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

IN THE MATTER OF:

[redacted]

Reg. No.: 14-019670
Issue No.: 2009
Case No.: [redacted]
Hearing Date: July 15, 2015
County: Wayne-District 19

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 July 15, 2015, from Detroit, Michigan. Participants on behalf of Claimant included Claimant; [redacted], Claimant's mother; and [redacted], hearing representative with [redacted], Claimant's authorized hearing representative (AHR). Participants on behalf of the Department of Health and Human Services (Department) included [redacted] Medical Contact Specialist.

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional records. The requested documents were received. The record closed on August 14, 2015, and the matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

Did the Department properly determine that Claimant was not disabled for purposes of the Medical Assistance (MA-P) 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 May 15, 2014, Claimant submitted an application for public assistance seeking MA-P benefits, with request for retroactive coverage to March 2014 (Exhibit A, pp. 10-13).

2. On October 21, 2014, the Medical Review Team (MRT) found Claimant not disabled (Exhibit A, pp. 14-15).

3. On October 29, 2014, the Department sent Claimant and the AHR a Benefit Notice denying the application based on MRT's finding of no disability (Exhibit A, pp. 3-4).

4. On December 19, 2014, the Department received the AHR's timely written request for hearing (Exhibit A, pp. 2, 8-9).

5. Claimant alleged disabling impairment due to epilepsy.

6. At the time of hearing, Claimant was [redacted] years old with a [redacted], birth date; she was [redacted]" in height and weighed about [redacted] pounds.

7. Claimant is a high school graduate and has an associate's degree.

8. Claimant has no employment history.

9. 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 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.

MA-P benefits are available to disabled individuals. BEM 105 (January 2014), p. 1; BEM 260 (July 2014), pp. 1-4. Disability for MA-P purposes is 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). To meet this standard, a client must satisfy the requirements for eligibility for Supplemental Security Income (SSI) receipt under Title XVI of the Social Security Act. 20 CFR 416.901.

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 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 MA-P 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 12 months. 20 CFR 416.922.

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). 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); see also *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985). Basic work activities means the abilities and aptitudes necessary to do most jobs, including (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). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28. If such a finding is not clearly established by medical evidence or if the effect of an impairment or combination of impairments on the individual's ability to do basic work activities cannot be clearly determined, adjudication must continue through the sequential evaluation process. *Id.*; SSR 96-3p.

In the present case, Claimant alleges disabling impairment due to epilepsy that she testified began following a traumatic brain injury she suffered when she was seven years old and fell off a hammock. The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

Claimant's record includes office visits with a neurologist from March 15, 2010, to February 8, 2013, with reported ongoing seizure episodes (Exhibit A, pp. 32-53). On February 8, 2013, the neurologist noted Claimant's history of obesity, hypokalemia, head injury, left hemispheric complex partial epilepsy, epileptic and nonepileptic seizures and anxiety. The doctor did not identify any abnormalities in her physical examination of Claimant. She adjusted Claimant's medication and suggested a diet

change (Exhibit A, pp. 32-34). Notes from the August 28, 2013, noted that Claimant's seizures had improved on a regimen of 4000 mg twice daily of Keppra and 250 mg twice daily Topamax (Exhibit A, pp. 82-83).

On June 12, 2014, Claimant was brought to the hospital following a seizure, with reported eye blinking and deviation, rhythmic jerking movements, and loss of consciousness. She had had several back-to-back seizures that were witnessed by both parents, emergency medical services, the emergency department staff, and the presiding doctor. A head CT showed no acute hemorrhage. A head EEG showed the presence of sharp wave in the bilateral frontal areas, more prominent on the left and suggestive of potential for seizure disorder. Claimant had numbness and tingling in her fingers and a mild headache. She was treated on Ativan and Zofran and discharged on June 13, 2014, in stable condition (Exhibit A, pp. 54-66).

On July 10, 2014, Claimant's family doctor completed a medical examination report, DHS-49, listing Claimant's diagnoses as seizure disorder, dysmenorrhea, and fungal rash. The doctor noted that Claimant was obese. The doctor concluded that Claimant's condition was stable and indicated that she had no limitations, finding that she could (i) frequently lift and carry 10 pounds, occasionally lift and carry 25 pounds, and never lift and carry 50 pounds or more; (ii) stand and/or walk about six hours in an 8-hour workday; (iii) sit about 6 hours in an 8-hour workday; (iv) use either arm or hand to reach or push/pull; and (v) use either foot or leg to operate foot and leg controls. The doctor wrote that Claimant had no physical limitations but noted that she could not drive until she was 6 months seizure-free (Exhibit A, pp. 29-31.)

On August 22, 2014, Claimant's pediatric neurologist completed a medical examination report, DHS-49, listing Claimant's primary diagnoses as complex partial epilepsy, with diagnoses of catamenial epilepsy and traumatic brain injury also pertinent. The doctor did not make any comments pertaining to her examination of Claimant or identify any limitations (Exhibit A, pp. 16-17).

On September 1, 2014, Claimant went to the hospital after experiencing 2 to 3 seizures, including an 8-minute seizure. She was postictal at the time of exam, able to state her name but obviously disoriented (Exhibit 1, pp. 2-4).

On October 21, 2014, Claimant neurologist examined Claimant to address concerns that her seizures were continuing and lasting longer, up to 7 minutes as opposed to 30 seconds. The doctor noted that Claimant had sustained a traumatic brain injury at age [redacted] and suffered a right hemiparesis (weakness of entire side). While her seizures had been mostly catamenial, they were now occurring weekly. Her complex partial seizures consisted of staring, nonsensical talking, spitting, body tingling, and vomiting afterwards; she had them all day when she had a seizure day. The doctor also noted that Claimant suffered from anxiety disorder (Exhibit 1, pp. 5-11).

An October 29, 2014, electroencephalogram (EEG) showed moderately abnormal waking, with drowsy and brief light sleep recurring because of left frontal anterior or temporal sharp waves, spikes and irregular 2 to 3 Hz activity. The result was strongly suggestive of left frontal and anterior temporal partial seizure disorder (Exhibit 2, pp. 52-53).

Notes from a November 26, 2014, office visit indicated that Claimant had been seizure free for two weeks (Exhibit 2, pp. 12-14). Notes from a December 1, 2014 telephone encounter showed that Claimant was on high drug levels but still seizing (Exhibit 1, p. 20).

Office notes from Claimant's March 18, 2015, office visit with a [redacted], a pediatric neurologist, indicate that, although she had been seizure free since adding Lacosamide to her regimen, in the past four months she had had several seizures at night which began during sleep. Generally, Claimant could sense a seizure coming, get out of bed, call her parents, recline on the couch and then she has nonsensical talking and may stare, have twitching, or drool for one to eight minutes. Afterwards she had a headache and went back to sleep. She also stared a lot during the day and responded only after being called several times. At school, she sometimes got tired and dozed in class. While the doctor noted that Claimant's condition had initially improved, she had increased nocturnal seizures and staring spells (Exhibit 2, pp. 7-11).

Claimant was hospitalized from March 23, 2015, to March 25, 2015, in order to have her seizure activity evaluated via a 48 hour video EEG. The first night, the EEG showed that she had two left hemisphere partial seizures each lasting ten seconds with confusion and disorientation and, in the second seizure, right arm posturing. She awakened with mild gagging and complaints about her right arm. She had no seizures the second night (Exhibit 2, pp. 1-6). An MRI showed left temporal MST (multiple subpial transection) with hippocampal atrophy (Exhibit 2, p. 25, 49-51).

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 12 months. 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 of whether 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 the medical record presented, listings 11.02 (epilepsy, convulsive), 11.03 (epilepsy, nonconvulsive), and 11.18 (cerebral trauma) were considered. To meet a listing under 11.02, there must be convulsive epilepsy (grand mal or psychomotor), documented by detailed description of a typical seizure pattern, including all associated phenomena, occurring more frequently than once a month, in spite of at least 3 months of prescribed treatment with (A) daytime episodes (loss of consciousness and convulsive seizures) or (B) nocturnal episodes manifesting residuals which interfere significantly with activity during the day. To meet a listing under 11.03, there must be nonconvulsive epilepsy (petit mal, psychomotor, or focal), documented by detailed description of a typical seizure pattern including all associated phenomena, occurring more frequently than once weekly in spite of at least 3 months of prescribed treatment with alteration of awareness or loss of consciousness and transient postictal manifestations of unconventional behavior or significant interference with activity during the day.

The medical records reflect Claimant having ongoing seizures beginning with a traumatic head injury when she was [redacted] years old. Beginning October 2014, Claimant's was having weekly complex partial seizures with staring spells and secondary generalized tonic-clonic seizures. Her complex partial seizures last up to six minutes and involve staring, nonsensical talking, body tingling, spitting, sensations of not being able to breath, and post-seizure vomiting. Although there was an indication in the medical records that Claimant's seizures had stopped for a brief two week period, notes from Claimant's March 18, 2015, office visit with her neurologist indicated that in the four months prior to the appointment she had had several seizures at night which began during sleep that involved Claimant sensing an upcoming seizure, getting out of bed, calling her parents, reclining on the couch and then having nonsensical talking and possible staring, twitching, or drooling for one to eight minutes. Afterwards she had a headache and went back to sleep. During the day, she stared a lot and responded only after being called several times and sometimes would get tired and doze in class. A 48 hour video EEG on March 25, 2015, showed that Claimant had two left hemisphere partial seizures on the first night each lasting ten seconds with confusion and disorientation and, in the second seizure, right arm posturing and awakened with mild gagging and complaints about her right arm.

While there was testimony at the hearing that Claimant's condition had improved with new medication, the medical evidence presented shows that Claimant had seizures more frequently than once weekly with alteration of awareness or loss of consciousness and transient postictal manifestations of unconventional behavior or significant interference with activity during the day. As such, her epilepsy meets, or is equal in severity to, the criteria for Listing 11.03 in Appendix 1 of the Guidelines.

Additionally, in order to be considered disabled under 11.03, the evidence must also show that the impairment persists despite the fact that the individual has been following prescribed antiepileptic treatment for at least three months, which is ordinarily determined from objective clinical findings in the report of the physician currently

providing treatment for epilepsy, particularly the blood levels of phenytoin sodium or other antiepileptic drugs. When seizures are occurring at the frequency stated in 11.02 or 11.03, evaluation of the severity of the impairment must include consideration of the serum drug levels. To establish that seizures are occurring despite treatment there must be evidence of (i) an ongoing relationship with a treatment source with a history of the treatment regimen and the patient's response to it; (ii) a satisfactory description by the treating physician of the treatment regimen and response, in addition to corroboration of the nature and frequency of seizure; and (iii) the record of anticonvulsant blood levels. Social Security Ruling 87-6.

In this case, the record shows that Claimant had an ongoing treatment relationship, as described above, and she was prescribed Keppra, Topamax and Vimpat. The March 2015 lab results revealed that Claimant's drug levels were within, or above, recommended ranges (Exhibit 2, pp. 7, 31, 38, 39). The only notation made by Claimant's doctor concerning her lab results was a vitamin D deficiency (Exhibit 2, p. 7). In light of the evidence showing compliance with treatment, Claimant has established that her condition meets or satisfies the criteria under listing 11.03. Because Claimant's impairments meet, or equal, the severity of a listing, Claimant is disabled under Step 3 and the analysis ends.

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Claimant disabled for purposes of the MA-P benefit programs.

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 May 15, 2014, MA-P application, with request for retroactive coverage to March 2015, 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 August 2016.

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

Date Signed: **8/25/2015**

Date Mailed: **8/25/2015**

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]