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

IN THE MATTER OF:

[redacted]

Reg. No.: 2011-41699
Issue No.: 2009
Case No.: [redacted]
Hearing Date: September 15, 2011
County: Wayne (82-49)

ADMINISTRATIVE LAW JUDGE: Robert J. Chavez

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon claimant's request for a hearing. After due notice, a hearing was held on September 15, 2011, at the Department of Human Services (Department) office in Wayne County, Michigan, District 49. Claimant was represented at the hearing by [redacted].

ISSUE

Was the denial of claimant's application for Medical Assistance program (MA-P) and retroactive MA-P benefits for lack of disability correct?

FINDINGS OF FACT

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

1. Claimant applied for MA-P and retroactive MA-P on December 28, 2006, with retroactive Medicaid to September 2006.

2. Claimant was 62 years old at the time of his death, [redacted].

3. Claimant had a 12th grade education.

4. Claimant was not currently working.

5. Claimant had a prior work history consisting of unskilled work.

6. On [redacted] claimant presented to the hospital with reports of rectal bleeding.

7. Claimant had a medical history at that time of hypertension and hepatitis C.

8. Claimant also reported dizziness and presyncopal symptoms.

9. There was also indication of potential pulmonary embolism.

10. Test results conducted at that time were consistent with polycystic kidney disease, pleural effusions and potential cysts of the liver.

11. There are no further medical reports related to this condition.

12. There are no pieces of evidence in the file that detail work-related limitations.

13. Blood tests run in [redacted] showed normal levels of the chemical values tested.

14. Claimant was discharged on [redacted].

15. Claimant has not presented evidence of any further hospitalizations.

16. Medical records from [redacted] indicate the presence of hepatitis C and cellulitis.

17. No medical records were presented that document the continuance of these conditions, or whether these conditions affected work-related activities.

18. On June 24, 2011, the Medical Review Team denied MA-P and Retro MA-P, stating drug and alcohol materiality.

19. This denial was an effort to reconstruct the previous denial, which was lost.

20. On October 16, 2007, claimant requested a hearing based on a presumed negative case action of August 1, 2007.

21. On August 10, 2011, the State Hearing Review Team (SHRT) denied MA-P and retroactive MA-P, stating that claimant was capable of other work.

22. On September 15, 2011, a hearing was held before the Administrative Law Judge.

23. Claimant submitted additional evidence; on November 9, 2011, SHRT again denied claimant's case stating that claimant did not have a severe impairment.

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). The Department 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 Bridges Reference Manual (BRM).

Federal regulations require that the Department use the same operative definition of the term "disabled" as is used by the Social Security Administration for Supplemental Security Income (SSI) under Title XVI of the Social Security Act. 42 CFR 435.540(a).

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

This is determined by a five step sequential evaluation process where current work activity, the severity and duration of the impairment(s), statutory listings of medical impairments, residual functional capacity, and vocational factors (i.e., age, education, and work experience) are considered. These factors are always considered in order according to the five step sequential evaluation, and when a determination can be made at any step as to the claimant's disability status, no analysis of subsequent steps are necessary. 20 CFR 416.920

The first step that must be considered is whether the claimant is still partaking in SGA. 20 CFR 416.920(b). To be considered disabled, a person must be unable to engage in SGA. A person who is earning more than a certain monthly amount (net of impairment-related work expenses) is ordinarily considered to be engaging in SGA. The amount of monthly earnings considered as SGA depends on the nature of a person's disability; the Social Security Act specifies a higher SGA amount for statutorily blind individuals and a lower SGA amount for non-blind individuals. Both SGA amounts increase with increases in the national average wage index. The monthly SGA amount for statutorily blind individuals for 2011 is $1,640. For non-blind individuals, the monthly SGA amount for 2011 is $1,000.

In the current case, the Department has presented no evidence or allegations that claimant is engaging in SGA at the time of the application. Therefore, the Administrative Law Judge finds that claimant is not engaging in SGA and, thus, passes the first step of the sequential evaluation process.

The second step that must be considered is whether or not the claimant has a severe impairment. A severe impairment is an impairment expected to last 12 months or more (or result in death), which significantly limits an individual's physical or mental ability to perform basic work activities. The term "basic work activities" means the abilities and aptitudes necessary to do most jobs. Examples of these 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.

20 CFR 416.921(b).

The purpose of the second step in the sequential evaluation process is to screen out claims lacking in medical merit. *Higgs v. Bowen* 880 F2d 860, 862 (6th Cir, 1988). As a result, the Department may only screen out claims at this level which are "totally groundless" solely from a medical standpoint. This is a *de minimus* standard in the disability determination that the court may use only to disregard trifling matters. As a rule, any impairment that can reasonably be expected to significantly impair basic activities is enough to meet this standard.

In the current case, claimant has not presented medical evidence of an impairment expected to last 12 months or more (or result in death), which significantly limits the physical or mental ability to perform basic work activities.

Claimant applied for benefits on [redacted], with a retroactive application for [redacted]. At that time, claimant was in the hospital for complications of polycystic kidney disease, pleural effusions and potential cysts of the liver. Claimant was noted to have dizziness and near syncopal episodes. There is no further medical evidence documenting the persistence of this condition.

Claimant apparently had blood work done in [redacted]; this blood work was completely normal.

There is no other evidence showing that claimant continued with this condition or that this condition continued to present a severe impairment that lasted 12 months. Claimant died in [redacted] of a condition unrelated to the alleged impairments.

While claimant's condition was undoubtedly severe at the time of application, there is no evidence that claimant's condition was expected to persist for the required 12-month time period. No evidence has been presented that claimant's condition persisted until the time of his death, or even 12 months after his admission. The last known treatment in [redacted] was completely normal; if claimant's condition were truly not improving, the undersigned would have expected further admissions. Furthermore, medical

documentation of hepatitis C in [redacted], while compelling, does not spell out whether claimant had any work-related limitations to this impairment, or whether the hepatitis C was severe enough to need hospitalizations or reduce claimant's residual capacity.

Furthermore, even if the undersigned were to disregard the durational issue, there is no indication in the medical record that claimant's impairments affected claimant's work-related abilities. Claimant presented to the hospital with rectal bleeding, dizziness, and pre-syncopal episodes. There is no documentation as to whether this was an isolated incident or a part of a pattern that could have prevented claimant's ability to work. Succinctly put, there is no competent material evidence that would allow the Administrative Law Judge to draw the conclusion that claimant meets the requirements of step 2.

While the undersigned acknowledges that claimant's condition at the time of his admission in [redacted] was serious, there is no evidence that the condition persisted. Furthermore, there was no evidence that the condition prevented claimant from participating in any work-related activities. Claimant has failed to meet the burden of proof in showing that his condition is expected to last 12 months and, therefore, cannot pass step two.

For that reason, the undersigned finds that claimant does not meet the durational requirement under the Medical/Vocational grid rules found at 20 CFR 416.909, and cannot be considered disabled. As a finding of not disabled can be made at step two, no further evaluation is required.

In the present case, claimant has not presented the required competent, material, and substantial evidence which would support a finding that claimant has an impairment or combination of impairments which would significantly limit the physical or mental ability to do basic work activities. 20 CFR 416.920(c). Although claimant has complained of medical problems, the clinical documentation submitted by claimant is not sufficient to establish a finding that claimant is disabled. There is no objective medical evidence to substantiate claimant's claim that the impairment or impairments are severe enough to reach the criteria and definition of disabled. Accordingly, after careful review of claimant's medical records, this Administrative Law Judge finds that claimant is not disabled for the purposes of MA-P.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that claimant is not disabled for the purposes of MA-P. Therefore, the decisions to deny claimant's application for MA-P and Retro MA-P were correct.

Accordingly, the Department's decision in the above-stated matter is, hereby, AFFIRMED.

Robert J. Chavez
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: March 7, 2012

Date Mailed: March 8, 2012

NOTICE: Michigan Administrative Hearing System (MAHS) 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. MAHS 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. (60 days for FAP cases)

The claimant may appeal the Decision and Order to Circuit Court within 30 days of the receipt 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.

Claimant may request a rehearing or reconsideration for the following reasons:

- A rehearing **MAY** be granted if there is newly discovered evidence that could affect the outcome of the original hearing decision.
- A reconsideration **MAY** be granted for any of the following reasons:
  - misapplication of manual policy or law in the hearing decision,
  - typographical errors, mathematical error, or other obvious errors in the hearing decision that effect the substantial rights of the claimant:
  - the failure of the ALJ to address other relevant issues in the hearing decision.

Request must be submitted through the local DHS office or directly to MAHS by mail at
Michigan Administrative Hearings
Reconsideration/Rehearing Request
P. O. Box 30639
Lansing, Michigan 48909-07322

RJC/pf

cc: [redacted]