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

IN THE MATTER OF:

[redacted]

Reg. No.: 2013-2998
Issue No.: 2009
Case No.: [redacted]
Hearing Date: January 23, 2013
County: Branch

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

HEARING DECISION

This matter is before the undersigned Ad ministrative Law Judge upon Claimant's request for a hearing made pursuant to Mi chigan Compiled Laws 400.9 and 400.37, which gov ern the administrative hearing a nd appeal process. After due notice, a telephone hearing was commenced on J anuary 23, 2013, from Lansing , Michigan. Claimant personally appeared and testified. Participants on behalf of the Department of Human Services (Department) included Eligibility Specialist [redacted] [redacted]

ISSUE

Whether the Department of Human Serv ices (the department) properly denied Claimant's application for Medical Assistance (MA-P) and Retro-MA?

FINDINGS OF FACT

The Administrative Law Judge, based upon the com petent, material and substantial evidence on the whole record, finds as material fact:

(1) On August 15, 2012, Cla imant filed an applicati on for MA-P and Retro-MA benefits alleging disability.

(2) On September 13, 2012, the M edical Review T eam (MR T) denied Claimant's application for MA-P and Retro-MA indicating that her impairment(s) lacked duration. (Depart Ex. A, pp 171-172).

(3) On September 18, 2012, the department caseworker sent Claimant notice that her application was denied.

(4) On September 28, 2012, Claim ant filed a request for a hearing to contest the department's negative action.

(5) On December 4, 2012, the State Hearing Review Team (SHRT) found Claimant's condition is improving or expected to improve within 12 months from date of onset. (Depart Ex. B, pp 1-2).

(6) Claimant has a history of aorto iliac stenosis, gastroesophageal reflux disease (GERD), arthritis, chronic obstructive pulmonary disease (COPD), hypertension, hyperlipidemia, infected mesh, depression, and fibromyalgia.

(7) Claimant is a 50 year old woman whose birthday is [redacted]. Claimant is 5'9" tall and weighs 205 lbs. Claimant completed high school.

(8) Claimant had not applied for Social Security disability benefits at the time of the hearing.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department, (DHS or department), 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).

Disability is defined as the inability to do any substantial gainful activity 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). The person claiming a physical or mental disability has the burden to establish it 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). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/ duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and, (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (e.g., age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4). If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3 to Step 4. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

As outlined above, the first step looks at the individual's current work activity. In the record presented, Claimant is not involved in substantial gainful activity and testified that she has not worked since October, 2010. Therefore, she is not disqualified from receiving disability benefits under Step 1.

The severity of the individual's alleged impairment(s) is considered under Step 2. The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b). An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b). Examples include:

1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

5. Responding appropriately to supervision, co-workers and usual work situations; and

6. Dealing with changes in a routine work setting. *Id.*

The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). An impairment qualifies as non-severe only if, regardless of a claimant's age, education, or work experience, the impairment would not affect the claimant's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985).

In the present case, Claimant alleges disability due to aortoiliac stenosis, gastroesophageal reflux disease (GERD), arthritis, chronic obstructive pulmonary disease (COPD), hypertension, hyperlipidemia, infected mesh, depression, and fibromyalgia.

On October 19, 2011, Claimant followed up with her treating physician following a very large incisional hernia repair on 9/26/11. She was doing quite well except for discomfort and a bulge in the abdomen. There was a seroma that had developed since her last visit. With her permission, aseptically the seroma was aspirated. About 90 ml of serosanguineous fluid was evacuated and she felt better. She was instructed to continue on weight restrictions, and no heavy lifting or straining for another four weeks.

On November 9, 2011, Claimant followed up with her physician regarding her hernia repair. Claimant was complaining of not feeling well. She had right arm pain and was scheduled for an MRI. She had some nausea which was chronic. She was prescribed Phenergan but did not have any. She had a cough that appeared to be wet. The lungs had diminished breath sounds with occasional rales. There appeared to be no evidence of any seroma. There was scab formation in the middle of the incision with minimal erythema. There was no abdominal tenderness. The physician opined Claimant may have bronchitis and abdominal strain from coughing. She was prescribed Bactrim twice a day and Phenergan for nausea.

On December 7, 2011, Claimant saw her physician for a check up following her hernia repair. She had no complaints and minimal discomfort. She was on normal activity.

Her lungs were clear. Her abdomen was soft. The physician noted a tiny seroma, but not enough to aspirate. The wound itself was healing well. Claimant was released to normal activity.

On January 25, 2012, Claimant presented to her treating physician with abdominal pain. There was no evidence of a recurrent hernia. She had developed a scab in the middle of the incision measuring 2x3 cm with a very firm subcutaneous nodule. The physician suspected this to be a fatty necrosis. Claimant was treated conservatively with Aleve and instructed to return if it became worse for debridement.

On January 26, 2012, a CT abdomen and pelvis with contrast showed an interval ventral hernia repair with adjacent fluid collection developing since the previous study, suggesting a postoperative seroma.

On January 30, 2012, Claimant returned to her physician with abdominal discomfort. She had a scab and what appeared to be fatty necrosis of the abdominal wall after ventral incisional hernia repair. The CT scan showed a small seroma. The scab measured about 2.5 cm in diameter. There was seroma underneath it, likely fatty necrosis. Claimant stated she had drainage from the area. Debridement was recommended. She agreed and the scab in its entirety was debrided down to subcutaneous fat and good bleeding tissue which was controlled using pressure. The wound appeared to be quite hemostatic and healthy. The plan was to manage the wound conservatively, and Claimant was instructed on daily packing and dressing changes. She was also to continue on Norco for pain control and given a prescription for Bactrim.

On February 8, 2012, Claimant saw her physician concerning the debridement. Claimant stated that there was another spot a little higher than the first one. On exam, the ulcer which was debrided on 1/30/12 appeared to be granulating well. There was second one above it, smaller, and approximately 0.5 cm in diameter. There was no purulent drainage. They were curetted and triple antibiotic ointment and a dressing was applied. Claimant was instructed to continue with daily dressing changes and to apply antibiotics and return in two weeks.

On February 22, 2012, Claimant presented to the emergency department. She had a repair of an incisional hernia in September, 2012, which developed a wound seroma that was aspirated. She then developed an ulcer over the abdominal wall which was debrided a couple of on 2/8/12. The wound had been draining quite heavily. She had been having a lot of abdominal pain, fever, and chills. She was admitted to the hospital in anticipation of debridement of the abdominal wall and the abdominal wall seroma. She appeared to be quite uncomfortable. She was afebrile. The lungs had diminished breath sounds with an occasional wheeze. There was an ulcer in the abdominal wall measuring about 4x4 cm. There was scant yellow drainage. There was granulation tissue but no necrotic tissue. There was a second ulcer near the first one measuring less than 0.5 cm. The abdomen in general was tender but there was no abdominal wall erythema. She was diagnosed with an abdominal wall ulcer with infection, infected

seroma, status-post repair of ventral incisional hernia and started on IV antibiotics. On 2/23/12, Claimant underwent debridement of the abdominal wound, drainage of seroma and placement of a drain. She was discharged on February 24, 2012, with a diagnosis of abdominal wound with fatty necrosis, seroma status post repair of ventral incisional hernia.

On February 29, 2012, Claimant returned to her physician reporting that she was feeling much better. Most of her pain had resolved. She had some nausea the day before, but she was eating well. On exam, the abdomen was flat and soft. The wound was healing well, with no erythema, induration, or drainage. The J-P drain was still showing some serious drainage, about 20-30 cc a day. The plan was to continue with the J-P drain and she was placed on Flagyl and was to continue Bactrim. She was scheduled to return the following week.

On March 7, 2012, Claimant saw her physician and the J-P drain was removed. Half of the sutures were also removed and triple antibiotic ointment and a dressing were applied. She was given a refill of Vicodin and scheduled for a follow-up visit to remove the remaining sutures.

On March 14, 2012, Claimant returned to her physician complaining of some drainage from the wound. She was afebrile to the touch. The wound had actually healed well. There was a crisscross area in the center that appeared to have a small scab and a scant amount of serous drainage. It was nonpurulent. There was no erythema. The remaining sutures were removed. The wound itself appeared to have closed completely. Claimant was instructed that she could increase her activity as tolerated and to continue to apply Bacitracin ointment on the wound for a few days and then keep it open to dry.

On April 28, 2012, Claimant presented to the emergency department with an abdominal wound. She underwent a hernia repair and since then she has had some irritation at the hernia repair site as well as a chronic wound that was not healing well. The symptoms had been ongoing since September, 2011. Claimant stated she was just frustrated and fed up and wanted to be referred to another doctor. She had no fevers, chills, sweats, nausea, vomiting, or dysuria. The abdominal pain was mainly from the wound itself. There was no new drainage. It had been stable for several months. She stated it was not getting better. She had no other complaints. There was no lymphangitic streaking or redness, and no evidence of an abscess or deeper infection. Her main complaint was that the wound was not healing. The wound was an approximately 4x4 circular shape in the periumbilical region just above the umbilicus. Claimant was in no acute distress. She underwent a wound culture. She did not warrant a CAT scan or blood work as the pain was all from a chronic wound that was easily visualized. She was started on Keflex and Bactrim and referred for a consult with the wound clinic and she was discharged home.

On July 5, 2012, Claimant was seen by her primary care physician for an ulcer on her abdomen which was secondary to infected mesh which was draining. She did not have

insurance and was referred to the University of Michigan. On examination, the ulcer was clean. There was some scab which was removed and dressings were placed.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). In the present case, Claimant testified that she had arthritis, chronic obstructive pulmonary disease (COPD), hypertension, infected mesh, depression, and fibromyalgia. Based on the lack of objective medical evidence that the alleged impairment(s) are severe enough to reach the criteria and definition of disability, Claimant is denied at Step 2 for lack of a severe impairment and no further analysis is required.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Claimant not disabled for purposes of the MA-P benefit programs.

Accordingly, it is ORDERED:

The Department's determination is **AFFIRMED**.

Vicki L. Armstrong
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: April 12, 2013

Date Mailed: April 12, 2013

NOTICE: Administrative Hearings 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. Administrative Hearings 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.

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the mailing 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

VLA/las

cc: [redacted]