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

IN THE MATTER OF:

[redacted]

Reg. No.: 14-005617
Issue No.: 2009
Case No.: [redacted]
Hearing Date: August 27, 2014
County: Lapeer

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

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; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, an in-person hearing was held on August 27,2014, from Lapeer, Michigan. Claimant, represented by [redacted] of [redacted] appeared and testified. Participants on behalf of the Department of Human Services (Department) included Eligibility Specialist [redacted].

ISSUE

Whether the Department properly determined that Claimant was not disabled for purposes of the Medical Assistance (MA) benefit program?

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 January 21, 2014, Claimant filed an application for MA/Retro-MA benefits alleging disability.

(2) On March 22, 2014, the Medical Review Team (MRT) denied Claimant's application for MA-P/Retro-MA, indicating a lack of duration of 12 months.

(3) On March 28, 2014, the Department sent Claimant notice that his application was denied.

(4) On June 25, 2014, Claimant filed a request for a hearing to contest the Department's negative action.

(5) Claimant has a history of pancreatitis, pseudocysts, hypertension, non-Hodgkin's lymphoma, splenomegaly and mild degenerative disc disease.

(6) Claimant is a 38 year old man whose birthday is [redacted].

(7) Claimant is 5'11" tall and weighs over 184 lbs.

(8) Claimant has a high school education.

(9) Claimant was applying for Social Security disability benefits at the time of the hearing.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Human Services Bridges Administrative Manual (BAM), Department of Human Services Bridges Eligibility Manual (BEM), and Department of Human Services Reference Tables Manual (RFT).

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Family Independence Agency) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

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 has never been involved in substantial gainful activity. Therefore, he 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 pancreatitis, pseudocysts, hypertension, non-Hodgkin's lymphoma, splenomegaly and mild degenerative disc disease. As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s).

Claimant testified he can walk 100 yards, stand 10 minutes, sit for half an hour and carry up to 20 pounds. He stated he does not drink alcohol or use illegal drugs and smokes 4 cigarettes a day and has never had an alcohol or drug problem.

On [redacted], was admitted to the hospital with previous history of gastroesophageal reflux disease, remote history of Hodgkin disease, and inguinal lymph nodes, status post radiation 20 years ago. Previous history of recurrent pancreatitis related to alcohol. His last alcohol use was two weeks ago. This was Claimant's third admission; first in August, 2013, with acute gastroenteritis, acute pancreatitis, and large pseudocyst. At that time, Claimant was recommended for pseudocyst drainage. Claimant had a follow-up MRI in October, 2013, which showed some Subacute hemorrhage in the spleen, but pancreas was totally normal. Claimant again continued to drink 3 to 4 times a week and came back to the hospital on [redacted], with the same kind of symptoms and then after being admitted to the hospital, was discharged in good condition. Now, Claimant was doing well, but he went to his primary care physician, where they draw blood tests and amylase was 413, lipase was 1189, and he was sent to the emergency department. An ultrasound did not show any significant change. Claimant was discharged on [redacted], with a diagnosis of acute pancreatitis with recurrent pancreatitis. The physician indicated Claimant "has to stop alcohol."

On [redacted], Claimant presented to the emergency department a few hours after he had a drink of alcohol. He was admitted to the hospital and discharged on [redacted] with a diagnosis of: acute pancreatitis likely alcohol induced and chronic alcohol abuse.

On [redacted], Claimant was admitted to the hospital with acute on chronic pancreatitis, hypertension, history of non-Hodgkin lymphoma and alcohol abuse, possible withdrawal. He was discharged on [redacted], in stable condition.

On [redacted], Claimant presented to the hospital with abdominal pain and nausea. Claimant stated he drank a pint of alcohol last night and woke at 5am with left upper quadrant abdominal pain. Claimant admitted drinking alcohol on a daily basis and tobacco use. Diagnosis: acute pancreatitis secondary to alcohol, hypokalemia, and mild leukocytosis, Claimant was strictly advised to quit alcohol.

On [redacted], Claimant presented to the emergency department. He had left the hospital against medical advice the day before on [redacted]. He was being treated for acute pancreatitis. He was unable to explain why he left. However, he stated when he got home, he drank alcohol and his pain increased, so he came back to the emergency department. Alcohol level on admission was 0.37. The physician indicated Claimant is a smoker and a drinker. Claimant was unable to tell the physician how much he actually drinks. Diagnosis: Ethyl alcohol-induced pancreatitis, low potassium, low magnesium, thrombocytopenia, likely secondary to ethyl alcohol abuse, ethyl alcohol abuse, history of non-Hodgkin lymphoma, hypertension and gastroesophageal reflux disease.

On [redacted], Claimant was admitted to the hospital for acute on chronic pancreatitis. He was discharged on [redacted], to follow up with his primary care physician.

On [redacted] Claimant's treating physician completed a Medical Examination Report on behalf of the Department. Claimant is diagnosed with pancreatitis, insomnia, alcohol abuse and opioid use. The physician limited Claimant to lifting no more than 20 pounds and standing/walking less than 2 hours in a workday. The physician indicated the limitations were not expected to last more than 90 days. The physician opined Claimant's condition was stable.

This Administrative Law Judge finds that the objective medical evidence of record does not support Claimant's contention that he is suffering from a severe physical impairment that has lasted or is expected to last for at least 12 months.

Furthermore, there is no objective medical evidence to show that any of the conditions listed during his numerous hospital stays have lasted or are expected to last for 12 months or that they would limit Claimant's ability to perform basic work activities. This Administrative Law Judge finds that the objective medical evidence does not support Claimant's contention that he is suffering from a medically determinable severe impairment that has lasted or is expected to last for 12 months. Accordingly, Claimant is precluded from a finding of disability at Step 2 and no further analysis is needed.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Claimant not disabled for purposes of the MA benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is **AFFIRMED**.

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

Date Signed: **9/3/2014**

Date Mailed: **9/3/2014**

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NOTICE OF APPEAL: A party may appeal this Hearing Decision in the circuit court in the county in which he/she resides, or the circuit court in Ingham County, within 30 days of the receipt date.

A party may request a rehearing or reconsideration of this Hearing Decision from the Michigan Administrative Hearing System (MAHS) within 30 days of the mailing date of this Hearing Decision, or MAHS may order a rehearing or reconsideration on its own motion.

MAHS may grant a party's Request for Rehearing or Reconsideration 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 party requesting a rehearing or reconsideration 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 this Hearing Decision is mailed.

A written request may be faxed or mailed to MAHS. If submitted by fax, 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

cc: [redacted]