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

IN THE MATTER OF:

[redacted]

Reg No.: 2012 73451
Issue No.: 2009
Case No.: [redacted]
Hearing Date: November 28, 2012
Oakland County DHS (03)

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

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, an in person hearing was held in Walled Lake, Michigan on November 28, 2012. The Claimant appeared and testified. Witnesses [redacted], and [redacted] also appeared. Steven Hosmer, of ADVOMAS the Claimant's Authorized Hearing Representative, (AHR) also appeared on Claimant's behalf. Sharon Sabbath, ES, appeared on behalf of the Department of Human Services ("Department").

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of Medical Assistance ("MA-P") benefits?

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 January 27, 2012 the Claimant submitted an application for public assistance seeking MA-P.

2. On May 24, 2012 the Medical Review Team ("MRT") found the Claimant not disabled. (Exhibit 1)

3. The Department notified the Claimant of the MRT determination on June 1, 2012.

4. On August 27, 2012, the Department received the Claimant's timely written request for hearing.

5. On October 9, 2012, the State Hearing Review Team ("SHRT") found the Claimant not disabled. Exhibit 2

6. An Interim Order was issued on December 4, 2012 which ordered the Department obtain additional new medical evidence to be submitted to the State Hearing Review Team (consultative psychiatric exam). The Claimant through his AHR was ordered to obtain medical evaluations (DHS 49) for the Claimant's treating physicians. The new medical evidence was submitted to the SHRT on February 15, 2013 and March 8, 2013.

7. On April 30, 2013 the State Hearing Review Team found the Claimant not disabled.

8. The Claimant alleges mental disabling impairment(s) due to Bipolar Disorder, Depression and Obsessive Compulsive Disorder.

9. The Claimant has alleged physical disabling impairments due to seizure disorder, and migraine, venous stasis and post phlebitis syndrome with lower extremity swelling, and asthma.

10. At the time of hearing, the Claimant was 29 years old with a [redacted] birth date; was 5'11" in height; and weighed 287 pounds. The Claimant is obese.

11. The Claimant has a high school education with one year of college. The Claimant stopped attending college due to mental problems and a hospitalization in 2002. The Claimant has a limited work history working at a supermarket bagging groceries and stocking shelves until he was fired due to his attendance. This job ended approximately 5 years ago.

12. The Claimant's impairments have lasted, or are expected to last, continuously for a period of 12 months or longer.

CONCLUSIONS OF LAW

The Medical Assistance program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department of Human Services, formerly known as the Family Independence Agency, 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 Bridges Reference Tables ("RFT").

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-relate 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 applicants 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 (i.e. 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 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 three to step four. 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 four and five. 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) An individual is not disabled regardless of the medical condition, age, education, and work experience, if the individual is working and the work is a substantial, gainful activity. 20 CFR 416.920(a) (4) (i) Substantial gainful activity means work that involves doing significant and productive physical or mental duties and is done (or intended) for pay or profit. 20 CFR 416.910(a) (b) Substantial gainful activity is work activity that is both substantial and gainful. 20 CFR 416.972 Work may be substantial even if it is done on a part-time basis or if an individual does less, with less responsibility, and gets paid less than prior employment. 20 CFR 416.972(a) Gainful work activity is work activity that is done for pay or profit. 20 CFR 416.972(b)

In addition to the above, when evaluating mental impairments, a special technique is utilized. 20 CFR 416.920a(a) First, an individual's pertinent symptoms, signs, and laboratory findings are evaluated to determine whether a medically determinable mental impairment exists. 20 CFR 416.920a(b)(1) When a medically determinable mental impairment is established, the symptoms, signs and laboratory findings that substantiate the impairment are documented to include the individual's significant history, laboratory findings, and functional limitations. 20 CFR 416.920a (e) (2) Functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. *Id.;* 20 CFR 416.920a(c) (2) Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality is considered. 20 CFR 416.920a(c)(1) In addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of functional limitation. 20 CFR 416.920a(c)(3) The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4) A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. *Id.* The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. *Id.*

After the degree of functional limitation is determined, the severity of the mental impairment is determined. 20 CFR 416.920a(d) If severe, a determination of whether the impairment meets or is the equivalent of a listed mental disorder is made. 20 CFR 416.920a(d)(2) If the severe mental impairment does not meet (or equal) a listed impairment, an individual's residual functional capacity is assessed. 20 CFR 416.920a(d)(3)

As outlined above, the first step looks at the individual's current work activity. In the record presented, the Claimant is not involved in substantial gainful activity therefore is not ineligible for disability benefits under Step 1.

The severity of the Claimant's alleged impairment(s) is considered under Step 2. The Claimant 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, the Claimant alleges disability based on mental disabling impairments due to Bi Polar Disorder, Depression and Obsessive Compulsive Disorder.

The Claimant has alleged physical disabling impairments due to seizure disorder, and migraine, venous stasis and post phlebitis syndrome with lower extremity swelling, and asthma.

A summary of the claimant's Medical evidence follows.

The Claimant was admitted to the hospital on January 16, 2012 due to new onset seizure disorder with placement of PEG tube (feeding tube), was placed on a ventilator and was in critical condition. At the time of his admission he was incapacitated and was deemed by his treating doctor to be unable to make his own medical decisions. A follow up letter dated February 7, 2012 indicated that his treating doctor anticipated long term recovery for the Claimant. At the time of discharge he was still weak and required help with daily living activities.

Since the hospitalization the Claimant has not had another seizure. The Claimant's discharge summary indicated that the Diagnosis was respiratory failure with trach removal, seizure, etiology unknown, new onset, bipolar psychosis, depression, gastritis, and asthma. The hospital stay lasted from January 16, 2012 through February 9, 2012. Claimant was discharged home in stable condition.

The Claimant's Hematologist (doctor) performed an examination on February 20, 2013 at which time the diagnosis was venous stasis and post phlebitis syndrome with lower extremity swelling. The following limitations were imposed. The Claimant was limited to standing less than 2 hours in an 8 hour work day. Assistive devices were not necessary. No other limitations were imposed.

In both December 2011 and October 2011 the Claimant's then treating psychiatrist indicated that he is unable to sustain gainful employment due to his then psychiatric condition and met a diagnosis of Bipolar Disorder with psychosis features and Obsessive Compulsive Disorder.

An examination was conducted by the Claimant's therapist, a licensed psychologist . It was noted that Claimant's hygiene was marginal and that Claimant began outpatient therapy in November 2012 and the report was written in January 2013. The report noted history of auditory hallucinations and that judgment and decision making was impaired. The report noted that the Claimant has never lived independently from his

parents. The diagnosis was Bipolar Disorder with social anxiety and depression, the GAF score was 52 down from the prior GAF of 56.

A Medical Examination Report was conducted by Claimant's neurologist on January 15, 2013. The Report indicates a current diagnosis of seizure and migraine. The report noted that Claimant was improving. There were no physical limitations imposed. A separate letter was provided by the same neurologist indicating that the new onset seizures at age of 28 are thought to be related, at least in part, to a lowered seizure threshold due to medications, Geodon, and Concerta. A prior Medical Examination report completed in April 2012 by the same neurologist indicated ongoing seizure precautions indicated as no heights, no driving for 6 months after seizure.

The Claimant was also evaluated in April 2012 by his treating psychiatrist at that time. The diagnosis was bipolar disordered most recent episode was depressed, current GAF was 45 highest GAF was 55.

A Psychological assessment completed in February 2012. At the time of the examination the Claimant had completed one year of college but could not return due to his mental health symptoms becoming worse. The report notes that the Claimant is stable when he is taking his medications, and was off medications when his parents could not afford to pay them. The report notes that Claimant continues to have depression, low motivation, tends to isolate, has poor personal hygiene, memory loss and has a difficult time concentrating with a history of manic behavior. The exam notes noted that he was anxious, speech was coherent, goal directed and normal rate and rhythm. No auditory or visual disturbances, no delusions, and no looseness of association or flight of ideas. The diagnosis portion of the examination was not copied or provided.

In January 2013 the Claimant's treating psychiatrist provided a letter regarding his mental health treatment. The letter dated 1/11/13 notes, clinical depression, blood clotting disorder, seizure disorder, asthma, chronic bronchitis, high blood pressure and pulmonary issues. The Report notes Claimant is seen by a therapist for Bipolar Disorder with psychosis, Obsessive Compulsive Disorder and Social Anxiety Disorder. The letter concludes that the Claimant is unable to sustain gainful employment due to his physical and mental health concerns

A consultative Psychiatric Examination was conducted on December 14, 2012. During the exam the Claimant did exhibit obsessive-compulsive behavior where Claimant would constantly wipe the conference table in front of him and note the smudges he had made and had to be redirected by the examiner. The Claimant's fund of general knowledge was fair, could perform simple addition, subtraction, multiplication. The examiner's diagnosis was Bipolar Disorder with a GAF of 60. The Claimant's ability to

relate to others was markedly impaired because of his social phobia. Claimant was believed to have the mental ability to understand, remember and carry out simple tasks. He seems to have the ability to learn and work independently as evidence by his prior work history. Claimant's ability to maintain attention, concentration, persistence and pace when performing routine, well learned tasks depends on his ability to cope with the specific situation. Claimant's ability to withstand stress and pressures associated with day to day work is markedly impaired due to his rapid mood change. The examiner concluded that the prognosis was guarded.

Subsequently, a DHS 49E dated 1/8/13 was also submitted in conjunction with the December 14, 2012 psychiatric examination. The exam noted with regard to Understanding and Memory, moderate limitations regarding the ability to carry out simple one step instructions, and detailed instructions, and ability to maintain attention and concentration for extended periods. The Claimant was moderately limited in the following areas: ability to perform activities within a schedule, maintain regular attendance and be punctual within customary tolerances, sustain an ordinary routine without supervision. The Claimant was markedly limited in his ability to work in coordination with or proximity to others without being distracted by them .

As regards Social Interaction the Claimant was markedly limited in his ability to interact appropriately with the general public, ask simple questions or request assistance, ability to get along with co workers or peers without distracting them or exhibiting behavioral extremes, ability to accept instructions and respond appropriately to criticism from supervisors ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.

As regards Adaption, the Claimant was markedly limited in his ability to travel in unfamiliar places or use public transportation and moderately limited in ability to respond appropriately to change in the work setting and set realistic goals or make plans independently.

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the Claimant has presented some objective medical evidence establishing that she does have some physical and mental limitations on his ability to perform basic work activities. Accordingly, the Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months therefore, the Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's impairment, or combination of impairments, is listed in

Appendix 1 of Subpart P of 20 CFR, Part 404. The Claimant asserts mental disabling impairments due to Bipolar Disorder, Depression and Obsessive Compulsive Disorder.

Listing 12.04 defines affective disorders as being characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Generally, affective disorders involve either depression or elation. The required level of severity for this disorder is met when the requirements of 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 distractability; 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 on 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;

In this case, the record reveals ongoing treatment for bipolar disorder with one hospitalization. Medical records document a pervasive loss of interest in activities, episodes of extreme anxiety, and extreme depression and marked restrictions of social functioning and difficulties maintaining concentration, persistence or pace as well as adaption. The claimant has been treating consistently with breaks only due to lack of insurance coverage and sees his Psychiatrist monthly and participates in therapy. His GAF scores have ranged from 60 to 45. The Claimant credibly testified that he suffers from emotional problems and that he suffers anger issues monthly and his appetite fluctuates due to his mood swings. His sleep is often interrupted and he is often tired and anxious. The Claimant credibly testified that he continues to have poor concentration and memory problems. The Claimant's social interactions are limited to his family and his dogs. He has no friends and tends to isolate. The Claimant has noted poor personal hygiene and loses track of his personal care. The Claimant testified credibly that cooking, cleaning and grocery shopping are only done a little bit. Due to Claimant's circulatory problems in his legs he testified that he can stand only 10 minutes at a time and sit only 30 minutes to an hour, he cannot squat and cannot bend at the waist due to balance problems.

The Claimant's parents also attended the hearing and indicated that Claimant has severe social anxiety which causes him not to want to leave the house and he keeps his distance form people.

The records and evaluations of the Claimant's treating psychiatrist indicate that the Claimant will need continuing treatment and is as of January 2013 markedly limited in maintaining social functioning.

A thorough consultative psychiatric examination summarized above clearly noted the Claimant's prognosis was guarded and that Claimant ability to withstand stress and pressures associated with day to day work is markedly impaired due to his rapid mood change. The DHS 49 E summarized in detail above also found the Claimant markedly impaired in areas of social functioning, working with others and being distracted by them, and was markedly limited in all areas of Social Interaction.

As a result, the medical records and testimony demonstrate clearly that the Claimant has marked restrictions in daily living and social functioning and adaptation and has a GAF score which fluctuates but on average is low. Deference was also accorded to the medical opinion of the Claimant's treating psychiatrist. The evaluations of the treating physician and the medical conclusion of a "treating " physician is "controlling" if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record under 20 CFR§ 404.1527(d)(2),

Ultimately, based on the medical evidence, the Claimant's impairment(s) meets, or is the medical equivalent of, a listed impairment within 12.00, specifically 12.04 A , 3 Bipolar Syndrome. Accordingly, the Claimant is found disabled at Step 3 with no further analysis required.

In this case, the Claimant is found disabled for purposes of the MA-P program. In light of this Decision the Claimant may consider applying for State Disability Assistance Program.

DECISION AND ORDER

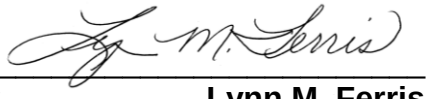
The Administrative Law Judge, based on the above findings of fact and conclusions of law finds the Claimant disabled for purposes of the MA-P benefit program.

Accordingly, It is ORDERED:

1. The Department's determination is REVERSED.

2. The Department shall initiate processing of the January 27, 2012 application for MA-P and determine the Claimant's eligibility and determine if all other non-medical criteria are met and inform the Claimant and his AHR of the determination in accordance with Department policy.

3. The Department shall review the Claimant's continued eligibility in May 2014 in accordance with department policy.



Lynn M. Ferris
Administrative Law Judge
For Maura Corrigan, Director
Department of Human Services

2012-73451/LMF

Date Signed: May 21, 2013

2012-73451/LMF

Date Mailed: May 21, 2013

NOTICE: Michigan Administrative Hearing System (MAHS) 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. MAHS 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. (60 days for FAP cases)

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the receipt 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 at

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

LMF/tm

cc: [redacted]
Oakland County (03) DHS/1843
[redacted]
EQAD
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L. Ferris