STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

[redacted]

Reg. No.: 201131927
Issue No.: 2009
Case No.: [redacted]
Hearing Date: January 18, 2012
County: Ottawa County DHS

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

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, an in-person hearing was held on January 18, 2012. Claimant, represented by [redacted] of [redacted], personally appeared and testified.

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional medical evidence. The new evidence was forwarded to the State Hearing Review Team ("SHRT") for consideration. On April 20, 2012, the SHRT found Claimant was not disabled. This matter is now before the undersigned for a final decision.

ISSUE

Whether the Department of Human Services (the department) properly denied Claimant's application for Medical Assistance (MA-P)?

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 November 9, 2010, Claimant filed an application for MA benefits alleging disability.

2. On January 18, 2011, the Medical Review Team (MRT) denied Claimant's application for MA-P indicating that Claimant's impairment lacked duration.

3. On January 26, 2011, the department sent notice to Claimant that his application for Medicaid had been denied.

4. On April 25, 2011, Claimant filed a request for a hearing to contest the department's negative action.

5. On May 23, 2011, the State Hearing Review Team (SHRT) upheld the denial of MA-P benefits indicating Claimant retains the capacity to perform a wide range of light work. (Department Exhibit B, pp 1-2).

6. Claimant has a history of a bipolar disorder, major depressive disorder, attention deficit hyperactivity disorder (ADHD), and degenerative disc disease with central canal stenosis.

7. On May 19, 2010, Claimant presented to the emergency room after a motor vehicle accident. He was intoxicated and had attempted suicide by crashing his car into a tree while not wearing a seatbelt. The airbags did deploy. He was ambulatory at the scene and brought to the emergency room for evaluation. His serum alcohol level was 0.167. His liver enzymes were slightly elevated. Chest x-ray, cervical spine and pelvis x-rays were all negative. Claimant has had chronic low back pain since January 2008 when he had a snowmobile accident. He had an L5-S1 annular tear on the MRI in January 2008. Part of his depression issues stem from his constant pain. Suicide attempt is being managed by psychiatry. (Department Exhibit A, pp 24-25).

8. On May 20, 2010, Claimant was admitted to the psychiatric unit on a voluntary basis. Claimant was fairly superficial in his engagement with treatment, denying suicidal ideation almost from the beginning of the hospitalization and minimizing the seriousness of the attempt, basically saying he would not try suicide again, because why bother, it didn't work. Psychological testing was suggestive of depressive and avoidance personality traits with major depression and anxiety being prominent features. The diagnostic consideration was prominently notable for personality disorder. Claimant was discharged on May 25, 2010, with a diagnosis of Axis I: Major depression, recurrent, severe; Axis II: Passive aggressive traits; Axis III: Status post motor vehicle accident, back pain; Axis IV: Chronic mental illness; Axis V: GAF=21. Stable on discharge, however, prognosis is quite guarded given his recent attempt and very minimal coping skills and minimal engagement with treatment process. (Department Exhibit A, pp 10, 32-73).

9. On August 19, 2010, Claimant's MRI lumbar spine without contrast showed degenerative discogenic changes and degenerative facet arthropathy at the L4-L5 and L5-S1 levels quite similar compared to the prior study. There is minimal improvement at the L4-L5 level with mild regression of a small disc protrusion as compared to 3/7/08. (Department Exhibit A, pp 79-80).

10. On September 26, 2010, Claimant went to the emergency room complaining of back pain. When the physician originally went in to talk with Claimant, the physician noticed Claimant first wandering around the hallways then in and out of empty rooms looking rather confused. One of the nurses directed Claimant back to his room. When the physician went in to talk to Claimant, his history was very wandering and at times was completely incoherent and he would answer questions and then the subject would change midsentence and would not make any sense at all. Claimant was accompanied by his parents who stated that this was unusual behavior for him. Claimant lives with his sister and his sister states that he has not slept in 2 or 3 days. Claimant said he has not slept because of pain. Claimant was alert, not oriented. He was able to move without difficulty. He walked around the room rapidly, at one point he told the physician he was going to stand at attention while the physician examined him and proceeded to stand at attention. Throughout the course in the emergency department, Claimant vacillated between falling asleep and being difficult to awaken to being up walking around the department, difficult to contain. Claimant will be evaluated by CMH. Provisional Diagnoses: (1) Evaluation of mental status changes; (2) back pain. (Department Exhibit A, pp 90-94).

11. On September 29, 2010, an MRI lumbar spine without intravenous contrast compared to MRI performed on 2/19/10, revealed a large posterior and left parecentral disc extrusion at L4-L5, increased in size and extending into the left lateral recess with compression of the traversing left L5 nerve root, correlate for left L5 radiculopathy. Moderate central canal stenosis at L4-L5, increased. (Department Exhibit A, pp 97-98).

12. On November 1, 2010, Claimant was evaluated by an orthopedic surgeon. A review of his lumbar MRI compared with priors show progression of the disc rupture at L4-L5 with left L5 nerve root impingement as well as lumbar spinal stenosis at L4-L5. The surgeon's overall impression was that Claimant's chronic back pain was likely secondary to progression of the disc rupture at L4-L5 and left L5 nerve root impingement. Treatment options were thoroughly discussed as well as alternatives. Surgery in the form of microscopic lumbar discectomy was reviewed as well as decompressive lumbar laminectomy and interbody fusion. A full decompressive lumbar laminectomy followed by fusion would allow complete decompression bilaterally as well as addressing the primary cause of the disc rupture, which may be instability at L4-L5. This would have the best chance of addressing Claimant's chronic back pain as well as radicular leg pain. (Department Exhibit A, pp 108-109).

13, On November 5, 2010, Claimant was suspected of a morphine overdose when his sister found him unconscious on the couch. Evaluation in the emergency room showed oxygen saturations on room air at 91%. He was tachycardic and febrile. Also, CPK's were markedly elevated. Troponins were elevated as well. Claimant had a bedside bronchoscopy. Because of his elevated troponins, he underwent an echocardiogram which showed diffusely decreased contractility of the myocardium with an ejection fraction between 40 and 45%. Chest x-rays showed some pulmonary vascular congestion as well as the aspiration pneumonia and he was felt to be in mild congestive heart failure. As a result, he was started on ACE inhibitors and beta blockers. A psychiatric consult was obtained. He was started on his usual medications, Cymbalta, Zyprexa and Depakote. A repeat echocardiogram was obtained a few days later and there was a slight improvement with his ejection fraction now between 45 and 50%. His CPK's gradually returned to normal and a second chest x-ray showed improvement of his pneumonia. He was to be discharged to home on November 11, 2010, with instructions to follow-up with his primary care physician. (Department Exhibit A, pp 113-126).

14. On November 14, 2010, Claimant went to the emergency room complaining of abdominal pain. A CT examination of the abdomen and pelvis for kidney stone protocol was unremarkable. He was diagnosed with (1) acute dysuria and (2) lower abdominal pain, prescribed ibuprofen and discharged. (Department Exhibit A, pp 142-145).

15. On November 18, 2010, Claimant saw his primary physician for follow-up of his hospital visit for abdominal pain. Symptoms attributed to recent catheter when in ICU. Recheck of overdose. He is living with his sister who accompanied him to the appointment. He has no plans to follow-up with an agency psychiatrist. Claimant was cooperative, depressed, and unkempt. Claimant's sister agreed to hold Claimant's opioid medication and other psych meds and to dispense as appropriate. Claimant is not to have any medication in his possession and he and his sister are both in agreement, again. (Department Exhibit A, pp 149-151).

16. On February 24, 2011, Claimant was admitted to the hospital with an elevated creatine kinase (CPK) and concerns of renal failure. He came to the hospital after 4 days of gradually increasing swelling and pain in his back. He was admitted to the hospital in November 2010 after a massive overdose and he was found unconscious and sitting down for a long period of time. At that point, he had an elevated CPK and his troponin was elevated. He stated he had started working a job and was taking handfuls of ibuprofen. Claimant was discharged on February 27, 2011 and prescribed Flexeril, Depakote, Colace, Cymbalta, Zyprexa, Cipro, MS Contin and Norco. (Claimant Exhibit A, pp 1-2).

17. On October 13, 2011, Claimant was brought to the emergency room by his parents who were concerned he was suffering from acute mania. He has a history of bipolar disorder. He has been sleeping very little despite the fact that he chronically takes up to 8 Tylenol PM tablets every night. He suffers from depression chronically, but this is worse than usual. He has chronic back pain for which he takes morphine. Past medical history included chronic back pain, bipolar disorder, rhabdomyolysis, November 2010 overdosed on morphine, severely stressed heart, and attempted suicide in May 2010 by running truck into tree. Claimant was evaluated by Community Mental Health (CMH) who offered crisis home placement, but Claimant refused to go. Claimant was discharged on October 14, 2011, with a final diagnosis of (1) bipolar disorder; (2) peripheral edema; (3) elevated liver enzymes, and (4) elevated CPK. (Claimant Exhibit A, pp 3-9).

18. On October 28, 2011, Claimant underwent a mental status exam on behalf of the department. He has difficulty in constructing his thoughts into speech. His speech is interrupted, but it is not clear that he has actual blocking. Eye contact is variable and indirect. He smiles a great deal even when talking about distracting matters and when asked this, he says, "it's a deflection." He denies hearing voices and denies paranoid ideation. He has mood swings both up and down. Persistent suicidal ideation and a history of suicide attempts. Sleep is "horrible," "especially the past couple of weeks." Appetite is okay. Concentration is poor and has always been so. He denies racing thoughts. His mood at this time appears to be dysphoric, but covered by much inappropriate smiling. No abnormal movements noted. Cognition is grossly intact, but apparently slowed to some degree as he has some trouble remembering sequence and chronology of treatment events. Diagnoses: Axis I: Bipolar I disorder, ADHS inattentive type; Axis V: GAF=50. (Department Exhibit A, pp 26-28).

19. On November 15, 2011, Claimant saw his therapist at CMH. Claimant had not slept the last two nights. He was mentally depressed. He had no energy during the day. He was having suicidal thoughts, he thinks about it once a day. He was laughing at inappropriate times, multiple times. He was laughing when he said, "I should just take myself out." (Claimant Exhibit A, p 24).

20. On February 20, 2012, Claimant was transported to the hospital for a mental health evaluation after being found sitting in his car with multiple hoses connected from the cars exhaust pipe into the interior of the car. Claimant confirms that his intent was to kill himself with carbon monoxide poisoning. He was observed on 100% oxygen by mask for about one hour. Carboxy hemoglobin essentially negligible at 1%. He remained stable under observation throughout the rest of emergency department

course. Chemistries show no evidence of anion gap acidosis or electrolyte abnormalities. Complete blood count normal. Mental health evaluation performed through Ottawa County crisis intervention worker. Clinical petition and certification filed on Claimant's behalf. Currently waiting bed placement for admission. Diagnosis: Suicide attempt by carbon monoxide exposure; depression with suicidal ideation, and bipolar disorder. (Department Exhibit A, pp 31-33).

21. Claimant is a 29 year-old man whose birthday is [redacted]. Claimant is 6'1" tall and weighs 245 lbs. Claimant completed high school.

22. Claimant was appealing the denial of Social Security disability benefits at the time of the hearing.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by the 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 (formerly known as the Family Independence Agency) administers the MA program pursuant to MCL 400.10, *et seq*., and MCL 400.105. Department policies are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

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-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, do 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);

(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).

The residual functional capacity 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 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 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 CFR 416.967(b). Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work. 20 CFR 416.967(c). Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work. 20 CFR 416.967(d).

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).

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).

Based on Finding of Facts #6-#20 above this Administrative Law Judge answers:

Step 1: No.

Step 2: Yes.

Step 3: Yes. Claimant has shown, by clear and convincing documentary evidence and credible testimony, that his mental impairments meet or equal Listing 12.04(C):

12.04 ***Affective disorders***: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

Step 3: Yes. Claimant has shown, by clear and convincing documentary evidence and credible testimony, that his mental impairments meet or equal Listing 12.04(C):

12.04 ***Affective disorders***: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

C. Medically documented history of a 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 a 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.

Accordingly, this Administrative Law Judge concludes that Claimant is disabled for purposes of the MA program. Consequently, the department's denial of his November 9, 2010, MA/Retro-MA application cannot be upheld.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides the department erred in determining Claimant is not currently disabled for MA/Retro-MA eligibility purposes.

Accordingly, the department's decision is **REVERSED**, and it is Ordered that:

1. The department shall process Claimant's November 9, 2010, MA/Retro-MA application, and shall award him all the benefits he may be entitled to receive, as long as he meets the remaining financial and non-financial eligibility factors.

2. The department shall review Claimant's medical condition for improvement in May 2014, unless his Social Security Administration disability status is approved by that time.

3. The department shall obtain updated medical evidence from Claimant's treating physicians, physical therapists, pain clinic notes, etc. regarding his continued treatment, progress and prognosis at review.

/s/_____
Vicki L. Armstrong
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: May 15, 2012

Date Mailed: May 15, 2012

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 mailing 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.

VLA/cr

cc: [redacted]