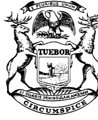


STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

Date Mailed: June 28, 2018
MAHS Docket No.: 18-003949
Agency No.:
Petitioner: .

ADMINISTRATIVE LAW JUDGE: Vicki Armstrong

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 May 30, 2018, from Lansing, Michigan. Petitioner personally appeared and testified.

The Department of Health and Human Services (Department) was represented by Eligibility Specialist Martha Sherman and Assistance Payment Supervisor Rose Ward. Ms. Sherman and Ms. Ward testified on behalf of the Department. The Department submitted 472 exhibits which were admitted into evidence. The record was closed at the conclusion of the hearing.

ISSUE

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

FINDINGS OF FACT

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

1. On September 18, 2017, Petitioner applied for SDA. [Hearing Summary].

2. On February 24, 2018, the Medical Review Team denied Petitioner's SDA application. [Dept. Exh. 41-47].

3. Petitioner is diagnosed with epilepsy, traumatic brain injury, febrile seizures, tonic-clonic seizures, headaches, hypertension and pre-glaucoma.

4. Petitioner presented to neurology for a follow-up on August 25, 2015. He had several seizures on August 1, 2015, and a neighbor called an ambulance for him. While in the emergency department, he was observed to have 5-6 tonic-clonic seizures within one hour. The attending physician consulted with a neurologist who recommended Petitioner be transferred to Butterworth Hospital for a neurology consultation. Petitioner had no seizures during the night but had a tonic-clonic seizure while in his room in the hospital on August 2, 2015. The MRI of Petitioner's brain was negative for acute changes, but he had some white matter changes that may represent sequela of chronic small vessel ischemia. He was discharged home in stable condition on August 4, 2015. In February 2015, he was in the emergency department for chest pain when he had a seizure witnessed by the provider. Petitioner was scheduled for a follow-up with neurology in May 2015, but never went. Petitioner has a history of febrile seizures and attended special education while in school. He has sustained multiple head injuries from several car accidents and dirt bike accidents while not wearing a helmet. He has a traumatic brain injury. He went through two windshields and a sunroof in car accidents. He was in the Intensive Care Unit for 5 days in 1993 because of a car accident that he does not remember. During the follow up on December 2, 2016, Petitioner reported he continues to have frequent seizures. He reported recently house sitting where he had two seizures and called 911. Petitioner woke up and the police were around him, one of which told him he had 10 seizures before the arrival of the ambulance, but he did not remember the ambulance arriving. He did not end up going to the hospital. Petitioner indicated that he is having nocturnal seizures at least once or twice a week. He lives in a camper and knows he has a seizure because he wakes with some sort of injury since there is not much room in there. Sometimes he has urinary incontinence or bites his tongue or cheek. At times his right hand starts shaking and twitching before his seizures. He often forgets to take his Dilantin and his nighttime dose of Keppra. He stated he does much better with taking medications in the morning. He drinks alcohol daily. Petitioner complains of double and blurred vision frequently. He sees flashes of lights in his peripheral vision. He has problems with balance. He feels he falls toward the right. He has memory issues and forgets little things. This has gotten worse over the past several months. He has headaches on a daily basis with the pain is throbbing on the left side. He has photophobia. He has a tremor. Petitioner states he has a hard time holding coffee. He also struggles with using a screwdriver due to his tremor. Petitioner states that he cannot drive and has a hard time getting his medications from the pharmacy. He also has no money and no income. He ran out of propane, so now he has no heat. He has filed for disability. [Dept. Exh. 3-7].

5. On August 1, 2016, a CT of Petitioner's head showed no evidence of intracranial abnormalities with a curvilinear region of increased density within the frontal lobe which most likely represents a developmental venous abnormality. The MRI of the brain revealed a white matter change within the right periatrial white matter which was nonspecific but may represent sequela of chronic small vessel ischemia.

Differential considerations including demyelinating and inflammatory etiologies. His comprehensive metabolic panel was also abnormal. [Dept. Exh. 409-472].

6. On December 1, 2016, Petitioner saw his primary care physician for his continuing seizures. He was assessed with a seizure disorder and alcohol abuse. The physician noted that Petitioner has barriers to care including chronic conditions, comorbidities, he's disabled, he lives in poverty, he has no transportation and marijuana substance abuse. [Dept. Exh. 132-140].

7. On December 2, 2016, Petitioner followed up with neurology. Petitioner reported fatigue, neck pain and stiffness, dizziness, tremors, seizures, weakness and lightheadedness, confusion, decreased concentration and sleep disturbance. Petitioner was noted to be nervous/anxious. The motor examination revealed bilateral upper extremity tremors. The left side was more prominent on end action, with arms outstretched and at rest. The right was present for all, but most prominent with hands under the chin. The Romberg test was positive for falling backwards. Gait and station were normal. Petitioner stood with a narrow based and walked with a normal stride and arm swing. He had difficulty with heel walking. Diagnosis: Partial seizure disorder, essential tremor, chronic daily headaches, sleep disturbances and alcohol abuse. Petitioner was referred for (electromyograph) EMG, (electroencephalogram) EEG and (epilepsy monitoring unit) EMU testing. [Dept. Exh. 93-99].

8. On December 12, 2016, Petitioner was instructed to follow-up with his primary care physician, following an emergency room visit. Petitioner was diagnosed with a closed fracture of the coccyx. Petitioner had a seizure on December 10, 2016 and fell against a log. He went to the emergency room on [redacted], with worsening pain and was diagnosed with the fracture. Petitioner's primary care physician noted that Petitioner was standing, bent over in pain, and was unable to sit down. [Dept. Exh. 142-151].

9. On March 1, 2017, while in his primary care physician's office, Petitioner had at least 3 grand mal seizures in a row before returning to his normal baseline by the end of the visit. Petitioner was assessed with a seizure disorder, alcohol abuse, history of substance abuse, chronic low back pain with bilateral sciatica since the fall with the tailbone fracture, lumbago with sciatica on the left side, and chronic pain. The physician indicated that Petitioner is overusing his Tizanidine muscle relaxer medication. Petitioner is also having leg pain in both legs, they become tingling and numb. This happens to his hands too. Petitioner continues to have seizures almost daily. He rarely goes two days without a seizure. He was in the process of an active grand mal tonic-clonic seizure in the office, relenting briefly with regaining some degree of alertness and conversation and relaxation of the body, before falling back into another one. He had at least three seizures. He refused to go to the emergency room. [Dept. Exh. 152-157].

10. On [redacted], Petitioner was admitted to the epilepsy monitoring unit with seizure-like activity. He was discharged in stable condition on [redacted], with

a problem list of alcohol abuse, anxiety, hypertension, asthma, history of Dilantin noncompliance, seizure disorder and tobacco abuse. During his stay he had no seizures. He had one nonepileptic event that was not similar to the home events. Petitioner's Levetiracetam XR and Topiramate doses were increased on discharge and his Phenytoin was discontinued. [Dept. Exh. 101-117].

11. On August 31, 2017, Petitioner presented to neurology for continued follow-up of his epilepsy. Petitioner was assessed with a seizure disorder and alcohol abuse. The neurologist opined that Petitioner has many factors worsening his seizures: alcoholism, poor sleep, poor adherence, etc. The neurologist noted that even when Petitioner is compliant with medication, he continues to have seizures. [Dept. Exh. 118-125].

12. On March 22, 2018, Petitioner saw his neurologist for follow-up of his seizures. He was last seen in the clinic on November 29, 2017. He reported an increase in seizure activity and thinks he is having on average 4-5 a week, and sometimes 2 in one day. He had a seizure recently where he wet his pants. He stated he always bites his tongue. He spent a lot of the winter with friends, because he had no propane to heat his trailer. He is back home now but has no heat. He cannot sleep because he is cold. He was admitted to the EMU on April 24-27, 2017. During his stay in the EMU, he had no seizures. He had one nonepileptic event that was not similar to his typical home events. He complained of hallucinations with the increase in Keppra since August 2017. He continues to have seizures frequently. His most recent seizure was 2 weeks ago. He had 3 in a row witnessed by a friend. He had not missed any medication. His friend said the seizures looked like the normal ones except he was drooling. He reported a really bad seizure recently where he bruised both sides of his hips and woke up with blood in the inside of his left ear. He has daily headaches. The headaches have been worse since the seizure with the blood in his ear. Petitioner has been unable to work. He used to do factory work. He does some odd jobs for friends and neighbors. The results of the epilepsy monitor showed he has generalized background slowing which indicates the presence of a mild, nonspecific, encephalopathy. Three patient events were recorded and were not epileptic. [Dept. Exh. 8-14].

13. On April 12, 2018, Petitioner followed up with his primary care physician regarding his epilepsy. Petitioner began having seizures four years ago. The problem is recurrent. Date of last seizure was April 9, 2018. Petitioner reported he had 1-2 seizures the other day lasting a couple of minutes each time and he has them 3-4 times a week. On examination, Petitioner was positive for seizures and tremors. [Dept. Exh. 22-27].

14. On May 30, 2018, during the hearing, Petitioner credibly testified that he has epilepsy and has three to four seizures every few days. Petitioner is 5'10" and 160 pounds and is a high school graduate through special education.

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.

Current legislative amendments to the Act delineate eligibility criteria as implemented by department policy set forth in program manuals. 2004 PA 344, Sec. 604, establishes the State Disability Assistance program. It reads in part:

> Sec. 604 (1). The department shall operate a state disability assistance program. Except as provided in subsection (3), persons eligible for this program shall include needy citizens of the United States or aliens exempt from the Supplemental Security Income citizenship requirement who are at least 18 years of age or emancipated minors meeting one or more of the following requirements:
>
> (b) A person with a physical or mental impairment which meets federal SSI disability standards, except that the minimum duration of the disability shall be 90 days. Substance abuse alone is not defined as a basis for eligibility.

Specifically, this Act provides minimal cash assistance to individuals with some type of severe, temporary disability which prevents him or her from engaging in substantial gainful work activity for at least ninety (90) days.

A person is disabled for SDA purposes if he or 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.

•Is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS), see Medical Certification of Disability. BEM 261, pp 1-2 (7/1/2014).

Disability is defined 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 (90 days for SDA). 20 CFR 416.905(a). The person claiming a physical or mental disability has the burden to establish it 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 CRF 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). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and, (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (e.g., age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4). If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3 to Step 4. 20 CFR 416.920(a)(4); 20 CFR

416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability. 20 CFR 416.927(e).

As outlined above, the first step looks at the individual's current work activity. In the record presented, Petitioner is not involved in substantial gainful activity and testified that he has not worked in two years. Therefore, he is not disqualified from receiving disability benefits under Step 1.

The severity of the individual's alleged impairment(s) is considered under Step 2. The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b). An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b). Examples include:

1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

5. Responding appropriately to supervision, co-workers and usual work situations; and

6. Dealing with changes in a routine work setting. *Id.*

The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). An impairment qualifies as non-severe only if, regardless of a petitioner's age, education, or work experience, the impairment would not affect the petitioner's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985).

In the present case, Petitioner alleges disability due to epilepsy. As previously noted, Petitioner bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, Petitioner has presented medical evidence establishing that he does have some physical limitations on his ability to perform basic work activities, based on his epilepsy diagnosis. The medical evidence has established that Petitioner has an impairment, or combination thereof, that has more than a *de minimis* effect on Petitioner's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, Petitioner is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. Petitioner has epilepsy.

Listing 11.00 (neurological-adult) was considered in light of the objective evidence. Based on the Listing 11.02, Petitioner's impairments are severe, in combination, if not singly, (20 CFR 404.15.20 (c), 416.920(c)), in that Petitioner is significantly affected in his ability to perform basic work activities (20 CFR 404.1521(b) and 416.921(b)(1)).

Listing 11.02(C) requires generalized tonic-clonic seizures, occurring at least once every 2 months for at least 4 consecutive months despite adherence to prescribed treatment and a marked limitation in one of the following:

1. Physical functioning; or
2. Understanding, remembering, or applying information; or
3. Interacting with others; or
4. Concentrating, persisting, or maintaining pace; or
5. Adapting or managing oneself.

As indicated by Petitioner during his testimony, and supported by the medical evidence in the file, Petitioner has three-four seizures every few days of which he is not able to remember, but are reported to him by neighbors and friends, or he discovers through the bruising on his body. The seizures have been witnessed by first responders and in emergency rooms. Petitioner also had three grand mal seizures while in his primary care physician's office for a follow-up appointment regarding his epilepsy. Petitioner's

neurologist noted that even when Petitioner is compliant with medication, he continues to have seizures. The results of the epilepsy monitor showed he has generalized background slowing which indicates the presence of a mild, nonspecific, encephalopathy. Accordingly, this Administrative Law Judge finds Petitioner's impairments meet or equal Listing 11.02(C) and concludes Petitioner is disabled for purposes of the SDA program.

DECISION AND ORDER

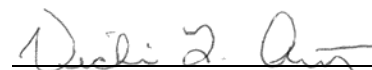
The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner disabled for purposes of the SDA benefit program.

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. The Department shall process Petitioner's September 18, 2017, SDA application, and shall award him all the benefits he may be entitled to receive, as long as he meets the remaining financial and non-financial eligibility factors.

2. The Department shall review Petitioner's medical condition for improvement in June 2019, unless his Social Security Administration disability status is approved by that time.



VLA/hb

Vicki Armstrong
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) 763-0155; 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

Rose Ward
1018 Newell
PO Box 640
White Cloud, MI 49349

Newaygo County, DHHS

BSC3 via electronic mail

L. Karadsheh via electronic mail

Petitioner