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

IN THE MATTER OF:

[redacted]

Reg. No. 201145470
Issue No. 2009
Case No. [redacted]
Hearing Date: November 14, 2011
Wayne County DHS (82)

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 November 14, 2011 from Detroit, Michigan. The claimant appeared and testified; [redacted] appeared as Claimant's authorized hearing representative. [redacted] also testified and 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) 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 6/9/11, Claimant applied for MA benefits.

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

3. On 6/28/11, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (See Exhibits 1-2).

4. On 7/6/11, DHS denied Claimant's application for MA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On 7/22/11, Claimant requested a hearing disputing the denial of MA benefits.

6. On 9/2/11, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual (see Exhibit 80), in part, by application of Medical-Vocational Rule 202.21.

7. On 11/14/11, an administrative hearing was held and Claimant provided new medical documents.

8. The newly presented medical evidence was sent to SHRT for a reconsideration of disability.

9. O n 12/15/11, SHRT determined that Claimant was not a disabled individual (see Exhibits 84-85), in part, by application of Medical-Vocational Rule 202.20.

10. As of the date of the administrative hearing, Claimant was a 46 year old male ([redacted]) with a height of 6'1 '' and weight of 271 pounds.

11. Claimant has no known current usage of tobacco, alcohol or illegal substances.

12. Claimant's highest education year completed was the 12th grade.

13. As of the date of hearing, Claimant had not received any medical coverage since approximately 2005.

14. Claimant stated that he is a disabled individual based on impairments involving chest pain, shortness of breath, dizzy spells, heart problems, hypertension, diabetes and pain associated with his left leg, back and shoulders.

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 controlling DHS regulations are those that were in effect as of 6/2011, the month of the application which Claimant contended was wrongly denied. 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 though DHS does always offer the program to applicants. It was not disputed that Claimant's only potential category for Medicaid eligibility would be as a disabled individual.

Disability for purposes of MA benefits 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 SSI 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 functionally 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).

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 and 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). 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. Some documents were admitted as exhibits but were not necessarily relevant to the disability analysis; thus, there may be gaps in exhibits numbers.

The majority of presented medical documentation involved a hospital admission beginning [redacted]. A History and Physical report (Exhibits 11-14) dated [redacted] was presented. It was noted that Claimant came to the emergency room following complaints of shortness of breath. A history of asthma, diabetes and hypertension was noted. Upon examination, Claimant denied ongoing chest pain or shortness of breath. The examining physician started Claimant on the IV heparin, aspirin, beta-blocker and ACE inhibitor. Claimant was referred for a cardiothoracic consultation. The treating physician provided an assessment of non-ST elevation myocardial infraction with no ST-elevation from the EKG. Further assessments of uncontrolled hypertension, uncontrolled diabetes mellitus and a history of morbid obesity were provided. A comparable impression was provided the next day (see Exhibits 17-18) except that community acquired pneumonia was added.

A Consultation Report (Exhibits 56-57) dated [redacted] was presented. It was noted that Claimant underwent urgent cardiac catheterization which demonstrated 100% occlusion of the right coronary, 70% occlusion of the proximal LAD and 95% occlusion of the circumflex with multiple lesions of 40-50% in the proximal circumflex.

Bypass surgery was discussed with Claimant. Claimant was given a 10-12% risk factor due to Claimant's morbid obesity, diabetes, myocardial infarct and congestive heart failure. It was noted that this was a significantly high risk factor.

A Consultation document dated [redacted]1 (Exhibits 58-59) was presented. It was noted that Claimant underwent three vessel coronary artery bypass graft surgery. An operative report (Exhibits 60-61) was presented which described the surgery.

Other pre-operation documents (Exhibits 62-66) were presented though not notable, other than remaining consistent with other documents. Additional treatment documents dated [redacted] (see Exhibits 19-53) were provided. The documents were not notable other than demonstrating the assessment process during Claimant's hospitalization.

A discharge summary (Exhibits 54-55) dated [redacted] was provided. Claimant was found to have an acute non-ST elevation myocardial infraction. A cardiac cath revealed that Claimant's ejection fraction was 40-50%. Claimant's right coronary artery was found to be "severely diseased". Claimant was prescribed 13 medications (See Exhibit 55) and instructed to check his blood sugar levels twice per day.

A DHS form entitled Medical Examination Report (Exhibits 67-68) dated [redacted] was presented. It was noted that Claimant needed help dressing, wore glasses, had shortness of breath with exertion and was obese due to overeating. Claimant's condition was stable. The examining physician noted several limitations on Claimant. Claimant was to never lift/carry ten pounds or more but could occasionally lift/carry less than 10 pounds. Claimant was limited to standing or walking less than two hours in an eight hour day. A cane was needed for Claimant's ambulation. The physician also limited Claimant from performing repetitive actions such as: reaching, pushing/pulling, fine manipulating and operating foot/leg controls. Claimant had no limits on repetitive simple grasping. Claimant was further limited in some unspecified way concerning sustained concentration and comprehension. It was also noted that Claimant could not meet needs in the home concerning meals and housekeeping. It was also noted that Claimant was on multiple medications. Some of the medications included: Lasix (20 mg qd), Lopressor (50 mg qd), Prinivil (10 mg qd), Cordarone (200 mg bid), Plavix (75 mg qd) and several others.

A Medical Examination Report (Exhibits 81-82) dated [redacted] from Claimant's treating physician was presented. The form contained identical limitations to Claimant than as noted on the form dated [redacted].

A Classification of Patients with Diseases of the Heart form (Exhibit 83) dated [redacted] from Claimant's treating physician was presented. The DHS form lists four different functional capacities and five different therapeutic classifications. Claimant was described as a patient with cardiac disease resulting in marked limitation of physical

activity; comfortable at rest but less than ordinary activity causes fatigue, palpitation, dyspnea or anginal pain. The therapeutic classification was that Claimant was a patient whose ordinary physical activity should be markedly restricted.

Additional surgery documents (Exhibits 70-73) were presented. These documents were not notable other than maintaining consistency with other documents.

Claimant's friend completed an Activities of Daily Living (Exhibits 75-79), a questionnaire designed for clients to provide information about their abilities to perform various day-to-day activities. The form was undated though it is known that DHS received the form on [redacted]. Claimant noted trouble sleeping due to anxiety. Claimant noted he used to mow the lawn and perform housework but now gets tired easily. Claimant stated he needs help getting dried off after a shower and getting dressed. Claimant stated he buys his own food but needs help cooking it because he cannot stand too long. Claimant indicated that he has lost 59 pounds, plans his meals concerning price and calorie intake and is eating healthier.

Based on the presented evidence, Claimant established marked restrictions to the performance of physical basic work activities. Claimant's standing and walking are limited to less than two hours/day. Claimant uses a cane for ambulation. Claimant is to never perform repetitive actions of pushing, pulling, lifting/carrying ten pounds or more or fine manipulation. These restrictions are significant restrictions of physically-based basic work activities.

Claimant's physician answered that Claimant's condition will last beyond 90 days (a longer option was not provided on the form); this answer was given once on a form dated [redacted] and again on a form dated 10/5/11. No evidence indicated that Claimant's condition would be resolved sooner. It is found that Claimant's impairments will last beyond one year.

Based on the presented evidence, it is found that Claimant established suffering from a severe impairment. Accordingly, the disability analysis moves to step three.

The third step of the sequential analysis requires a determination whether Claimant'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 Claimant's impairments are listed and deemed to meet the 12 month requirement, then the claimant is deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step.

The listed impairment Claimant is most likely to meet concerns Claimant's heart impairment. Cardiovascular impairments are covered by Listing 4.00. The coronary artery disease and occlusions are best covered by Listing 4.04 which reads:

4.04 Ischemic heart disease, with symptoms due to myocardial ischemia, as described in 4.00E3-4.00E7, while on a regimen of prescribed treatment (see 4.00B3 if there is no regimen of prescribed treatment), with one of the following:

A. Sign- or symptom-limited exercise tolerance test demonstrating at least one of the following manifestations at a workload equivalent to 5 METs or less:

1. Horizontal or downsloping depression, in the absence of digitalis glycoside treatment or hypokalemia, of the ST segment of at least -0.10 millivolts (-1.0 mm) in at least 3 consecutive complexes that are on a level baseline in any lead other than a VR, and depression of at least -0.10 millivolts lasting for at least 1 minute of recovery; or

2. At least 0.1 millivolt (1 mm) ST elevation above resting baseline in non-infarct leads during both exercise and 1 or more minutes of recovery; or

3. Decrease of 10 mm Hg or more in systolic pressure below the baseline blood pressure or the preceding systolic pressure measured during exercise (see 4.00E9e) due to left ventricular dysfunction, despite an increase in workload; or

4. Documented ischemia at an exercise level equivalent to 5 METs or less on appropriate medically acceptable imaging, such as radionuclide perfusion scans or stress echocardiography.

OR

B. Three separate ischemic episodes, each requiring revascularization or not amenable to revascularization (see 4.00E9f), within a consecutive 12-month period (see 4.00A3e).

OR

C. Coronary artery disease, demonstrated by angiography (obtained independent of Social Security disability evaluation) or other appropriate medically acceptable imaging, and in the absence of a timely exercise tolerance test or a timely normal drug-induced stress test, an MC, preferably one experienced in the care of patients with cardiovascular disease, has concluded that performance of exercise tolerance testing would present a significant risk to the individual, with both 1 and 2:

1. Angiographic evidence showing:

a. 50 percent or more narrowing of a nonbypassed left main coronary artery; or

b. 70 percent or more narrowing of another nonbypassed coronary artery; or

c. 50 percent or more narrowing involving a long (greater than 1 cm) segment of a nonbypassed coronary artery; or

d. 50 percent or more narrowing of at least two nonbypassed coronary arteries; or

e. 70 percent or more narrowing of a bypass graft vessel; and

2. Resulting in very serious limitations in the ability to independently initiate, sustain, or complete activities of daily living.

The medical evidence established that Claimant had multiple heart issues amounting to ischemic heart failure. The issues originally arose during a time Claimant was not under a prescribed treatment. The symptoms and limitations continued after heart surgery.

There was evidence that Claimant had total occlusion and near total occlusion of other arteries. These impairments are sufficient to establish (c)(1)(b) of the above listing was met. Part (c)(2) of the above listing was met by Claimant's treating physician statements that limiting RFC and daily activities.

There was no evidence establishing whether Claimant could sustain an exercise tolerance test. Despite the absence of evidence concerning Claimant's ability to perform an exercise test, Claimant established heart defects which meet the SSA listing. The exercise test requirement is somewhat secondary and not found to be particularly troubling in meeting the above SSA listing.

It is found that Claimant meets the SSA listing for ischemic heart disease and is a disabled individual. Accordingly, the DHS denial of Claimant's application for MA benefits based on Claimant not being a disabled individual was improper.

It should be noted that even if Claimant was found to not meet a SSA listing, it would have been found that Claimant was incapable of performing his past employment and incapable of performing other employment based on residual function capacity limitations prescribed by Claimant's physician. Thus, even if Claimant was found not to meet a SSA listing, Claimant would have been found disabled at step five of the disability analysis.

It should also be noted that the finding of disability only applies to Claimant's application for MA benefits and is intended to only last for a one year period. Future findings of disability shall be redetermined by DHS in accordance with their policies.

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 for MA benefits. It is ordered that DHS:

(1) reinstate Claimant's MA benefit application dated 6/9/11;
(2) upon reinstatement, evaluate Claimant's eligibility for MA benefits on the basis that Claimant is a disabled individual;
(3) supplement Claimant for any benefits not received as a result of the improper denial; and

(4) if Claimant is found eligible for future MA benefits, to schedule a review of benefits in one year from the date of this administrative decision.

The actions taken by DHS are REVERSED.

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

Date Signed: 1/4/12

Date Mailed: 1/4/12

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 to:

Michigan Administrative hearings
Reconsideration/Rehearing Request
P. O. Box 30639
Lansing, Michigan 48909-07322

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cc: [redacted]