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

IN THE MATTER OF:

[redacted]

Reg. No.: 2013 65615
Issue Nos.: 2009, 4009
Case No.: [redacted]
Hearing Date: October 30, 2013
DHS County: Wayne County (15)

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

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; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on October 30, 2013, from Detroit, Michigan. Participants on behalf of Claimant included the Claimant. [redacted] also appeared as a witness. The Claimant's AHR [redacted] appeared on the Claimant's behalf. Participants on behalf of the Department of Human Services (Department) included [redacted] Medical Contact Worker.

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of the Medical Assistance (MA-P) benefit program and State disability Assistance (SDA) benefit program?

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 May 14, 2013, the Claimant submitted an application for public assistance seeking MA-P and SDA.

2. On August 9, 2013, the Medical Review Team ("MRT") found the Claimant not disabled. (Exhibit 1)

3. The Department notified the Claimant of the MRT determination on August 9, 2013.

4. On August 14, 2013, the Department received the Claimant's written request for hearing.

5. On October 1, 2013, the State Hearing Review Team ("SHRT") found the Claimant not disabled. (Exhibit 2)

6. An Interim Order was issued October 31, 2013. The new evidence was submitted to the State Hearing Review Team on February 21, 2014.

7. On May 2, 2014, the State Hearing Review Team found the Claimant not disabled.

8. The Claimant alleges physical disabling impairments due to anemia, ulcerative colitis and associated pain, diarrhea, fatigue, pulmonary embolism, left leg deep vein thrombosis, with Coumadin treatment, shortness of breath and weakness secondary to HIV.

9. The Claimant has alleged mental disabling impairments including depression and schizoaffective disorder including auditory hallucinations.

10. At the time of hearing, the Claimant was 21 years old with a [redacted] birth date. The Claimant is now 22 years of age. Claimant is 6'2" in height; and weighed 140 pounds and has gained some weight due to seeing a nutritionist.

11. The Claimant has no past substantial gainful employment.

12. The Claimant's impairments have lasted or are expected to last for 12 months duration or more.

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.

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program purusant to MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 –

400.3180. Department policies are found in BAM, BEM, and RFT. A person is considered disabled for SDA purposes if the person has a physical or mental impairment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a). The person claiming a physical or mental disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-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). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and, (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (e.g., age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a) (4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If

a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4). If impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3 to Step 4. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

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

The severity of the Claimant's alleged impairment(s) is considered under Step 2. The Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b). An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b). Examples include:

1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

> 5. Responding appropriately to supervision, co-workers and usual work situations; and dealing with changes in a routine work setting.
>
> *Id.*

The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). An impairment qualifies as non-severe only if, regardless of a Claimant's age, education, or work experience, the impairment would not affect the Claimant's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985).

The Claimant alleges physical disabling impairments due to anemia, ulcerative colitis and associated pain, diarrhea, fatigue, pulmonary embolism, left leg deep vein thrombosis, with Coumadin treatment, shortness of breath and weakness secondary to HIV.

The Claimant has alleged mental disabling impairments including depression and schizoaffective disorder with auditory hallucinations.

A summary of the Claimant's Medical evidence follows.

On October 9, 2013, the Claimant was seen for a psychiatric evaluation in the hospital clinic. The Claimant was referred by a crisis clinic. The Claimant presented with suicidal thoughts. At the time of the examination, the Claimant describes strong paranoia and hearing voices telling him to kill himself. By way of further history, the patient indicated taking an overdose in June 2011 due to voices telling him to take pills. The Claimant's mental status was depressed and worried with auditory hallucinations and paranoia. The diagnosis was psychosis, not otherwise specified, depression. The GAF score was 60. At the end of the examination it was determine that the patient felt safe being treated as an outpatient and [redacted] was discontinued. Sleeping medication Ativan was also prescribed. The Claimant was also taking Risperdal because of hearing voices. This medication was discontinued due to tachycardia of 115.

A Mental Residual Functional Capacity Assessment was completed on December 30, 2013 based upon an examination in July 2013. This assessment was completed by the Claimant's treating psychiatrist the following marked limitations were noted; Sustained Concentration and Persistence: Claimant was markedly limited in his ability to perform

activities within a schedule, maintain regular attendance and be punctual within customary tolerances, ability to carry out detailed instructions and maintain attention and concentration for extended periods and ability to work in coordination with or proximity to others without being distracted by them, ability to complete a normal workday and worksheet without interruptions from psychologically based symptoms and to perform at a consistent pace without unreasonable number and length of rest periods. Understanding and Memory: the Claimant was moderately limited in his ability to remember locations and work like procedures, understand and remember one or two step instructions and remember detailed instructions. Social Interaction: the Claimant was markedly limited in his ability to interact appropriately with the general public, the ability to accept instructions and respond appropriately to criticism from supervisors, the ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes; the Claimant was moderately limited in the ability to ask simple questions or request assistance and maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness. Adaptation: the Claimant was markedly limited in his ability to respond appropriately to change in the work setting and his ability to set realistic goals or make plans independently of others. The Claimant was moderately limited in this category with regard to his ability to travel in unfamiliar places or use public transportation and to be aware of normal hazards and take appropriate precautions.

The examiner concluded with a diagnosis of schizoaffective disorder due to experiencing auditory hallucinations and paranoia. The Claimant presented with a blunt affect as well as anxiety and sadness.

A psychiatric psychological examination report was also provided by the Claimant's psychiatrist. The date of service was September 17, 2013. The presenting problem was that the Claimant continued to hear voices which tell him to hurt himself and that people want to harm him. At the time Claimant denied suicidal feelings or violence. At the time of the evaluation, the Claimant's sleep habits were good. In May of 2011, evaluation notes that the Claimant was hospitalized for three days due to suicidal thoughts. The report notes that Claimant has a history of drinking alcohol, smoking marijuana and taking right contents. The results of a mental status examination were that the Claimant was cooperative is thought process was spontaneous and normal his emotional affect was blunted anxious and sad with auditory hallucinations. The Claimant's mental thought content was noted to be preoccupied with paranoid ideation. The Claimant's insight and judgment was good the diagnosis was schizoaffective disorder depressive type, cannabis dependence, early full remission. The GAF score was 39 the Claimant was recommended for atypical antipsychotics drug thereapy, psychotherapy and medical follow-up.

A Medical Examination Report was completed by the Claimant's Doctor of Internal Medicine who has treated him for over a year. The current diagnosis was HIV, ulcerative colitis, deep vein thrombosis, low back pain, iron deficiency anemia, pulmonary embolism and depression. The examiner relied upon laboratory tests, Doppler studies, colonoscopy and imaging in evaluating the patient. At the time, the Claimant was evaluated as stable. The following limitations were imposed the Claimant could lift less than 10 pounds occasionally; stand and/or walk less than two hours in the 8 hour workday, could perform simple grasping with both hands, but could not push or pull with either hands or arms or operate foot controls with either foot. The medical findings that supported the limitations were noted as low back pain and the physical examination conducted. The limitations were expected to last more than 90 days.

A medical report regarding HIV infection was also provided. The report was dated January 31, 2013. The report was completed by the Claimant's infectious disease doctor and noted hematologic abnormalities which included anemia, diarrhea and left leg blood clot. The anemia and diarrhea were noted as continuous and also noted the patient had marked difficulties in maintaining social functioning or difficulties in completing tasks in a timely manner due to deficiency in concentration, persistence or pace. At the time of the visit, the remarks note that the patient has been anemic for several visits with the hemoglobin of 7.9 on the last lab draw; patient has received several blood transfusions since being in my care. Patient has ulcerative colitis and diagnosed and hospitalized for lower leg blood clots which require blood thinners which complicate as a risk factor the ulcerative colitis bleeding risk. Test results from an infectious disease center were also attached to the evaluation. At the time of the evaluation, the Claimant's T cells CD3, and CD 8 were high.

An updated Medical Examination Report dated January 31, 2013 was provided by the Claimant's Infectious Disease physician. This treating doctor has seen the Claimant cents January 2011. At that time, the Claimant was noted to have a current diagnosis of HIV, ulcerative colitis, possible hemorrhoids and severe anemia. The Claimant's general presentation noted pallor and emaciation. At the time, the Claimant weighed 135 pounds and was 6'2". The Claimant had left lower quadrant tenderness in his abdomen and was noted as deteriorating. Limitations were imposed limiting the Claimant to lifting/carrying less than 10 pounds, the Claimant could not reach or push pull with either hand or operate foot controls with either foot. The findings to support the limitations noted patient has weakness/fatigue due to anemia secondary to blood loss. It was also noted that the Claimant's mother was his caregiver and assisted him with the activities of daily living.

An updated Medical Examination Report was completed by the Claimant's Infectious Disease Doctor on October 31, 2013. The diagnosis was essentially the same the Claimant's weight was 147 pounds. The report noted that the examination areas were

all within normal limits except that under the mental examination area decreased recall of previous conversations during visit regarding health concerns was noted. The Claimant was evaluated as stable. The Claimant was evaluated as capable of occasionally lifting/carrying 10 pounds and could stand or walk at least two hours in an eight hour workday the Claimant could use his hands and arms in all areas evaluated, as well as his legs and feet for foot controls. A further note regarding mental limitations with regard to comprehension and sustained concentration with history of depression was noted. As regards ability to meet his needs in the home, his Dr. noted assistance was needed with cooking and cleaning.

The Claimant was seen in October 2013 and treated for pulmonary embolism's and was admitted for observation for a two-day stay. At the time of the admission, it was noted that the Claimant had reported two days with dypsnea. During this admission, the Claimant had a full medical review with normal ejection fraction 50 to 55%, a chest x-ray, a CT of the thorax for pulmonary embolism. The discharge diagnosis was exertional shortness of breath likely secondary to HIV, anemia, ejection fraction is 50 to 55% and mild dehydration. The Claimant was discharged home in stable condition and recommended to follow up with the hospital anticoagulation clinic as well as his infectious disease physician. At the time of this admission, it was noted that while wearing a pulse oximetry device the Claimant's pulse increased significantly over 200 bpm requiring further evaluation for his exertional shortness of breath and was admitted for observation.

The Claimant was seen in the emergency room on June 22, 2013 due to suicidal ideation. At the time he presented the Claimant was hearing voices and had suicidal ideation. Last CD4 count was noted as normal. The Claimant was admitted for a two-day stay and was discharged to outpatient referral for ongoing therapy and possible pharmacological initiation. The final impressions/diagnosis was acute suicidal ideation, chronic HIV and chronic ulcerative colitis. The blood tests performed were negative for drug use or alcohol.

The Claimant was seen in the emergency room on August 9, 2013 due to deep vein thrombosis and Coumadin levels. The Claimant's [redacted] medication levels were increased and he was released to his primary care physician.

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the Claimant has presented objective medical evidence establishing that he does have some physical limitations on his ability to perform basic work activities. Accordingly, the Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the

impairments have lasted continuously for twelve months; therefore, the Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404.

The Claimant alleges physical disabling impairments due to anemia, ulcerative colitis and associated pain, diarrhea, fatigue, pulmonary embolism, left leg deep vein thrombosis, with Coumadin treatment, shortness of breath and weakness secondary to HIV.

The Claimant has alleged mental disabling impairments including depression and schizoaffective disorder with auditory hallucinations.
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Listing 14.08 HIV Infection was examined in light of the evidence presented and it is determined that the severity requirements, resistance to treatment and limitations on activities of daily living were not demonstrated by the Medical Evidence available and presented. Ultimately, it is found that the Claimant suffers from some medical conditions; however, the Claimant's impairments do not meet the intent and severity requirement of that listing.

Listing 12.04 was also examined in light of the Claimant's diagnosis for schizoaffective disorder and depression. The listing provides:

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 …

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;

The Claimant's medical evidence provided by psychiatric evaluations from the Claimant's treating psychiatrist summarized above was reviewed to determine whether listing 12.04, affective disorders has been demonstrated. Particular weight was given to both the Mental Residual Functional Capacity Assessment performed December 30, 2013 and a prior examination on September 17, 2013. Without question, the Mental Residual Functional Capacity Assessment establishes that the Claimant has severe marked limitations in abilities necessary to sustain gainful employment. With respect to Listing 12.04, A, depressive syndrome, which requires meeting for at least four categories which in Claimant's case include appetite disturbance with loss of weight, difficulty concentrating or thinking, decreased energy, thoughts of suicide and hallucinations and paranoid thinking.

Listing 12.04 also requires that functional capacities for daily living and social functioning, concentration persistence and pace or decompensation be evaluated and that at least two categories must be demonstrated. In the Claimant's case the Mental Residual Functional Capacity Assessment demonstrates marked limitations in sustained concentration persistence and pace, understanding and memory, social interaction, and adaptation the specifics of which are fully outlined above.

The Claimant also credibly testified to a continuation of auditory hallucinations, three suicide attempts since 2011, difficulties focusing, limited social interaction and limited to his family only, and difficulty getting along with people in general feeling very frustrated and overwhelmed and paranoid.

Based on the evaluation of Claimant's treating psychiatrist it is determined that deference must be given to this evaluation as the Claimant has seen this doctor for some time. Consideration was also given to the Claimant's several inpatient admissions for suicidal ideation. The evaluations and medical opinions of a "treating "physician is "controlling" if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record. 20 CFR§ 404.1527(d)(2), Deference was given by the undersigned to objective medical testing and clinical observations of the Claimant's treating physician

Therefore, it is determined based upon the objective medical evidence and a review of the entire record that the Claimant is found disabled, at Step 3 with no further analysis required.

Although not required by this decision, as the Claimant has found been found disabled at Step 3 of this Decision, it is noteworthy that the Claimant's family practice doctor as well as his infectious disease doctor have limited and restricted the Claimant due to his physical impairments and illnesses to a less than sedentary capacity.

As the Claimant has been found disabled for medical assistance based on disability he is also deemed disabled for the State Disability Assistance program.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Claimant not disabled for purposes of the MA-P benefit program.

Accordingly, it is ORDERED:

The Department's determination is REVERSED

☒ THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE OF MAILING OF THIS DECISION AND ORDER:

1. The Department is ORDERED to initiate a review of the application dated May 14, 2013 for MA-P and SDA, if not done previously, to determine Claimant's non-medical eligibility.

2. The Department shall issue a supplement to the Claimant for SDA benefits if Claimant applied for SDA and was otherwise entitled to receive in accordance with Department Policy.

3. A review of this case shall be set for May 2015.

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

Date Signed: May 30, 2014

Date Mailed: May 30, 2014

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

LMF/tm

cc: [redacted]