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

IN THE MATTER OF:

Reg. No.:	2014 12779
Issue No.:	2009, 4009
Case No.:	
Hearing Date:	March 12, 2014
County:	Wayne County DHS (43)

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 March 12, 2014 from Detroit, Michigan. Participants on behalf of Claimant included the Claimant. Participants on behalf of the Department of Human Services (Department) included , FIM.

ISSUE

Whether the Department properly determined that Claimant is not "disabled" for purposes of the Medical Assistance (MA-P) program and the State Disability Assistance Program?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. On September 24, 2013, Claimant applied for MA-P and SDA.

2. On November 1, 2013, the Medical Review Team denied Claimant's request.

3. The Department sent the Claimant's AHR the Notice of Case Action dated November 5, 2013 denying the Claimant's MA-P application. Exhibit 1

4. On November 12, 2013, the Claimant submitted to the Department a timely hearing request.

5. On January 15, 2014, the State Hearing Review Team ("SHRT") found the Claimant not disabled and denied Claimant's request.

6. An Interim Order was entered on April 8, 2014 and new evidence was provided to the State Hearing Review Team (SHRT) on April 8, 2014. The SHRT denied disability on May 19, 2014.

7. Claimant at the time of the hearing was 46 years old with a birth date of [redacted] Claimant's height was 5'4" and weighed 214 pounds with a BMI of 39.5.

8. Claimant completed high school and some college taking classes in liberal arts, and criminal justice.

9. Claimant has employment experience as an expediter, entering computer information in computers. The Clamant last worked in 2009 and was a treatment specialist, counselor for children.

10. Claimant alleges physical disabling impairments due to fibromyalgia, ankle pain from ankle injury and surgery, arthritis in spine, and hypertension.

11. Claimant has alleged mental disabling impairments which include major depressive disorder, recurrent, severe with psychosis.

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

CONCLUSIONS OF LAW

MA-P is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department administers MA-P 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 Bridges Reference Manual (RFT).

Pursuant to Federal Rule 42 CFR 435.540, the Department uses the Federal Supplemental Security Income (SSI) policy in determining eligibility for disability under MA-P. Under SSI, 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 set order is used to determine disability. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience are reviewed. If there is a finding that an individual is disabled or not disabled at any point in the review, there will be no further evaluation. 20 CFR 416.920.

Medical evidence may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of the impairment(s), including symptoms, diagnosis and prognosis, what an individual can do despite impairment(s), and the physical or mental restrictions. 20 CFR 416.927(a)(2).

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability. 20 CFR 416.927(e).

For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph (B) of the listings for mental disorders (descriptions of restrictions of activities of daily living, social functioning; concentration, persistence or pace; and ability to tolerate increased mental demands associated with competitive work). 20 CFR, Part 404, Subpart P, Appendix 1, 12.00(C).

The residual functional capacity is what an individual can do despite limitations. All impairments will be considered in addition to ability to meet certain demands of jobs in the national economy. Physical demands, mental demands, sensory requirements and other functions will be evaluated. 20 CFR 416.945(a).

To determine the physical demands (exertional requirements) of work in the national economy, we classify jobs as sedentary, light, medium and heavy. These terms have the same meaning as they have in the Dictionary of Occupational Titles, published by the Department of Labor. 20 CFR 416.967.

Pursuant to 20 CFR 416.920, a five-step sequential evaluation process is used to determine disability. An individual's current work activity, the severity of the impairment, the residual functional capacity, past work, age, education and work experience are evaluated. If an individual is found disabled or not disabled at any point, no further review is made.

The first step is to determine if an individual is working and if that work is "substantial gainful activity" (SGA). If the work is SGA, an individual is not considered disabled regardless of medical condition, age or other vocational factors. 20 CFR 416.920(b).

Secondly, the individual must have a medically determinable impairment that is "severe" or a combination of impairments that is "severe." 20 CFR 404.1520(c). An impairment or combination of impairments is "severe" within the meaning of regulations if it

significantly limits an individual's ability to perform basic work activities. An impairment or combination of impairments is "not severe" when medical and other evidence establish only a slight abnormality or a combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work. 20 CFR 404.1521; Social Security Rulings (SSRs) 85-28, 96-3p, and 96-4p. If the Claimant does not have a severe medically determinable impairment or combination of impairments, he/she is not disabled. If the Claimant has a severe impairment or combination of impairments, the analysis proceeds to the third step.

The third step in the process is to assess whether the impairment or combination of impairments meets a Social Security listing. If the impairment or combination of impairments meets or is the medically equivalent of a listed impairment as set forth in Appendix 1 and meets the durational requirements of 20 CFR 404.1509, the individual is considered disabled. If it does not, the analysis proceeds to the next step.

Before considering step four of the sequential evaluation process, the trier must determine the Claimant's residual functional capacity. 20 CFR 404.1520(e). An individual's residual functional capacity is his/her ability to do physical and mental work activities on a sustained basis despite limitations from his/her impairments. In making this finding, the trier must consider all of the Claimant's impairments, including impairments that are not severe. 20 CFR 404.1520(e) and 404.1545; SSR 96-8p.

The fourth step of the process is whether the Claimant has the residual functional capacity to perform the requirements of his/her past relevant work. 20 CFR 404.1520(f). The term past relevant work means work performed (either as the Claimant actually performed it or as is it generally performed in the national economy) within the last 15 years or 15 years prior to the date that disability must be established. If the Claimant has the residual functional capacity to do his/her past relevant work, then the Claimant is not disabled. If the Claimant is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth step.

In the fifth step, an individual's residual functional capacity is considered in determining whether disability exists. An individual's age, education, work experience and skills are used to evaluate whether an individual has the residual functional capacity to perform work despite limitations. 20 CFR 416.920(e).

Claimant alleges physical disabling impairments due to fibromyalgia, ankle pain from ankle injury and surgery, arthritis in spine, and hypertension.

Claimant has alleged mental disabling impairments which include major depressive disorder, recurrent, severe with psychosis..

A summary of the Claimant's medical evidence presented at the hearing follows.

A Medical Examination Report was completed on October 11, 2013. The current diagnosis was fibromyalgia, polymyositis, depression, hypertension, ankle injury and

surgery. At the examination, the Claimant was 5’4” and weighed 204 pounds. Her blood pressure was 133/67. The examiner noted the Claimant was dysthemic. The Claimant’s condition was listed in stable and was expected to last more than 90 days. The following limitations were imposed, the Claimant was evaluated as capable of frequently lifting up to 10 pounds and occasionally 20 pounds. The Claimant could stand and/or walk less than two hours in an eight-hour workday and sit less than six hours in an eight-hour workday. There were no limitations with regard to the repetitive use of hands and arms. The Claimant was restricted from operating foot/leg controls with either foot/leg. The medical findings used to support the limitations were depression, history of ankle surgery, and hypertension. The Claimant was evaluated as capable of meeting her needs in the home.

A new Medical Examination Report completed by the Claimant’s doctor who had seen her since July 2013, was completed on March 18, 2014 and was completed by the same doctor as the previous examination. The diagnosis was fibromyalgia, polymyositis, depression, hypertension, and ankle fusion. The Claimant’s weight at the time of the exam was 218 pounds. Claimant’s blood pressure was 130/90. The examiner noted decreased range of motion in the ankle. The Claimant’s condition was rated as stable and limitations were imposed which were expected to last more than 90 days. The Claimant could frequently lift 10 pounds and never 20 pounds. The Claimant could stand or walk less than two hours in an eight-hour work day and sit less than six hours in an eight-hour workday. No limitations with respect to repetitive action in hands or arms were imposed. The Claimant was restricted from operating foot/leg controls with either foot/leg.

A Mental Residual Functional Capacity Assessment was completed on March 18, 2014 on the Claimant by the Claimant’s therapist. The Claimant was markedly limited in several respects. With respect to understanding and memory, the Claimant was markedly limited in the ability to understand and remember detailed instructions, but not significantly limited in ability to remember locations and work like procedures, and ability to understand and remember one – two step instructions.

With respect to sustained concentration and persistence, the Claimant was markedly limited in the ability to carry out detailed instructions, to maintain attention and concentration for extended periods, ability to work in coordination with or proximity to others without being distracted by them, and ability to complete a normal workday and worksheet without interruptions from psychologically based symptoms, and to perform at a consistent pace without an unreasonable number and length of rest periods. Claimant was not significantly limited in her ability to carry out simple one or two-step instructions and ability to sustain an ordinary routine without supervision. The Claimant was moderately limited in her ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances, and ability to make simple work related decisions.

With regard to social interaction, the Claimant was markedly limited in the ability to accept instructions and respond appropriately to criticism from supervisors. Moderately

limited in the ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes. There was no evidence of limitation with regard to ability to ask simple questions or request assistance, or ability to maintain socially appropriate behavior, and to adhere to basic standards of neatness and cleanliness.

With respect to adaption, the Claimant was markedly limited in the ability to respond appropriately to changes in the work setting, ability to travel in unfamiliar places or use public transportation, and ability to set realistic goals or make plans independently of others. The Claimant was not significantly limited in the ability to be aware of normal hazards and take appropriate precautions. A psychiatric evaluation was also completed at this time, the current treatment was that the Claimant's receives monthly medication review. The diagnosis was major depressive disorder, recurrent, severe with psychotic features. History of self-abuse was noted. No GAF score was provided.

A psychiatric evaluation was also completed on September 5, 2013. As expressed at the examination, the Claimant's need for treatment was due to depression, anxiety, poor sleep, auditory hallucinations, and delusions. The report discloses a long history of mental problems. This history included a suicide attempt at age 15 and placement in a group home. At the time of the exam, the Claimant reported poor memory and concentration, crying spells, extreme mood swings, feelings of worthlessness and hopelessness, and somatic symptoms. Claimant reported auditory hallucinations beginning approximately 4 months prior to the examination with voices telling her to hurt herself and that she is worthless. The Claimant reported sleeping 4 to 6 hours at night with interrupted sleep. No substance abuse was reported. The following was observed by the Examiner, the Claimant's mood was depressed, affect was flat, behavior was tearful, and appearance was well groomed. The Claimant's thought content was coherent, delusions were noted, as well as auditory hallucinations. Intellectual functioning was average, orientation was full, speech was normal, short-term memory was moderately impaired, judgment was fair, no risk of self-harm was noted, long term memory was moderately impaired, and insight was poor.

The diagnosis was major depressive disorder, recurrent severe with psychotic features. Rule out noted bipolar disorder, most recent episode depressed, severe with psychotic features. Also noted ruled out anxiety and posttraumatic stress disorder. The GAF score was 50. The prognosis indicated that the patient exhibited a serious chronic condition that will require continuous treatment. Patient exhibits multiple conditions/illness that generally indicates high complexity and require continuous integrated treatments. Change oriented treatment plan is recommended, support oriented treatment plan is recommended, the Claimant's altered mood was noted and evaluated as very severe.

A mental residual functional capacity assessment was also completed in October 2013. The Claimant was markedly limited in understanding and memory with regard to ability to understand and remember detailed instructions. With regard to sustained concentration and persistence, the Claimant was markedly limited in ability to carry out detailed instructions, ability to maintain attention and concentration for extended periods, and ability to complete a normal workday and worksheet without interruptions

from psychologically based symptoms and perform at a consistent pace without unreasonable number and length of rest periods. The Claimant was not significantly limited in any category regarding social interaction. With regard to adaptation, the Claimant was markedly limited in ability to respond appropriately to change in the work setting, ability to travel in unfamiliar places or use public transportation and ability to set realistic goals or make plans independently.

A consultative psychiatric evaluation was completed April 2, 2013 prior to Claimant's current treatment for her mental impairments. The examining doctor noted major depressive disorder, recurrent with psychotic features in partial remission and panic disorder, chronic. The GAF score was 59. The medical source statement concluded "based on today's evaluation, the patient has decreased ability for interacting, communicating and socializing, secondary to major depressive disorder, recurrent and panic disorder. This interferes with her ability for socializing despite the medications. The exam also notes that the Claimant was anxious but pleasant, expressed feeling helpless and worthless, but denies any attempts or plans to suicide and expressed auditory hallucinations.

The Claimant's family practice physician who has seen her since April 2012 completed a psychiatric evaluation which is not going to be considered for this evaluation, as it is determined that that doctor is not qualified to conduct such an examination.

The Claimant was seen by her family practice physician on April 30, 2013 for follow up regarding her hypertension and generalized muscle aches and pain with a chronic low back pain which is worsening. Prior to that visit, the Claimant had a cardiac stress test which was negative. Active patient problem list included obesity, anxiety, degenerative arthritis of the cervical spine, mild persistent asthma, fibroid with excessive frequent menstruation, fibromyalgia, cervical radiculopathy, chronic low back pain, anemia, iron deficiency, panic attacks, atypical chest pain and chronic headaches. A review of systems were negative for any abnormalities and the physical examination noted extremities were normal, not traumatic, no cyanosis or edema**.** The doctor discussed with patient need to check blood pressure daily. The encounter diagnosis was fibromyalgia, myofascial muscle pain, anxiety and depression, chronic headaches, hypertension, GERD, and normal cardiac stress test. The Claimant was referred to a rheumatologist for further evaluation of fibromyalgia and myofascial muscle pain. No additional medical records were provided.

At the hearing, the Claimant credibly testified to ongoing severe symptoms which included daily crying, panic attacks, ongoing auditory hallucinations and a suicide attempt one month prior to the hearing. Although the Claimant testified her memory was okay, she testified that her concentration was very poor and that she avoids social interactions. The Claimant has disrupted sleep patterns and wakes up often with nightmares. It is also noted that the Claimant spoke very slowly, displayed a flat affect and stuttered.

Here, Claimant has satisfied requirements as set forth in steps one and two, as Claimant is not employed and has demonstrated impairments which have met the Step 2 severity requirements.

In addition, the Claimant's impairments have been examined in light of the listings and after a review of the evidence, the Claimant's impairments, the medical evidence and testing and the Claimant's testimony, it is determined that the combination of both mental and physical impairment in combination are sufficient to meet listing 12.04 and 12.06 or their medical equivalent. Although Fibromyalgia was alleged and diagnosed by the Claimant's primary care physician and a referral to a neurologist was made, no medical records were provided. Notwithstanding that the Listing for fibromyalgia was not met, this treating doctor has seen the Claimant for at least a year and evaluated her consistently at less than sedentary due to the long extensive list of medical problems outlined above. The treating doctors imposed limitations, which match much of the Claimant's testimony regarding her physical abilities. As a treating doctor's evaluation, deference was given to the two evaluations performed, both of which place the Claimant at less than sedentary.

Also considered were the mental impairments. Listing 12.04 Affective disorders and Listing 12.06 Anxiety Related Disorders were also reviewed. At the time of the hearing, the Claimant was in treatment for a year and showed little improvement. The prognosis indicated that the patient exhibited a serious chronic condition that will require continuous treatment. The Claimant has a lifelong history of mental impairment. Two psychiatric examinations were available with the same diagnosis, Major Depressive Disorder, recurrent severe with psychosis. Two Mental Residual Functional Capacity Assessments were part of the evidence and were completed by the Claimant's treating therapist who holds an MSW degree and APW, and is a Nurse Practitioner and treats and sees the Claimant. However, based upon the mental residual functional capacity examination's being completed by an MSW rather than a psychiatrist, the requisite marked limitations were not established as required by the listings evidentiary requirements. However weight is given to these evaluations as the therapist was well familiar with the Claimant's abilities and capacities, and rated her consistently as markedly limited in the categories that are required to exhibit capabilities to perform jobs. The limitations imposed in the Mental Residual Functional Capacity Assessment were consistent with the psychiatric evaluations. Based upon the combination of the many medical problems outlined above, the Claimant's obesity and the severe mental impairments which are ongoing and are supported by two evaluations, and evaluations of marked limitations which have a significant effect on the ability to work, it is found the Claimant meets the equivalent of listing 12.04 and 12.06. Therefore it is determined that the Claimant is disabled for purposes of the MA-P and SDA programs at Step 3 with no further analysis required.

As the Claimant is determined to be disabled for purposes of MA-P, the Claimant is also deemed disabled for purposes of SDA.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that Claimant is medically disabled as of September 2010.

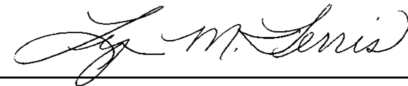
Accordingly, the Department's determination is REVERSED.

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 September 24, 2013, for MA-P and SDA, and any retroactive application, if not done previously, to determine Claimant's non-medical eligibility.

2. The Department shall issue a supplement to the Claimant for any SDA benefits she is otherwise entitled to receive, if any, in accordance with Department policy.

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



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

Date Signed: July 9, 2014

Date Mailed: July 9, 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

cc: