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

IN THE MATTER OF:

[redacted]

Reg. No.: 2012-57974
Issue No.: 2009;4031
Case No.: [redacted]
Hearing Date: August 30, 2012
County: Newaygo County

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 August 30, 2012, from Lansing, Michigan. Claimant and her mother per sonally appeared and provided te stimony. Participants on behalf of the Department of Human Serv ices (Department) incl uded Lead Eligibility Specialist [redacted] [redacted]

ISSUE

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

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 3, 2011, Claimant filed an application for MA/Retro-MA and SDA benefits alleging disability.

(2) On May 22, 2012, the Medical Re view Team (MRT) denied Claimant's application for MA-P and Retro-MA i ndicating Claimant was capable of performing other work. SDA was denie d based on lack of duration. (Department Exhibit A, pp 10-11).

(3) On May 25, 2012, the department ca seworker sent Claimant notice that her application was denied.

(4) On June 7, 2012, Claimant filed a request for a hearing to contest the department's negative action.

(5) On July 18, 2012, the State Hearing Review Team (SHRT) found Claimant retained the capacity to perform a wide range of simple, unskilled work. SDA was denied due to lack of duration. (Department Exhibit B, pp 1-2).

(6) Claimant has a history of paranoia, bipolar disorder, premenstrual dysphoric disorder (PMDD), obsessive compulsive disorder (OCD), posttraumatic stress disorder (PTSD), anxiety, insomnia and gastroesophageal reflux disease (GERD).

(7) Claimant is a 21 year old woman whose birthday is [redacted]. Claimant is 5'5" tall and weighs 218 lbs. Claimant completed the eleventh grade.

(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 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 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).

Pursuant to Federal Rule 42 CFR 435.540, the Department of Human Services uses the federal Supplemental Security Income (SSI) policy in determining eligibility for disability under the Medical Assistance program. Under SSI, disability is defined as:

> . . . the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905

The SDA program differs from the federal MA regulations in that the durational requirement is 90 days. This means that the person's impairments must meet the SSI disability standards for 90 days in order for that person to be eligible for SDA benefits.

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 never worked. 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 paranoia, bipolar disorder, premenstrual dysphoric disorder (PMDD), obsessive compulsive disorder (OCD), posttraumatic stress disorder (PTSD), and anxiety, insomnia and gastroesophageal reflux disease (GERD).

On January 5, 2011, Claimant saw her primary care physician for a medication follow-up. She had been recently diagnosed with bipolar manic depression and was known to have sleep disturbance, delusional behaviors and tangential thinking. She was started on Seroquel two weeks prior, and reported she was sleeping better. She was more alert and did not have racing thoughts. She was appropriate to forms of discussion and had no movement disturbance on exam, and no evidence of tremors or tardive-type movements. She remained obese, but far less anxious than her previous visit. Her physician opined that she was responding nicely to the Seroquel and had considerable improvement in her bipolar symptoms.

On February 16, 2011, Claimant saw her primary care physician to discuss her Seroquel treatment. Two months ago, she had been taking 100 mg nightly for her bipolar disorder and anxiety control. She had good relief for the first 2-3 weeks. She stated that the Seroquel had not been working as well recently, and her mother stated that Claimant's younger brother had returned home and hazed and taunted Claimant constantly, causing her to have more extremes of behavior and mood changes. She had tangential thought processes and limited ability to pay attention while in the office. Her physician suggested limiting her contact with her younger brother as he appeared to be a precipitating event for her mood disorder. Her dosage of Seroquel was increased.

On March 18, 2011, Claimant followed up with her primary care physician regarding her medications. She had recently been treated with an increased dose of Seroquel at nighttime to correct both sleep disturbance as well as thought disturbance. She smiled spontaneously during the examination. She was alert and oriented, not sedated. She denied delusions or hallucinations. She was not homicidal or suicidal. She was much more optimistic about her future. Her physician opined that there had been a dramatic improvement in her bipolar disorder since the increase in Seroquel dosage.

On September 2, 2011, Claimant saw her primary care physician regarding her insomnia. She had been sleeping well and was now having some problems with insomnia and agitation at night. She was slightly tangential, but not delusional and was not hallucinating. She appeared psychiatrically stable but her bipolar disorder was not being optimally controlled. She also still had physical problems relating to her obesity.

On November 17, 2011, Claimant saw her therapist at community mental health. She had been off her medications of Seroquel and Trazodone the past week because the

family was unable to afford them. Claimant presented as tired and lethargic and stated she had not been sleeping well without her medications. She stated she was depressed most of the time. She reported anhedonia, isolating herself, and had not been attending school for several weeks.

On December 2, 2011, Claimant underwent an intake assessment. Claimant reported sleeping only a few hours a night. She stated she had mood swings, anxiety and worrying. She reported chest pain when worrying about things and anger issues. She stated she does not leave the house alone due to anxiety about being alone. She reported being successfully treated for bipolar disorder but recently lost her Medicaid and went off her medications. Diagnoses: Axis I: Bipolar disorder; Generalized anxiety disorder; Axis V: GAF=50.

On January 4, 2012, Claimant underwent a psychiatric/psychological evaluation at community mental health. Claimant was flat in her presentation. She was guarded and a poor historian. Her speech productivity and rate were slow. She deferred to others when questioned. Diagnoses: Axis I: Bipolar affective disorder; Axis II: Personality disorder; Axis III: Obesity; Axis IV: Situational, family; Axis V: GAF=40.

On May 7, 2012, Claimant underwent a psychological evaluation on behalf of the department. She described her self-esteem as low, and showed very limited insight into her own dynamics. She was oriented, alert and non-spontaneous. She complained of paranoid thoughts, and reported that at times she felt hopeless and worthless. She described a sleep and appetite disturbance. Her affect was flat. She was mostly quiet, reserved and withdrawn. Diagnoses: Axis I: Dysthymia-mild; Axis II: Limited intellectual ability; Axis IV: Severity of psychosocial stressors-mild; Axis V: GAF= 50-55. The examining psychologist opined that the potential for her to become gainfully employed in a simple, unskilled work situation on a sustained and competitive basis was guarded to fair. He opined that she may be able to function in a very simple work situation with appropriate training and supervision. Based on the exam, she also appeared to have no difficulty understanding, remembering or following through with simple instructions and there appeared to be few restrictions to her ability to perform simple, repetitive, concrete tasks.

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 was disabled based on her paranoia, bipolar disorder, premenstrual dysphoric disorder (PMDD), obsessive compulsive disorder (OCD), posttraumatic stress disorder (PTSD), anxiety, insomnia and gastroesophageal reflux disease (GERD).

As indicated earlier, the person claiming mental disability has the burden to establish it through the use of competent medical evidence. In this case, Claimant's medical records show that when Claimant is on appropriate medications there is a significant improvement in her bipolar symptoms. Furthermore, the evidence failed to show that her mental impairment was expected to last for a continuous period of 12-months.

Indeed, the evidenc e showed just the opposite, wherein she had significant improvement in her bipolar sym ptoms after only a few weeks of taking Seroquel. While from the records, it is obvious Claimant functions better when on medication, the medical records do not show that her mental impairment(s) are severe enough to reac h the criteria and definition of disability. Therefore, 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 As sistance program: to receive State Disability Assist ance, a person must be disabled, caring for a disable d 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 exc eeding 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 dis abled 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 14, 2012

Date Mailed: September 17, 2012

NOTICE: Administrative Hearings may or der a rehearing or reconsideration on either its own motion or at t he request of a party within 30 days of the mailing date of this Decision and Order. Administrative Hear ings will not orde r a rehearing or reconsideration on the Department's mo tion where the final decis ion 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/las

cc: [redacted]