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

IN THE MATTER OF:

[redacted]

Reg. No.: 14-002394
Issue No.: 2009; 4009
Case No.: [redacted]
Hearing Date: October 15, 2014
County: Wayne (82)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

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; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10. After due notice, an in-person hearing was held on October 15, 2014 from Detroit, Michigan. Participants included the above-named Claimant. [redacted] testified and appeared as Claimant's legal counsel / authorized hearing representative (AHR). Participants on behalf of the Department of Human Services (DHS) included [redacted], Specialist.

ISSUE

The issue is whether DHS properly denied Claimant's application for Medical Assistance (MA) and State Disability Assistance (SDA) for the reason that Claimant is not a disabled individual.

FINDINGS OF FACT

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

1. On [redacted], Claimant applied for SDA and MA benefits.

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

3. On [redacted] the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 1-2).

4. On [redacted], DHS denied Claimant's application for MA and SDA benefits and mailed a Notice of Case Action (Exhibits 54-55) informing Claimant of the denial.

5. On [redacted], Claimant's AHR requested a hearing disputing the denial of MA and SDA benefits.

6. On [redacted], SHRT determined that Claimant was not a disabled individual, in part, by determining that Claimant can perform past relevant work.

7. As of the date of the administrative hearing, Claimant was a 27 year old female with a height of 5'4'' and weight of 140 pounds.

8. Claimant has no known relevant history of alcohol or illegal substance abuse.

9. Claimant's highest education year completed was the 12th grade.

10. As of the date of the administrative hearing, Claimant was an ongoing Healthy Michigan Plan recipient since 4/2014.

11. Claimant alleged disability based on impairments and issues including bipolar disorder, memory lapses, gastritis, and lumbar pain.

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. Department policies are contained in the Department of Human Services Bridges Administrative Manual (BAM) and Department of Human Services Bridges Eligibility Manual (BEM) and Department of Human Services Reference Tables Manual (RFT).

The Medicaid program is comprised of several sub-programs which fall under one of two categories; one category is FIP-related and the second category is SSI-related. BEM 105 (10/2010), p. 1. To receive MA under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled. *Id*. Families with dependent children, caretaker relatives of dependent children, persons under age 21 and pregnant, or recently pregnant, women receive MA under FIP-related categories. *Id*. AMP is an MA program available to persons not eligible for Medicaid through the SSI-related or FIP-related categories though DHS does always offer the program to applicants. It was not disputed that Claimant's only potential category for Medicaid eligibility would be as a disabled individual.

Disability for purposes of MA benefits is established if one of the following circumstances applies:

- by death (for the month of death);

- the applicant receives Supplemental Security Income (SSI) benefits;
- SSI benefits were recently terminated due to financial factors;
- the applicant receives Retirement Survivors and Disability Insurance (RSDI) on the basis of being disabled; or
- RSDI eligibility is established following denial of the MA benefit application (under certain circumstances).
  BEM 260 (7/2012) pp. 1-2

There was no evidence that any of the above circumstances apply to Claimant. Accordingly, Claimant may not be considered for Medicaid eligibility without undergoing a medical review process which determines whether Claimant is a disabled individual. *Id*., p. 2.

Generally, state agencies such as DHS must use the same definition of SSI disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally defined as the inability to do any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905. A functionally identical definition of disability is found under DHS regulations. BEM 260 (7/2012), p. 8.

Substantial gainful activity means a person does the following:
- Performs significant duties, and
- Does them for a reasonable length of time, and
- Does a job normally done for pay or profit. *Id*., p. 9.

Significant duties are duties used to do a job or run a business. *Id*. They must also have a degree of economic value. *Id*. The ability to run a household or take care of oneself does not, on its own, constitute substantial gainful activity. *Id*.

The person claiming a physical or mental disability has the burden to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a).

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled. 20 CFR 416.920. If there is no finding of disability or lack of disability at each step, the process moves to the next step. 20 CFR 416.920 (a)(4).

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily

considered to be engaging in SGA. The monthly amount depends on whether a person is statutorily blind or not. "Current" work activity is interpreted to include all time since the date of application. The 2013 monthly income limit considered SGA for non-blind individuals is $1,040.

Claimant credibly denied performing any employment since the date of the MA application; no evidence was submitted to contradict Claimant's testimony. Based on the presented evidence, it is found that Claimant is not performing SGA and has not performed SGA since the date of MA application. Accordingly, the disability analysis may proceed to step two.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the 12 month duration requirement. 20 CFR 416.920 (a)(4)(ii). The impairments may be combined to meet the severity requirement. If a severe impairment is not found, then a person is deemed not disabled. *Id*.

The impairments must significantly limit a person's basic work activities. 20 CFR 416.920 (a)(5)(c). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. *Id.* Examples of basic work activities include:

- physical functions (e.g. walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling)
- capacities for seeing, hearing, and speaking, understanding; carrying out, and remembering simple instructions
- use of judgment
- responding appropriately to supervision, co-workers and usual work situations; and/or
- dealing with changes in a routine work setting.

Generally, federal courts have imposed a de minimus standard upon claimants to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v Bowen,* 880 F2d 860, 862 (6th Cir. 1988). Similarly, Social Security Ruling 85-28 has been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirement is intended "to do no more than screen out groundless claims." *McDonald v. Secretary of Health and Human Servs.*, 795 F.2d 1118, 1124 (1st Cir. 1986).

SSA specifically notes that age, education, and work experience are not considered at the second step of the disability analysis. 20 CFR 416.920 (5)(c). In determining whether Claimant's impairments amount to a severe impairment, all other relevant

evidence may be considered. The analysis will begin with a summary of the relevant submitted medical documentation.

An Initial Psychosocial (Exhibits 23-39) dated [redacted] was presented. The documents were signed by a mental health agency employee with an unspecified job title. It was noted that Claimant reported depression and erratic concentration. Observations of Claimant included the following: orientation x4, intact memory, alert, normal concentration, good judgment, unremarkable thought content, unremarkable thought processes, normal stream of mental activity, unremarkable presentation, unremarkable speech characteristics, and appropriate affect. Suicidal ideation during Claimant's teenage years was noted. It was noted that Claimant independently performs ADLs. No history of sexual abuse was noted. An Axis diagnosis of dysthymic disorder was noted. Claimant's GAF was noted to be 60.

A Psychiatric Evaluation (Exhibits 21-22) dated [redacted] was presented. The evaluation was completed by a newly treating psychiatrist. It was noted that Claimant reported anxiety, sadness, loss of interest, hopelessness, low energy, decreased appetite, insomnia, mood swings, racing thoughts, pressured speech, irritability, forgetfulness, poor concentration, and low motivation. Claimant reported that psychological stressors were overwhelming. Notable observations of Claimant included the following: good grooming, timeliness, orientation x4, sadness, fidgetiness, irritable behavior, normal speech, intact judgment, logical, coherent, average intelligence, and fair insight. An Axis I diagnosis of bipolar disorder, moderate (most recent episode depressed) was noted. Claimant's GAF was noted to be 48. A plan of psychotherapy was recommended. Newly prescribed meds were Neurontin, Cymbalta, and Desyrel.

Various mental health agency treatment documents (Exhibits A155-A310) were presented. The notes covered various Claimant appointments from 5/2013-9/2013. Regular Claimant complaints of anxiety and depression were noted. It was noted that Claimant attended regular counseling sessions (typically 3-4 times per month).

A Psychiatric/Psychological Examination Report (Exhibits 11-12) dated [redacted] was presented. The form was completed by a treating counselor with an unstated history of treating Claimant. A diagnosis of bipolar disorder, most recent episode manic (moderate) was noted.

A Mental Residual Functional Capacity Assessment (Exhibits 12-13) dated [redacted] was presented. The assessment was noted as completed by a treating counselor with an unstated history with Claimant. This form lists 20 different work-related activities among four areas: understanding and memory, sustained concentration and persistence, social interaction and adaptation. A therapist or physician rates the patient's ability to perform each of the 20 abilities as either "not significantly limited", "moderately limited", "markedly limited" or "no evidence of limitation". Claimant's counselor opined that Claimant was markedly restricted in the following abilities:

- Sustaining an ordinary routine without supervision

- Asking simple questions or requesting assistance
- Accepting instructions and responding appropriately to criticism
- Traveling to unfamiliar places including use of public transportation

Various mental health agency treatment documents (Exhibits A111-A154) were presented. The notes covered various Claimant appointments from 10/2013-12/2013. On [redacted], Claimant reported racing thoughts, sadness, loss of interest, hopelessness, decreased appetite, anxiety, insomnia, and mood swings; a plan of psychotherapy was noted. On [redacted], Claimant reported having black-outs; Claimant's weight was noted to be 216 pounds. On [redacted], it was noted that Claimant reported increased stress from a lawsuit related to Claimant's dog killing someone. On [redacted] Claimant reported reduced anger and better communication. On [redacted], it was noted that Claimant reported recurring dreams about her dog dying.

Various mental health agency treatment documents (Exhibits A77-A110) were presented. The notes covered various Claimant appointments from 1/2014-3/2014. Various telephone counseling appointments were noted. On [redacted], it was noted that Claimant reported that she "throws up 200 times per day".

A Medication Review Note (Exhibit 44) dated [redacted] was presented. It was noted that Claimant complained of increased anxiety. In response, Claimant's psychiatrist noted that a discontinuance of Klonopin and an increase of Ativan was noted.

An Update Assessment (Exhibits 49-72) from a treating social worker was presented. Notable observations of Claimant included the following: alert, orientation x4, normal concentration, fair judgment, unremarkable thought content, no hallucinations, unremarkable thought process, slowed stream of mental activity, soft characteristic of speech, passive presentation, and anxious affect. It was reported that anxiety was at its worst and that she barely leaves the house. It was noted that Claimant reported daily nausea though two hospital encounters verified no physical problems. It was noted that Claimant was a daily marijuana smoker. Noted prescribed medications included Neurontin, Cymbalta, Klonopin, Saphris, and Desyrel. Axis I diagnoses of bipolar disorder and somatization disorder were noted. Claimant's GAF was noted to be 45.

Mental health agency treatment documents (Exhibits A38-A43) dated [redacted] were presented. It was noted that Claimant took too much Ativan which caused Claimant to slur words and feel very drowsy.

Mental health agency treatment documents (Exhibits A25-A37) dated [redacted] were presented. A goal to have custody and/or see kids more often was noted. A 27 year history of bipolar disorder was noted. It was noted that Claimant reported nausea since 9/2013, though no medical basis for the nausea was found. It was noted that Claimant's anger control has improved since beginning counseling.

Mental health agency treatment documents (Exhibits A23-A24) dated [redacted] were presented. A treating social worker noted that Claimant's nausea could be caused by past trauma; it was noted that Claimant's insurance did not cover trauma therapy.

Mental health agency treatment documents (Exhibits A21-A22) dated [redacted] were presented. It was noted that Claimant was a no-show for an appointment.

Mental health agency treatment documents (Exhibits A14-A15) dated [redacted] were presented. It was noted that Claimant reported problems with a court case and with an energy service shut-off threat

Mental health agency treatment documents (Exhibits A14-A18) dated [redacted] were presented. A treating social worker noted the following observations of Claimant: intact memory, psychomotor agitation, fair judgment, tearful at times, and logical and coherent thoughts. It was noted that Claimant would pursue relationship counseling. Claimant's GAF was noted to be 55. It was noted that Claimant reported a recent increase in anxiety meds helped only a little. It was noted that Claimant has not seen her kids and that she feels overwhelmed with most things. Psychiatrist notes indicated that meds worked well other than controlling anxiety. It was noted that Claimant was a pack per day smoker. Claimant's weight was noted to be 169 pounds.

Mental health agency treatment documents (Exhibits A12-A13) dated [redacted] were presented. It was noted that Claimant reported anxiety. It was noted that Claimant reported jealousy over a relationship.

Mental health agency treatment documents (Exhibits A10-A11) dated [redacted] were presented. A treating social worker noted the following observations of Claimant: intact memory, psychomotor agitation, fair judgment, tearful at times, and logical and coherent thoughts. It was noted that Claimant would pursue relationship counseling. Reported Claimant anxiety was noted. Claimant's GAF was noted to be 55.

Mental health agency treatment documents (Exhibits A3-A9) dated [redacted] were presented. It was noted that Claimant reported nausea and gallbladder pains related to recent surgery. A plan of monthly medical appointments was noted. An AIMS score of 0 was noted.

Mental health agency treatment documents (Exhibits A1-A2) dated [redacted] were presented. It was noted that Claimant reported needing an income. A plan for Claimant to attend 1-4 monthly appointments with a care coordinator was noted.

Presented documents verified that Claimant complained of ongoing psychological problems for over a one year period. Symptoms of anxiety, hopelessness, crying spells, insomnia and weight loss were all sufficiently verified. The evidence was sufficient to presume a degree of concentration and social interaction restrictions. It is found that

Claimant established having a severe impairment. Accordingly, the disability analysis may move to step three.

The third step of the sequential analysis requires a determination whether the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920 (a)(4)(iii). If Claimant's impairments are listed and deemed to meet the 12 month requirement, then the claimant is deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step.

Claimant's most prominent impairment appears to be depression. Depression is an affective disorder covered by Listing 12.04 which reads as follows:

> **12.04** ***Affective disorders***: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation. The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.
>
> A. Medically documented persistence, either continuous or intermittent, of one of the following:
> 1. Depressive syndrome characterized by at least four of the following:
> a. Anhedonia or pervasive loss of interest in almost all activities; or
> b. Appetite disturbance with change in weight; or
> c. Sleep disturbance; or
> d. Psychomotor agitation or retardation; or
> e. Decreased energy; or
> f. Feelings of guilt or worthlessness; or
> g. Difficulty concentrating or thinking; or
> h. Thoughts of suicide; or
> I. Hallucinations, delusions, or paranoid thinking
> OR
> 2. Manic syndrome characterized by at least three of the following:
> a. Hyperactivity; or
> b. Pressure of speech; or
> c. Flight of ideas; or
> d. Inflated self-esteem; or
> e. Decreased need for sleep; or
> f. Easy distractibility; or
> g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
> h. Hallucinations, delusions or paranoid thinking
> OR

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);
AND
B. Resulting in at least two of the following:
1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration
OR
C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:
1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

Starting with Part A, psychological treatment records sufficiently verified that Claimant reported ongoing symptoms of decreased appetite (verified by weight loss), anhedonia, sleep disturbance, and decreased energy. It is found that Claimant meets Part A of the above listing.

Presented records also verified that Claimant has immense difficulty in leaving her house. The difficulty is consistent with marked social restrictions.

GAFs between 41-50 were regularly noted. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF within the range of 41-50 is representative of a person with “serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g. no friends, unable to keep a job).” Claimant’s GAF is consistent with marked restrictions.

Presented records were suggestive that Claimant lost custody of her children but is still able to see them. Details were not apparent, however, Claimant testified credibly that she was neglectful and forgetful with her children. The loss of custody of children is consistent with marked restrictions in concentration.

Claimant testified that she suffers recurring black-outs. Claimant testified that the black-outs were more like short-term memory losses The symptom is consistent with presented evidence and is suggestive of marked restrictions.

Presented records verified regular increases in psychiatric medication. This consideration is suggestive of marked restrictions.

Based on the presented evidence, it is found that Claimant sufficiently meets the requirements of Listing 12.04. Accordingly, Claimant is a disabled individual and it is found that DHS improperly denied Claimant's MA application.

It should be noted that this finding of disability is not permanent. With further treatment, it is hopeful that Claimant will be able to maintain employment in the near future.

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. DHS administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. DHS policies for SDA are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (1/2013), p. 4. The goal of the SDA program is to provide financial assistance to meet a disabled person's basic personal and shelter needs. *Id*. To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older. BEM 261 (1/2012), p. 1.

A person is disabled for SDA purposes if he/she:

- receives other specified disability-related benefits or services, see Other Benefits or Services below, or
- resides in a qualified Special Living Arrangement facility, or
- is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability; or
- is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS).
  Id.

It has already been found that Claimant is disabled for purposes of MA benefits based on a finding that Claimant's impairments meet SSA Listing 12.04. The analysis and finding applies equally for Claimant's SDA benefit application. It is found that Claimant is a disabled individual for purposes of SDA eligibility and that DHS improperly denied Claimant's application for SDA benefits.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that DHS improperly denied Claimant's application for MA and SDA benefits. It is ordered that DHS:

(1) reinstate Claimant's MA and SDA benefit application dated [redacted];
(2) evaluate Claimant's eligibility for benefits subject to the finding that Claimant is a disabled individual;
(3) initiate a supplement for any benefits not issued as a result of the improper application denial; and
(4) schedule a review of benefits in one year from the date of this administrative decision, if Claimant is found eligible for future benefits.

The actions taken by DHS are **REVERSED**.

Christian Gardocki
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: **11/7/2014**

Date Mailed: **11/7/2014**

CG / hw

NOTICE OF APPEAL: A party may appeal this Hearing Decision in the circuit court in the county in which he/she resides, or the circuit court in Ingham County, within 30 days of the receipt date.

A party may request a rehearing or reconsideration of this Hearing Decision from the Michigan Administrative Hearing System (MAHS) within 30 days of the mailing date of this Hearing Decision, or MAHS may order a rehearing or reconsideration on its own motion.

MAHS may grant a party's Request for Rehearing or Reconsideration 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 party requesting a rehearing or reconsideration 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 this Hearing Decision is mailed.

A written request may be faxed or mailed to MAHS. If submitted by fax, 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: [redacted]