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

IN THE MATTER OF:

Reg. No.:	15-004942
Issue No.:	4009
Case No.:	
Hearing Date:	May 14, 2015
County:	Barry

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 May 14, 2015, from Lansing, Michigan. Participants on behalf of Claimant included the Claimant, and , . Participants on behalf of the Department of Health and Human Services (Department) included , Assistance Payments Supervisor, and , Eligibility Specialist.

ISSUE

Whether the Department properly determined that Claimant was not disabled for purposes of the Medical Assistance (MA) and/or State Disability Assistance (SDA) 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. On December 15, 2014, Claimant applied for SDA.

2. On January 6, 2015, the Medical Review Team (MRT) found Claimant not disabled.

3. On January 9, 2015, the Department notified Claimant of the MRT determination.

4. On March 26, 2015, the Department received Claimant's timely written request for hearing.

5. Claimant alleged disabling impairments including shaking, eye changes, leg problems, knee sprain, swelling, balance problems, injured left pointer finger,

memory and concentration problems, depression, anxiety, bipolar disorder, and panic attacks.

6. At the time of hearing, Claimant was ██ years old with an ██████████, birth date; was 5'4" in height; and weighed 295 pounds.

7. Claimant completed the 8th grade, earned a GED, attended some college, and has a work history including gas station late shifts.

8. Claimant's impairments have lasted, or are expected to last, continuously for a period of 90 days or longer.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and 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 Department of Human Services) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

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 disabling impairments including shaking, eye changes, leg problems, knee sprain, swelling, balance problems, injured left pointer finger, memory and concentration problems, depression, anxiety, bipolar disorder, and panic attacks. While some older medical records were submitted and have been reviewed, the focus of this analysis will be on the more recent medical evidence.

A [redacted], Neurocognitive Examination report listed findings of: abnormal intellectual profile, abnormal achievement profile, abnormal neurocognitive study,

abnormal psychological profile, and variability in performance effort. Clinical impressions were: by history and not related to motor vehicle collision (MVC) learning disability and attention deficit disorder, bipolar disorder/mood disorder, and personality difficulties; TBI associated with MVC; borderline to mild cognitive difficulties associated with the MVC/closed head injury; and adjustment disorder with mixed features associated with MVC exacerbating pre-existing mood disorder.

[REDACTED] records from [REDACTED] through [REDACTED], document diagnoses including major depressive disorder, generalized anxiety disorder, cannabis dependence, and borderline personality disorder. Rule out diagnoses included bipolar disorder, intermittent explosive disorder, and antisocial personality disorder. Claimant's Global Assessment of Functioning (GAF) remained at 30 during this time period. Noted issues included Claimant often threatens her father, was on probation for attempting to run her boyfriend over with a vehicle, has difficulty sleeping, constantly worries, self-harm ideation, memory problems, irritability, loses her temper easily, poor concentration, and psychiatric hospitalizations for severe aggression.

A [REDACTED], emergency department/urgent care provider report documented treatment for a cut of the left index finger.

A [REDACTED], neurocognitive consultation/recheck indicated: pre-existing learning disorder and attention deficit disorder, personality difficulties, and bipolar disorder; associated with/exacerbated by MVC status post TBI resulting in mild cognitive difficulties, adjustment disorder, personality difficulties, and bipolar disorder; and adjustment disorder. The summary and plan indicated Claimant requires ongoing conjoint treatment with psychiatry and psychology through [REDACTED] to manage aggression and emotional discord.

On [REDACTED], Claimant returned to the emergency department/urgent care provider because she was worried about the finger wound being painful and not healed all the way. Claimant's difficulties interacting with the staff were noted.

An [REDACTED], lab report indicates a left calf mass was removed and found to be a lipoma with focal fat necrosis.

An [REDACTED], treatment record noted diagnoses of bladder incontinence, frequent urination, cystic acne, and chronic diarrhea.

Letters from [REDACTED] document that Claimant had been placed on probation for disruptive behavior in [REDACTED], and indicate another situation occurred in [REDACTED]. On [REDACTED], Claimant was suspended effective immediately based on disruptive activity, failure to comply with official requests, and violence.

[REDACTED] patient health summaries noted active problems including chronic headaches, GERD, hypertension, asthma, bipolar disorder,

depression, anxiety, head injury, contusion of left knee, left leg pain, dermoid cyst of leg, laceration of hand, and irritable bowel syndrome. These records also indicate Claimant underwent an appendectomy for acute appendicitis and gangrenous appendicitis with a discharge date of [REDACTED].

A [REDACTED], emergency department/urgent care provider report documented treatment for abdominal pain.

A [REDACTED], statement from Claimant's father described his observations of Claimant's worsening condition.

[REDACTED] records from [REDACTED] through [REDACTED], document diagnoses including major depressive disorder, generalized anxiety disorder, and bipolar disorder. Claimant's GAF remained at 30 in [REDACTED] and was not included on the more recent records. In part, the [REDACTED] records noted Claimant's ongoing difficulties at home and a recent hospitalization at [REDACTED]

A [REDACTED], family medicine and eye doctor records documents that Claimant was seen for nystagmus and blurred vision.

Part of a [REDACTED], report from the treating mental health provider was submitted documenting diagnoses of major depressive disorder and generalized anxiety disorder. It was noted that Claimant had a significant vehicle accident in late [REDACTED] and began experiencing severe mood swings including being verbally threatening and physically aggressive. Three inpatient psychiatric hospitalizations were noted, [REDACTED], [REDACTED], and [REDACTED]. Regarding daily functioning, it was noted that a letter from February 25, 2015, was supposed to be attached. It also appears there was at least one more page of this report that was not submitted, which would be expected to include any further diagnosis information and the name and signature of the person that wrote this report.

[REDACTED], occupational therapy records documented treatment for left index finger chronic regional pain syndrome. Claimant reported the occupational therapy has been very helpful. The most recent diagnosis was left index finger paresthesia with possible complex regional pain syndrome versus old digital nerve injury.

[REDACTED] treatment records documented that Claimant was seen for conditions including right knee contusion, visual changes, chronic pain, and sprain of left knee.

An [REDACTED], x-ray of the left knee showed a density consistent with a probable non-ossifying fibroma or similar probably benign distal femoral shaft lesion as well as minimal spurring at the inferior patellar articular aspect and questionable at the anteromedial aspect of the medial manlacal compartment.

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, or can be expected to last, continuously for 90 days; therefore, the Claimant is not disqualified from receipt of SDA 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 numerous conditions including history of traumatic brain injury, learning disorder and attention deficit disorder, personality difficulties, bipolar disorder, mild cognitive difficulties, adjustment disorder, bladder incontinence, chronic headaches, GERD, hypertension, asthma, depression, anxiety, left leg pain, dermoid cyst of leg, laceration of hand, irritable bowel syndrome, nystagmus, blurred vision, and left index finger chronic regional pain syndrome.

Based on the objective medical evidence, considered listings included 12.00 Mental Disorders. Claimant's credible testimony and the medical records support that Claimant meets or equals the criteria for listing 12.08 Personality Disorder. Claimant has a documented history of deeply ingrained, maladaptive patterns of behavior as required as well as marked restrictions of activities of daily living, marked difficulties in maintaining social functioning, and marked difficulties in maintaining concentration, persistence or pace. Accordingly, the Claimant is found disabled at Step 3.

In this case, the Claimant is found disabled for purposes SDA benefits as the objective medical evidence establishes a physical or mental impairment that met the federal SSI disabiltiy standard with the shortened duration of 90 days. In light of the foregoing, it is found that Claimant's impairments did preclude work at the above stated level for at least 90 days.

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 SDA benefit program.

DECISION AND ORDER

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

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE OF MAILING OF THIS DECISION AND ORDER:

1. Initiate a review of the application dated December 15, 2014, for SDA, 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 June 2016.

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

Colleen Lack
Administrative Law Judge
for Nick Lyon, Director
epartment of Health and Human Services

Date Signed: **5/29/2015**

Date Mailed: **5/29/2015**

CL/jaf

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: