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

IN THE MATTER OF:

Reg. No.:	201223980
Issue No.:	2009, 4031
Case No.:	
Hearing Date:	March 15, 2012
	Wayne County DHS (57)

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 15, 2012 from Detroit, Michigan. The claimant appeared and testified; Beverly Snider appeared and testified on behalf of Claimant. On behalf of Department of Human Services (DHS), , Specialist, appeared and testified.

ISSUE

The issue is whether DHS properly denied Claimant's application for Medical Assistance (MA) and State Disability Assistance (SDA) 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 7/14/11, Claimant applied for SDA and MA benefits including retroactive MA benefits from 4/2011.

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

3. On 12/20/11, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (See Exhibit 3).

4. On 12/28/11, DHS denied Claimant's application for MA and SDA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On 1/13/12, Claimant requested a hearing disputing the denial of SDA and MA benefits.

6. On 2/10/12, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual (see Exhibits 83-84), in part, by application of Medical-Vocational Rule 201.18.

7. As of the date of the administrative hearing, Claimant was a [redacted] year old male ([redacted]) with a height of 6'1 '' and weight of 285 pounds.

8. Claimant is a tobacco user with no known relevant history of alcohol or illegal substance abuse.

9. Claimant's highest education year completed was the 8th grade.

10. Claimant has no current health insurance and last received health coverage approximately 10 years ago.

11. Claimant stated that he is a disabled individual based on impairments of: coronary artery disease, kidney removal complications, knee problems, high blood pressure (HBP), and various psychological problems including schizophrenia and bipolar disorder.

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 7/2011, the month of the application which Claimant contends 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 2011 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).

SSA specifically notes that age, education, and work experience are not considered at the second step of the disability analysis. 20 CFR 416.920 (5)(c). In determining whether Claimant's impairments amount to a severe impairment, all other 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.

A Medical Social Questionnaire (Exhibits 7-9) dated [redacted] was presented. The DHS form is intended to be completed by clients for general information about claimed impairments, treating physicians, previous hospitalizations, prescriptions, medical test history, education and work history. Claimant noted that his impairments included: pain following a right kidney removal, HPB, left knee problems and unspecified musculoskeletal issues. Claimant listed a hospitalization from 2/2010 to have his kidney removed. Claimant also noted a 1999 hospitalization to have a stent inserted for his right kidney.

A Medical Examination Report (Exhibits 10-11) dated [redacted] was completed by Claimant's treating physician. It was noted that the physician first treated Claimant on 5/5/11 and last examined Claimant on [redacted]. The physician provided diagnoses of hypertension, hyperlipidemia, arthritis and nephrectomy. An impression was given that Claimant's condition was stable. It was noted that Claimant can meet his household needs.

A hospital treatment document (Exhibit 13) dated 9/8/00 verified insertion and removal of a stent to assist Claimant with kidney function. A hospital treatment document (Exhibit 15) concerned a follow-up to Claimant's 2/2010 kidney removal surgery.

A hospital treatment document (Exhibit 14), dated [redacted] noted Claimant's reports of pain associated with his right side. It was noted that Claimant reported his pain is improved compared to before the kidney removal but his pain and tightness have

increased since the procedure. It was noted that Claimant reported his pain worsens when he moves.

A Physician Documentation Sheet (Exhibits 19-22) dated [redacted] was presented. It was noted that Claimant reported a gradual increase in knee pain. Claimant was noted as a pack per day smoker. Listed medications included: aspirin, hydrochlorothiazide, Lisinopril and Zocor. A differential diagnosis was given for arthritis in the knee. Claimant was prescribed Vicodin in response to complaints of knee pain.

A Physician Documentation Sheet (Exhibits 23-26) dated [redacted] was presented. It was noted that Claimant reported flank pain starting three weeks prior. The pain was aggravated by certain positions. Claimant reported no relief from the pain. X-rays and CAT-scan were taken; the results showed no abnormal findings. Discharge instructions recommended Vicodin as needed. Similar complaints from Claimant were noted in an office note from [redacted] (see Exhibit 39).

Hospital records (Exhibits 27-36) from a [redacted] service date were presented. It was noted that Claimant reported left knee pain. Claimant also reported an increased "popping" of his knee over the last 10 months. It was noted that Claimant reported increased pain when walking and an increase in popping when descending stairs. An assessment was given of mild left knee arthritis and a possible meniscal tear. An MRI was ordered. A physical examination revealed mild crepitus noted with flexion and extension of the knee. Range of motion was limited by five degrees in flexion.

An Office Note (Exhibits 40-41) from a [redacted] service date was presented. It was noted that an MRI revealed mild effusion of the knee. A small area of cortical irregularity with subchondral edema in the medial femoral condyle was noted. Overlying cartilage was noted as intact. Claimant was given a corticosteroid injection into his knee.

An Office Note (Exhibits 37-38) from a treatment dated [redacted] was presented. It was noted that Claimant received a Kenalog injection of the knee on [redacted]. Claimant reported the injection helped for three days, but the pain returned to where it was prior to the injection. Claimant was given a refill of pain medication and enrolled in physical therapy.

Various medical documents (Exhibits 42-71) from 2010 and 2011 were presented. The documents were unremarkable, other than remaining consistent with other submitted documents.

A Physical Examination Report (Exhibits 78-82) dated [redacted] was presented. The corresponding assessment noted pain associated with Claimant's kidney removal, left knee pain with a decreased range of motion and a history of coronary artery disease and uncontrolled HTN. It was noted that Claimant requires use of a cane due to pain

and comfort level for distances longer than 5 steps. Decreased ranges of motion were noted in both of Claimant's knees, both shoulders and lumbar spine flexion.

Claimant completed an Activities of Daily Living (Exhibits 73-77) dated [redacted]; this questionnaire was designed for clients to provide information about their abilities to perform various day-to-day activities. Claimant noted difficulty sleeping due to flank and knee pain. Claimant noted he fixes his own meals. Claimant noted he does not clean, nor does he do his own shopping.

Claimant testified that he took the following prescriptions: Carvedilol, Zestoretic, Lisinopril, Nifedipine, Zocor, Aspirin, Vicodin, Hyalagen and Redpidol. Claimant testified that he feels fatigued after taking his prescriptions.

Claimant testified that he has a two block walking limit; he stated that his leg feels like it's burning if he walks longer. He stated that he needs to rest 15 minutes before he can restart walking. Claimant noted he can only sit for 20 minute periods due to pain in his stomach and back. Claimant also noted that bending is difficult due to pain from where his kidney was removed.

Claimant's knee pain was medically verified. Medical documentation supported finding that Claimant had lifelong knee problems which worsened in 2011. Medical documentation supported finding that Claimant had knee pain requiring pain management in the form of prescriptions and injections. The physical examination report from [redacted] noted that Claimant requires use of a cane for any distances longer than 5 steps. A decreased range of motion in the knee is also supportive of finding restrictions in the performance of basic work activities. It is found that Claimant established a significant impairment in the performance of basic work activities.

The physical examination report dated [redacted] was nearly one year prior to the date of the administrative hearing. It was noted that the knee popping began when Claimant was 30 years of age, but that the pain was increasingly problematic. Claimant testified that his knee pain was an ongoing problem and has not subsided. The documented complaints were sufficient to establish a knee problem which lasted longer than 12 months. It is found that Claimant's knee pain meets the durational requirements for a severe impairment.

As it was found that Claimant established 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 three.

The third step of the sequential analysis requires a determination whether the 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 meet the

listing requirements and meet the 12 month duration requirement, then the claimant is to be deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step.

One of Claimant's primary impairments involved knee pain. Musculoskeletal issues are covered by Listing 1.00. Knee pain is covered by Listing 1.02 which 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.

Claimant's knee problems are not, by themselves, sufficient to meet the above listing. Claimant requires the use of a single cane, not two canes. The medical evidence was lacking in identifying walking limits for Claimant, other than a necessity for Claimant to use a cane for longer than five steps. The examining physician from the 3/17/11 dated examination noted Claimant's gait improves with a cane; this implies some degree of ambulation improvement by cane usage.

Though Claimant's walking is impaired, it is not sufficiently impaired, by itself, to meet the above listing. However, Claimant had other physical problems which may contribute to ambulation difficulties.

Claimant testified that he had ongoing flank pain stemming from a kidney removal operation. Claimant testified that the scar tissue from the kidney removal procedure attached to his side and causes him great discomfort. Though Claimant's complaint does not involve a joint injury, it would be reasonably linked to making ambulation more difficult. The medical records established that Claimant complained of the pain in 9/2010. Based on the presented medical records and Claimant's testimony, it is reasonable to conclude that the pain has never been resolved. Adding to the list of problems is heart problems stemming from coronary artery disease which would affect breathing to some degree and make ambulation more difficult.

Based on the presented evidence, it is found that Claimant established meeting the listing for joint dysfunction due to ambulation problems primarily relating to joint dysfunction. Accordingly, it is found that DHS improperly denied Claimant's MA benefit application.

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).

It has already been found that Claimant is disabled for purposes of MA benefits based on the finding that Claimant meets the SSA listing for joint dysfunction. The analysis and finding equally applies to Claimant's application for SDA benefits. It is found that DHS improperly denied Claimant's application for SDA benefits on the basis that Claimant is not a disabled individual.

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 and SDA benefits. It is ordered that DHS:

(1) reinstate Claimant's MA and SDA benefit application dated 7/14/11, including retroactive MA benefits from 4/2011;
(2) evaluate Claimant's eligibility for MA and SDA 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 denial; 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 or SDA benefits.

The actions taken by DHS are REVERSED.

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

Date Signed: March 30, 2012

Date Mailed: March 30, 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: