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

IN THE MATTER OF:

[redacted]

Reg. No.: 2013-40640
Issue No.: 2009, 4031
Case No.: [redacted]
Hearing Date: August 8, 2013
County: Ionia (00)

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, a telephone hearing was held on August 8, 2013, from Detroit, Michigan. Participants included the above-named Claimant. [redacted], Claimant's landlord, and [redacted], Claimant's therapist, testified on behalf of Claimant. Participants on behalf of the Department of Human Services (DHS) included [redacted], Specialist.

ISSUE

The issue is whether DHS properly denied Claimant's application for Medical Assistance (MA) 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 benefits, including retroactive MA benefits from 10/2012.

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 application for MA 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 benefits.

6. On [redacted]/13, SHRT determined that Claimant was not a disabled individual, in part, by determining that Claimant can perform past relevant work.

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

8. On [redacted]/13, Claimant presented new medical documents (Exhibits A1-A74).

9. On [redacted]13, an updated hearing packet was forwarded to SHRT.

10. On [redacted]/13, SHRT determined that Claimant was not disabled, in part, by determining that Claimant can perform past relevant work.

11. On [redacted]/13 the Michigan Administrative Hearings System received the hearing packet and updated SHRT decision.

12. As of the date of the administrative hearing, Claimant was a [redacted]-year-old female with a height of 5'4'' and weight of 187 pounds.

13. Claimant is an ongoing tobacco smoker and a relevant history of alcohol and illegal substance abuse.

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

15. As of the date of the administrative hearing, Claimant was an Adult Medical program recipient.

16. Claimant alleged disability based on impairments and issues including degenerative disc disease, arthritis, ankle pain, wrist pain and psychological impairments.

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).

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 monthly income limit considered SGA for non-blind individuals is $1,040.

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.

Various handwritten medical clinic documents (Exhibits 72-81) were presented. The documents ranged in date from [redacted]/2012-[redacted]/2012. Various diagnoses included: asthma, pneumonia, bronchitis, anxiety, gastritis, mastitis/sinusitis and PTSD.

Various lab results (Exhibits 82-92; 100-104) from [redacted]/2012 and [redacted]/2012 were presented. The results were not accompanied with any medical analysis.

Medical records (Exhibits 59-64) from [redacted]/2012 were presented. It was noted that Claimant presented with a complaint of cough. It was noted that a chest x-ray was negative.

Various handwritten clinic documents (Exhibits 23, 27-33; 37; 43-58) were presented. The documents ranged in date from [redacted]/2012 through [redacted]/2013. Various diagnoses included: pneumonia, anxiety, depression, bronchitis, left knee strain, lower back pain, contusions on chest and pelvis, myositis and allergies. The notes regularly documented prescriptions for Norco.

MRI reports of Claimant's lower back (Exhibits 65-69; A5-A6) dated [redacted]/12 were presented. An impression was noted of the following: small left-sided herniation at L1-L2 without stenosis, central disc bulge without stenosis at L4-L5 and L5-S1, bilateral foraminal narrowing at L5-S1. It was noted that mild nerve root compromise at L5-S1 could not be excluded.

A radiography report of Claimant's left knee (Exhibits 70-71) dated [redacted]/12 was presented. It was noted that Claimant fell and complained of pain and her knee giving

out. An impression of bone marrow edema was noted. It was noted there was no evidence of fracture.

A physician letter (Exhibit 112) dated [redacted]/12 was presented. Noted diagnoses included osteoarthritis of left hip and bursitis of left hip. It was noted that Claimant received a cortisone shot into her left hip.

A physician letter (Exhibits 110-11) dated [redacted]/12 was presented. It was noted that Claimant sought a prescription of pain pills on the same day she filled a prescription. It was noted that Claimant reported that someone stole her original prescription. It was noted that Claimant was given a note by the physician stating that he would not be responsible for prescribing Claimant any more pain medication.

A letter (Exhibit 38) from Claimant's social worker dated [redacted]/12 was presented. It was noted that Claimant receives individual and group therapy.

A drug test result (Exhibits 24-26; 34-36) dated [redacted]/12 was presented. It was noted that Claimant was positive for cocaine.

Medical documents (Exhibits 106-109) dated [redacted]/13 were presented. It was noted that Claimant presented with complaints of hip, back and ankle pain. It was noted that an injection to treat Claimant's back pain was not recommended because Claimant continues to smoke. A history of broken wrist and ankle was noted. It was also noted that Claimant had hardware placed in her wrist and ankle. It was noted that an x-ray of Claimant's right ankle showed satisfactorily healing. It was also noted that Claimant's right wrist was healed.

A Note (Exhibit 22; 105) dated [redacted]/13 from a physician was presented. It was noted that Claimant underwent a facet block. It was noted that no adverse reactions were observed.

A Psychiatric Evaluation (Exhibits 137-142) dated [redacted]/13 was presented. An Axis I diagnosis of dysthymic disorder and PTSD was noted. Claimant's GAF was 51. It was noted that Claimant was in therapy. It was noted that Claimant has a history of drug addiction, therefore, benzodiazepines would not be prescribed. It was noted that Claimant reported a history of night terrors.

Various psychiatric treatment documents (Exhibits 126-330) were presented. The documents ranged in date from [redacted]/2011 through [redacted]/2012. On [redacted]/11, Claimant's GAF was 50. The records show that Claimant regularly attended therapy throughout 2012.

Various psychiatric treatment documents (Exhibits A40-A74) were presented. The documents ranged in date from 3/2013 through [redacted]/2013. A Medication Review (Exhibit 48) noted Claimant's GAF to be 51.

Hospital documents (Exhibits A19-35) dated [redacted]/13 were presented. A Psychiatric Consultation (Exhibits A7-A17) associated with the hospitalization was also presented. It was noted that Claimant presented with altered mental status. It was noted that an overdose was suspected but that a drug screening found Claimant only positive for prescribed benzodiazepines. It was noted that Claimant reported a possible adverse reaction to medication and that she denied taking an overdose of medication. A GAF of 51-60 was noted. It was noted that Claimant reported being sexually assaulted. It was noted that Claimant was tearful throughout the consultation interview. It was noted that Claimant's behavior may have been related to withdrawal from narcotics.

Claimant alleged disability, in part, based on various pains in her lower back, ankle and wrist. A history of wrist and ankle surgery was verified. The only medical statements addressing problems with wrists or ankle noted that x-rays verified no basis for Claimant's complaints.

Radiography of Claimant's lower back from [redacted]/2012 was more supportive of the claim of disability. A herniation and disc bulge were verified, but stenosis was not. It was noted that a mild compromised nerve root could not be excluded as a possibility. The radiography is consistent with some abnormalities that may affect Claimant's ability to walk for extended period and ability to bend and/or lift weight. Claimant established a significant impairment to performing basic work activities.

Claimant has a substantial psychiatric history. The records verified Claimant's attendance in therapy since 2011. Claimant's GAF was regularly noted to be either 50 or 51. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF within the range of 51-60 is representative of someone with moderate symptoms or any moderate difficulty in social, occupational, or school functioning. 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)." Claimant's relatively low GAF is consistent with psychological impairments to performing basic work activities. Claimant's lack of sleep was well documented as was her erratic behavior. It is found that Claimant has psychological impairments significantly impacting her ability to perform basic work activities.

The presented evidence showed that Claimant regularly saw a physician and psychiatrist. Despite Claimant's treatment, there was little evidence of improvement in Claimant's back or psychiatric problems. It is found that Claimant established meeting 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 psychological-related. Diagnosis for dysthymic disorder and PTSD were noted. Claimant's symptoms appear to be anxiety-related which is best 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.

Much of Claimant's medical history was not particularly sympathetic. It was noted that Claimant has a history of drug abuse including an apparent drug distribution conviction. It was noted that Claimant used drugs as recently as [redacted]/2012. Claimant's records also strongly implied an addiction to pain medication.

A letter (Exhibits A1-A3) dated [redacted]/13 from Claimant's landlord was presented. Claimant's landlord also testified on behalf of Claimant. The landlord was also a social worker and claimed to be Claimant's caregiver. The letter speculated that Claimant's PTSD was severe based on his observation of Claimant's chronic sleep deprivation. The author noted that he witnessed numerous premature awakenings by Claimant. The letter author noted that Claimant attempted volunteer work, which did not last long, likely because lack of sleep made Claimant irritable, argumentative and unable to follow directions. The letter is not medical evidence that may be considered but it was tremendously well-written, thoughtful and logical. If nothing else, the letter painted a much clearer picture of Claimant's struggles than did the hundreds of submitted therapy documents.

Starting with Part A, presented documents establish Claimant's reoccurring problems with sleeping, in particular, night terrors. It was also documented that the terrors related to abuse from a past boyfriend. It is found that Claimant meets Part A of the above listing.

Turning to Part B, medical records established that Claimant had PTSD and dysthymic disorder. Medical records established that despite ongoing therapy, Claimant's GAF remained stagnant at 50 or 51. Claimant's GAF places her in a range representative of a high-functioning person with marked restrictions and/or low functioning with moderate impairments. The evidence was strongly suggestive of marked difficulties to concentration and social functioning, both related to PTSD symptoms.

Based on the presented evidence, it is found that Claimant meets the listing for anxiety disorders. Accordingly, the denial of Claimant's application is found to be improper.

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 benefits. It is ordered that DHS:

(1) reinstate Claimant's MA benefit application dated [redacted]/13, including retroactive MA benefits from [redacted]/2012;
(2) evaluate Claimant's eligibility for MA 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: 11/6/2013

Date Mailed: 11/6/2013

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]