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

IN THE MATTER OF:

[redacted]

Reg. No.: 201342224
Issue No.: 2009
Case No.: [redacted]
Hearing Date: August 19, 2013
County: Oakland (04)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

Following Claimant's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10. After due notice, an in-person hearing was held on August 19, 2013, from Pontiac, Michigan. Participants included the above-named Claimant. [redacted] testified and appeared as Claimant's authorized hearing representative (AHR). Participants on behalf of the 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 2/[redacted]/13 Claimant applied for MA benefits.

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

3. On 3/[redacted]/13, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 1-2).

4. On 4/[redacted]/13, DHS denied Claimant's application for MA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On 4/[redacted]/13, Claimant's AHR requested a hearing disputing the denial of MA benefits.

6. On 6/[redacted]/13, SHRT determined that Claimant was not a disabled individual, in part, by application of Medical-Vocational Rule 201.21.

7. On 8/[redacted]/13, an administrative hearing was held.

8. On 8/[redacted]/13, an Interim Order Extending the Record was mailed to Claimant and Claimant's AHR allowing 60 days from the date of hearing to submit a Medical Examination Report from Claimant's treating physician to address Claimant's sitting restrictions.

9. On 11/[redacted]/13, Claimant's AHR submitted additional medical records.

10. On 11/[redacted]/13, an updated hearing packet was forwarded to SHRT.

11. On 1/[redacted]/14, SHRT determined that Claimant was not disabled, in part, by application of Medical-Vocational Rule 201.21.

12. On 1/[redacted]/14 the Michigan Administrative Hearings System received the hearing packet and updated SHRT decision.

13. As of the date of the administrative hearing, Claimant was a 46-year-old female with a height of 5'6'' and weight of 209 pounds.

14. Claimant is an ongoing tobacco smoker.

15. Claimant's highest education year completed was the 12th grade.

16. As of the date of the administrative hearing, Claimant was an Adult Medical Program recipient since approximately 6/2013.

17. Claimant alleged disability based on impairments and issues including lower back pain and blastomycosis.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by the Title XIX of the Social Security Act, 42 USC 1396-1396w-5, and is implemented by 42 CFR 400.200 to 1008.59. The Department of Human Services (formerly known as the Family Independence Agency) administers the MA program pursuant to MCL 400.10 and MCL 400.105. Department policies are contained in the Department of Human Services Bridges Administrative Manual (BAM) and Department of Human Services Bridges

Eligibility Manual (BEM) and Department of Human Services Reference Tables Manual (RFT).

Prior to a substantive analysis of Claimant's hearing request, it should be noted that Claimant's AHR noted special arrangements in order to participate in the hearing; specifically, an in-person hearing was requested. Claimant's AHR's request was granted and the hearing was conducted accordingly.

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 (10/2010), p. 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:

- 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).
  BEM 260 (7/2012) pp. 1-2

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 (7/2012), p. 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 2013 monthly income limit considered SGA for non-blind individuals is $1,040.

Claimant denied performing 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.

Duplicate radiology documents (Exhibits A4, A7, A8) of Claimant's lumbar were presented. The documents appeared to be poorly copied. The documents were ignored due to failing to note a date of service.

A CT scan report (Exhibit A5) dated 11/23/09 was presented. It was noted that a disc bulge was present at L4-L5 though there was no evidence of stenosis or foraminal narrowing. It was noted that Claimant had moderate foraminal narrowing though no stenosis at L5-S1. It was also noted that the radiology suggested a diffuse disc bulge at L5-S1.

DHS presented a Medical Examination Report (Exhibits 3-4) dated 2/[redacted]/12. It was noted that the physician completing the form first examined Claimant in 2007 and last examined Claimant on 6/[redacted]/12. Noted Claimant complaints included fatigue, lumbar back pain, lymph node problems, anxiety and irritability. Noted physician diagnoses included lumbar facet joint arthropathy, coccidiomycosis, S1 joint syndrome, depression and generalized anxiety disorder. It was noted that Claimant's condition was stable. It was noted that Claimant could meet her household needs.

Hospital documents (Exhibits 13-69) from an admission dated 2/[redacted]/13 were presented. It was noted that Claimant presented with a head injury following a fall in the shower; complaints of right-sided hip pain were also noted. It was noted that radiography verified that Claimant had no fractures or dislocations. Following a physical examination, it was

noted that Claimant's strength was 4/5 in the lower right extremity and that joint range of motion was intact in all extremities. It was noted that Claimant's cranial nerves were intact and that reflexes were 2+ in all extremities. An MRI report of Claimant's lumbar noted degenerative changes at L5-S1 including a right foraminal radial tear causing thecal sac effacement and moderate bilateral neural foraminal narrowing (see Exhibits A3; A6; A9). An MRI report of Claimant's right hip was unremarkable. It was noted that there was no stenosis. It was noted that Claimant was treated with pain medication. It was noted that Claimant reported pain improving from 10/10 to 6/10. It was noted that Claimant was ambulating well with a walker. On 2/[redacted]/13, it was noted that Claimant stated that she could return home. It was noted that Claimant's lack of insurance limited her access to medications.

A Medical Examination Report (Exhibits A1-A2) dated 9/[redacted]/13 was presented. The report was completed by a physician with an approximate two-month history with Claimant. The physician diagnosed Claimant with the following: lumbar stenosis, hypertension, anxiety, major depressive disorder, GERD, hypothyroidism and vitamin D deficiency. An imbalanced gait and lumbar spasms were noted. An impression was given that Claimant's condition was deteriorating. Claimant's physician noted that Claimant had limitations that were expected to last at least 90 days. Claimant was noted to be restricted to occasional lifting of under 10 pounds and never 10 pounds or more. Claimant was noted to be restricted to less than 6 hours of sitting in an 8-hour workday, Claimant was noted to be restricted to standing less than 2 hours in an 8-hour workday. Claimant was noted as restricted from operating feet or leg controls and pushing/pulling with her arms. Claimant was noted to be restricted to simple grasping and reaching with her left side. Claimant was noted to be restricted in social interactions. It was noted that Claimant can meet household needs.

Claimant's primary impairments were back-related. It was verified by a treating physician that Claimant was restricted in walking and lifting. Claimant's physician's statements noted reliance on the MRI from 2/[redacted]/13 and lab work from 8/[redacted]/13. Claimant's physician's statements were consistent with presented radiography. The restrictions were also consistent with hospital documentation verifying a loss of strength in a lower extremity. It is found that Claimant established significant impairment to performing basic work activities since at least 2/2013. It is probable that Claimant's impairments have and will last 12 months or longer.

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 only established severe impairment is lumbar degeneration. 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.

There was evidence that Claimant had reduced motor strength, had an unbalanced gait and that she fell at least once due to standing difficulties. A diagnosis of stenosis was noted by Claimant's treating physician. This evidence is suggestive that Claimant has an inability to ambulate effectively.

It was established that Claimant's treating physician opined that Claimant could not walk and/or stand for more than two hours in an 8-hour day. Claimant's physician further opined that Claimant could not sit for 6 hours in an 8-hour workday. The opinions of Claimant's physician are consistent with finding that Claimant is unable to work due to back pain. The findings are also consistent with an inability to ambulate effectively.

Claimant appeared to be in significant pain during the hearing. Claimant testified that she can only walk 10-15 feet before needing to stop due to lumbar pain. Claimant also testified that she is restricted in sitting also due to lumbar pain. Claimant testified that she cannot walk stairs and uses a walking aid at all times.

Claimant has a lengthy past relevant work history. Claimant testified that she worked from 1998-2012 as a direct care worker. Claimant testified that she can no longer perform the walking, standing or lifting to perform her past employment. Claimant's strong work history makes it more likely that Claimant is unable to work, as opposed to not wanting to work. Claimant's work history bolsters her testimony concerning ambulation restrictions.

Based on the presented evidence, it is found that Claimant meets the requirements for listing 1.04. Accordingly, it is found that Claimant is a disabled individual and that DHS erred in denying Claimant's MA benefit application.

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 perform the following actions:

(1) reinstate Claimant's MA benefit application dated 2/[redacted]/13;
(2) evaluate Claimant's eligibility for MA benefits subject to the finding 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: 2/10/2014

Date Mailed: 2/10/2014

NOTICE OF APPEAL: 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 or Reconsideration was made, within 30 days of the receipt date of the Decision and Order of Reconsideration or Rehearing Decision.

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).

A Request for Rehearing or Reconsideration may be granted when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion;
- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the client;
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The Department, AHR or the claimant must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date the hearing decision is mailed.

The written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-07322

CG/hw

cc: [redacted]