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

IN THE MATTER OF:

Reg. No.: 2014 13744
Issue No.: 2009, 4009
Case No.:
Hearing Date: March 12, 2014
County: Wayne County (41)

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. , a witness for the Claimant, also appeared on behalf of the Claimant. Participants on behalf of the Department of Human Services (Department) included , Hearing Coordinator and , Medical Contact Worker.

ISSUE

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

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 July 30, 2013, Claimant applied for MA-P and SDA.

2. On October 31, 2013, the Medical Review Team denied Claimant's request.

3. The Department sent the Claimant a Notice of Case Action dated November 5, 2013, denying the Claimant's MA-P and SDA application.

4. On November 14, 2013, Claimant's AHR submitted to the Department a timely hearing request.

5. On January 16, 2014, the State Hearing Review Team ("SHRT") found the Claimant not disabled and denied Claimant's request.

6. An Interim Order was issued on March 13, 2014 ordering the Claimant to submit additional medical evidence.

7. On June 18, 2014, the State Hearing Review Team denied Claimant's request and found Claimant not disabled.

8. Claimant at the time of the hearing was 53 with an [redacted] birth date. The Claimant is now [redacted] years old. Claimant height was 4'11" and weighed 143 pounds.

9. Claimant completed high school to the 10th grade and earned a GED. Claimant has no prior work experience in the past 15 years.

10. The Claimant has alleged mental disabling impairments including major depression, and anxiety with recurrent panic attacks.

11. Claimant alleges physical disabling impairments due to carpal tunnel in left hand, (dominant) lumbar pain, left hip pain, hypertension and asthma. The Claimant's impairments have lasted or are expected to last longer than 12 months duration.

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 impariment which meets federal 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.

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).

The Claimant has alleged mental disabling impairments including major depression and anxiety with recurrent panic attacks.

Claimant alleges physical disabling impairments due to carpal tunnel in left hand, (dominant), lumbar pain, left hip pain, hypertension and asthma.

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

A Medical Examination Report was completed on March 21, 2014 by the Claimant's family practice doctor. This doctor had seen the Claimant for two years prior to the examination. The Claimant's current diagnosis was hypertension, hyperlipidemia, asthma, anxiety, agoraphobia and major depression. The exam noted that there were multiple open healing lesions on Claimant's scalp from picking. Diminished breath sounds and scattered wheezing, and the Claimant was noted as being anxious. The doctor indicated that the Claimant was deteriorating. There were no physical limitations imposed. The doctor did impose mental limitations regarding social interaction and sustained concentration. The evaluation reported that the Claimant's anxiety symptoms were exacerbated in public and in crowds. Depression was ongoing, with ongoing symptoms which are resistant to treatment. The Claimant was found capable of meeting her needs in the home.

A Psychiatric Examination Report was completed on November 12, 2013. It was completed by the Claimant's psychiatrist. The examination notes that the Claimant had no past psychiatric inpatient or outpatient treatment, and had been receiving Zoloft and Buspar from her primary care physician. During the interview, the Claimant noted that as regards alcohol, she uses alcohol "at least half a pint at one time," and started drinking at age 20. Can drink all day and night if she is involved in a party. Currently drinks three times per week. Her emotional reactions were sad but stable with a fair range of emotion. There was no delusional thought process or perceptual disturbances noted and no thoughts of hurting herself or others. Judgment and insight were rated as fair. The diagnosis was anxiety disorder, panic disorder without agoraphobia and major depressive disorder recurrent, moderate, the GAF score was not given. Recommendation was total abstinence from alcohol discussed, as were medications to assist Claimant's mental impairments. Case management services were recommended.

A follow-up examination was conducted on November 26, 2013. At the time the Claimant reported that she had drank alcohol four times in the last weeks. She was sleeping okay with no crying spells. Claimant was taking her medications. Her exam was within normal limits in all categories and the diagnosis remained the same.

A subsequent evaluation was conducted on December 23, 2013. The presenting complaints were as follows. Claimant reported feeling a little better with a couple of small panic episodes due to stress of the holidays. Sleeping well, has many dreams making her panic like they used to. No crying spells. Reported drinking one week ago and alcohol breath detected. Grooming was average, attitude and behavior was within normal limits, speech was normal, mood was within normal limits, affect was in normal limits, thought process was normal, thought content appropriate, no perceptual

disturbances were noted, and the Claimant was fully oriented. No suicidal ideation was noted. The diagnosis was the same. The Claimant was noted as improving.

On December 11, 2013, the Claimant was seen for a Consultative Internal Medicine Examination. Claimant was evaluated due to complaints of major depressive disorder, anxiety, high blood pressure, high cholesterol, left hip and back pain, and carpal tunnel in left hand. The exam notes that alcohol history is positive for drinking, and that she has been a heavy drinker. The Claimant presented with no acute distress. Her respiratory, cardiovascular, gastrointestinal examination was within normal limits. There was noted mild tenderness to palpation in the lower lumbar area. No obvious spinal deformity, swelling or muscle spasm noted. The Claimant was able to get on and off the exam table slowly. Both tandem walk and heel toe walk are done slowly. The Claimant could perform a squat to 70% of the distance. Straight leg raising was negative.

The Consultative Examining Doctor's impression was that Claimant has major depression and anxiety. Claimant was being followed by a mental health specialist and taking medication. Hypertension was noted, but concluded that the blood pressure is under fair control on the current drug regimen. Hyperlipidemia was under dietary control. Carpal tunnel syndrome of the left hand was noted with brace, but no follow-up since 1994. Left hip and back pain was noted as chronic left hip and back pain, and she is being followed by her primary care physician.

The examining doctor concluded based upon the history and the exam, the examinee may have difficulty with repetitive and heavy use of her left hand, as well as prolonged standing, stooping and squatting on the left side. There is no evidence of neurological disorder or joint instability, and she does not use a cane or aid for walking. The examinee does need long-term ongoing care for her mental health concerns. The physical abilities examination noted that the Claimant complained of pain while standing, bending, stooping, carrying, pushing and pulling as well as getting on and off the exam table. Assistive devices were not deemed necessary.

The Interim Order issued in this case requested that the Claimant obtain an updated psychiatric evaluation and Mental Residual Functional Capacity Assessment from her treating psychiatrist. The updated medical information was not received.

The Claimant has been seen regularly by a doctor at [redacted]. A summary of those visits follows. The Claimant was seen for her cough and lower back pain on January 17, 2013. At the time, her diagnosis was anxiety caused by driving, chronic obstructive asthma, unspecified anxiety and elevated transaminase/LDH. At the time of this visit, the Claimant had an acute upper respiratory infection. Two days prior to that doctor's visit, the Claimant was diagnosed with community acquired pneumonia and placed on antibiotics. On February 2013, the Claimant was seen for a left temporal headache, fatigue. The assessment was likely a tension headache and deconditioning, and slowly returning to regular activity was discussed. A progress note on March 12, 2013, noted that the Claimant had been isolating herself severely and retreating to bed all day. On March 26, 2013, the Claimant was diagnosed with shingles but no lesions,

with burning pain noted; Claimant also was complaining of left flank backache. The Claimant was seen on April 24, 2013, and still continued to have shingles symptoms and was prescribed pain medication.

The Claimant was referred by her family practice doctor to [redacted] are regarding her panic attacks and fatigue on July 2, 2013. At that time, the objective assessment was depressed mood, anhedonia, hypersomnia, fatigue, feelings of worthlessness/guilt, hopelessness and impaired memory. Her anxiety symptoms were racing thoughts, psychomotor agitation, and difficulty concentrating. Substance abuse was noted; alcohol yes occasionally, other drugs no. Anxiety attacks caused by driving were noted, as was fatigue and agoraphobia with panic disorder. The comments at the time of this referral noted that Claimant seems overwhelmed by physical limitations and financial obligations with no resources.

The Claimant was given a psychosocial evaluation and assessment on July 8, 2013. The Claimant presented with fatigue, headache and flu times two. The Claimant was ill recurrently, then with pneumonia, then with shingles. At the time, the Claimant presented with depressed mood, anhedonia, hypersomnia, fatigue, feelings of worthlessness/guilt, hopelessness and impaired memory, weight gain from eating and not moving enough. The Claimant described a severe panic attack one year prior while driving, requiring her to repeatedly stop at gas stations to avoid panic and get out of the car. One of the abnormal findings was fatigue. No suicidal ideation was presented. The Claimant acknowledged drinking alcohol a couple of times per week, not to get drunk. The clinical impressions noted that the stress and limitations of being sick, as well as the debt that is accumulating and inability to pay for what she needs, has brought on anxiety and depressive symptoms. At the time, based on testing, the evaluator put her in the range of severe depression, moderate. The Claimant indicated a desire to be able to function and get through these problems. The diagnosis was severe depressive disorder. The current GAF score was 55, the year previously had been 70.

The Claimant has been seen monthly by her mental health provider. At the time of the hearing, the Claimant was still receiving psychiatric treatment.

Here, Claimant has satisfied requirements as set forth in steps one and two, as Claimant is was not employed. At the time of the hearing, Claimant last worked in 2007 and her impairments 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 do not meet a listing as set forth in Appendix 1, 20 CFR 416.926. Listing 12.04 Affective Disorders and 12.06 Anxiety Related Disorders were examined in light of the Claimant's ongoing treatment and the assessments of both the consultative examiner and her primary care physician. However, the medical evidence was not sufficient to meet the evidentiary threshold required. Based upon the objective medical evidence referenced above the Claimant does not meet the listing.

Therefore, vocational factors will be considered to determine Claimant's residual functional capacity to do relevant work.

The fourth step of the analysis to be considered is whether the Claimant has the ability to perform work previously performed by the Claimant within the past 15 years. As the Claimant has no past relevant work to be considered, no assessment can be made at Step 4. Therefore, it is determined that the Claimant is no longer capable of past relevant work. Thus a Step 5 analysis is required 20 CFR 416.920(e).

Claimant has expressed a number of symptoms and limitations, as cited above, as a result of her mental limitations caused by her extreme anxiety and depression, her carpal tunnel syndrome in her dominant hand, back pain and left hip pain. Claimant credibly testified to the following symptoms and abilities: the Claimant could not walk more than one-half block, could perform a squat about 70% of the way, and could not bend at the waist as it caused back spasm and pain. The Claimant also experiences hip pain when bending. The Claimant also indicated that she has difficulty showering due to panic attacks. The Claimant could carry up to 10 pounds. The Claimant also has pain in her left leg and hip recurrent causing her difficulty in walking distances and climbing stairs.

In the final step of the analysis, the trier of fact must determine if the Claimant's impairment(s) prevent the Claimant from doing other work. 20 CFR 416.920(f). This determination is based upon the Claimant's:

1. residual functional capacity defined simply as "what can you still do despite your limitations?" 20 CFR 416.945;
2. age, education, and work experience, 20 CFR 416.963-965; and
3. the kinds of work which exist in significant numbers in the national economy which the Claimant could perform despite her limitations. 20 CFR 416.966.

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.

> Sedentary work. Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in

> carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. 20 CFR 416.967(a).
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> Light work. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little; a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. 20 CFR 416.967(b).
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> Medium work. Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work. 20 CFR 416.967(c).
>
> Heavy work. Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work. 20 CFR 416.967(d).

In Step 5, an assessment of the individual's residual functional capacity and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v). At the time of hearing, the Claimant was ██ years old and, thus, considered to be an individual approaching advanced age for MA-P purposes. The Claimant has a GED, and has back pain and standing issues that did not meet a listing. Her family practice doctor attested to mental limitations and problematic treatment, as well as ongoing prescriptions for anxiety medications that included ████ and █████ which were continued by her mental health care provider. The Consultative examiner found that Claimant as she presented on examination would need ongoing, long term mental health treatment and had physical limitations and concluded based upon the history and the exam, "The examinee may have difficulty with repetitive and heavy use of her left hand, as well as prolonged standing, stooping and squatting on the left side. Physical abilities examination noted that the Claimant complained of pain while standing, bending, stooping, carrying, pushing and pulling as well as getting on and off the exam table." Disability is found if an individual is unable to adjust to other work. *Id.* At this point in the analysis, the burden shifts from the Claimant to the Department to present proof that the Claimant has the residual capacity to substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984).

While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to

meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

After a review of the entire record, including the Claimant's testimony and medical evidence presented, and the objective medical evidence provided by the Claimant's doctors and the consultative examiner's findings suggesting that the Claimant's physical restrictions place her at sedentary work, it is determined that the total impact caused by the physical impairment suffered by the Claimant, and ongoing mental impairments necessitating long term treatment and management, must be considered and, therefore, it is determined that the Claimant is capable of sedentary work as she cannot meet the required standing, sitting or lifting requirements for light work. It is also determined that while alcohol abuse was suggested, alcohol was not deemed material to this decision.

In light of the foregoing, it is found that the Claimant maintains the residual functional capacity for work activities on a regular and continuing basis to meet the physical and mental demands required to perform sedentary work as defined in 20 CFR 416.967(a). Based upon the foregoing review of the entire record using the Medical-Vocational Guidelines [20 CFR 404, Subpart P, Appendix II] as a guide, specifically Rule 201.09, it is found that the Claimant is disabled for purposes of the MA-P program at Step 5.

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 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. A person is considered disabled for SDA purposes if the person has a physical or mental impariment 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.

As the Claimant has been found disabled for MA-P, she is also deemed disabled for purposes of the SDA program as well.

DECISION AND ORDER

Accordingly, the Department's decision is hereby 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 July 30, 2013 for MA-P and SDA, and any retro MA-P if not done previously, to determine Claimant's non-medical eligibility.

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

3. A review of this case shall be conducted in July 2015.

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

Date Signed: July 18, 2014

Date Mailed: July 21, 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: