STATE OF MICHIGAN

STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

[redacted]

Reg. No.: 2010-17252
Issue No.: 2009
Case No.: [redacted]
Hearing Date: April 22, 2010
Wayne County DHS (18)

ADMINISTRATIVE LAW JUDGE: Colleen M. Mamelka

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Claimant's request for a hearing. After due notice, a hearing was held in Taylor, Michigan on Thursday, April 22, 2010. The Claimant appeared and testified. The Claimant was represented by [redacted] of [redacted]. [redacted] appeared on behalf of the Department.

During the hearing, the Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional medical evidence. The evidence was received, reviewed, and entered as Exhibits 3, 4 and 5. This matter is now before the undersigned for a final decision.

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of the Medical Assistance ("MA-P") benefit program?

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. The Claimant submitted an application for public assistance seeking MA-P benefits on September 25, 2009 and November 16, 2009.

2. On November 6th and 18th, 2009, the Medical Review Team ("MRT") found the Claimant not disabled. (Exhibit 1, pp. 1, 2, 21, 22)

3. On November 16, 2009, the Department notified the Claimant of the MRT determination(s). (Exhibit 1, p. 109)

4. On January 13, 2010, the Department received the Claimant's written request for hearing.

5. On February 11, 2010, the State Hearing Review Team ("SHRT") found the Claimant not disabled. (Exhibit 2)

6. The Claimant alleged physical disabling impairments due to back pain, carpal tunnel syndrome ("CTS"), degenerative disc disease, spinal bifida, ulcer, scoliosis, chronic obstructive pulmonary disease ("COPD"), stomach pain, colitis, incontinence, acid reflux, and migraine headaches.

7. The Claimant alleged mental disabling impairments due to anxiety and depression.

8. At the time of hearing, the Claimant was 52 years old with an [redacted] birth date; was 5'2" in height; and weighed 130 pounds.

9. The Claimant is a high school graduate with some vocational training and an employment history in stocking, hotel/home cleaning, in a factory, as a guard, lunch mom, bartender, and as a waitress.

10. The Claimant's impairments have lasted, or are expected to last, continuously for a period of 12 months or longer.

CONCLUSIONS OF LAW

As a preliminary matter, the Claimant has previously applied for MA-P benefits with the most recent Hearing Decision dated March 31, 2009 being a denial. Accordingly, this decision focuses on subsequent medical evidence.

The Medical Assistance ("MA") program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department of Human Services ("DHS"), formerly known as the Family Independence Agency, pursuant to MCL 400.10 *et seq* and MCL 400.105. Department policies are found in the Bridges Administrative Manual ("BAM"), the Bridges Eligibility Manual ("BEM"), and the Bridges Reference Manual ("BRM").

Disability is defined as the inability to do any substantial gainful activity 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) The person claiming a physical or mental disability has the burden to establish it 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-relate activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913 An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a) Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicants takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3) The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2)

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1) The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (i.e. age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need 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) If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from step three to step four. 20 CFR 416.920(a)(4); 20 CFR 416.945 Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1) An individual's residual functional capacity assessment is evaluated at both steps four and five. 20 CFR 416.920(a)(4) In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv) In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a) An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a) The individual has the responsibility to

provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6)

In addition to the above, when evaluating mental impairments, a special technique is utilized. 20 CFR 416.920a(a) First, an individual's pertinent symptoms, signs, and laboratory findings are evaluated to determine whether a medically determinable mental impairment exists. 20 CFR 416.920a(b)(1) When a medically determinable mental impairment is established, the symptoms, signs and laboratory findings that substantiate the impairment are documented to include the individual's significant history, laboratory findings, and functional limitations. 20 CFR 416.920a(e)(2) Functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. *Id.;* 20 CFR 416.920a(c)(2) Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality is considered. 20 CFR 416.920a(c)(1) In addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of functional limitation. 20 CFR 416.920a(c)(3) The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4) A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. *Id.* The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. *Id.*

After the degree of functional limitation is determined, the severity of the mental impairment is determined. 20 CFR 416.920a(d) If severe, a determination of whether the impairment meets or is the equivalent of a listed mental disorder is made. 20 CFR 416.920a(d)(2) If the severe mental impairment does not meet (or equal) a listed impairment, an individual's residual functional capacity is assessed. 20 CFR 416.920a(d)(3)

As outlined above, the first step looks at the individual's current work activity. In the record presented, the Claimant is not involved in substantial gainful activity therefore is not ineligible for disability benefits under Step 1.

The severity of the Claimant's alleged impairment(s) is considered under Step 2. The Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b) An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c)

Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b) Examples include:

1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

5. Responding appropriately to supervision, co-workers and usual work situations; and

6. Dealing with changes in a routine work setting.

Id. The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985) An impairment qualifies as non-severe only if, regardless of a claimant's age, education, or work experience, the impairment would not affect the claimant's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985)

In the present case, the Claimant alleges disability due to back pain, CTS, degenerative disc disease, spinal bifida, ulcer, scoliosis, COPD, stomach pain, colitis, incontinence, acid reflux, migraine headaches, anxiety, and depression. In support of her claim, older records from as early as 2005 were submitted which document treatment for ulcerative colitis, hip/back/knee pain, abdominal pain, diarrhea, hiatal hernia repair, gastritis, pancreatitis, anxiety, acid reflux, pneumonia, electrolyte imbalance, and diverticulitis.

On [redacted], a psychiatric evaluation was performed. The diagnoses were major depressive disorder, recurrent (in partial remission), and panic disorder. The Global Assessment Functioning ("GAF") was 60.

On [redacted], the Claimant presented to the hospital with complaints of nausea, dry heaves, diarrhea, and abdominal pain. The hemoglobin was 13. The discharge summary was not submitted so it's not clear what the final diagnoses were.

On [redacted], the Claimant was admitted to the hospital with complaints of abdominal distension, vomiting, and suspected obstruction. The hemoglobin was 11.8

and albumin was 4, and magnesium was 2.1. The Claimant was discharged on [redacted] with the diagnosis of gastric ulcers.

On [redacted], the Claimant was admitted to the hospital with complaints of abdominal pain and distension. Initially, there was evidence of small bowel dilation and obstruction/bleeding however an x-ray confirmed a nonspecific gas pattern. The hemoglobin was 14.9 and albumin was 4.3. The Claimant was discharged on [redacted].

On [redacted], the Claimant presented to the hospital with evidence of acute gastritis. An x-ray revealed gastric distention of the abdomen. An esophagogastroduodenoscopy confirmed gastritis. The hemoglobin was 10.7 and albumin was 4.2. The Claimant was treated and discharged on [redacted].

On [redacted], the Claimant was admitted to the hospital with complaints of abdominal pain, distension, and vomiting. The CT scan was negative except for some changes in liver suggestive of cirrhosis. The Claimant was discharged on [redacted] with the diagnoses of intractable nausea, vomiting, incomplete high small bowel obstruction, and history of gastric ulcer, reflux ulcerative esophagitis, and history of colitis.

On [redacted], the Claimant was admitted to the hospital with complaints of abdominal pain and bloating. The Claimant underwent an EGD and upper GI which showed widening of the second portion of the duodenum with thickened mucosal folds. Biopsies were obtained but the results were not documented. The Claimant's hemoglobin ranged from 10.9 to 13.3 and albumin of 4. An MRI revealed spondylolisthesis of the L4-5 region as well as mild disc bulges of L3-4 and L-4-5 without stenosis. An abnormal CAT scan was suggestive of liver disease. The Claimant was discharged on [redacted].

On [redacted], the Claimant was admitted to the hospital with complaints of abdominal pain. The Claimant's history of abdominal pain, diarrhea bloating, dry heaves were resolved with nasogastric decompression of the GI tract. The Claimant's hemoglobin was 13.3 and albumin of 3.8. The reason for the recurrence was not found. The discharge summary was not submitted.

On [redacted], the Claimant presented to the hospital with complaints of abdominal pain, vomiting, and diarrhea. The reason for the recurrent symptoms was unknown. The Claimant's BMI was 23.2. The discharge summary was not admitted.

On [redacted], the Claimant presented to the emergency room with complaints of abdominal pain, nausea, and vomiting. The Claimant's hemoglobin was 12.2. The

Claimant was admitted however the discharge summary was not submitted so it is unclear what the final diagnoses were or the length of stay.

On [redacted], the Claimant was admitted to the hospital with complaints of abdominal pain. A GI evaluation for her symptoms was negative. During her stay, a pain consultation was done which documented no motor deficits. The impression was chronic abdominal pain with an acute exacerbation secondary to multiple medical problems related to abdomen and recent elevated liver enzymes with questionable cirrhosis and chronic back pain secondary to facet syndrome and history of narcotic abuse and misuse. The Claimant has a narcotic agreement with the pain clinic. A discharge summary was not submitted so it is unclear what the discharge diagnoses were or how long (at least until [redacted]) the Claimant remained hospitalized.

On [redacted], the Claimant was admitted to the hospital with complaints of abdominal pain. The discharge summary was not submitted.

On [redacted], a Medical Examination Report was completed on behalf of the Claimant. The current diagnoses were headaches, chronic pancreatitis, ulcerative colitis, anxiety, and irritable bowel syndrome ("IBS"). The Claimant, who is 5'2", weighed 129 pounds. The Claimant was in stable condition and found able to occasionally lift/carry less than 10 pounds; stand and/or walk at least 2 hours in an 8-hour workday; sit less than 6 hours during this same time frame; and able to perform repetitive actions with all extremities. Mental limitations were noted in memory, sustained concentration, and social interaction.

On [redacted], the Claimant had a liver biopsy. Under a microscope sections revealed cirrhotic liver (stage 4) with severe inflammation (grade 4) with moderate steatosis. The Claimant's hemoglobin was 13.3.

On [redacted], a liver biopsy (from [redacted]) confirmed cirrhosis secondary to steatohepatitis.

On [redacted], a Medical Examination Report was completed on behalf of the Claimant by a treating internist. The current diagnoses were gastroesophageal reflux disease, GERD, peptic ulcer disease, and cirrhosis. The Claimant weighed 137 pounds. The Claimant was in stable condition and it was marked that she had no limitations and that any limitations were not expected to last more than 90 days. The Claimant was unable to lift/carry any weight; did not need an assistive device for ambulation; and was unable to perform repetitive actions with her upper extremities. The Claimant had no mental limitations.

On [redacted], the Claimant attended an independent psychiatric evaluation. The diagnosis was bipolar disorder, depressed type. The Psychiatrist opined that the

Claimant was able to understand, retain, and follow simple instructions and was generally restricted to performing simple routine repetitive tasks. A Mental Residual Functional Capacity Assessment was completed which found that the Claimant was not markedly limited in any category and was moderately limited in 5 of the 20 factors.

On [redacted], the Claimant was admitted to the hospital with complaints of abdominal pain. The discharge summary was not submitted.

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the Claimant has presented some medical evidence establishing that she does have some physical and mental limitations on her ability to perform basic work activities. The medical evidence has established that the Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, the Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The Claimant has alleged physical and mental disabling impairments due to back pain, CTS, degenerative disc disease, spinal bifida, ulcer, scoliosis, COPD, stomach pain, colitis, incontinence, acid reflux, migraine headaches, anxiety, and depression.

Listing 5.00 defines digestive system impairments. Disorders of the digestive system include gastrointestinal hemorrhage, hepatic (liver) dysfunction, inflammatory bowel disease, short bowel syndrome, and malnutrition. 5.00A They may also lead to complications, such as obstruction, or be accompanied by manifestations in other body systems. 5.00A Symptoms and signs of IBD include diarrhea, fecal incontinence, rectal bleeding, abdominal pain, fatigue, fever, nausea, vomiting, arthralgia, abdominal tenderness, palpable abdominal mass (usually inflamed loops of bowel) and perineal disease. 5.00E2 Surgical diversion of the intestinal tract, including ileostomy and colostomy, does not preclude any gainful activity if you are able to maintain adequate nutrition and function of the stoma. 5.00E4

Listing 5.06 discusses inflammatory bowel disease ("IBD"). The IBD must be documented by endoscopy, biopsy, appropriate medically acceptable imaging, or operative findings with:

A. Obstruction of stenotic areas (not adhesions) in the small intestine or colon with proximal dilatation, confirmed by appropriate medically acceptable imaging or in surgery, requiring hospitalization for intestinal

decompression or for surgery, and occurring on at least two occasions at least 60 days apart within a consecutive 6-month period.

OR

B. Two of the following despite continuing treatment as prescribed and occurring within the same consecutive 6-month period:

1. Anemia with hemoglobin of less than 10.0 g/dL, present on at least two evaluations at least 60 days apart; or

2. Serum albumin of 3.0 g/dL or less, present on at least two evaluations at least 60 days apart; or

3. Clinically documented tender abdominal mass palpable on physical examination with abdominal pain or cramping that is not completely controlled by prescribed narcotic medication, present on at least two evaluations at least 60 days apart; or

4. Perineal disease with a draining abscess or fistula, with pain that is not completely controlled by prescribed narcotic medication, present on at least two evaluations at least 60 days apart; or

5. Involuntary weight loss of at least 10 percent from baseline, as computed in pounds, kilograms, or BMI, present on at least two evaluations at least 60 days apart; or

6. Need for supplemental daily enteral nutrition via a gastrostomy or daily parenteral nutrition via a central venous catheter.

In this case, since [redacted], the Claimant was admitted (as opposed to emergent care) to the hospital approximately every three weeks due to abdominal pain, nausea, vomiting, diarrhea, and weight loss despite prescribed treatment. After review of the entire medical records, it is found that the Claimant's impairments meet, or are the medical equivalent thereof, a listed impairment within 5.00, specifically, 5.06. Accordingly, the Claimant is found disabled at Step 3 with no further analysis required.

DECISION AND ORDER

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

Accordingly, it is ORDERED:

1. The Department's determination is REVERSED.

2. The The Department shall initiate review of the September 25, 2009 application to determine if all other non-medical criteria are met and inform the Claimant and her Representative of the determination in accordance with department policy.

3. The Department shall supplement for any lost benefits (if any) that the Claimant was entitled to receive if otherwise eligible and qualified in accordance with department policy.

4. The Department shall review the Claimant's continued eligibility in February 2012 in accordance with department policy.

Colleen M. Mamelka

Colleen M. Mamelka
Administrative Law Judge
For Maura Corrigan, Director
Department of Human Services

Date Signed: ___1/31/2011_____

Date Mailed: ____1/31/2011_____

NOTICE: **Administrative Hearings may order a** rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative Hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the mailing of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt date of the rehearing decision.

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cc: [redacted]