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

IN THE MATTER OF:

Reg. No.:	2013-62437
Issue No.:	2009
Case No.:	
Hearing Date:	October 31, 2013
County:	Wayne (18)

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 October 31, 2013, from Taylor, Michigan. Participants included the above-named Claimant. , Claimant's daughter, testified on behalf of Claimant. testified and appeared as Claimant's authorized hearing representative. Participants on behalf of the Department of Human Services (DHS) included , Medical Contact Worker.

ISSUE

The issue is whether DHS properly denied Claimant's application for Medical Assistance (MA) for the reason 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 , Claimant applied for MA benefits, including retroactive MA benefits from 2/2013 (see Exhibits 75-76).

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

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

4. On [redacted], DHS denied Claimant's application for MA benefits and mailed a Notice of Case Action (Exhibits 66-68) informing Claimant of the denial.

5. On [redacted] Claimant's AHR requested a hearing disputing the denial of MA benefits (see Exhibit 69).

6. On [redacted], SHRT determined that Claimant was not a disabled individual, in part, by application of Medical-Vocational Rule 202.11.

7. On [redacted] an administrative hearing was held.

8. Claimant presented new medical documents (Exhibits A1-A115) at the hearing.

9. During the hearing, Claimant waived the right to receive a timely hearing decision.

10. During the hearing, Claimant and DHS waived any objections to allow the admission of any additional medical documents considered and forwarded by SHRT.

11. On [redacted], an Updated Interim Order Extending the Record was mailed to Claimant to allow 60 days from the date of hearing to submit the following: Medical Examination Report from a primary care physician, Psychological/ Psychiatric Examination Report from a treating physician/psychologist and a Mental Residual functional Capacity Assessment from a treating physician/psychologist.

12. On [redacted], Claimant submitted additional documents (Exhibits B1-B40; C1-C11).

13. On [redacted], an updated hearing packet was forwarded to SHRT and an Interim Order Extending the Record for Review by State Hearing Review Team was subsequently issued which extended the record an additional 90 days.

14. On [redacted], SHRT determined that Claimant was not disabled, in part, by application of Medical-Vocational Rule 202.11 as determined by a Disability Determination Explanation (Exhibits D1-D14).

15. On [redacted], the Michigan Administrative Hearings System received the updated hearing packet and updated SHRT decision.

16. As of the date of the administrative hearing, Claimant was a 54-year-old female with a height of 5'3'' and weight of 111 pounds.

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

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

19. As of the date of the administrative hearing, Claimant was an Adult Medical Program recipient since approximately 11/2012.

20. Claimant alleged disability based on impairments and issues including neuropathy, leg pain, arm pain, right hand pain, diabetes, COPD, arthritis, thyroid problems and various psychiatric problems.

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 credibly denied performing any employment since the date of the MA application; no evidence was submitted to contradict Claimant's testimony. Based on the presented evidence, it is found that Claimant is not performing SGA and has not performed SGA since the date of MA application. 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 a summary of the relevant submitted medical documentation.

An Adult Biopsychosocial Assessment (Exhibits 38-52) dated [redacted] was presented. The assessment was completed by an unknown employee from an unknown agency. It

was noted that Claimant reported the following symptoms: anxiety, poor sleep, depression, guilt, extreme anger, grief, loss of appetite, hopelessness and helplessness. It was noted that Claimant previously considered suicide.

Four handwritten treatment documents (Exhibits 18-21) were presented. Chronologically, the documents were dated [redacted]. Complaints of back pain were noted. Noted diagnoses included hypertension and hyperlipidemia.

A physician letter (Exhibits 22-25; 54-58) from an examination dated [redacted] was presented. It was noted that Claimant complained of total body pain, ongoing for six months. It was noted that MRIs would be order for Claimant's brain and lumbar spine.

An MRI report of Claimant's brain (Exhibit 16) dated [redacted] was presented. It was noted the MRI was performed in response to Claimant complaints of headaches and dizziness. Impressions of an old lacunar infarct and microangiopathic changes were noted.

An MRI report of Claimant's lumbar (Exhibit 17) dated [redacted] was presented. It was noted that an MRI was performed in response to Claimant's complaints of back pain. Compromise of the neural foramina was noted at L4-L5. DDD, herniation and effacement upon the left neural foramen were noted at L5-S1. Significant spinal stenosis was noted at L2-L3.

Progress Notes (Exhibits 26-37) from an unspecified medical treater were presented. It was noted that Claimant presented on [redacted] with complaints of high blood pressure, arthritis in hips, carpal-tunnel syndrome in both wrists, heart problems and back pain. Medical treatment was not documented. It was noted that Claimant smoked marijuana. It was noted that Claimant was advised to stop smoking marijuana while she took medication.

A Medical Examination Report (Exhibits 14-15) dated [redacted] from Claimant's treating physician was presented. The physician noted an approximate 7-month history of treating Claimant. The physician provided diagnoses of joint pain and arthritis. Other diagnoses were noted, but too illegible to read. Reduced reflexes (4/5) were noted on Claimant's right. An impression was given that Claimant's condition was stable. The physician opined that Claimant could occasionally lift 10 pounds but never more than 20. The physician opined that Claimant could stand/walk less than 2 hours per 8-hour workday. Claimant's physician noted that Claimant could not operate foot/leg controls or perform fine manipulation. It was noted that Claimant can meet household needs.

A treating neurologist letter (Exhibits 59-60) dated [redacted] was presented. Claimant's neurologist noted an abnormal examination. Peripheral polyneuropathy from diabetes was noted as an impression. Claimant's neurologist noted that Claimant's radiating back pain was not explained by electrodiagnostic testing.

Progress Notes (Exhibits A1-A4; A93-A96) dated [redacted] from a treating physician were presented. It was noted that Claimant appeared for a follow-up appointment following hospitalization. It was noted that Claimant was a tobacco smoker. An assessment of COPD was noted. It was noted that Claimant received various medications.

Treating physician documents (Exhibits A97-A99) from an office visit dated [redacted] were presented. It was noted that Claimant presented for a follow-up. It was noted that Claimant complained of chest pain. An assessment of DM was noted. A plan to start Metformin was noted.

Respiratory testing results (Exhibits A5-A8) dated [redacted] were presented. A COPD risk of 2% was noted if Claimant stopped smoking.

Progress Notes (Exhibits A104-A106) from a treating physician were presented. It was noted that Claimant presented for follow-up of obstructive sleep apnea. It was noted that medications were prescribed and a follow-up in 2 months was scheduled.

Treating physician documents (Exhibits A100-A103) from an office visit dated [redacted] were presented. It was noted that Claimant presented for diabetes treatment. It was noted that a Metformin prescription would continue.

A physician letter (Exhibit A9) dated [redacted] was presented. It was noted that Claimant underwent a sleep study. An impression of obstructive sleep apnea syndrome was noted. It was noted that a CPAP would be implemented though a Progress Note (Exhibit A15) dated 6/19/13 noted Claimant did not use a CPAP machine.

Treating physician documents (Exhibits A81-A90) from an office visit dated [redacted] were presented. It was noted that Claimant presented for a follow-up diabetes check-up. A complaint of fatigue was noted. An impression of a mildly enlarged thyroid gland was noted.

Hospital documents (Exhibits A19-A27) dated [redacted] were presented. It was noted that Claimant reported headaches, visual changes and paresthesia on the right side of the face. A physical exam noted Claimant was positive for weakness. It was noted that a CT of the head was unremarkable. It was noted that x-rays of Claimant's chest showed no acute process.

An office visit document (Exhibits A77-A80) dated [redacted] was presented. It was noted that Claimant complained of neck, shoulder and arm pain. A treatment plan was not noted.

An office visit document (Exhibits A55-A59) dated [redacted] was presented. It was noted that Claimant takes four block walks, three times per week. It was noted that Claimant reported complaints of blurry vision. It was noted that an MRI of the brain verified that Claimant previously suffered a small stroke.

Hospital documents (Exhibits A28-A59) from an encounter dated [redacted] were presented. It was noted that Claimant presented with complaints of nausea and vomiting, ongoing for 2 days. Complaints of fatigue and dizziness were also noted. It was noted that Claimant had large amounts of fecal matter. It was noted that an esophagogastroduodenoscopy was performed.

Psychotherapy treatment documents (Exhibits B1-B26) from various 2013 dates were presented. The documents noted Claimant's ongoing treatment for depression.

Various medical treatment documents (Exhibits B27-B40; C1-C11) were presented. The documents verified more medical appointments and were notable only in remaining consistent with previously summarized documents.

Claimant testified that back pain causes her to take 15 minutes to walk two blocks. Claimant's testimony was consistent with presented radiology which verified problems at multiple vertebrae spaces. Claimant's testimony was also consistent with treating physician statements concerning her walking ability. Claimant's back problems are ongoing and found to restrict Claimant's ambulation since 2012.

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 back 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.

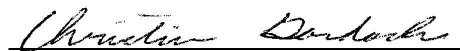
Presented radiology verified that Claimant has “significant spinal stenosis” at L2-L3. Stenosis was also noted at L1 and L3-L4. Encroachment on the neural foramen was noted at L5-S1 and L4-L5. Significant abnormalities including bulges and/or herniation were noted at each of Claimant’s vertebrae. Claimant’s spinal abnormalities are such that Claimant is unlikely to ambulate effectively. It is found that Claimant meets the Listing for 1.04 and is a disabled individual.

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 [redacted], including retroactive MA benefits from 2/2013;
(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: 4/3/2014

Date Mailed: 4/3/2014

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: