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

IN THE MATTER OF:

[redacted]

MAHS Reg. No.: 15-016440
Issue No.: 2009
Agency Case No.: [redacted]
Hearing Date: November 12, 2015
County: Wayne (19)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

Following Petitioner'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 4-way telephone hearing was held on November 12, 2015, from Detroit, Michigan. Petitioner appeared and was represented by [redacted], testified on behalf of Petitioner. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], medical contact worker.

ISSUE

The issue is whether DHHS properly denied Petitioner's Medical Assistance (MA) eligibility for the reason that Petitioner 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 March 13, 2014, Petitioner applied for MA benefits, including retroactive MA benefits from January 2014.

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

3. On June 29, 2015, the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibits 196-198).

4. On July 7, 2015, DHHS denied Petitioner's application for MA benefits and mailed a Benefit Notice informing Petitioner's authorized representative of the denial.

5. On September 1, 2015, Petitioner's AHR requested a hearing disputing the denial of MA benefits.

6. As of the date of the administrative hearing, Petitioner was a 51-year-old female; Petitioner was 49 years-old at the time she applied for MA benefits.

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

8. Petitioner has no history of employment from the last 15 years.

9. Petitioner alleged disability based on restrictions related to diagnoses of obsessive-compulsive disorder (OCD), chronic obstructive pulmonary disorder (COPD), carpal-tunnel syndrome (CTS), and right-sided pain related to an motor vehicle accident.

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 Bridges Administrative Manual (BAM), Bridges Eligibility Manual (BEM), and Reference Tables Manual (RFT).

Prior to a substantive analysis of Petitioner's hearing request, it should be noted that Petitioner's AHR noted special arrangements in order to participate in the hearing; specifically, a 3-way telephone hearing was requested. Petitioner'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 (10/2010), 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 Petitioner'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 (7/2012) pp. 1-2

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

Generally, state agencies such as DHHS 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 (7/2012), 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 CFR 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. The 2015 monthly income limit considered SGA for non-blind individuals is $1,090.

Petitioner credibly denied performing any employment since the date of the MA application; no evidence was submitted to contradict Petitioner's testimony. Based on the presented evidence, it is found that Petitioner 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 Petitioners 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 Petitioner'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.

A physician letter (Exhibit 103) dated November 20, 2012, was presented. It was noted Petitioner's problems included OCD, COPD, chronic pain, post-traumatic stress disorder (PTSD), depression, and fibromyalgia. It was also noted Petitioner had arthritis in her left knee, left shoulder, lumbar, and all fingers. Petitioner's physician stated that it was impossible for Petitioner to work.

Various prescriptions and handwritten treatment documents from 2012 and 2013 (Exhibits 79-97; 99-102; 104-108; 112; 114-129; 134-140; 144-145; 161-163; 169; 171-174; 178-194; A6) were presented. Treatment for shoulder pain, COPD, OCD, degenerative joint disease, HTN, bipolar disorder was noted. Prescribed medications included Vicodin and morphine.

A handwritten Psychiatric Assessment from a treating psychiatrist (Exhibits 65-67; 71-73) dated December 11, 2013, was presented. Symptoms of depression and anxiety were noted. Petitioner reported she was a cutter when she was young. An absence of drug abuse was noted. Diagnoses of recurrent major depressive disorder and panic disorder were noted. Petitioner's GAF was noted to be 41.

A handwritten medical treatment document (Exhibits 78; 133; 143) dated January 15, 2014, was presented. Assessments of left shoulder pain and OCD were noted. Petitioner was prescribed Norco and Morphine.

Hospital documents (Exhibits 34-51) from an admission dated January 20, 2014, were presented. It was noted that Petitioner presented with complaints of pain and swelling in her right forearm and left leg, ongoing for 1 month. It was noted that Petitioner reported bandages, antibiotic cream, and amoxocillin did not improve wounds. An impression of right arm and left excoriation secondary to severe scratching was noted. A discharge date was not noted, though it appeared to be January 21, 2014 (the latest date a medical note was documented).

Petitioner's hospitalization from January 20, 2014, included various psychiatric notes dated January 21, 2014. Petitioner reported a 30 year habit of picking; worse after her mother died. It was noted Petitioner felt stressed from living with her boyfriend's children. Passive suicidal wishes (though ideation was denied) were noted. Good sleep (with Ambien) was noted. A psychiatric hospitalization from 2009 related to depression was noted. Petitioner reported she attended group therapies and saw a psychiatrist. An Axis I diagnosis of OCD and depression were noted. Petitioner's GAF was noted to be 41-50.

A handwritten medical treatment document (Exhibit 77)/ dated February 12, 2014, was presented. Assessments of cellulitis and OCD were noted.

A handwritten psychiatric progress note (Exhibits 64; 70) dated February 11, 2014, was presented. A diagnosis of major depressive disorder was noted. Prescribed medication included Effexor and Ambien.

Emergency room documents (Exhibits 52-62) from an admission dated March 2, 2014, were presented. It was noted that Petitioner had a history of alcohol and tobacco abuse, and apparent cocaine abuse Petitioner reported OCD which caused her to pick at her skin. Recent treatment for cellulitis was noted. It was noted that Petitioner presented with complaints of pain and swelling in her right forearm and left leg, ongoing for 1 month. It was noted that Petitioner reported bandages, antibiotic cream, and amoxocillin did not improve wounds. An impression of right arm and left excoriation secondary to severe scratching was noted.

A handwritten medical treatment document (Exhibit 75; 113; 175; A7) dated March 10, 2014, was presented. It was noted Petitioner had a rash all over her body. An assessment of cellulitis was noted. A cream was prescribed.

A handwritten psychiatric progress note (Exhibits 63; 69) dated April 8, 2014, was presented. It was noted petitioner had a rash.

A handwritten medical treatment document (Exhibits 98; 132; 142) dated April 9, 2014, was presented. It was noted Petitioner had a rash all over her body. An assessment of cellulitis was noted. A cream was prescribed.

A handwritten medical treatment document (Exhibit 74; 111; 176; A17) dated June 11, 2014, was presented. It was noted Petitioner picks her skin. Assessments for and treatment of COPD and OCD were noted.

A handwritten psychiatric progress note (Exhibit 68) dated July 1, 2014, was presented. A diagnosis of major depressive disorder was noted. Prescribed medication included Klonopin and Effexor, and Ambien.

A handwritten medical treatment document (Exhibit 110) dated July 9, 2014, was presented. It was noted Petitioner reported shoulder and hand pain.

A handwritten medical treatment document (Exhibits 130; 141) dated September 3, 2014, was presented. An assessment of HTN, chronic shoulder pain, and possible scabies was noted.

A handwritten medical treatment document (Exhibit 109; 177) dated September 24, 2014, was presented. It was noted Petitioner had her lower teeth pulled.

Medical clinic documents (Exhibits 147-148; A1-A2) dated October 29, 2014, was presented. It was noted Petitioner presented with a body rash; it was noted Petitioner had OCD and picks at her rash. Petitioner reported severe joint pain and swelling. Petitioner also reported dyspnea for short distances of walking. Assessments of dermatitis, OCD, COPD, and PTSD status post motor vehicle accident were noted. Ventolin, Neurontin, Morphine, and Albuterol were noted as prescribed.

Medical clinic documents (Exhibits 149-150; A3-A4) dated November 26, 2014, was presented. Petitioner's complaints mirrored those from October 29, 2014. Assessments from October 29, 2014, were also repeated. Gabapentin was noted as a new medication.

A handwritten medical treatment document (Exhibit 176) dated December 5, 2014, was presented. It was noted Petitioner reported ongoing right shoulder and right hip pain.

Medical clinic documents (Exhibits 151-152; A8-A9) dated December 24, 2014, was presented. Petitioner complained of dyspnea, right flank pain, and right hip/buttock pain. Morphine and Norco were prescribed.

An x-ray report of Petitioner's right shoulder (Exhibit 165) dated January 16, 2015, was presented. An impression of an unremarkable right shoulder radiograph was noted.

An x-ray report of Petitioner's left shoulder (Exhibit 166) dated January 16, 2015, was presented. An impression of an unremarkable left shoulder radiograph was noted.

An x-ray report of Petitioner's lumbosacral spine (Exhibit 167) dated January 16, 2015, was presented. An impression of mild degenerative changes was noted.

An x-ray report of Petitioner's thoracic spine (Exhibit 168) dated January 16, 2015, was presented. An impression of no acute process or significant degenerative changes was noted.

Medical clinic documents (Exhibits 153-154; 164; A5; A10-A11) dated January 21, 2015, were presented. Petitioner complained of tooth and chronic shoulder pain. Petitioner requested an increase in pain medication. An assessment of chronic left shoulder pain, COPD, HTN, fibromyalgia, OCD, GERD, and anxiety were noted. Petitioner's medications included morphine (60 mg; 2x per day) and Neurontin (300mg; 3x per day).

Medical clinic documents (Exhibits 146; 155-156; A12-A13) dated February 18, 2015, were presented. Petitioner reported ongoing shoulder and back pain. Petitioner reported Norco 45 was not helping and Petitioner wanted an increase in Neurontin. Various medications were prescribed. Assessments of COPD, seizures, and joint pain were noted. Prescriptions of Norco and morphine were noted.

Medical clinic documents (Exhibits 157-158; A14-A15) dated March 16, 2015, were presented. Petitioner reported generic morphine did not help alleviate pain. Various medications were prescribed. It was noted Petitioner stopped drinking for an unspecified time.

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Medical clinic documents (Exhibits 159-160; A16) dated April 13, 2015, were presented. It was noted Petitioner reported being unable to hold items with her hands. Petitioner reported the problem was ongoing for several months, though it was noted Petitioner had not previously reported the problem.

Medical clinic documents (Exhibits A18-A21) dated November 2, 2015, were presented. Petitioner's O2 level was noted to be 97%. Active diagnoses included HTN, COPD, left shoulder pain, GERD, fibromyalgia, OCD, and convulsions. Active medications included Albuterol, Morphine Sulfate, Neurontin, Ventolin, Norco 10-325, Prednisone, and Sumatriptan Succinate.

A conclusion that Petitioner exhibits drug-seeking behavior and/or may be affected by ongoing drug and alcohol abuse was somewhat supported by evidence. It was noted Petitioner was intoxicated and positive for cocaine at her most recent hospital visit before March 2, 2014. Petitioner testimony conceded she used alcohol and crack cocaine three months before the hearing.

Petitioner testified she has a history of breast cancer. Petitioner testified she lost her right breast due to cancer about 3 years earlier. Petitioner testified a recent mammogram discovered a lump which has yet to be tested.

Presented records did not indicate any impairments related to breast cancer. There was no indication Petitioner undergoes chemotherapy or other cancer treatment. There was no indication of ongoing cancer testing. Past treatment for breast cancer was not apparent. It is found Petitioner did not establish an impairment related to breast cancer.

Petitioner alleged she is restricted due to breathing difficulties related to COPD. Petitioner testified she utilizes a nebulizer every 4 hours. Petitioner testified she is also a smoker, a probable material contributor to any breathing difficulties of Petitioner.

Pulmonary function testing was not presented. The only apparent testing related to breathing problems indicated Petitioner's O2 level was 97%, a level considered to be normal. Presented evidence did indicate Petitioner is prescribed respiratory medications (e.g. Ventolin and albuterol). A diagnosis for COPD was also verified. Petitioner established some impairment related to breathing difficulties.

Petitioner testified she was in a car accident in 1984. Petitioner testified the accident broke all of her vertebrae, her collar bone, and crushed the right side of her body. Petitioner testified she has sitting restrictions of 10-15 minutes because of the accident. Petitioner testified she wears a lumbar brace. Petitioner testified she still has anxiety whenever she is in a vehicle. Petitioner's testimony was not well-supported by the medical evidence.

Impairments related to a car accident (other than PTSD) were not apparent. Sitting restrictions were not apparent. The only abnormalities verified by radiology were mild

degenerative changes in Petitioner's lumbar; this is not particularly indicative of sitting restrictions.

Petitioner testimony strongly indicated severe physical problems. She testified she can "barely get out of bed" due to pain. Petitioner testified she is restricted to 5-10 minutes of walking; Petitioner conceded she may be able to walk further if she utilized a cane.

Petitioner testified she has CTS. She testified she cannot feel her fingers. Petitioner testified she utilizes a left wrist brace.

Petitioner testified she also struggles with ADLs. She testified dressing takes longer than it should. Petitioner testified she can bathe and shower but only after taking her pain medication. Petitioner testified she relies on her boyfriend to do her shopping and laundry because she is physically incapable of neither.

Petitioner's boyfriend's testimony generally corroborated the testimony of Petitioner. He testified Petitioner can only walk about 100 feet on one of her good days. He testified that Petitioner cannot climb stairs.

A testifying MDHHS specialist also testified that she observed Petitioner walk slowly to the hearing room. MDHHS testimony also indicated Petitioner appeared for the hearing with a lumbar brace and left wrist brace.

Regular complaints of pain and pain medication prescription were verified; this is somewhat supportive of Petitioner's testimony. A diagnosis of fibromyalgia was also indicated. Fibromyalgia is of a nature that it could cause inexplicable and severe body pain.

Regular treatment for CTS and body pains was verified via diagnoses and medications. It is found that Petitioner established severe physical impairments due to CTS and body pain.

Petitioner testified she sees a psychiatrist every 3 months. Petitioner testified she used to have monthly appointments until her insurance changed. Petitioner testified she would like to see a therapist and/or group therapy but lacks transportation. Petitioner testified she has OCD and picks her skin; Petitioner's boyfriend testified he witnessed Petitioner do this. Petitioner testified she used to be a cutter; Petitioner's boyfriend testified Petitioner will cut herself when she is upset. Petitioner testified she spends most of her time crying and watching television.

Petitioner's and her boyfriend's testimony was highly indicative of psychological problems which restrict Petitioner's ability to work. The testimony was reasonably consistent with Petitioner's medical history. It is found Petitioner has severe psychological impairments.

It is found that Petitioner established significant impairment to basic work activities for a period longer than 12 months. Accordingly, it is found that Petitioner 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 Petitioner'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 Petitioner's impairments are listed and deemed to meet the 12 month requirement, then the Petitioner is deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step.

Petitioner's primary impairment was depression. Depression 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.

Presented evidence also suggested Petitioner has OCD which causes her to pick her skin and/or cut herself. OCD is a personality disorder covered by SSA Listing 12.08 which reads as follows:

12.08 Personality disorders: A personality disorder exists when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress. Characteristic features are typical of the individual's long-term functioning and are not limited to discrete episodes of illness. The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Deeply ingrained, maladaptive patterns of behavior associated with one of the following:
1. Seclusiveness or autistic thinking; or
2. Pathologically inappropriate suspiciousness or hostility; or
3. Oddities of thought, perception, speech and behavior; or
4. Persistent disturbances of mood or affect; or
5. Pathological dependence, passivity, or aggressivity; or

6. Intense and unstable interpersonal relationships and impulsive and damaging behavior;

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.

Petitioner and her boyfriend testified that Petitioner experiences symptoms of anhedonia, decreased energy, concentration difficulties, and sleep disturbance. The complaints were also generally consistent with presented records. Petitioner sufficiently meets Part A of the affective disorder listing.

Medical records established that Petitioner picks her skin despite medical evidence recommending otherwise. Petitioner's OCD was not well explored during the hearing, however, the evidence sufficiently established self-damaging behavior.

A treating psychiatrist assessed Petitioner GAF to be 41 in December 2013. The following month, a hospital physician assessed Petitioner's GAF to be in the range of 41-50.

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)."

Petitioner's GAF is indicative of marked restrictions. Presented documents were not clear on how Petitioner was markedly restricted.

Presented evidence would have been more compelling had Petitioner presented ongoing psychiatric/psychologist treatment documents. The absence of such documents failed to establish specifics of a psychiatric impairment. For example, there was no indication of social interaction restrictions or psychological restrictions related to ADL completion. Even concentration difficulties cannot be inferred as good concentration was noted during Petitioner's January 2014 hospitalization (see Exhibit 41).

A listing for joint dysfunction (Listing 1.02) was considered based on Petitioner's complaints of various joint pains. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively and/or that Petitioner cannot perform fine and gross movements.

A listing for chronic pulmonary insufficiency (Listing 3.02) was considered based on Petitioner's complaints of dyspnea. The listing was rejected due to a lack of respiratory testing evidence.

A listing for chronic skin infections (Listing 8.04) was considered based on Petitioner's recurrent cellulitis. The listing was rejected due to a failure to establish extensive fungating or extensive ulcerating skin lesions that persist for at least 3 months despite continuing prescribed treatment.

It is found that Petitioner failed to establish meeting or equaling a SSA listing. Accordingly, the analysis moves to step four.

The fourth step in analyzing a disability claim requires an assessment of the Petitioner's residual functional capacity (RFC) and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if it is determined that a Petitioner can perform past relevant work. *Id*.

Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

Petitioner testified she has not worked in the last 30 years. Petitioner testified that part of the reason she did not work was that her husband supported her. Petitioner testified that her husband died in 2009. Petitioner testimony indicated that she did not pursue SSA benefits until recently because she did not qualify while she was married. Petitioner's testimony was consistent with presented evidence.

Without SGA earnings from the past 15 years, it can only be concluded that Petitioner cannot return to perform past relevant employment. Accordingly, the analysis may proceed to the fifth and final step.

In the fifth step in the process, the individual's RFC in conjunction with his or her age, education, and work experience, are considered to determine whether the individual can engage in any other substantial gainful work which exists in the national economy. SSR 83-10. While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983);

Kirk v Secretary, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). To determine the physical demands (i.e. exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967.

Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b) Even though weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additionally limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.*

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.*

Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.*

Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands are considered non-exertional. 20 CFR 416.969a(a). Examples of non-exertional limitations include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (e.g. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i)-(vi) If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the

rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2)

The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.* In using the rules of Appendix 2, an individual's circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, is compared to the pertinent rule(s).

Given Petitioner's age, education and employment history a determination of disability is dependent on Petitioner's ability to perform sedentary employment. For sedentary employment, periods of standing or walking should generally total no more than about 2 hours of an 8-hour workday. Social Security Rule 83-10.

Physician statements of Petitioner's restrictions were not presented. Restrictions can be inferred based on presented documents.

Petitioner's medical history established regular complaints of body pain and discomfort. The complaints were not verified by testing such as radiology, though fibromyalgia was a verified diagnosis which could explain the complaints. It is likely that Petitioner's drug and/or alcohol abuse history contributed to ongoing body pains. Medical treatment for body pains was well-established by Petitioner's recurring complaints and prescription history.

It was also established that Petitioner has severe psychological problems in the form of depression and OCD. A history of skin picking and cutting was well-documented.

Based on Petitioner's combined physical and mental impairments, it is improbable that Petitioner could sustain any level of employment. A consideration of Petitioner's ongoing alcohol and drug abuse materially contributing to her functioning abilities was undertaken. Ultimately, Petitioner's drug and alcohol abuse was not proven to be related to Petitioner's psychiatric problems. Petitioner's physical problems, though likely caused in part by past drug and/or alcohol abuse, appear to not be curable by Petitioner's permanent abstention from further abuse.

It is found that Petitioner is a disabled individual based on a combination of mental and physical impairments. Accordingly, it is found that MDHHS improperly denied Petitioner's MA application.

DECISION AND ORDER

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

(1) reinstate Petitioner's MA benefit application dated March 13, 2014, including retroactive MA benefits from January 2014;
(2) evaluate Petitioner's eligibility for benefits subject to the finding that Petitioner 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 Petitioner is found eligible for future benefits.

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

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

Date Signed: **11/20/2015**

Date Mailed: **11/20/2015**

CG/tm

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 copy of the claim or application for appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Hearing Decision from 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]