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

IN THE MATTER OF:

[redacted]

Reg. No.: 201138427
Issue No.: 2009, 4031
Case No.: [redacted]
Hearing Date: September 20, 2011
Wayne County DHS (18)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

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 telephone hearing was held on September 20, 2011 from Detroit, Michigan. The claimant appeared and testified; Michael Jones also appeared on behalf of Claimant. On behalf of Department of Human Services (DHS), [redacted], Specialist, appeared and testified.

ISSUE

The issue is whether DHS properly denied Claimant's application for Medical Assistance (MA) and State Disability Assistance (SDA) benefits on the basis that Claimant is not a disabled individual.

FINDINGS OF FACT

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

1. On 2/28/11, Claimant applied for SDA and MA benefits.

2. Claimant's only basis for MA and SDA benefits was as a disabled individual.

3. On 5/31/11, the Medical Review Team (MRT) determined that Claimant was not a disabled individual.

4. On 6/9/11, DHS denied Claimant's application for MA and SDA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On 6/14/11, Claimant requested a hearing disputing the denial of SDA and MA benefits.

6. On 7/14/11, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual (see Exhibits 79-80) based, in part, on Vocational-Rule 202.13.

7. As of the date of the administrative hearing, Claimant was a 51 year old female (DOB 7/11/60) with a height of 5'7'' and weight of 300 pounds.

8. Claimant smokes approximately 0-2 cigarettes per day and has no relevant history of alcohol or drug abuse.

9. Claimant's highest level of education completed was high school.

10. Claimant last received medical coverage in 2007.

11. Claimant claimed to be a disabled individual based on impairments of asthma/breathing problems and various problems related to her knee, hip and back.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). DHS (formerly known as the Family Independence Agency) administers the MA program 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 Reference Tables Manual (RFT).

The undersigned will refer to the DHS regulations in effect as of 6/2011, the month of the DHS decision which Claimant is disputing. Current DHS manuals may be found online at the following URL: http://www.mfia.state.mi.us/olmweb/ex/html/.

MA provides medical assistance to individuals and families who meet financial and nonfinancial eligibility factors. The goal of the MA program is to ensure that essential health care services are made available to those who otherwise would not have financial resources to purchase them.

The Medicaid program is comprised of several sub-programs which fall under one of two categories; one category is FIP-related and the second category is SSI-related. BEM 105 at 1. To receive MA under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled. *Id*.

Families with dependent children, caretaker relatives of dependent children, persons under age 21 and pregnant, or recently pregnant, women receive MA under FIP-related categories. *Id*. AMP is an MA program available to persons not eligible for Medicaid through the SSI-related or FIP-related categories. It was not disputed that Claimant's only potential category for Medicaid would be as a disabled individual.

Disability is established if one of the following circumstances applies (see BEM 260 at 1-2):

- by death (for the month of death);
- the applicant receives Supplemental Security Income (SSI) benefits;
- SSI benefits were recently terminated due to financial factors;
- the applicant receives Retirement Survivors and Disability Insurance (RSDI) on the basis of being disabled; or
- RSDI eligibility is established following denial of the MA benefit application (under certain circumstances).

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

Generally, state agencies such as DHS must use the same definition of disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally defined as the inability to do any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905. A nearly identical definition of disability is found under DHS regulations. BEM 260 at 8.

Substantial gainful activity means a person does the following:

- Performs significant duties, and
- Does them for a reasonable length of time, and
- Does a job normally done for pay or profit. *Id*. at 9.

Significant duties are duties used to do a job or run a business. *Id*. They must also have a degree of economic value. *Id*. The ability to run a household or take care of oneself does not, on its own, constitute substantial gainful activity. *Id*.

The person claiming a physical or mental disability has the burden to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 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, are insufficient to establish disability. 20 CFR 416.927.

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled. 20 CFR 416.920. If there is no finding of disability or lack of disability at each step, the process moves to the next step. 20 CFR 416.920 (a)(4).

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person is statutorily blind or not. The current monthly income limit considered SGA for non-blind individuals is $1,000.

In the present case, Claimant denied having any employment since the date of the MA application; no evidence was submitted to contradict Claimant's testimony. Without ongoing employment, it can only be concluded that Claimant is not performing SGA. It is found that Claimant is not performing SGA; accordingly, the disability analysis may proceed to step two.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the 12 month duration requirement. 20 CFR 416.920 (a)(4)(ii). The impairments may be combined to meet the severity requirement. If a severe impairment is not found, then a person is deemed not disabled. *Id*.

The impairments must significantly limit a person's basic work activities. 20 CFR 416.920 (a)(5)(c). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. *Id.* Examples of basic work activities include:

- physical functions (e.g. walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling)
- capacities for seeing, hearing, and speaking, understanding; carrying out, and remembering simple instructions
- use of judgment
- responding appropriately to supervision, co-workers and usual work situations; and/or
- dealing with changes in a routine work setting.

Generally, federal courts have imposed a de minimus standard upon claimants to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v Bowen,* 880 F2d 860, 862 (6th Cir. 1988). Similarly, Social Security Ruling 85-28 has

been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirement is intended "to do no more than screen out groundless claims." *McDonald v. Secretary of Health and Human Servs.*, 795 F.2d 1118, 1124 (1st Cir. 1986).

In determining whether Claimant's impairments amount to a severe impairment, all relevant evidence may be considered. The analysis will begin with the submitted medical documentation.

The testifying DHS witness (who was also Claimant's assigned specialist) completed a Social Summary (Exhibits 3-5) dated 5/13/11. The document noted Claimant's alleged impairments of anxiety attacks, left knee replacement and back spasms. Claimant provided no additional testimony or documentation concerning anxiety attacks. Thus, that alleged impairment will not be considered further, due to the lack of evidence to support its consideration.

A Medical Social Questionnaire (Exhibits 4.5-6) dated 4/11/11 was completed by Claimant. Claimant noted two previous hospitalizations, on 11/23/2010, due to left knee pain and a 1/14/2011 hospitalization due to chest pain. Claimant noted her illness was bone to bone left knee pain. She noted that her knee pops and burns and is swollen. She noted that her doctor recommended a left knee replacement.

A Medical Examination Report dated 3/19/11 was completed by Claimant's treating physician. Claimant testified she rarely see her treating physician due to her lack of health insurance. Claimant was diagnosed with left knee degenerative joint disease (DJD) and left pes anserine bursitis. It was noted that constant knee pain was a chief complaint of Claimant's. It was also noted that Claimant is in need of household assistance.

An examination report (Exhibits 22-23) from Claimant's treating physician was submitted. It was noted that Claimant complained of a left knee pain level of 5/10. It was also noted that stretching increases the pain. The physician noted an impression of left knee DJD and pes anserine bursitis. Injections to address Claimant's pain complaints were given.

An examination report dated 9/25/10 (Exhibits 20-21) from Claimant's treating physician. Claimant saw her physician complaining of a pain level of 8/10. Claimant stated that movement exacerbates the pain. It was also noted that Claimant has a range

of motion of 0-120 degrees in the left knee, there was no bruising or swelling. Motor tests were performed on the knee and several related areas showed Claimant functioned 5/5 for each test.

An examination report dated 11/30/10 (Exhibits 18-19) showed similar results. This examination included an additional statement concerning an injection that was given to Claimant. The report found the same results concerning range of motion and motor testing as the test from 9/25/10.

A letter dated 12/7/10 (Exhibit 15) from Claimant's treating doctor was submitted. The physician noted Claimant exhausted non-surgical options and recommended a consideration of surgical options.

An examination report dated 3/12/11 (Exhibits 16-17) was submitted. It was noted that Claimant saw her treating doctor on that date concerning a 10/10 pain level in her knee. It was noted that Claimant uses a cane and that standing worsens the pain. Range of motion and motor tests were given and again there were no negative signs.

An examination report dated 3/27/10 from Claimant's treating doctor noted Claimant reported doing very well following an arthroscopy and that Claimant felt ready to return to work. Claimant was cleared to work without restrictions.

An examination report dated 3/7/10 (Exhibit 25) noted Claimant had an upcoming knee surgery. The diagnosis of left knee DJD was noted. Other impressions were given but not noted here because they were not referenced in subsequent medical documents by the physician.

Other pre-surgery documents (Exhibits 27-33) refer to a left meniscus tear on Claimant's left knee. However, as post-surgery documents do not refer to the tear, it is presumed that the tear is not an ongoing problem. Though the tear may not be an ongoing issue, Claimant's reports of pain following her surgery clearly show other knee impairments.

Hospital documents dated 1/14/11 (Exhibits 34-57) were submitted. The documents note Claimant went to the hospital concerning a complaint of severe chest pain. A past history of GERD and hyperlipidemia were noted. Claimant's obesity, family illnesses, sedentary lifestyle and smoking were each noted. X-rays and an EKG were performed but showed no issues. A stress test was positive. It was documented that a SPECT revealed a slightly decreased perfusion at the anterior wall on the stress scan. It was recommended that Claimant see a cardiologist for further evaluation. It was also recommended that Claimant consider cardiac catheterization, though this was not done, presumably due to a lack of health insurance. It was noted that Claimant was chest-pain

free prior to her leaving the hospital though it was also noted that Claimant could still suffer a heart attack and may have left too quickly.

Hospital documents dated 11/23/10 (Exhibits 58-70) were also presented. These documents appear to refer to a hospital visit by Claimant concerning a 10/10 level of knee pain. It was noted that Claimant ambulates without assistance. Claimant was prescribed Vicodin (500 mg@ 1-2/day) in response to her complaints. It is not believed Claimant was able to fill her prescription due to her lack of health insurance.

Hospital documents dated 11/23/10 verified that four x-rays were taken of Claimant's knee. The x-rays found no fractures or dislocations. It was noted that there was medical joint space narrowing and patellofemoral interval narrowing. Spurring was also noted along with suprapatellar joint effusion.

Claimant submitted documents concerning her daily living activities (Exhibits 71-73). Claimant noted problems sleeping due to left knee pain. Claimant noted she performs housework but needs to take frequent breaks (every 10 minutes) due to the knee pain. Claimant testified she goes shopping but utilizes a scooter to do so. Claimant indicated she was told by her physician that she needs a total knee replacement and is unable to work until she gets one.

Based on the presented evidence, Claimant established a severe impairment based on her left knee problems. The evidence established that Claimant is impaired from all physical activities involving her knee (squatting, walking, standing et al) due to the left knee problems. Though Claimant can perform these activities, she can do so only with rest and patience. Further, Claimant complaints of pain were credible and well established. The pain complaints would affect Claimant's concentration and efficiency. It is found that Claimant established a severe impairment due to her left knee pain. Accordingly, the analysis may move to step three.

Claimant's primary impairment appears to be problems with his leg. Musculoskeletal issues are covered by Listing 1.00. Claimant's impairment does not appear to be specifically diagnosed so the most relevant listing would be for joint dysfunction. The listing reads:

> **1.02** ***Major dysfunction of a joint(s) (due to any cause)***: Characterized by gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankylosis, instability) and chronic joint pain and stiffness with signs of limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With:

> A. Involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in inability to ambulate effectively, as defined in 1.00B2b;
> OR
> B. Involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively, as defined in 1.00B2c.

As indicated above, the ability to ambulate effectively is defined by SSA in 1.00B2b. This definition reads:

> Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. Ineffective ambulation is defined generally as having insufficient lower extremity functioning (see 1.00J) to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities.

Further guidelines are provided in 1.00B2. This section reads:

> To ambulate effectively, individuals must be capable of sustaining a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living. They must have the ability to travel without companion assistance to and from a place of employment or school. Therefore, examples of ineffective ambulation include, but are not limited to, the inability to walk without the use of a walker, two crutches or two canes, the inability to walk a block at a reasonable pace on rough or uneven surfaces, the inability to use standard public transportation, the inability to carry out routine ambulatory activities, such as shopping and banking, and the inability to climb a few steps at a reasonable pace with the use of a single hand rail.

Part B of the above listing involves upper extremity joints and is not relevant to Claimant’s circumstances. Part A is relevant and will be considered.

The analysis as to whether Claimant meets the above listed impairment will begin with an analysis as to whether Claimant has an inability to ambulate effectively. There are no direct statements from Claimant’s physicians that Claimant has an inability to ambulate effectively. Claimant’s use of a cane is insufficient, by itself, to meet the above listing which requires the use of two canes to establish ineffective ambulation. However, the evidence tends to support that Claimant cannot ambulate effectively.

Claimant testified that she uses a cane to get everywhere. This testimony was confirmed by her boyfriend (who also testified). Claimant's complaints of pain were persuasive and well documented. Claimant went to the hospital on previous occasion based solely on her knee pain. Claimant's daily activities description and testimony all pointed to a finding that she is unable to ambulate effectively.

It is less clear whether a gross anatomical deformity was established. The medical records made no references to any of the examples of deformity within the above listing. However, when considering the totality of Claimant's knee problems (spurring, joint space narrowing, patellofemoral narrowing and joint effusion) it is found that a gross deformity was established. As it was also established that joint space narrowing and an inability to ambulate effectively also occurred, it is found that Claimant meets the above impaired listing. Accordingly, it is found that Claimant is a disabled individual and DHS erred in denying Claimant's application for MA benefits.

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. DHS administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. DHS policies for SDA are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 at 4. The goal of the SDA program is to provide financial assistance to meet a disabled person's basic personal and shelter needs. *Id*. To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older. BEM 261 at 1.

A person is disabled for SDA purposes if the claimant (see BEM 261 at 1):

- receives other specified disability-related benefits or services, see Other Benefits or Services below, or
- resides in a qualified Special Living Arrangement facility, or
- is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability; or
- is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS).

The undersigned has already found Claimant to be disabled for purposes of MA benefits by finding that Claimant meets the listed impairment for joint failure. This finding makes Claimant automatically eligible for SDA benefits based on the lesser 90 day durational requirement. It is found that DHS improperly denied Claimant's application for SDA benefits.

DECISION AND ORDER

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

- reregister Claimant's application dated 2/28/11 for MA and SDA benefits;
- process Claimant's application based on the finding that Claimant is a disabled individual;
- supplement Claimant for any benefits not received as a result of the improper denial; and
- if Claimant is deemed eligible for MA and/or SDA benefits, schedule Claimant for a benefit redetermination date of 9/2012.

The actions taken by DHS are REVERSED

Christian Gardocki
Administrative Law Judge
For Maura Corrigan, Director
Department of Human Services

Date Signed: September 23, 2011

Date Mailed: September 23, 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.

CG/hw

cc: [redacted]

[redacted]