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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-005225
Issue No.: 4009
Case No.: [redacted]
Hearing Date: May 21, 2015
County: Wayne-District 18 (Taylor)

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

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 21, 2015, from Detroit, Michigan. Participants on behalf of Claimant included Claimant and [redacted], Claimant's mother. Participants on behalf of the Department of Health and Human Services (Department) included [redacted], Medical Contact Specialist.

ISSUE

Whether the Department properly determined that Claimant was not disabled for purposes of the State Disability Assistance (SDA) 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 December 26, 2014, Claimant submitted an application for public assistance seeking SDA benefits.

2. On February 25, 2015, the Medical Review Team (MRT) found Claimant not disabled (Exhibit A, pp. 1-6).

3. On March 2, 2015, the Department sent Claimant a Notice of Case Action denying the application based on MRT's finding of no disability (Exhibit A, pp. 80-83).

4. On April 8, 2015, the Department received Claimant's timely written request for hearing.

5. Claimant alleged physical disabling impairment due to chronic obstructive pulmonary disease (COPD), gout, diabetes, carpal tunnel syndrome (CTS), arthritis, and sleep apnea.

6. Claimant alleged mental disabling impairment due to depression.

7. On the date of the hearing, Claimant was [redacted] years old with a [redacted], birth date; he is [redacted] in height and weighs about [redacted] pounds.

8. Claimant received a GED.

9. Claimant has an employment history of work as laborer.

10. 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 Human Services Bridges Administrative Manual (BAM), Department of Human Services Bridges Eligibility Manual (BEM), and Department of Human Services Reference Tables Manual (RFT).

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 disabled person is eligible for SDA. BEM 261 (July 2014), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

To determine whether an individual is disabled for SSI purposes, the trier of fact must apply a five-step sequential evaluation process and consider the following:

> (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)(1) and (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).

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 SGA, then the individual must be considered 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 for SDA 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 90 days. 20 CFR 416.922; BEM 261, p. 2.

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 mean 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. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, 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 v Bowen,* 880 F2d 860, 862-863 (CA 6, 1988), citing *Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985).

In the present case, Claimant alleges physical disabling impairment due to COPD, gout, diabetes, CTS, arthritis, sleep apnea, and mental disabling impairment due to depression. The medical evidence presented at the hearing was reviewed and is summarized below.

Claimant's medical documents showed diagnoses of acute respiratory failure, acute liver failure on March 30, 2014, acute renal failure on March 30, 2014, obesity, diabetes mellitus, obstructive sleep apnea, elevated troponin, smoking history, COPD with acute exacerbation, gout, shortness of breath, pulmonary hypertension (secondary), thrombocytopenia, and hypertension (Appendix A, pp. 11, 17-18, 22-23, 27-28, 35-36, 42, 46). Claimant's past medical history included a myocardial infarction (Exhibit A, p. 28). An April 21, 2014, progress note from Claimant's primary care physician noted normal back range of motion, knee pain and swelling (Exhibit A, pp. 11-16). At April 28, 2014, October 3, 2014, and October 29, 2014 office visits, the doctor noted dyspnea on exertion, wheezing and COPD, lower extremity edema, hypertension, chronic artery disease, arthralgia, and diabetes mellitus (Exhibit A, pp. 17-21, 37, 43). A gout flare-up was noted at the June 3, 2014, August 29, 2014, and October 29, 2014 office visits (Exhibit A, pp. 22-26, 32-34, 41-45). Neck and back pain was positive at the July 28, 2014 office visit (Exhibit A, pp. 27-31). Claimant complained of tingling in his right hand and knee pain at the October 3, 2014 office visit (Exhibit A, pp. 35-40). Knee pain, back pain and gout were Claimant's complaints at the December 1, 2014 office visit (Exhibit A, pp. 46-53). Back pain and tingling in both hands continued at the December 29, 2014 and January 30, 2015 office visits (Exhibit A, pp. 54-64).

An August 7, 2014, echocardiogram report showed that Claimant's ejection fraction was 67%, his left ventricular systolic function was normal, and he had mild diastolic dysfunction (Exhibit A, pp. 65-66). An August 29, 2014, x-ray of Claimant's right knee showed small degenerative spurs but otherwise unremarkable (Exhibit A, p. 7). A

September 4, 2014, letter from a follow-up exam with Claimant's pulmonologist showed that Claimant was using the CPAP but still feeling very tired and not sleeping well at night. Claimant complained of a lot of back pain, a recent gout attack, some leg selling, and gaining weight. (Exhibit A, pp. 8-9.) A December 5, 2014, x-ray of Claimant's lumbar spine showed small degenerative spurs on anterior aspect of L1-2 but otherwise unremarkable (Exhibit A, p. 10).

On February 13, 2015, Claimant's primary care physician submitted a letter dated February 5, 2015, indicating that Claimant was disabled due to severe sleep apnea, congestive heart failure, pulmonary hypertension, and shortness of breath. The doctor also submitted a medical examination report, DHS-49, identifying Claimant's diagnoses and chief complaints as diabetes, numbness and tingling in hands, and back pain. His weight was [redacted] pounds. In his examination of Claimant, the doctor noted that Claimant suffered from shortness of breath, chest pain on exercise, morbid obesity, cardiac dysrhythmia, right leg edema +2, pulmonary hypertension, systolic murmur, lower back pain, and depression. The doctor also noted a history of sleep apnea. The doctor found that Claimant suffered from depression with memory loss and difficulties reading and writing. The doctor indicated Claimant could (i) frequently lift less than 10 pounds, occasionally lift 10 pounds, and never lift more; (ii) stand and/or walk less than 2 hours in an 8-hour workday; and (iii) sit less than 6 hours in an 8-hour workday. (Exhibit A, pp. 67-70.)

On January 5, 2015, Claimant's psychiatrist at [redacted] since October 3, 2014, completed a psychiatric/psychological examination report, DHS-49-D, identifying Claimant as suffering from major depressive disorder, recurrent, and adjustment disorder with mixed anxiety and depression with a global assessment functioning score (GAF) of 53. The doctor noted that Claimant complained of low energy, lack of motivation, sleeping a lot, overeating, and feeling overwhelmed and hopeless. The psychiatrist also completed a mental residual functional capacity assessment, DHS-49-E, regarding Claimant's mental impairments and how they affected his activities. The psychiatrist concluded that Claimant had moderate limitations regarding his ability to (i) sustain an ordinary routine without supervision; (ii) interact appropriately with the general public; (iii) ask simple questions or request assistance; (iv) get along with co-workers or peers without distracting them or exhibiting behavioral extremes; (v) maintain socially appropriate behavior and adhere to basic standards of neatness and cleanliness; (vi) respond appropriately to change in the work setting; and (vii) be aware of normal hazards and take appropriate precautions. The psychiatrist concluded that Claimant had marked limitations regarding his ability to (i) remember locations and work-like procedures; (ii) understand and remember one or two-step instructions; (iii) understand and remember detailed instructions; (iv) carry out simple one or two step instructions; (v) carry out detailed instructions; (vi) maintain attention and concentration for extended periods; (vii) perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; (viii) work in coordination with or proximity of others without being distracted by them; (ix) complete a normal workday and worksheet without interruptions from

psychologically based symptoms and perform at a consistent pace without an unreasonable number and length of rest periods; (x) accept instructions and respond appropriately to criticisms from supervisors; (xi) travel in unfamiliar places or use public transportation; and (xii) set realistic goals or make plans independently of others. Claimant's ability to make simple work-related decisions was between moderately and markedly limited. In the remarks/comments section of the assessment, the doctor stated:

> C/t suffers from depression. He has erratic sleep that impacts his ability to maintain regular routine. He has periods of irritability and problems interacting with others. His obesity causes physical limitations and emotional problems. Poor concentration and anxiety make it difficult to follow rules and complete projects in a timely manner.

(Exhibit A, pp. 75-79.)

In consideration of the de minimus 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 90 days. 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.

Based on Claimant's diagnosis of, and treatment for, major depressive disorder, recurrent, Listing 12.00 (mental disorders), particularly 12.04 (affective disorders), was considered. Affective disorders under 12.04 are characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. The required level of severity for these disorders is met (i) when the requirements in both A and B are satisfied **or** (ii) when the requirements in C are satisfied:

> A. Medically documented persistence, either continuous or intermittent, of one of the following:
>
> 1. Depressive syndrome characterized by at least four of the following:
>
> a. Anhedonia or pervasive loss of interest in almost all activities; or
> b. Appetite disturbance with change in weight; or
> c. Sleep disturbance; or
> d. Psychomotor agitation or retardation; or
> e. Decreased energy; or
> f. Feelings of guilt or worthlessness; or
> g. Difficulty concentrating or thinking; or

h. Thoughts of suicide; or
i. Hallucinations, delusions, or paranoid thinking; or

2. Manic syndrome characterized by at least three of the following:
a. Hyperactivity; or
b. Pressure of speech; or
c. Flight of ideas; or
d. Inflated self-esteem; or
e. Decreased need for sleep; or
f. Easy distractibility; or
g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
h. Hallucinations, delusions or paranoid thinking; or

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

AND

B. Resulting in at least two of the following:
1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:
1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

In this case, Claimant was diagnosed with major depressive disorder, recurrent and adjustment disorder with mixed anxiety and depression. The January 5, 2015 mental residual functional capacity assessment and psychiatric/psychological examination report of Claimant establish that Claimant's mental condition satisfied at least four of the elements of 12.04.A.1: Claimant suffered from erratic sleep, difficulty concentrating, decreased energy, and feeling overwhelmed and hopeless. (Exhibit A, pp. 75-79).

In the mental residual functional capacity assessment of Claimant, the psychiatrist concluded that Claimant had marked limitations regarding his ability to (i) remember locations and work-like procedures; (ii) understand and remember one or two-step instructions; (iii) understand and remember detailed instructions; (iv) carry out simple one or two step instructions; (v) carry out detailed instructions; (vi) maintain attention and concentration for extended periods; (vii) perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; (viii) work in

coordination with or proximity of others without being distracted by them; (ix) complete a normal workday and worksheet without interruptions from psychologically based symptoms and perform at a consistent pace without an unreasonable number and length of rest periods; (x) accept instructions and respond appropriately to criticisms from supervisors; (xi) travel in unfamiliar places or use public transportation; and (xii) set realistic goals or make plans independently of others. Claimant's ability to make simple work-related decisions was between moderately and markedly limited. The psychiatrist also noted that Claimant had periods of irritability and problems dealing with others and, because of his condition, was unable to maintain a regular routine and to follow rules and complete projects in a timely manner. (Exhibit A, pp. 78-79.) The limitations identified by Claimant's psychiatrist result in Claimant having marked restriction in activities of daily living and marked difficulties in maintaining concentration, persistence or pace, the elements of 12.04.B.1 and B.3.

Because Claimant's mental condition satisfies four elements of 12.04A.1 and two elements of 12.04B, his mental condition is of a severity to meet or medically equal the criteria of Listing 12.04 of Appendix 1 of the Guidelines. Therefore, Claimant is disabled under Step 3 and no further analysis is required.

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 BEGIN DOING 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. Process Claimant's December 26, 2014, SDA application to determine if all the other non-medical criteria are satisfied and notify Claimant of its determination;

2. Supplement Claimant for lost benefits, if any, that Claimant was entitled to receive if otherwise eligible and qualified;

3. Review Claimant's continued eligibility in December 2015.

Alice C. Elkin
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Signed: **6/01/2015**

Date Mailed: **6/01/2015**

ACE / tlf

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]