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

IN THE MATTER OF:

[redacted]

Reg. No. 201238009
Issue No. 2009
Case No. [redacted]
Hearing Date: May 30, 2012
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 May 30, 2012 from Detroit, Michigan. The claimant appeared and testified. [redacted] testified on behalf of Claimant. [redacted] appeared as Claimant's authorized hearing representative. [redacted], Specialist, appeared on behalf of DHS.

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 9/27/11, Claimant applied for MA benefits (see Exhibits 5-13).

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

3. On 1/12/12, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 14-15).

4. On 1/24/12, DHS denied Claimant's application for MA benefits and mailed a Notice of Case Action (Exhibits 106-108) informing Claimant of the denial.

5. On 3/6/12, Claimant requested a hearing disputing the denial of MA benefits (see Exhibit 1).

6. On 4/23/12, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual (see Exhibit 127), by determining that Claimant's impairments are improving or are expected to improve within 12 months from the date of onset.

7. As of the date of the administrative hearing, Claimant was a [redacted] year old male with a height of 6'1'' and weight of 208 pounds.

8. Claimant has no known relevant history of tobacco, alcohol or drug abuse.

9. Claimant's highest education year completed was the 12th grade via general equivalency degree.

10. As of the date of the administrative hearing, Claimant had no health insurance coverage, and has not had medical coverage since approximately the year 2000.

11. Claimant alleged that he is disabled based on impairments and issues including nerve damage in legs, left hand function, finger dysfunction on the right hand and a mild stroke.

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 9/2011, 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 Social Summary (Exhibits 17-18) dated [redacted] was presented. A Social Summary is a standard DHS form to be completed by DHS specialists, which notes alleged impairments and various other items of information; Claimant's form was completed by Ms. Lampkins, a social worker. Listed impairments included: left ulna fracture, left olecranon fracture, lumbar and right femur fracture.

A Medical Social Questionnaire (Exhibits 19-21) dated [redacted] was presented. The Claimant completed form allows for reporting of claimed impairments, treating physicians, previous hospitalizations, prescriptions, medical test history, education and work history; Claimant's form was again completed by Ms. Lampkins. It was noted that Claimant has a fractured leg and is wheelchair bound. It was noted that Claimant was hospitalized from [redacted], due to a closed head injury stemming from an assault. It was documented that the assault included a crow bar and a baseball bat which had spikes (see Exhibit 48). Claimant testified that he was assaulted by persons on [redacted] baseball bats and pipes. The records from the 9/2011 hospitalization were submitted (see Exhibits 22-103).

On [redacted], various X-rays were taken. It was noted that Claimant had a fracture of the distal left ulna shaft (see Exhibit 24). It was noted that Claimant had a fracture of the proximal phalanx of the right index finger (see Exhibit 26). It was noted that Claimant had comminuted fracture of the distal femoral shaft just proximal to the condyle (see Exhibit 28). It was noted that there was laceration in the soft tissue of the right elbow and fracture of the proximal left ulna involving the ulna were notch (see Exhibit 30). It

was noted that subcutaneous emphysema was present in the chest wall (see Exhibit 35).

A CT scan of Claimant's brain (see Exhibits 32-33) revealed no bleeding or hemorrhaging. A corresponding physical examination demonstrated minimal disc bulge at C4-C5 and C5-C6 (see Exhibit 33). Minimal arthritis was also noted in the vertebrae (see Exhibit 33). A CT scan of Claimant's abdomen resulted in a physician impression of moderate right pneumothorax, fractures of the right ninth and tenth ribs and fractures of the transverse processes of L1 and right transverse process of L2 (see Exhibits 36-37). A CT scan of Claimant's right femur resulted in an impression of comminuted displaced fracture of the distal femur (see Exhibits 38-39).

It did not appear that discharge instructions from the hospitalization were presented. It was noted on [redacted] that Claimant was not able to return home because he was not able to ambulate.

A Medical Examination Report (Exhibits 109-110) dated in [redacted] was completed by a physician. It was not noted when the physician first treated or last examined Claimant. The physician provided a diagnosis of leg fracture. An impression was given that Claimant's condition was improving. It was noted that Claimant was limited for more than 90 days in all lifting and carrying. It was noted that Claimant requires use of a wheelchair. It was noted that Claimant was able to meet his needs in the home. Claimant had no mental limitations.

A medical needs form (Exhibit 111) dated [redacted] from a physician was presented. It was noted that Claimant has a need for assistance with meal preparation, shopping, laundry, housework, bathing and taking medication. It was noted that Claimant was non-ambulatory and has a need for special transportation.

A Physician's Orders listing Claimant's prescriptions (Exhibit 112) dated [redacted]2 was submitted. The list was intended to cover Claimant's medication for 2/2012. Listed medications included Lisinopril and Hydrocodone.

Various lab results (Exhibits 113-116, 119-125) from Claimant's nursing center were presented. No medical reports were submitted with the results, so no conclusions were drawn from the lab results, other than it was noted that Claimant's renal function was within normal limits (see Exhibit 119).

An updated Medical Examination Report (Exhibits 128-129) 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]. An impression was given that Claimant's condition was stable. It was noted that Claimant cannot meet his household needs. It was noted that Claimant was totally disabled at the present. It was

noted that Claimant needs a wheelchair for ambulation. A Medical Needs form (Exhibit 130) dated [redacted] from the same physician also noted that Claimant cannot work at any job.

Claimant testified that he is able to stand for approximately 10-15 minutes, but with pain in his legs. Claimant estimated that he has comparable walking restrictions. Claimant stated that he tries to walk but leg pain prevents him from doing so for more than a few minutes. Claimant stated he uses a wheelchair to ambulate. Claimant stated he has no pain when sitting.

Claimant's broken femur and related injuries established a significant impairment to the performance of basic work activities. His wheelchair use was verified by a treating physician. The duration of Claimant's impairment is less clear.

It is clear that Claimant's injuries began on [redacted], the date that Claimant was assaulted. It was established that as of [redacted], Claimant was still wheelchair bound (see Exhibits 128-129). There was no question that Claimant's inability to ambulate on [redacted] was caused by injuries suffered from [redacted]. Thus, a period of disability for eight months was established.

The only certain way to determine Claimant's status 12 months following his injury is to obtain medical documentation from [redacted] or later. The present circumstances do not allow for such a luxury. Thus, it must be determined whether Claimant is likely to be disabled for the following four months.

It would have been helpful had medical records been presented to explain why Claimant is still wheelchair bound eight months following a broken femur. The medical records did not cite nerve damage, bone fusion problems or other issues which may have prevented a routine healing. Claimant testified that he has nerve damage in his legs which makes it painful for him to walk. Claimant's testimony was reasonable in light of the assault he endured; however, the testimony could not be confirmed by the medical documents.

It is known that the treating physician considered Claimant's condition to be stable, rather than improving. An improving condition would be less supportive of a finding that Claimant's impairments are expected to last 12 months or longer.

Some weight can be given to the already passed period of time since the assault. Eight months of being wheelchair bound is more likely to lead to a 12 month period of disability than a shorter passage of time.

It also was of concern that the only medical evidence of Claimant's current condition came from a physician who listed an address the same as Claimant's nursing center. A

physician working for the nursing center may have a bias in getting insurance coverage for Claimant because it could assist the nursing center in reimbursement for their housing and medical costs. The potential for bias would have been less of a concern had there been medical evidence to explain the need for a wheelchair rather than the mere statement that a wheelchair is needed. 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.* Despite the concern of potential conflict, the treating physician's statements are the best medical evidence of Claimant's current condition. The potential for conflict was not based on any evidence though it was part of the decision writing process. As noted above, the physician's opinion should be given additional weight as Claimant's treating physician. Though it can only be speculated, the evidence tended to establish that Claimant's impairments are expected to last 12 months or longer.

It is found that Claimant established a significant impairment to the performance of basic work activities and that the impairment is expected to last 12 months or longer. Accordingly, Claimant established a severe impairment and the disability analysis may proceed 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 to be deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step.

Claimant's primary impairment was radiculopathy in his hip and leg. The pain was not diagnosed. Based on the presented evidence, the most appropriate SSA listing would be for joint dysfunction. The listing for joint dysfunction 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.

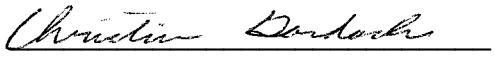
It was established that Claimant's femur was broken. It would be reasonable to presume some joint dysfunction for a wheelchair bound assault victim. It is not of major concern whether Claimant's inability to ambulate effectively was caused by nerve damage or joint dysfunction. What is most relevant is that physical impairments resulted in the inability for Claimant to ambulate effectively. Claimant's wheelchair bound status establishes an inability to ambulate effectively. It is found that Claimant meets the listing for joint dysfunction and that Claimant is a disabled individual. Accordingly, the DHS denial of Claimant's application for MA benefits was improper.

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 9/27/11;
(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 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: June 14, 2012

Date Mailed: June 14, 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]