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

IN THE MATTER OF:

[redacted]

Reg. No.: 14-001276
Issue No.: 2009
Case No.: [redacted]
Hearing Date: August 13, 2014
County: WAYNE- 19 (INKSTER)

ADMINISTRATIVE LAW JUDGE: Lynn 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 three way telephone hearing was held on August 13, 2014 from Detroit, Michigan. Participants on behalf of Claimant included Claimant. [redacted], the Claimant's Authorized Hearing Representative (AHR), also appeared on Claimant's behalf. Participants on behalf of the Department of Human Services (Department) included [redacted] Medical Contact Worker/Eligibility Specialist.

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional records. Interim Orders extending the record were issued on August 14, 2014, September 9, 2014 and October 10, 2014, ordering the Claimant's AHR to provide additional medical records from Claimant's psychiatrist, including a mental residual functional capacity assessment. The ordered records were not received. In light of the lapse of the period for the record extension and the failure to provide requested documents, the record was closed and this matter is now before the undersigned for a final determination.

ISSUE

Did the Department properly determine that Claimant was not disabled for purposes of the Medical Assistance (MA-P) 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. On October 3, 2013, Claimant submitted an application for public assistance seeking MA-P benefits and retro MA-P application to July 2013.

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

3. On January 6, 2014, the Department sent Claimant a Notice of Case Action denying the application based on MRT's finding of no disability.

4. On April 3, 2014, the Department received Claimant's timely written request for hearing.

5. On June 18, 2014, the State Hearing Review Team (SHRT) found Claimant not disabled.

6. Claimant alleged mental disabling impairments which include depression and anxiety. The Claimant's treating psychiatrist has diagnosed the Claimant with major depressive disorder, recurrent severe without psychotic features, cannabis dependence and opioid abuse and current GAF score of 42 as of July 30, 2014. A subsequent evaluation dated August 20, 2014 the diagnosis was bipolar disorder most recent episode depressed, moderate, cannabis dependence, and opioid abuse with a GAF score for 55.

7. The Claimant has alleged physical disabling impairments which include diabetic neuropathy, diabetes mellitus type I, hypertension, diabetic gastroparesis, erosive gastritis, extensive esophageal ulceration, dueodenitis, intractable abdominal pain, cyclic vomiting syndrome.

8. At the time of hearing, Claimant was 23 years old with a [redacted] birth date; she was 5''5" in height and weighed 116 pounds.

9. Claimant has an 11th grade education and no relevant full time work history of substantial gainful employment.

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).

MA-P and SDA benefits are available to disabled individuals. 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, Claimant must be disabled as defined in Title XVI of the Social Security Act. 20 CFR 416.901. Disability for MA purposes 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).

In order to determine whether or not an individual is disabled, federal regulations require application of a five-step sequential evaluation process. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider (1) whether the individual is engaged in substantial gainful activity (SGA); (2) whether the individual's impairment is severe; (3) whether the impairment and its duration meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) whether the individual has the residual functional capacity to perform past relevant work; and (5) whether the individual has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4)

In general, the individual has the responsibility 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, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. 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) Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

Step One

As outlined above, the first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is substantial gainful activity (SGA), then the individual must be considered as not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means

work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Claimant has not engaged in SGA activity during the period for which assistance might be available. Therefore, Claimant is not ineligible under step 1 and the analysis continues to step 2.

Step Two

Under step 2, the severity of an individual's alleged impairment(s) is considered. If the individual does not have a severe medically determinable physical or mental impairment that meets the duration requirement, or a combination of impairments that is severe and meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 12 months. 20 CFR 416.922.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). An impairment, or combination of impairments, is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a); see also *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921(b). Examples include (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b).

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. A disability claim obviously lacking in medical merit may be dismissed. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may be employed as an administrative convenience to screen out claims that are totally 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). However, under the *de minimus* standard applied at step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs* at 862.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). In the present case, Claimant alleges disability due to mental disabling impairments which include depression, and anxiety. The Claimant has alleged physical disabling impairments which include diabetic neuropathy, diabetes mellitus type I, hypertension, diabetic

gastroparesis, erosive gastritis, extensive esophageal ulceration, duodentis, intractable abdominal pain, and cyclic vomiting syndrome.

The medical records document current treatment with a mental health provider and therapist beginning approximately in July 2014. The Claimant also had one inpatient hospitalization in 2010 due to a suicide attempt, and was at Harbor Oaks for one week. No other hospitalizations have been presented.

First, Second and Third Interim Orders were issued requesting that the Claimant/ Claimant's AHR obtain a DHS 49 from the Claimant's current primary care doctor and a DHS 49 D and E from her treating psychiatric doctor. Despite several extensions so that the ordered medical evidence could be obtained, the requested evaluations were not provided.

A summary of the medical records regarding the Claimant's alleged mental health impairments follows. The Claimant was assessed by her current mental health care provider on July 30, 2014. At the time of the assessment, Claimant reported that she was irritated and angered by her husband and was so mad that she grabbed a knife and was concerned that she would do so again. Claimant's mood was depressed, anxious, angry and irritable. The Claimant had reported loss of weight between 40 and 50 pounds within less than two months, with nausea. An evaluation and diagnosis was completed on October 4, 2014. The diagnosis was major depressive disorder, recurrent severe without psychotic features. Cannabis dependence, and opioid abuse current GAF score was 42.

In a subsequent evaluation completed by her treating psychiatrist dated August 20, 2014, the diagnosis was bipolar disorder, most recent episode depressed, moderate; cannabis dependence, opioid abuse with a GAF score of 55. The severity of the presenting illness was rated as moderate, and the Claimant was taking no medications at the time. Signs and symptoms were mood swings, racing of thoughts, crying spells, decreased sleep, anxiety and depression. The Claimant was prescribed Risperdal and Trazodone. The report notes marijuana use the day of exam. The Claimant's attitude was cooperative, speech was soft, affect was congruent with mood, and thought described as labile. There was no impact on mood on Claimant's overall functioning noted, no impairment to thought process – goal oriented, averages less than 3 meals a day with difficulty falling asleep. Concentration was adequate and Claimant could maintain focus and impulse control was adequate

Claimant was seen by her therapist on July 30, 2014. The Claimant reported excessive sadness, tearfulness for no specific reasons, feelings of anger, irritation and easily annoyed. She reported no motivation to get out of bed, difficulty falling asleep and sleeping only 3 to 4 hours at night. Claimant's appetite was poor and reported having to force herself to eat with up-and-down moods, moderate concentration levels, feeling fatigued with no energy and isolation. These symptoms have been experienced for the last two years and Claimant decided she needed to seek treatment. The report notes

prior treatment at [redacted] inpatient in 2010. At the time, the Claimant reported use of marijuana 12 times in the last 30 days with the use pattern of 4 to 6 times a week and use 250 days in the past year. A history of heroin use approximately 10 days of the past year was noted, with the latest use two months prior to the appointment. Claimant indicated she had no suicidal ideation. At the time of the exam, the Claimant's memory was normal, judgment fair, insight fair and impulse control was fair and mood was depressed. The report notes the Claimant uses marijuana almost daily. As part of her treatment plan, the Claimant was to address drug abuse relapse and this was to be an area of discussion with her therapist with referral to [redacted]) support groups in the future for assistance. The Claimant was also rated as having Moderate/High nutritional risks requiring further follow up. The Claimant's judgment, insight, and impulse control were rated as fair, and the therapist noted as evidence for this evaluation that suicide was attempted once, has been in patient, and uses marijuana almost daily and dropped out of high school. The report noted that the Claimant did not have substance use disorder, but also notes abstinence was unknown and noted relapse history. The report notes that she smokes marijuana to help with her physical health issues. The Claimant's prognosis was rated as good.

The Claimant has alleged physical disabling impairments, which include diabetic neuropathy, diabetes mellitus type I, hypertension, diabetic gastroparesis, erosive gastritis, extensive esophageal ulceration, duodentis, intractable abdominal pain, cyclic vomiting syndrome. A summary of the Claimant's medical records with respect to her alleged physical impairments follows.

2013

The Claimant was seen by her treating Doctor for an office visit on March 27, 2013. At the time, the complaints included diabetes managed with insulin and associated symptoms including blurred vision and fatigue. Anxiety with an onset of one and a half months was also reported. The Claimant also had had a miscarriage. At the time, the symptoms reported were anxiety, fearful thoughts, depressed mood, fatigue or loss of energy, feelings of guilt or worthlessness, panic attacks and restlessness. Negatives included compulsive thoughts and behaviors, diminished interest or pleasure, hallucinations, manic episodes, poor concentration, indecisiveness, significant change in appetite (weight loss or gain greater than 5%) and sleep disturbance. Patient was seen shortly after an abortion.

The Claimant was seen on April 4, 2013 for an office visit. At the time, pertinent negatives included blurred vision, fatigue, chest pain, dypsnea, foot ulcer, hypoglycemia, polydipsia, polyuria, polyphagia and sensory neuropathy. The diagnosis was type I diabetes. At the time, the clinical assessment was type I diabetes uncontrolled and Claimant was referred to endocrinology for evaluation for an insulin pump. The medical records and evidence do not establish whether the insulin pump was completed.

The Claimant was seen in the ER on July 19, 2013 due to abdominal pain. The Claimant was admitted to the hospital for a one-day stay with vomiting and abdominal pain. The discharge diagnosis included vomiting – persistent, diabetic gastroparesis and noncompliance. The medical records note that the Claimant had been seen in the ER seven or eight times since the end of May 2013. A prior endoscopy revealed no evidence of H pylori, but did show chemical gastritis. The Claimant had been to the ER 4 times in the last week. The Claimant appeared to be non-compliant with her medications. The records indicate that the Claimant made repeated demands for morphine or dilaudid with note of suspicion of drug seeking behavior.

The Claimant was admitted on August 28-29, 2013 and September 2, 2013 with nausea, vomiting and muscle aches. She was diagnosed at that time with hypokalemia, dehydration and urinary tract infection, with intractable vomiting/nausea (cyclic vomiting syndrome); she was discharged in improved condition. The Claimant was also made aware of a health clinic for diabetes follow up due to her failure to have routine care for diabetes and insulin care. In the August admission, the notes indicate that the Claimant does not take her medications, including insulin when not feeling well and practiced only minimal compliance. The notes indicate that the patient repeatedly demanded of staff that she wanted her pain medications.

The Claimant was seen in the ER on September 16, 2013 with nausea vomiting and emesis. Her blood sugars were elevated. The discharge diagnosis included vomiting persistent, dehydration, diabetes, intractable nausea, vomiting gastritis and gastroduodenitis.

The Claimant was seen again on September 24, 2013 with the same symptoms as the two previous admissions, blood pressure was elevated, but the examination was otherwise unremarkable. Claimant underwent laparoscopic cholecystectomy (gall bladder removal) and was released in stable condition. The Claimant was seen again on October 1, 2013. with abdominal pain, nausea and vomiting. Her clinical presentation was consistent with previous diagnosis of esophageal ulcer and likely gastroparesis related to diabetes.

The Claimant was seen in the emergency room on October 5, October 6, October 12 and October 14, 2013, with abdominal pain and emesis. The notes indicate that the Doctor noted Claimant was attempting to dictate the order of medications given to her by her nurses. The report notes that “She was asking often about her medications she was getting and to give her what she had been given last time. She was taking Norco’s chronically.” She was found to have pelvic inflammatory disease and was treated. Thereafter, the Claimant was seen in the ER again on November 18, 2013 with the same or similar complaints. Claimant had a CT scan of the abdomen and pelvis on two occasions, which were normal. The Claimant was admitted again on November 20, 2013 to November 25, 2013, with abdominal pain, nausea and vomiting secondary to extensive esophageal ulceration, erosive gastricduodenitis, hypertension, diabetes and depression.

The Claimant was admitted on November 27 to November 29, 2013 with dehydration, intractable abdominal pain and peptic ulcer disease. Thereafter, the Claimant was seen in the ER on December 2, 2013 with the same or similar complaints. Other than tenderness in the epigastric area, the physical examination was otherwise unremarkable; mood and affect were noted as normal.

2014

On January 11, 2014, the Claimant was seen in the emergency room with abdominal pain, nausea and vomiting, with complaints of being unable to eat. During her examination, the medical records note that patient has had a number of workup for these complaints from surgery, ER, primary care physician, psychiatric, etc. She has had multiple labs, CT, etc. It has been determined that she has THC cyclic vomiting syndrome. Patient reports "she tells me that she has been trying really hard to cut back and is going to Alcoholics Anonymous for support. She has cut back at least in half but is still smoking; she understands that this will continue until she is able to quit which she is working on."

The Claimant was seen on January 15, 2014 in the emergency room with complaints of repetitive emesis uncontrolled with home remedies. The report notes that patient has been here numerous times in the past with similar type of complaints diagnosed with cyclical vomiting related to marijuana use, and she states she continues to use marijuana, but not as much. She is presently having some minimal abdominal pain. The notes indicate that Claimant remained in the ER for one hour and was discharged home with the impression of repetitive emesis diagnosed previously as cyclical emesis related to marijuana use.

On January 31, 2014, Claimant was seen and admitted to the hospital for abdominal pain, nausea and vomiting. The Claimant indicated she did not have insurance and takes her insulin whenever she can get a prescription from the hospital.

Claimant was seen in the emergency room on February 14, 2013 and was ambulatory, and reported with complaints of abdominal pain with vomiting onset one day ago. The Claimant was released after a one day stay. While in the hospital, patient's vomiting was observed and eventually subsided. At the time of the admission, the Claimant was found to be five weeks pregnant.

The Claimant was seen on February 17, 2014 with complaints of abdominal pain and emesis and hematemesis. A CT of the abdomen and pelvis was performed which was essentially unremarkable. At the time of the admission, the patient's lab results were significant for a high white blood cell count. The Claimant was admitted with intractable nausea and vomiting, acute gastritis, abdominal pain and leukocytosis. The Claimant was given a psychiatric consult during the admission and was observed to be nervous and internally occupied responding to questions briefly in soft tones. At the time of the

exam, the notes indicate mood seems dysphoric and irritable with constricted affect, thought content was occupied with medical issues, hopeless and worthless, denied any auditory or visual hallucinations. Cognition was fair, insight and judgment and impulse control were fair. The impression was mood disorder not otherwise specified, marijuana abuse. The GAF score was 40. Claimant was recommended for outpatient treatment.

The Claimant was admitted to the hospital on March 29, 2014. The impression was abdominal pain, suspect peptic ulcer disease with intractable nausea and vomiting, possible reflex esophagitis, more likely rule out mild gastroparesis. Other problems noted included depression, hypertension and anxiety. At the time of her discharge, the Claimant's diagnosis was vomiting, persistent, dehydration diabetes type I, intractable nausea vomiting, hypokalemia, gastritis and gastroduodenitis.

The Claimant was seen on April 4, 2014 for an office visit. At the time, pertinent negatives included blurred vision, fatigue, chest pain, dypsnea, foot ulcer, hypoglycemia, polydipsia, polyuria, polyphagia and sensory neuropathy. The diagnosis was type I diabetes. At the time, the clinical assessment was type I diabetes uncontrolled, and was referred to endocrinology for evaluation for an insulin pump. The medical records do not indicate whether an insulin pump was expedited.

The Claimant was admitted for a one-day stay on April 16, 2014, with complaints of nausea, vomiting intractable emesis and severe abdominal pain. She arrived by ambulance. Medical records note she has a history of cyclic vomiting, appears to induce vomiting by either gagging herself or sticking her fingers in her throat. This is observed in the emergency department. It appears to be an eating disorder, she is thin and frail. Currently uses marijuana at least one or two times per week. The impression upon discharge was repetitive nausea, vomiting with history of cyclical emesis secondary to marijuana abuse.

On April 18, 2014, the Claimant arrived at the ER by ambulance. At the time of the visit, the Claimant complained of abdominal pain despite previous medications given while in the ER. Once again, the medical notes indicate that patient has a history of cyclic vomiting thought at least in part to be related to marijuana use. Mother is concerned that she also has an eating disorder, frequently gags and makes herself throw up. While being transported by ambulance, the notes indicate patient showed no outward signs of pain. Notes also indicate the patient was noncompliant with her insulin.

Claimant was transported to the emergency room on May 6, 2014 and May 4, 2014 with nausea vomiting, after a three day period of these symptoms. During the May 6, 2014 ER visit, the Claimant arrived by ambulance due to vomiting and abdominal pain for the past week. At the time the Claimant was seen, the Claimant was administered pain medication and given a series of medications including insulin. The report notes marijuana use 1 to 2 times per week. The Claimant was seen in the ER two days prior as well. Claimant had a positive drug urine screen for THC and an elevated white blood cell count.

During the May 4, 2014 visit to the ER for abdominal pain, cyclic vomiting thought to be associated with marijuana use, she reported again with abdominal pain that she rates at about of 9/10. At the time EMS delivered the patient, the blood glucose level was 560. At the time of examination, patient admitted to marijuana use that has continued despite the fact that she has been directed that she needs to stop this. Medical records note patient repeatedly was asking for narcotics and was given Dilaudid. The doctor's notes again relate that it was reiterated that patient needs to stop smoking dope.

The Claimant was seen on May 19 2014 in the emergency room. At that time, the Claimant complained of abdominal pain, nausea and vomiting, and arrived by ambulance. The notes indicate current marijuana use 1 to 2 times per week. Claimant was discharged from the emergency room. During her admission, the medical records indicate that "she keeps using marijuana despite knowing that the marijuana is causing these issues. She still abuses the substance that cause the nausea, vomiting and abdominal pain." Today, she came in with a two day history of nausea, vomiting and abdominal pain. She has not been taking her insulin as often as she is supposed. During this admission, the Claimant was observed ambulating around the room in no acute distress. Notes indicate that the patient has been known to stick her fingers down her throat in an attempt to make herself vomit. During this admission the Claimant was advised that by continuing to use cannabis she is precipitating a lot of her symptoms. She stated she understood. She said she was trying to quit cannabis use. "I ask her if it was harder to quit cannabis use or deal with the side effects, she said it was harder to deal with the side effects." It was explained to her that she would not be receiving any injections of narcotics as before, as there was concern about her history of substance abuse and reliance on the ER for her medical care. She has not followed up appropriately even though she has been asked to multiple times in the past. The report further notes the Claimant is able to drink multiple cups of water in the ER without any distress. The Claimant was again encouraged to take her insulin as directed and stop using cannabis. It is contributing to a lot of these unpleasant symptoms that she is constantly seen in the emergency department for and she agrees to do so.

On May 22, 2014, the Claimant presented for four hours with nausea, vomiting and abdominal pain with a pain score of seven. The notes indicate current marijuana use 1 to 2 times per week. The medical records note that due to her frequent visits, this is always and repeatedly due to cannabis hyperemesis syndrome. She continues to smoke. She has not had any vomiting for the last two hours here. She is requesting Dilaudid and Ativan. The notes indicate the treating Doctor was not going to give her any narcotics, and noted she does not have any medical need to be in the emergency room anymore and was discharged. The impression was cyclical vomiting due to continued and ongoing marijuana abuse. The patient was advised to stop smoking marijuana. At this time, she will be placed in waiting rooms of patients. The notes further indicate that Claimant was seen for similar symptoms two days prior in the ER.

On June 10, 2014, the Claimant was admitted to the hospital with complaints of abdominal pain. Admission notes indicate that an EGD with biopsy was done in April 2014, which demonstrated gastritis and esophagitis. Patient admits she has not taken any of her medications as directed or followed up in the past two months. At the time of the admission, her psychiatric evaluation was normal mood and affect, behavior is normal, judgment and thought content normal. Examination of the abdomen was normal. The Claimant was admitted in fair condition. The assessment indicated acute abdominal pain associated with nausea, vomiting, probably due to underlying gastritis plus uncontrolled diabetes, gastrointestinal bleeding, probably due to retching secondary to vomiting, hypertension, uncontrolled diabetes secondary to noncompliance. Anxiety and depression. The Claimant was seen by a consult physician who noted the patient was admitted several months ago with the same complaint. The patient has poor compliance with medications and her insulin, plus she is taking a lot of narcotics. The impression noted combination of gastroparesis, versus reflex esophagitis, versus anxiety and irritable bowel or functional. Notes indicate patient is type I diabetic and may need consult from endocrinologists to control the proper diabetes and medication. Other medical problems including anxiety and depression.

On June 15, 2014, the Claimant was admitted for a one day stay due to abdominal pain, vomiting and dry heaving. At the time she was seen, medical records indicate that she is well known to the facility with a history of cyclic vomiting felt to be secondary to marijuana use. At the time, the notes indicate that the patient was trying to cut back on her marijuana use. The medical notes indicate that the Claimant repeatedly asked for pain medications and the treating Doctor elected not to give her any narcotics and had a fairly frank discussion about the fact that she continues to use marijuana despite multiple ER visits and hospitalizations for cyclic vomiting; and until which time she stops using this, it is likely that most emergency departments will not provide her with narcotics. She does verbalize understanding. At the time the Claimant was awake, alert, tearful and asking for pain meds repeatedly.

The Claimant was seen at the clinic on an outpatient basis on August 1, 2014. A review of systems indicated the Claimant was positive for abdominal pain, constipation and diarrhea, as well as fatigue. Claimant was prescribed Reglan for stomach pain until the blood sugars were controlled and was given an ace inhibitor to protect her kidneys. The Claimant was referred to a psychiatrist for depression and anxiety, and was started on Paxil.

The Claimant was seen on August 15, 2014 with complaints of abdominal pain described as epigastric with a key, burning and sharp sensations occurring after meals. At the time of the office visit, the Claimant was positive for heart burn, fatigue and sensory deficit. The Claimant was referred to endocrinology for her diabetes and metabolism, as well as a gastroenterology consult. No medical records were provided for these referral visits.

As summarized above, Claimant has presented medical evidence establishing that she does have some mental and physical limitations on her ability to perform basic work activities. In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Claimant suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 12 months. Therefore, Claimant has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step Three

Step 3 of the sequential analysis of a disability claim requires a determination if the individual'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 an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

Claimant's record reflects mental disorders. Based on the record presented, several listings in 12.00 concerning mental disorders, specifically Listings 12.04 (affective disorder), 12.06 (anxiety related disorders),12.08 (personality disorder), 12.09 (substance addiction disorder), were considered.

The evaluation of disability on the basis of mental disorders requires documentation of a medically determinable impairment(s), consideration of the degree of limitation such impairment(s) may impose on the individual's ability to work, and consideration of whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. See Listing 12.00A. The existence of a medically determinable impairment(s) of the required duration must be established through medical evidence consisting of symptoms, signs, and laboratory findings, to include psychological test findings. 12.00B. The evaluation of disability on the basis of a mental disorder requires sufficient evidence to (1) establish the presence of a medically determinable mental impairment(s), (2) assess the degree of functional limitation the impairment(s) imposes, and (3) project the probable duration of the impairment(s). Listing 12.00 D.

In this case, the record confirms the diagnoses of major depressive disorder, recurrent, severe without psychotic features; bipolar disorder, cannabis dependence, and opioid abuse. Claimant had a most recent GAF of 55. The record presented showed no evidence of any marked restriction in any of the four functional areas or any repeated episodes of decompensation necessary to support any of the considered listings in 12.00. A mental residual functional assessment was requested but not provided. The most recent evaluation by the treating psychiatrist indicates that symptoms are moderate. The evidence presented is not sufficient to establish the degree of severity to meet any of the listings considered or the medically equivalent of any listing.

The Claimant also has various physical impairments, most notably cyclic vomiting, a diagnosis of cannabinoid Hyperemesis Syndrome, diabetes mellitus type l as well as

diabetic neuropathy, hypertension, diabetic gastroparesis, erosive gastritis, extensive esophageal ulceration, dueodenitis, and intractable abdominal pain. Listings 5.00 was reviewed and considered including 5.08 weight loss due to any digestive disorder and though the Claimant has lost weight, her BMI did not meet the requisite 17.5 required by the listing nor were any of the other sub listing's severity requirements met.

Accordingly, Claimant cannot be found disabled, or not disabled, at Step 3 based on her mental and physical conditions. While various additional conditions have been reported in the medical records such as diabetic neuropathy, no objective evidence was provided to support the diagnosis.

Because Claimant's physical and mental conditions are insufficient to meet, or to equal, the severity of a listing, Claimant is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Step 4, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. Impairments, and any related symptoms, may cause physical and mental limitations that affect what a person can do in a work setting. 20 CFR 416.945(a)(1). RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s) and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4). The total limiting effects of all impairments, including those that are not severe, are considered. 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicants takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If the limitations and restrictions imposed by the individual's impairment(s) and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2).

For mental conditions, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). Four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of mental functional limitation. 20 CFR 416.920a(c)(3). The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. Id. The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. Id.

When a person has a combination of exertional and nonexertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination unless there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969a(d).

In this case, the record shows that Claimant alleged both exertional and nonexertional limitations.

At the hearing, Claimant testified that she had difficulty walking more than two or three blocks, and standing more than 15 to 20 minutes because she becomes lightheaded and dizzy. Although capable of taking care of her personal hygiene, Claimant described periods where due to depression, she does not attend to her personal hygiene. The Claimant also testified to leg cramps which were not mentioned or identified anywhere in the voluminous medical records. Claimant testified she could carry up to 20 pounds occasionally and for approximately 2 blocks. The Claimant indicated that she continued to use marijuana for her appetite once or twice a week, and does not have a medical marijuana card. The Claimant further testified that she was compliant with her insulin for

her diabetes. It is noteworthy that nowhere in the medical records were any complaints of dizziness or lightheadedness reported, were any leg cramping reported and do not contain evidence of compliance with insulin use.

As regards her mental impairments, the Claimant noted crying spells for no reason and that her current living situation with her boyfriend's parents created anxiety. Claimant further testified that due to her depression, she does not sleep much and has restlessness when sleeping. The Claimant noted that at times her concentration was shaky, but she is able to see her friends who visit her at her house. Claimant otherwise testified that her memory was good.

The evidence presented does establish some limitations on Claimant's ability to meet exertional work demands with respect to lifting and carrying objects weighing 20 pounds or more.

Claimant's record also showed nonexertional limitations. Claimant testified that she had concentration issues when she is not feeling well and suffers from personal hygiene inattentiveness when depressed. Otherwise, the Claimant was capable of grocery shopping, doing laundry, loading the dishwasher and vacuuming when not otherwise feeling ill.

In light of the Claimant's testimony, which call to question some of her complaints which are not reported in the voluminous medical documentation, and the lack of medical evidence to support mental limitations on Claimant's ability to perform work activities, the restriction on Claimant's RFC is, at most, mild to moderate.

Step Four

The fourth step in analyzing a disability claim requires an assessment of Claimant's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

As the Claimant has no significant gainful activity of a full-time nature, the Claimant has no relevant past work experience, and thus the analysis must proceed to Step Five because the Claimant cannot be found disabled or not disabled at step four.

Step 5

In step 5, an assessment of Claimant's RFC 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 this point in the analysis, the burden shifts from Claimant to the

Department to present proof that Claimant has the RFC to obtain and maintain substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984).

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).

See *Felton v DSS* 161 Mich App 690, 696 (1987). Once the Claimant makes it to the final step of the analysis, the Claimant has already established a *prima facie* case of disability. *Richardson v Secretary of Health and Human Service*s, 732 F2d 962 (6th Cir, 1984). Moving forward, the burden of proof rests with the State to prove by substantial evidence that the Claimant has the residual function capacity for SGA.

This Administrative Law Judge finds that Claimant has the residual functional capacity to perform work at no more than a light work level. Claimant has not presented objective medical evidence that would demonstrate a marked mental impairment.

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). The age for younger individuals (under 50) generally will not seriously affect the ability to adjust to other work. 20 CFR 416.963(c). If the individual can adjust to other work, then there is no disability. Disability is found if an individual is unable to adjust to other work. *Id.*

In this case, Claimant has an 11th grade education and no significant work experience, with moderate limitations in her mental ability to perform basic work activities. Based on the Claimant's testimony and a 11th grade education, the Claimant's residual functional capacity would allow her to perform at best light work and consistently perform sedentary work, which given her age and education would require a finding that she is not disabled at Step 5 pursuant to rule 202.17 (light work) or rule 201.18 (sedentary work).

Due to the repeated and significant emergency room visits, as well as hospital admissions for abdominal pain, nausea and vomiting, Claimant's ability to sustain and maintain employment is questionable. Additionally, although no vocational evidence has been provided by the Department, it would appear that the frequency of illness would make it unlikely that jobs that would accommodate frequent illness and absences would be available in the national economy. Accordingly, after review of the entire record and

in consideration of Claimant's age, education, work experience, and RFC, Claimant is found disabled at Step 5.

Since the tables and grids could not be relied upon to furnish the evidence of disability or non-disability, the Department had the burden of offering other evidence to that effect especially of a job in the national economy which the Claimant could perform but no vocational expert testified. Nor did the Department point anything in the record to support the conclusion that the Claimant could perform other work. Since the Department has not shown not shown there was a job in the national economy which the plaintiff could perform, the Department has failed to provide vocational evidence which establishes that Claimant has the residual functional capacity for substantial gainful activity and that given Claimant's age, education, and work experience, there are significant numbers of jobs in the national economy which Claimant could perform despite Claimant's limitations. Accordingly, this Administrative Law Judge concludes Claimant is disabled for purposes of the MA program at Step 5. Wilson v Heckler 743 F.2d 281, 222(CA 4 1984).

Lastly, given the significance and repeated references throughout the medical records presented to ongoing marijuana use and the diagnosis of Marijuana Hyperemesis Syndrome on several occasions during hospital and ER admissions, the repeated admonitions to the Claimant to cease marijuana use to alleviate her cyclic vomiting symptoms, a discussion and analysis of whether drug abuse is material and a contributing material cause to the Claimant's current disability, specifically her cyclical vomiting syndrome is required.

Section 223 (d)(2)© and 1614 (a)(3)(J) of the Social Security Act ("Act") provide that a Claimant "shall not be considered to be disabled… If alcoholism or drug addiction… Would be a contributing factor material to the determination that the individual is disabled. The issue which must be considered and determined is whether the Claimant would continue to be disabled if he or she stopped using drugs, which in this case is marijuana. It must be determined whether drug addiction is material to the finding that in this case that the Claimant is disabled. In this case the Claimant has been found to be marijuana dependent by her psychiatrist's diagnosis which has been previously discussed in this Decision. A drug addiction determination is required as there is medical evidence from an acceptable medical source that establishes that the Claimant has a substance use disorder and is disabled. In this case, the Claimant's marijuana use is not her only impairment.

Claimant's drug abuse is not the only disabling impairment, thus her other remaining impairments must be examined as it has been determined that her cyclic vomiting syndrome by itself, while the Claimant is dependent upon her abusing marijuana, is disabling.

The medical records clearly document that the Claimant's cyclic vomiting is due to and related to her frequent marijuana use and is reversible or at least would improve if the Claimant ceased her drug use. The medical records amply demonstrate that on numerous occasions which are fully documented in this Decision, the Claimant was given medical advice from a treating medical source to cease using marijuana. This medical treatment directive was given by the doctors who were repeatedly treating her, and she acknowledges in those records that she understands that the marijuana use was related to her abdominal pains and cyclic vomiting. Notwithstanding this direct and candid medical advice, Claimant persisted against the medical advice of her doctors in her marijuana use. The record demonstrates that the Claimant ignored her doctor's repeated treatment determinations and recommendations that she cease marijuana use.

While the Claimant testified that several months prior to the hearing she ceased using marijuana for 2 to 3 weeks and her symptoms did not improve, this testimony in and of itself does not support a finding that her diagnosis of Marijuana Hyperemesis Syndrome is not accurate. The Claimant's Authorized Representative argued that one of the symptoms of this syndrome would be that cessation of cannabis use would resolve the symptoms. However, the Claimant's testimony regarding this limited period of abstinence in order to be persuasive must also be supported by other medical sources, such as a nurse practitioner, and/or other sources such as family member familiar with knowledge as to how the Claimant functioned during a period of abstinence. No such supporting testimony was offered. The undersigned was also troubled by Claimant's testimony and her credibility as related to her marijuana use in that she testified she used marijuana only once or twice a week, however, this testimony was not supported by medical records submitted by her treating psychiatrist, which noted that Claimant uses marijuana almost daily and has smoked 250 days in the last year.

In conclusion, due to Claimant's numerous and repeated admissions due to cyclic vomiting, the finding that no work would be available for an individual with this type of hospital ER and admit record, the fact that marijuana cessation would likely improve her condition based upon the medical opinions of the doctors who treated the Claimant on numerous occasions as documented in this Decision, it is determined that Drug Addiction is material and thus requires a finding that the Claimant is not disabled.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law finds Claimant **not** disabled for purposes of the MA-P benefit program.

Accordingly, It is ORDERED that the Department's determination is AFFIRMED.

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

Date Signed: **12/9/2014**

Date Mailed: **12/9/2014**

LMF / tm

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 48909-8139

cc: [redacted]