STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF: [redacted]

Claimant

Reg. No.: 2008-16428
Issue No.: 2009, 4031
Case No.: [redacted]
Load No.: [redacted]
Hearing Date:
February 23, 2009
Emmet County DHS

ADMINISTRATIVE LAW JUDGE: Colleen M. Mamelka

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Claimant's request for a hearing. After due notice, a telephone hearing was conducted from [redacted] on February 23, 2009. The Claimant appeared and testified. The Claimant was represented by [redacted]. [redacted]r appeared on behalf of the Department. At the Claimant's request, the record was extended to allow for the submission of further medical evidence.

The additional medical information was received and forwarded to the State Hearing Review Team ("SHRT") for a determination. SHRT found the Claimant not disabled and capable of performing past employment. This matter is now before the undersigned for a final decision.

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of the Medical Assistance ("MA-P") and the State Disability Assistance ("SDA") benefits.

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 February 12, 2008, the Claimant submitted a public assistance application seeking MA-P and State Disability Assistance ("SDA") benefits.
2. On March 14, 2008, the Medical Review Team ("MRT") denied the Claimant's SDA based upon a Social Security Ruling. (Exhibit 1, pp. 3, 4)
3. The Claimant's application was not part of the hearing packet, however, the Department testified that the Claimant applied for both MA-P and SDA benefits.
4. The MRT did not make a determination regarding disability for MA-P purposes.
5. On September 18, 2008, the Department sent the Claimant an eligiblity notice informing the Claimant that her SDA benefits were denied. (Exhibit 1, p. 2)
6. On March 22, 2008, the Department received the Claimant's Hearing Request protesting the determination that the Claimant is not disabled. (Exhibit 1, p. 1)
7. On May 20, 2008 and March 13, 2009, the State Hearing Review Team ("SHRT") determined the Claimant was not disabled finding her capable of performing past relevant work. (Exhibit 2, pp. 1, 2)
8. The Claimant's alleged physical disabling impairments are due to chronic pain and fibromyalgia, back pain, carpal tunnel, and narcolepsy.
9. The Claimant's alleged mental impairments are due to depression and bipolar disorder.
10. The Claimant's impairment(s) will last or have lasted for a period of 12 months or longer.

11. At the time of hearing, the Claimant was 38 years old with an [redacted] birth date; was 5' 7" and weighed 160 pounds.

12. The Claimant completed through the 11th grade and has a work history as a general laborer, cashier, and salesperson.

CONCLUSIONS OF LAW

The Medical Assistance ("MA") program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department of Human Services ("DHS"), formally known as the Family Independence Agency, pursuant to MCL 400.10 *et seq* and MCL 400.105. Department policies are found in the Program Administrative Manual ("PAM"), the Program Eligibility Manual ("PEM"), and the Program Reference Manual ("PRM").

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. 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-relate 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 416.929(a)

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 applicants 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 (i.e. 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 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 three to step four. 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 four and five. 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)

As outlined above, the first step looks at the individual's current work activity. An individual is not disabled regardless of the medical condition, age, education, and work experience, if the individual is working and the work is a substantial, gainful activity. 20 CFR 416.920(a) (4) (i) In the record presented, the Claimant is not involved in substantial gainful activity and last worked in approximately 1998. The Claimant is not ineligible for disability under Step 1.

The severity of the Claimant's alleged impairment(s) is considered under Step 2. 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 severe only if, regardless of a claimant's age, education, or work experience, the impairment would not affect the claimant's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985)

In support of the Claimant's disability, several older medical records were submitted. The majority of the "older" records are from psychiatric treatment received through the . These records date back from as early as 2002. The records document extensive psychiatric treatment, to include hospitalizations, as well as substance abuse treatment. Diagnoses vary slightly, however, mainly document major depression, bipolar type 2, and mood disorder. In September 2006, a treating psychiatrist opined, based upon his several years of treatment that the Bipolar Disorder diagnosis may not be accurate and that, in addition to her substance abuse, that Claimant was borderline Personality Disorder with antisocial and dependent traits. Suicidal ideation was also noted. The Claimant's GAF was as low as 30. The Claimant's history of fibromyalgia was also noted, as well as narcolepsy (diagnosed in April 2007)

On November 12th through November 16, 2007, the Claimant was admitted (voluntarily) at . The Claimant was diagnosed with Bipolar Affective Disorder and borderline Personality Disorder. The Claimant's GAF at admission was 30, and 40 at discharge.

Treatment records from [redacted] dated December 2007 diagnose the Claimant with Depressive Disorder, Dysthymic Disorder, Opioid Dependence, History of poly substance abuse and stimulant abuse, Anxiety Disorder, and borderline personality disorder. The Claimant was prescribed [redacted]e.

On November 27th, December 4th, 10th, 19th of 2007 and January 21st, February 20th of 2008, the Claimant was treated at [redacted]. for back, hip, and knee pain, and sleep disturbance issues. A nerve conduction study performed on December 4th and 10th, were within normal limits with no abnormalities noted. The study was not consistent with lumbosacral nerve root compression/radiculopathy, lumbar radiculitis, lumbar plexopathy, or lower extremity peripheral neuropathy. Additionally, there was no electro diagnostic evidence of Carpal Tunnel Syndrome or Cubital Tunnel Syndrome. Concerns were noted regarding the reluctance in prescribing either an increase dosage of the Fentanyl-patch or increasing it's frequently, "given her long and substantial history of narcotic over utilization and/or abuse." The physical examinations of the Claimant's back documented "diminished tenderness" with "full lumbosacral spine active rand of motion."

On February 8, 2008, the Claimant attended a follow-up appointment at the [redacted] where she treats for her narcolepsy. The Claimant's treating physician documented that the narcolepsy was well controlled with Concerta for her daytime sleepiness without side effects. The Claimant's night sleep was well controlled provided she takes her psychiatric medication, Trazodone.

On March 18th, the Claimant treated with [redacted] for back, hip, and knee pain, extremity numbness, fatigue, depression, and sleep difficulties. The

Claimant was exhibiting clear signs of narcotic withdrawal. Local ice packs were recommended for the Claimant's back, hip, and knee pain as well as a home exercise program.

On April 4, 2008, the Claimant's treating physician from sent the Claimant a letter informing her that he would not longer provide medical care/services to the Claimant due to her ongoing narcotic/opioid abuse/over utilization and her "incessant calling" requesting additional narcotic medication.

On April 15, 2008, the Claimant was treated at for complaints of upper and lower back, hip, and knee pain with limb numbness and paresthesia, arthralgia, depression and sleeping difficulties secondary to pain. The physical exam found full lumbosacral spine range of motion. Several issues were noted to include: somatization, lumbago, multilevel lumbar degenerative disc disease, thoracolumbar scoliosis, cervicalgia, thoracalgia, myofascial pain syndrome, chronic pain syndrome, hypertension, narcolepsy, depression, anxiety, PTSD, and narcotic addition.

On April 20, 2008, the Claimant's previous treating physician from Rehabi completed an assessment of the Claimant's physical and mental capacities. Physically the Claimant was found able to sit approximately 3 hours of an 8 hour work day; stand and walk approximately 2 hours. An MRI from September of 2005, was reviewed and documented the Claimant's disc herniation at L4-5. The Claimant was able to occasionally lift/carry up to 20 pounds with frequently lifting of 10 pounds. The Claimant's carpal tunnel was discussed as well as stooping, reaching, climbing, squatting, kneeling, etc., limitations. The Claimant's mental limitations were further documented. The Claimant's ability to relate to coworkers, interact with superiors, and function independently were markedly limited, as well as her ability to handle complex job instructions. The Claimant's use of

judgment and ability to deal with work stresses was more than markedly limited. The ability to handle personal and social adjustments was more than markedly limited. Episodes of decomposition for extended durations were over four. Most limitations appeared to follow the death of her spouse in 1999. Ultimately, the Claimant's prognosis was very poor.

Treatment/progress notes from the [redacted] document concerns regarding the several requests (and prescriptions) for pain medication.

[redacted] medical records document treatment on August 1st and 7th, October 23, 2008, and November 18, 2008 for abdominal cramps, nausea, vomiting, and back pain. On August 4, 2008, a MRI of the Claimant's spine was taken which revealed abnormal hypertrophic facets at L4-5 with a mild posterior annular protrusion at L4-5.Treatment records note the Claimant's disheveled and tired appearance. The Claimant was treated with pain medications, generally [redacted] On August 7, 2008, the Claimant signed a controlled Medication Agreement acknowledging the Claimant's agreement that she will not attempt to obtain any controlled medicine from other health care providers.

On October 5, 2008, the Claimant's treating physician from [redacted] authored a letter opining that the Claimant was disabled both on a physical and mental capacity basis, independent of drug and/or alcohol addiction or dependence. The Claimant is able to perform some activities however her ability to reliably and consistently perform gainful/productive work was found "impossible."

On November 6, 2008, the [redacted] discharged the Claimant from its practice based upon the Claimant's failure to follow medical advice, not being forthright and truthful, and for failing a drug screen.

In this case, the Claimant has presented medical evidence establishing that she does have some physical limitations affecting her ability to perform basic work activities such as standing, walking, sitting, lifting, carrying, pushing and pulling. In addition, the Claimant has submitted medical evidence that she does have some psychological limitations on her ability to perform basic work activities such as comprehending and concentration. Ultimately, the medical evidence has established that the Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months. Therefore, the Claimant 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 Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. Appendix I, Listing of Impairments discusses the analysis and criteria necessary to support a finding of a listed impairment.

Listing 1.00 defines musculoskeletal system impairments. Disorders of the musculoskeletal system may result from hereditary, congenital, or acquired pathologic processes. 1.00A Impairments may result from infectious, inflammatory, or degenerative processes, traumatic or developmental events, or neoplastic, vascular, or toxic/metabolic diseases. 1.00A Regardless of the cause(s) of a musculoskeletal impairment, functional loss for purposes of these listings is defined as the inability to ambulate effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment, or the inability to perform fine and gross movements effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment. Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very

seriously with the individual's ability to independently initiate, sustain, or complete activities. 1.00B2b(1) Ineffective ambulation is defined generally as having insufficient lower extremity function to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities. (Listing 1.05C is an exception to this general definition because the individual has the use of only one upper extremity due to amputation of a hand.) *Id.* To ambulate effectively, individuals must be capable of sustaining a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living. 1.00B2b(2) They must have the ability to travel without companion assistance to and from a place of employment or school. . . . *Id.*

Categories of Musculoskeletal include:

1.02 Major dysfunction of a joint(s) due to any cause: Characterized by gross anatomical deformity (e.g. subluxation, contracture, bony or fibrous ankylosis, instability) and chronic joint pain and stiffness with signs of limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With:

A. Involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in inability to ambulate effectively as defined in 1.00B2b; or

B. Involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, wrist, hand), resulting in inability to perform fine and gross movements effectively a defined in 1.00B2c

1.03 Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint, with inability to ambulate effectively, as defined in 1.00B2b, and return to effective ambulation did not occur, or is not expected to occur, within 12 months of onset.

1.04 Disorders of the spine (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, and vertebral fracture), resulting in compromise of a nerve root (including the cauda equine) or spinal cord. With:

A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine); or

B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours; or

C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b. (see above definition)

The Claimant asserts physical disabling impairments due to back pain, hip, and knee pain, as well as fibromyalgia. The medical evidence does not establish that the Claimant is unable to ambulate effectively. Further, the Claimant is able to walk without the use of assistive devices. The objective medical records do not support a finding of disabled under this Listing.

The Claimant's also asserts mental disabling impairments due to depression and Bipolar disorder. Listing 12.00 encompasses adult mental disorders. The evaluation of disability on the basis of mental disorders requires documentation of a medically determinable impairment(s) and consideration of the degree in which the impairment limits the individual's ability to work, and whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. 12.00A The existence of a medically determinable impairment(s) of the required duration must be established through medical evidence consisting of symptoms, signs, and laboratory findings, to include psychological test findings. 12.00B The evaluation of disability on the basis of a mental disorder requires sufficient evidence to (1) establish the presence of a medically determinable mental impairment(s), (2) assess the degree of functional limitation the

impairment(s) imposes, and (3) project the probable duration of the impairment(s). 12.00D The evaluation of disability on the basis of mental disorders requires documentation of a medically determinable impairment(s) and consideration of the degree in which the impairment limits the individual's ability to work consideration, and whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. 12.00A

Listing 12.04 defines affective disorders as being characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Generally, affective disorders involve either depression or elation. The required level of severity for these disorders is met when the requirements of both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:

    a. Anhedonia or pervasive loss of interest in almost all activities; or

    b. Appetite disturbance with change in weight; or

    c. Sleep disturbance; or

    d. Psychomotor agitation or retardation; or

    e. Decreased energy; or

    f. Feelings of guilt or worthlessness; or

    g. Difficulty concentrating or thinking; or

    h. Thoughts of suicide; or

    i. Hallucinations, delusions, or paranoid thinking; or

2. Manic syndrome characterized by at least three of the following:

    a. Hyperactivity; or

    b. Pressure of speech; or

    c. Flight of ideas; or

    d. Inflated self-esteem; or

    e. Decreased need for sleep; or

    f. Easy distractibility; or

g. Involvement in activities that have a high probability of painful consequences which are not recognized; or

h. Hallucinations, delusions, or paranoid thinking; or

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes)'

AND

B. Resulting in at least two of the following:

1. Marked restriction on activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or

2. A residual disease process that has resulted in such marginal adjustment that even minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or

3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

In this case, medical evidence shows that the Claimant has recurrent, major depression, anxiety, bipolar, with borderline personality disorder. The Claimant's psychiatric treatment has continued for more than 12 months, with suicidal ideations noted. The Claimant's reported GAFs range from 30 to 40. Further, sleep disturbance, decreased energy and fatigue, difficulty concentrating are medically documented as well as marked restrictions on the Claimant's daily activities and social functioning are documented. Currently, the Claimant attends counseling

every week and sees a psychiatrist every two to three months unless needed. The medical records also document the Claimant's narcotic addition/abuse however the Claimant's treating providers indicate the Claimant's significant impairments exist independent of any substance abuse. Based upon the submitted medical documentation, the Claimant's mental impairment(s) meets the criteria within 12.04 thus she is found to be disabled for purposes of the Medical Assistance program under this Listing. Accordingly, the Claimant's eligibility under Step 4 is not necessary.

The State Disability Assistance ("SDA") program, which provides financial assistance for disabled persons, was established by 2004 PA 344. DHS administers the SDA program purusant to MCL 400.10 *et seq.* and Michigan Administrative Code ("MAC R") 400.3151 – 400.3180. Department policies are found in PAM, PEM, and PRM. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal SSI disability standards for at least ninety days. Receipt of SSI or RSDI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness (MA-P) automatically qualifies an individual as disabled for purposes of the SDA program.

In this case, the Claimant is found disabled for purposes of continued Medical Assistance ("MA-P") entitlement, therefore the Claimant's is found disabled for purposes of continued SDA benefits.

DECISION AND ORDER

The Administrative Law Judge, based upon the findings of fact and conclusions of law, finds the Claimant disabled for purposes of continued Medical Assistance program and the State Disability Assistance program.

It is ORDERED:

1. The Department's determination is REVERSED.

2. The Department shall initiate review of the February 12, 2008 application to determine if all other non-medical criteria are met and inform the Claimant and her attorney of the determination.

3. The Department shall supplement the Claimant any lost benefits she was entitled to receive if otherwise eligible and qualified in accordance with department policy.

4. The Department shall review the Claimant's continued eligibility in April of 2010 in accordance with department policy.

/s/
Colleen M. Mamelka
Administrative Law Judge
For Ishmael Ahmed, Director
Department of Human Services

Date Signed: ______

Date Mailed: ______

NOTICE: Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

The Claimant may appeal the Decision and Order to the Circuit within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the recip date of the rehearing decision.

CMM/jlg

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