RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: September 13, 2016
MAHS Docket No.: 16-007780
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

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; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on July 28, 2016, from Detroit, Michigan. Petitioner appeared and represented himself. The Department of Health and Human Services (Department) was represented by [redacted], Hearing Facilitator, and [redacted], Eligibility Specialist.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. A DHS-49D, psychiatric/psychological examination evaluation, and DHS-49E, mental residual functional capacity assessment, completed and signed by Petitioner's psychiatrist were received and marked into evidence as Exhibit C. The record closed on August 26, 2016, and the matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

Did the Department properly determine that Petitioner 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 February 9, 2016, Petitioner submitted an application seeking medical and cash assistance on the basis of a disability.

2. On May 19, 2016, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 6-12, 38-56).

3. On May 25, 2016, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit A, pp. 4-5).

4. On June 15, 2015, the Department received Petitioner's timely written request for hearing concerning the denial of his SDA application (Exhibit A, pp. 2-3).

5. Petitioner alleged disabling impairment due to severe obsessive-compulsive disorder (OCD).

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

7. Petitioner has a GED.

8. At the time of application, Petitioner was not employed.

9. Petitioner has an employment history of work as telemarketer and transcriber.

10. Petitioner has a pending disability claim with the Social Security Administration (Exhibit B).

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 Health and 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.

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (July 2015), 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).

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) 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 in this process, 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

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, Petitioner was not working during the period for which assistance might be available. Because Petitioner was not engaged in SGA, he is not ineligible under Step 1 and the analysis continues to Step 2.

Step Two

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that 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. 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, such as (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). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, 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.

In the present case, Petitioner alleges disabling impairment due to OCD. The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

In a psychosocial evaluation completed [redacted], Petitioner reported struggling with OCD for 12 to 14 years. He stated he was unable to enjoy even simple things and described his symptoms as loss of interest, decreased energy, sleep difficulties, easy distractibility, racing thoughts, anxiety, worry, panic attacks, checking things repeatedly, perfectionism, fear, working relationship problems. He indicated anxiety, obsessions, and panic attacks kept him trapped in his own mind for long periods of time and could be triggered by anything. He indicated he was wary of medication but would like to try counseling twice monthly. He was diagnosed with OCD and assessed a risk level of the low. (Exhibit A, PP. 77-79).

The medical file includes psychiatry notes dated [redacted] (Exhibit A, PP. 112-198). The psychiatrist treated Petitioner for his long standing history of intrusive thoughts regarding his body image that caused significant distress and frustration. In notes entered following the [redacted] visit, the psychiatrist assessed Petitioner with a global assessment of functioning (GAF) score of 55. The psychiatrist prescribed Luvox, 20 mg at bedtime for 10 days to be increased to 100 mg following that for OCD/anxiety. (Exhibit A, PP. 187-194). At the [redacted] visit, Petitioner reported compliance with medication, but the psychiatrist indicated the script did not corroborate his statement. Petitioner reported experiencing insomnia and fatigue on Luvox and indicated it decreased his anxiety somewhat but did not help with his obsessive thoughts regarding his body image. Petitioner reported he continued to use his compulsive behavior of thinking two thoughts at the same time to offset the obsessive thoughts. He was prescribed Zoloft. (Exhibit A, PP. 195-204).

At the [redacted] visit, Petitioner reported to the psychiatrist that his OCD was paralyzing, making him unable to do anything because he had to visualize his ideal physical self each time he moved. He reported that Zoloft helped a tiny bit with anxiety but caused migraine headaches. (Exhibit A, PP. 205-214). At the [redacted] visit, Petitioner reported to his psychiatrist that he had daily headaches and his GERD was worse. The psychiatrist noted that Petitioner was not tolerating his medication (Luvox, Zoloft and Prozac) well and continued to be anxious and have OCD symptoms. Petitioner reported that if he did not distract himself by doing things like playing video games or watching TV, he would get obsessive thoughts and had to visualize his ideal self all the time. (Exhibit A, PP. 215-224.)

At the [redacted] visit, Petitioner reported that he had not started taking Celexa because it had not been called into his pharmacist; however, the psychiatrist noted that record showed that both Celexa and omeperazle were both called in and Petitioner picked up the omeperazle prescription. He reported that since he stopped using Prozac, his migraines had ended. He continued to get obsessive thoughts and had to visualize his ideal self or feel highly anxious. (Exhibit A, PP. 25-233.) At the [redacted] visit, Petitioner reported to his psychiatrist that the Celexa was not helping him but was making him more tired. He continued to spend most of the day dealing with this OCD. The doctor continued to recommend that Petitioner get labs done. (Exhibit A, PP. 234-243.)

At the [redacted] visit, Petitioner reported that Effexor made him more irritable but did not reduce his anxiety. He continued to spend substantially most of the day visualizing his ideal self, relying on playing video games to not think about his obsession. The psychiatrist noted that he had spoken to Petitioner's therapist and she reported that he did not comply with the recommendations she made. (Exhibit A, PP. 244-253.) At the [redacted] visit, Petitioner reported no change in his OCD or anxiety. He continued to have to visualize his ideal self whenever he moved from one position to the other. The psychiatrist indicated that because Petitioner was not responding to medications and/or experiencing side effects he wanted a urine drug screen, but Petitioner was unable to provide one that day. (Exhibit A, PP. 254-263.)

At the [redacted] session, the psychiatrist outlined medication Petitioner had tried that had failed: Effexor was ineffective at 100 film milligrams and produced side effects of fatigue; Celexa was a treatment failure; Luvox caused insomnia and sexual side effects; Zoloft resulted in headaches; Prozac produced gastrointestinal side effects; and clomipramine produced side effects of mild fever, fatigue, insomnia, and an increase of anxiety independent of the OCD symptoms that Petitioner reported as intolerable. The psychiatrist noted that Petitioner had intermittent eye contact, fidgeting, anxious affect, logical/linear thought process, no evidence of hallucinations, and appropriate/intact judgment. (Exhibit A, PP. 264-273.)

Therapy session notes show attendance on [redacted]

[redacted] (Exhibit A, PP. 88-186).

On [redacted], Petitioner's psychiatrist completed a verification of disability on Petitioner's behalf for the Michigan State Housing Development Authority. (Exhibit 1).

On [redacted], Petitioner's psychiatrist who had treated Petitioner since [redacted], completed a psychiatric evaluation, confirming a diagnosis of OCD. The psychiatrist indicated that Petitioner had struggled with OCD symptoms for 14 years: excessive anxiety, panic, fears, checking things repeatedly, perfectionism, body image difficulties, easy distractibility, racing thoughts, and concentration and sleep difficulties. He had previously been in mental health counseling in [redacted]. Petitioner was participating in mental health counseling 1 to 2 times monthly. He had participated in psychiatric sessions for medication management from [redacted] to [redacted]. He stopped using various medications because of severe and unmanageable side effects; the only medications available were antipsychotics which were not tried because of potential side effects. The psychiatrist indicated that Petitioner's OCD was "triggered by anything and everything depending on the day" and made it difficult for him to perform normal daily tasks, including maintaining a job. The OCD left him mentally and physically exhausted. (Exhibit C.)

On[redacted], Petitioner's psychiatrist completed a mental residual functional capacity assessment, DHS-49-E, regarding Petitioner's mental impairments and how they affected his activities. The psychiatrist concluded that Petitioner had **moderate** limitations regarding his ability to work in coordination with or proximity of others without being distracted by them; interact appropriately with the general public; and be aware of normal hazards and take appropriate precautions. The psychiatrist concluded that Petitioner had **marked** limitations regarding his ability to remember locations and work-like procedures; understand and remember one or two-step instructions; understand and remember detailed instructions; carry out simple one or two step instructions; carry out detailed instructions; maintain attention and concentration for extended periods; perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; sustain an ordinary routine without supervision; make simple work-related decision; 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; ask simple questions or request assistance; accept instructions and respond appropriately to criticisms from supervisors; get along with co-workers or peers without distracting them or exhibiting behavioral extremes; maintain socially appropriate behavior and adhere to basic standards of neatness and cleanliness; respond appropriately to change in the work setting; travel in unfamiliar places or use public transportation; and set realistic goals or make plans independently of others. (Exhibit C)

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner

suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner 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 the medical evidence presented in this case, listing 12.06 (anxiety-related disorders) was considered. To meet a listing under 12.06, the requirements of both A and B must be satisfied or the requirements of both A and C must be satisfied:

A. Medically documented findings of at least one of the following:

1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:
    a. Motor tension; or
    b. Autonomic hyperactivity; or
    c. Apprehensive expectation; or
    d. Vigilance and scanning; or
2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or
3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or
4. Recurrent obsessions or compulsions which are a source of marked distress; or
5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;

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. Resulting in complete inability to function independently outside the area of one's home.

In this case, Petitioner has been diagnosed by a psychiatrist with OCD that the psychiatrist indicated was "triggered by anything and everything depending on the day" and made it difficult for Petitioner to perform normal daily tasks. Petitioner testified that he had compulsive thoughts concerning his "ideal physical self" that were ongoing and that he had to counter with two positive thoughts. The record indicates that various drugs were tried but were either ineffective or had unmanageable side effects. The record shows that Petitioner was able to concentrate enough to play video games but that he engaged in such activities in order to keep his mind preoccupied and limit his OCD thoughts. Therefore, the medical evidence establishes that Petitioner has recurrent obsessions or compulsions which were a source of marked distress, thereby satisfying the requirement under 12.06.A.4.

The DHS-49E completed by Petitioner's psychiatrist's showed that Petitioner had marked limitations at completing even simple tasks, sustaining an ordinary routine, getting along with coworkers or peers, or maintaining socially appropriate behavior. Petitioner testified that he was able to bathe and dress himself and do chores but any activity would take an extremely long time because he had to perform a series of rituals and repetitive behaviors to complete a task. Attempts at working were short-lived because of Petitioner's unmanageable thoughts. Various medication were prescribed but had not been able to manage Petitioner's thoughts or control his anxiety. The evidence was sufficient to show that Petitioner's impairment met or equaled the requirements of 12.06B.

Because Petitioner's impairment meets, or equals, the requirements of 12.06A and 12.06B, Petitioner **is disabled** at 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 Petitioner **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. Reregister and process Petitioner's February 9, 2016 SDA application to determine if all the other non-medical criteria are satisfied and notify Petitioner of its determination;

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

3. Review Petitioner's continued eligibility in March 2017.

ACE/tlf

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

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; 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

DHHS

[redacted]

Petitioner

[redacted]

Via Email:

[redacted]