

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

IN THE MATTER OF:

[REDACTED]

Reg. No.: 2014-28623
Issue No(s): 2009
Case No.: [REDACTED]
Hearing Date: June 12, 2014
County: Ottawa County DHS

ADMINISTRATIVE LAW JUDGE: Colleen Lack

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 June 12, 2014, from Lansing, Michigan. Participants on behalf of Claimant included [REDACTED] the Claimant, and [REDACTED], Authorized Hearing Representative. Participants on behalf of the Department of Human Services (Department) included [REDACTED] Eligibility Specialist and Hearing Facilitator.

During the hearing, Claimant waived the time period for the issuance of this decision, in order to allow for the submission of additional medical evidence. The evidence was received, reviewed, and forwarded to the State Hearing Review Team ("SHRT") for consideration. The SHRT found Claimant not disabled. This matter is now before the undersigned for a final determination.

ISSUE

Whether the Department properly determined that Claimant was not disabled for purposes of the Medical Assistance (MA) 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 applied for Medicaid (MA-P) and retroactive MA-P.
2. On November 13, 2013, the Medical Review Team (MRT) found Claimant not disabled.
3. On November 26, 2013, the Department notified Claimant of the MRT determination.

4. On February 19, 2014, the Department received Claimant's timely written request for hearing.
5. On May 2, 2014, and July 14, 2014, the State Hearing Review Team (SHRT) found Claimant not disabled.
6. Claimant alleged physical disabling impairments of back and neck pain from bulging discs and scoliosis, lyme disease, fibromyalgia, irregular heartbeat, arthritis and vertigo.
7. Claimant alleged mental disabling impairments due to depression and post-traumatic stress disorder (PTSD).
8. At the time of hearing, Claimant was 46 years old with a [REDACTED], birth date; was 5' in height; and weighed 180 pounds.
9. Claimant has a high school education and has a work history of plastic molding factory work.
10. Claimant's impairments have lasted, or are expected to last, continuously for a period of 12 months or longer.

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.

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 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, 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 (i.e. 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 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 three to step four. 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 416.945(a)(1). An individual's residual functional capacity assessment is evaluated at both steps four and five. 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).

As outlined above, the first step looks at the individual's current work activity. In the record presented, the Claimant is not involved in substantial gainful activity. Therefore, Claimant is not ineligible for disability benefits under Step 1.

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). 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). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921(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 back and neck pain from bulging discs and scoliosis, lyme disease, fibromyalgia, irregular heartbeat, arthritis, vertigo, depression and post-traumatic stress disorder (PTSD).

On March 30, 2014 Claimant was seen in the Emergency Department for legs feeling heavy. The doctors could not appreciate any lower extremity edema. A nebulizer treatment resolved Claimant's dyspnea. Diagnosis was COPD exacerbation.

A March 28, 2014, record from [REDACTED] documents treatment for obesity, chronic smoker's cough and multiple tiny lung nodules likely of no concern.

On December 23, 2013, Claimant attended a consultative psychological examination. Claimant's diagnoses were: somatic symptom disorder with predominant pain, pervasive, moderate; PTSD with delayed expression; unspecified neurocognitive disorder; other specified personality disorder; persistent depressive disorder (dysthymia) with anxious distress, moderate; and unspecified schizophrenia spectrum

and other psychotic disorder. Based on the examination, it appeared Claimant was capable of understanding simple, concrete instructions/directions meant to lead to the completion of a task; her retention may be compromised by mental health issues and neuro-cognitive issues; her follow through may be compromised by a combination of her mental and physical health issues as they appear to be restricting her ability to perform simple, repetitive physical tasks.

A September 25, 2013 Psychosocial Assessment documents diagnoses of PTSD, psychotic disorder, and mild mental retardation. Claimant's full scale IQ was 63. Claimant's Global Assessment of Functioning (GAF) was 52. Progress notes documented significant changes with mental status, psychiatric risk, health or safety through January 2014.

Claimant was hospitalized from August 6, 2013 through August 10, 2013, with discharge diagnoses of: atypical chest pain, resolved, unclear etiology; leukocytosis, acute on chronic, unclear etiology; depression/anxiety/psychosis, appears stabilized and subjectively to baseline; subjective dyspnea, transient resolved; chronic pain syndrome, stable and at baseline over years; possible pulmonary nodule; possible personality changes, subjectively resolved; recent diagnosis of Lyme disease which appears equivocal; nonspecific mediastinal adenopathy; possible coronary artery disease, patient declined stress test.

Records from [REDACTED] document treatment for auditory and visual hallucinations, pelvic pain, internal hemorrhoid, Lyme disease (bartonella infection), hyperlipidemia, fibromyalgia muscle pain, impaired fasting glucose, dysuria and trouble sleeping.

Claimant was seen by an orthopedic and sports medicine doctor for neck pain and right arm pain. An October 7, 2012 MRI showed mild broad based posterior disc bulging at C5-6 level but was otherwise unremarkable. The October 10, 2012 assessment indicates idiopathic scoliosis, rib torsion and neck pain. The January 9, 2013 assessment added limb pain to the prior diagnoses. The January 29, 2013 assessment diagnoses were idiopathic scoliosis, neck pain, limb pain, and paresthesia. During the March 25, 2013 office visit EMG testing was reviewed, which was normal for the right upper extremity. Assessment diagnoses were unchanged. A May 30, 2013, x-ray showed degenerative disc disease of the lumbar spine. The May 30, 2013 progress note again documented: Claimant's descriptions of her neck and right arm pain, as well as numbness and tingling in legs feet and toes; Claimant's report that it is alleviated with use of the TEN's unit; and the trials of various medications. Assessment diagnoses included idiopathic scoliosis, neck pain, limb pain, sacroiliac dysfunction and lumbago.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, Claimant has presented medical evidence establishing that she does have some limitations on the ability to perform basic work activities. The medical evidence has established that the 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, 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, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The evidence confirms diagnosis and treatment of multiple impairments including: COPD, atypical chest pain, leukocytosis, chronic pain syndrome, Lyme disease, possible coronary artery disease, fibromyalgia muscle pain, idiopathic scoliosis, neck pain, limb pain, sacroiliac dysfunction, lumbago, somatic symptom disorder with predominant pain, PTSD, and depression/anxiety/psychosis with auditory and visual hallucinations.

Based on the objective medical evidence, considered listings included: 1.00 Musculoskeletal System, 3.00 Respiratory System, 4.00 Cardiovascular System, 11.00 Neurological, and 12.00 Mental Disorders.

It appears that the medical evidence meets or equals the intent and severity requirements of listings 12.03 and/or 12.05. The consultative psychological examination report indicates that while Claimant was capable of understanding simple, concrete instructions/directions meant to lead to the completion of a task; her retention may be compromised by mental health issues and neuro-cognitive issues; her follow through may be compromised by a combination of her mental and physical health issues as they appear to be restricting her ability to perform simple, repetitive physical tasks. The CMH records documented a full scale IQ of 63 as well as significant changes with mental status, psychiatric risk, health or safety through January 2014. The medical treatment records are also supportive of Claimant's mental health impairments. Accordingly, the Claimant is found disabled at Step 3.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Claimant disabled for purposes of the MA benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is **AFFIRMED**.

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. Initiate a review of the application dated October 3, 2013, if not done previously, to determine Claimant's non-medical eligibility. The Department shall inform Claimant of the determination in writing. A review of this case shall be set for September 2015.

2. Issue the Claimant any supplement she may thereafter be due.



Colleen Lack
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: August 11, 2014

Date Mailed: August 11, 2014

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

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

MAHS may grant a party's Request for Rehearing or Reconsideration when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion;
- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the client;
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The party requesting a rehearing or reconsideration must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date this Hearing Decision is mailed.

A written request may be faxed or mailed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

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

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

201428623/CL

CL/hj

cc:

