STATE OF MICHIGAN
RICK SNYDER
GOVERNOR
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: January 30, 2018
MAHS Docket No.: 17-013974
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, an in-person hearing was held on January 2, 2018, from Monroe, 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 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 January 26, 2017, Petitioner applied for SDA benefits.

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

3. On October 9, 2017, the Disability Determination Service (DDS) determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 10-40).

4. On October 12, 2017, MDHHS denied Petitioner's application for SDA benefits.

5. On October 20, 2017, Petitioner requested a hearing disputing the denial of SDA benefits (see Exhibit 1, pp. 2-3).

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 [redacted]-year-old female.

8. Petitioner has persistent skin lesions ongoing for at least 3 months, despite prescribed treatment.

## 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 requested a hearing to dispute the denial of a 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. 5-8) dated October 12, 2017, 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.

Petitioner alleged that she was disabled (i.e., certified as unable to work for at least 90 days). Petitioner alleged no other basis for SDA eligibility.

Generally, state agencies must use the same definition of disability as used for Supplemental Security Income (SSI) (see 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. The remainder of the analysis considers the specific disability evaluation set forth by federal SSI regulations.

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In general, you have to prove … that you are blind or disabled. 20 C.F.R. § 416.912(a). You must inform us 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 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 2017 monthly income limit considered SGA for non-blind individuals is $[redacted]

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, we 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, we 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).

If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. 20 C.F.R. § 416.920 (5)(c). We will not consider your age, education, and work experience. *Id*. The second step analysis will begin with a summary of presented medical documentation and Petitioner's testimony.

Physician office visit notes (Exhibit A, pp. 186-192, 441-446, 512-519) dated [redacted], were presented. It was noted Petitioner had not seen a primary care physician (PCP) since [redacted] Petitioner was referred to ophthalmology for complaints of "floaters" in eyes. Petitioner was referred to dermatology for complaints of rash. Keflex was prescribed for nose rash. Petitioner was referred to headache clinic for complaints of headache. Lab work was planned and performed on [redacted] (see Exhibit 1, pp. 457-473).

Physician office visit notes (Exhibit A, pp. 193-196, 447-452, 520-523) dated [redacted] were presented. ANA testing was noted to be positive. It was noted Petitioner complained of fevers, though it was noted her body temperature was 96-97 degrees. It was noted Petitioner brought a bag of hair, the contents of which reportedly was coming out of her skin. It was noted Petitioner's skin showed numerous excoriated papules. "Numerous" hyper pigmented macules were noted to be consistent with post-inflammatory hyperpigmentation. Skin lesions were noted to be consistent with pruigo nodularis resulting from chronic scratching and/or picking. A possible neurotic component was noted (Petitioner testimony specifically denied scratching or picking her skin). Various medications were prescribed. A diagnosis of rosacea was noted; it was also noted Petitioner disputed the diagnosis and contended that she had cellulitis. Follow-up with a PCP was recommended rather a return visit.

A health record (Exhibit 1, pp. 474-475) dated [redacted], was presented. Diagnoses included nose cellulitis, chronic migraines, and pilonidal cyst.

Physician office visit notes (Exhibit 1, p. 196, 378) dated [redacted], were presented. Petitioner reported vision floaters, ongoing for two months. An impression of posterior vitreous detachment (PVD) OS was noted. No treatment was apparent, but it was noted that the natural history of PVD was discussed. Follow-up in a year was planned. Petitioner reported to a skin specialist that she had vitreal detachments in both eyes and was legally blind in left eye (see Exhibit 1, p. 197).

Urgent care office visit notes (Exhibit 1, pp. 42-47) dated [redacted], were presented. A complaint of a sudden and spreading nose and body rash, ongoing 2-3 days, was noted. Diagnoses included cellulitis of external nose, and chronic migraines. It was noted Petitioner reported cellulitis was worsening and requested more antibiotics. Keflex was prescribed.

Urgent care office visit notes (Exhibit 1, pp. 88-93) dated [redacted], were presented. The documents functionally mirrored notes dated [redacted]. Cellulitis was later noted to be “resolved” (see Exhibit 1, p. 100).

Physician office visit notes (Exhibit 1, pp. 197-198, 379-383, 452-456) dated [redacted] were presented. Petitioner reported topical cream has helped get bone flecks out of skin. Petitioner reported fatigue due to medication. Petitioner reported balance problems, ongoing for 3 months. A depression screening was negative though anxiety was noted. Medication was prescribed for allergies and headaches. A physical therapy (PT) evaluation was planned in response to balance complaints. RICE was recommended for bicep tendinopathy; Petitioner declined imaging.

An internal medicine examination report (Exhibit 1, pp. 99-108, 423-432) dated [redacted] was presented. The report was noted as completed by a consultative physician. Petitioner reported fatigue, exhaustion, mental fogginess, low immunity, migraine headaches, a history of falls, vision changes, resolved cellulitis, bilateral knee pain, right shoulder bursitis, neck pain, and bilateral hand tendinitis. Petitioner reported a lupus diagnosis based on recent blood testing. Tandem walk, toe walk, and heel walk were noted as performed. A normal gait was noted. Multiple non-draining lesions were noted on Petitioner’s face, abdomen, and buttocks; numerous severe excoriated areas on Petitioner’s legs were also noted. Reduced ranges of motion were noted in right shoulder abduction (100°- normal 150°), right shoulder forward elevation (100°- normal 150°) and other right shoulder movements. Cervical spine and bilateral knee ranges of motion were normal. Petitioner was noted capable of sitting and standing, without any stated restrictions. Climbing stairs was assessed as slow and difficult for Petitioner. Impressions included lupus with fatigue, chronic migraines, pruigo nodularis, bilateral knee pain, right shoulder bursitis, vision abnormalities, and balance abnormalities.

A PT evaluation (Exhibit 1, pp. 384-389) dated [redacted], were presented. Slight right shoulder motion limits were noted due to a fall on [redacted]. Impressions of recurrent falls, right shoulder pain, and impaired static balance were noted. Skilled PT was planned to address deficits.

Various PT notes (Exhibit 1, pp. 395-405) from [redacted] were presented. On [redacted], it was noted that Petitioner reported 3/10 right shoulder pain; balance activities were performed. On [redacted], it was noted that Petitioner fell over the weekend; struggle with high balance activities was noted. On [redacted] it was noted that orthostatic hypotension, motion sensitivity, headaches, anxiety, and vision issues contributed to balance problems. On [redacted], it was noted Petitioner required "prolonged rest breaks" for activities; left-sided strength and additional PT was recommended for improving gait. On [redacted], it was noted Petitioner reported a sore shoulder though it was "much improved" since beginning therapy. On [redacted], improved coordination and difficulties with use of trekking poles were noted. On [redacted], improved balance reactions and mild instability with ambulation were noted.

A mental status examination report (Exhibit 1, pp. 95-98, 433-436) dated [redacted] was presented. The report was noted as completed by a consultative licensed psychologist. Petitioner reported anxiety and depression related to health concerns. Reported psychological symptoms included sadness, crying spells, nervousness, and excessive worrying. Noted observations of Petitioner made by the consultative examiner include the following: low mood, clear and logical speech, subdued affect, intact insight, intact judgment, and indecisiveness. Diagnoses included unspecified depression and generalized anxiety. A fair-to-guarded prognosis was noted. Outpatient mental health services were recommended. The examiner opined that employment did not seem to be a viable option due to health concerns.

Emergency room documents (Exhibit 1, pp. 409-412) dated [redacted], were presented. It was noted that Petitioner presented with pain related to a recently treated buttocks abscess. A complaint of dry cuticles was also noted. Petitioner declined pain medication. A warm compress and PCP follow-up were recommended.

A neurosurgeon letter (Exhibit 1, pp. 1-2) dated [redacted], was presented. Treatment for a 3-4 mm pituitary lesion was noted; a diagnosis of a cyst or microadenoma was noted. Multiple scabs on Petitioner's arms and abdomen were noted. Normal muscle strength was noted. It was noted further neurosurgeon appointments were not needed as there was no apparent endocrine or surgical pathology.

Various black and white photos (Exhibit 1, pp. 120-129, 134-181) were presented. Dates of photographs were not indicated. Petitioner testimony implied that the photos were taken recently (perhaps within the past 12 months). The photos appeared to show numerous marks on Petitioner's buttocks, abdomen, legs, and face.

Petitioner testified she was in a car accident in [redacted]. Petitioner testified the accident happened after she blacked-out while driving. Petitioner's testimony implied that the accident is relevant to current diagnoses.

Petitioner testified she could not perform past employment as a software engineer because of sitting restrictions, poor vision, and a lack of concentration. Petitioner testified she quit past employment as a financial advisor because of ongoing problems with organization and forgetfulness.

Petitioner testified she has difficulty with concentration and/or "brain fog". As an example, Petitioner testified she has problems with simple math even though she had a minor in mathematics. Petitioner also testified she quit employment from the past 15 years after temporarily losing a check.

Petitioner testified she has ongoing imbalance problems. Petitioner testified she fell on her right shoulder on [redacted]. Petitioner testified that PT helped, but she stopped attending due to recurrent illness reportedly due to a weakened immune system. Petitioner testified that she has not been diagnosed with an illness explaining her imbalance.

Petitioner testified she has vision problems, in part, due to floaters. Petitioner testified she has 20/20 vision in her left eye, though close-up reading is difficult. Petitioner testified that her eyes are sensitive to light. Petitioner testified that her physician is waiting a year before surgery is attempted.

Petitioner testified she has recurring migraine headaches 2-3 times per week. Petitioner testified that neurology testing was negative and there is no known explanation for her headaches.

Petitioner testified she injured her left knee in [redacted] and her right knee in [redacted] Petitioner testified she has ongoing bilateral knee pain.

Petitioner testified she lives in a residence which is compliant with the Americans with Disabilities Act. Petitioner testified she has used a cane since [redacted]. Petitioner testimony estimated she can walk ¼ of a mile before stopping. Petitioner testified she can stand 10-15 minutes without being fatigued. Petitioner testimony estimated she can sit for 30 minutes. Petitioner testified she has no lifting restrictions.

Petitioner testified that showering is painful because of skin lesions. Petitioner testified that dressing is difficult because of right shoulder pain. Petitioner testified that laundry is difficult due to kneeling. Petitioner testified she stopped driving in [redacted] due to sitting difficulties. Petitioner testified shopping is difficult due to a weakened immune system and concentration difficulties. Petitioner testified she sleeps 10 hours per day.

Presented medical records generally verified a medical treatment history consistent with exertional restrictions due to vision, skin lesions, imbalance, and shoulder pain.

Presented records also generally verified degrees of concentration restrictions due to physical problems. 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, we also consider the medical severity of your impairment(s). 20 C.F.R. § 416.920 (4)(iii). If you have an impairment(s) that meets or equal one of our listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, we will find that you are disabled. *Id*. If you have an impairment(s) which meets the duration requirement and is listed in appendix 1 or is equal to a listed impairment(s), we will find you disabled without considering your age, education, and work experience. *Id*. 20 C.F.R. § 416.920 (d).

Petitioner's primary complaint appeared to be chronic skin lesions. Petitioner testified the closest diagnosis is chronic pilonidal disease. A consultative physician diagnosed Petitioner with prurigo nodularis. Symptoms for dermatitis closely resemble Petitioner's complaints such that consideration of the SSA listing for dermatitis is appropriate.

> **8.05 *Dermatitis*** (for example, psoriasis, dyshidrosis, atopic dermatitis, exfoliative dermatitis, allergic contact dermatitis), with extensive skin lesions that persist for at least 3 months despite continuing treatment as prescribed.

Petitioner testified she's had recurrent skin lesions since [redacted] Petitioner testified her skin is better than it was in 2010, but still very problematic. Compared to [redacted] Petitioner testified that her lesions are smaller, but the area of lesions has expanded. Petitioner testified that she keeps the bone and hair that is pushed-out of her skin. Petitioner testified she thinks a previous surgery is related to the lesions. Petitioner testified that the lesions are very itchy. Petitioner testified she spends 8-12 hours on bad days debriding her lesions; Petitioner testified that 3-4 days per week are bad days. Petitioner's testimony was highly indicative of meeting listing requirements.

Presented documents seemed atypical given Petitioner's complaints. Given Petitioner's reported symptoms, regular dermatologist treatments would be expected; no such records were apparent.

Petitioner testimony implied an ongoing skin problem for several years. Given Petitioner's testimony, a lengthy treatment history and fairly certain diagnosis would be expected. Petitioner presented a handful of treatment records from [redacted] none of which provided a certain diagnosis.

Presented medical records also verified "numerous" excoriated macules in [redacted]. Treatment for nose cellulitis followed in [redacted]. Multiple non-draining lesions and numerous severe excoriated areas throughout Petitioner's body were noted by a consultative examiner in [redacted]. Buttocks abscess treatment was noted in

[redacted]. A pituitary lesion with noting of multiple skin lesions occurred in [redacted].

Overall, Petitioner's presented medical records were unusual, though consistent with Petitioner's testimony implying that skin lesions are extensive and persistent. Presented records were also sufficiently consistent with finding that Petitioner was complaint with prescribed treatments.

It is found that presented medical records sufficiently established extensive skin lesions occurring for at least 3 months despite prescribed treatment. Thus, Petitioner meets the listing for dermatitis and is a disabled individual. Accordingly, it is found that MDHHS improperly denied Petitioner's SDA application.

## DECISION AND ORDER

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

(1) reinstate Petitioner's SDA benefit application dated January 26, 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 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/

**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]