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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-006896
Issue No.: 2009
Case No.: [redacted]
Hearing Date: June 4, 2015
County: Wayne (18)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

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; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10. After due notice, a telephone hearing was held on June 4, 2015, from Detroit, Michigan. Participants included the above-named Claimant. [redacted] testified and appeared as Claimant's authorized hearing representative (AHR). Participants on behalf of the Michigan Department of Health and Human Services (MDHHS) included [redacted] medical contact worker.

ISSUE

The issue is whether MDHHS properly denied Claimant's Medical Assistance (MA) eligibility for the reason that Claimant is not a disabled individual.

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 [redacted] Claimant applied for MA benefits, including retroactive MA benefits from June 2013.

2. Claimant's only basis for MA benefits was as a disabled individual.

3. On [redacted], the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 9-13).

4. On [redacted], MDHHS denied Claimant's application for MA benefits and mailed a Benefit Notice (Exhibits 554-555) informing Claimant of the denial.

5. On [redacted], Claimant's AHR requested a hearing disputing the denial of MA benefits (see Exhibit 553).

6. As of the date of the administrative hearing, Claimant was a 33 year old female.

7. Claimant has not earned substantial gainful activity since before the first month of benefits sought.

8. Claimant's highest education year completed was the 12th grade, via general equivalency degree.

9. Claimant has a history of semi-skilled employment, with no known transferrable job skills.

10. Claimant alleged disability based on restrictions related to diagnoses of vulvar vestibulitis, anxiety, and other psychological impairments.

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. Department policies are contained in the Department of Human Services Bridges Administrative Manual (BAM) and Department of Human Services Bridges Eligibility Manual (BEM) and Department of Human Services Reference Tables Manual (RFT).

Prior to a substantive analysis of Claimant's hearing request, it should be noted that Claimant's AHR noted special arrangements in order to participate in the hearing; specifically, a 3-way telephone hearing was requested. Claimant's AHR's request was granted and the hearing was conducted accordingly.

The Medicaid program is comprised of several sub-programs which fall under one of two categories; one category is FIP-related and the second category is SSI-related. BEM 105 (October 2010), p. 1. To receive MA under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled. *Id*. Families with dependent children, caretaker relatives of dependent children, persons under age 21 and pregnant, or recently pregnant, women receive MA under FIP-related categories. *Id*. It was not disputed that Claimant's only potential category for Medicaid eligibility would be as a disabled individual.

Disability for purposes of MA benefits is established if one of the following circumstances applies:

- by death (for the month of death);

- the applicant receives Supplemental Security Income (SSI) benefits;
- SSI benefits were recently terminated due to financial factors;
- the applicant receives Retirement Survivors and Disability Insurance (RSDI) on the basis of being disabled; or
- RSDI eligibility is established following denial of the MA benefit application (under certain circumstances).
  BEM 260 (July 2012) pp. 1-2

There was no evidence that any of the above circumstances apply to Claimant. Accordingly, Claimant may not be considered for Medicaid eligibility without undergoing a medical review process which determines whether Claimant is a disabled individual. *Id*., p. 2.

Generally, state agencies such as MDHHS must use the same definition of SSI disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally defined as the inability to do any substantial gainful activity (SGA) 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 functionally identical definition of disability is found under MDHHS regulations. BEM 260 (July 2012), p. 8.

SGA means a person does the following: performs significant duties, does them for a reasonable length of time, and does a job normally done for pay or profit. *Id*., p. 9. Significant duties are duties used to do a job or run a business. *Id*. They must also have a degree of economic value. *Id*. The ability to run a household or take care of oneself does not, on its own, constitute SGA. *Id*.

The person claiming a physical or mental disability has the burden 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 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).

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled. 20 CFR 416.920. If there is no finding of disability or lack of disability at each step, the process moves to the next step. 20 CFR 416.920 (a)(4).

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person is statutorily blind or not. "Current" work activity is interpreted to include all time since

the date of application. The 2013 monthly income limit considered SGA for non-blind individuals is $1,040.

Claimant credibly denied performing any employment since the date of the MA application; no evidence was submitted to contradict Claimant's testimony. Based on the presented evidence, it is found that Claimant is not performing SGA and has not performed SGA since the date of MA application. Accordingly, the disability analysis may proceed to step two.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the 12 month duration requirement. 20 CFR 416.920 (a)(4)(ii). The impairments may be combined to meet the severity requirement. If a severe impairment is not found, then a person is deemed not disabled. *Id*.

The impairments must significantly limit a person's basic work activities. 20 CFR 416.920 (a)(5)(c). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. *Id.* Examples of basic work activities include:

- physical functions (e.g. walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling)
- capacities for seeing, hearing, and speaking, understanding; carrying out, and remembering simple instructions
- use of judgment
- responding appropriately to supervision, co-workers and usual work situations; and/or
- dealing with changes in a routine work setting.

Generally, federal courts have imposed a de minimus standard upon claimants to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v Bowen,* 880 F2d 860, 862 (6th Cir. 1988). Similarly, Social Security Ruling 85-28 has been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirement is intended "to do no more than screen out groundless claims." *McDonald v. Secretary of Health and Human Servs.*, 795 F.2d 1118, 1124 (1st Cir. 1986).

SSA specifically notes that age, education, and work experience are not considered at the second step of the disability analysis. 20 CFR 416.920 (5)(c). In determining whether Claimant's impairments amount to a severe impairment, all other relevant evidence may be considered. The analysis will begin with a summary of presented medical documentation.

Hospital documents (Exhibits 175-203) from an encounter dated [redacted], were presented. It was noted that Claimant presented with complaints of abdominal pain and vomiting. Radiology noted no abdomen abnormalities. Claimant was provided with various medications and discharged.

Hospital documents (Exhibits 81-90; 253-261) from an encounter dated [redacted], were presented. It was noted that Claimant was treated for a sprained ankle.

Hospital documents (Exhibits 91-108; 262-277) from an encounter dated [redacted], were presented. It was noted that Claimant `was treated for spasms following an allergic reaction to compazine. Claimant's GAF was noted to be 30+. An Axis IV diagnosis of chronic mental illness and poor compliance was noted.

Hospital documents (Exhibits 44-80; 112-148) from an admission dated [redacted], were presented. It was noted that Claimant presented following an apparent overdose of Xanax, Adderall, Suboxone, and Soma. Other known problems included hepatitis C, chronic anemia, and peptic ulcer. It was noted that Claimant was in respiratory failure and intubated. It was noted that was given fluids and various meds and she stabilized. It was noted that Clamant denied that the overdose was a suicide attempt. It was noted that Claimant complained of body pain and wanted increased pain medications. It was noted that Claimant responded well to medical treatment. It was noted that Claimant was discharged to outpatient treatment. Noted discharge diagnoses included abdominal pain, hepatitis C, and overdose. A discharge date of [redacted] was noted.

Hospital documents (Exhibits 109-11); 278-280 from an admission dated [redacted], were presented. It was noted that Claimant was brought by paramedics with altered mental status following a drug overdose. It was noted that Claimant denied attempting suicide.

Hospital documents (Exhibits 149-154; 281-286) from an encounter dated [redacted], [redacted] were presented. It was noted that Claimant was treated after she tripped and hurt her ankle. Claimant reported a pain level of 10/10. An impression of no acute process was noted following ankle x-rays.

Hospital documents (Exhibits 155-157; 287-289) from an encounter dated [redacted] 2013, were presented. It was noted that Claimant appeared after she was raped. It was noted that the rapist was a friend whom Claimant invited over to use marijuana and crack.

Hospital documents (Exhibits 162-174; 294-304) from an admission dated [redacted], were presented. It was noted that Claimant was admitted after hearing voices and cutting her left wrist; the incident was noted as a suicide attempt. Discharge diagnoses included major depressive disorder, recurrent, and possible polysubstance

abuse. Claimant's GAF at discharge was noted to be 45. A discharge date of September 25, 2013, was noted.

Hospital documents (Exhibits 158-161; 290-293) from an encounter dated [redacted], were presented. It was noted that Claimant presented with a complaint of right ankle pain after falling off of her porch. Radiology was negative.

Hospital documents (Exhibits 305-319) from an encounter dated [redacted], were presented. It was noted that Claimant presented with back pain following a slip and fall. Following blood work, a diagnosis of urinary tract infection was noted.

A mental status examination report (Exhibits 25-29) dated [redacted], was presented. The report was noted as completed by a consultative psychologist. The following mental health symptoms were reported by Claimant: past psychotic episodes and suicide attempts, lack of motivation, anxiety, hallucinations, hopelessness, helplessness, and concentration difficulties. Claimant's arm was noted to be "severely scarred." Noted observations of Claimant made by the consultative examiner include the following: polite, flat affect, serious and depressed mood, logical and well organized, and slow speech spoken in low whispered tones. Diagnoses of major depressive disorder with psychotic features (recurrent and moderate-to-severe), benzodiazepine addiction (in early remission), and borderline personality disorder with cluster B traits were noted. A guarded prognosis was noted.

Hospital documents (Exhibits 204-207) from an encounter dated [redacted], were presented. It was noted that Claimant presented after falling 3-5 feet onto her back. A CT scan of Claimant's head and x-rays of Claimant's lumbar were noted as unremarkable.

Hospital documents (Exhibits 209-216) from an encounter dated [redacted], were presented. It was noted that Claimant presented after overdosing on Xanax. A diagnosis of depressive disorder was noted.

Hospital documents (Exhibits 217-219) from an encounter dated [redacted], were presented. It was noted that Claimant presented with skin swelling. A diagnosis of an unspecified allergic reaction was noted.

Hospital documents (Exhibits 220-223) from an encounter dated [redacted] were presented. It was noted that Claimant presented with a complaint of headache, ongoing for approximately 8 hours. A CT of Claimant's head was noted to be normal.

Hospital documents (Exhibits 224-232) from an encounter dated [redacted], were presented. It was noted that Claimant was brought by police after being found wandering. It was noted that Claimant was a chronic drug abuser. Claimant's GAF was noted to be 26.

Psychiatric hospital documents (Exhibits 378-389) from an admission dated May 5, 2014, were presented. It was noted that Claimant presented after taking an overdose of medications. Claimant reported a lack of focus due to audio hallucinations. Fair insight and judgment were noted. Claimant reported that she was sexually abused as a child. Claimant denied current substance abuse. Claimant reported feeling better as hospitalization progressed, though anxiety and depression were present. Claimant's mood was considered more stable. Claimant's GAF at discharge was 42. A discharge date of May 12, 2014 was noted.

Hospital documents (Exhibits 233-237) from an encounter dated [redacted] were presented. It was noted that Claimant presented after falling 3-5 feet onto her buttocks. X-rays of Claimant's thorax were noted as unremarkable.

Hospital documents (Exhibits 238-241) from an encounter dated [redacted] were presented. It was noted that Claimant presented with a complaint of vaginal discharge and right wrist pain. Right wrist radiology was negative. A diagnosis for the vaginal discharge was not apparent.

Hospital documents (Exhibits 242-246) from an encounter dated [redacted] were presented. It was noted that Claimant presented with skin swelling and back pain following a fall. Claimant was given Benadryl and steroids.

Hospital documents (Exhibits 247-251) from an encounter dated [redacted] were presented. It was noted that Claimant presented with abdominal pain and vomiting. Radiology demonstrated possible mild colonic ileus.

Additional hospital encounters were verified. The encounters were not relevant to the claim of disability other than adding to Claimant's staggering number of verified hospital encounters.

Various psychiatric treatment records (Exhibits 390-544) from 2013-2015 were presented. The documents were not notable other than being consistent with other treatment records.

Claimant testified that she hears voices despite taking medications. Claimant testified that her medications are periodically adjusted and there may be 6-8 month periods without hallucinations before they return. Claimant testified that her depression "seems a little better" though she is unsure why.

Claimant testified that she was sexually abused as a child. Claimant testified that she saw a therapist for about a year but stopped attending because she thought she felt better and thought that she could handle the depression. Claimant testified that her psychiatrist told her that she is always "under the line."

Medical records noted that Claimant reported that she lost custody of her child shortly after she gave birth (see Exhibit 25). It was noted that the child was taken shortly after Claimant was interviewed and demonstrated psychotic behavior. Claimant testified that she does not expect to ever regain custody.

During the hearing, Claimant estimates she has attempted suicide 6-7 times. Claimant testified that most of her previous attempts were overdoses; Claimant stated she tried once to slit her wrists.

Claimant established a long history of psychotic behaviors. Though Claimant's psychotic symptoms appear to have lessened, it was sufficiently established that Claimant still has hallucinations and self-destructive tendencies.

It is found that Claimant established significant impairment to basic work activities for a period longer than 12 months. Accordingly, it is found that Claimant established having a severe impairment and the disability analysis may proceed to Step 3.

The third step of the sequential analysis requires a determination whether the Claimant'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 Claimant's impairments are listed and deemed to meet the 12 month requirement, then the claimant is deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step.

Claimant's most prominent impairment appears to be bipolar disorder. Bipolar disorder is an affective disorder covered by Listing 12.04 which reads as follows:

> **12.04** ***Affective disorders***: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation. The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or 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.

Claimant’s AHR noted that Claimant was diagnosed with bipolar disorder I. Such a diagnosis is appropriate for a medical history involving at least one manic or manic/depressive episode. Generally, it is a more severe and debilitating disorder than bipolar disorder II.

Presented records verified a history of suicide attempts, a psychiatric hospitalization, and psychotic symptoms. Claimant’s substantial mental treatment history was indicative

of marked concentration and social restrictions that would prevent the performance of any employment.

Presented documents verified that Claimant had a very low GAF at the time of a psychiatric hospitalization admission; this is typical of most psychiatric hospitalizations. A better gauge of a client's functional level is the GAF at hospital discharge. In Claimant's case, her highest hospital discharge functioning level was 45. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF within the range of 41-50 is representative of a person with "serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g. no friends, unable to keep a job)." The GAF is consistent with marked restrictions. Claimant's lower GAFs are consistent with being influenced by hallucinations which is further support for marked restrictions.

Based on the presented evidence, it is found that Claimant meets Listing 12.04. There was evidence that Claimant's drug use may be material to a finding of disability. At least one usage of crack cocaine was documented. Despite some evidence of drug materiality, the overall evidence did not suggest that drug addiction contributes to Claimant's recurrent psychotic behaviors. Accordingly, Claimant is disabled and Claimant's drug use is immaterial to the finding.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that MDHHS improperly denied Claimant's application for MA benefits. It is ordered that MDHHS:

(1) reinstate Claimant's MA benefit application dated [redacted], including retroactive MA benefits from June 2013;
(2) evaluate Claimant's eligibility for benefits subject to the finding that Claimant is a disabled individual;
(3) initiate a supplement for any benefits not issued as a result of the improper application denial; and
(4) schedule a review of benefits in one year from the date of this administrative decision, if Claimant is found eligible for future benefits.

The actions taken by MDHHS are **REVERSED**.

Christian Gardocki
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Signed: **6/23/2015**

Date Mailed: **6/23/2015**

CG / hw

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]