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

IN THE MATTER OF:

[redacted]

Reg. No.: 2012-49652
Issue No.: 2009;4031
Case No.: [redacted]
Hearing Date: July 5, 2012
County: Marquette

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

HEARING DECISION

This matter is before the undersigned Admini strative Law Judge upon the Claimant's request for a hearing made pursuant to Mi chigan Compiled Laws 400.9 and 400.37, which gov ern the administrative hearing a nd appeal process. After due notice, a telephone hearing was commenced on July 5, 2012, from Lansing, Mi chigan. Claimant personally appeared and test ified. Participants on behalf of the Department of Human Services (Department) included Elig ibility Specialist [redacted] and Assistant Payment Supervisor [redacted]

During the hearing, Claimant wa ived the time period for the i ssuance of this decision in order to allow for the submission of addi tional medic al evidenc e. The new evidenc e was forwarded to the State Hearing Review Team (SHRT) for consideration. On September 11, 2012, t he SHRT found Claimant was not disabled. This matter is no w before the undersigned for a final decision.

ISSUE

Whether the Department of Human Se rvices (the department) properly denied Claimant's application for Medical Ass istance (MA-P), Retro-MA and State Dis ability Assistance (SDA)?

FINDINGS OF FACT

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

(1) On November 22, 2011, Claimant filed an application for MA-P, Retro-MA and SDA benefits alleging disability.

(2) On March 19, 2012, the Medical Review Team (MRT) denied Claimant's application for MA-P and Retro-MA indicating that she was capable of past relevant work based on her non exertional impairment. SDA was denied because the physical or mental impairment does not prevent employment for 90 days or more.

(3) On March 26, 2012, the department caseworker sent Claimant notice that her application was denied.

(4) On April 26, 2012, Claimant filed a request for a hearing to contest the department's negative action.

(5) On June 5, 2012, the State Hearing Review Team (SHRT) found Claimant was not disabled because she retained the capacity to perform light, unskilled work. (Department Exhibit B, pp 1-2).

(6) Claimant has a history of depression, anxiety, post traumatic stress disorder, panic attacks, arthritis, carpal tunnel, hypoglycemia, dyslexia and Aspergers.

(7) Claimant is a 34 year old woman whose birthday is [redacted]. Claimant is 5'1" tall and weighs 210 lbs. Claimant completed high school.

(8) Claimant had applied for Social Security disability benefits at the time of the hearing.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department, (DHS or department), 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 State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. The Department of Human Services (DHS or department) administers the SDA program pursuant to MCL 400.10, *et seq.*, and Mich Admin Code, Rules 400. 3151-400.3180. Department policies are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

Current legislative amendments to the Act delineate eligibility criteria as implemented by department policy set forth in program manuals. 2004 PA 344, Sec. 604, establishes the State Disability Assistance program. It reads in part:

> Sec. 604 (1). The department shall operate a state disability assistance program. Except as provided in subsection (3), persons eligible for this program shall include needy citizens of the United States or aliens exempt from the Supplemental Security Income citizenship requirement who are at least 18 years of age or emancipated minors meeting one or more of the following requirements:
>
> (b) A person with a physical or mental impairment which meets federal SSI disability standards, except that the minimum duration of the disability shall be 90 days. Substance abuse alone is not defined as a basis for eligibility.

Specifically, this Act provides minimal cash assistance to individuals with some type of severe, temporary disability which prevents him or her from engaging in substantial gainful work activity for at least ninety (90) days.

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a). 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 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). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and, (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of

his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (e.g., age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4). If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3 to Step 4. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

As outlined above, the first step looks at the individual's current work activity. In the record presented, Claimant is not involved in substantial gainful activity and testified that she has not worked since March, 2011. Therefore, she is not disqualified from receiving disability benefits under Step 1.

The severity of the individual's alleged impairment(s) is considered under Step 2. The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b). An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work

experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b). Examples include:

1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

5. Responding appropriately to supervision, co-workers and usual work situations; and

6. Dealing with changes in a routine work setting. *Id.*

The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). An impairment qualifies as non-severe only if, regardless of a claimant's age, education, or work experience, the impairment would not affect the claimant's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985).

In the present case, Claimant alleges disability due to depression, anxiety, post traumatic stress disorder, panic attacks, arthritis, carpal tunnel, hypoglycemia, dyslexia and Aspergers.

On June 30, 2011, Claimant met with a new physician to establish care. She presented with a headache that was on and off the past 4 days. She stated she had a history of gestational diabetes and mental illness and was not taking any medications. She reported anxiety, depression, insomnia and anhedonia. She was diagnosed with diabetes mellitus, and counseled on exercise and diet.

On July 15, 2011, Claimant followed-up with her primary care physician complaining of being fearful, tearful and having panic attacks. She reported a history of domestic violence. She was diagnosed with depression and anxiety and treated with Effexor. Her appearance and affect were noted as abnormal. She was Dysthymic, unhappy, fearful, anxious, anhedonic, sad, tearful, and

showed guilt, grieving and worry. Her thought content revealed impairment. Her blood glucose was abnormal. She was assessed with obesity and adjustment disorder with anxiety and depressed mood.

On November 13, 2011, Claimant voluntarily admitted herself to the inpatient psychiatric unit. She stated that she had recently moved to the Upper Peninsula five months ago to move in with her boyfriend and had just learned he was breaking up with her. She stated she had been off her Effexor since moving to the Upper Peninsula. Her mental status exam revealed her affect was flat to blunted, which was congruent with her reported mood of depressed. She was endorsing suicidal ideations which were passive in nature. Her thought process was linear and goal directed. Her memory was intact. She was alert and oriented. Her grooming was mildly disheveled. Her speech was quiet but had a regular rate and rhythm and her insight and judgment appeared to be fair. Diagnosis: Axis I: Major depressive disorder, recurrent, severe, without psychosis; Generalized anxiety disorder with agoraphobia and panic attacks; Axis III: Past history of asthma; Arthritis of her knees and hips; Carpal tunnel disease; Axis V: GAF: 25. She was started on Effexor and Ventolin. She was experiencing somatic and physical complaints and was given Prazosin and Restoril which was effective in sleep stabilization. She also complained of gastrointestinal upset and esophageal burning and was started on Prilosec which was effective. She had arthritis. She had a hard time around large groups. Her grooming improved. Her eye contact was fifty percent. She expressed a readiness for discharge and denied any feelings of self-harm, suicidal or homicidal ideation. Cognition was intact. There was no evidence of thought disorder. She denied hallucinations, delusions and paranoia. She had some mild anxiety. Her insight and judgment were intact. She was discharged on November 18, 2011.

On February 7, 2012, Claimant's primary care physician wrote a letter to whom it may concern stating Claimant was unable to work due to her mental and physical disabilities.

On February 17, 2012, Claimant presented at the [redacted] to establish care. Claimant had multiple issues she wanted to be evaluated for. She asked about getting a thyroid ultrasound, if she had bronchitis, and reported pain in her left index finger. She also had problems walking and used a cane for that. She reported coughing up blood over the past day and colored phlegm. She demonstrated a cough in the office, but it was dry. She was currently living at the Harbor House after being abused by her boyfriend. She moved from Florida four months ago. She was alert and oriented, but seemed very anxious and was a poor historian. She was diagnosed with acute bronchitis and treated with Zithromax. She had multiple psychiatric diagnoses and was on current medications for them. The left finger joint pain was believed to be arthritis and not related to her carpal tunnel.

On February 28, 2012, Claimant's primary care physician wrote a letter indicating that Claimant relates a history of anxiety and was hospitalized with severe depression. She has a history of asthma and uses an inhaler. She has chronic stomach upset, which is aggravated by food. She has problems with her blood sugar dropping when she does not eat well. Her breathing problems are worsened by being in cold weather. Her anxiety seems to be an ongoing issue for years. She has had multiple admissions for this. She also complains of problems sleeping. She has generalized anxiety disorder and complains of low back pain.

On July 18, 2012, Claimant had a pulmonary function test. The examining physician noted Claimant gave a poor effort. The flow-volume curve supported limited ability to interpret testing. The spirometry suggested mild restrictive ventilatory defect. Total lung capacity was severely reduced and gas exchange severely reduced yet the estimate of reliability was low. Claimant stated that she gave her maximal efforts but complained of chest pain on full inspiration and exhalation. She used Ventolin MDI Qid and Flovent 220 2 puffs Bid. She smoked a pack of cigarettes every three days for less than a year. She had a lot of difficulty with testing with questionable effort.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). In the present case, Claimant testified that she had depression, anxiety, post traumatic stress disorder, panic attacks, arthritis, carpal tunnel, hypoglycemia, dyslexia and Aspergers. Based on the lack of objective medical evidence supporting her alleged impairments are severe enough to reach the criteria and definition of disability, Claimant is denied at step 2 for lack of a severe impairment and no further analysis is required.

The department's Bridges Eligibility Manual contains the following policy statements and instructions for caseworkers regarding the State Disability Assistance program: to receive State Disability Assistance, a person must be disabled, caring for a disabled person or age 65 or older. BEM, Item 261, p 1. Because Claimant does not meet the definition of disabled under the MA-P program and because the evidence of record does not establish that Claimant is unable to work for a period exceeding 90 days, Claimant does not meet the disability criteria for State Disability Assistance benefits.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Claimant not disabled for purposes of the MA-P/Retro-MA and SDA benefit programs.

Accordingly, it is ORDERED:

The Department's determination is **AFFIRMED**.

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

Date Signed: September 27, 2012

Date Mailed: September 27, 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 mailing date of the rehearing decision.

VLA/las

cc: [redacted]