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

IN THE MATTER OF:

[redacted]

Reg. No.: 2013-42426
Issue No.: 2009
Case No.: [redacted]
Hearing Date: August 21, 2013
County: Monroe DHS

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

Following Claimant's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10. After due notice, an in-person hearing was held on August 21, 2013, from Monroe, Michigan. Participants included the above-named Claimant. [redacted] testified and appeared as Claimant's authorized hearing representative. [redacted] Claimant's ex-spouse, testified on Claimant's behalf. Participants on behalf of the Department of Human Services (DHS) included [redacted], Medical Contact Worker.

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 [redacted]/13, Claimant applied for MA and SDA benefits, including retroactive MA benefits from [redacted]/2013.

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

3. On [redacted]/13, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 7-8).

4. On [redacted]/13, DHS denied Claimant's applications for MA and SDA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On [redacted]/13, Claimant's AHR requested a hearing disputing the denial of MA and SDA benefits.

6. On [redacted]/13, SHRT determined that Claimant was not a disabled individual, in part, by application of Medical-Vocational Rule 203.25.

7. On [redacted]/13, an administrative hearing was held.

8. Claimant presented new medical documents (Exhibits A1-A9) at the hearing.

9. On [redacted]/13, the hearing packet was forwarded to SHRT.

10. On [redacted]/13, SHRT determined that Claimant was not disabled, in part, by application of Medical-Vocational Rule 204.00

11. As of the date of the administrative hearing, Claimant was a [redacted]-year-old male with a height of 5'9'' and weight of 180 pounds.

12. Claimant is a pack/week cigarette smoker and has no known relevant history of alcohol or illegal substance abuse.

13. Claimant's highest education year completed was 12th grade via general equivalency degree.

14. As of the date of the administrative hearing, Claimant was an Adult Medical Program (AMP) recipient since [redacted]/2013.

15. Claimant alleged disability based on impairments and issues including degenerative back arthritis, seizures and leg pain.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by the Title XIX of the Social Security Act, 42 USC 1396-1396w-5, and is implemented by 42 CFR 400.200 to 1008.59. The Department of Human Services (formerly known as the Family Independence Agency) administers the MA program pursuant to MCL 400.10 and MCL 400.105. Department policies are contained in the Department of Human Services Bridges Administrative Manual (BAM) and Department of Human Services Bridges Eligibility Manual (BEM) and Department of Human Services Reference Tables Manual (RFT).

Prior to a substantive analysis of Claimant's hearing request, it should be noted that the request noted special arrangements were required for Claimant's hearing participation. It was noted that Claimant required his caregiver to be at the hearing and that he needed a private ride. Claimant's caregiver was present at the hearing. Claimant also testified that he arranges for transportation on his own. Claimant testified that he was able to participate in the hearing without further accommodation.

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 (10/2010), p. 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:

- 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).
  BEM 260 (7/2012) pp. 1-2

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 (7/2012), p. 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 2013 income limit is $1040/month.

Claimant denied performing 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; accordingly, 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 relevant submitted medical documentation.

A Medical Examination Report (Exhibits 10-11) dated [redacted]/13 from a physician was presented. It was noted that the physician saw Claimant one time only, on [redacted]/13. The physician provided diagnoses of seizures and a closed head injury. An impression was given that Claimant's condition was stable. It was noted that Claimant can meet household needs.

Hospital documents (Exhibits 70-101) verifying a [redacted]/12 admission were presented. It was noted that Claimant presented with injuries after he was assaulted. It was noted that a witness indicated that the attacker did not use weapons. It was noted that Claimant had multiple facial lacerations. It was noted that Claimant had a history of alcohol and tobacco abuse. It was noted that CT scans showed left orbital fracture and nasal bone fracture. A CT of the head was noted as negative. It was noted that Claimant's lip was lacerated and sutured in the ER. It was noted that Claimant received antibiotics, fluids and other medications during the admission. It was noted that Claimant was discharged on [redacted]/12 in stable condition.

Hospital documents (Exhibits 57-69) dated [redacted]/12 were presented. It was noted that Claimant presented with alcohol intoxication.

Hospital documents (Exhibits 53-6) from an admission dated [redacted]/12 were presented. It was noted that Claimant presented with complaints of a bug bite.

Hospital documents (Exhibits 21-53) verifying a [redacted]/13 admission were presented. It was noted that Claimant presented with complaints of shakiness, weakness, alcohol ingestion and suicidal thoughts. It was noted that Claimant reported medicating himself

with alcohol and marijuana because of his life's difficulties. It was noted that Claimant complained of seizures, which were ongoing for the prior year. It was noted that Claimant reported losing consciousness when he has a seizure. An assessment noted an altered mental state due to hepatic encephalopathy from acute alcohol intoxication, seizures, elevated transaminases noted as likely due to alcohol, generalized weakness, substance abuse, major depression including suicidal ideation, gastroesophageal reflux disease and deep vein thrombosis. A psychiatric evaluation noted the following Axis I diagnoses: pain disorder, mood disorder, panic disorder and alcohol dependence. Claimant's GAF was 45. It was noted that Claimant did not meet criteria for psychiatric admission. It was noted that Claimant's symptoms could be treated with Risperdal and Cogentin. It was noted that Claimant was referred to a community mental health agency. Consultation documents (Exhibits 29-30) noted that Claimant is likely having partial seizures and that an EEG will be arranged. It was noted that a CT scan of Claimant's brain showed a large arachnoid cyst, which was stable since the last exam. A radiology report of Claimant's lumbar noted mild spondylotic changes at L5-S1 and no significant stenosis at any vertebrae. It was noted that views of Claimant's right knee were taken following Claimant reports of pain; an impression of a non-acute knee was given. An echo of Claimant's heart led to an impression of normal left ventricle ejection fraction and normal right ventricle systolic function. A discharge date was not readily apparent, though [redacted]/13 was the last date noted within the batch of documents.

Treatment documents (Exhibits 106-107) dated [redacted]/13 were presented. It was noted that Claimant presented with complaints of seizures and chronic lower back pain. It was noted that Claimant took Keppra and Norco for pain.

An EEG report (Exhibit 112) dated [redacted]/13 was presented. An impression of an abnormal EEG for patient's age was noted.

A psychiatric medical report (Exhibits 117-120) dated [redacted]/13 was presented. It was noted that Claimant had an unstable gait. It was noted that Claimant reported the following symptoms: short-term memory loss, extreme sadness, difficulty with concentration, nightmares, mood swings, crying spells, anger outbursts, anhedonia, dysphoria, irritability, nervousness, extreme fear and paranoia. It was noted that Claimant was molested as a child and that he feels overwhelmed by his symptoms. It was noted that Claimant's household chores were performed by family and friends. It was noted that Claimant does not drive. Axis I diagnoses noted by the examinining physician included: PTSD, major depressive disorder, cognitive disorder, generalized anxiety disorder and panic disorder. The examiner noted Claimant's GAF to be 45. Claimant's prognosis was guarded. It was noted that Claimant could benefit by treatent for PTSD and stress management. The examiner noted that she suspects that the pressure of employment would be a major factor in decompensation.

Treatment documents (Exhibits 104-106) dated [redacted]/13 were presented. It was noted that Claimant presented with a need for medication refills. It was noted that Claimant's seizures were decreasing in frequency. It was noted that Claimant tried taking Norco

only when necessary. It was noted that Claimant reported panic attacks and was very irritable toward others. It was noted that Claimant was not suicidal.

Treatment documents (Exhibits 109-111) dated [redacted]/13 were presented. It was noted that Claimant reported a couple of seizures since last visit, including a 10-minute seizure the night before the appointment. It was noted that Claimant complained of radiating back pain. It was noted that Claimant complained of daily headaches and leg weakness. It was noted that Claimant frequently fell and that he walks with a cane to help his balance. It was noted that Claimant reported difficulty sleeping and anxiety. It was noted that Claimant had a normal attention span, normal muscle strength in all extremities and normal gait. Tenderness was noted in the paraspinal area. All cranial nerves were noted as intact.

Treatment documents (Exhibits 102-104) dated [redacted]/13 were presented. It was noted that Claimant presented with adverse reactions to Respiadol. It was noted that Claimant complained of bad thoughts, bad dreams, personality changes, stress and anxiety. An assessment included PTSD, nonepileptic seizures and chronic pain. A plan was noted to continue current medications and refer Claimant to neuropsychiatry.

Treatment documents (Exhibits A7-A8) dated [redacted]/13 were presented. It was noted that Claimant complained of burning and cramping in his legs. It was noted that Claimant's speech was abnormal. It was noted that Claimant reported increasing shaking and leg weakness.

A Psychiatric/Psychological Examination Report (Exhibits A1-A3) dated [redacted]13 was presented. It was noted that the examination was completed by an examiner seeing Claimant for the first time. The examiner signed as an MA LLP. It was noted that Claimant scored 8/30 on a mini mental state examination. Claimant's GAF was noted as 35. The examiner noted diagnoses of cognitive disorder and PTSD. It was noted that Claimant had limited social functioning and memory.

The examiner also completed a Mental Residual Functional Capacity Assessment (Exhibits A4-A5) dated [redacted]/13 which was presented. This form lists 20 different work-related activities among four areas: understanding and memory, sustained concentration and persistence, social interaction and adaptation. A therapist or physician rates the patient's ability to perform each of the 20 abilities as either "not significantly limited", "moderately limited", "markedly limited" or "no evidence of limitation". The examiner determined that Claimant was markedly limited in 19 of 20 abilities.

Claimant alleged disability primarily on cognitive and psychological restrictions. An examining psychologist determined that Claimant's GAF was 35. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a score of 31-40 is representative of "some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood." The same examiner determined that Clamant score 8/30 on a mini

mental state examination; a score below 9 is known to be indicative of severe cognition impairments. A different treating physician determined Claimant's GAF to be 45. DSM IV states that 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)." Based on Claimant's low GAFs and low scoring on the MMSE, significant impairments to performing basic work activities can be presumed. The marked restricted in social and concentration abilities noted by an examining psychologist was further proof of impairment. Claimant established significant impairments to performing basic work activities.

Claimant seeks a claim of disability beginning in [redacted]/2013. It was established that Claimant's injuries coincided with an assault from [redacted]/2012. Claimant established a basis for disability beginning in [redacted]/2013.

The nature of Claimant's closed head injury and the evidence is such that Claimant's condition is not likely to substantially improve within 12 months. It is found that Claimant meets the durational requirements for a severe impairment.

As it was found that Claimant established significant impairment to basic work activities for a period longer than 12 months, it is found that Claimant established having a severe impairment. Accordingly, the disability analysis may move 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.

Claimant's most prominent impairment appears to be PTSD and/or anxiety disorder. Claimant's disorders are covered by Listing 12.06 which reads:

> **12.06** ***Anxiety-related disorders***: In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders.
>
> 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 both A and C are satisfied.
>
> A. Medically documented findings of at least one of the following:
> 1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:
> a. Motor tension; or

b. Autonomic hyperactivity; or
c. Apprehensive expectation; or
d. Vigilance and scanning; or

2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or

4. Recurrent obsessions or compulsions which are a source of marked distress; or

5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;

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. Resulting in complete inability to function independently outside the area of one's home.

Starting with Part A, an examining physician noted that Claimant reported daily panic attacks (see Exhibit 117). It was further noted that Claimant has intense fear and paranoia. A second examiner noted similar symptoms (see Exhibit A1-A3) such as fearfulness and a high level of anxiety. It is found that Claimant meets Part A of the above listing.

Turning to Part B, it was established that Claimant has marked difficulty in concentration and social functioning. One examining psychologst (see Exhibits A4-A5) explicitly stated that Claimant is markedly limited in the following concentration abilities: carrying out simple instructions, maintaining attention and concentration for extended periods, making simple work-related decisions and sustaining an ordinary routine without supervision. The examiner also found Claimant limited in the following social abilities: interacting appropriately with the public, accepting instructions and responding to criticisms, getting along with others and maintaining socially acceptable behavior while adhering to basic standards of cleanliness. The restrictions were consistent with another examiner's findings that Claimant's GAF was 45, which is indicative of marked restrictions. It is found that Claimant is markedly limited in concentration and social function.

Based on the presented evidence, it is found that Claimant meets the listing for anxiety disorders. Accordingly, it is found that DHS improperly denied Claimant's application dated [redacted]/13.

It should be noted that SHRT suggested that drug and/or alcohol abuse was material to the disability analysis. There was evidence of alcohol and drug abuse by Claimant. An analysis was not undertaken because two examiners did not cite the materiality of drug or alcohol abuse in evaluating Claimant for psychological disorders.

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. DHS administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. DHS policies for SDA are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 at 4. The goal of the SDA program is to provide financial assistance to meet a disabled person's basic personal and shelter needs. *Id*. To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older. BEM 261 at 1.

A person is disabled for SDA purposes if the claimant (see BEM 261 at 1):

- receives other specified disability-related benefits or services, see Other Benefits or Services below, or
- resides in a qualified Special Living Arrangement facility, or
- is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability; or
- is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS).

It has already been found that Claimant is disabled for purposes of MA benefits, effective 1/2013, based on a finding that Claimant's impairments meet the SSA listing for anxiety disorders. The analysis and finding equally applies to Claimant's application for SDA benefits. It is found that DHS improperly denied Claimant's application for SDA benefits.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that DHS improperly denied Claimant's application for MA and SDA benefits. It is ordered that DHS perform the following actions:

(1) reinstate Claimant's MA and SDA benefit application dated [redacted]/13, including retroactive MA benefits from [redacted]/2013;
(2) evaluate Claimant's eligibility for MA and SDA benefits subject to the finding that Claimant is a disabled individual;
(3) initiate a supplement for any benefits not issued as a result of the improper application denial; and
(4) schedule a review of benefits in one year from the date of this administrative decision, if Claimant is found eligible for future MA benefits.

The actions taken by DHS are **REVERSED**.

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

Date Signed: 10/31/2013

Date Mailed: 10/31/2013

NOTICE OF APPEAL: 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 or Reconsideration was made, within 30 days of the receipt date of the Decision and Order of Reconsideration or Rehearing Decision.

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).

A Request for Rehearing or Reconsideration may be granted when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion;
- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the client;
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The Department, AHR or the claimant must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date the hearing decision is mailed.

The written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

If submitted by mail, the written request must be addressed as follows:

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

CG/hw

cc: [redacted]