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

IN THE MATTER OF:

[redacted]

Reg. No. 201221628
Issue No. 2009
Case No. [redacted]
Hearing Date: March 5, 2012
Macomb County DHS (20)

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 March 5, 2012 from Detroit, Michigan. The claimant appeared and testified; [redacted] testified on behalf of Claimant and appeared as Claimant's authorized hearing representative and translator. On behalf of Department of Human Services (DHS), [redacted], Specialist, appeared and testified.

ISSUE

The issue is whether DHS properly terminated Claimant's ongoing Medical Assistance (MA) benefit eligibility 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. Claimant was an ongoing MA benefit recipient.

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

3. On 12/8/11, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 4-5).

4. On 12/13/11, DHS terminated Claimant's MA benefits effective 1/2012 and mailed a Notice of Case Action informing Claimant of the termination.

5. On 12/21/11, Claimant requested a hearing disputing the termination of MA benefits.

6. On 2/7/12, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual (see Exhibits 71-72), in part, by finding that Claimant has no significant impairment to the performance of basic work activities.

7. As of the date of the administrative hearing, Claimant was a 58 year old female (DOB 11/11/53) with a height of 5'2 '' and weight of 125 pounds.

8. Claimant was homeschooled and has no discernible education grade of completion.

9. As of the date of the administrative hearing, Claimant has no health coverage and last received coverage in 12/2011.

10. Claimant claimed to be a disabled individual based on impairments related to cirrhosis, high protein kidney levels, hepatitis B, back pain and abdominal discomfort.

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 12/2011, 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 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). 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.

Once an individual has been found disabled for purposes of MA benefits, continued entitlement is periodically reviewed in order to make a current determination or decision as to whether disability remains in accordance with the medical improvement review standard. 20 CFR 416.993(a); 20 CFR 416.994. In evaluating a claim for ongoing MA benefits, federal regulations require a sequential evaluation process be utilized. 20 CFR 416.994(b)(5). The review may cease and benefits continued if sufficient evidence supports a finding that an individual is still unable to engage in substantial gainful activity. *Id.* Prior to deciding an individual's disability has ended, the department will develop, along with the Claimant's cooperation, a complete medical history covering at least the 12 months preceding the date the individual signed a request seeking continuing disability benefits. 20 CFR 416.993(b). The department may order a consultative examination to determine whether or not the disability continues. 20 CFR 416.993(c).

The first step in the analysis in determining the status of a claimant's disability requires the trier of fact to consider the severity of the impairment(s) and whether it meets or equals a listed impairment in Appendix 1 of subpart P of part 404 of Chapter 20. 20 CFR 416.994(b)(5)(i). If a listing is met, an individual's disability is found to continue and no further analysis is required.

Claimant alleged several medical problems though the most significant involved liver function. SSA impairment policy states the following concerning how liver disease is evaluated:

> *General. Chronic liver disease* is characterized by liver cell necrosis, inflammation, or scarring (fibrosis or cirrhosis), due to any cause, that persists for more than 6 months. Chronic liver disease may result in portal hypertension, cholestasis (suppression of bile flow), extrahepatic manifestations, or liver cancer. (We evaluate liver cancer under 13.19.) Significant loss of liver function may be manifested by hemorrhage from varices or portal hypertensive gastropathy, ascites (accumulation of fluid in the abdominal cavity), hydrothorax (ascitic fluid in the chest cavity), or encephalopathy. There can also be progressive deterioration of laboratory findings that are indicative of liver dysfunction. Liver transplantation is the only definitive cure for end stage liver disease (ESLD).
>
> 2. *Examples of chronic liver disease* include, but are not limited to, chronic hepatitis, alcoholic liver disease, non-alcoholic steatohepatitis (NASH), primary biliary cirrhosis (PBC), primary sclerosing cholangitis (PSC), autoimmune

hepatitis, hemochromatosis, drug-induced liver disease, Wilson's disease, and serum alpha-1 antitrypsin deficiency. Acute hepatic injury is frequently reversible, as in viral, drug-induced, toxin-induced, alcoholic, and ischemic hepatitis. In the absence of evidence of a chronic impairment, episodes of acute liver disease do not meet 5.05.

Listing 5.05 which covers chronic liver disease is the most applicable listing to Claimant's impairments. This listing would mandate a finding of disability based on liver disease if Claimant's condition meets the following:

A. Hemorrhaging from esophageal, gastric, or ectopic varices or from portal hypertensive gastropathy, demonstrated by endoscopy, x-ray, or other appropriate medically acceptable imaging, resulting in hemodynamic instability as defined in 5.00D5, and requiring hospitalization for transfusion of at least 2 units of blood. Consider under disability for 1 year following the last documented transfusion; thereafter, evaluate the residual impairment(s).
OR
B. Ascites or hydrothorax not attributable to other causes, despite continuing treatment as prescribed, present on at least 2 evaluations at least 60 days apart within a consecutive 6-month period. Each evaluation must be documented by:
1. Paracentesis or thoracentesis; or
2. Appropriate medically acceptable imaging or physical examination and one of the following:
a. Serum albumin of 3.0 g/dL or less; or
b. International Normalized Ratio (INR) of at least 1.5.
OR
C. Spontaneous bacterial peritonitis with peritoneal fluid containing an absolute neutrophil count of at least 250 cells/mm3
OR
D. Hepatorenal syndrome as described in 5.00D8, with on of the following:
1. Serum creatinine elevation of at least 2 mg/dL; or
2. Oliguria with 24-hour urine output less than 500 mL; or
3. Sodium retention with urine sodium less than 10 mEq per liter.
OR
E. Hepatopulmonary syndrome as described in 5.00D9, with:
1. Arterial oxygenation (PaO2) on room air of:
a. 60 mm Hg or less, at test sites less than 3000 feet above sea level, or
b. 55 mm Hg or less, at test sites from 3000 to 6000 feet, or
c. 50 mm Hg or less, at test sites above 6000 feet; or
2. Documentation of intrapulmonary arteriovenous shunting by contrast-enhanced echocardiography or macroaggregated albumin lung perfusion scan.
OR
F. Hepatic encephalopathy as described in 5.00D10, with 1 and either 2 or 3:

1. Documentation of abnormal behavior, cognitive dysfunction, changes in mental status, or altered state of consciousness (for example, confusion, delirium, stupor, or coma), present on at least two evaluations at least 60 days apart within a consecutive 6-month period; and
2. History of transjugular intrahepatic portosystemic shunt (TIPS) or any surgical portosystemic shunt; or
3. One of the following occurring on at least two evaluations at least 60 days apart within the same consecutive 6-month period as in F1:
a. Asterixis or other fluctuating physical neurological abnormalities; or
b. Electroencephalogram (EEG) demonstrating triphasic slow wave activity; or
c. Serum albumin of 3.0 g/dL or less; or
d. International Normalized Ratio (INR) of 1.5 or greater.
OR
G. End stage liver disease with SSA CLD scores of 22 or greater calculated as described in 5.00D11. Consider under a disability from at least the date of the first score.

A Medical Examination Report (Exhibits 11-12) dated [redacted] was completed by Claimant's treating physician. It was noted that the physician first treated Claimant on [redacted] and last examined Claimant on [redacted]. The physician provided diagnoses of: chronic hepatitis B with compensated liver cirrhosis, membranous glomerulosclerosis and hyperlipidemia / hypertriglyceridemia. "No hepatomegaly" was noted as part of a physical examination for Claimant's abdomen. Older medical documents showed Claimant was hospitalized in 2010 for liver dysfunction. A "final report" dated [redacted] from a hospital admission noted that end stage liver disease was suspected (see Exhibit 69).

Hepatitis B is not covered by a SSA listing but is generally evaluated under the listing for liver disease. Though liver problems were established, there is a lack of evidence that Claimant's ongoing liver dysfunction is severe enough to meet any parts of the above listing. The Medical Examination report noted that Claimant suffers from cirrhosis but "no hepatomegaly" is interpreted to mean that Claimant's liver currently functions in a normal capacity. It is found that Claimant failed to establish meeting the listing for liver disease.

A listing for spinal disorders (Listing 1.04) was considered based on Claimant's LBP complaints. The medical records were devoid of back pain causes. For example, there were no records verifying x-rays or an MRI of Claimant's back. There was not a specific diagnosis for Claimant's back pain. This listing was rejected due to a lack of evidence and a failure to establish a spinal disorder resulting in a compromised nerve root.

It is found that Claimant failed to establish meeting a SSA listing. Accordingly, the analysis moves to step two.

The second step of the analysis considers whether medical improvement occurred. CFR 416.994(b)(5)(ii). Medical improvement is defined as any decrease in the medical severity of the impairment(s) which was present at the time of the most favorable medical decision that the individual was disabled or continues to be disabled. 20 CFR 416.994(b)(1)(i). If medical improvement is established, the analysis proceeds to step three; if there is no medical improvement, the analysis proceeds to step four.

It is presumed that Claimant's original award of MA benefits was based on liver disease. The Medical Examination Report that cites Claimant's abdomen has no hepatomegaly is persuasive evidence of medical improvement. Though Claimant cannot be said to be "cured" from liver disease (which is consistent with a current diagnosis of cirrhosis) a lack of hepatomegaly is evidence that Claimant is in remission from the disease. It is found that medical improvement occurred and the analysis may move to step three.

Step three considers whether the medical improvement relates to the ability do work as dictated by 20 CFR 416.994 (b)(1)(i)-(iv). CFR 416.994(b)(5)(iii). The determination requires improvement of a person's residual function capacity (RFC) based on the impairment(s) that was present at the time of the most recent favorable medical determination. *Id*. If medical improvement is not related to the ability to do work then the process moves to step four. If medical improvement is related to the ability to do work, the process moves to step five.

RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations

In the present case, there was little direct evidence concerning Claimant's RFC. The medical records did not specifically restrict Claimant in any capacity. Again, the best evidence are the physical examination conclusions from Claimant's treating physician. In 2010, Claimant was hospitalized under suspicion of end stage liver disease, an exceptionally serious diagnosis; one that would be expected to make Claimant physically helpless. A lack of hepatomegaly is a massive improvement from end stage liver disease and would reasonably lead to a finding that Claimant's medical improvement increased her RFC. It is found that Claimant has medically improved as it related to her RFC; accordingly, the analysis moves to step five.

Step five of the analysis considers whether all the current impairments in combination are severe. 20 CFR 416.994(b)(5)(v). When the evidence shows that all current impairments in combination do not significantly limit physical or mental abilities to do basic work activities, these impairments will not be considered severe and the claimant will not be considered disabled. *Id*. If the impairments are considered severe, the analysis moves to step six. *Id*.

The impairments must significantly limit a person's basic work activities. 20 CFR 416.921 (a). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921 (b). 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. (*Id*.)

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).

Claimant alleged impairments of cirrhosis caused by hepatitis B, kidney dysfunction, abdominal discomfort requiring fluid drainage maintenance and back pain. Claimant testified she can walk half of a mile before she is out of breath; Claimant stated it takes her 90 minutes before she recoups. Claimant stated she has difficulties in performing functions such as squatting, kneeling and standing due to unspecified leg problems.

The medical documents offer no explicit support for finding that Claimant suffers shortness of breath or leg problems. The medical documents show no current liver or kidney problems.

A chief complaint of fatigue was noted by Claimant's treating physician. Medical records from 9/2011 note Claimant's cholesterol level, triglyceride level, LDL cholesterol, non-HDL cholesterol and Cholesterol/HDL levels were all high. High cholesterol could potentially affect energy level though the records did not provide a specific correlation between fatigue and high cholesterol.

Giving significant respect for the de minimus standard required at this step of the analysis, it is found that Claimant's reported fatigue would significantly affect her ability to perform basic work activities. It is expected that the fatigue has lasted or will last for 12 months or longer.

As it was found that Claimant established a significant impairment to basic work activities for a period longer than 12 months, it is found that Claimant established having a severe impairment. Accordingly, the disability analysis may move to step six.

The sixth step in analyzing a disability claim requires an assessment of the Claimant's RFC and past relevant employment. 20 CFR 416.994(b)(5)(vi). An individual is not disabled if it is determined that a claimant can perform past relevant work. *Id*.

Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

Claimant has never held employment. Without any employment history, it cannot be found that Claimant can return to past relevant employment. Accordingly, the analysis moves to step seven.

In the seventh and last step in the process, the individual's RFC in conjunction with his or her age, education, and work experience, are considered to determine whether the individual can engage in any other substantial gainful work which exists in the national economy. SSR 83-10. While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

To determine the physical demands (i.e. exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967. The definitions for each are listed below.

Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b) Even though weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additionally limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.*

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.*

Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.*

Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands are considered nonexertional. 20 CFR 416.969a(a). Examples of non-exertional limitations include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i)-(vi) If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2)

The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.* In using the rules of Appendix 2, an individual's circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, is compared to the pertinent rule(s).

For purposes of this decision, an analysis of medium work shall be adopted. It is not believed that Claimant could reasonably be expected to lift more than 50 pounds or to routinely lift items weighing more than 25 pounds. Thus, it is found that Claimant is not capable of an exertional level greater than medium work.

Based on Claimant's age (advanced age), education (marginal or none) and work history (none), Medical-Vocational Rule 203.10 is found to apply. This rule dictates a finding that Claimant is disabled. Accordingly, it is found that DHS improperly terminated Claimant's ongoing MA benefit eligibility.

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 eligibility effective 1/2012;
(2) evaluate Claimant's ongoing eligibility for MA benefits subject to the finding that Claimant is a disabled individual;
(3) supplement Claimant for any benefits not received as a result of the improper termination; and
(4) schedule a review of benefits in one year from the date of this administrative decision if Claimant is found eligible for future MA benefits.

The actions taken by DHS are REVERSED.

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

Date Signed: March 13, 2012

Date Mailed: March 13, 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 to:

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

CG/hw

cc: [redacted]