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

**IN THE MATTER OF:**

[redacted]

Reg. No.: 201320883
Issue No.: 2009
Case No.: [redacted]
Hearing Date: May 8, 2013
County: Oakland DHS (04)

**ADMINISTRATIVE LAW JUDGE:** Christian Gardocki

## HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 following Claimant's request for a hearing. After due notice, an in-person hearing was conducted on May 8, 2013, from Pontiac, Michigan. Participants included the above-named claimant. [redacted] testified and appeared as Claimant's authorized hearing representative (AHR). Deidre Gabriel 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 7/26/12, Claimant applied for MA benefits, including retroactive MA benefits from 4/2012.

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

3. On 10/30/12, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 1-2).

4. On 11/2/12, DHS denied Claimant's application for MA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On 12/28/12, Claimant requested a hearing disputing the denial of MA benefits.

6. On 3/19/13, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual, in part, by application of Medical-Vocational Rule 204.00

7. As of the date of the administrative hearing, Claimant was a [redacted] year old male with a height of 5'8" and weight of 181 pounds.

8. Claimant has no known relevant history of tobacco, alcohol 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 had no health coverage.

11. Claimant alleged that he is disabled based on impairments and issues including: post-traumatic stress disorder (PTSD), seizures, a closed head injury, heart murmur, cognitive dysfunction and various psychological problems.

## CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). DHS (formerly known as the Family Independence Agency) administers the MA program pursuant to MCL 400.10, et seq., and MCL 400.105. Department policies are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

MA provides medical assistance to individuals and families who meet financial and nonfinancial eligibility factors. The goal of the MA program is to ensure that essential health care services are made available to those who otherwise would not have financial resources to purchase them.

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 at 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 (see BEM 260 at 1-2):

- 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).

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 at 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 2011 monthly income limit considered SGA for non-blind individuals is $1,000. The 2012 income limit is $1010/month.

In the present case, Claimant denied having 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 presented medical records.

Hospital documents (Exhibits 206-213) from an encounter dated [redacted] were presented. It was noted that Claimant presented after having three seizures on the prior day. A postictal symptom of general weakness was noted. It was noted that Claimant likely suffered pseudo-seizures.

Hospital documents (Exhibits 214-224) from an encounter dated [redacted] were presented. It was noted that Claimant had seizures while waiting in the emergency room for a ride from a previous discharge. It was noted that Claimant was observed to be shaking while removing his clothes. It was noted that Claimant likely suffered pseudo-seizures.

A Psycho-Social Assessment (Exhibits dated [redacted] from Claimant's treating psychological agency was presented. It was noted that Claimant was referred by his adult foster care (AFC) home for treatment. It was noted that Claimant reported: mood swings, depression, hopelessness, racing thoughts, a lack of sleep, and excessive feelings of happiness and sadness. A history of sexual abuse was noted. An Axis I diagnosis of bipolar disorder was noted. Claimant's GAF was noted as 45. Treatment documents (Exhibits 674-693) covering the next six months were presented and noted GAF levels from 45 to 50.

Hospital documents (Exhibits 225-235) from an encounter dated [redacted] were presented. It was noted that Claimant reported a seizure in his bed after feeling light-headed. It was noted that Claimant had a mild headache which was typical for his postictal state. A diagnosis of seizure disorder was noted.

Hospital documents (Exhibits 236-239) from an encounter dated [redacted] were presented. It was noted that Claimant reported a seizure at church and postictal headache.

Hospital documents (Exhibits 240-251) from an encounter dated [redacted] were presented. It was noted that Claimant was found on his bathroom floor after having a seizure. It was noted that Claimant may have a closed head injury, stemming from an accident on 2/20/12 when Claimant was a pedestrian and was hit by a car. It was noted that AFC staff reported that Claimant had numerous seizures since the accident, including two on the day of presenting to the hospital. A discharge diagnosis of non-epileptic seizures was noted.

Hospital documents (Exhibits 252-258) from an encounter dated [redacted] were presented. It was noted that Claimant presented with chest pain and seizures.

Hospital documents (Exhibits 70-79; 120-129) from an admission dated [redacted] were presented. It was noted that Claimant presented with complaints of seizures. It was noted that radiology of Claimant's head showed no intracranial process.

Hospital documents (Exhibits 80-88; 130-138) from an admission dated [redacted] were presented. It was noted that Claimant presented with complaints of seizures and vomiting. It was noted that Claimant was discharged after the vomiting was resolved.

Hospital documents (Exhibits 89-95; 139-145) from an encounter dated [redacted] were presented. It was noted that Claimant presented following two seizures at home.

Hospital documents (Exhibits 166-174) from an encounter dated [redacted] were presented. It was noted that Claimant returned after a very recent discharge when he had a small seizure in his jaw.

Hospital documents (Exhibits 153-158) from an encounter dated [redacted] were presented. It was noted that Claimant presented with complaints of seizures. Discharge diagnoses of seizures (unspecified) and sub-therapeutic dilantin levels were noted.

Hospital documents (Exhibits 159-165) from an encounter dated [redacted] were presented. It was noted that Claimant presented with complaints of seizures. A discharge diagnosis of seizures (unspecified) was noted.

Hospital documents (Exhibits 175-187) from an encounter dated [redacted] were presented. It was noted that Claimant presented following a syncopal episode after consuming 10 energy drinks. Discharge diagnoses included dizziness related to drinking 10 energy drinks.

Hospital documents (Exhibits 19-31; 188-195) from an admission dated [redacted] were presented. It was noted that Claimant presented after a seizure episode which was accompanied by left-side pain. It was noted that Claimant was found lying on the side of a road. It was noted that a CT of the head showed no intracranial process and all testing was negative. It was noted that Claimant was discharged on [redacted] and received medications for seizure disorder, and sleep apnea. It was noted that Claimant's ejection fraction was 55-60%. Discharge diagnoses included: syncope, chest pain, seizure disorder and sleep apnea.

Hospital documents (Exhibits 32-61; 66-69; 97-110) from an admission dated [redacted] were presented. It was noted that Claimant presented with a request for seizure monitoring. It was noted that Claimant reported having 20 seizures per month. It was noted that his last seizure occurred two days prior when he got lightheaded and blacked out. It was noted that 5 CT scans from 2011 ad 2012 were negative. It was noted that an MRI from 10/2011 was also negative. It was noted that EEG-Video testing was performed and showed 7 events over a three hour period. An impression was noted that Claimant probably has complex partial seizures, mostly preceded by auras in the form of light-headedness, drowsiness and headaches. A psychological evaluation noted that

Claimant's insight and judgment were fair-poor. An Axis I diagnosis of schizoaffective disorder was noted. Claimant's GAF was noted as 55-60. It was noted that Claimant was discharged on 8/24/12. Discharge diagnoses included: bipolar disorder, pseudo-seizures, asthma, bronchitis, and PTSD.

Hospital documents (Exhibits 62-65; 96; 112-118; 146-152) from an encounter dated 8/25/12 were presented. It was noted that Claimant presented after convulsing on the floor, though Claimant remained alert and oriented. It was also noted that Claimant complained of right arm pain. It was noted that Claimant was discharged after x-rays of the arm were negative. It was noted that Claimant was in foster care but was refused by his most recent home so a new placement was found for Claimant.

Additional hospital documents (259-1179) were presented. The documents verified that Claimant went to the hospital for seizure treatment on the following dates: [redacted] (noted that Claimant hit his head twice during seizure), [redacted] (for non-seizure injury), [redacted] Additional hospital encounters may have occurred but were not noted due to their repetitive nature.

The presented medical documentation verified extensive treatments for seizures, many of which were witnessed by hospital and/or AFC staff. The records established that Claimant suffers seizures on a near-daily basis, often multiple times per day.

The records also established that the seizures were caused by psychological rather than physical obstacles. All medical testing, which included multiple radiography testing, tended to verify no physical abnormalities. It was verified that Claimant had a history of a bipolar disorder diagnosis. Also, many hospital records noted that Claimant suffered pseudo-seizures, a psychologically based seizure. The chronic and high frequency nature of Claimant's seizure was verifiable proof that Claimant has basic work restrictions.

The records established that Claimant has suffered seizures for most of his life, but significantly more so since 2/2012, the month when Claimant was hit by a car. The nature of Claimant's diagnosis is such that it has and will likely continue for a 12 month period or longer.

Based on the presented evidence, it is found that Claimant established a severe restriction from no later than 4/2012. 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 primary impairment appears to be a regular pattern of seizures. Presented medical documents tend to show that Claimant's seizures are psychological based (i.e. pseudo-seizures) rather than neurologically based. The presented records also verified a diagnosis for bipolar disorder. A listing for bipolar disorder is covered by Listing 12.04 and reads:

> **12.04** ***Affective disorders***: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation. 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 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 distractibility; 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 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. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or

2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or

3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

Starting with Part A, psychological treatment records verified that Claimant has regular symptoms of suicidal ideation, sleep disturbance, feelings of worthlessness and psychomotor agitation. It is found that Claimant meets Part A of the listing for affective disorders.

Looking at Part C, it was established that Claimant has been an AFC resident from a time prior to 4/2012, the first month where MA benefits were sought. The evidence shows that the placement in the AFC is medically necessary due to Claimant's chronic seizures and suicidal ideation. At least one attempted suicide by Claimant was documented (when Claimant held a knife to his throat) and Claimant testified about two other incidents. The medical evidence verified that Claimant has the inability to function outside of a highly supportive living arrangement. It is found that Claimant also meets Part C of the listing for affective disorders.

Based on the presented evidence, Claimant meets the listing for affective disorders and is a disabled individual. Accordingly, it is found that DHS erred in denying Claimant's MA benefit application.

## 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 7/26/12, including retroactive MA from 4/2012;
(2) evaluate Claimant's eligibility for MA benefits on the basis 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: 5/28/2013

Date Mailed: 5/28/2013

**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

CG/hw

cc: [redacted]