STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: April 20, 2017
MAHS Docket No.: 17-001594
Agency No.: [redacted]

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned administrative law judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10; and Mich Admin Code, R 792.11002. After due notice, an in-person hearing was held on March 20, 2017, from Port Huron, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted] specialist.

ISSUE

The issue is whether MDHHS properly terminated 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. Petitioner was an ongoing SDA benefit recipient.

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

3. On [redacted], Disability Determination Services determined that Petitioner was not a disabled individual for purposes of SDA eligibility (see Exhibit 1, pp. 1-8).

4. On [redacted], MDHHS terminated Petitioner's eligibility for SDA benefits, effective February 2017.

5. On [redacted], Petitioner requested a hearing disputing the termination of SDA benefits.

6. MDHHS did not establish Petitioner medically improved.

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. 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 (July 2015), p. 1. A person is disabled for SDA purposes if he [or she]:

- Receives other specified disability-related benefits or services…, 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., pp. 1-2.

Generally, state agencies such as MDDHS must use the same definition of disability as used under SSI regulations (see 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. 20 CFR 416.905. MDHHS adopted a functionally identical definition of disability (see BEM 260 (July 2015, p. 10)). The definition of SDA disability is identical except that only a 90 day period of disability is required.

Substantial gainful activity 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. BEM 260 (July 2015), p. 10. 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 substantial gainful activity. *Id*.

Once an individual has been found disabled for purposes of disability-related benefits, continued entitlement is periodically reviewed in order to make a current determination or decision as to whether disability remains in accordance with the medical improvement review standard. 20 CFR 416.993(a); 20 CFR 416.994.

It was not disputed that MDHHS terminated Petitioner's SDA eligibility due to a determination that Petitioner was no longer disabled. The only issue to be determined is if MDHHS properly determined Petitioner to no longer be disabled.

In evaluating a claim for ongoing disability benefits, federal regulations require a sequential evaluation process be utilized. 20 CFR 416.994(b)(5). The review may cease and benefits continued if sufficient evidence supports a finding that an individual is still unable to engage in substantial gainful activity. *Id.* Prior to deciding if an individual's disability has ended, the department will develop, along with the petitioner's cooperation, a complete medical history covering at least the 12 months preceding the date the individual signed a request seeking continuing disability benefits. 20 CFR 416.993(b). The department may order a consultative examination to determine whether or not the disability continues. 20 CFR 416.993(c).

The below-described evaluation process is applicable for clients that have not worked during a period of disability benefit eligibility. There was no evidence suggesting that Petitioner received any wages since receiving disability benefits.

The first step in the analysis in determining the status of a petitioner's disability 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 and no further analysis is required. This consideration requires a summary and analysis of presented medical documents.

The focus at this step will be on Petitioner's more recent medical records- specifically, those from 2015 through the present. The analysis will begin with a summary of Petitioner's internal medicine records.

Physician office visit notes (Exhibit 1, pp. 98-101) dated [redacted], were presented. It was noted that Petitioner reported ongoing reflux and indigestion. A previously performed EGD was noted to be negative. An ongoing diagnosis of GERD was noted.

Physician office visit notes (Exhibit 1, pp. 128-131) dated [redacted], were presented. Ongoing GERD and hernia treatment was noted.

Hospital procedural notes (Exhibit 1, pp. 125-126) dated [redacted], were presented. It was noted Petitioner underwent an esophagogastroduodenoscopy. Findings included mild gastritis and mild duodenitis.

Physician office visit notes (Exhibit 1, pp. 128-131) dated [redacted], were presented. Ongoing problems included depression, anxiety, tobacco use, pleural effusion, GERD, hernia, and dyspepsia. An endoscopy was planned.

Physician office visit notes (Exhibit 1, pp. 95-97) dated [redacted], were presented. It was noted that Petitioner appeared for an annual physical. Diagnoses included vaginitis, esophagitis, tinea corporis, pelvic pain, and anxiety.

Hospital procedural notes (Exhibit 1, pp. 123-124) dated [redacted], were presented. It was noted Petitioner underwent an esophageal manometry. A generally normal interpretation was noted.

Physician assistant office visit notes (Exhibit 1, pp. 9-15) dated [redacted], were presented. Complaints of chronic heartburn, nausea, and abdominal pain were noted. It was noted Petitioner began receiving Vitamin D and B-12 injections. Lipitor was noted as recently started. Ongoing physical problems included unspecified abdominal pain, hyperlipidemia, vitamin deficiencies, ulcer without bleeding, and duodenitis. Medication was prescribed for abdominal pain.

Physician assistant office visit notes (Exhibit 1, pp. 16-23) dated [redacted], were presented. Ongoing abdominal pain was reported. Various medications were prescribed. A PHQ score of 7 (mild depression) was noted. It was noted Petitioner had no new complaints.

Presented documents verified an internal medicine treatment history for various acute problems (e.g. tinea corporis, vaginitis, ulcer…). None of the acute problems will be considered as causing any restrictions.

Ongoing treatment for GERD was verified. Digestive listings (Listings 5.00) were considered. Petitioner does not meet any SSA listings.

Petitioner testified she is awaiting cardiac results in response to complaints of heart palpitations. No cardiac treatment was verified.

It is found Petitioner failed to present evidence of meeting a SSA listing based on physical problems. The analysis will proceed to consider whether Petitioner meets any listing for psychological disorders.

Medication review notes (Exhibit 1, pp. 73-74) dated [redacted], were presented. Petitioner reported thinking about an unstated trauma after recently talking with her son. Lamictal, Xanax, and Seroquel were continued.

Medication review notes (Exhibit 1, pp. 71-72) dated [redacted], were presented. Petitioner reported improvement in mood due to change of seasons. Lamictal, Seroquel, and Xanax were continued.

Medication review notes (Exhibit 1, pp. 69-70) dated [redacted], were presented. Petitioner reported keeping busy with reading and chores. Seroquel and Xanax were continued. A plan of eventually starting Lamictal was noted.

Medication review notes (Exhibit 1, pp. 67-68) dated [redacted], were presented. Petitioner reported ongoing anxiety and stressors. Reported symptoms included consuming thoughts, high anxiety, feeling overwhelmed, thoughts of being "better off dead", thoughts off self-harm, and racing thoughts. Mental exam assessments included flat affect, guarded conversation, fair insight, and fair judgment. Lamictal was prescribed; other meds were continued.

Medication review notes (Exhibit 1, pp. 65-66) dated [redacted], were presented. Petitioner reported stress in driving 128 miles per day to transport her adult son to work. Petitioner reported racing thoughts when trying to sleep. Mental exam assessments included 5/10 mood, fair judgment, and fair insight. Medications were continued.

Medication review notes (Exhibit 1, pp. 63-64) dated [redacted], were presented. Petitioner reported ongoing life stressors including boyfriend problems, disrupted sleep in transporting her so to and from work, and forgetting medication. Petitioner reported forgetting to take Lamictal as prescribed. Mental exam assessments by a nurse practitioner included a self-described "testy" mood, fair insight, and fair judgment.

Medication review notes (Exhibit 1, pp. 61-62) dated [redacted], were presented. Petitioner reported improved sleep. Petitioner reported to being able afford to leave living situation. Observations of Petitioner included flat affect, good eye contact, fair judgment, and fair insight.

Medication review notes (Exhibit 1, pp. 59-60) dated [redacted], were presented. Petitioner reported increased depression and stress, primarily due to living situation. Petitioner reported exhaustion and crying episodes. Observations of Petitioner included flat affect, good eye contact, fair judgment, and fair insight.

Medication review notes (Exhibit 1, pp. 57-58) dated [redacted], were presented. Petitioner reported increased depression and stress, primarily due to living situation. Observations of Petitioner included not conversational, limited judgment, and limited insight. Lamictal was increased.

Medication review notes (Exhibit 1, pp. 54-56) dated [redacted], were presented. Petitioner reported various family stressors. Observations of Petitioner included flat affect, unpressured speech, limited judgment, and limited insight. Medications were continued.

Medication review notes (Exhibit 1, pp. 51-53) dated [redacted], were presented. Observations of Petitioner included flat affect, unpressured speech, limited judgment,

and limited insight. Petitioner reported feeling trapped in current living situation with a boyfriend.

Medication review notes (Exhibit 1, pp. 49-50) dated [redacted]2016, were presented. Tearfulness and flat affect were noted. Lamictal was increased due to anticipation of depression worsening due to holidays.

Medication review notes (Exhibit 1, pp. 46-48) dated [redacted], were presented. Vitamin supplements were prescribed to address reported exhaustion. It was noted Petitioner considered a return to work. Increased Xanax usage due to stress was reported. Petitioner reported feeling trapped due to stressful living situation with boyfriend. Lamictal was increased. Seroquel and Xanax were continued.

Medication review notes (Exhibit 1, pp. 44-45) dated[redacted], were presented. It was noted Petitioner reported difficulty remembering to take medicine and vitamins in the morning. Petitioner reported ongoing exhaustion despite recent vitamin supplements. Petitioner reported feeling overwhelmed and depressed, in part, due to taking care of boyfriend with cancer. Observations of Petitioner included flat affect, focused, and reality-based. Limited-to-fair insight and judgment were noted. Ongoing psychological diagnoses included bipolar disorder (Type I), PTSD, and borderline personality disorder. Medication compliance was discussed.

Petitioner's psychological treatment history was most notable for anxiety. Anxiety disorders are covered by Listing 12.06, which reads as follows:

> **12.06** ***Anxiety-related disorders***: In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders.
>
> 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 both A and C are satisfied.
>
> A. Medically documented findings of at least one of the following:
> 1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:
> a. Motor tension; or
> b. Autonomic hyperactivity; or
> c. Apprehensive expectation; or
> d. Vigilance and scanning; or
> 2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or
4. Recurrent obsessions or compulsions which are a source of marked distress; or
5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;

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. Resulting in complete inability to function independently outside the area of one's home.

Petitioner testified she sees a therapist twice per month. Petitioner testified she has seen her psychiatrist (she's actually her nurse practitioner) for the last 1 ½ years. Petitioner testified she has been taking medication since 2007.

Petitioner testified she is not social. Petitioner testified she has a boyfriend, but he is verbally abusive. Petitioner testified she stays in her room on most days. Petitioner testified she occasionally goes to the store and drives herself to medical appointments.

Petitioner testified she is in a "black hole" that she is unable to leave. Petitioner testified she is unable to focus on any single activity. Petitioner testified that she has recurrent racing thoughts. As an example, Petitioner testified she tried to work as a food preparer, but was fired after 3 days.

Petitioner's testimony was generally indicative of marked restrictions to concentration and social function. Presented records were highly lacking for multiple reasons.

All presented medication reviews were performed by a nurse practitioner. The documents have a significant obstacle in finding that presented evidence justifies a finding of meeting the listing for anxiety disorders.

SSR 06-03p provides guidance on what SSA accepts as "acceptable medical sources". Licensed physicians and licensed or certified psychologists are acceptable medical sources. Nurse practitioners and social workers are not "acceptable medical sources". SSR 06-03p goes on to state why the distinction between medical sources and non-medical sources is important.

> First, we need evidence from "acceptable medical sources" to establish the existence of a medically determinable impairment. Second, only "acceptable medical sources" can give us medical opinions. Third, only "acceptable medical

sources" can be considered treating sources, as defined in 20 CFR 404.1502 and 416.902, whose medical opinions may be entitled to controlling weight.

Diagnoses of depression and anxiety were documented by internal medicine physicians in recent records and by psychologists and psychiatrists in records from before 2015. It can be inferred that Petitioner has some degree of ongoing obstacles, based on Petitioner's treatment history and the nature of her disorders. The severity of Petitioner's psychological obstacles, based on recent treatment records, is less clear.

Disability based on psychological disorders are often supported by psychiatric evaluations. No such evaluation was presented.

Mental health treatment records typically provide a global assessment functioning (GAF) level. A GAF is very insightful numeric assessment into a patient's functioning level. A GAF since 2013 was not provided.

Degrees of restrictions are sometimes documented on assessments of residual functional capacity. No such assessments were provided.

Presented evidence was not necessarily inconsistent with meeting SSA levels, however, it was insufficient to support finding that Petitioner has marked psychological restrictions. It is found Petitioner failed to establish meeting any SSA listings. Accordingly, the analysis may proceed to the second step.

The second step of the analysis considers whether medical improvement occurred. 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).

MDHHS presented a Medical-Social Eligibility Certification (Exhibit 1, pp. 530-531) dated [redacted]. The document verified that MDHHS approved Petitioner's claim of disability.

MDHHS presented a Medical-Social Eligibility Certification (Exhibit 1, pp. 143-144) dated [redacted]. The document verified that MDHS approved Petitioner's ongoing claim of disability.

Presented disability certifications did not explain the basis of approval for Petitioner's claim of disability, though MDHHS presented medical records that were considered in the disability findings. The analysis will undertake a summary of presented treatment records from 2014 and earlier used in the disability determinations.

Various internal medicine records from 2014 and earlier (Exhibit 1, pp. 102-113, 150-213, 777-1079) were presented. Various treatments for abdominal pain, cardiac palpitations, pericardial effusion, bloating, recurring vaginal infections, breast implant

complications, and constipation were noted. A 30+ history of smoking was noted (see Exhibit 1, p. 192). In April 2013, normal Spirometry results were noted. In May 2013, cardiac testing was negative for ischemia and noted normal sinus rhythm (see Exhibit 1, pp. 189-190). An ejection fraction of 62% was noted.

Past treatment records were indicative that previous determinations of disability were related to physical problems. This conclusion is consistent with more recent records which also failed to verify any recurrent physical problems which would restrict Petitioner's work abilities.

Past treatment records were not indicative of work restrictions. More recent treatment records were not indicative of work restrictions. Concerning physical and/or exertional restrictions, medical improvement appears to be irrelevant. The analysis will proceed to evaluate improvement based on Petitioner's psychological function.

Various psychological treatment records from 2014 and earlier (Exhibit 1, pp. 75-92, 228-412, 540-773) were presented. Regular complaints of anxiety, depression, and stress were documented. Ongoing psychiatric treatment was documented.

In June 2013, a psychiatrist evaluated Petitioner's GAF to be 40 (see Exhibit 1, pp. 230). Petitioner's psychiatrist also determined Petitioner had marked restrictions to maintaining concentration for extended periods, maintaining a work schedule, working in coordination with others, completing a normal workday without psychological interruption, interacting with the public, responding to workplace changes, and setting realistic goals (see Exhibit 1, pp. 231-232). Diagnoses of bipolar disorder and PTSD were stated.

The most recent verified GAF was 35. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF level from 31-40 is described as "some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood."

Petitioner testified she has a history of suicide attempts. Petitioner testified she last attempted suicide in 2010 when she overdosed on medications. Petitioner testified the corresponding hospitalization lasted 3-4 days. Petitioner testified her stomach was pumped around 2008 when she also attempted suicide by overdosing on medication; Petitioner testified the resulting hospitalization lasted approximately 12 days. Petitioner testimony estimated a history of 4-5 psychological hospitalizations.

Petitioner testified she has not attempted suicide in the last 5 years. Presented records documented feelings of hopelessness (e.g. feeling better-off dead), but no suicidal ideation or attempts. The lack of recent suicide attempts and/or documented suicidal ideation could be inferred as medical improvement. Petitioner denied any improvement in her psyche despite a lack of suicide attempts.

Petitioner's recently reported psychological complaints generally mirror her past psychological complaints. Petitioner's insight and judgment varied from fair-to-impaired, similar to older records. There has been no notable changes in medication. There have been no apparent reductions in symptoms severity.

As noted in the first step of the analysis, recent treatment records were not particularly insightful into evaluating Petitioner's psyche. The absence of a recent GAF, psychiatric evaluation, and/or mental residual functional capacity assessment renders a current finding of disability to be challenging. The same is true in finding of medical improvement. Petitioner's more recent treatment history is not sufficiently insightful to evaluated Petitioner's psychological progress.

It is found that MDHHS failed to establish medical improvement. Accordingly, the analysis may proceed directly to the fourth step.

Step 4 of the analysis considers whether any exceptions apply to a previous finding that no medical improvement occurred or that the improvement did not relate to an increase in RFC. 20 CFR 416.994(b)(5)(iv). If medical improvement related to the ability to work has not occurred and no exception applies, then benefits will continue. CFR 416.994(b). Step 4 of the disability analysis lists two sets of exceptions.

The first group of exceptions allow a finding that a claimant is not disabled even when medical improvement had not occurred if it is established that the claimant can engage is substantial gainful activity. The exceptions are:

(i) Substantial evidence shows that the individual is the beneficiary of advances in medical or vocational therapy or technology (related to the ability to work;
(ii) Substantial evidence shows that the individual has undergone vocational therapy related to the ability to work;
(iii) Substantial evidence shows that based on new or improved diagnostic or evaluative techniques the impairment(s) is not as disabling as previously determined at the time of the most recent favorable decision;
(iv) Substantial evidence demonstrates that any prior disability decision was in error.
20 CFR 416.994(b)(1)(3)

The second group of exceptions also allow a finding that a claimant is not disabled when medical improvement has not occurred. The exceptions do not require a showing that a claimant can engage is substantial activity. The exceptions are:

(i) A prior determination was fraudulently obtained;
(ii) The individual failed to cooperate;
(iii) The individual cannot be located;
(iv) The prescribed treatment that was expected to restore the individual's ability to engage in substantial gainful activity was not followed.
20 CFR 416.994(b)(4)

There was no evidence that any of the above exceptions are applicable. It is found that Petitioner is still a disabled individual. Accordingly, it is found that MDHHS improperly terminated Petitioner's SDA eligibility.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that MDHHS improperly terminated Petitioner's eligibility 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 eligibility, effective February 2017;
(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 no less than twelve months from the date of this administrative decision, if Petitioner is found eligible for future benefits.

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

CG/hw

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

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

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

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

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

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

DHHS

[redacted]

Petitioner

[redacted]