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

IN THE MATTER OF:

[redacted]

Reg. No.: 201321126
Issue No.: 2009
Case No.: [redacted]
Hearing Date: March 28, 2013
County: Macomb DHS (12)

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 conducted on March 28, 2013, from Clinton Township, Michigan. Participants included the above-named claimant. Participants on behalf of the Department of Human Services (Department) 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 8/2/12, Claimant applied for MA benefits, including retroactive MA benefits from 7/2012.

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

3. On 10/4/12, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 40-39).

4. On 10/10/12, DHS denied Claimant's application for MA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On 1/3/13, Claimant requested a hearing disputing the denial of MA benefits.

6. On 2/21/13, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual (see Exhibit 41), in part, by determining that Claimant could perform past relevant employment.

7. As of the date of the administrative hearing, Claimant was a [redacted] year old male with a height of 5'5'' and weight of 190 pounds.

8. Claimant has no known relevant history of alcohol or illegal substance abuse.

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

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

11. Claimant alleged that he is disabled based on impairments and issues including MRSA, kyphosis, diabetes, lower back pain and a broken arm and collarbone.

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. It should be noted that medical documents presented by DHS were numbered in reverse order; thus, cited exhibits are noted from high number to low number.

An undated and unsigned document listing nine questions related to depression were submitted. It was noted that Claimant's responses to the questions resulted in a score of a severe level of depression.

Lab results (Exhibits 18-17) dated 7/12/11 were presented. It was noted that Claimant's hemoglobin level indicated pre-diabetes.

A handwritten medical treatment record (Exhibit 24) dated [redacted] was presented. It was noted that Claimant was seen regarding the flu and for a check of sugar. Previous treatment documents (Exhibits 23-22, 20-19) were submitted, but not considered because they were illegible.

A medical record (Exhibits 28) dated [redacted] was presented. It was noted that Claimant was re-prescribed the following medications: Paxil, Metformin, Klonopin and Glyburide.

A medical record (Exhibits 28) dated [redacted] was presented. It was noted that Claimant was re-prescribed Flexeril.

A medical record (Exhibits 28) dated [redacted] was presented. It was noted that Claimant was re-prescribed the following medications: Paxil, Flexeril, Vicodin and Glyburide.

Hospital documents (Exhibits 16-1) were presented. It was noted that Claimant presented on [redacted] with complaint of a painful abdomen abscess. It was noted that Claimant had a history of similar abscesses and MRSA. A final diagnosis of acute abdomen wall abscess with possible necrotizing fasciitis was noted. A diagnosis of non-insulin diabetes was also noted. It was noted that the hospital drained the abscess and administered various antibiotics. It was noted that Claimant was discharged on [redacted].

A Medical Examination Report (Exhibits 30-29) 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 type 2 diabetes, chronic pain, anxiety disorder/panic disorder and lumbar radiculopathy. An impression was given that Claimant's condition was stable. It was noted that Claimant can meet household needs.

Claimant testified that he has reoccurring problems with MRSA, so much so, that he has a PICC line in his right arm so he can receive daily treatments for antibiotics. The history of MRSA was verified. Claimant's daily need for antibiotics was not verified, but was somewhat established merely by the presence of a PICC line.

Claimant testified that he suffers from kyphosis, a back disorder causing a hump-back appearance. Claimant stated that the disorder crushes his spine and causes severe pain. Claimant's testimony was not fully supported, though there was a reference to lumbar radiculopathy by Claimant's treating physician. The physician did not identify the degree or cause of the radiculopathy.

The verified diagnosis of lumbar radiculopathy can reasonably lead to a presumption to some difficulties in ambulation and concentration due to back pain. This is sufficient evidence of basic work restrictions in the step two analysis.

Claimant testified that he has no health insurance and that he dealt with the kyphosis since birth. It was established that Claimant was diagnosed with the radiculopathy in 9/2012. Based on the nature of the pain and Claimants lack of health insurance, it is probable that Claimant's pain has and/or will persist for a 12 month period. It is found that Claimant meets the durational requirements for a severe impairment.

As it was found that Claimant established significant impairment to basic work activities for a period longer than 12 months, it is found that Claimant established having a severe impairment. Accordingly, the disability analysis may move to step three.

The third step of the sequential analysis requires a determination whether the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920 (a)(4)(iii). If Claimant's impairments 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 appeared to be back pain caused by kyphosis. 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.

Claimant testified that he occasionally uses a cane and has difficulty walking due to his back pain and spine curvature. The presented medical records only verified a general back problem, lumbar radiculopathy. The records failed to note the degree of radiculopathy or any radiography in support of the diagnosis. There is insufficient evidence to justify a finding that Claimant ambulates ineffectively.

A listing for anxiety-related disorders (Listing 12.06) was considered based on Claimant's treating physician's diagnosis of an anxiety disorder. The only evidence concerning the disorder was: a diagnosis, a prescription for an anti-depressant (Paxil) and an apparent self-test where Claimant's score noted depression. There was no records of therapy or hospitalizations related to anxiety. There was no evidence of the degree of Claimant's anxiety. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Claimant had a complete inability to function outside of his home.

A listing for chronic skin infections (Listing 8.04) was considered based on Claimant's history of abscesses related to MRSA. The listing was rejected due to a failure to establish infections of three month periods despite prescribed treatment.

It is found that Claimant failed to establish meeting a SSA listing. Accordingly, the analysis moves to step four.

The fourth step in analyzing a disability claim requires an assessment of the Claimant's residual functional capacity (RFC) and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if it is determined that a claimant can perform past relevant work. *Id*.

Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

Claimant testified that his past relevant employment consists of his 15 years spent as a high-low driver in a factory. Claimant testified that the job was primarily sedentary and required skills that he can still perform. Claimant also testified that he could perform the employment once he heals from a recent broken collarbone.

A claimant's testimony is not always consistent with medical records. Occasionally, a claimant is overly-optimistic when testifying concerning work abilities. In the present case, Claimant's testimony was consistent with the presented medical records. It is found that Claimant may perform his past employment, and is not a disabled individual. Accordingly, it is found that DHS properly denied Claimant's application requesting MA benefits.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that DHS properly denied Claimant's MA benefit application dated 8/2/12, including retroactive MA benefits from 7/2012, based on a determination that Claimant is not disabled. The actions taken by DHS are AFFIRMED.

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

Date Signed: 4/5/2013

Date Mailed: 4/5/2013

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]