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

IN THE MATTER OF:

[redacted]

Reg. No.: 201270872
Issue No.: 2009
Case No.: [redacted]
Hearing Date: February 27, 2013
County: Wayne DHS (76)

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 February 27, 2013, from Detroit, Michigan. Participants included the above-named claimant. [redacted] testified on behalf of Claimant. [redacted] testified and appeared as Claimant's authorized hearing representative. 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 3/29/12, Claimant applied for MA benefits, including retroactive MA benefits from 2/2012.

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

3. On 5/9/12, the Medical Review Team (MRT) determined that Claimant was not a disabled individual.

4. On 5/14/12, DHS denied Claimant's application for MA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On 8/6/12, Claimant's AHR submitted a hearing request (Exhibit 2) on behalf of Claimant to DHS disputing the denial of MA benefits.

6. On 10/3/12, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual (see Exhibits 513-514), in part, by application of Medical-Vocational Rule 202.20.

7. On 2/27/13, an administrative hearing was held.

8. During the hearing, Claimant presented new medical documents (Exhibits A1-A35).

9. The new medical documents were forwarded to SHRT.

10. On 5/29/13, SHRT determined that Claimant was not a disabled individual, in part, by application of Medical-Vocational Rule 202.20.

11. As of the date of the administrative hearing, Claimant was a [redacted] year old male with a height of 6'0'' and weight of 173 pounds.

12. Claimant was an alcohol abuser as of 2011, and has no known relevant history of tobacco or drug abuse.

13. Claimant's highest education year completed was the 11th grade.

14. As of the date of the administrative hearing, Claimant had no medical coverage.

15. Claimant alleged disability based on impairments and issues including: hand pain, weak legs, pancreatitis, neuropathy, high blood pressure (HBP), diabetes and ankle infections.

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).

It should be noted that Claimant's AHR hearing request noted special arrangements to participate in the administrative hearing; specifically, an in-person hearing was requested. Claimant's AHR's request was granted.

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 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.

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.

Hospital documents (Exhibits 468-484) stemming from a hospitalization from [redacted]-[redacted]1 were presented. It was noted that Claimant presented with complaints of a right ankle abscess. It was noted that Claimant was noncompliant with diabetes medication. It was noted that the abscess was drained and antibiotics were provided. It was noted that Claimant was given instructions on low-cost medication programs.

Hospital documents (Exhibits 429-467) stemming from a hospitalization from [redacted] were presented. It was noted that Claimant presented with complaints of abdominal and back pain. It was noted that a physician declined to see Claimant because Claimant had not previously seen the physician for follow-ups- presumably after the previous hospitalization. Diagnoses included: uncontrolled diabetes, hyperglycemia, severe diabetic neuropathy and poor compliance. It was noted that Claimant last drank alcohol four months ago. It was noted that a PICC line was inserted. Discharge diagnoses included: spontaneous bacterial peritonitis and cirrhosis with intrahepatic cholestasis.

Hospital documents (Exhibits 407-428) stemming from an admission from [redacted] were presented. It was noted that Claimant was brought to the hospital after being found unconscious. It was noted that Claimant was doing better after hypoglycemia was addressed. It was noted that Claimant received antibiotic and respiratory treatments. Discharge diagnoses included DM secondary to chronic pancreatitis. A discharge of [redacted] was noted.

Hospital documents (Exhibits 362-406) stemming from an admission from [redacted] were presented. It was noted that Claimant presented with complaints of fatigue and upper abdominal pain. It was noted that Claimant had uncontrolled diabetes. It was noted that Claimant was given blood sugar testing materials. It was noted that Claimant should have followed-up, but did not, after a previous hospital encounter. It did not appear that discharge documents were provided, but Claimant appeared to be discharged on [redacted].

Hospital documents (Exhibits 297-331) stemming from an admission from [redacted] were presented. It was noted that Claimant presented with complaints of abdominal pain. It was noted that Claimant was discharged on [redacted] and was given instructions to follow a diet.

Hospital documents (Exhibits 332-361) stemming from an admission from [redacted] were presented. It was noted that Claimant presented with complaints of right foot pain and bleeding. It was noted that Claimant was discharged on [redacted]. The first listed discharge diagnosis was right foot abscess.

Hospital documents (Exhibits 215-296) stemming from an admission from [redacted] were presented. It was noted that Claimant presented with complaints of abdominal pain, and vomiting. It was noted that Claimant tried to take Lortab for the pain, but to no avail. It was noted that a physical examination found that Claimant had chronic toe ulcers. It was noted that Claimant was admitted. A diagnosis of hyperglycemia was noted. Discharge documents were not provided.

Hospital documents (Exhibits 7-13; 169-214; A33-A35) stemming from an admission from [redacted] were presented. It was noted that Claimant presented with complaints of right foot pain, vomiting and abdomen pain. A discharge diagnosis of acute on chronic pancreatitis related to alcohol abuse was noted. Other noted diagnoses included diabetes (type 2), uncontrolled and osteomyelitis of the foot. It was noted that medications were given. It was also noted that Claimant was non-compliant with treatment (see Exhibit 169). It was noted that Claimant had recent alcohol intake (see Exhibit 178), while other documentation noted alcohol consumption last occurred over one year ago (Exhibit 180).

Hospital documents (Exhibits 14-17; 485-512; A21-A25) stemming from an admission from 6[redacted] were presented. It was noted that Claimant presented with complaint of left buttocks pain due to abscesses. A diagnosis of cellulitis was noted. It was noted that no surgeries were performed.

Hospital documents (Exhibits 18-48; 65-114; A26-A32) stemming from an admission from [redacted] were presented. It was noted that Claimant presented, complaining of abdomen pain. Diagnoses of transient hypotension, hyperglycemia and constipation secondary to narcotic analgesics were noted; possible diabetic gastropathy was also noted. Discharge appeared to occur on [redacted].

Hospital documents (Exhibits 46-161; A10-A20) stemming from a hospitalization over [redacted] were presented. It was noted that Claimant presented with complaints of a rectal abscess. The problem was noted as severe. It was noted that Claimant was treated with antibiotics and that the abscess was drained.

Hospital documents (Exhibits A6-A9) from a hospitalization from [redacted] were presented. It was noted that Claimant presented with complaints of rectal pain. It was noted that unroofing and debridement of the abscess was performed.

Hospital documents (Exhibits A1-A5) from a hospitalization from [redacted] were presented. It was noted that Claimant presented with complaints of a hand abscess. It was noted that Claimant was treated with medications and was placed on a strict diabetic diet. A final diagnosis of cellulitis was noted.

Claimant alleged disability, in part, based on exertional restrictions Claimant testified that he is limited to 2 ½ blocks of walking due to leg fatigue. He stated that he is limited to 15-20 minutes of standing before getting light-headed.

It was established that Claimant suffers from chronic pancreatitis due to years of alcohol abuse. It was further established that Claimant has uncontrolled diabetes. The records established that Claimant was regularly hospitalized (13 times between 7/2011 and 1/2013) due to complications related to diabetes and/or pancreatitis. The sheer number of hospitalization Claimant underwent is sufficient to presume significant restrictions to basic work activities.

It was considered whether Claimant was partially at fault for the hospitalizations. Cellulitis and/or abscesses are problems known to be prevalent among drug users. During the hearing, Claimant became very defensive when questioned about drug abuse. Though Claimant's symptoms can be caused by drug abuse, diabetes and/or pancreatitis are also plausible explanations. It should be noted that medical records did not associate drug abuse with as the reason for any of Claimant's hospitalizations. Thus, drug abuse is not found to be relevant to the claim of disability.

It was not disputed that Claimant had a long history of alcohol abuse. Claimant testified that he has not consumed alcohol for two years. The presented medical records made references to a shorter period of sobriety for Claimant. The documents also made an occasional reference to more recent alcohol consumption by Claimant. Ultimately, alcohol consumption was rejected as a cause related to the hospitalizations because alcohol consumption was never cited as a cause for the hospitalizations.

Medical documentation often cited noncompliance as a cause for Claimant's problems. Though the noncompliance might be relevant to Claimant's poor health, it is not deemed to be a significant factor. First, the references of noncompliance were noted in only 3 of 13 hospitalizations; thus, there were plenty of hospitalizations where noncompliance was not a factor. Also, it was not well documented how Claimant was noncompliant.

There was one clear reference that Claimant failed to attend important follow-up appointments but other references were less clear. Most importantly, Claimant's noncompliance appeared to be primarily based on his lack of access to insurance and income rather than intentional self-destruction. It is found that medical noncompliance is not a factor to the claim of disability.

The medical records established that Claimant's hospitalizations and impairments began at least since 2/2012 and have continued for 12 months. This period establishes the durational requirements for a severe impairment to performing basic work activities.

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 appears to be chronic abscesses and ulcers related to pancreatitis and/or diabetes. The most applicable SSA listing for Claimant appears to be chronic skin infections which reads:

> **8.04** ***Chronic infections of the skin or mucous membranes,*** with extensive fungating or extensive ulcerating skin lesions that persist for at least 3 months despite continuing treatment as prescribed.

The above SSA listing was primarily intended to cover persons who suffer ulcers, lesions, abscesses or other skin conditions that are so severe that medication and treatment do not resolve the conditions. Those circumstances are not on-point with Claimant's disability claim. Claimant has chronic flare-ups of new and different abscesses. At this point in the analysis, Claimant's lack of medication compliance is a problem because there is no evidence that Claimant's skin conditions are essentially untreatable. Nevertheless, the number of hospitalizations and the seriousness of Claimant's diagnoses tend to justify a finding that Claimant's chronic skin infections meet the above listing. Based on the presented evidence, it is found that Claimant meets the listing for skin infections. Accordingly, Claimant is found to be a disabled individual.

It should be noted that had Claimant been found to not meet a SSA listing, Claimant would have been found incapable of performing past relevant work and incapable of performing even sedentary employment due to exertional restrictions combined with the regularity of Claimant's hospitalizations.

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 3/29/12, including retroactive MA benefits back to 2/2012;
(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: 6/25/2013

Date Mailed: 6/25/2013

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]