2 that there was no medical improvement or at Step 3 that the medical improvement is not related to the individual's ability to work, the exceptions in 20 CFR 416.994(b)(3) and (b)(4) are considered. If none of them apply, the disability will be found to continue. If an exception from the first group of exceptions to medical improvement applies, the analysis proceeds to Step 5. If an exception from the second group of exceptions to medical improvement applies, the disability is found to have ended. The second group of exceptions to medical improvement

may be considered at any point in this process. 20 CFR 416.994(b)(5)(iv).

Step 5. If medical improvement is shown to be related to an individual's ability to do work or if one of the first group of exceptions to medical improvement applies, **all** the individual's current impairments in combination are considered to determine whether they are severe in light of 20 CFR 416.921. This determination considers all the individual's current impairments and the impact of the combination of these impairments on the individual's ability to function. If the RFC assessment in Step 3 shows significant limitation of the individual's ability to do basic work activities, the analysis proceeds to Step 6. When the evidence shows that all the individual's current impairments in combination do not significantly limit the individual's physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature and the individual will no longer be considered to be disabled. 20 CFR 416.994(b)(5)(v).

Step 6. If the individual's impairment(s) is severe, the individual's current ability to do substantial gainful activity is assessed in accordance with 20 CFR 416.960; i.e., the individual's RFC based on all current impairments is assessed to determine whether the individual can still do work done in the past. If so, disability will be found to have ended. 20 CFR 416.994(b)(5)(vi).

Step 7. If the individual is not able to do work done in the past, the individual's ability to do other work given the RFC assessment made under Step 6 and the individual's age, education, and past work experience is assessed (unless an exception in 20 CFR 416.994(b)(5)(viii) applies). If the individual can, the disability has ended. If the individual cannot, the disability continues. 20 CFR 416.994(b)(5)(vii).

Step 8. Step 8 may apply if the evidence in the individual's file is insufficient to make a finding under Step 6 about whether the individual can perform past relevant work. If the individual can adjust to other work based solely on age, education, and RFC, the individual is no longer disabled, and no finding about the individual's capacity to do past relevant work under Step 6 is required. If the individual may be unable to adjust to other work or if 20 CFR 416.962 may apply, the individual's claim is assessed under Step 6 to determine whether the individual can perform past relevant work. 20 CFR 416.994(b)(5)(viii).

Step One

Step 1 in determining whether an individual's disability has ended requires the trier of fact to consider the severity of the impairment(s) and whether it meets or equals a listed impairment in Appendix 1 of subpart P of part 404 of Chapter 20. 20 CFR

416.994(b)(5)(i). If a listing is met, an individual's disability is found to continue with no further analysis required.

The medical record presented was reviewed and is briefly summarized below.

On [redacted], Petitioner presented at [redacted] for progressively worsening vertex headache after lumbar puncture performed for her bilateral retroorbital headache. Petitioner indicated that both the headaches and blurred vision had worsened over the previous two months. Petitioner was admitted and not discharged until [redacted] Petitioner had a MRI of the brain on [redacted] which was normal. [redacted] consulted with another one of Petitioner's treating physician who determined that Petitioner had significant damage to the optic nerve and visual field as well as significant papilledema.

Petitioner's [redacted] medical records also indicated that she had bilateral central vision loss and a large central scotoma on her visual field testing. The treating physician agreed with the neurosurgery consultation and there was consideration given to VP shunt as next therapeutic step. On [redacted], the VP shunt was inserted.

On [redacted], Petitioner presented at [redacted] in which she reported feeling better, less depressed since being prescribed Pristiq 100 mg but was still anxious. She indicated that she was sleeping better with medication but continued to have headaches and body pains. Petitioner continued to appear for monthly appointments with [redacted] through [redacted]. In most reports, Petitioner continued to report sleeping better. Petitioner complained that her shunt was causing her pain. On [redacted], Petitioner reported being moderately anxious and having mild depression. Petitioner indicated that she slept fairly well, was not suicidal and was sober. By [redacted], Petitioner reported that she was depressed, was experiencing poor sleep, being moderately anxious but not suicidal. Petitioner continued to report feeling anxious. During the [redacted] visit, Petitioner reported being very anxious and depressed after having been denied Social Security benefits.

On [redacted], a CT Head w/IV Contrast was performed with an impression of right frontal approach ventriculostomy shunt catheter appears to project intraparenchymal, however the degree of ventriculomegaly appeared to be improved. There was no evidence of an acute intracranial process.

On [redacted], Petitioner was admitted to [redacted] and discharged the next day. Images of the heart were obtained. There was no evidence of stress-induced ischemia or scar and there was normal ejection fraction. Petitioner was also diagnosed with both cluster headaches and migraine headaches.

Petitioner was admitted to the hospital on [redacted] for observation and was discharged on [redacted]. On [redacted], Petitioner complained of a

malfunction with her shunt. Petitioner indicated that for the previous months, she had been experiencing blurred vision, head pain, unsteadiness on her left and numbness and tingling to her hands and feet. Petitioner further stated that she felt as if the wire in her abdomen from the VP shunt was moving, and occasional dizziness. Following an examination, findings included: right frontal shunting catheter with the tip terminating in the region of the left caudate head was demonstrated. There was a slit like appearance of the left lateral ventricle.

Also on [redacted] Petitioner received a neurosurgery consultation and an ophthalmology consultation. It was determined that no acute neurosurgical intervention was needed. Further, there was no evidence of papilledema noted.

In light of the medical evidence presented, listings 2.02 (loss of central visual acuity) and 12.04 (depressive, bipolar and related disorders) were considered. To achieve a listing under 2.02, an individual's central acuity must be 20/200 or less in the better eye with use of a correcting lens. Because the medical evidence did not establish that Petitioner's central acuity was 20/200 or less, she did not meet a listing under 2.02.

Further, to meet a listing under 12.04, the following is required:

A. Medical documentation of the requirements of paragraph 1 or 2:
    1. Depressive disorder, characterized by <u>five</u> or more of the following:
        a. Depressed mood;
        b. Diminished interest in almost all activities;
        c. Appetite disturbance with change in weight;
        d. Sleep disturbance;
        e. Observable psychomotor agitation or retardation;
        f. Decreased energy;
        g. Feelings of guilt or worthlessness;
        h. Difficulty concentrating or thinking; or
        i. Thoughts of death or suicide.

    2. Bipolar disorder, characterized by <u>three</u> or more of the following:
        a. Pressured speech;
        b. Flight of ideas;
        c. Inflated self-esteem;
        d. Decreased need for sleep;
        e. Distractibility;
        f. Involvement in activities that have a high probability of painful consequences that are not recognized; or
        g. Increase in goal-directed activity or psychomotor agitation.

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 medical record does not reflect that Petitioner has five more of the conditions outlined in 12.04A1 or three or more of the conditions outlined in 12.04B2. Although Petitioner's medical records show that she has a history of depression for at least two years, there were several occasions in which Petitioner indicated that she was less depressed when taking he prescribed medication. Therefore, Petitioner's condition does not meet a listing under 12.04.

Because the medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration, a disability is not continuing under Step 1 of the analysis, and the analysis proceeds to Step 2.

Step Two

If the impairment(s) does not meet or equal a Listing under Step 1, then Step 2 requires a determination of whether there has been medical improvement as defined in 20 CFR 416.994(b)(1). 20 CFR 416.994(b)(5)(ii). Medical improvement is defined as any decrease in the medical severity of the impairment(s) which was present at the time of the most favorable medical decision that the individual was disabled or continues to be disabled. 20 CFR 416.994(b)(1)(i). For purposes of determining whether medical improvement has occurred, the current medical severity of the impairment(s) present at the time of the most recent favorable medical decision that found the individual disabled, or continued to be disabled, is compared to the medical severity of that impairment(s) at the time of the favorable decision. 20 CFR 416.994(b)(1)(vii). If there is medical improvement, the analysis proceeds to Step 3, and if there is no medical improvement, the analysis proceeds to Step 4. 20 CFR 416.994(b)(5)(ii).

The most recent favorable decision finding Petitioner disabled is the [redacted] Hearing Decision which found Petitioner disabled for purposes of the SDA benefits. The medical evidence relied at that point included that Petitioner had mild limitations on her activities of daily living; moderate to marked limitations in her social functioning; marked limitations in her concentration, persistence or pace; and, where her [redacted]

[redacted] hospitalization included a psychiatric consultation, one episode of decompensation.

The evidence presented in connection with this review did show medical improvement in Petitioner's condition from that presented in the [redacted] Hearing Decision, the most recent favorable decision finding Petitioner disabled. Because there was medical improvement, the analysis proceeds to Step 3.

Step Three

If there has been medical improvement, it must be determined whether there is an increase in the individual's residual functional capacity (RFC) based on the impairment(s) that was present at the time of the most recent favorable medical determination. The medical evidence now shows that Petitioner no longer has suicidal thoughts; Petitioner's sleeping had improved; and Petitioner was less depressed when taking her medication as prescribed. As such, there has been a medical improvement in Petitioner's moderate to marked limitations of previous complaints and improvement in episodes of decompensation. Petitioner continued to report that she was unable to perform some activities of daily living and further reported limited social function. Because Petitioner's medical improvement is related to her ability to do work, the analysis proceeds to Step 5. 20 CFR 416.994(b)(5)(iii).

Step 5

Where medical improvement is shown to be related to an individual's ability to do work, **all** the individual's current impairments in combination are considered to determine whether they are severe in light of 20 CFR 416.921. An individual's impairments are not severe only if, when considered in combination, they do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

In this case, Petitioner presented with additional non-exertional conditions which included headaches and loss of vision. Medical evidence supports Petitioner's claims of severe headaches and marked vision loss. A review of the medical evidence cited at Step 1 shows that, taken together, a severe impairment has been established. The evidence presented was sufficient to establish that Petitioner's impairments have more than a minimal effect on her ability to perform basic work activities. Therefore, the impairments are severe, and the analysis proceeds to Step 6.

Step 6

Under Step 6, the individual's RFC based on all current impairments is assessed to determine whether the individual can still do work done in the past. If so, disability will be found to have ended. 20 CFR 416.994(b)(5)(vi).

Limitations can be exertional, non-exertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional

limitations. 20 CFR 416.969a(b). The exertional requirements, or physical demands, of work in the national economy are classified as sedentary (involving lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools and occasionally walking and standing), light (involving lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds, or a good deal of walking or standing, or sitting most of the time with some pushing and pulling of arm or leg controls), medium (involving lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds), heavy (involving lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds), and very heavy (involving lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more). 20 CFR 416.967; 20 CFR 416.969a(a).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only non-exertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2).

In this case, Petitioner began complaining that her vision was becoming more impaired shortly after the shunt was inserted in her brain on [redacted]. Petitioner presented to the hospital on multiple occasions with decreased vision. As previously stated, the medical evidence showed that that Petitioner experienced bilateral central vision loss and a large central scotoma on her visual field testing. Petitioner further testified that she consistently wakes up with headaches which cause blurred vision, dizziness and sensitively to light. Therefore, based on the evidence on the record, including Petitioner's testimony, it is found that Petitioner has additional limitations to her non-exertional RFC that result in an inability to do sustained work because of headaches and loss of vision. Thus the analysis continues to Step 7.

Step 7

Under Step 7, the individual's RFC based on all current impairments is assessed to determine whether the individual can perform work other than that performed in the past. If the individual can, the disability has ended. If the individual cannot, the disability continues. 20 CFR 416.994(b)(5)(vii). Because of substantial non-exertional RFC including frequent and persistent headache resulting in blurred vision and dizziness as well as the deteriorating overall vision, Petitioner is unable to adjust to other work. Department did not present any evidence of other work available for Petitioner to

perform given her limitations. Based on her current non-exertional RFC, Petitioner is unable to do work done in the past or other work. Accordingly, Petitioner is disabled at Step 7, and the analysis ends.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Petitioner **has** a continuing disability for purposes of the SDA benefit program. Therefore, Petitioner's SDA eligibility **continues** and the Department **did not act** in accordance with Department policy when it closed her SDA case.

Accordingly, the Department's determination is **REVERSED**.

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE THE ORDER WAS ISSUED:

1. Reinstate Petitioner's SDA case effective [redacted];

2. Issue supplements to Petitioner for any lost SDA benefits that she was entitled to receive from [redacted] ongoing if otherwise eligible and qualified in accordance with Department policy;

3. Notify Petitioner of its decision in writing; and

4. Review Petitioner's continued SDA eligibility in [redacted] in accordance with Department policy.

JAM/tlf

Jacquelyn A. McClinton
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

Via Email: [redacted]

Petitioner – Via First-Class Mail: [redacted]