May 25, STATE OF MICHIGAN

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

IN THE MATTER OF:

[redacted]

Reg. No. 201238290
Issue No. 2009, 4031
Case No. [redacted]
Hearing Date: May 24, 2012
Oakland County DHS (04)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the claimant's request for a hearing. After due notice, a telephone hearing was held on May 24, 2012. The claimant appeared and testified; [redacted] testified on behalf of Claimant. On behalf of Department of Human Services (DHS), [redacted], Specialist, appeared and testified.

ISSUE

The issue is whether DHS properly denied Claimant's application for Medical Assistance (MA) and State Disability Assistance (SDA) on the basis that Claimant is not a disabled individual.

FINDINGS OF FACT

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

1. On 9/23/11, Claimant applied for SDA and MA benefits.

2. Claimant's only basis for MA and SDA benefits was as a disabled individual.

3. On 1/20/12, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 2-3).

4. On 1/26/12, DHS denied Claimant's application for MA and SDA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On 3/2/12, Claimant requested a hearing disputing the denial of SDA and MA benefits.

6. On 4/28/12, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual (see Exhibit 104) based, in part, by application of Medical-Vocational Rule 204.00.

7. As of the date of the administrative hearing, Claimant was a [redacted] year old female with a height of 5'1'' and weight of 165 pounds.

8. Claimant has a history of alcohol and cocaine abuse.

9. Claimant's highest education year completed was the 12th grade.

10. As of the date of the administrative hearing, Claimant had no health coverage though she was receiving free prescriptions through [redacted]

11. Claimant contended that she is a disabled individual based on an impairment of depression.

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). DHS (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 controlling DHS regulations are those that were in effect as of 9/2011, the month of the application which Claimant contends was wrongly denied. Current DHS manuals may be found online at the following URL: http://www.mfia.state.mi.us/olmweb/ex/html/.

MA provides medical assistance to individuals and families who meet financial and nonfinancial eligibility factors. The goal of the MA program is to ensure that essential health care services are made available to those who otherwise would not have financial resources to purchase them.

The Medicaid program is comprised of several sub-programs which fall under one of two categories; one category is FIP-related and the second category is SSI-related. BEM 105 at 1. To receive MA under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled. *Id*.

Families with dependent children, caretaker relatives of dependent children, persons under age 21 and pregnant, or recently pregnant, women receive MA under FIP-related categories. *Id*. AMP is an MA program available to persons not eligible for Medicaid through the SSI-related or FIP-related categories though DHS does always offer the program to applicants. It was not disputed that Claimant's only potential category for Medicaid eligibility would be as a disabled individual.

Disability for purposes of MA benefits is established if one of the following circumstances applies (see BEM 260 at 1-2):

- by death (for the month of death);
- the applicant receives Supplemental Security Income (SSI) benefits;
- SSI benefits were recently terminated due to financial factors;
- the applicant receives Retirement Survivors and Disability Insurance (RSDI) on the basis of being disabled; or
- RSDI eligibility is established following denial of the MA benefit application (under certain circumstances).

There was no evidence that any of the above circumstances apply to Claimant. Accordingly, Claimant may not be considered for Medicaid eligibility without undergoing a medical review process which determines whether Claimant is a disabled individual. *Id*. at 2.

Generally, state agencies such as DHS must use the same definition of SSI disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally defined as the inability to do any substantial gainful activity (SGA) 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 functionally identical definition of disability is found under DHS regulations. BEM 260 at 8.

Substantial gainful activity means a person does the following:

- Performs significant duties, and
- Does them for a reasonable length of time, and
- Does a job normally done for pay or profit. *Id*. at 9.

Significant duties are duties used to do a job or run a business. *Id*. They must also have a degree of economic value. *Id*. The ability to run a household or take care of oneself does not, on its own, constitute substantial gainful activity. *Id*.

The person claiming a physical or mental disability has the burden to establish a disability 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 make appropriate mental adjustments, if a

mental disability is alleged. 20 CRF 413.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a).

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled. 20 CFR 416.920. If there is no finding of disability or lack of disability at each step, the process moves to the next step. 20 CFR 416.920 (a)(4).

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person is statutorily blind or not. The 2011 monthly income limit considered SGA for non-blind individuals is $1,000.

In the present case, Claimant denied having any employment since the date of the MA application; no evidence was submitted to contradict Claimant's testimony. Without ongoing employment, it can only be concluded that Claimant is not performing SGA. It is found that Claimant is not performing SGA and the disability analysis may proceed to step two.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the 12 month duration requirement. 20 CFR 416.920 (a)(4)(ii). The impairments may be combined to meet the severity requirement. If a severe impairment is not found, then a person is deemed not disabled. *Id*.

The impairments must significantly limit a person's basic work activities. 20 CFR 416.920 (a)(5)(c). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. *Id.* Examples of basic work activities include:

- physical functions (e.g. walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling)
- capacities for seeing, hearing, and speaking, understanding; carrying out, and remembering simple instructions
- use of judgment
- responding appropriately to supervision, co-workers and usual work situations; and/or
- dealing with changes in a routine work setting.

Generally, federal courts have imposed a de minimus standard upon claimants to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v Bowen,* 880 F2d 860, 862 (6th Cir. 1988). Similarly, Social Security Ruling 85-28 has

been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirement is intended "to do no more than screen out groundless claims." *McDonald v. Secretary of Health and Human Servs.*, 795 F.2d 1118, 1124 (1st Cir. 1986).

SSA specifically notes that age, education, and work experience are not considered at the second step of the disability analysis. 20 CFR 416.920 (5)(c). In determining whether Claimant's impairments amount to a severe impairment, all other relevant evidence may be considered. The analysis will begin with the submitted medical documentation. Some documents were admitted as exhibits but were not necessarily relevant to the disability analysis; thus, there may be gaps in exhibits numbers.

Claimant testified that she is unable to obtain or maintain employment due to her issues with depression. Claimant did not assert any physical (e.g. walking, standing, lifting…) that contribute to her claimed disability. Claimant stated she has been depressed for several years, in particular, since 2004, the year her son died. Claimant has a history of multiple psychological hospitalizations and a history of drug and alcohol dependence.

A Social Summary (Exhibits 4-5) dated [redacted] was presented. A Social Summary is a standard DHS form to be completed by DHS specialists which notes alleged impairments and various other items of information. It was noted that Claimant reported the following impairments: manic bipolar disorder, depression, attention deficit hyperactivity disorder (ADHD) and chemical dependency.

A Medical Social Questionnaire (Exhibits 94-96) dated [redacted] was presented. The Claimant completed form allows for reporting of claimed impairments, treating physicians, previous hospitalizations, prescriptions, medical test history, education and work history. Seven previous hospitalizations for chemical dependence or suicidal thoughts were noted. The hospitalizations ranged from 2004-2011. A list of prescriptions was given but Claimant testified that she currently took the following medications: Celexa, Effexor, Gabapentin, Risperidone, Zenlasaxine and Trazadone.

Documents (Exhibits 9-50 and 103) concerning a hospital admission were presented. It was noted that Claimant was admitted on [redacted] based on Claimant's report of suicidal ideation. Claimant reported that her home was in foreclosure, her husband was abusive and that she may not have a job to return to. It was noted that Claimant reported a relapse following treatment for cocaine addiction in 7/2011. Claimant reported suffering: panic attacks which affected her vision, progressively worsening depression, feeling sad

and hopeless, low energy and low motivation. It was also noted that Claimant felt anxiety and panic attacks. Claimant also reported manic episodes where she felt impulsive and hyperactive.

It was noted that Claimant was hospitalized following an intentional overdose of Celexa. It was noted that Claimant drank a pint of alcohol two times per week, smoked marijuana every other day and smoked crack cocaine every other day.

A hospital doctor provided a final diagnosis based on Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV). Axis I represents the acute symptoms that need treatment. Axis II is to note personality disorders and developmental disorders. Axis III is intended to note medical or neurological conditions that may influence a psychiatric problem. Axis IV identifies recent psychosocial stressors such as a death of a loved one, divorce or losing a job. Axis V identifies the patient's level of function on a scale of 0-100 in what is called a Global Assessment of Functioning (GAF) Scale. Axis I diagnoses included bipolar disorder mixed with psychotic features, alcohol abuse, marijuana abuse and cocaine abuse. Claimant had no Axis II or Axis III disorders or conditions. Axis IV noted “moderate” stressors. Claimant’s GAF at admission was 30; a GAF within the range of 21-30 reflects behavior that is considerably influenced by delusions or hallucinations OR serious impairment, in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).

It was noted that Claimant was doing better and felt no suicidal ideation upon her [redacted] discharge. Claimant’s GAF at discharge was 42; a GAF within the range of 41-50 is representative of a person with “serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g. no friends, unable to keep a job).”

A Psychiatric Evaluation (Exhibits 52-57) dated [redacted] from Claimant’s treating doctor was submitted. It was noted that Claimant has struggled with concentration since her days in school. It was noted that Claimant complained of: mood swings, racing thoughts, sleeping difficulties, anxiousness and irritability. Claimant denied having suicidal thoughts at the time of the evaluation but reported that she was hospitalized in 2004 and 2011 for suicidal thoughts. It was noted that Claimant was six months clean at the time of evaluation. To treat Claimant’s reported symptoms, the following medications were prescribed: Invenga, Neurontin, Effexor, Clonidine and Straterra.

A DSM-IV evaluation was provided. Claimant was diagnosed with bipolar disorder and ADHD. Axis II was left blank. Axis III noted hypothyroidism. Axis IV noted problems with her support group, economic problems, a lack of healthcare, criminal history, behavioral/personality issues and problems relating to a social environment. Claimant’s GAF was 45-50. A GAF within the range of 41-50 is representative of a person with

"serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g. no friends, unable to keep a job)."

Hospital records (Exhibits 64-69) from a [redacted] emergency room visit from [redacted] were presented. Claimant was diagnosed with a lower back strain with muscle spasms.

Hospital records (Exhibits 70-73) from a [redacted] admission were presented. It was noted that Claimant was discharged on the same date. The records only included various lab results, none of which were deemed to be relevant.

Records (Exhibits 74-93) from a hospital admission from [redacted] were presented. It was noted that Claimant reported feeling increased depression following the death of her nine month old child. It was noted that Claimant and her children were sleeping on the floor at a friend's house when the child was found on the floor to be not breathing. Claimant reported no prior psychological treatment. Claimant reported a history of alcohol abuse, but no other drug use. A final diagnosis of bipolar disorder and alcohol abuse was provided.

Claimant completed an Activities of Daily Living (Exhibits 97-101) dated [redacted]; this is a questionnaire designed for clients to provide information about their abilities to perform various day-to-day activities. Claimant noted restless sleep and being up and down at night. Claimant noted that she prepares her own meals and does laundry and the dishes. Claimant noted that she shops for her food and makes a list with someone so she does not forget what she is buying. Claimant noted she doesn't read, but that she watches television or listens to the radio. Claimant noted that she takes daily walks for 30-60 minutes. Claimant noted that she visits wither friends and family. Claimant noted that she stopped drinking alcohol. Claimant noted she has difficulty in keeping appointments.

Claimant testified that she has no physical restrictions to gaining or maintaining employment. Thus, the entire analysis will consider only Claimant's psychological restrictions.

Multiple physicians including Claimant's treating physician diagnosed Claimant with psychological disorders, depression and/or bipolar disorder. Claimant's history of suicidal ideation was well established by multiple hospitalizations. Claimant's current medications, four anti-depressants, mood stabilizer and anti-psychotic medication were supportive of finding that Claimant has significant obstacles to performing basic work activities. The medical documentation was lacking in describing specific obstacles.

Claimant testified that she has low motivation and energy. Claimant testified that she feels alone and abandoned. Claimant also stated she sometimes spends 3-4 days in

bed. There was sufficient medical support for finding that Claimant would have difficulties in maintaining the necessary motivation and persistence in maintaining employment. It is found that Claimant established suffering significant impairments to performing basic work activities.

The evidence tended to establish that Claimant has a several year history involving psychological disorders, in particular, since the death of Claimant's child. The evidence tended to establish that Claimant's impairments have and will last for a period of 12 months or longer. It is found that Claimant established meeting the durational requirements for a severe impairment. As Claimant established the requirements for a severe impairment to performing basic work activities, the disability analysis may proceed to step three.

The third step of the sequential analysis requires a determination whether the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920 (a)(4)(iii). If Claimant's impairments are listed and deemed to meet the 12 month requirement, then the claimant is deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step.

The impairment for which Claimant most persuasively established was for depression. The listing for depression is covered by affective disorders and reads:

> **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. The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.
>
> A. Medically documented persistence, either continuous or intermittent, of one of the following:
> 1. Depressive syndrome characterized by at least four of the following:
> a. Anhedonia or pervasive loss of interest in almost all activities; or
> b. Appetite disturbance with change in weight; or
> c. Sleep disturbance; or
> d. Psychomotor agitation or retardation; or
> e. Decreased energy; or
> f. Feelings of guilt or worthlessness; or
> g. Difficulty concentrating or thinking; or
> h. Thoughts of suicide; or
> I. Hallucinations, delusions, or paranoid thinking
> OR
> 2. Manic syndrome characterized by at least three of the following:

a. Hyperactivity; or
b. Pressure of speech; or
c. Flight of ideas; or
d. Inflated self-esteem; or
e. Decreased need for sleep; or
f. Easy distractibility; or
g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
h. Hallucinations, delusions or paranoid thinking

OR

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

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration

OR

C. Medically documented history of 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.

Starting with Part B of the above listing, there was little evidence that Claimant is markedly restricted in performing daily activities. There was a lack of evidence that Claimant requires any notable assistance in performing activities such as bathing, grooming, shopping, cooking or cleaning.

Claimant's testimony implied that she has social difficulties and few friends, but there was little evidence of marked difficulties in social functioning. Claimant currently lives with a friend and there appears to be no difficulties in maintaining that relationship. The submitted psychological evaluation described Claimant "within normal limits" concerning affect, speech and attitude though her mood was described as dysphoric and anxious.

Generally, the record lacked evidence of marked difficulties in maintaining concentration. Claimant's concentration was described as within normal limits by her treating psychiatrist.

Based on the presented evidence, Claimant failed to meet at least three of the four requirements for meeting Part B of the above listing. Accordingly, Claimant does not meet Part B of the above listing.

Looking at Part C, there was no evidence that Claimant is in such a fragile state that a minimal increase in demands would result in decompensation; nor was there evidence that Claimant requires a highly supportive living arrangement. It was well documented that Claimant suffered depression since 2004. The effects of Claimant's depression included repeated drug relapses and suicidal ideation; these symptoms cause more than a limited impact on the performance of basic work activities.

Claimant's repeated psychiatric hospitalizations could be construed to be repeated episodes of decompensation. SSA states the following about the issue:

> The term *repeated episodes of decompensation, each of extended duration* in these listings means three episodes within 1 year, or an average of once every 4 months, each lasting for at least 2 weeks. If you have experienced more frequent episodes of shorter duration or less frequent episodes of longer duration, we must use judgment to determine if the duration and functional effects of the episodes are of equal severity and may be used to substitute for the listed finding in a determination of equivalence.

All of Claimant's previous hospitalizations were not verified. Medical records established that Claimant was hospitalized from [redacted]. Only one previous hospitalization (from 2004) was noted in the medical records from the 8/2011 hospitalization (see Exhibit 14). It was noted that Claimant received outpatient treatment on and off since 2004 (see Exhibit 52). It was noted that Claimant sought treatment two times in 2010. It was noted that Claimant was six months clean as of [redacted].

None of Claimant's hospitalizations were verified to be two weeks in duration as required by the SSA listing. However, Claimant's relapses were sufficiently frequent and

lengthy to justify that her depression meets the SSA listing. It is found that Claimant established meeting the SSA listing for depression.

It was not disputed that Claimant's hospitalizations were affected by drug usage. When drug usage is relevant to an impairment then an additional analysis must be performed. SSA provides guidance on disability findings that may be impacted by substance abuse. Social Security Rule 82-60 states:

> Where the definition of disability is met in a title XVI claim, and there is evidence of drug addiction or alcoholism, a determination must also be made as to whether the drug addiction or alcoholism was a factor material to the finding of disability for purposes of applying the treatment and representative payee provisions. In making this decision the key issue is whether the individual would continue to meet the definition of disability even if drug and/or alcohol use were to stop. If he or she would still meet the definition, drug addiction or alcoholism is not material to the finding of disability and the treatment and representative payee provisions do not apply. The drug addiction and alcoholism requirements are imposed only where (1) the individual's impairment(s) is found disabling and drug addiction and/or alcoholism is a contributing factor material to the determination of disability, and (2) the same impairment(s) would no longer be found disabling if the individual's drug addiction or alcoholism were eliminated, as, for example, through rehabilitation treatment.

There was no question that Claimant's drug and alcohol usage is a contributing factor to the determination of disability. Claimant's previous hospitalizations correspond with her drug and alcohol relapses. The more difficult question is whether Claimant's depression would still be disabling without alcohol and drug use. The question is difficult because drug usage is a common escape for those suffering depression. Thus, it is difficult to determine to what extent drug abuse contributes to depression or the depression contributes to the drug abuse.

Though Claimant was found to be sympathetic, The correlation between Claimant's relapses and hospitalizations cannot be overlooked. When Claimant uses, she is unable to function. When Claimant does not use, the evidence tended to establish that Claimant is not socially impaired, lacking in concentration or incapable of performing her daily activities. It is found that Claimant's drug usage is material to her impairment. Accordingly, it is found that Claimant is not a disabled individual.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that DHS properly denied MA and SDA benefits to Claimant based on a

determination that Claimant was not disabled. The actions taken by DHS are AFFIRMED.

Christian Gardocki
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: June 7, 2012

Date Mailed: June 7, 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.

Claimant may request a rehearing or reconsideration for the following reasons:

- A rehearing **MAY** be granted if there is newly discovered evidence that could affect the outcome of the original hearing decision.
- A reconsideration **MAY** be granted for any of the following reasons:
  - misapplication of manual policy or law in the hearing decision,
  - typographical errors, mathematical error, or other obvious errors in the hearing decision that effect the substantial rights of the claimant:
  - the failure of the ALJ to address other relevant issues in the hearing decision.

Request must be submitted through the local DHS office or directly to MAHS by mail to:

Michigan Administrative hearings
Reconsideration/Rehearing Request
P. O. Box 30639
Lansing, Michigan 48909-07322

CG/hw

201238290/CG

cc: