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

IN THE MATTER OF:

Reg. No.:	2013-62638
Issue No.:	2009
Case No.:	
Hearing Date:	October 31, 2013
County:	Wayne (18)

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 October 31, 2013, from Taylor, Michigan. Participants included the above-named Claimant. f testified and appeared as Claimant's authorized hearing representative. Participants on behalf of the Department of Human Services (DHS) included Medical Contact Worker.

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 /13, Claimant applied for MA benefits, including retroactive MA benefits from /2013.

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

3. On /13, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 1-2).

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 application of Medical-Vocational Rule 203.28.

7. As of the date of the administrative hearing, Claimant was a [redacted]-year-old female with a height of 5'7" and weight of 155 pounds.

8. Claimant has no known relevant history of alcohol, tobacco or illegal substance abuse.

9. Claimant's highest education year completed was the 12th grade.

10. As of the date of the administrative hearing, Claimant was an Adult Medical Program recipient since approximately [redacted]/2013.

11. Claimant alleged disability based on impairments and issues including back pain, anxiety, racing thoughts, epilepsy and panic attacks.

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 Claimant's AHR noted special arrangements in order to participate in the hearing; specifically, an in-person hearing was requested. Claimant's AHR's request was granted and the hearing was conducted accordingly.

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.

Hospital documents (Exhibits 96-104; 149-174) dated /12 and /12 were presented. It was noted that Claimant presented with pelvic pain. It was noted that Claimant was evaluated for ectopic pregnancy. Various follow-up documents (Exhibits 175-181) from the following months were presented. The documents failed to note any information related to impairments to employment.

A Psychiatric Evaluation (Exhibits 15-16) dated /12 from a psychiatrist was presented. It was noted that Claimant presented with complaints of depression, difficulty sleeping, loss of appetite. It was noted that Claimant cannot keep a job. A diagnosis of major depressive disorder (single episode; moderate) was noted. Claimant's GAF was noted as 50. It was noted that Claimant took Prozac, Desyrel and Topamax.

A Vaginitis/Vaginosis Panel (Exhibit 105) dated /12 was presented. It was noted that 11 tests were ran for abnormalities. It was noted that no abnormalities were detected.

Hospital documents (Exhibits 37; 119-121; 291-304) dated /13 were presented. It was noted that Claimant presented with complaints of pelvic pain. An impression of an unremarkable uterus was noted following radiography of the uterus. A discharge diagnosis of vaginal bleeding was noted.

Hospital documents (Exhibits 36; 117-118; 305-311) dated /13 were presented. It was noted that Claimant presented with complaints of swollen glands. A discharge diagnosis of urinary tract infection was noted.

Hospital documents (Exhibits 115-116; 141-148) dated /13 were presented. It was noted that Claimant presented with complaints of nausea and vomiting. A diagnosis of urinary tract infection was noted.

Hospital documents (Exhibits 35; 95) dated 13 were presented. It was noted that Claimant presented with complaints of a seizure. A CT was taken of Claimant's head and an impression of a normal examination was noted. A discharge diagnosis of syncope (unspecified) was noted.

Hospital documents (Exhibits 34; 223-230) dated /13 were presented. It was noted that Claimant presented with complaints of difficulty sleeping and a rapid heartbeat. A discharge diagnosis of anxiety was noted.

A Psychiatric Evaluation (Exhibits 13-14) dated /13 from a nurse practitioner was presented. It was noted that Claimant presented with complaints of anxiety, decreased

appetite, low energy, insomnia, panic attacks, intrusive thoughts and sadness. A diagnosis of mood disorder due to anxiety disorder was noted. Claimant's GAF was 50.

A Vaginitis/Vaginosis Panel (Exhibit 122) dated /13 was presented. It was noted that 11 tests were ran for abnormalities. It was noted that no abnormalities were detected.

A Medical Progress Noted dated /13 from Claimant's treating psychiatrist was presented. It was noted that Claimant reported ongoing anxiety, insomnia and decreased appetite. It was noted that Claimant sought Xanax for increased anxiety. It was noted that Claimant had good grooming, timeliness, orientation x4, normal speech, and no psychosis. A nervous mood was noted.

Hospital documents (Exhibits 33; 110; 112; 182-190) dated /13 were presented. It was noted that Claimant presented with complaints of exposure to asbestos and/or black mold. An impression of no acute pulmonary process was noted following radiography of Claimant's chest. A discharge diagnosis of feared pneumonia was noted.

Hospital documents (Exhibits 32; 111; 113; 123-140; 191-204) dated /13 were presented. It was noted that Claimant presented with complaints of pelvic pain. It was noted that all radiography of Claimant's abdomen and pelvis revealed no evidence of acute process. A discharge diagnosis of an ovarian cyst was noted.

Hospital documents (Exhibits 30; 205-212) dated /13 were presented. It was noted that Claimant presented with complaints of syncope. A discharge diagnosis of syncope was noted.

Hospital documents (Exhibits 31; 114; 213-222) dated /13 were presented. It was noted that Claimant presented with complaints of right-sided abdominal pains. A generic discharge diagnosis of abdominal pain was noted. It was noted that radiography was taken of Claimant's pelvis and an impression of suboptimal evaluation of the right adnexa was noted.

Hospital documents (Exhibits 29; 231-237) dated /13 were presented. It was noted that Claimant presented with complaints of right-sided leg pain. A discharge diagnosis of right lumbar radiculopathy was noted.

A Progress Note (Exhibit 12) dated /13 from a nurse practitioner was presented. It was noted that Claimant complained of anxiety, racing thoughts, decreased appetite, low energy, insomnia, panic attacks, sadness and paranoia. A mental status exam noted no abnormalities other than poor insight. Noted diagnoses included mood disorder, panic disorder and major depressive disorder. Claimant's GAF was 50.

Hospital documents (Exhibits 28; 238-244) dated /13 were presented. It was noted that Claimant presented with complaints of throat pain and right-sided pain. A discharge diagnosis of pharyngitis was noted.

Hospital documents (Exhibits 40; 245-254) from an admission dated ███/13 were presented. It was noted that Claimant presented with complaints of a possible seizure and generalized weakness. It was noted that Claimant reported a miscarriage and other life changes creating depression and anxiety. A discharge diagnosis of generalized weakness was noted.

A Medical Progress Noted dated ███/13 from Claimant's treating nurse practioner was presented. It was noted that Claimant reported ongoing anxiety and depression symptoms. It was noted that Claimant had good grooming, timeliness, orientation x4, normal speech, no obsessive or compulsive thoughts, intact judgment. It was noted that Claimant had poor insight and somatic delusion. It was noted that Risperdal was discontinued as a medication. It was noted that Claimant received prescriptions for Xanax and Celexa.

A Medical Examination Report (Exhibits 6-7; 273-275) dated ███/13 was presented. The form was completed by a treating neurologist with an approximate four- week history with Claimant. Noted diagnoses included seizures, depression and severe anxiety. It was noted that Claimant had lumbar radiculopathy. It was noted that Claimant's condition was deteriorating. It was noted that Claimant could occasionally lift 10 pounds but never 20 pounds. It was noted that Claimant could stand and/or walk at least two hours in an 8-hour workday and that she was restricted to less than 6 hours of sitting. It was noted that Claimant could not meet her household needs because she is unable to stay home alone.

Claimant presented other psychological/psychiatric treatment documents (Exhibits 41-94; 259-263; 276-282) dated from 11/2012 through 4/2013. Generally, the documents verified ongoing treatment for Claimant including consistent reporting of ongoing anxiety and other psychological symptoms by Claimant. There were notices of missed appointments on 1██/13, ███/13, ███/13 and ██/13 by Claimant.

Claimant alleged disability, in part, based on exertional restrictions. Claimant's treating physician noted that Claimant cannot lift 20 pounds, a relatively significant restriction. Claimant's physician also limited Claimant to two hours of standing.

Treating source opinions cannot be discounted unless the Administrative Law Judge provides good reasons for discounting the opinion. *Rogers v. Commissioner,* 486 F. 3d 234 (6th Cir. 2007)*; Bowen v Commissioner.* The present case justifies some skepticism in recognizing the treating physician's restrictions.

There was some evidence that Claimant has seizures, but not much. There was no apparent evidence that Claimant takes seizure medication. There was no confirmed explanation for any seizures as radiology was negative. Seizures were not noted to be particularly worrisome in any of Claimant's multiple hospitalizations, other than one. There is simply little evidence of the degree or quantity of Claimant's seizures. For purpose of this decision, it will be presumed that Claimant has some seizures to justify lifting and standing restrictions.

Claimant also alleged back pain restrictions. There was no radiology presented to support any back problems.

Claimant presented documentation of 13 emergency room visits over a two month period. Through all of Claimant's exertional complaints, none were established to be a significant impairment expected to last 12 months or longer. The sheer amount of visits may be evidence of psychological impairments. Evidence tended to establish that Claimant had anxiety problems and the anxiety increased following a miscarriage. The absence of emergency room visits following 4/2013 is consistent with Claimant's anxiety being at its worst through ██/2012 to █/2013.

Claimant established suffering numerous psychological symptoms. Presented records only verified that Claimant only received treatment for six months, at most. The records also showed some problems for Claimant in attending appointments; nevertheless, psychological symptoms likely to last for 12 months or longer were established.

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 anxiety. Anxiety 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, the medical records sufficiently verified that Claimant regularly suffers panic attacks at least once per day. It is found that Claimant meets the requirements for Part A of the above listing.

Turning to Part B, there was evidence of difficulties with concentration but insufficient evidence of marked social restrictions or problems with performing daily activities. There was no evidence of psychological hospitalizations.

There was evidence suggesting that Claimant could meet Part C of the anxiety disorder listing. Claimant's treating physician noted that Claimant cannot be home alone; the statement implies an inability to function independently outside of the home. The statement would have been more persuasive if from Claimant's treating psychiatrist rather than a treating neurologist. In either case, there was little other evidence to sufficiently establish that Claimant is unable to function outside of her home.

Listings for epilepsy (Listings 11.02 and 11.03) were also considered. The listings were rejected due to a failure to establish any pattern of seizures, either in severity or quantity.

It is found that Claimant failed to establish meeting a SSA listing. Accordingly, the analysis moves to step four.

The fourth step in analyzing a disability claim requires an assessment of the Claimant's residual functional capacity (RFC) and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if it is determined that a claimant can perform past relevant work. *Id.*

Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

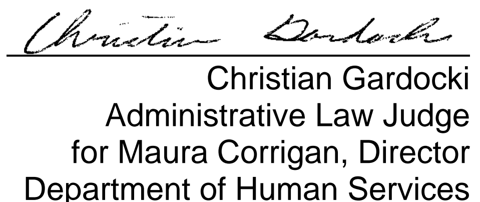
Claimant testified that she had past relevant employment as a waitress. Claimant's alleged seizures would make such employment inadvisable. Claimant's testimony was consistent with the presented evidence.

Claimant had past employment performing work at an optical office. Claimant testified that she performed work on the computers, phones and some lifting. Claimant testified that she cannot sit still long enough to perform her past employment. Assuming this employment required Claimant to sit six or more hours in an eight-hour shift, there was some evidence that Claimant could not perform the required sitting. Claimant's treating neurologist restricted Claimant to less than six hours of sitting but there is no known reason for the restriction. Based on presented documents, the only plausible basis for a sitting restriction would be lower back pain. An emergency room visit for lower back pain (with 12 other visits) is not compelling evidence to verify such a restriction. A generic diagnosis of radiculopathy also does not justify such a sitting restriction.

Based on the presented evidence, it is found that Claimant can perform past relevant employment. Accordingly, the DHS denial of MA benefits was proper.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that DHS properly denied Claimant's MA benefit application dated 2/14/13, including retroactive MA benefits from █/2013, based on a determination that Claimant is not disabled. The actions taken by DHS are **AFFIRMED**.



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

Date Signed: 11/27/2013

Date Mailed: 11/27/2013

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: