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

IN THE MATTER OF:

[redacted]

Reg. No.: 201268050
Issue No.: 2009
Case No.: [redacted]
Hearing Date: January 9, 2013
County: Wayne DHS (19)

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 January 9, 2013, from Inkster, Michigan. Participants included the above-named claimant. [redacted] as Claimant's authorized hearing representative. Participants on behalf of Department of Human Services (DHS) included [redacted], Medical Contact Worker.

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 1/6/12, Claimant applied for MA benefits (see Exhibits 4-10), including retroactive MA benefits from 10/2011-12/2011.

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

3. On 6/25/12, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 11-12).

4. On 7/5/12, DHS denied Claimant's application for MA benefits and mailed a Notice of Case Action (Exhibits 59-61) informing Claimant of the denial.

5. On 7/30/12, Claimant requested a hearing (see Exhibits 2-3) disputing the denial of MA benefits.

6. On 9/26/12, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual (see Exhibit 72-73), in part, by application of Medical-Vocational Rule 201.24.

7. On 1/9/13, an administrative hearing was held.

8. At the hearing, Claimant presented new medical documents (Exhibits A1-A47).

9. The new medical documents were forwarded to SHRT.

10. On 3/11/13, SHRT determined that Claimant was not a disabled individual (see Exhibits B1-B2), in part, by application of Medical-Vocational Rule 201.24.

11. As of the date of the administrative hearing, Claimant was a [redacted] year old male with a height of 5'10'' and weight of 162 pounds.

12. Claimant has no known relevant history of tobacco, alcohol or illegal substance abuse.

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

14. As of the date of the administrative hearing, Claimant had no medical coverage but received help from friends and family paying for medical expenses.

15. Claimant alleged that he is disabled based on back-related impairments.

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. The 2012 income limit is $1010/month.

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 relevant submitted medical documentation.

A letter (Exhibit 33) from Claimant's treating physician dated [redacted] was presented. It was noted that the physician began seeing Claimant in 2/2011 for treatment of back pain, but that Claimant's pain recently worsened due to a workplace injury. It was noted that an MRI verified degenerative changes and bulging discs at multiple vertebrae. It was noted that a steroid injection was given to treat Claimant's pain, but the injection increased Claimant's pain. It was noted that Claimant reported neck pain problems in 9/2011. It was noted that Claimant was scheduled for lumbar spinal fusion in 10/2011, and cervical fusion in 1/2012.

Hospital documents (Exhibits 36-38; A13-A21) noting a [redacted] admission were presented. It was noted that Claimant presented with radiating back pain complaints and ambulation difficulties. It was noted that imaging studies verified grade I, L5-S1 lytic spondylolistetic with severe disk degeneration and severe bilateral foraminal stenosis. Mild central stenosis and disk displacement was noted at C4-C5. A bulging disc was noted at L5-S1. It was noted that Claimant underwent spinal fusion surgery on [redacted].

Various copies of prescriptions (Exhibits 49-53) filled on [redacted] were presented. The prescribed medications included Oxycontin and Diazepam.

A consultative mental examination report (Exhibits 67-71) dated [redacted] was presented. It was noted that Claimant complained of depression related to back pain. It was noted that Claimant has difficulty sleeping and cries easily at times. Axis I diagnoses were given of major depressive disorder, moderate and adjustment disorder with anxiety. Claimant's GAF was 45. Claimant's prognosis was guarded. It was noted that Claimant's mental ability to relate to others was moderately impaired. Claimant was also noted as moderately impaired in understanding, remembering and carrying out instructions. Claimant's ability to maintain concentration, persistence and pace was noted as moderately to severely impaired. Claimant's ability to withstand pressure and stress was noted as significantly impaired.

Hospital documents (Exhibits 20-32; A22-A35) were presented. The documents verified an admission on [redacted]. A discharge date was not explicitly noted but hospital notes are made through [redacted]. It was noted that Claimant presented with complaints of a full-body skin rash, nausea and vomiting. An impression was given that the nausea and

vomiting were side effects related to medication. It was noted that the skin rash was likely an allergic reaction to drugs. It was noted that Claimant responded well to IV hydration and IV Solu-Medrol.

A Medical Examination Report (Exhibits 18-19) dated [redacted] was completed by Claimant's treating physician. It was noted that the physician last examined Claimant on [redacted]; the physician did not note the first date of examination but other evidence supported 2/2011 as an approximate time of first examination. The physician provided diagnoses of chronic lower back pain and neck pain. An impression was given that Claimant's condition was stable. It was noted that Claimant can meet household needs.

A radiology report (Exhibits A3-A4) dated [redacted] was presented. It was noted that an MRI of Claimant's cervical spine was taken. It was noted that Claimant had degenerative disc disease (DDD) at C3-C4 through C5-C6 without significant spinal canal stenosis. A radiology report (Exhibits A9-A10), dated [redacted], noted no substantial changes with the MRI from [redacted].

A radiology report (Exhibits A5-A6) dated [redacted] was presented. It was noted that an MRI of Claimant's lumbar spine was taken. It was noted that there was spine stabilization hardware at L4-S1. An impression of mild grade I spondylolisthesis at lumbosacral junction was noted. A similar impression was given on [redacted] (see Exhibits A7-A8).

A medical statement (Exhibits 34-35; supplicated by Exhibits 65-66) dated [redacted] from Claimant's treating physician was presented. It was noted that Claimant had limited range of lumbar motion. It was noted that Claimant had a positive straight leg raising test. Claimant's pain was noted as extreme. The physician restricted Claimant to 15 minute periods of sitting and standing. It was noted that Claimant was completely restricted from lifting, bending, stooping and working. It was noted that Claimant was frequently required to raise his legs.

A medical statement (Exhibits 63-64) dated [redacted] from Claimant's treating physician was presented. Claimant's pain was noted as severe. The physician restricted Claimant to 30 minute periods of sitting and 15 minutes of standing. It was noted that Claimant was completely restricted from working, but occasionally capable of bending and stooping. It was noted that Claimant was occasionally required to raise his legs. Claimant was restricted to lifting of no more than 5 pounds.

Hospital documents (Exhibits A11-A12; A43-A46) were presented. An admission on 8/27/12 and discharge on [redacted] was noted. It was noted that Claimant presented with complaints of a gradual increase in severe neck pain. It was noted that Claimant received pain medication and was discharged. An EMG was recommended, but not performed.

A Medical Examination Report (Exhibits A1-A2) dated 1[redacted] was completed by Claimant's treating physician. It was noted that the physician last examined Claimant on

[redacted]. The physician provided diagnoses of neck pain, lumbar pain, cervical radiculopathy and lumbar radiculopathy. An impression was given that Claimant's condition was deteriorating and that he was unlikely to return to work. It was noted that Claimant can meet household needs. It was noted that Claimant was completely restricted from performing all listed repetitive hand, arm and leg actions. It was noted that Claimant was restricted from lifting 10 pounds or more. It was noted that Claimant was restricted to standing and or walking less than 2 hours in an eight hour workday.

Claimant testified that he suffers severe cervical and lumbar spine pain since 10/2011. Despite fusion surgery, Claimant testified that he is capable of sitting no more than 20-30 minutes and that walking a single block would be "a beautiful goal". Claimant testified that he might be able to lift a gallon of milk but would be shaky. Claimant testified that he walks with a cane, but barely. Claimant testified that he used to use a walker for ambulation

Several documents from Claimant's treating physician restricted Claimant from performing basic activities including lifting 10 pounds, repetitive arm actions and standing for longer than 15 minutes. The medical documents were supportive of the restrictions. It is found that Claimant has severe basic work restrictions.

The records verified that Claimant's impairments began no later than 10/2011, the month of Claimant's fusion surgery. Claimant established meeting the 12 month durational requirement of a severe restriction.

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.

Claimant's most prominent impairment is cervical and lumbar pain. Spinal disorders are covered by Listing 1.04 which reads:

> **1.04** ***Disorders of the spine*** (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the cauda equina) or the spinal cord. With:
>
> A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by

> sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine);
> OR
> B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours;
> OR
> C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b.

Looking at Part C, the inability to ambulate effectively is a requirement. SSA defines this as follows:

> 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.

It was verified by MRI that Claimant has severe lumbar spinal stenosis at L5-S1; this was true even after surgical intervention. The requirement of pseudoclaudication is verified by the repeated complaints by Claimant concerning radiating pain. Claimant's treating physician restricted Claimant to 30 minute periods of standing, zero work and less than 10 pounds of lifting; this is strongly suggestive of ambulation restrictions. The presented evidence was sufficient to establish that Claimant has an inability to ambulate effectively. It is found that Claimant meets the Listing 1.04 (c). Accordingly, it is found that Claimant is a disabled individual and 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 1/6/12, including retroactive MA benefits from 10/2011-12/2011.
(2) evaluate Claimant's eligibility for MA benefits on the basis that Claimant is a disabled individual;
(3) initiate a supplement for any benefits not issued as a result of the improper application 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: 3/19/2013

Date Mailed: 3/19/2013

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]