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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. 2008-25283
Issue No. 2009, 4031
Case No: [redacted]
Load No. [redacted]
Hearing Date:
October 16, 2008
DHS County:
Montmorency

ADMINISTRATIVE LAW JUDGE: Judith Ralston Ellison

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9; and MCL 400.37 upon Claimant's request for a hearing. After due notice, a hearing was held on October 16, 2008 at the Department of Human Service (Department) in Montmorency County. The Claimant appeared for the hearing.

The record was left open to obtain additional medical information. The medical information was submitted to the State Hearing Review Team (SHRT) and the application was denied. This matter is now before the undersigned for final decision. Department Exhibit 1, pp. 83-90 were not included as valid evidence used in this decision due to fact that the documents were not dated to the time of the assessments and conclusions and conclusions therein.

ISSUES

Whether the Department properly determined the Claimant is "not disabled" for purposes of Medical Assistance based on disability (MA-P) and retroactive MA-P for the months of February, March and April 2008 and State Disability Assistance (SDA) programs?

FINDINGS OF FACT

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

(1) On June 5, 2008 the Claimant applied for MA-P and SDA.

(2) On July 1, 2008 the Department denied the application; and on December 8, 2008 the SHRT guided by Vocational Rule 202.20 denied the application because medical records were evidence for the capacity to perform light work.

(3) On July 8, 2008 the Claimant filed a timely hearing request to protest the Department's determination.

(4) Claimant's date of birth is [redacted]; and the Claimant is forty-three years of age.

(5) Claimant completed grade 12 and service in the US Navy for three years; and can read and write English and perform basic math.

(6) Claimant last worked in 2006 in sales for a nursery; doing stocking and customer service, and at a grocery store, at [redacted] as a cashier, and operated a sport fishing boat.

(7) Claimant has alleged a medical history of diagnosis of bipolar disorder, seizures, a head injury, and a cervical spine injury causing pain and hand problems with tingling/numbness

(8) September 2007 and January 2008, in part:

> September 2007: MRI cervical spine: CONCLUSION: Anomaly at C3-4. Narrowing of C4-5 disc space with osteophyties and foraminal bony stenosis. Progressive stenosis of central spinal canal by disc protrusion and spondylithic bar with mild compression of cervical cord, progressive since prior study. Department Exhibit (DE) 1, pp. 24-26.
>
> January 2008: DISCHARGE DIAGNOSIS: Alcohol withdrawal; acute delirium; Seizures; Depression; Tobacco use. Re-admitted after recent discharge for alcohol withdrawal. EKG unremarkable, CT head unremarkable except volume loss greater than expected for age, Chest X-ray: no acute disease. When weaned off all

medications except prn Haldol, her agitation lessened and she improved. Mental status slowly cleared and two days before discharge she was back to normal with orientation times 3 and independently cares for self and function. Metoprolol helped her blood pressure. Administration of antibiotics cleared hospital acquired pneumonia. Had alcohol induced liver disease and medication was changed to Keppra and her liver disease did not cause complications. Traumatic seizure disorder was treated with Keppra and she did not have seizures while hospitalized. Discharged to home improved to follow up with PCP and alcohol rehabilitation. [redacted] Department Exhibit (DE) 1, pp. 10-18.

(9) June 2008, in part:

CURRENT DIAGNOSIS: Bipolar disorder and DJD of Neck with radiculopathy.
WT 172; BP 130/81.
NORMAL EXAMINATION AREAS: General; HEENT; Respiratory;
Cardiovascular, Abdominal, Neuro.
Findings: Musculoskeletal: tenderness in neck. Mental: bipolar disorder, ETOH history.
CLINICAL IMPRESSION: Stable.
PHYSICAL LIMITATIONS: Limitations in lifting/carrying: unknown. No assistive devices are needed; use of both hand/arms for simple grasping, reaching, pushing/pulling, fine manipulating; use of both feet/legs for operating controls. Can meet own need in home.
MENTAL LIMITATIONS: bipolar disorder and ETOH.
Medical Needs: chronic lifetime illness. Ambulatory without need for transportation or help at home. Return to work of any kind: unknown. [redacted]. [redacted] DE 1, pp. 76-77.

(10) August and September 2008, in part:

August: MEDICAL EVALUATION: History: States had two seizures in past six months. Currently takes Depakote and seizure frequency has diminished. Smokes one-half pack per day. Denies alcohol.
PHYSICAL EXAMINATION: Well developed well nourished overweight in no obvious distress, alert, cooperative, followed commands and well-orientated. Affect, dress, effort were all appropriate. Memory was intact with normal concentration. Insight and judgment both appropriate. Vital signs: BP 180/78, WT 170 pounds, HT 64", visual acuity without correction was right 20/20, left 20/20. Eyes/Ears, Skin, Neck, Chest, Heart, Abdomen, Vascular, Musculoskeletal, Neuro, Reflexes: [All within normal limits.] [redacted]

PSYCHIATRIC/PSYCHOLOGICAL REPORT on evaluation of [redacted] spends lot of time on the computer playing games and chatting and this is how she keeps in touch with her daughters. She states watching TV, riding a bike and loves to walk, visits with friends and attends AA three times a week.

> Diagnoses: Axis I: Major depression, recurrent, moderate to severe. R/O bipolar disorder. Axis II Probable personality disorder. Axis V: GAF 60. [redacted]
>
> [redacted] Psychiatric Discharge summary: Suicidal thoughts and urges. Long standing history of depression. Medically cleared in ER. History of alcoholism with last drink April 2008. Physical Examination: No acute distress, orientated times 3, Vital sings normal. HEENT, Neck, Lungs, Heart, Abdomen, Extremities, Neurologic, Cranial nerves: [All within normal limits.] with no focal signs.
>
> Mental Status Exam: Alert, orientated times 3, no psychomotor agitation but mild psychomotor retardation, fair eye contact, speech soft, slow but goal directed. Associations intact. No evidence of hallucinations or delusions. Mood quite depressed. Affect constricted and congruent with her mood. Insight and judgment were fair, memory and cognition were intact. In course of hospitalization her Celexa was cut out and started on Effexor and adjusted Depakote upward. On day of discharge she minimized any symptoms that she presented with initially, including suicidal thoughts, no medication side effects. Prescription was arranged so that she could afford to pay/obtain the medications. Follow up arranged with [redacted] DE N, pp. 11-18.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the MA program pursuant to MCL 400.1 *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).

Federal regulations require that the department use the same operative definition for "disabled" as used for Supplemental Security Income (SSI) under Title XVI of the Social Security Act. 42 CFR 435.540(a).

> "Disability" is:
>
> > . . . 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 CFR416.905

In determining whether an individual is disabled, 20 CFR 416.920 requires the trier of fact to follow a sequential evaluation process by which current work activity; the severity of impairment(s); residual functional capacity, and vocational factors (i.e., age, education, and work experience) are assessed in that order. A determination that an individual is disabled can be made at any step in the sequential evaluation. Then evaluation under a subsequent step is not necessary.

First, the trier of fact must determine if the individual is working and if the work is substantial gainful activity (SGA). 20 CFR 416.920(b). In this case, under the first step, Claimant testified to not performing SGA since 2006. Therefore, Claimant is not disqualified for MA at step one in the evaluation process.

Second, in order to be considered disabled for purposes of MA, a person must have a "severe impairment" 20 CFR 416.920(c). A severe impairment is an impairment which significantly limits an individual's physical or mental ability to perform basic work activities. Basic work activities mean the abilities and aptitudes necessary to do most jobs. 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. 20 CFR 416.921(b)

The purpose of the second step in the sequential evaluation process is to screen out claims lacking in medical merit. The court in *Salmi v Sec'y of Health and Human Servs*, 774 F2d 685 (6th Cir 1985) held that an impairment qualifies as "non-severe" only if it "would not affect the claimant's ability to work," "regardless of the claimant's age, education, or prior work experience." *Id.* At 691-92. Only slight abnormalities that minimally affect a claimant's ability to work can be considered non-severe. *Higgs v Bowen*, 880 F2d 860, 862 (6th Cir. 1988); *Farris v Sec'y of Health & Human Servs*, 773 F2d 85, 90 (6thCir 1985).

In this case, the Claimant has presented medical evidence to support a finding that the Claimant has mental/physical limitations which impact her abilities to perform basic work activities. It is necessary to continue to evaluate the Claimant's impairments under step three.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's mental impairments are listed in Appendix 1 of Subpart P of 20 CFR, Part 404. Based on the hearing record, the undersigned finds that the Claimant's medical record will not support findings that the mental/physical impairment is a "listed impairment(s)" or equal to a listed impairment. 20 CFR 416.920(a) (4) (iii). According to the medical evidence, alone, the Claimant cannot be found to be disabled.

Appendix I, Listing of Impairments (Listing) discusses the analysis and criteria necessary to a finding of a listed impairment. In this matter, the medical records establish a diagnosis of depression and bipolar disorder and cervical spine injuries and seizure disorder. See finding of facts 8-10.

Appendix 1 of Subpart P of 20 CFR, Part 404. Listing 12.04, *Affective Disorders* is relevant to the diagnosis of Depression and Bipolar Disorder. After reviewing the criteria of the

listings, the undersigned finds the Claimant's medical records do not substantiate that the Claimant's mental impairment meets the intent or severity of listing requirements of 12.04.

The Claimant's mental disorder was diagnosed concomitant with active substance abuse including alcohol; and according to the medical records, the Claimant's last alcohol ingestion was alleged to be [redacted] As of September 2008 the Claimant was in mental health treatment and taking prescribed medications. On hospital discharge, the Claimant denied suicidal ideation. The medical records indicate the Claimant is independent in ADLs and fully functional: i.e. riding bikes and taking walks and using the computer. See finding of facts 8-10.

The Claimant has no medical evidence to establish the criteria, intent and severity of a loss of physical function required under Appendix 1 of Subpart P of 20 CFR, Part 404, listing 1.00. [redacted] found full use of upper and lower extremities and did not find neurological deficits. The Claimant was fully ambulatory. See finding of facts 8-10. Appendix 1 of Subpart P of 20 CFR, Part 404, Listing 11.00 *Neurological System* discusses seizure disorders. For one thing, brain testing results were not conclusive for brain dysfunction causing seizures; and the Claimant was actively drinking alcohol to excess until April 2008. Fact 8, the medical professions opined that the seizures were related to alcohol withdrawal. Finally, the Claimant is prescribed and presumably taking Depakote with was increased in September 2008. There was no established medical record of seizures from June 2008.

In this case, this Administrative Law Judge finds the Claimant is not presently disabled at the third step for purposes of the Medical Assistance (MA) program. Sequential evaluation under step four or five is necessary. 20 CFR 416.905.

In the fourth step of the sequential evaluation of a disability claim, the trier of fact must determine if the Claimant's impairment(s) prevent Claimant from doing past relevant work. 20

CFR 416.920(e). Residual functional capacity (RFC) will be assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what you can do in a work setting. RFC is the most you can still do despite your limitations. All the relevant medical and other evidence in your case record applies in the assessment. See 20 CFR 416.945.

Claimant's past relevant work was basically related to retail businesses in plant/ nursery services and cashier positions. At hearing the Claimant testified she could not return to past relevant work. This is persuasive to the undersigned that the Claimant cannot return to past relevant work.

In the fifth step of the sequential evaluation of a disability claim, the trier of fact must determine: if the claimant's impairment(s) prevent him/her from doing other work. 20 CFR 416.920(f). This determination is based on the claimant's:

> (1) "Residual function capacity," defined simply as "what you can still do despite your limitations,"20 CFR 416.945.
>
> (2) Age, education and work experience, and
>
> (3) The kinds of work which exist in significant numbers in the national economy which the claimant could perform despite his/her impairments.
>
> 20 CFR 416.960. *Felton v DSS*, 161 Mich App 690, 696-697, 411 NW2d 829 (1987).

It is the finding of the undersigned, based upon the medical evidence, objective physical findings, and hearing record that Claimant's RFC for work activities on a regular and continuing basis is functionally limited to sedentary work. Appendix 2 to Subpart P of Part 404—Medical-Vocational Guidelines 20 CFR 416.967(a):

> *Sedentary work:* Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and

> small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

Claimant at forty-three is considered a *younger individual;* a category of individuals age 18 to 49. Under Appendix 2 to Subpart P: Table No. 1—Residual Functional Capacity: Maximum Sustained Work Capability Limited to Sedentary Work as a Result of Severe Medically Determinable Impairment(s), Rule 201.28, for younger individual, age 18 to 49; education: high school graduate or more; previous work experience, skilled or semiskilled—skills not transferable; the Claimant is "not disabled" per Rule 201.28.

It is the finding of the undersigned, based upon the medical data and hearing record that Claimant is "not disabled" at the fifth step.

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 1939 PA 280, as amended. The Department of Human Services (formerly known as the Family Independence Agency) administers the SDA program pursuant to MCL 400.1 et seq., and MAC R 400.3151-400.3180. Department policies are found in the Program Administrative Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM).

A person is considered disabled for purposes of SDA if the person has a physical or mental impairment 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. Other specific financial and non-financial eligibility criteria are found in PEM 261.

In this case, there is insufficient evidence to support a finding that Claimant's impairments meet the disability requirements under SSI disability standards, and prevents other work for ninety days. This Administrative Law Judge finds the Claimant is "not disabled" for purposes of the SDA program.

DECISION AND ORDER

The Administrative Law Judge, based on the findings of fact and conclusions of law, decides that the Claimant is "not disabled" for purposes of the Medical Assistance program and the State Disability Program.

It is ORDERED; the Department's determination in this matter is AFFIRMED.

/s/_____
Judith Ralston Ellison
Administrative Law Judge
For Ishmael Ahmed, Director
Department of Human Services

Date Signed: __February 26, 2009____

Date Mailed: __February 26, 2009____

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 Circuit Court 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 receipt date of the rehearing decision.

JRE/jlg

cc: [redacted]