GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ORLENE HAWKS
DIRECTOR

Date Mailed: July 26, 2019
MOAHR Docket No.: 19-005666
Agency No.:
Petitioner:

ADMINISTRATIVE LAW JUDGE: Zainab A. Baydoun

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 June 26, 2019, from Detroit, Michigan. Petitioner appeared for the hearing and represented herself. The Department of Health and Human Services (Department) was represented by , Hearing Facilitator.

During the hearing, the Department's hearing packet Exhibit A, pages 1 through 1101 was admitted into the record as evidence. However, subsequent to the closure of the record in this matter, it was discovered that medical records that did not belong to Petitioner (pages 791 to 1101) were erroneously included in the evidence packet admitted as Exhibit A on behalf of the Department. Those documents were removed from Exhibit A, and Exhibit A now consists of pages 1 through 790.

ISSUE

Did the Department properly determine that Petitioner was not disabled for purposes of continued State Disability Assistance (SDA) benefit program eligibility?

FINDINGS OF FACT

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

1. Petitioner was an ongoing recipient of SDA cash assistance benefits. Petitioner was approved for SDA benefits based on a Hearing Decision issued on May 14, 2014, by Administrative Law Judge (ALJ) Christian Gardocki, which found that Petitioner's impairments met or were the equivalent to SSA listing 1.04 for spinal disorders. ALJ Gardocki ordered a review of Petitioner's eligibility to be initiated one year later.

2. In or around March 2018, Petitioner was approved for ongoing SDA benefits based on a Disability Determination Service (DDS) finding that at the time, she had inability to sustain a 40-hour work week without the interference of her psychological symptoms, which was supported by several medical source statements reviewed, indicating Petitioner was disabled due to her symptoms. It was noted that Petitioner continued to have recurrent episodes of depression with intense suicidal ideations. DDS ordered that Petitioner's continued SDA eligibility be reviewed in one year. (Exhibit B)

3. In March 2019, the Department and DDS initiated a review of Petitioner's continued eligibility for SDA benefits.

4. On or around April 22, 2019, the DDS found Petitioner not disabled for purposes of continued SDA benefits. DDS determined that Petitioner was capable of performing other work. There was no evidence presented to indicate that DDS assessed Petitioner's mental impairments as they relate to her ability to perform work activities, as the analysis of medical evidence of record found in the DDS decision does not include any reference to Petitioner's extensive mental health treatment records. (Exhibit A, pp. 33-49)

5. On May 7, 2019, the Department sent Petitioner a Notice of Case Action advising her that effective June 1, 2019, her SDA benefits would be terminated based on DDS' finding that she is not disabled. (Exhibit A, pp. 12-15)

6. On May 15, 2019, Petitioner requested a hearing disputing the Department's termination of her SDA benefits and the DDS finding that she was not disabled.

7. Petitioner's hearing request also indicates that she is disputing the closure of her Family Independence Program (FIP) case. Petitioner confirmed that this box was checked in error, as she was not a recipient of FIP benefits. Thus, the hearing request as it relates to the FIP will be dismissed with Petitioner's consent.

8. Petitioner alleged continuing disabling impairments due to spine issues, arthritis, pinched nerves, fibromyalgia, migraines, vertigo, depression, bipolar II disorder, and post-traumatic stress disorder (PTSD).

9. As of the hearing date, Petitioner was ██ years old with an August 6, ████ date of birth. She was ██" and weighed approximately ███ pounds. Petitioner has a high school education and has reported employment history of work as a manager at a dollar store, in the food/beverage department at a hotel for which she was a room service server and/or bartender and doing clerical work/data entry. Petitioner has not been employed since 2012.

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

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

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

In this case, Petitioner has not engaged in SGA at any time since she became eligible for SDA. Therefore, her disability must be assessed to determine whether it continues.

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

> **Step 1.** If the individual has an impairment or combination of impairments which meets or equals the severity of an impairment listed in 20 CFR Appendix 1 of subpart P of part 404, the disability will be found to continue. 20 CFR 416.994(b)(5)(i).
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> **Step 2.** If a listing is not met or equaled, it must be determined whether there has been medical improvement as defined in paragraph (b)(1)(i) of 20 CFR 416.994 and shown by a decrease in medical severity. If there

has been a decrease in medical severity, Step 3 is considered. If there has been no decrease in medical severity, there has been no medical improvement unless an exception in Step 4 applies. 20 CFR 416.994(b)(5)(ii).

Step 3. If there has been medical improvement, it must be determined whether this improvement is related to the individual's ability to do work in accordance with 20 CFR 416.994(b)(1)(i) through (b)(1)(iv); *i.e.*, there was an increase in the individual's residual functional capacity (RFC) based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to the individual's ability to do work, the analysis proceeds to Step 4. If medical improvement *is* related to the individual's ability to do work, the analysis proceeds to Step 5. 20 CFR 416.994(b)(5)(iii).

Step 4. If it was found at Step 2 that there was no medical improvement or at Step 3 that the medical improvement is not related to the individual's ability to work, the exceptions in 20 CFR 416.994(b)(3) and (b)(4) are considered. If none of them apply, the disability will be found to continue. If an exception from the first group of exceptions to medical improvement applies, the analysis proceeds to Step 5. If an exception from the second group of exceptions to medical improvement applies, the disability is found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process. 20 CFR 416.994(b)(5)(iv).

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

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

> **Step 7.** If the individual is not able to do work done in the past, the individual's ability to do other work given the RFC assessment made under Step 6 and the individual's age, education, and past work experience is assessed (unless an exception in 20 CFR 416.994(b)(5)(viii) applies). If the individual can, the disability has ended. If the individual cannot, the disability continues. 20 CFR 416.994(b)(5)(vii).
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> **Step 8.** Step 8 may apply if the evidence in the individual's file is insufficient to make a finding under Step 6 about whether the individual can perform past relevant work. If the individual can adjust to other work based solely on age, education, and RFC, the individual is no longer disabled, and no finding about the individual's capacity to do past relevant work under Step 6 is required. If the individual may be unable to adjust to other work or if 20 CFR 416.962 may apply, the individual's claim is assessed under Step 6 to determine whether the individual can perform past relevant work. 20 CFR 416.994(b)(5)(viii).

Step One

Step 1 in determining whether an individual's disability has ended requires the trier of fact to consider the severity of the impairment(s) and whether it meets or equals a listed impairment in Appendix 1 of subpart P of part 404 of Chapter 20. 20 CFR 416.994(b)(5)(i). If a listing is met, an individual's disability is found to continue with no further analysis required.

In the present case, Petitioner alleged continuing disabling impairments due to spine issues, arthritis, pinched nerves, fibromyalgia, migraines, vertigo, depression, bipolar II disorder, and post-traumatic stress disorder (PTSD). The medical evidence presented since the March 2018 DDS decision finding Petitioner disabled was thoroughly reviewed and is briefly summarized below.

Records from Petitioner's April 2018 to February 2019 visits at [redacted] show that she continued to receive treatment for diagnoses including myalgia cervicodorsal T-L and L-S myofascitis, occipital neuralgia, radiculitis in the lumbosacral region and the cervical region on the left, cervicalgia, low back pain, and pain in the right hip. During an April 5, 2018 visit, Petitioner complained of pain in her lower back, neck, and right hip. She reported that her hip pain is on the right side, that it is constant and throughout the day, and that the pain is sharp and aching. She identified associated signs and symptoms of weakness, tenderness and stiffness. Her neck pain radiated to her left shoulder and included numbness and tingling. Petitioner's back pain reportedly radiated to her bilateral legs and was aggravated by daily activities. Upon musculoskeletal examination, cervical lordosis was decreased, tenderness to the cervical paraspinal muscles, and tenderness to palpation were noted in the bilateral cervical paraspinals. Flexion is decreased to 10%, cervical extension decreased to 15%, and cervical lateral rotation decreased on the left to 10%. Spurling's test was positive on the left and she had full range of motion to the bilateral shoulders, elbows and wrists. Lumbar lordosis was decreased, and there was tenderness to palpation

noted in the bilateral lumbar paraspinals, bilateral sciatic notch, bilateral PSIS, and bilateral piriformis. Lumbar flexion was decreased to 15%, lumbar extension decreased to 15%, lumbar lateral rotation decreased to 15% and straight leg testing is positive bilaterally. Plantar response was going down bilaterally. During subsequent visits, Petitioner continued to report symptoms associated with her neck back and hip pain for which she was receiving medication and acupuncture treatment. Records indicate that in September 2018, examination of the cervical spine showed forward flexed rounded shoulder posture, and tenderness to palpation was noted in the left upper trapezius, left infraspinatus, bilateral cervical paraspinals, left rhomboids, left supraspinatus, left latissimus dorsi and left levator scapulae. She had cervical stiffness with moderate to severe spasms of her suboccipitals, cervical and bilateral cervicodorsal and scapular muscles. Her Spurling signs were positive bilaterally, her DTRs, sensation, and growth strength were symmetric. Tenderness to palpation was noted in the bilateral gluteus medius, bilateral lumbar paraspinals, bilateral trochanter, bilateral PSIS, bilateral sciatic notch and bilateral piriformis. She had L – S stiffness with palpable spasms of her L – S paraspinals and gluteus muscles. She had bilateral SI joint tenderness with positive provocative maneuvers. In November 2018, similar findings were noted including moderate cervical/cervicodorsal spinal stiffness, and moderate to severe palpable spasms of the above referenced areas with identifiable trigger points. There was increased pain on extension, flexion, and bilateral rotation of the cervical spine and the upper cervical provocation maneuvers reproduced her headaches. In February 2019, Petitioner reported left-handed numbness along with continuing neck, lower back and bilateral hip pain. (Exhibit A, pp. 93 – 152)

On January 9, 2019, Petitioner underwent NCV and EMG testing which showed no electrodiagnostic evidence of radiculopathy or peripheral neuropathy. (Exhibit A, pp. 145-148)

An MRI of Petitioner’s lumbar spine completed on September 21, 2018 showed minimal disc bulging at the L3 – L4 level with no disc herniation although mild facet arthropathy was noted, minimal disc bulging and mild facet arthropathy with thickening of the ligamentum flavum at the L4 L5 level with no evidence of discrete disc herniation and the spinal canal and neuro foramina were patent. Mild facet arthropathy at the L5 – S1 level were noted. Findings indicated relatively mild multilevel degenerative changes of the lumbar spine without evidence of significant spinal canal or foraminal narrowing. An MRI of the cervical spine performed on the same date showed trace disc osteophyte complex formation with tiny left central disc herniation at the C4 – C5 level, tiny left central disc rotation which mildly indents the ventral thecal sac at the C5 – C6 level. Findings indicated tiny disc herniations at C4 – C5 and C5 – C6 without significant spinal canal or foraminal narrowing. No evidence of disc herniation was found. (Exhibit A, pp. 149-152)

A letter dated May 23, 2019 from Petitioner’s treating physician indicated that Petitioner has been a patient of his for the last five years, that she suffers from chronic pain syndrome involving the neck, back, and hips. The doctor was of the opinion that Petitioner is unable to do any physically demanding work activities. (Exhibit A, p. 31)

Records from Petitioner's mental health treatment at [redacted] from April 2018 to February 2019 were reviewed and show that she continued to receive therapy and medication treatment for diagnosis of Bipolar disorder II, major depressive disorder recurrent episode with psychotic features, and anxiety and panic related to PTSD. (Exhibit A, pp. 612-790). Medication Review Notes from April 2018 indicate that Petitioner continues to feel sad and unmotivated, that she has ongoing pain and thoughts of death. Records show that Petitioner had previous history of recurrent episodes of depression with crying, intense suicidal ideations, and paranoid thoughts. Petitioner reported that she is unable to tolerate people as they annoy her and that she is angry about her life all the time. Petitioner's mood was noted to be depressed and she had a constricted neutral affect with chronic thoughts of being better off dead, although no current suicidal ideations. Petitioner's major depressive disorder was associated with childhood trauma and adult occupational and relationship failures. Petitioner's doctor indicated that she was genuinely disabled by her symptoms. Progress notes from April 2018 indicate that Petitioner had mood swings, feelings of depression, feelings of anger and disappointment, that she struggled with motivation and increasing anxiety. During a June 7, 2018 medication review, Petitioner reported childhood physical abuse and seeing her father attempting to murder her mother. Her mother was saved by her younger sister; however, this has made Petitioner feel inadequate and guilty that she was unable to save her mother herself. She has always been depressed and felt disassociated from her body. She reported that 11 years ago she was drinking with a male friend and he raped her. She reported having flashbacks and nightmares of that. Progress notes from July 2018 show that Petitioner presented as tense, resistant, withdrawn, and sad. Petitioner was noted to be at risk of harm to herself, as she had suicidal thoughts and stated that she thought about how to make it look like an accident to her family. Petitioner was given recommendations on how to deal with her anxiety and panic disorder. Medication review Notes from Petitioner's August 16, 2018 visit with her psychiatrist show that Petitioner was assessed as still feeling depressed, that she has chronic pain, fibromyalgia and is no longer able to do little things. Notes indicate that her boyfriend makes her feel bad about not functioning, that they are arguing every day, that she is unable to support herself and she is convinced that she has no value and is unable to function. Petitioner reported that she feels she is being watched by people driving by and knows that anyone looking at her garden is actually looking at her to prove she is not disabled. The doctor indicated that Petitioner was still exhibiting signs of paranoia. Notes further indicate that Petitioner suffers from trust issues, nightmares, anger and on edge feelings as a result of her PTSD. A mental status exam on that date showed she was an anxious woman with full range of affect, her mood was depressed, her thought process logical and goal directed, she had thoughts of being better off dead and indicates she would likely commit suicide if she does not get disability. She reported that she has been prevented from committing suicide by her relationship with her nephew and her pets but thinks of herself as not worth having around and being an inadequate sister, daughter, and aunt. Her insight and judgment were assessed as being impaired and her PHQ–9 score was 14: moderate. Therapy progress notes from September 11, 2018 indicate that Petitioner was hospitalized overnight due to a suicide attempt after having relationship issues with her live-in boyfriend where she felt physically rejected, as well as rejection from a new

person she was interested in, not hearing back from disability and had been drinking all day. She reported that after two incidents of rejection, she went into her room took her medications that she would normally take, then took a handful of Klonopin and wrote a suicide note. She later found out it was six pills in addition to her prescriptions and an entire day of drinking. She was taken to the hospital via ambulance and placed on suicide watch overnight. A suicide crisis plan was put in place that Petitioner agreed to follow. A mental health assessment was completed on September 25, 2018 during which it was noted that Petitioner still struggles with depression, anxiety, insomnia, trouble sleeping, poor appetite, mood swings, paranoia and that she had a suicide attempt at the beginning of the month. Her locus assessment score was 19. October 3, 2018 medication review notes indicate that Petitioner was observed to be much calmer than previous appointments, her thought process was logical and goal directed, there were no suicidal ideations on the date of that appointment, her mood was hopeful, more positive and thoughtful. There was no evidence of psychosis and her insight and judgment were improved. The clinical summary indicates that Petitioner has history of trauma and disability due to fibromyalgia that is being treated with pain medications. Psychotic depression was also referenced, and it was noted that she has prominent somatic symptoms, her outlook has improved since an accidental overdose on alcohol and pills as she is no longer suicidal although she is taking narcotics again. Medication review notes from her February 13, 2019 appointment show that Petitioner reported being able to do some cleaning and housework although she still has back pain, neck pain and numbness in her hands. She reported getting back together with her boyfriend, although they are not living together. Comments from the doctor after a mental status exam showed that she presented as pleasant and calm on the day of her appointment, that her thought process was logical and goal directed, her thought contents were negative for suicidal ideations that day and there was no evidence of psychosis. (Exhibit A, pp. 612-790).

Petitioner presented a letter dated June 5, 2019 from her treating psychiatrist which indicated that she currently remains in a severe depression and is unable to function well enough to work and is unable to support herself. (Exhibit 1)

Petitioner presented 2 pages of a 4-page Wayne City Police Department Case Report (September 17, 2011) documenting that she was the victim of sexual assault. She also presented a Personal Protection Order filed on or around March 14, 2013 against the perpetrator of her sexual assault. (Exhibit A, pp. 28-30)

Based on the medical evidence presented in this case, listings 1.04 (disorders of the spine), 12.04 (depressive, bipolar and related disorders), 12.06 (anxiety and obsessive-compulsive disorders), 12.08 (personality and impulse-control disorders), and 12.15 (trauma and stressor related disorders) were considered.
The most recent favorable decision which rendered Petitioner disabled is the March 20, 2018 DDS decision finding that she had inability to sustain a 40-hour work week without the interference of her psychological symptoms, which was supported by several medical source statements reviewed indicating Petitioner was disabled due to her symptoms. It was noted that Petitioner continued to have recurrent episodes of

depression with intense suicidal ideations. Petitioner was determined disabled based on her nonexertional impairments. (Exhibit B). There was no evidence that in connection with the current review, DDS evaluated or assessed Petitioner's continuing disability based on her mental impairments.

Upon review, the medical evidence presented including the MRI reports does not show that Petitioner's physical impairments meet or equal the required level of severity of listing 1.04 to be considered as disabling without further consideration. However, as referenced above, the medical evidence presented with the current review showed that Petitioner continued to receive ongoing mental health treatment with a psychiatrist and a therapist for the conditions that rendered her disabled in the March 2018 DDS decision. Petitioner's medical record reflects recurrent severe depressive disorder and PTSD characterized by depressed mood with crying and anger, diminished interest in activities, sleep disturbances, feelings of guilt/worthlessness, recurrent thoughts of death or suicide, and a suicide attempt in September 2018 which resulted in an overnight hospitalization and Petitioner placed on suicide watch. There was also evidence that Petitioner has been exposed to various forms of trauma as a result of her sexual assault and her witnessing the attempted murder of her mother. As a result, the record shows that Petitioner experiences nightmares, flashbacks, sleep disturbances, and paranoia.

Additionally, the Department did not establish that there has been an improvement in Petitioner's conditions and impairments since the time of her March 2018 approval, as there was insufficient evidence to show a decrease in the medical severity of the impairments. 20 CFR 416.994(b)(1)(i); 20 CFR 416.994(b)(5)(ii).

At the hearing, and with respect to her mental impairments, Petitioner testified that she continues to suffer from hallucinations, anxiety, and panic attacks that prevent her from leaving her house, as she has fears that she will see the man who sexually assaulted her out in the community. She testified that she suffers from nightmares and flashbacks and that she has difficulty focusing for more than 15 to 30 minutes. Petitioner reported suffering from crying spells daily which last hours and that she has verbal anger issues, with daily suicidal ideations. She further reported that she spends most of her time alone due to her depression.

Upon thorough review, the medical evidence presented with the current review continues to support the prior DDS finding of a mental/nonexertional disability. When combined, Petitioner's mental impairments meet or are the equivalent to the required level in severity to the criteria in Appendix 1 of the Guidelines to be considered as disabling without further consideration. Thus, Petitioner's disability is continuing at Step 1 and no further analysis is required.

DECISION AND ORDER

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

Accordingly, the hearing request with respect to the FIP case is **DISMISSED** and the Department's SDA determination is **REVERSED**.

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

1. Reinstate Petitioner's SDA case effective June 1, 2019;

2. Issue supplements to Petitioner for any lost SDA benefits that she was entitled to receive from June 1, 2019, ongoing if otherwise eligible and qualified in accordance with Department policy;

3. Notify Petitioner of its decision in writing; and

4. Review Petitioner's continued SDA eligibility in March 2020 in accordance with Department policy.

ZB/tlf

Zainab A. Baydoun
Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

Via Email:

Petitioner – Via First-Class Mail: