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

IN THE MATTER OF:

[redacted]

Reg. No.: 2015-27
Old Reg. No.: 2014-11834
Issue No.: 2009
Case No.: [redacted]
Hearing Date: March 26, 2014
County: Gladwin

ADMINISTRATIVE LAW JUDGE: Vicki Armstrong

HEARING DECISION

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to the Claimant's Authorized Hearing Representative's (AHR) timely Request for Rehearing/Reconsideration of the Hearing Decision generated by the assigned Administrative Law Judge (ALJ) at the conclusion of the hearing conducted on March 26, 2014, and mailed on June 12, 2014, in the above-captioned matter.

The Rehearing and Reconsideration process is governed by the Michigan Administrative Code, Rule 400.919, *et seq.*, and applicable policy provisions articulated in the Bridges Administrative Manual (BAM), specifically BAM 600, which provide that a rehearing or reconsideration must be filed in a timely manner consistent with the statutory requirements of the particular program or programs that is the basis for the claimant's benefits application, and **may** be granted so long as the reasons for which the request is made comply with the policy and statutory requirements.

This matter having been reviewed, an Order Granting Reconsideration was mailed on November 10, 2014.

ISSUE

Whether the Department properly determined that Claimant was not disabled for purposes of the Medical Assistance (MA) benefit programs?

FINDINGS OF FACT

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

1. Findings of Fact No. 1 through 6 under Registration Number 2014-11834 are incorporated by reference.

2. On March 26, 2014, a hearing was held resulting in a Hearing Decision mailed on June 12, 2014, which found the Claimant was not disabled.

3. On July 11, 2014, Claimant's authorized representative requested reconsideration/rehearing.

4. The Request for Rehearing/Reconsideration was GRANTED.

CONCLUSIONS OF LAW

In the instant case, Claimant requested rehearing/reconsideration asserting misapplication of policy that would impact the outcome of the original hearing decision.

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a). The person claiming a physical or mental disability has the burden to establish it 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). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant 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).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (e.g., age, education, and work experience) to determine if an individual can 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 to 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). If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3 to Step 4. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1).

An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). 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). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability. 20 CFR 416.927(e).

As outlined above, the first step looks at the individual's current work activity. In the record presented, Claimant last worked in 1999, and is not involved in substantial gainful activity. Therefore, she is not disqualified from receiving disability benefits under Step 1.

The severity of the individual's alleged impairment(s) is considered under Step 2. The individual 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 916.920(a)(4)(ii); 20 CFR 916.920(b). 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 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b). Examples 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. *Id.*

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 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). 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).

In the present case, Claimant alleges disability due to diabetes mellitus type 1 – insulin dependent, diabetic ketoacidosis, retinopathy, lumbago, lumbar spine degenerative disc disease, cervicalgia deep vein thrombosis, obstructive sleep apnea, urinary tract infection, methicillin sensitive Staph aureus, peripheral neuropathy, gastroparesis, fibromyalgia, depression, restless leg syndrome, arthritis, scoliosis, osteoarthritis, hypertension, mitral valve prolapse and severe depression.

In support of her claim, older records from as early as 2003 were submitted, which document treatment/diagnosis for diabetes mellitus, fibromyalgia, lumbago, lumbar spine degenerative disc disease, cervicalgia, and depression.

On September 10, 2010, Claimant's treating physician completed a Medical Examination Report on behalf of the department. Claimant was diagnosed with fibromyalgia, diabetes mellitus type 1 – insulin dependent uncontrolled, obstructive sleep apnea, osteoarthritis, restless leg syndrome, depression gastroesophageal reflux disease, chronic lumbago, chronic nausea and vomiting and generalized anxiety. The physician noted Claimant's gait was slow but steady with a single point cane used on the right side. The physician opined Claimant's condition was stable but she was unable to meet her own needs in the home. She required assistance with mobility and transferring as well as household chores.

A screening by Community Mental Health on 10/12/11, indicated a diagnosis of: Axis I: Major depressive disorder, recurrent, moderate; Axis II: none; Axis III: none; Axis IV: problem with primary support group; Axis V: GAF=45. Claimant only had one appointment and failed to keep the follow-up appointment and did not return calls.

On August 8, 2012, Claimant was admitted to the hospital after presenting to the emergency department with nausea and vomiting for the past three days. She was admitted and started on an insulin drip. She was given IV Reglan and Zofran for her nausea. Her blood sugars came down and her anion gap closed. She was discharged in stable condition on August 10, 2012, with a diagnosis of diabetic ketoacidosis.

On November 6, 2012, Claimant was admitted with hyperglycemia and ketoacidosis. She also had dehydration and hypomagnesemia. She was treated with IV insulin and IV fluids. She also received IV antibiotics for her abnormal urine. She was discharged on November 8, 2012, with a diagnosis of: diabetic ketoacidosis, urinary tract infection, dehydration, hypomagnesemia, iron deficiency anemia, type 1 diabetes, fibromyalgia, chronic back pain, scoliosis, gastroparesis and elevated LFTs.

Claimant presented to the emergency department on November 18, 2012, for a suicide attempt. She has a history of diabetes mellitus and a history of chronic pain syndrome. She stated she got tired of the pain. Because of this, she stopped taking her insulin which she was hoping she would go into diabetic ketoacidosis and pass. Upon emergency department evaluation, her blood sugar was noted to be 703, and she was admitted to the hospital. Claimant was discharged on 11/20/12 with a diagnosis of: suicide attempt, resolved (mood disorder secondary to pain); mood disorder secondary to pain; hyperglycemia; diabetes mellitus, chronic pain and fibromyalgia.

On November 23, 2012, Claimant presented as a new patient to Dr. Tanasescu-Koga for follow-up of a hospitalization for diabetic ketoacidosis and chronic pain syndrome. The physician indicated Claimant is actively suicidal, refusing insulin unless her chronic pain syndrome is adequately addressed. The physician recommended Claimant be wheeled down to the emergency room immediately for lab work as well as insulin. Claimant initially refused, vehemently refused any kind of treatment, but upon further discussion, she did accept being taken to the ER and treated, pending that she would be admitted and would see Dr. Danawaia.

Claimant was admitted for a suicide attempt, hyperglycemia, type 1 diabetes, fibromyalgia and chronic back pain on November 23, 2012. Claimant stated she wanted to end her life because of pain and not taking her insulin. She believes that she cannot take her insulin and wants herself to pass by going into DKA. Upon stabilization of the medical problem with hypoglycemia, she will be managed by psychiatry for further evaluation. Claimant was discharged in stable condition on 11/24/12, with a diagnosis of: hyperglycemia, type 1 diabetes, dehydration, chronic pain and fibromyalgia.

An emergency screening by Community Mental Health on 11/23/12 indicated a diagnosis of: Axis I: Major depressive disorder, recurrent, moderate; Axis II: none; Axis III: none; Axis IV: Economic problems, problem with primary support group, and other psychosocial and environmental problems; Axis V: GAF=25. Claimant stated she does not want to live due to chronic pain.

During an office visit on November 29, 2012, that Claimant was following up with a Dr. Danawaia after a hospitalization for suicidal ideations and diabetic ketoacidosis. The physician noted Claimant had stopped taking insulin because she was not able to get her pain medications and she did not want to live in pain.

Claimant sought services at Community Mental Health on December 20, 2012. Claimant has a history of depression, which may be related to her poor physical health and chronic pain. She does not find joy in living. She has had thoughts that pain would end if she stopped using insulin and died. Twice in the past year she has stopped her insulin, but sought medical care. She does not feel hopeful about life. Sleep and appetite are negatively impacted. She becomes agitated easily. Diagnosis: Axis I: Major depressive disorder, recurrent, moderate; Axis II: none; Axis III: Diabetes ketoacidosis type 1, uncontrolled; Axis IV: Economic problems, problem with primary support group, and problem related to social environment; Axis V: GAF=40.

On February 5, 2013, Claimant presented to the emergency department complaining of abdominal pain, nausea, vomiting and a blood sugar too high to be read at home. Her glucose in the ER was found to be over 660. She has a history of uncontrolled diabetes. She was admitted to the progressive care unit, started on an insulin drip, given IV fluids and glucose was monitored closely. Over the subsequent 24 hours, glucose normalized and she was feeling better. She was discharged on 2/6/13, with a diagnosis of: Hyperglycemia, insulin dependent diabetes mellitus, chronic pain, right knee pain status post recent injury, hyponatremia, elevated liver enzymes, anemia and depression.

An emergency screening by Community Mental Health on 4/16/13 indicated a diagnosis of: Axis I: Major depressive disorder, recurrent, moderate; nicotine dependence; polysubstance dependence; Axis II: none; Axis III: none; Axis IV: Economic problems, problem with primary support group, and other psychosocial and environmental problems; Axis V: GAF=24. Claimant stated she does not want to live due to chronic pain.

Claimant was admitted to the hospital on April 17, 2013, after presenting to the emergency department with generalized weakness, an inability to ambulate and tremors in her upper extremities. On evaluation, she was found to have a urinary tract infection. Claimant was discharged on April 22, 2013, able to ambulate and tolerating orals with no history of fever overnight. Discharge diagnosis: Generalized weakness with the inability to ambulate, resolved; Acute Escherichia coli urinary tract infection; Diabetes mellitus type 1, uncontrolled; severe depression; chronic backache; urinary dysfunction and thyroid dysfunction.

Claimant had been recently discharged on 5/31/13, and was readmitted on 6/2/13, for the same problems, weakness of the lower extremities, shaking of the lower extremities and difficulty ambulating because of the weakness and shaking. At home she walks with a walker. Claimant wished to be assessed as do not resuscitate. She was discharged on 6/4/13, with a diagnosis of: restless leg syndrome, diabetes mellitus uncontrolled, urinary tract infection and severe depression.

On August 8, 2013, Claimant underwent a mental status evaluation by the Disability Determination Service. Diagnosis: Axis I: Major depressive disorder, severe, recurrent, without psychotic features; Axis II: none; Axis III: Diabetes, fibromyalgia, neuropathy, chronic pain and scoliosis; Axis IV: Problems with primary support, social isolation, unemployment; Axis V: GAF=50. Prognosis is guarded. The examining psychologist opined Claimant appears to have a depressed mood for most of the day, diminished interest in activities, and difficulty sleeping. It appears she has recurrent thoughts of death, as she would prefer to be dead rather than be alive due to her chronic pain. At this time, it appears she will have difficulty sustaining consistent work based on her physical and mental health difficulties.

Claimant presented to the emergency department on November 18, 2013, with intractable vomiting and nausea. She was also noted to be slightly alkalotic secondary to nausea and vomiting. Her liver enzymes were elevated. She was stabilized and given IV fluids. She was continued on antinausea medications and her proton pump inhibitor dose was doubled. She was discharged home in stable condition.

On November 26, 2013, Claimant presented to the emergency department feeling “weird.” She explained she usually gets this feeling right before she goes into diabetic ketoacidosis. She had not taken her insulin due to her nausea. During the hospital course, she was hydrated with IV fluids and restarted on her Lantus with a sliding scale. In addition, she was found to be hypotensive, with her systolic blood pressure in the 70s and 80s. She received several fluid boluses. She contributed the weird feeling to her low blood pressure. Her Clonidine was discontinued. Her systolic blood pressure was in the low 100’s at discharge. She was discharged home in stable condition on 11/28/13, with a diagnosis of: nausea, resolved; hypotension likely secondary to blood pressure medication; type 1 diabetes better controlled; chronic back pain and fibromyalgia better controlled, depression and benign hypertension.

On December 2, 2013, presented to the emergency department with nausea and vomiting. In the ED, her beta hydroxybutyrate elevated at 5.11, sugar at 332, BUN 4, creatinine 0.4, electrolytes were basically normal. Liver enzymes were normal. She was admitted for observation. During her hospital stay, she was given fluids and insulin for coverage. Sugars came down. She started doing better. She started on clear liquids and improved. She had Phenergan added. She was discharged on 12/4/13, with a diagnosis of: abdominal pain, mild DKA, nausea and vomiting, intractable back pain, neuropathy, depression, history of gastroesophageal reflux disease, and diabetes gastroparesis.

Claimant presented to the emergency department on January 11, 2014, with sepsis. Claimant has a known history of insulin-dependent diabetes with gastroparesis. She has persistent nausea and vomiting that required a Zofran infusion as an outpatient through a PICC line that was placed a week prior to her admission on her right arm. She was admitted with sepsis and found to be bacteremic with methicillin sensitive Staph aureus and bacteriuria as well, found to have infected right PICC line catheter sit with redness, erythema, tenderness and puffiness and she received IV antibiotic therapy initially with Vancomycin and Rocephin. She was febrile with peripheral leukocytosis. The PICC line from her right arm was removed and a new PICC line was placed on the left arm. She was receiving IV hydration, potassium, magnesium and calcium supplements for her low electrolyte levels. She was started on anticolagulation with heparin and then Coumadin. She had a supratherapeutic INR level that required her Coumadin level to be titrated. She was discharged on January 20, 2014, with a diagnosis of: Methicillin sensitive Staph aureus bacteremia secondary to infected PICC line, deep vein thrombosis of the right arm pain at the site of the PICC line, hypocalcemia that was resolved, urinary tract infection with methicillin sensitive Staph aureus, and insulin-dependent diabetes with gastroparesis.

On March 25, 2014, a Medical Examination Report was completed on behalf of the Department. Claimant is diagnosed with chronic pain syndrome, peripheral neuropathy, anemia and major depression. The form indicates Claimant's condition is stable and she can meet her own needs in the home but requires assistance with dishes, laundry and vacuuming. She has no mental limitations. Physically she is limited to occasionally lifting up to 20 pounds, standing/walking less than 2 hours and sitting less than 6 hours in an 8-hour workday, and no reaching. It is unclear from the form who conducted the actual exam and as a result the form is given little weight.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). Based on the medical evidence, Claimant has presented medical evidence establishing that she does have some physical and mental limitations on her ability to perform basic work activities. The medical evidence has established that Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, Claimant is not disqualified from receipt of MA-P benefits under Step 2 and the ALJ erred in finding otherwise.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The evidence confirms treatment/diagnoses of diabetes mellitus type 1 – insulin dependent, diabetic ketoacidosis, retinopathy, lumbago, lumbar spine degenerative disc disease, cervicalgia deep vein thrombosis, obstructive sleep apnea, urinary tract infection,

methicillin sensitive Staph aureus, peripheral neuropathy, gastroparesis, fibromyalgia, depression, restless leg syndrome, arthritis, scoliosis, osteoarthritis, hypertension, mitral valve prolapse and severe depression.

Listing 1.00 (musculoskeletal system), Listing 4.00 (cardiovascular system), Listing 5.00 (digestive system), Listing 12.00 (mental disorders) and Listing 14.00 (immune system disorders) were considered in light of the objective evidence. Based on the foregoing, it is found that Claimant's impairment(s) do not meet the intent and severity requirement of a listed impairment; therefore, Claimant cannot be found disabled at Step 3. Accordingly, the Claimant's eligibility is considered under Step 4. 20 CFR 416.905(a).

The fourth step in analyzing a disability claim requires an assessment of the individual's residual functional capacity ("RFC") and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if he/she can perform past relevant work. *Id*.; 20 CFR 416.960(b)(3). 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). 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). RFC is assessed based on impairment(s) and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

This step examines the physical and mental demands of the work done by Claimant in the past. 20 CFR 416.920(f). Claimant has a history of less than gainful employment. As such, there is no past work for Claimant to perform, nor are there past work skills to transfer to other work occupations. Accordingly, Step 5 of the sequential analysis is required.

The fifth and final step of the analysis applies the biographical data of the applicant to the Medical Vocational Grids to determine the residual functional capacity of the applicant to do other work. 20 CFR 416.920(g). See *Felton v DSS* 161 Mich. App 690, 696 (1987). Once Claimant reaches Step 5 in the sequential review process, Claimant has already established a *prima facie* case of disability. *Richardson v Secretary of Health and Human Services,* 735 F2d 962 (6th Cir, 1984). At that point, the burden of proof is on the state to prove by substantial evidence that Claimant has the residual functional capacity for substantial gainful activity.

Claimant credibly testified that she has a limited tolerance for physical activities and is unable to stand or sit for lengthy periods of time. Claimant stated she uses a cane and alternatively a wheelchair for ambulation.

Claimant is 47 years old, with a high school education. A review of Claimant's medical records support her testimony of using an assistive device back to 2003, from an injury in 1999. Moreover, Claimant's psychiatric records document suicidal ideation back to 2011. In addition, Claimant's medical records are consistent with her testimony that she is unable to engage in even a full range of sedentary work on a regular and continuing basis. 20 CFR 404, Subpart P. Appendix 11, Section 201.00(h). See Social Security Ruling 83-10; *Wilson v Heckler*, 743 F2d 216 (1986).

The Department 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.

As a result, the ALJ's determination which found Claimant not disabled at Step 2 (non-severe impairment), is VACATED and the Department's determination which found Claimant is not disabled is **REVERSED**.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, it is determined that Administrative Law Judge erred in affirming the Department's determination which found Claimant not disabled.

Accordingly, it is ORDERED:

1. The ALJ's Hearing Decision mailed on June 12, 2014, under registration Number 14-007016 which found Claimant not disabled is VACATED.

2. The Department's determination which found Claimant not disabled is **REVERSED**.

3. The Department shall initiate processing of the May 15, 2013, application to include any applicable requested retroactive months, to determine if all other non-medical criteria are met and inform Claimant of the determination in accordance with Department policy.

4. The Department shall supplement for any lost benefits (if any) that Claimant was entitled to receive if otherwise eligible and qualified in accordance with Department policy.

5. The Department shall review Claimant's continued eligibility in December, 2015, in accordance with Department policy.

IT IS SO ORDERED.

Vicki Armstrong
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

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

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

VLA/las

NOTICE: The law provides that within 30 days of receipt of the this Decision, the Claimant may appeal it to the circuit court for the county in which he/she lives or the circuit court in Ingham County.

cc: [redacted]