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

IN THE MATTER OF:

[redacted]

Reg. No.: 2014 32096
Issue No.: 2009
Case No.: [redacted]
Hearing Date: July 16, 2014
County: Wayne County DHS (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 July 16, 2014, from Detroit, Michigan. Participants on behalf of Claimant included the Claimant. [redacted] Claimant's Authorized Hearing Representative, appeared on his behalf. Participants on behalf of the Department of Human Services (Department) included [redacted] Medical Contact Worker.

ISSUE

Whether the Department of Human Services (DHS or Department) properly determined that Claimant is not "disabled" for purposes of the Medical Assistance program (MA-P)?

FINDINGS OF FACT

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

1. The Claimant submitted an application for public assistance seeking MA-P benefits on December 5, 2013.

2. On December 27, 2013, the Medical Review Team ("MRT") found the Claimant not disabled.

3. The Department notified the Claimant and the Claimant's AHR of the MRT determination on January 2, 2014.

4. On March 11, 2014, the Department received the Claimant's timely written request for hearing. (Exhibit 1)

5. On March 27, 2014, the State Hearing Review Team ("SHRT") found the Claimant not disabled. (Exhibit 2)

6. An Interim Order was issued on July 17, 2014 in this matter so that additional medical evidence could be obtained by the Claimant and the Department. The Claimant submitted new medical evidence which was reviewed.

7. Claimant has alleged physical disabling impairments due to severe Hydradenitis superativa, with a severe inflammation in the groin and the perineal architecture.

8. The Claimant has alleged mental disabling impairments, including depression and post-traumatic stress disorder.

9. At the time of hearing, the Claimant was 58 years old with a [redacted] birth date; was 6'0 " in height; and weighed 178 pounds.

10. The Claimant has a GED. The Claimant has no employment history.

11. At the time of the hearing, the Claimant was not substantially gainfully employed and is currently not working.

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

CONCLUSIONS OF LAW

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

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Family Independence Agency) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

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 pursuant 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.

Federal regulations require that the Department use the same operative definition for "disabled" as used for Supplemental Security Income (SSI) under Title XVI of the Social Security Act. 42 CFR 435.540(a).

> "Disability" is:
>
> …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.

In determining whether an individual is disabled, 20 CFR 416.920 requires the trier of fact to follow a sequential evaluation process by which current work activity, the severity of the impairment(s), statutory listings of medical impairments, residual functional capacity, and vocational factors (i.e., age, education, and work experience) are assessed in that order. When a determination that an individual is or is not disabled can be made at any step in the sequential evaluation, evaluation under a subsequent step is not necessary.

First, the trier of fact must determine if the individual is working and if the work is substantial gainful activity. (SGA) 20 CFR 416.920(b).

In this case, Claimant is not currently working. Claimant testified credibly that he is not currently working and the Department presented no contradictory evidence. Therefore, Claimant may not be disqualified for MA at this step in the sequential evaluation process.

The severity of the Claimant's alleged impairment(s) is considered under Step 2. The Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(b)(c).

A severe impairment is an impairment expected to last twelve months or more (or result in death) which significantly limits an individual's physical or mental ability to perform basic work activities. The term "basic work activities" means the abilities and aptitudes necessary to do most jobs. Examples of these include:

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

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting. 20 CFR 416.921(b).

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

As a result, the Department may only screen out claims at this level which are "totally groundless" solely from a medical standpoint. The *Higgs* court used the severity requirement as a "*de minimus* hurdle" in the disability determination. The *de minimus* standard is a provision of a law that allows the court to disregard trifling matters.

Claimant alleged physical disabling impairments, with chronic lumbar back pain including bilateral lower back pain due to degenerative disc disease, with cervical disc bulging and spurring, COPD, obesity, severe arthritis both knees, high blood pressure, torn ligament in her back and broken hand secondary to a car accident on April 30, 2014.

The Claimant has not alleged any mental disabling impairment(s).

In this case, the Claimant presented medical evidence which is summarized below.

The Claimant has been diagnosed with severe Hydradenitis superativa with a severe inflammation in the groin and the perineal architecture.

On June 26, 2014, the Claimant was seen at a pain clinic for pain management consultation at the request of his treating Doctor for groin pain. At the time he reported for evaluation, the Claimant's pain was described as 10/10 in severity, with burning quality radiating into his sides. Muscle spasm was also reported. History of multiple episodes of testicular torsion, Hydradenitis superativa in the groin region, multiple tests for hydrocele and torsion. Evidence of multiple surgeries in the groin area, with scarring on left groin and apparent graft tissue taken from right thigh were noted. The thigh and groin area was tender to palpation. The assessment was muscle spasm and pain in the pelvic groin and pereneal. The Claimant was prescribed multiple narcotic pain medications and noted that consideration of the bilateral lumbar sympathetic blockade will be discussed; a follow-up appointment after evaluation of medication efficacy.

In July 2013, the Claimant was seen due to a request that he not be placed in a dorm typesetting due to post-traumatic stress disorder. At that time, a single cell accommodation was not recommended. The Claimant was seen also in July 2013 by a psychiatrist who indicated a GAF score of 61 with a deferred diagnosis. The Claimant was also seen on July 28, 2013 due to emotional difficulty regarding the death of his best friend and his aunt who both meant a lot to him. The Claimant received a psychiatric evaluation while incarcerated on May 17, 2013 as a result of a parole board risk assessment.

While incarcerated, the Claimant was seen on April 22, 2013 for an open four centimeter groin will. At the time, the assessment was the Claimant was in fair condition and the wound was open. The Claimant was advised to keep the wound clean and dry. The Claimant was examined on April 5, 2013 with a diagnosis of hydradenitis with concentric pain in the genital region, integumentary disruption left scrotal/leg increase, exquisite tenderness palpation, left inguinal region and left testicle mass. The Claimant was prescribed pain medication. At the time of this diagnosis, no further surgical intervention was ordered due to prior poor results. The records note prior incidents of Hydradentitis in 1996, with excision of involved skin of the pubic region and down into the left inguinal region. Another procedure in August 1990 due to scrotal lesions involving freeing of the left testicle of adhesions. In 2001, the removal of the left testicle was recommended which was not pursued. As a result of these conditions, the Claimant was prescribed and allowed boxer shorts so as to not further worsen this condition. Throughout this period, Claimant was given a series of antibiotics for treatment.

The Claimant was seen for a crisis intervention and psychiatric assessment and evaluation as a result of recommendations that he be placed an open dorm situation while incarcerated. At the time of the examination, the patient's mood was described as anxious, depressed and afraid. At the time of the assessment, the Claimant was diagnosed with an adjustment disorder with mixed anxiety and depression as well as a personality disorder, the GAF score was 61. Also during incarceration, the Claimant was in the chronic care clinic for hepatitis C, chronic liver disease in 2011, and bleeding in the urine and rectum in March 2012.

The Claimant was seen in September 2013 at the emergency room with acute exacerbation of chronic pelvic/growing pain. The Claimant reported pain of 10/10 in the groin and scrotal area. The examiner noted marked bi lateral testicular tenderness with no masses appreciated and groin tenderness to palpation with no palpable masses. Claimant was discharged for follow up with urology and referred to his community health care provider. The Claimant was seen in community care services for an assessment for both the mental health and physical health in January 2014. The Claimant was evaluated as needing psychiatric and case management services, as well as medical services.

The psychiatric evaluation was conducted on December 17, 2013. At the time of presentation, the Claimant indicated that he struggles with people, nightmares, is depressed and sometime just does not speak for three or four days. At the time of the evaluation, the Claimant's judgment was evaluated as fair, his concentration was normal and he presented as guilt ridden. At the time of the evaluation, the GAF score was 48. The Claimant was diagnosed with major depressive disorder recurrent moderate and post-traumatic stress disorder. Major depressive disorder single incident with psychotic process and generalized anxiety disorder were to be ruled out.

Claimant was seen by his psychiatrist on March 4, 2014. At the time, his affect was constricted in his mood dysphoric. Continuing nightmares were noted. In addition, his medications were changed. At the time, the GAF score remained the same as the previous visit. The Claimant was seen on May 13 2014, at which time he indicated hospitalization due to problems with his growing depression, anxiety and sleep problems, as well as poor appetite were reported as ongoing; the GAF score remained the same. The Claimant was prescribed Abilify to improve depression. The Claimant was seen again on May 30th 2014, and exhibited profuse depression and sadness over his posttraumatic stress disorder symptoms from child hood, when he killed a man who was beating his mother. At that time, his status was poor to fair.

The Claimant was seen for groin pain on November 21, 2013 in the emergency room. The patient presented with bilateral testicular pain. At the time of presentation the Claimant had difficulty urinating and chills. The examination of the genitourinary area indicated bilateral scarring in the inguinal area, bilateral groin and scrotal tenderness. The doctor's notes indicated skin area changes

suggestive of fungal infection. The Claimant was discharged with a fungal infection of the groin, prescribed pain medication and was referred to urology. A CT of the pelvis was obtained and noted no inflammatory process with multiple vascular calcifications evident. There was no pelvic abscess found. Multiple sonographic images noted the left testicle was irregular in shape and appearance compared to the right with significantly decreased flow on the left.

In this case, Claimant has presented the required medical data and evidence necessary to support a finding that he has significant physical and mental limitations upon ability to perform basic work activities. Medical evidence has clearly established that Claimant has an impairment (or combination of impairments) that has more than a minimal effect on Claimant's work activities. Further, the impairments have lasted continuously for twelve months; therefore, the Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's impairment, or combination of impairments, meets or medically equals the criteria of an impairment listed in Appendix 1 of Subpart P of 20 CFR, Part 404. (20 CFR 416.920 (d), 416.925, and 416.926.) This Administrative Law Judge finds that the Claimant's medical record will support a finding that Claimant's impairment(s) is a "listed impairment" or equal to a listed impairment. See Appendix 1 of Subpart P of 20 CFR, Part 404, Part A.

This Administrative Law Judge consulted Listing 8.06 Hydradenitis suppurativa when making the evaluation of listings. The Listing requires Hydradenitis suppurativa**,** with extensive skin lesions involving both axillae, both inguinal areas or the perineum that persist for at least 3 months despite continuing treatment as prescribed. It is determined that the Medical evidence provided meets or is the medical equivalent of the listing requirements.

The Claimant's credible testimony established that he has difficulty and is limited with bending, cannot squat and can walk two blocks. The Claimant can stand 30 minutes and sit for an hour. He sometimes requires assistance getting out of the bathtub and cannot touch his toes at all times depending on pain. The medications for both his pain and mental impairments which include Seroquel and Ability, keep him very drowsy and sleepy. The Claimant indicated the heaviest weight he could lift or carry was five of pounds. Claimant has some relief with pain with medication, with persistent pain level of 3 out 10.

Assuming arguendo that the Claimant was otherwise deemed not disabled at Step 3, the Claimant would have been found not disabled at Step 4 as he has no past relevant work. The Claimant would be found disabled at Step 5 as well, given his age (58 advanced age), and his ability to perform at best sedentary work.

DECISION AND ORDER

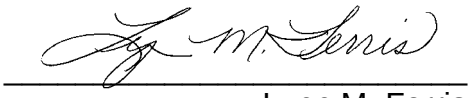
The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the Claimant is disabled for the purposes of MA and SDA programs. Therefore, the decisions to deny Claimant's application for MA–P and SDA were incorrect.

Accordingly, the Department's decision in the above stated matter 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 processing the Claimant's MA–P application dated December 5, 2013, consistent with the application and award required benefits, provided Claimant meets all non-medical standards required for eligibility as well.

2. The Department is further ORDERED to initiate a review of the Claimant's disability case in November 2015 in accordance with Department policy.



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

Dated: November 3, 2014
Mailed: November 3, 2014

NOTICE OF APPEAL: The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely Request for Rehearing or Reconsideration was made, within 30 days of the receipt date of the Decision and Order of Reconsideration or Rehearing Decision.

Michigan Administrative Hearing System (MAHS) may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. MAHS will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request (60 days for FAP cases).

A Request for Rehearing or Reconsideration may be granted when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision;

- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion;
- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the client;
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The Department, AHR or the Claimant must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date the hearing decision is mailed.

The written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-07322

LMF/tm

cc: [redacted]