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: 2009-39606
Issue No: 2009; 4031
Case No: [redacted]
Load No: [redacted]
Hearing Date:
October 27, 2009
Genesee County DHS

ADMINISTRATIVE LAW JUDGE: Jay W. Sexton

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 telephone hearing was held on October 27, 2009 in Flint. Claimant personally appeared and testified under oath.

The department was represented by Mary Humbarger (ES).

The Administrative Law Judge appeared by telephone from Lansing.

ISSUES

(1) Did claimant establish a severe mental impairment expected to preclude her from substantial gainful work, **continuously**, for one year (MA-P) or 90 days (SDA)?

(2) Did claimant establish a severe physical impairment expected to preclude her from substantial gainful work, **continuously**, for one year (MA-P) or 90 days (SDA)?

FINDINGS OF FACT

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

(1) Claimant is an MA-P/SDA applicant (May 29, 2009) who was denied by SHRT (October 1, 2009) based on claimant's ability to perform unskilled sedentary work. SHRT relied on Med-Voc 204.00 as a guide. The Record closed on October 27, 2009. The disputed eligibility period is May 27, 2009 to October 27, 2009.

(2) Claimant's vocational factors are: age--44; education--9th grade; post high school education--obtained a certification as a nurse aide (expired); work experience--child care provider for DHS.

(3) Claimant has not performed Substantial Gainful Activity (SGA) since 2003 when she was a child care provider for DHS.

(4) Claimant has the following unable-to-work complaints:

(a) Memory dysfunction;
(b) Side effects from prescription medications;
(c) Difficulty spelling words;
(d) Drug free for one year;
(e) Abstinent from alcohol for one year;
(f) Major depression;
(g) Back pain; and
(h) Osteoarthritis.

(5) SHRT evaluated claimant's medical evidence as follows:

OBJECTIVE MEDICAL EVIDENCE (October 1, 2009)

SHRT decided that claimant is able to perform unskilled work under 20 CFR 416.968(a). SHRT evaluated claimant's impairments using SSI Listings 1.03, 1.04, 12.04 and 12.09. SHRT decided that claimant does not meet the applicable SSI Listings. SHRT denied disability based on Med-Voc Rule 204.00 and claimant's ability to perform unskilled work.

(6) Claimant is homeless and is staying with a friend. Claimant performs the following Activities of Daily Living (ADLs): dressing, bathing, cooking, dishwashing, light cleaning, mopping, vacuuming, laundry and grocery shopping (needs help). Claimant does not

use a cane, walker, wheelchair, or shower stool. Claimant does not wear braces. Claimant received inpatient hospital care in 2008 for a psychiatric condition. Claimant was not hospitalized in 2009.

(7) Claimant has a valid driver's license and drives an automobile approximately 12 times a month. Claimant's computer skills are unknown.

(8) The following medical records are persuasive:

(a) A December 10, 2008 Medical Examination Report (DHS-49). The M.D. psychiatrist provided the following current diagnoses:

Polysubstance dependence (alcohol, marijuana, tobacco, alcohol and crack cocaine), rule out bipolar mood disorder. Rule out panic disorder versus alcohol withdrawal; social anxiety disorder and borderline personality traits. The psychiatrist states that claimant has no physical limitations.

The psychiatrist states that claimant's mental limitations include reduced comprehension, reduced memory function, reduced ability to concentrate, reduced ability to read and write and reduced ability to engage in social interaction.

NOTE: The psychiatrist did not state that claimant is totally unable to work.

(b) A December 10, 2008 Medical Needs form (FIA-54A) was reviewed. The psychiatrist provided the following diagnoses: anxiety disorder, bipolar disorder and polysubstance dependence.

The psychiatrist states that claimant does not have a medical need for assistance with personal care activities. Claimant is unable to perform her usual occupation; for a duration of claimant's incapacity is six months.

(c) A September 3, 2008 psychiatric evaluation plan was reviewed.

The psychiatrist provided the following background:

Claimant is a 43-year-old widowed Caucasian woman who presents for initial psychiatric assessment at GTI with a request for case management and medication management services. She was referred by [redacted] on her discharge from [redacted]). Claimant is not receiving mental health services other than crisis care. She is currently homeless and resides with a friend she met at [redacted]. She gave her daughter's address at [redacted], as a contact; claimant is not living with her daughter. Claimant is unemployed and has no insurance.

The psychiatrist provided the following mental status evaluation:

Claimant is alert and oriented to person, place, date and time with hints. She is able to name presidents times four with prompts. Her fund of knowledge is fair as evidenced in the ability to name five major cities in Michigan and a few current events. Her intellect appears average based on vocabulary, fund of knowledge and educational history. Her memory is intact to immediate, short and long-term as evidenced by the ability to recall 3/3 objects at one, at zero, at one and five minutes, as well as recount dates and events that can be documented.

* * *

The psychiatrist provided the following DSM-IV diagnoses:

Axis I--polysubstance dependence (alcohol, cocaine, marijuana); polysubstance dependence: tobacco, alcohol, and crack cocaine; rule out bipolar disorder; rule out panic disorder versus alcohol withdrawal.

Axis V/GAF--35.

(c) An [redacted] history and physical exam was reviewed.

The [redacted] physician provided the following background:

Claimant was a 43-year-old widow, mother of two children, 26 and 13. Her 13-year-old daughter was given legal custody (sic), the 26-year-old married daughter. Claimant had a 7th grade education, but later obtained a GED and is currently unemployed. She was admitted via emergency room with severe depression and suicidality. She stated that she lost her job taking care of an old man and then she lost her car and even her house. Currently, she has become homeless. Nevertheless, she has been using cocaine, $20 worth on a daily basis and alcohol a case a day. Claimant had a history of delirium tremens and blackout spells. She was also in jail a couple of times for assault and battery. She is so down and dejected that everybody would be better off without her. She stated that her life has no purpose or meaning left for her anymore. She could not sleep, eat, or concentrate. She also claimed that she was beaten up by the gang in the neighborhood.

* * *

Physical examination:

On physical examination, she gives a history of multiple contusions of the head due to beating.

HOSPITAL COURSE:

* * *

Claimant stated she is always self-destructive and always doing things against her and her family. Because of a man committing suicide and leaving a note, his family and friends all accused her of murder. She was traumatized with repeated nightmares for sometime. She also revealed that another man blew off his head when she told him to go ahead and do it when he threatened to kill himself. She could not take this anymore and she went wild with alcohol and drugs. She never felt the same ever since. She was often dejected, despondent, and feeling hopeless, helpless, and useless. She was also asking repeatedly: ‘do I have a chance and myself esteem is zero, my past is haunting, I feel totally useless, no use trying and I am ready to give up. Toward the end of her hospital stay, her suicidal impulses lessened and affect was again still level. Her concentration and participation in the various programs were still limited.

Sleep was fragmented. She was not really amenable to reason and persuasion. She was anxious, restless and agitated. Participation was still limited and was demanding Vicodin. By the time the patient was released from the hospital, however, she had made significant improvement through introspection and self-reflection. She was compliant and receptive to intervention. She was sleeping and eating better. By the time she was released from the hospital, she was free of suicidal and homicidal ideation or psychotic processes.

* * *

(d) An [redacted] psychiatric medical report was reviewed.

The psychiatrist provided the following history:

* * *

When asked for the chief complaints and symptoms, she stated to having been diagnosed with bipolar disorder and to have been 'clean for eight months' from crack cocaine and alcohol. She stated, 'no I am just trying to get it together.' She stated to have symptoms of crying spells, racing thoughts where she would repeat over and over in her mind about things I did, would have and could have did.' She has decreased sleep, suicidal ideations and a weight gain of approximately 70 pounds over the past eight months and decreased concentration.

PERSONAL HISTORY:

* * *

Claimant reportedly signed over partial custody of her younger daughter to the older daughter approximately two years ago. She stated she has worked three or four months as a substitute mail carrier, and a certified nurse aide and at a machine shop. She reported a three to four-year dependence on crack cocaine and alcohol. She stated that she has currently been clean for approximately eight months. During the time of her abuse and dependence, she was reportedly homeless in the east side of Flint. She stated she currently smokes half a pack of cigarettes per day.

* * *

> MENTAL TREND:
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> There was no evidence of any hallucinations, delusions or thoughts controlled by others. She reported sleep disturbances and recent weight gain within the last eight months. She stated to have fleeting suicidal thoughts.
>
> * * *
>
> Based on today's evaluation claimant would likely work well with female coworkers. She will do well accepting criticism from authority. She demonstrated some impairments in her general fund of information, concentration for digits as well as recent memory. Her affect thought and sense of judgment are found to be within normal limits.
>
> DSM diagnosis:
>
> Axis I: major depressive disorder, recurrent, moderate severity; cocaine dependence, early full remission, alcohol dependence, early fully remission;
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> Axis V/GAF--35--40.
>
> * * *
>
> **NOTE:** The [redacted] psychiatrist did not state that claimant is totally unable to work.
>
> * * *

(9) Claimant alleges disability based on a combination of mental impairments: Memory dysfunction and major depression. Claimant did provide a DHS-49D and a DHS-49E. The physician who provided the DHS-49 states that claimant has no physical limitations. The psychiatrist reports that claimant has mental limitations in the following areas: Comprehension, memory, sustained concentration, reading/writing and social interaction. The psychiatrist did not state that claimant is totally unable to work.

(10) Claimant alleges disability based on a combination of physical impairments: Abstinence from drugs for one year; abstinence from alcohol for one year; back pain, and osteoarthritis. The physician who completed the Medical Examination Report (DHS-49, dated December 10, 2008) reported that claimant does not have any severe physical limitations. The

physician who provided the DHS-49 did not state that claimant was totally unable to work.

(11) Claimant recently applied for federal disability benefits (SSI) with the Social Security Administration. Social Security denied her application. Claimant filed a timely appeal.

(12) Claimant currently smokes one-half pack of cigarettes per day, against medical advice (AMA). Claimant has abstained from street drugs for approximately one year; claimant has abstained from alcohol for approximately one year.

CONCLUSIONS OF LAW

CLAIMANT'S POSITION

Claimant thinks she is entitled to MA-P/SDA benefits based on the impairments listed in Paragraph #4 above.

DEPARTMENT'S POSITION

The department thinks that claimant has the Residual Functional Capacity (RFC) to perform normal unskilled work activities.

The department evaluated claimant's impairments using SSI Listings 1.03, 1.04, 12.04 and 12.09.

The department decided that claimant does not meet any of the applicable SSI Listings. The department denied claimant's request for disability benefits based on Med-Voc Rule 204.00 as a guide.

LEGAL BASE

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 400.10, *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).

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. The Department of Human Services (DHS or department) administers the SDA program pursuant to MCL 400.10, *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).

Pursuant to Federal Rule 42 CFR 435.540, the Department of Human Services uses the federal Supplemental Security Income (SSI) policy in determining eligibility for disability under the Medical Assistance program. Under SSI, 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 set order is used to determine disability. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience is reviewed. If there is a finding that an individual is disabled or not disabled at any point in the review, there will be no further evaluation. 20 CFR 416.920.

If an individual is working and the work is substantial gainful activity, the individual is not disabled regardless of the medical condition, education and work experience. 20 CFR 416.920(c).

If the impairment or combination of impairments does not significantly limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. Age, education and work experience will not be considered. 20 CFR 416.920.

Statements about pain or other symptoms do not alone establish disability. There must be medical signs and laboratory findings which demonstrate a medical impairment.... 20 CFR 416.929(a).

> ...Medical reports should include –
>
> (1) Medical history.
>
> (2) Clinical findings (such as the results of physical or mental status examinations);
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> (3) Laboratory findings (such as blood pressure, X-rays);
>
> (4) Diagnosis (statement of disease or injury based on its signs and symptoms).... 20 CFR 416.913(b).

In determining disability under the law, the ability to work is measured. An individual's functional capacity for doing basic work activities is evaluated. If an individual has the ability to perform basic work activities without significant limitations, he or she is not considered disabled. 20 CFR 416.994(b)(1)(iv).

Basic work activities are the abilities and aptitudes necessary to do most jobs. Examples of these 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).

Medical findings must allow a determination of (1) the nature and limiting effects of your impairment(s) for any period in question; (2) the probable duration of the impairment; and (3) the residual functional capacity to do work-related physical and mental activities. 20 CFR 416.913(d).

Medical evidence may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of the impairment(s), including your symptoms, diagnosis and prognosis, what an individual can do despite impairment(s), and the physical or mental restrictions. 20 CFR 416.927(a)(2).

All of the evidence relevant to the claim, including medical opinions, is reviewed and findings are made. 20 CFR 416.927(c).

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).

A statement by a medical source finding that an individual is "disabled" or "unable to work" does not mean that disability exists for the purposes of the program. 20 CFR 416.927(e).

When determining disability, the federal regulations require that several considerations be analyzed in sequential order. If disability can be ruled out at any step, analysis of the next step is <u>not</u> required. These steps are:

1. Does the client perform Substantial Gainful Activity (SGA)? If yes, the client is ineligible for MA. If no, the analysis continues to Step 2. 20 CFR 416.920(b).

2. Does the client have a severe impairment that has lasted or is expected to last 12 months or more or result in death? If no, the client is ineligible for MA. If yes, the analysis continues to Step 3. 20 CFR 416.920(c).

3. Does the impairment appear on a special listing of impairments or are the client's symptoms, signs, and laboratory findings at least equivalent in severity to the set of medical findings specified for the listed impairment? If no, the analysis continues to Step 4. If yes, MA is approved. 20 CFR 416.290(d).

4. Can the client do the former work that he/she performed within the last 15 years? If yes, the client is ineligible for MA. If no, the analysis continues to Step 5. 20 CFR 416.920(e).

5. Does the client have the Residual Functional Capacity (RFC) to perform other work according to the guidelines set forth at 20 CFR 404, Subpart P, Appendix 2, Sections 200.00-204.00? If yes, the analysis ends and the client is ineligible for MA. If no, MA is approved. 20 CFR 416.920(f).

The department decides eligibility based on mental impairments using the following standards:

> **(a) Activities of Daily Living.**
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> **...Activities of daily living** including adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for one's grooming and hygiene, using telephones and directories, using a post office, etc. 20 CFR, Part 404, Subpart P, App. 1, 12.00(C)(1).
>
> **(b) Social Functioning**
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> **...Social functioning** refers to an individual's capacity to interact independently, appropriately, effectively, and on a sustained basis with other individuals. 20 CFR, Part 404, Subpart P, App. 1, 12.00(C)(2).
>
> Social functioning includes the ability to get along with others, such as family members, friends, neighbors, grocery clerks, landlords, or bus drivers. You may demonstrate impaired social functioning by, for example, a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, or social isolation. You may exhibit strength in social functioning

by such things as your ability to initiate social contacts with others, communicate clearly with others, or interact and actively participate in group activities. We also need to consider cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority (e.g., supervisors), or cooperative behaviors involving coworkers. 20 CFR, Part 404, Subpart P, App. 1, 12.00(C)(2).

(c) Concentration, Persistence or Pace.

...Concentration, persistence or pace refers to the ability to sustain focused attention and concentration sufficiently long to permit the timely and appropriate completion of tasks commonly found in work settings. 20 CFR, Part 404, Subpart P, App. 1, 12.00(C)(3).

Limitations in concentration, persistence, or pace are best observed in work settings, but may also be reflected by limitations in other settings. In addition, major limitations in this area can often be assessed through clinical examination or psychological testing. Wherever possible, however, a mental status examination or psychological test data should be supplemented by other available evidence. 20 CFR, Part 404, Subpart P, App. 1, 12.00(C)(3).

(d) Sufficient Evidence:

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). Medical evidence must be sufficiently complete and detailed as to symptoms, signs, and laboratory findings to permit an independent determination. In addition, we will consider information from other sources when we determine how the established impairment(s) affects your ability to function. We will consider all relevant evidence in your case record. 20 CFR 404, Subpart P, App. 1, 12.00(D).

(e) Chronic Mental Impairments:

...Chronic Mental Impairments: Particular problems are often involved in evaluating mental impairments in individuals who have long histories of repeated hospitalizations or prolonged outpatient

> care with supportive therapy and medication. For instance, if you have chronic organic, psychotic, and affective disorders you may commonly have your life structured in such a way as to minimize your stress and reduce your signs and symptoms.... 20 CFR 404, Subpart P, App. 1, 12.00(E).

A statement by a medical source (MSO) that an individual is "disabled," or "unable to work" does not mean that disability exists for purposes of the MA-P/SDA programs. 20 CFR 416.927(e).

Claimant has the burden of proof to show by a preponderance of the medical evidence in the record that her mental/physical impairments meet the department's definition of disability for MA-P/SDA purposes. PEM 260/261. "Disability," as defined by MA-P/SDA standards is a legal term which is individually determined by consideration of all factors in each particular case.

STEP #1

The issue at Step 1 is whether claimant is performing Substantial Gainful Activity (SGA). If claimant is working and earning substantial income, she is not disabled for MA-P/SDA.

SGA is defined as the performance of significant duties over a reasonable period of time for pay. Claimants who are working, or otherwise performing Substantial Gainful Activity (SGA), are not disabled regardless of medical condition, age, education or work experience. 20 CFR 416.920(b).

The vocational evidence of record shows that claimant is not currently performing SGA.

Therefore, claimant meets the Step 1 disability test.

STEP #2

The issue at Step 2 is whether claimant has impairments which meet the SSI definition of severity/duration. Claimant must meet an impairment which is expected to result in death, has existed for 12 months and/or totally prevents all basic work activities. 20 CFR 416.909.

Also, to qualify for MA-P, the claimant must satisfy both the gainful work and the duration criteria. 20 CFR 416.920(a).

Applying the *de minimus* standard, claimant meets the Step 2 disability test.

STEP #3

The issue at Step 3 is whether the claimant meets the Listing of Impairments in the SSI regulations. Claimant does not allege disability based on the Listings.

However, SHRT evaluated claimant's eligibility using SSI Listings 1.03, 1.04, 12.04 and 12.09. Based on the current medical evidence in the record, SHRT decided that claimant does not meet any of the applicable SSI Listings.

Therefore, claimant does not meet the Step 3 eligibility test.

STEP #4

The issue at Step 4 is whether claimant is able to do her previous work. Claimant last worked as a day care provider for DHS. This was light/medium work.

The medical evidence of record establishes that claimant has a history of memory problems, major depression, back pain and osteoarthritis. Claimant's impairments preclude her from heavy lifting.

Since claimant is unable to perform the light/medium work she was performing as a DHS day care provider, claimant is not able to return to her previous work.

STEP #5

The issue at Step 5 is whether claimant has the Residual Functional Capacity (RFC) to do other work.

Claimant has the burden of proof to show by the medical evidence in the record that her combined impairments meet the department's definition of disability for MA-/SDA purposes.

First, claimant alleges disability based on a combination of mental impairments: Memory dysfunction and major depression. A recent Medical Examination Report, prepared by a psychiatrist (December 10, 2008) contains the following diagnoses: Polysubstance dependence (alcohol, cocaine and marijuana) and tobacco, alcohol and crack cocaine; rule out bipolar disorder; rule out panic disorder versus alcohol withdrawal; social anxiety disorder/anti-social and borderline personality traits. The examining physician stated that claimant was unable to return to her usual occupation for six months. Significantly, the physician who prepared the DHS-49 stated that claimant had no physical limitations. Although claimant does have limitations based on her back dysfunction, the medical evidence of record does not show that claimant is fully unable to perform sedentary work due to her physical impairments.

Second, claimant testified that a major impediment to her return to work was her back pain and osteoarthritis. Unfortunately, the evidence of pain, alone, is insufficient to establish disability for MA-P/SDA purposes. The Administrative Law Judge concludes that claimant's testimony about her pain is profound and credible, but out of proportion to the objective medical evidence as it relates to claimant's ability to work.

In short, the Administrative Law Judge is not persuaded that claimant is totally unable to work based on her combined impairments. Claimant performs significant number of Activities of Daily Living, has an active social life with her relatives and friends, drives an automobile approximately twelve times a month.

Considering the entire medical record, in combination with claimant's testimony, the Administrative Law Judge concludes that claimant is able to perform simple, unskilled sedentary work (SGA). In this capacity, she is able to work as a ticket taker for a theater, as a parking lot attendant, and as a greeter for [redacted].

Based on this analysis, the department correctly denied claimant's MA-P/SDA application under Step 5 of the sequential analysis, as presented above.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that claimant does not meet the MA-P/SDA disability requirements under PEM 260/261.

SO ORDERED.

/s/ _____
Jay W. Sexton
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: May 7, 2010

Date Mailed: May 7, 2010

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.

JWS/tg

cc: [redacted]