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

IN THE MATTER OF:

Reg. No.: 2014 4616
Issue No.: 2009, 4009
Case No.:
Hearing Date: February 26, 2014
County: Wayne County 57

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 February 26, 2014 from Detroit, Michigan. Participants on behalf of Claimant included Claimant. Participants on behalf of the Department of Human Services (Department) included , Medical Contact Worker.

ISSUE

Whether the Department properly determined that Claimant was not disabled for purposes of the Medical Assistance (MA-P) 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. Claimant was an ongoing MA-P and SDA recipient based on a September 8, 2011 application and finding of eligibility finding that Claimant was disabled.

2. On August or September 1, 2013, the Department reviewed Claimant's ongoing MA-P eligibility.

3. On September 6, 2013, the MRT found Claimant no longer disabled.

4. On September 6, 2013, the Department sent Claimant a Notice of Case Action closing the MA-P case.

5. On September 20, 2013, the Department received Claimant's timely written request for hearing.

6. On December 12, 2013, the State Hearing Review Team (SHRT) found Claimant not disabled.

7. An Interim Order was issued February 26, 2014 to obtain updated medical information and DHS 49's and DHS 49 D and E from Claimant's treating doctors. On May 15, 2014, the new evidence was submitted to the State Hearing Review Team.

8. On June 13, 2014, the SHRT issued a decision and found the Claimant not disabled.

9. Claimant has alleged mental disabling impairments including major depression, anxiety and auditory hallucinations.

10. The Claimant has alleged physical disabling impairments including fibromyalgia, chronic lumbar pain, osteoarthritis in both knees, chronic pain and obesity.

11. At the time of hearing, Claimant was 44 years old with a [redacted] birth date.

12. At the time of hearing, Claimant was 5'4" in height, weighed approximately 219 pounds, and had recently gained 20 pounds.

13. Claimant has a High School education and 2 years of college courses. The Claimant has an employment history of working as a home health care aide and doing working in a hospital passing patient trays.

14. Claimant's impairments have lasted, or are expected to last, continuously for a period of 12 months or longer.

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 the Department of Human Services Bridges Administrative Manual (BAM), Department of Human Services Bridges Eligibility Manual (BEM), and Department of Human Services Bridges Reference Tables (RFT).

A disabled individual is eligible for MA-P and SDA. BEM 105 (January 2014), p. 1; BEM 260 (July 260); BEM 261 (July 2013), p. 1. In order to receive MA benefits based upon disability or blindness, Claimant must be disabled or blind as defined in Title XVI of the Social Security Act. 20 CFR 416.901. Disability is 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).

Once an individual has been found disabled for purposes of MA benefits, continued entitlement is periodically reviewed in order to make a current determination or decision as to whether disability remains in accordance with the medical improvement review standard. 20 CFR 416.993(a); 20 CFR 416.994(a). In evaluating whether an individual's disability continues, 20 CFR 416.994 requires the trier of fact to follow a sequential evaluation process to assess current work activities, severity of impairment(s), and the possibility of medical improvement and its relationship to the individual's ability to work. The review may cease and benefits continued if sufficient evidence supports a finding that an individual is still unable to engage in substantial gainful activity. 20 CFR 416.994(b)(5). Prior to deciding an individual's disability has ended, the Department will develop, along with Claimant's cooperation, a complete medical history covering at least the 12 months preceding the date the individual signed a request seeking continuing disability benefits. 20 CFR 416.993(b). The Department may order a consultative examination to determine whether or not the disability continues. 20 CFR 416.993(c).

Step One

The first step in the analysis in determining whether an individual's disability has ended requires the trier of fact to consider the severity of the impairment(s) and whether it meets or equals a listed impairment in Appendix 1 of subpart P of part 404 of Chapter

20. 20 CFR 416.994(b)(5)(i). If a Listing is met, an individual's disability is found to continue with no further analysis required.

In the present case, Claimant alleges a physical disabling impairment due to fibromyalgia, chronic lumbar pain, osteoarthritis in knees, chronic pain and obesity.

Claimant has alleged mental disabling impairments including major depression, anxiety and auditory hallucinations.

A Medical Examination Report was completed on June 10, 2013 by the Claimant's doctor of Internal Medicine. The doctor had been treating the Claimant since April 2012. The diagnosis was poly arthritis, depression, general joint pain, TMJ, arthritis, and carpal tunnel syndrome. The Claimant was 5'4" and weighed 225 pounds (BMI 38.62). General comments noted that the Claimant had a flat affect and fatigue and weakness. The musculoskeletal exam noted that Claimant uses a cane due to osteoarthritis of knees. The Claimant was stable with no major improvement and limitations were imposed. The Claimant could frequently lift less than 10 pounds and occasionally 10 pounds. The Claimant could stand and/or walk at least 2 hours in an 8-hour workday and was not limited in ability in the use of her hand/arms and feet/legs. The Medical Findings cited to support the limitations were suffers from degenerative disc disease and knees made worse by her obesity, currently tested for possible vasculitis. She is clinically depressed and receiving counseling. She was determined to be unable to meet her needs in the home.

The annual psychiatric evaluation was conducted by the Claimant's treating Psychiatrist on April 26, 2013. At the time of the evaluation, the Claimant was post-hospitalization due to her mental problems. The presenting complaints included anxiety, sadness, and loss of interest, hopelessness, low energy, decreased appetite, insomnia, loss of libido, hearing voices, irritability, forgetfulness and poor concentration. The symptoms were noted as being present for greater than 10 years. Psychosocial stressors are overwhelming. At the time of the examination, the Claimant's thought process was fair, non-command auditory hallucinations were noted, visual hallucinations were noted, no delusional thought, no obsessive or compulsive thought and average intelligence. After assessment no risk of suicide was noted. The diagnosis was major depressive disorder, recurrent, severe with psychotic features. The GAF score was 50. The notes indicate that the patient remained symptomatic. Psychotherapy was recommended.

The initial psychosocial evaluation conducted on September 30, 2013, indicated that at the time the Claimant had been a member in treatment for approximately 2 years. At the time, she was presenting with severe depression, self-injurious behavior, sleep problems, and hypersomnia. Note was made of auditory and visual hallucinations. At the time her judgment was fair, her thought content was delusional, auditory

hallucinations were noted as well as a paranoid thought process, her thought processes were also racing, and her speech was pressured. Although oriented to person, place and time, Claimant was evaluated in having limited insight, impulsive judgment and below average intellectual functioning, with depressed mood and flat affect. The assessment for suicide noted prior suicide attempts and noted psychiatric disorders including mood disorders, psychotic disorder, with key symptoms which included impulsivity, hopelessness, anxiety/panic and insomnia. Suicidal behaviors were noted with a moderate risk due to multiple risk factors with few protective factors, suicidal ideation with planned suicide but no intent, and hospitalization admission may be necessary depending on risk factors. Behavioral concerns included verbal aggression and self-abuse. The use of a cane for walking was also noted. No drug or alcohol abuse was noted. The Claimant was prescribed ██████ and █████. As part of the plan, the notes indicate that the Claimant would be discharged and receive a reduction in treatment services when she is able to maintain mental and emotional stability for one year or longer through gaining insight into her diagnosis, identity and implement needed steps for independent living and minimization of symptoms. The report noted frequent crying spells and recent self-injurious activity. The final examination gave a diagnosis of major depressive disorder, recurrent severe with psychotic features. The GAF score was 45.

A current Mental Residual Functional Capacity Assessment was performed on March 20, 2014 by the Claimant's treating Psychiatrist. In that examination, the Claimant was found markedly limited in many categories. In Understanding and Memory, the Claimant was found markedly limited in her ability to understand and remember one or two-step instructions, and understand and remember detailed instructions. The Claimant was moderately limited in her ability to remember locations and work like procedures.

With regard to Sustained Concentration and Persistence, the Claimant was markedly limited in her ability to carry out detailed instructions, ability to carry out simple, one or two step instructions, ability to maintain attention and concentration for extended periods, ability to perform activities within a schedule maintain regular attendance and be punctual within customary tolerances. The Claimant was markedly limited in her ability to sustain an ordinary routine without supervision, ability to work in coordination with or proximity to others without being distracted, ability to make simple work related decisions, and the 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.

As regards Social Interaction, the Claimant was markedly limited in ability to interact appropriately with the general public, ability to accept instructions and respond appropriately to criticism from supervisors, ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes. The Claimant was

moderately limited in her ability to ask simple questions and not significantly limited in her ability to maintain socially appropriate behavior and to adhere to basic neatness and cleanliness. With regard to Adaptation, the Claimant was markedly limited in all categories, including her ability to respond appropriately to change in the work setting, ability to be aware of normal hazards and take appropriate precautions ability to travel in unfamiliar places or use public transportation, and ability to set realistic goals or make plans independently of others.

A Psychiatric Evaluation was completed on July 2, 2013 at which time the following was noted. The Claimant was referred to [redacted] post hospital. The history of present illness was anxiety, sadness, loss of interest, hopelessness, low energy, decreased appetite, insomnia, loss of libido, hearing voices, irritability, forgetfulness and poor concentration. These symptoms have been present for greater than ten years. The patient's trauma history included childhood physical abuse, childhood sexual abuse, childhood emotional abuse, past physical abuse as an adult, past emotional abuse as an adult and ongoing sexual abuse. At the time of the exam the Claimant presented with fair insight, non-command auditory hallucinations, visual hallucinations, no delusional thought, no obsessive-compulsive thought and average intelligence. No suicidal ideation. The Diagnosis was Major Depressive Disorder Recurrent Severe with Psychotic Features. The GAF score was 50.

The Claimant's treating doctor completed an evaluation regarding pain management on May 31, 2013. At the time of the evaluation, the evaluating doctor noted that the Claimant was depressed and was not following instructions well due to her pain. Range of motion in her neck was somewhat limited but was inconsistent. Strength of upper and lower extremities is possibly somewhat weak but inconsistent. Straight leg raising test is mildly positive but inconsistent, there was weakness in both hands and arms bilaterally, but inconsistent. There is pain, tenderness and muscle spasm along the lower lumbar paraspinal muscles. At the time of the visit, the patient was given a bilateral lower lumbar facet joint nerve block under ultrasound guidance in a divided dose. The indications were that the patient was diagnosed with low back pain, arthritis and facet joint disorders. There is tenderness at the lower lumbar paraspinal especially at the facet joint. Therefore, lumbar facet joint nerve blocks were performed.

A Medical Examination Report was performed by the pain management Doctor on March 24, 2014. At that time the Doctor noted the current diagnosis was nerve root irritation S1. Under musculoskeletal, the Doctor noted the strength of the upper and lower extremities is somewhat weak but consistent. Straight leg raising test mildly positive weaknesses noted in both hands, but consistent. The clinical impression was that there was no change. Limitations were imposed the Claimant was limited from carrying/ lifting less than 10 pounds frequently and occasionally 10 to 20 pounds. The

Claimant could stand or walk less than two hours in an eight-hour workday and the Claimant could operate foot leg controls with her left leg only.

A review of the Claimant's medical evidence provided by her doctors and their evaluation of her conditions from the Claimant's treating doctor summarized above was reviewed to determine whether listing 12.04 Affective disorders has been demonstrated. In addition, Particular weight was given to both the DHS 49's completed by the Claimant's treating doctors and the current Mental Residual Capacity Assessment completed in March 2014. The Listing requires the following:

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;

The Claimant credibly testified to ongoing treatment for her severe depression and anxiety as well as her auditory hallucinations. The Claimant credibly testified to ongoing anger issues and having broken dishes due to her anger. Claimant also indicated she

made a suicide attempt in prior year. Claimant indicated that at times she goes three days without eating and that her concentration is not good. Her social interactions are limited to her family only and her therapist. At the time of the hearing, she had not eaten for a day. She has received ongoing treatment and psychotherapy for at least three years. As regards self-harm, Claimant indicated that approximately 2 months ago she had abused herself physically by self-cutting. She continues to hear voices and expressed extreme frustration and hopelessness and bouts of crying several times weekly.

A review of the Claimant's medical treatment records indicate that the Claimant has satisfied continuous or intermittent medically documented persistence of sleep disturbance, decreased energy, feelings of guilt or worthlessness, difficulty concentrating or thinking, thoughts of suicide, or hallucinations delusions or paranoid thinking satisfying 12.04 A1. In addition, Claimant has demonstrated through her medical records that she also meets the requirements of 12.04 B, as she has marked restrictions in activities of daily living, maintaining social functioning and maintaining concentration persistence or pace.

Based on the evaluation of Claimant's treating Psychiatrist, it is determined that deference must be given to this evaluation as the Claimant has been seen for some time, at least 3 years. 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). Also considered were the progress notes of her psychiatric treatment records presented which do not support medical improvement despite treatment, both therapeutic and with drugs. Deference was given by the undersigned to objective medical testing and clinical observations and the mental Residual Functional Capacity Assessment of the Claimant's treating psychiatrist. Based upon the foregoing, it is determined that the Claimant is disabled at Step 1 on a continuing basis ongoing and meets Listing 12.04 or its medical equivalent with no further analysis required. Therefore, it is determined the Claimant is disabled for purposes of the MA P program. As the Claimant is disabled for purposes of MA P, the Claimant is also deemed disabled for purposes of the SDA program as well.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Claimant disabled for purposes of the MA-P and SDA benefit program.

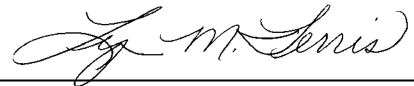
Accordingly, the Department's determination is REVERSED.

THE DEPARTMENT IS ORDERED TO BEGIN DOING 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. Review and reprocess the August or September, 2013 review application for MA-P and SDA to determine if all other non-medical criteria are met and notify Claimant of its decision in writing;

2. The Department shall issue a supplement to the Claimant for SDA benefits that the Claimant was otherwise eligible to receive in accordance with Department policy; and

3. Review Claimant's continued MA-P and SDA eligibility in July 2015 in accordance with Department policy.



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

Date Signed: July 15, 2014

Date Mailed: July 15, 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: