[redacted]

Date Mailed: October 12, 2018
MAHS Docket No.: 18-008237
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

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. After due notice, a 3 way telephone hearing was held on September 12, 2018, from Detroit, Michigan. The Petitioner was represented by [redacted], Attorney [redacted]. The Petitioner also appeared and testified. Assistant Attorney General, [redacted] represented the Michigan Department of Health and Human Services (Department). [redacted], Assistance Payment's Supervisor and [redacted], Eligibility Specialist appeared as witnesses on behalf of the Department.

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the Medical Assistance (MA) and/or State Disability Assistance (SDA) benefit programs?

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 6, 2018, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On July 3, 2018, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program.

3. On July 3, 2018, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability.

4. On August 9, 2018, the Department received Petitioner's timely written request for hearing.

5. Petitioner alleged disabling impairment due to mental impairment due to Anxiety and Obsessive-Compulsive disorder and Post Traumatic Stress Disorder. The Petitioner alleged physical impairment due to prior injuries sustained in a motor vehicle accident which involved a fractured pelvis, humeral fracture, right tibial fracture and left fibular fracture. He underwent open reduction internal fixation to the left humerus, surgical stabilization to both legs, as well is his pelvis. The Petitioner alleges ongoing pain, weakness with decreased range of motion and limited use of his left side with strength deficit to left lower and left upper and nerve damage to his left arm and bicep.

6. On the date of the hearing, Petitioner was [redacted] years old with a May 17, [redacted] birth date; he is [redacted] in height and weighs about [redacted] pounds.

7. Petitioner is *a* high school graduate and completed one year of basic college courses

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

9. Petitioner has an employment history of work as working at a law firm performing electronic computer work performing document research for the law firm's litigation and supervised 3 people assigning daily work assignments.

10. Petitioner has a pending disability claim with the Social Security Administration.

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.

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 minimis 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.

The medical evidence presented at the hearing, was reviewed and is summarized below.

Mental Impairment Medical Evidence

The Petitioner presented a mental residual functional capacity assessment completed by his therapist on May 25, 2018. And also signed by the physician's assistant. The Petitioner began treatment on January 2, 2018 and was seen biweekly with the date of last appointment May 23, 2018. At that time the GAF score was 50 and the prognosis was poor. At the time of the exam the GAF score had decreased by five points. The current diagnosis was posttraumatic stress disorder (PTSD) and OCD. There were no physical medical conditions that were listed as contributing to the mental impairment. The assessment indicates that the patient's impairment has lasted or is expected to last at least 12 months. The Petitioner was determined to not be a malingerer and was compliant with treatment.

The following determinations were made regarding Petitioner's Mental Residual Functional Capacity. The Petitioner's functioning with respect to Understanding and Memory were evaluated with no limitations imposed with respect to remembering locations and work -like procedures, ability to understand and remember short simple instructions and ability to understand and remember detailed instructions. The Petitioner's functioning with respect to sustained concentration, persistence and pace were evaluated with mild limitation for ability to carry out very short simple instructions; mild limitations were found for ability to carry out detailed instructions and marked limitation in ability to maintain attention and concentration for extended periods; and extreme limitations in ability to perform activities within a schedule, maintain regular attendance and be punctual with customary tolerances.

The Petitioner's functioning with respect to his ability to sustain an ordinary routine without special supervision was listed as extreme; ability to work in coordination with or proximity to others without being distracted by them was marked; ability to make simple work-related decisions was rated as marked limitation and the ability to complete a normal workday and workweek without interruptions from psychologically induced symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods was rated as extreme limitation.

The Petitioner's functioning with respect to social interactions with respect to the ability to interact appropriately with the general public were rated as extreme limitation; the ability to ask simple questions or request assistance was rated as marked; the ability to accept instructions and respond appropriately to current criticism from supervisors was rated as marked, the ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes was rated as marked and the ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness was moderately impaired. The Petitioner's functioning with respect to adaptation and the ability to respond appropriately to changes in the work setting was rated as marked limitation; the ability to be aware of normal hazards and take appropriate precautions was rated as mild; the ability to travel to unfamiliar places or use public transportation was rated as extreme limitation; ability to set realistic goals or make plans independently of others was rated as marked and finally the ability to tolerate normal levels of stress was rated as extreme limitation. The evaluation indicated that the Petitioner's impairments would substantially interfere on a regular and continuing basis at least 20% of the time. It was further estimated that the Petitioner would miss on a regular and sustained basis because of his mental impairment or treatment at least 20 days per month. The Petitioner's history of alcohol and/or substance use did not contribute to the patient's limitations set forth in the evaluation.

A consultative psychiatric examination was completed on September 8, 2017 at the request of the DDS. The Petitioner when asked indicated the reason for the evaluation was that he struggles with PTSD from a motor vehicle accident in 2002, has anxiety, social anxiety, as well as other physical impairments including ankle pain, pelvic pain, partial paralysis in his left arm, and chronic joint pain. Petitioner explained to the examiner that he does not like to be around people and feels everyone is watching him,

criticizing him, judging him and trying to get him in trouble. The Petitioner also reported anxiety even as a young child which was constant day and night. Currently, he awakens with anxiety with no apparent trigger. He counts and performs most acts three or five times or fears that something bad will happen. He cleans constantly and washes his hands all the time. He gets intrusive thoughts that if he touches things he will leave behind things that will get him into trouble for potential crime. He checks locks and appliances three or five times. He paces the floor in an exact pattern. He struggles from depressive symptoms that appear to be related to disappointment at having to struggle with anxiety so much. General observations by the examiner were that his mood was very anxious, thought patterns were spontaneous well organized and no problems in pattern or content of speech.

The examiner also noted that Petitioner did not appear to have a tendency to minimize or exaggerate symptomology. The Petitioner denied the presence of any auditory or visual hallucinations, delusions, obsessions persecutions or unusual powers. He denied feelings of worthlessness or suicidal intimation. Sleep patterns are restless and allow him to sleep only four to five hours per night.

The examiner concluded that the results of the mental status examination revealed abnormalities in concentration and also found that Petitioner met diagnostic criteria for generalized anxiety disorder, social anxiety disorder and obsessive-compulsive disorder. The examiner opined that Petitioner's prognosis is poor. A medical source statement was also completed by the examiner on the Social Security Administration form for that purpose.

As part of the evaluation, the examiner completed a Medical Source Statement with regard to Petitioner's mental functioning and ability to do work related activities. The examiner indicated that with respect to Petitioner's ability regarding understanding and remembering simple instructions, and carrying out simple instructions and carry out complex instructions, the Petitioner had moderate limitations. The ability to make judgments on complex work-related decisions were markedly limited, noting the factor used by the evaluator was based on patient's anxiety being so extreme that he will struggle to maintain focus and accomplish tasks especially with more complexity;
With respect to Petitioner's ability to interact appropriately with supervisors, coworkers and the public as well as respond to changes in the in a routine work setting affected by his impairments the examiner determined that petitioner was markedly limited. The Petitioner's limitations with respect to ability to interact appropriately with supervisors was evaluated as an extreme limitation. The examiner noted the factors supporting the evaluation stating "he has significant social anxiety that will impair his social interactions.

The Petitioner participates in ongoing treatment for his diagnosed mental impairments of PTSD, OCD and anxiety. On August 24, 2018 the Petitioner had a psychotherapy session at his mental health care provider. Current assessment noted some progress, although ongoing anxiety was noted. At baseline, patient isolates, experiences paranoia, engages in OCD rituals and is highly avoidant. He rarely leaves his

apartment, has no friends and is unable to work due to PTSD symptoms. Working on puzzles allows him to move his thoughts over to something other than his anxiety. Petitioner expressed desire to go and participate in self-help groups to address his anxiety. During the exam the mental status was noted as depressed anxious with constricted affect thought process was logical thought content was preoccupied/rumination, obsessional depressive paranoid and phobic; judgment and insight were with in normal limits.

On August 8, 2018, at a therapeutic session the Petitioner reported he felt he had gone backwards and was feeling significantly more anxious after witnessing a violent incident. His OC D was more attuned. He stays in his apartment has no friends his and unable to work. The anxiety was caused and connected to a man becoming violent at his attorney's office which frightened him.

At an examination at his mental health provider on July 20, 2018 patient reported that he has a narrator in his head and also is always interpreting what other people are thinking about what he's doing and he guesses about what they are thinking, the narrator explains the rationale. Moreover, OCD has always been part of my life counting tics etc. I have learned how to put them into my day in a way so that people don't notice. If I do them correctly, my day will go well. Patient also reports there are spirits who constantly are watching and looking for crack to steal my goodness away. They watch and stalk me and are always hovering. After the session the assessment was mixed obsessional thoughts and acts.

On June 15, 2018 the Petitioner was also seen for therapeutic session. Notes indicate that Petitioner told the therapist that "everything is getting worse right now, but it will get better next week after solstice". OCD symptoms have been more prominent. A depression test was given by the therapist noting an increase from a score of 7 to a score of 11 which indicates an increase from mild to moderate depression. Similar testing was done for anxiety with a prior score of 16 which was moderately severe to a score of 18 indicating severe anxiety.

On May 25, 2018 the Petitioner was seen at his mental health care provider and a medication review and problem list meeting was conducted by the doctor. On May 23 the Petitioner was seen by his therapist and reports at that session that he is feeling less anxious, getting in better sleep. Notes indicated that patient still presented at baseline with anxiety affect and mood. The Petitioner is actively engaged in watching videos recommended by his therapist on mindfulness and trauma by neuroscientist Dan Siegel. On May 2, 2018 in another visit with his therapist was conducted noting patient continues to experience chronic and moderate to severe symptoms of PTSD, including extreme avoidance and hyperarousal. At this time he is unable to work, his social life is limited to his mother and his fiancée, and he only leaves the apartment for appointments. His nightmares have stopped and are attributed to the changes in the time of year by the patient. Petitioner discussed going shopping and how it creates anxiety. On April 18, 2018 in a therapy session Petitioner reported his sleep was way off due to nightmares, causing him to be afraid to sleep. A medication review was

conducted and change in medications were discussed to improve symptoms management.

A psychiatric evaluation was conducted on April 4, 2018. Notes indicate the Petitioner has been on Prozac for 18 years with varying doses, too high a dose makes his judgment poor. High doses also affect his alcohol consumption. Patient reported current dose of Prozac has given him better judgment regarding alcohol and that he doesn't want to go anywhere near alcohol due to his father being an alcoholic. Petitioner reported his accident in 2002 which he relates to his diagnosis of PTSD and OCD. Social anxiety has been progressive and patient reports anxiety level is high with isolation in his apartment all the time. Anxiety rated by the patient as 8 out of 10. At this time, his anxiety testing scores 16 which correlates to severe anxiety correlated with reports of making multiple lists of things that need to be done fearing he will forget and that will cause something bad to happen with recurring thought constantly throughout the day. He describes his thinking in this manner is magical thinking "doing things a certain number of times, and if I skip it or don't do it, need to fix it or do it again and then I will feel like I am reset, and the rest of my day will be better". Reports feeling as if there are other world entities that are waiting for patient to do something wrong and waiting to take the magic from him. The interview notes indicate signs of depression, paranoia that others are plotting to get him in trouble, exhibits mania, anxiety and panic. The anxiety is mostly at night and are described as night terrors. The note indicates no past psychiatric hospitalizations. At the time of the exam last use of alcohol was one year ago. The exam notes indicate no use of illegal drugs. At the conclusion of the examination the assessment was posttraumatic stress disorder and mixed obsessional thoughts and acts. Notes indicate that OC D behavior began in childhood and teenage years. Medication change to address nightmares and in society with beta blocker Vistatil were discussed. Patient agreed to try alternative medication.

The Petitioner was seen at [redacted] his mental health care provider on March 28, 2018 for a session with his therapist. Progress was noted as minimal. Notes indicate that Petitioner's symptoms have increased due to being more active and out in the world with increasing night terrors. Reports that he wakes with a shock in the middle of his chest which wakes him from sleep and suffers increased heart rate, fast breathing. Notes indicate that Petitioner took himself off of buspirone due to cloudy thinking. Petitioner was provided education on the dangers of managing his own medications and discussed him seeing the psychiatrist. Notes indicate that if Petitioner takes less Prozac he is less likely to drink and his behavior is more controlled; risky behavior means for him self-medicating with alcohol to reduce anxiety. While Petitioner expressed missing going out and doing things, feelings of anxiety when he does them makes staying inside better. During the exam Petitioner's eye contact was average, mood depressed, speech clear perceptions with in normal limits thought content contain preoccupations/ruminations, depressive and paranoid. No delusions were reported intelligence was estimated as average and insight was partial. Petitioner's judgment was impaired for his ability to make reasonable decisions.

The Petitioner underwent a biopsychosocial assessment on January 19, 2018. During the assessment Petitioner indicated arthritis in his hips, legs and ankles have gotten worse over time as a result of his 2002 car accident. He is limited when climbing stairs. His left arm is still partially paralyzed. The Petitioner has not worked since 2010. The PTSD symptoms included avoidance, hypervigilance, nightmares, exaggerated startle reflex, obsessive thoughts causing him to stand aside for the most part where he feels comfortable. At the time of the interview Petitioner reported having two friends his mother and his roommate. The Petitioner painted a picture of persistent worrying constant making of lists, irrational thoughts about what could negatively impact issues on the list and out picturing the worst-case scenario. Thoughts are constantly swimming in his head. He reports using headphones in public so that people don't talk to him. Petitioner's OCD symptoms were pre-existing the automobile accident in 2002. There was no history of substance use disorder. The mental status exam noted that the Petitioner's eye contact was average and attitude toward the examiner was anxious, mood was depressed and anxious with constricted affect, thought content noted preoccupations/ruminations of sessional depressive paranoid phobic. The interpretive summary noted petitioner experiences severe PTSD which is exacerbated by pre-existing OCD he has gotten little to no treatment for his condition. The diagnosis description was posttraumatic stress disorder, unspecified.

The Petitioner was seen for an independent medical exam regarding a psychological evaluation. The examination was conducted on May 16, 2018. The examination was obtained on behalf of DDS. At the time of the interview the Petitioner was in therapy at his current mental health care provider [redacted]. Patient reported being on Prozac for years and confirmed high dose resulted in loss of judgment and tendency to drink. Patient reports OCD compulsive traits started in the fifth grade requiring perfect attendance Exam notes indicate that Patient struggled with alcohol abuse and had struggled with alcoholism and had been inpatient and outpatient. Petitioner admitted he struggled with significant drinking between the years of 2002 and 2014 with two DUIs including his accident. Reports of problems sleeping due to frequent intense nightmares described with reluctance and fear of going back to sleep to avoid the dreams. Self-esteem was noted as fair; a strong work motivation was noted. The stream of mental activity was a high level of circumstantiality, which was anxiety based. No disturbance with logic or organization. Patient presented with no delusions, hallucinations or suicidal intent with his most painful emotional experience intense anxiety. Sensorium and mental capacity orientation noted memory intact, provided intact information and calculations, his abstract thinking was intact and judgment as well.

The exam concluded with the following diagnosis, post-traumatic stress disorder, obsessive compulsive disorder, panic disorder and generalized anxiety disorder. The prognosis was guarded. Since his injury and post-trauma, it appears to have intensified rather than eased. Further analytical notes indicate that Petitioner's pre-trauma adjustments would accentuate an intense post-trauma reaction bringing a severe level of chaos and trauma into a person who tries to cope with environments by being a perfectionist. He is thought to have a strong positive work motivation and he would return when capable. He is cooperating with his current treatment. At this point in time,

he is thought to have significant obstacles to obtaining and especially maintaining employment he is reasonably bright and personable, the primary issue is would he be able to maintain employment. The Petitioner was evaluated at that time as having sufficient judgment to manage his benefit funds.

Physical Impairment Medical Evidence

The Petitioner was seen on May 30, 2018 by [redacted] for an independent medical evaluation requested by DDS. At the time of the exam, the chief complaints were arthritis and chronic pain. The patient reported a motor vehicle accident where he sustained a fractured pelvis, humeral fracture, right tibial fracture and left fibular fracture. He underwent open reduction internal fixation to the left humerus, surgical stabilization to both legs, as well is his pelvis. He had partial paralysis of his left arm and leg and underwent prolonged physical therapy. He continues to have weakness on the left side. He is not in any pain management now. He does not use an assistive device at present. Petitioner reported he can stand and walk 45 minutes and lift 5 pounds with his left arm and denies problems sitting. At the time of the physical examination the mental status was essentially normal. With regard to his musculoskeletal system his cervical spine and dorsal lumbar spine were within normal ranges of motion. With regard to his left shoulder all measurements were significantly reduced 10 to 20° in terms of rotation, elevation abduction and abduction. With regard to his left elbow, the range of motion with regard to supination was reduced 20°. His hip joint range of motion was normal, his knee flexion and extension on the left were 20° less than normal. His left ankle dorsiflexion was affected 50%, as was his wrist dorsiflexion. His hands and fingers right and left were both with in normal. The cranial nerves were intact and motor strength is 3/5 in the left lower and left upper extremities. Sensory is intact to light touch and pinprick. The patient walks with a mild limp on the left without use of an assistive device. Reflexes in the left bicep, triceps and ankle on the left were zero as compared to on the right as 2+. The exam conclusions were patient has diminished range of motion predominantly in the left shoulder and left ankle that appears to be due to postsurgical changes. He has associated weakness on the left side and atrophy due to his injuries. He is able to do orthopedic maneuvers and compensates with a mild left limp and the use of an assistive device on uneven ground would be indicated because of balance. He has laxity to the left ankle. His right side appears to be stable. He complains of associated pelvic fractures, but it appears to be stable at present. Of note the patient has a history of PTSD. This appears to be his more significant ailment cognitively, he appeared stable during the exam a neuropsychological evaluation would be helpful.

The Petitioner participated in out-patient occupational therapy at a rehabilitation hospital beginning January 5, 2017 the prescribing staff physician indicated therapy was to be performed two days a week. Occupational anticipated treatment needs were home program, neuromuscular reeducation, pain management, patient education and therapeutic activities and exercises. The rehab potential was rated as fair and evaluation of Petitioner's physical posture/orientation indicates he has limitations with respect to postural tolerance and would require of change of position or from

sit/stand/walk at will, to achieve a 2 to 4 hour duration. The following movements were noted with respect to the physical impairments. The Petitioner was limited to never performing deep static squat or crawl and rarely bend to standing, bend to sitting rotating trunk to standing, rotating trunk, sitting kneeling squat crouch and climbing stairs. With respect to reach, he could not reach with the left hand and but was able to frequently reach with his right hand. With respect to his left arm he was rated as rarely capable of reaching overhead with the left arm and only occasionally (33%) with the right arm. With respect to weight lifting restrictions it was noted floor to waist capability to lift 10 pounds only 5 to 10% of the time waist to shoulder lift 10 pounds only 55% to 10% of the time and overhead lifting pounds rarely, 0 to 5% of the time. Petitioner was capable of carrying two-handed 15 pounds rarely 0 to 5% of the time.

Notes indicate Petitioner was seen three times for occupational therapy from January 4, 2017 to January 12, 2017. He was capable of standing/walking tolerance of 20 – 40 minutes with reports of left ankle pain and right foot fatigue from continuous left lower extremity offloading. He was unable to complete aerobic testing therefor a fitness level could not be determined. He was able to walk up to 1.7 mi./hr to 3.4 mi/hr for seven minutes. He was unable to continue, due to labored gait and pelvic pain. He was able to life 20 pounds at pivot with deteriorating strength and labored movements, asymmetric heights of the load and compensatory techniques for left elbow range of motion limitations. Floor lifting shoulder lift with 10 pounds with deteriorating posture in left upper extremity strength. Patient was unable to sustain a squat.

After one month of physical therapy the Petitioner had endurance deficits, IADL deficits, impaired body mechanics with functional activities, mobility deficits, pain, safety awareness deficits and strength deficits. Notes indicate he displayed significant strength loss and nerve damage to left bicep. His left arm range of motion is limited at the elbow to 100° extension and 100° of the left shoulder abduction and left shoulder flexion. He demonstrates left upper extremity arthritic pain and substitution for left arm function.

The Petitioner was seen for a general well health examination on September 8, 2017. No complaint was recorded at that time for any new condition problems reviewed were genital warts, anxiety, obsessive-compulsive disorder, alcoholism, PTSD, depressive disorder, chronic pain due to injury, perianal pain, skin lesion and liver enzyme abnormality and weakness of left limb. The past medical history indicates alcohol overuse/abuse anxiety disorder and behavioral problems due to OCD PTSD regarding motor vehicle accident. At that time petitioner reported drinking four times weekly having 5 to 6 drinks. Further alcohol screening was conducted and the following questions and answers were provided by the Petitioner: how many times in the last year were you not able to stop drinking, noted two monthly; during the last year have you failed to do what you normally expected because of drinking?, answer no never; during the last year have you needed a first drink in the morning, answer no never; during the last year have you had a feeling of guilt or remorse after drinking, answer yes three times weekly; during the last year have you been unable to remember, answer no; have you or someone else been injured as a result of drinking, answer yes; has a friend relative doctor or other health worker been concerned about your drinking and suggested you cut down,

answer yes. The score for the prescreening for alcohol was 13. An additional test for drugs was also administered with a score of zero. The Petitioner was provided advice and assistance regarding stages of change for substance use. Patient is already working with the [redacted]recovery program and feels it is more effective than [redacted]. At that time the notes indicate that petitioner has alcohol dependence on complicated.

The Petitioner was seen on June 13, 2017 for abdominal pain. An x-ray was taken which determined non-obstructive bowel gas pattern, screw and plate fixation is noted at the pubic symphysis. There may be fragmentation along the midportion of the metallic plate. There is no widening noted at the pubic symphysis. The impression was nonobstructive bowel gas pattern. A CT of the head was also performed on that date due to head trauma. The ventricles appeared normal in size and position, there was no acute intracranial hemorrhage, midline shift or mass effect. No sizable extra axial fluid collection is noted. The impression was no acute hemorrhage, midline shift or mass effect. X-rays were also taken of the left shoulder, pelvis, bilateral hips and left ankle due to chronic pain. With respect to the pelvis and hips the x-rays noted that the miniplate placed in the pelvic area after an automobile accident injury was disrupted. The screws placed to hold the many plate in place were not suggestive of loosening fracture or other abnormalities. The hips appeared bilaterally normal without significant degenerative changes. With respect to the left ankle, x-ray noted laterally placed side plate with multiple holding screws across the lateral malleolus. There is calcification along the syndesmosis. Small calcification also seen inferior and peripheral to the medial malleolus tip. The impression was postsurgical and posttraumatic changes left humerus, across the top of the symphysis pubis and involving the ankle. A small plantar calcaneal spur noted. No acute fractures dislocations, significant degenerative changes otherwise.

The Petitioner was seen on January 28, 2016 regarding changes in level of consciousness, patient unresponsive with lump on head. A CT of the brain was obtained, and the findings were there is prominence of the skull in the right frontal region, presumably accounting for the “bump” which is old and probably congenital with the result of a negative CT of the brain. A CT of the cervical spine was also performed and noted degenerative changes with auto fusion at C4-5. The cervical spine otherwise appears negative. Upon admission at the emergency room the notes indicate that the differential diagnosis was alcohol intoxication.

Numerous records some miscellaneous, were reviewed regarding visits to the Petitioner’s primary care provider [redacted]. Entries of note include testing for rheumatoid factor, which was determined negative after testing November 10, 2017. Admission on July 30, 2017 for unresponsiveness from alcohol intoxication with acute respiratory failure requiring intubation. Another admission on June 13, 2017 for alcohol abuse lactic acidosis secondary to alcohol use with discharge diagnosis, alcohol abuse recurrent without withdrawal. The Petitioner was seen by an orthopedic specialist on June 7, 2016 at which time he was seen for painful hardware due to multiple fractures. Petitioner was given an injection of Medrol to the left elbow for pain. The Petitioner was also seen at Heartside on May 19, 2016 due to increased pain in shoulder and ankle.

X-ray of shoulder and ankle perform and referred by to the Ortho surgeon to ensure no shifting of hardware.

Medical records documenting a motor vehicle accident in February 2002 were also provided and indicated the following admission diagnosis: left open bimalleolar ankle fracture, right open tibial fracture, closed left humerus, left radial nerve neuropraxis, Pelvic ring injury fractured right superior and inferior pubic rami., mild traumatic brain injury, right sided degloving.

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 matter and the several mental status exams of both Petitioner's treating source and DDS examinations, it is determined that listing 12.06 Anxiety and Obsessive-Compulsive Disorders and 12.15 Trauma or Stressors-related Disorders were considered. The requirements of both listings are set forth below.

12.06 Anxiety and obsessive-compulsive disorders (see 12.00B5), satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1, 2, or 3:

1. Anxiety disorder, characterized by three or more of the following;

a. Restlessness;
b. Easily fatigued;
c. Difficulty concentrating;
d. Irritability;
e. Muscle tension; or
f. Sleep disturbance.

2. Panic disorder or agoraphobia, characterized by one or both:

    a. Panic attacks followed by a persistent concern or worry about additional panic attacks or their consequences; or
    b. Disproportionate fear or anxiety about at least two different situations (for example, using public transportation, being in a crowd, being in a line, being outside of your home, being in open spaces).

3. Obsessive-compulsive disorder, characterized by one or both:

    a. Involuntary, time-consuming preoccupation with intrusive, unwanted thoughts; or
    b. Repetitive behaviors aimed at reducing anxiety.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

    1. Understand, remember, or apply information (see 12.00E1).
    2. Interact with others (see 12.00E2).
    3. Concentrate, persist, or maintain pace (see 12.00E3).
    4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent;” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

    1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and
    2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

12.15 Trauma- and stressor-related disorders (see 12.00B11), satisfied by A and B, or A and C:

A. Medical documentation of all of the following:

    1. Exposure to actual or threatened death, serious injury, or violence;
    2. Subsequent involuntary re-experiencing of the traumatic event (for example, intrusive memories, dreams, or flashbacks);

3. Avoidance of external reminders of the event;
4. Disturbance in mood and behavior; and
5. Increases in arousal and reactivity (for example, exaggerated startle response, sleep disturbance).

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).
2. Interact with others (see 12.00E2).
3. Concentrate, persist, or maintain pace (see 12.00E3).
4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is "serious and persistent;" that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and
2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

Therefore, after a thorough review of the medical evidence set forth in detail in Step 2 of the Conclusions of Law, it is determined that the medical evidence shows that Petitioner's impairment of Anxiety and OCD diagnosis meets or is equal in severity to the criteria in Appendix 1 of the Guidelines for **Anxiety and obsessive-compulsive disorders, Listing 12.06 A. 1. and A. 3 and B** and as such is to be considered as disabled.

The Petitioner's past alcohol abuse was considered and was determined not material in that he is in treatment, has been sober for some time and none of the medical psych evaluators indicated that it was a material contributing factor to the Petitioner's current mental impairments. The DDA materiality, requires further analysis which follows in light of DDA evidence.

In this case, the medical evidence presented demonstrated past alcohol abuse by Petitioner. Hospital treatment records demonstrate that on two occasions the Petitioner was taken to the hospital due to alcohol abuse requiring treatment including intubation due to unconsciousness and extreme intoxication on another. The Petitioner's records indicate he does attend treatment for alcohol abuse. The Petitioner also advised

several examiners that when on high doses of Prozac, which he continues to be prescribed at a lower dose, he abused alcohol. The evidence presented did not support that his current treatment with Prozac caused a resumption of alcohol abuse and/or requiring hospitalization. Based upon the evidence presented the issue as to whether the Petitioner's drug and alcohol abuse referred to as DDA is material must be examined.

The burden of proof to establish disability throughout the sequential evaluation process remains with the Petitioner. Alcohol abuse must be reviewed following the analysis found in SSR 13-2p to determine whether alcohol abuse or addiction is a contributing factor material to the determination of disability. See Social Security Act, Sections 223(d)(2)(C) and 1614(a)(3)(J) of the Social Security Act (Act). Also considered is whether considering all the Petitioner's medically determinable impairments, whether the Petitioner would continue to be disabled if he stopped using alcohol; that is, it must be determined whether alcohol abuse (DDA) is material. SSR 13 – 2p.

Five questions are posed to determine materiality.

1. Does the claimant have DDA?

Based upon the medical documentation presented the answer is yes in that past hospitalizations and inpatient treatment are documented in the record. Medical records from his treating mental health provide indicate no alcohol use for one year and that Petitioner is attending a program similar to AA.

2. Is the claimant disabled considering all impairments including DDA?

Yes. The Petitioner mental impairment met listing 12.06 for Anxiety and Obsessive-Compulsive Disorders as found at Step 3 of the Hearing Decision.

3. Is DDA the only impairment?

DDA is not the only impairment. Petitioner has both mental and physical impairments as detailed in the review of medical evidence contained in the Hearing Decision at Step 2.

4. Is the other impairment(s) disabling by itself while the claimant is dependent upon or abusing drugs or alcohol?

The Petitioner's medical evidence clearly document severe anxiety and OCD as well as Post Traumatic Stress Disorder which by themselves are disabling. The Petitioner has been found to be markedly and extremely limited in the four categories analyzed in the detailed Step 2 medical evidence presented by several examiners none of who indicated that Petitioner's signs and symptoms would no longer be disabling if Petitioner continued to abuse alcohol. These impairments have continued to be severe while Petitioner is dependent upon or abusing alcohol. Several examinations noted alcohol

abuse history as disclosed by the Petitioner and continued to find serious limitations on abilities despite alcohol impairment.

5. Does the DDA cause or affect the claimant's medically determinable impairment(s)

The Petitioner's DDA for alcohol abuse does not significantly affect the Petitioner's mental impairments. Medical records presented document that Petitioner has suffered from anxiety and OCD since the age of 10 ongoing and the Petitioner's PTSD results from a serious automobile accident which occurred in 2002, which is related to and causes significant flash backs and night terrors (nightmares) described in Petitioner's PTSD symptoms. None of the medical examiners or IME evaluators gave an opinion that would support a conclusion that the Petitioner's Anxiety, OCD or PTSD is caused by his alcohol abuse, although it may affect those impairments. However, no medical source documents have addressed that question ie. how alcohol abuse affects the Petitioner's diagnosed anxiety, OCD and PTSD. The mental impairments, irrespective of DDA would continue to be disabling given the Petitioner's current mental status review even though he has not been abusing alcohol. In addition, the mental impairment evaluations with respect to Petitioner's abilities, regarding work related abilities, including ability to understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself and ability to sustain workplace behavior as assessed by the several mental status evaluations support a conclusion that these limitations would and have persisted despite alcohol abuse by Petitioner.

6. Would the other impairment(s) improve to the point of nondisability in the absence of DDA?

No. The current several mental status evaluations provide evidence that supports the Petitioner's continuing and ongoing disability after alcohol use ceased.

Based upon the foregoing analysis, it is determined that DDA is not material to the finding of disability based upon mental impairment for Listing 12.06 and thus it is determined that Petitioner is disabled at Step 3.

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 INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE THE ORDER WAS ISSUED:

1. The Department shall re-register and process Petitioner's February 6, 2018 SDA application to determine if all the other non-medical criteria are satisfied and notify Petitioner of its determination;

2. The Department shall supplement Petitioner for lost benefits, if any, that Petitioner was entitled to receive if otherwise eligible and qualified;

3. The Department shall review Petitioner's continued eligibility in October 2019.

LMF/tlf

Lynn M. Ferris
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) 763-0155; 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

Counsel for Respondent – Via USPS

[redacted]

Via Email:

[redacted]

Petitioner – Via USPS

[redacted]