STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS & RULES
FOR THE DEPARTMENT OF HUMAN SERVICES
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IN THE MATTER OF:

SOAHR Docket No. 2010-2707REHD
DHS Req. No: 2010-2212

[redacted],

Claimant
_____/

RECONSIDERATION DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 24.287(1) and 1993 AACS R 400.919 upon the request of the Claimant.

ISSUE

Did Claimant meet the Medical Assistance (MA-P) disability standard for the period of August 2007 through January 2009?

FINDINGS OF FACTS

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

1. Findings of Fact 1-5 from the Hearing Decision mailed on September 17, 2009, are incorporated herein by reference.

2. On February 8, 2009, Claimant died from mixed drug intoxication/drug overdose; and his death was considered accidental. (Claimant Exhibit A)

3. After receiving Claimant's Certificate of Death, SHRT approved Claimant for MA-P benefits for the month of February 2009 only.

4. On September 17, 2009, ALJ Janice Spodarek issued a Decision & Order in which the Administrative Law Judge upheld the approval of MA-P benefits for the month of February 2009.

5. On October 19, 2009, the State Office of Administrative Hearings and Rules for DHS received Claimant's request for Rehearing/Reconsideration.

6. On November 2, 2009, the State Office of Administrative Hearings and Rules, Administrative Hearings for DHS granted the Claimant's request for Reconsideration and issued notice of the Order of Reconsideration to the Claimant.

7. Claimant has a history of alcohol abuse. (Exhibit 1, pp. 32-34)

8. On August 12, 2007, Claimant was admitted to the hospital after being found unresponsive, next to empty bottles of pills at his bedside at home; and the assessment of Claimant revealed severe major depression, and suicide attempt with 30 tablets of Elavil and three (3) pints of alcohol. (Exhibit 1, p. 33)

9. After being admitted to the hospital on August 12, 2007, Claimant required mechanical ventilation; and Claimant's problem list included acute respiratory failure, bilateral pneumonia, tricyclic overdose, alcoholism, depression, and protein calorie malnutrition. (Exhibit 1, pp. 6 & 28)

10. A mental status exam on August 12, 2007, revealed the following: Claimant was a 52-year-old married man with clear, fluent and coherent speech; Claimant's thought process was goal directed and linear; there was no evidence of loose associations or flight of ideas; Claimant denied hallucinations either visual or auditory; there was no evidence of psychosis or delusions in Claimant's conversation; Claimant was oriented to person, place, time, and purpose; Claimant's recent and remote memory appeared to be intact; Claimant appeared to follow directions and verbal commands; Claimant did not appear to be easily distracted; Claimant's fund of knowledge was average; Claimant's mood was extremely dysphoric; Claimant's affect was tearful and sad; Claimant was cooperative; Claimant scored an 11/15 on the Geriatric Depression Screen, indicating severe depression; Claimant endorsed many symptoms of hopelessness and continued to be a high risk for subsequent suicidal attempts or gestures, unless treated as an inpatient psychiatrically; Clamant had a diagnoses of Major depression-recurrent-severe, and suicide attempt with tricyclic medication and alcohol; and Claimant was given a global assessment of functioning (GAF) score of 55. (Exhibit 1, pp. 31 & 32)

11. The CT of Claimant's head did not reveal an acute process, only left maxillary sinus disease. (Exhibit 1, p. 16)

12. Claimant's echocardiogram, done on August 20, 2007, revealed: an enlarged left atrium; a dilated left ventricle; a global ejection fraction of 50%; mild mitral regurgitation; mild tricuspid regurgitation; and no intracardiac thrombus or pericardial effusion. (Exhibit 1, p. 7)

13. On August 24, 2007, Claimant was discharged from the hospital for treatment of physical problems after it was determined by the medical doctor that Claimant had recovered; and Claimant improved gradually and came off the ventilator. (Exhibit 1, p. 6)

14. On August 24, 2007, Claimant was admitted into the psychiatric unit of the hospital for monitoring of his severe depression; and Claimant was discharged from inpatient psychiatric care on August 28, 2007. (Claimant Exhibit 1, p. 6)

15. At the time Claimant was discharged from the psychiatric unit of the hospital: he had a pretty broad affect; he easily engaged in conversation; his thought process was organized and goal directed; he was future oriented in his thinking; he denied any suicidal ideation; and there was no psychosis identified. (Exhibit 1, p. 3)

16. Claimant's underwent a psychological evaluation on September 12, 2007, which revealed: Claimant's speech was articulate with normal rate, volume and rhythm; he maintained good eye contact; Claimant did not have any bizarre or unusual mannerisms; Claimant's prescribed medication, reportedly, got rid of his depression; Claimant was not loose, circumstantial, or tangential; Claimant was not hallucinating, and he was in touch with reality; Claimant was having some short term memory loss, subjectively, otherwise his cognitive functions appeared to be grossly intact; Claimant was able to smile and laugh at one of the examiner's jokes during the interview; and Claimant was given a GAF score of 55. (Claimant Exhibit C, pp. 11 & 12)

17. According to a [redacted] report, dated January 23, 2008, the doctor determined that Claimant was most likely having residual depression due to his thyroid disease and chronic pain; and it was recommended that Claimant continue taking Elavil and get his thyroid gland tested. (Claimant Exhibit C, p. 22)

18. On January 30, 2008, the State Hearing Review Team (SHRT) denied Claimant's application for MA-P on the basis that Claimant's medical condition was improving or expected to improve with 12 months from the date of onset, and, therefore, he did not meet the MA-P duration standard.

19. Claimant's date of birth is March 30, 1955.

20. Claimant had past relevant work experience in the factory, and he was a construction worker. (Exhibit 1, p. 36)

21. Claimant had completed the 12th grade. (Exhibit 1, p. 36)

22. Claimant was not engaged in substantial gainful activity at any time relevant to this matter.

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 Family Independence Agency (FIA or agency) administers the MA program pursuant to MCL 400.10, *et seq*., and MCL 4000.105; MSA 16.490 (15). Agency 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 435.50, the Family Independence Agency 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*

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 a recovery and/or medical assessment of ability to do work-related activities or ability to reason and to make appropriate mental adjustments, if a mental disability is being alleged, 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908 and 20 CFR 416.929. By the same token, a conclusory statement by a physician or mental health professional that an individual is disabled or blind is not sufficient without supporting medical evidence to establish disability. 20 CFR 416.929.

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 –
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> (1) Medical history.
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> (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);
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> (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 aptitude necessary to do most jobs. Examples of these include –

> (1) Physical functions such as walking, standing, sitting, lifting, pushing, reaching, carrying, or handling;
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> (2) Capacities for seeing, hearing, and speaking;
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> (3) Understanding, carrying out, and remembering simple instructions;
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> (4) Use of judgment;
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> (5) Responding appropriately to supervision, co-workers and usual work situations; and
>
> (6) Dealing with changes in a routine work setting. 20CFR 416.921 (b).

The Residual Functional Capacity (RFC) is what an individual can do despite limitations. All impairments will be considered in addition to ability to meet certain demands of jobs in the national economy. Physical demands, mental demands, sensory requirements and other functions will be evaluated…20 CFR 416.945 (a).

To determine the physical demands (exertional requirements) of work in the national economy, we classify jobs as sedentary, light, medium, and heavy. These terms have the same meaning as they have in the Dictionary of Occupational Titles, published by the Department of Labor…20 CFR 416.967.

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. 20 CFR 416.967 (a).

Light work. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls…20 CCR 416.9677 (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 reflects 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, are reviewed and findings are made. 20 CFR 416.927 (c).

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).

If an individual fails to follow prescribed treatment which would be expected to restore their ability to engage in substantial gainful activity without good cause, there will not be a finding of disability… 20 CFR 416.994 (b)(4)(iv).

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) *General.* (1) If you are an adult, you can only be found disabled if you are unable 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. (See §416.905.) If you are a child, you can be found disabled only if you have a medically determinable physical or mental impairment(s) that causes marked and severe functional limitations and that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. (See §416.906.) Your impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. (See §416.908.)
>
> (2) Evidence that you submit or that we obtain 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 your impairment(s), includinq your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.
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> (b) *How we consider medical opinions.* In deciding whether you are disabled, we will always consider the medical opinions in your case record together with the rest of the relevant evidence we receive.
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> (c) *Making disability determinations.* After we review all of the evidence relevant to your claim, including medical opinions, we make findings about what the evidence shows.
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> (1) If all of the evidence we receive, including all medical opinion(s), is consistent, and there is sufficient evidence for us to decide whether you are disabled, we will make our determination or decision based on that evidence.
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> (2) If any of the evidence in your case record, including any medical opinion(s), is inconsistent with other evidence or is internally inconsistent, we will weigh all of the evidence and see whether we can decide whether you are disabled based on the evidence we have.

(3) If the evidence is consistent but we do not have sufficient evidence to decide whether you are disabled, or, if after weighing the evidence we decide we cannot reach a conclusion about whether you are disabled, we will try to obtain additional evidence under the provisions of §§416.912 and 416.919 through 416.919h. We will request additional existing records, recontact your treating sources or any other examining sources, ask you to undergo a consultative examination at our expense, or ask you or others for more information. We will consider any additional evidence we receive together with the evidence we already have.

(4) When there are inconsistencies in the evidence that cannot be resolved, or when despite efforts to obtain additional evidence the evidence is not complete, we will make a determination or decision based on the evidence we have.

(d) *How we weigh medical opinions.* Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (d)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) *Examining relationship.* Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.

(2) *Treatment relationship.* Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (d)(2)(i) and (d)(2)(ii) of this section, as well as the factors in paragraphs (d)(3) through (d)(6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.

(i) *Length of the treatment relationship and the frequency of examination.* Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(ii) *Nature and extent of the treatment relationship.* Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(3) *Supportability.* The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for an opinion, the more weight we will give that opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their opinions will depend on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including opinions of treating and other examining sources.

(4) *Consistency.* Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) *Specialization.* We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.

(6) *Other factors.* When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion. For example, the amount of understanding of our disability

programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the extent to which an acceptable medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(e) *Medical source opinions on issues reserved to the Commissioner.* Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(2) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; *i.e.,* that would direct the determination or decision of disability.

(1) *Opinions that you are disabled.* We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are “disabled” or “unable to work” does not mean that we will determine that you are disabled.

(2) *Other opinions on issues reserved to the Commissioner.* We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to subpart P of part 404 of this chapter, your residual functional capacity (see §§416.945 and 416.946), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (e)(1) and (e)(2) of this section.

(f) *Opinions of nonexamining sources.* We consider all evidence from nonexamining sources to be opinion evidence. When we consider the opinions of nonexamining sources, we apply the rules in paragraphs (a) through (e) of this section. In addition, the following rules apply to State agency medical and psychological consultants, other program physicians and psychologists, and medical experts we consult in connection with administrative law judge hearings and Appeals Council review:

(1) At the initial and reconsideration steps in the administrative review process, except in disability hearings, State agency medical and

psychological consultants are members of the teams that make the determinations of disability. A State agency medical or psychological consultant will consider the evidence in your case record and make findings of fact about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or equals the requirements for any impairment listed in appendix 1 to subpart P of part 404 of this chapter, and your residual functional capacity. These administrative findings of fact are based on the evidence in your case record but are not themselves evidence at these steps.

(2) Administrative law judges are responsible for reviewing the evidence and making findings of fact and conclusions of law. They will consider opinions of State agency medical or psychological consultants, other program physicians and psychologists, and medical experts as follows:

(i) Administrative law judges are not bound by any findings made by State agency medical or psychological consultants, or other program physicians or psychologists. However, State agency medical and psychological consultants and other program physicians and psychologists are highly qualified physicians and psychologists who are also experts in Social Security disability evaluation. Therefore, administrative law judges must consider findings of State agency medical and psychological consultants or other program physicians or psychologists as opinion evidence, except for the ultimate determination about whether you are disabled. See §416.912(b)(6).

(ii) When an administrative law judge considers findings of a State agency medical or psychological consultant or other program physician or psychologist, the administrative law judge will evaluate the findings using relevant factors in paragraphs (a) through (e) of this section, such as the physician's or psychologist's medical specialty and expertise in our rules, the supporting evidence in the case record, supporting explanations provided by the physician or psychologist, and any other factors relevant to the weighing of the opinions. Unless the treating source's opinion is given controlling weight, the administrative law judge must explain in the decision the weight given to the opinions of a State agency medical or psychological consultant or other program physician or psychologist, as the administrative law judge must do for any opinions from treating sources, nontreating sources, and other nonexamining sources who do not work for us.

(iii) Administrative law judges may also ask for and consider opinions from medical experts on the nature and severity of your impairment(s) and on

> whether your impairment(s) equals the requirements of any impairment listed in appendix 1 to subpart P of part 404 of this chapter. When administrative law judges consider these opinions, they will evaluate them using the rules in paragraphs (a) through (e) of this section.
>
> (3) When the Appeals Council makes a decision, it will follow the same rules for considering opinion evidence as Administrative Law judges Follow.

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 not 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, §§ 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).

We measure severity according to the functional limitations imposed by your medically determinable mental impairment(s). We assess functional limitations using the

> four criteria in paragraph B of the listings: activities of daily living; social functioning; concentration, persistence, or pace; and episodes of decompensation. 20 CFR, Part 404, Subpart P, App. 1, 12.00(B).
>
> ...Where "marked" is used as a standard for measuring the degree of limitation it means more than moderate, but less than extreme. A marked limitation may arise when several activities or functions are impaired or even when only one is impaired, so long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately and effectively, and on a sustained basis. 20 CFR, Part 404, Subpart P, App. 1, 12.00(C).

In determining how a severe mental impairment affects the client's ability to work, four areas considered to be essential to work are looked at:

> ...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).
>
> ...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).

We do not define "marked" by a specific number of different behaviors in which social functioning is impaired, but by the nature and overall degree of interference with function. For example, if you are highly antagonistic, uncooperative or hostile but are tolerated by local storekeepers, we may nevertheless find that you have a marked limitation in social functioning because that behavior is not acceptable in other social contexts. 20 CFR, Part 404, Subpart P, App. 1, 12.00(C)(2).

...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).

Episodes of decompensation are exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning, as manifested by difficulties in performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence, or pace. 20 CFR 404, Subpart P, App. 1, 12.00(C)(4).

Episodes of decompensation may be demonstrated by an exacerbation in symptoms or signs that would ordinarily require increased treatment or a less stressful situation (or a combination of the two). Episodes of decompensation may be inferred from medical records showing significant alteration in medication; or documentation of the need for a more structured psychological support system (e.g., hospitalizations, placement in a halfway house, or a highly structured and directing household); or other relevant

information in the record about the existence, severity, and duration of the episode. 20 CFR 404, Subpart P, App. 1, 12.00(C)(4).

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).

When we rate the degree of limitation in the first three functional areas (activities of daily living; social functioning; and concentration, persistence, or pace), we will use the following five-point scale: none, slight, moderate, marked, and extreme. When we rate the degree of limitation in the fourth functional area (episodes of decompensation), we will use the following four-point scale: none, one or two, three, four or more. The last is incompatible with the ability to do any gainful activity. 20 CFR 416.920a(c).

After we rate the degree of functional limitation resulting from the impairment(s), we will determine the severity of your mental impairment(s). 20 CFR 416.920a(d).

If we rate the degree of your limitation in the first three functional areas as “none” or “mild” and “none” in the fourth area, we will generally conclude that your impairment(s) is not severe, unless the evidence otherwise indicates that there is more than a minimal limitation in your ability to do any basic work activities. 20 CFR 416.920a(d)(1).

If your mental impairment(s) is severe, we will then determine if it meets or is equivalent in severity to a listed mental disorder. We do this by comparing the diagnostic medical findings about your impairment(s) and the rating of the degree of functional limitation to the criteria of the appropriate listed mental disorder. 20 CFR 416.920a(d)(2).

> If we find that you have a severe mental impairment(s) that neither meets nor is equivalent in severity to any listing, we will then assess your residual functional capacity. 20 CFR 416.920a(d)(3).

Claimant is not disqualified from receiving disability at Step 1, because he was not substantially gainfully employed at any time relevant to this matter. Therefore, the analysis continues to Step 2.

Claimant failed to establish that he had a severe impairment that prevented or was expected to prevent his ability to perform basic work activities for a continuous period of at least one (1) year. However, the finding of a severe impairment at Step 2 is a diminimus standard. Therefore, the analysis will continue to Step 3.

Claimant failed to provide any objective medical evidence to establish that he had a severe impairment that met or equaled any listing found at 20 CFR, Part 404, Subpart P, Appendix 1. Therefore, the analysis continues to step 4.

Claimant failed to provide the necessary objective medical evidence to establish that he was physically unable or was expected to be physically unable to do his past relevant work for a continuous period of one year, prior to February 2009. On August 12, 2007, Claimant was admitted to the hospital after being found unresponsive, next to empty bottles of pills at his bedside at home. After being admitted to the hospital on August 12, Claimant required mechanical ventilation, and his problem list included acute respiratory failure, bilateral pneumonia, tricyclic overdose, alcoholism, depression, and protein calorie malnutrition. The CT of Claimant's head did not reveal an acute process, only left maxillary sinus disease. Claimant's echocardiogram, done on August 20, 2007, revealed: an enlarged left atrium; a dilated left ventricle; a global ejection fraction of 50%; mild mitral regurgitation; mild tricuspid regurgitation; and no intracardiac thrombus or pericardial effusion. Claimant improved gradually during his hospital stay and came off the ventilators. By August 24, 2007, Claimant had recovered, physically, and was discharged from the hospital in stable condition.

At the time Claimant was hospitalized, he was diagnosed with major depression-recurrent-severe, and suicide attempt with tricyclic medication and alcohol. However, Claimant was given a GAF score of 55, which means he did not have a serious impairment in occupational, school or social functioning. (See [redacted]) On August 24, 2007, Claimant was admitted into the psychiatric unit of the hospital for monitoring of his severe depression. Claimant was discharged from inpatient psychiatric care on August 28, 2007. At the time Claimant was discharged from the psychiatric unit of the hospital: he had a pretty broad affect; he easily engaged in conversation; his thought process was organized and goal directed; he was future oriented in his thinking; he denied any suicidal ideation; and

there was no psychosis identified. A psychological evaluation completed on September 12, 2007, revealed: Claimant's speech was articulate with normal rate, volume and rhythm; he maintained good eye contact; Claimant did not have any bizarre or unusual mannerisms; Claimant's prescribed medication, reportedly, got rid of his depression; Claimant was not loose, circumstantial, or tangential; Claimant was not hallucinating, and he was in touch with reality; Claimant was having some short term memory loss, subjectively, otherwise his cognitive functions appeared to be grossly intact; Claimant was able to smile and laugh at one of the examiner's jokes during the interview; and Claimant was given a GAF score of 55 once again. In this case, Claimant failed to provide the necessary objective medical evidence to establish that he was mentally incapable or expected to be mentally incapable of doing his past relevant unskilled work for a continuous period of at least one (1) year, prior to February 2009.

Even if the analysis continued to the last step of the sequential evaluation, Claimant would have been considered not disabled at the time relevant to this matter. Based on the objective medical evidence on the record, Claimant was not precluded or expected to be precluded from doing at least medium work for a continuous period of at least one year. Medical vocational guidelines have been developed and can be found in 20 CFR, Subpart P, Appendix 2, Section 200.00. When the facts coincide with a particular guideline, the guideline directs a conclusion as to disability. 20 CFR 416.969. At the time relevant to this matter, Claimant was considered an individual closely approaching advanced age with a high school education and unskilled work experience. 20 CFR 416.963, 20 CFR 416.964, and 20 CFR 416.968. Using Medical Vocational Rule 203.18 as a guideline, clamant would be considered not disabled. According to this Medical Vocational Rule, an individual age 50 to 54 years old, with just a limited educational background and unskilled work experience, limited to medium work, is not disabled.

In conclusion, Claimant failed to establish that prior to February 2009, he met the standard for disability as set forth in the Social Security regulations. Accordingly, the denial of MA-P for the time period of August 2007 to January 2009 is upheld.

DECISION AND ORDER

This Administrative Law Judge, based on the above findings of fact and conclusion of law, decides that Claimant was not eligible for MA-P benefits during the period of August 2007 to January 2009.

[redacted]
DHS Reg. No: 2010-2212
SOAHR Docket No: 2010-2707 REHD
Reconsideration Decision

IT IS THEREFORE ORDERED that:

The Department's MA-P decision is AFFIRMED.

/s/
Marya A. Nelson-Davis
Administrative Law Judge
for Michigan Department of Human Services

cc: [redacted]

Date Signed: **January 4, 2010**
Date Mailed: **January 12, 2010**

*****Notice*****
The Claimant may appeal this Rehearing Decision to Circuit Court within 30 days of the mailing of this Rehearing Decision.