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: April 7, 2017
MAHS Docket No.: 17-000848
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, a telephone hearing was held on [redacted] from [redacted] Michigan. Petitioner appeared and was unrepresented. [redacted] Petitioner's case manager from Recovery Technology, testified on behalf of Petitioner. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], manager, and [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 1, pp. 5-16).

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

3. On [redacted], the Disability Determination Service determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 18-24).

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. As of the date of the administrative hearing, Petitioner was a [redacted]-year-old male.

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

8. Petitioner has various degrees of concentration, depression, anxiety, and social interaction restrictions.

9. Petitioner's restrictions would not preclude the performance of past employment as a packager.

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 1, pp. 1-4) 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 $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 documents (Exhibit 1, pp. 56-65) dated [redacted], were presented. It was noted Petitioner presented and reported "I hate being alive and I hate people." It was implied Petitioner presented after hearing a voice encouraging him to commit suicide. A long history of depression and anxiety were reported; Petitioner reported that he hated himself and he thinks 90% of people are stupid. Reported symptoms included sadness, irritability, anhedonia, hopelessness, helplessness, low energy, focus difficulty, sleep difficulty, and poor appetite. It was noted Petitioner had not been taking medications since [redacted]. Mental health assessments included mild irritability, poor eye contact, depressed mood, flat affect, goal-directed thought process, fair concentration, fair insight, and fair judgment. A plan included increasing dosage of Effexor. Seroquel, Vistaril, Ativan, and trazodone. Petitioner also reported chronic back pain; outpatient follow-up for back pain was recommended. Petitioner was deemed stable at discharge. Follow-up was planned on [redacted].

Behavioral treatment agency documents (Exhibit 1, pp. 71-75, 85-86) dated [redacted] was presented. Depression and anxiety were reported by Petitioner. Cannabis

use was deemed as questionably problematic. Mental health assessments included orientation x3, restricted affect, angry and dysthymic mood, and denial of suicidal ideation.

Medical center office visit notes (Exhibit 1, pp. 34-36) dated [redacted], were presented. It was noted that Petitioner presented for a wellness examination. Petitioner was noted to be a “heavy” tobacco smoker. Diagnoses were not stated.

Behavioral treatment agency documents (Exhibit 1, p. 37) dated [redacted], was presented. Diagnoses included major depressive disorder (recurrent with psychotic features), anxiety disorder, and mild cannabis use disorder. Ativan, Effexor, Seroquel, hydroxyzine, and trazodone were noted as active medications.

A Progress Note and PCP Meeting and Treatment Plan (Exhibit 1, pp. 76-85, 88-89) dated [redacted], were presented. Noted plans included case management to assist with pursuing resources, psychiatric services for mood stabilization, and selecting a PCP. Mental health assessments (by a social worker) of Petitioner included orientation x3, appropriate affect, angry and dysthymic mood, no hallucinations, and no suicidal ideation.

Social worker progress notes (Exhibit 1, pp. 90-91) dated [redacted], were presented. Mental health assessments noted a dysthymic mood. Affect was appropriate. Suicidal ideation and hallucinations were noted as not applicable.

Social worker progress notes (Exhibit 1, pp. 92-93) dated [redacted], were presented. Mental health assessments noted a dysthymic, angry, and anxious mood. Affect was appropriate. Suicide ideation and hallucinations were noted as not applicable.

Social worker progress notes (Exhibit 1, pp. 94-95) dated [redacted], were presented. Mental health assessments noted a dysthymic and anxious mood. Affect was appropriate. Suicide ideation and hallucinations were noted as not applicable.

An After Visit Summary (Exhibit A, p. 1) dated [redacted], was presented. Ongoing diagnoses of depression and panic disorder were noted. Current medications included Ativan, Effexor, Seroquel, hydroxyzine, and trazodone.

Petitioner testified he was originally raised by his grandmother. Petitioner testified he believes that his psychiatric problems began when his biological mother began custody of Petitioner when he was [redacted] years-old. Petitioner testified his mother was neglectful and worse. Petitioner testified when he was [redacted] years-old, he attempted to hang himself; Petitioner testified this was his only suicide attempt. Petitioner testified his youthful behaviors included cutting and burning himself. Hospital admission documents noted reported flashbacks of abuse (see Exhibit 1, p. 60). Petitioner reported his mother eventually surrendered custody back to his grandmother when he was [redacted] years-old.

Petitioner testimony alleged various impairments related to chronic back pain. Petitioner testified he is limited to walking of a mile and standing for 2 hours due to back pain. Petitioner estimated he is only capable of sitting 2-3 hours out of 8 hours due to back pain. Petitioner testified he previously used a cane, but no longer uses one. Petitioner testified physical therapy offered little pain relief. Petitioner testified he takes over-the counter Tylenol for pain. Petitioner testified his lower and upper back problems cause him pain in his mid-back. Petitioner also testified he experiences ongoing problems with his right elbow.

Back pain was documented as a complaint in some of Petitioner's psychological records. Little-to-no treatment for back pain, neck pain, and/or right elbow pain was presented. Spinal radiology was not presented. Physical therapy documents were not presented. Due to an absence of medical evidence, it is found that Petitioner failed to establish restrictions related to back and/or elbow pain.

Petitioner testified he does not have hallucinations. Petitioner testified he sometimes confuses dreams with real life.

Petitioner's case manager testified he has seen Petitioner approximate 10 times over the last [redacted] months. Petitioner's case manager testified Petitioner has "extremely high" anxiety about people. Petitioner's case manager testified Petitioner is particularly jittery when Petitioner is around people.

Petitioner testified anxiety, irritability, focus, and dealing with people are ongoing barriers to employment. Petitioner's testimony was consistent with presented records. Treatment documents verified a degree of psychological restrictions that have lasted since at least the date of Petitioner's SDA application. It is found that Petitioner established having a severe impairment and the disability analysis may proceed to the third step.

The third step of the sequential analysis requires determining whether the Petitioner's impairment, or combination of impairments, is listed in 20 CFR Part 404, Subpart P, appendix 1. 20 CFR 416.920 (a)(4)(iii). If a petitioner's impairments are listed and deemed to meet the durational requirement, then the petitioner is deemed disabled. If the impairment is unlisted or impairments do not meet listing level requirements, then the analysis proceeds to the next step.

Petitioner's primary diagnosis was depression and/or bipolar disorder. Both disorders are affective disorders covered by Listing 12.04 which reads as follows:

> **12.04** ***Affective disorders***: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation. The required level of

severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:
1. Depressive syndrome characterized by at least four of the following:
a. Anhedonia or pervasive loss of interest in almost all activities; or
b. Appetite disturbance with change in weight; or
c. Sleep disturbance; or
d. Psychomotor agitation or retardation; or
e. Decreased energy; or
f. Feelings of guilt or worthlessness; or
g. Difficulty concentrating or thinking; or
h. Thoughts of suicide; or
I. Hallucinations, delusions, or paranoid thinking
OR
2. Manic syndrome characterized by at least three of the following:
a. Hyperactivity; or
b. Pressure of speech; or
c. Flight of ideas; or
d. Inflated self-esteem; or
e. Decreased need for sleep; or
f. Easy distractibility; or
g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
h. Hallucinations, delusions or paranoid thinking
OR
3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);
AND
B. Resulting in at least two of the following:
1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration
OR
C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:
1. Repeated episodes of decompensation, each of extended duration; or

> 2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
> 3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

Presented records verified Petitioner has ongoing problems with anhedonia, suicidal ideation, decreased energy, and difficulties with focus. It is found Petitioner sufficiently meets Part A of the listing for affective disorders. The analysis will consider whether Petitioner also meets Part B or C.

Petitioner testified suicidal ideation is a recurrent problem. Petitioner testified he has voluntarily admitted himself at a hospital twice in the last [redacted] months due to suicidal ideation. Petitioner testified he tries to enjoy nature as a coping mechanism for stress and/or depression.

Petitioner testified he took only [redacted] showers in all of [redacted] Petitioner testified he often wears the same clothes for several days.

Petitioner testified he experiences panic attacks “pretty much every day.” Petitioner testified the panic attacks instill a feeling of hopelessness.

Petitioner testified he does not like to be around people. Petitioner testified he hates people “more than anything.” Petitioner testified his hatred of people extends to dealing with them on the telephone.

Petitioner’s testimony was indicative of marked restrictions in social interactions and/or concentration. The testimony was not well supported.

Petitioner testified he has been undergoing psychiatric treatment for several years. Petitioner presented only a few weeks of treatment records. The generally short period of treatment is not indicative of marked psychological restrictions.

The hospital encounter that was verified occurred at a time when Petitioner was not in psychiatric treatment. Presented records generally verified improvement in Petitioner’s condition (e.g. absence of suicidal intent and hallucinations) following hospitalization. This consideration is indicative of less severe restrictions when Petitioner is complaint with treatment.

Petitioner also presented very few records from a psychologist, psychiatrist and/or physician. One assessment from a SSA-utilized physician was not indicative of marked impairments.

MDHHS presented a Psychiatric Review Technique (Exhibit 1, pp. 104-121) dated [redacted]. The assessment was completed by a licensed psychologist. Petitioner was deemed to have moderate concentration and social restrictions. The assessor also determined Petitioner's circumstances did not meet Part C of the affective disorder listing or anxiety disorder listing (Listing 12.06). The assessments were consistent with presented evidence.

A listing for spinal disorders (Listing 1.04) was considered based on Petitioner's lumbar complaints. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root.

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

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

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

Petitioner testified he could not remember his employment history other than work he performed as a packager. Petitioner testified his job was to package speaker brackets. Petitioner testified he was fired due to excessive absences. Petitioner blamed his depression for his absences.

Petitioner testimony implied he could not perform his past employment due to psychological restrictions. Petitioner's testimony does not appear to be well supported. Petitioner's employment was described as reliant more on physical labor rather than social interactions. Presented documentation did not establish psychological restrictions which would cause excessive absences, as long as Petitioner was medication compliant.

It is found Petitioner is capable of performing past employment. Accordingly, Petitioner is not disabled and it is found that MDHHS properly denied Petitioner SDA application.

DECISION AND ORDER

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

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]