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

IN THE MATTER OF:

[redacted]

Reg. No.: 201237469
Issue No.: 2009
Case No.: [redacted]
Hearing Date: May 23, 2012
County: Monroe DHS

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 following Claimant's request for a hearing. After due notice, an in-person hearing was held on May 23, 2012 from Monroe, Michigan. Participants included the above named claimant; [redacted] testified on behalf of Claimant. Participants on behalf of Department of Human Services (DHS) included [redacted], Specialist.

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 12/8/11, Claimant applied for MA benefits.

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

3. On 2/15/12, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 1-2).

4. On 2/22/12, DHS denied Claimant's application for MA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On 3/1/12, Claimant requested a hearing disputing the denial of MA benefits.

6. On 4/27/12, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual (see Exhibit 152), in part, by application of Medical-Vocational Rule 202.13.

7. On 5/23/12, an administrative hearing was held.

8. Following the administrative hearing, Claimant presented new medical records (Exhibits 153-167).

9. The additional medical records were submitted to SHRT for reconsideration of Claimant's disability.

10. On 6/30/12, SHRT again determined that Claimant was not disabled, in part, by application of Medical-Vocational Rule 202.13.

11. As of the date of the administrative hearing, Claimant was a [redacted] year old male with a height of 5'9'' and weight of 165 pounds.

12. As of the date of the administrative hearing, Claimant had no known relevant history of tobacco, alcohol or other substance abuse.

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

14. As of the date of the administrative hearing, Claimant had ongoing health coverage through the Adult Medical Program for approximately the previous two years.

15. Claimant alleged that he is disabled based on impairments and issues including: learning disability, poor memory, vertigo, chronic obstructive pulmonary disorder (COPD), a rotator cuff injury and depression.

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).

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 Social Summary (Exhibits 17-18) dated [redacted] was presented. The form was completed by a DHS specialist. It was noted that Claimant alleged impairments of a blood clot, vertigo and COPD.

A Medical Social Questionnaire (Exhibits 21-23) dated [redacted] was presented. The form was completed by Claimant's sister. It was noted that Claimant had a blood clot in his lungs, was illiterate, suffered vertigo and had breathing problems. It was noted that Claimant took the following medication: Ventolin, Carvedilol and Coumadin.

A Psychological Evaluation (Exhibits 157-163) dated [redacted] was presented. It was noted that the evaluation was based on a clinical interview and various cognitive and psychological tests. It was noted that Claimant functioned in the borderline range of intelligence with extremely low verbal abilities and low average performance abilities. It was noted that Claimant had difficulties in expressing himself and that he was functionally illiterate. It was suspected that Claimant was once capable of performing heavy lifting employment, but struggled maintaining employment after his body lost conditioning.

Lab results (Exhibits 33-39) from 1/2011 and 10/2010 were presented. The only notable results were high glu-fat (110 mg/dl with 70-10 being normal) and low creatinine (.8 with .9-1.1 mg/dl being normal).

Medical notes (Exhibit 31) dated [redacted] from Claimant's physician were presented. It was noted that Claimant sought treatment for depression. Claimant reported constant sadness, poor sleep and constant crying. Zoloft was prescribed to Claimant.

Various radiology reports (Exhibits 111-124) were presented. An MRI of Claimant's brain (Exhibit 111) dated [redacted] was noted as unremarkable. Degenerative changes were noted in Claimant's lumbar spine on 6/23/11 (see Exhibit 115). Front lateral views of Claimant's heart (Exhibit 116) noted no acute process.

Medical notes (Exhibit 30) dated [redacted] from Claimant's physician were presented. It was noted that an MRI (see Exhibits 40-42) was previously done based on Claimant's reports of dizziness. It was noted that the only abnormality shown was mild bilateral atherosclerotic changes of carotids. Radiology reports (Exhibits 40-42) dated [redacted] were consistent with the notes by Claimant's physician. It was noted that Claimant cries less but still has difficulty sleeping.

An ultrasound report (Exhibit 138) dated [redacted] concerning Claimant's bilateral carotid duplex was presented. A conclusion of stenosis in the range of "1%-49%, more so towards 10%" was given.

A Psychiatric/Psychological Medical Report (Exhibits 13-16) dated [redacted] was presented. It was noted that Claimant reported crying for no reason. It was noted that Claimant often reported feeling nervous. Claimant reported feeling hopeless and helpless. It was noted that Claimant could repeat three of seven numbers going forward and that he was unable to repeat any of the seven numbers backward. The examining physician noted that Claimant showed difficulty with learning, memory, mood and health. It was noted that Claimant also had limits in personal interactions, understanding, judgment and engaging in simple to moderate tasks.

The examiner provided a diagnosis based on Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV). Axis I diagnoses were given for dysthymic disorder and anxiety disorder. Axis II noted a learning disorder. Claimant's GAF was 50. A GAF within the range of 41-50 is representative of a person with "serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g. no friends, unable to keep a job)." Claimant's prognosis was fair to guarded. It was noted that Claimant could benefit from psychotherapy.

An internal medicine report (Exhibits 3-12) dated [redacted] from a non-treating physician was presented. It was noted that Claimant reported a history of shortness of breath related to COPD, problems with dizziness and vertigo, a heart murmur possibly related to a hole in Claimant's heart and a learning disability. It was noted that Claimant quit smoking in 2009 following a 40 year habit of smoking 2-3 packs per day. It was noted that Claimant did not require a cane and was able to slowly get on and off the examination table. Claimant showed normal ranges of motion in all tested areas except in hip forward flexion and lumbar forward flexion. Claimant was found to have all listed physical abilities without noted restriction; the listed abilities included: sitting, standing, walking, carrying, pushing, dressing, climbing stairs and stooping. The examiner confirmed the existence of a heart murmur and noted that Claimant may have cardiovascular disease related to Claimant's history of smoking. It was noted that Claimant should avoid toxins, fumes, smoke and dust.

A cardiac physician letter (Exhibits 165-167) dated [redacted] was presented. It was noted that Claimant was asymptomatic and that a stress Myoview study showed normal findings.

An ultrasound report (Exhibit 140) dated [redacted] of the bilateral lower extremity venous duplex was given. It was noted that there was no evidence of superficial deep-vein thrombosis in the visualized veins.

Medical notes (Exhibit 29) dated [redacted] from Claimant's physician were presented. It was noted that Claimant went to the ER reporting difficulty breathing. It was noted that Claimant was diagnosed with a blood clot. Claimant was referred back to the ER.

A Medical Examination Report (Exhibits 19-20) 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 COPD, hypertension and PE (presumed to mean pulmonary embolism). An impression was given that Claimant's condition was stable. It was noted that Claimant cannot meet household needs.

Hospital records (Exhibits 43-97) from 12/2011 were presented. Complaints of chest pain and shortness of breath were noted. A history of COPD was noted and Claimant's hypertension and osteoarthritis was noted as stable (see Exhibit 59). A pulmonary embolism was noted (see Exhibit 62) and Claimant was started on Coumadin. [redacted] document noted Claimant had minimal shortness of breath with activity (Exhibit 64).

Medical testing (Exhibit 164) dated [redacted] of Claimant's lungs were presented. It was noted that spirometry and lung volumes were mildly restricted.

Medical notes (Exhibit 142) dated [redacted] were presented. It was noted that Claimant reported not having shortness of breath.

Assessments of functional capacities (Exhibits 153-156) dated [redacted] from Claimant's primary care physician (PCP) was presented. It was noted that Claimant could sit and stand for less than 1 hour of an 8 hour day. It was noted that Claimant would need to alternate sitting and standing throughout the day. It was noted that Claimant could not use his hands for pushing/pulling, simple grasping or fine manipulation. It was noted Claimant could not perform repetitive motions such as writing, typing or assembling with either hand or foot. It was noted that Claimant could never lift more than 5 pounds. It was noted that Claimant should not work with heights, machinery, driving exposure to dust or fumes. The basis of the restrictions was the diagnosis for COPD and embolism. It was noted that Claimant's pain was disabling and would prevent Claimant from performing sedentary employment. It was noted that Claimant had a significant handicap with sustained attention and concentration.

Claimant's sister completed an Activities of Daily Living (Exhibits 24-27) dated [redacted]; this is a questionnaire designed for clients to provide information about their abilities to

perform various day-to-day activities. It was noted that Claimant had difficulty sleeping due to joint pain and breathing problems. It was noted that Claimant takes his time performing personal needs or he gets dizzy. It was noted that Claimant prepares his own meals. It was noted that Claimant works around the house including doing laundry, washing dishes and changing light bulbs. It was noted that Claimant has a restricted driver's license due to an alcohol-related issue. Claimant testified that he could walk approximately 150 yards before getting dizzy. Claimant estimated that he was capable of lifting up to 30 pounds but it was not clarified how frequently. Claimant stated that he sometimes employs use of a cane for long walking distances.

The presented medical records established considerations of disability based on COPD, pulmonary embolism, cognitive dysfunction and depression. The most compelling evidence concerning restrictions based these diagnoses came from Claimant's PCP.

Looking at physical restrictions imposed by the PCP, Claimant was essentially found disabled. Claimant was determined to be incapable of: sitting or standing more than an hour in an 8 hour day, lifting more than 5 pounds and performing repetitive movements with his hand and feet. Treating source opinions cannot be discounted unless the Administrative Law Judge provides good reasons for discounting the opinion. *Rogers v. Commissioner,* 486 F. 3d 234 (6th Cir. 2007)*; Bowen v Commissioner.* The basis for the restrictions was COPD and PE.

There was no evidence of hospitalizations or notable medical treatment between the time that Claimant was diagnosed with a PE in 12/2011 and 6/2012, the month Claimant's PCP found Claimant so restricted. This tends to support that Claimant's conditions are not as disabling as the PCP concluded. The most recent medical testing from one year earlier showed only mild lung capacity restrictions; this tends to lend support that COPD is not a particularly taxing condition. The PE diagnosis could theoretically be disabling but the single hospitalization from 12/2011 is far from establishing the restrictions suggested by the PCP. Also, the PCP restricted Claimant from repetitive use of hands and feet; there was simply no medical evidence to justify such restrictions. Due to the lack of medical evidence to support the restrictions imposed by the PCP, the restrictions cited by the PCP will be given a minimum of probative value.

Despite the discounting of the PCP restrictions, the PE and COPD are of a nature that some restriction in physical activity is probable, just not to the extent as noted by the PCP. COPD and a PE can be presumed to restrict Claimant from strenuous activities such as heavy lifting and pulling. It is found that Claimant has some unspecified physical impairments to performing basic work activities.

Claimant reported an impairment of depression. It was established that Claimant sought treatment for the disorder and was prescribed Zoloft. The medication appeared to help as Claimant reported a substantial decrease in crying, though it was noted he still had difficulty with sleeping. Claimant's GAF of 50 was representative of psychological obstacles. Claimant's treating PCP concluded that Claimant was moderately

psychologically restricted due to problems with concentration, which is somewhat supported by the evidence. There is a sufficient basis to find that Claimant has psychological restrictions which would affect his ability to perform basic work activities.

Claimant's cognitive function was also shown to be impaired. The conclusions that Claimant was in the borderline range of intelligence and functionally illiterate were sufficient to show that Claimant has enormous obstacles in cognitive function.

Based on the presented medical evidence, Claimant's combination of physical, cognitive and psychological impairments were sufficient to establish impairments to the performance of basic work activities based on a de minimus standard. The impairments were established as enduring for over 12 months.

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 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 most compelling reliable medical evidence submitted involved Claimant's cognitive restrictions. Mental impairments are described under listing 12.00. The most applicable listing involves mental retardation. The mental retardation listing reads:

> ***12.05 Mental retardation***: Mental retardation refers to significantly subaverage general intellectual functioning with deficits in adaptive functioning initially manifested during the developmental period; i.e., the evidence demonstrates or supports onset of the impairment before age 22.
> The required level of severity for this disorder is met when the requirements in A, B, C, or D are satisfied.
> A. Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded;
> OR
> B. A valid verbal, performance, or full scale IQ of 59 or less;
> OR
> C. A valid verbal, performance, or full scale IQ of 60 through 70 and a physical or other mental impairment imposing an additional and significant work-related limitation of function;
> OR

D. A valid verbal, performance, or full scale IQ of 60 through 70, resulting in at least two of the following:
1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration.

Looking at Part A, there was little evidence that Claimant has any problems performing personal needs such as bathing, eating or any other daily activities due to a mental problem. Claimant does not meet Part A of the listing.

Claimant's full scale IQ was measured at 71 (see Exhibit 159). This measurement makes Claimant ineligible to meet the listing based on overall IQ performance.

Claimant's verbal IQ was measured at 66 (see Exhibit 159) and was considered extremely low. The verbal measurement makes Claimant potentially eligible for Parts C or D of the above listing.

It was established at step two of the disability analysis that Claimant had psychological and physical restrictions which would impair his performance of basic work activities; that was based on a de minimus standard. Though PE, COPD and depression are not disabling problems by themselves, the diagnoses are found to amount to a significant work-related limitation for Claimant. It is found that Claimant meets Part C of the SSA listing for mental retardation and that Claimant is a disabled individual. Accordingly, it is found that DHS improperly denied Claimant's application for MA 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 for MA benefits. It is ordered that DHS:

(1) reinstate Claimant's MA benefit application dated 12/8/11;
(2) 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) schedule a redetermination 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: August 13, 2012

Date Mailed: August 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 at
Michigan Administrative Hearings
Reconsideration/Rehearing Request
P. O. Box 30639
Lansing, Michigan 48909-07322

CG/hw

cc: [redacted]