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

IN THE MATTER OF:

Reg. No.:	2014-17908
Issue No.:	2009
Case No.:	
Hearing Date:	May 29, 2914
County:	Monroe

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 May 29, 2914, from Monroe, Michigan. Participants included the above-named Claimant. , testified and appeared as Claimant's authorized hearing representative (AHR). 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. Claimant's only basis for MA benefits was as a disabled individual.

3. On , the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 284-285).

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

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

6. On [redacted] SHRT determined that Claimant was not a disabled individual, in part, by determining that Claimant can perform past relevant employment.

7. As of the date of the administrative hearing, Claimant was a 34 year old male with a height of 6'2'' and weight of 180 pounds.

8. Claimant has a relevant history of substance abuse.

9. Claimant's highest education year completed was the 12th grade, via general equivalency degree.

10. As of the date of the administrative hearing, Claimant was an ongoing Medicaid recipient.

11. Claimant alleged disability based on impairments and issues including stroke complications, back pain, and sleep apnea.

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).

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. "Current" work activity is interpreted to include all time since the date of application. The [redacted] 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.

A Medical Examination Report (Exhibits 295-296) dated [redacted] from Claimant's treating physician was presented. Claimant's physician noted an approximate 9-month history of treating Claimant. Mild degenerative joint disease was noted in Claimant's lumbar. Anxiety, hypertension, insomnia, and non-radiating back pain were also noted. It was noted that Claimant was restricted to occasional lifting of 10 pounds. It was noted that Claimant could sit more than 6 hours in an 8 hour workday. It was noted that Claimant could stand and/or walk 6 hours in an 8 hour workday. An impression was given that Claimant's condition was stable. It was noted that Claimant can meet household needs.

Hospital documents (Exhibits 33-42; 162-172) dated [redacted] were presented. It was noted that Claimant presented following a drug overdose; it was noted elsewhere that Claimant's last drug use was 3 months ago. A drug screening showed that Claimant was positive for opiates and benzodiazepines.

Hospital documents (Exhibits 19-32; 173-184) dated [redacted] were presented. It was noted that Claimant presented with complaints of pain from a left elbow abscess. It was noted that the site of abscess was where Claimant recently pulled out an IV during a hospital stay for a drug overdose. A diagnosis of abscess was noted. It was noted that Claimant ambulated without gait disturbance. It was noted that an incision and drainage was performed (see Exhibit 46).

Hospital documents (Exhibits 43-144; 185-283) from an admission dated [redacted] were presented. It was noted that Claimant presented with complaints of 10/10 arm pain. It was noted that x-rays revealed soft tissue swelling. Diagnoses of drug abuse and cellulitis were noted. It was noted that Claimant was a pack per day smoker, marijuana user, and weekly heroin user. A complaint of back pain was noted; Norco and Ibuprofen were noted as prescribed for back pain. An assessment of an abscess and resolved leukocytosis was noted.

Medical Examination Reports (Exhibits 4-7; 160-161) dated [redacted] and [redacted]/[redacted] from Claimant's treating physician was presented. Claimant's physician noted an approximate 18 month history of treating Claimant. The physician provided diagnoses of insomnia, chronic pain, anxiety, and high blood pressure. An impression was given that Claimant's condition was stable. A previous stroke caused by high blood pressure was noted. Sleep apnea was noted as suspected. It was noted that Claimant required someone to cook for him. It was noted that Claimant was restricted to occasional lifting of 10 pounds, never more than 20 pounds. It was noted that over an 8 hour workday, Claimant was restricted to less than 2 hours of standing or walking and less than 6 hours of sitting. It was noted that Claimant could not perform repetitive reaching or

pushing/pulling. It was noted that Claimant had unspecified restrictions in following simple directions, memory, comprehension, and engaging social interactions.

It should be noted that Claimant's medical records are strongly suggestive of heroin use. Claimant's testimony denied any history of heroin abuse. Claimant's apparent drug use merits mentioning but the decision can be decided on other grounds.

The presented evidence verified that Claimant received treatment for an abscess. Presumably, the problem was resolved as no evidence was presented to suggest otherwise.

Presented records tended to verify some degree of back pain. Claimant's physician noted only "mild" DJD; this diagnosis is consistent with having no restrictions. Despite the mild diagnosis, Claimant's physician noted substantial walking and sitting restrictions for Claimant.

Treating source opinions cannot be discounted unless the Administrative Law Judge provides good reasons for discounting the opinion. *Rogers v. Commissioner,* 486 F. 3d 234 (6th Cir. 2007)*; Bowen v Commissioner.* The presented records provide ample reason for discounting the lifting and walking restrictions allegedly provided by Claimant's physician.

As noted above, a diagnosis of mild DJD is not consistent with lifting restrictions of less than 10 pounds. Further, no radiological or other evidence was presented to justify any lifting or walking restrictions. A previous stroke was referenced but there was zero evidence of such an occurrence, or if there was, that long-term impairments were caused. Claimant's physician apparently significantly increased Claimant's restrictions from [redacted] to [redacted] but there was no provided reason to justify the change.

Claimant's physician's statements were so wholly unsupported, thought was given that Claimant, not his doctor, completed the form. Based on the presented evidence, Claimant's physician's stated restrictions are completely rejected.

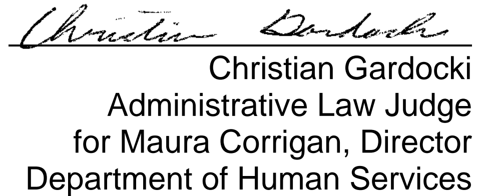
Back pain was referenced in Claimant's hospital stay but radiology was not presented to justify restrictions from back pain. Claimant is left with only evidence of an abscess (presumably resolved) and a drug-related hospital encounter.

Based on the presented evidence, it is found that Claimant does not have a severe impairment. Accordingly, the denial of Claimant's MA application is found to be proper.

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 5/31/13

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: 6/4/2014

Date Mailed: 6/4/2014

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: