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

IN THE MATTER OF:

Reg. No.:	14-006731
Issue No.:	2009
Case No.:	
Hearing Date:	August 18, 2014
County:	Wayne (19)

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 18, 2014, from Inkster, Michigan. Participants included the above-named Claimant. testified and appeared as Claimant's authorized hearing representative (AHR). , Claimant's spouse, testified on behalf of Claimant. 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 11/2013.

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 4-5).

4. On , 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. As of the date of the administrative hearing, Claimant was a 52 year old female with a height of 5'3'' and weight of 210 pounds.

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

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

9. Claimant alleged disability based on impairments and issues including bipolar disorder, depression, anxiety, high blood pressure, back pain, dizziness, slurred speech, back pain, and chronic obstructive pulmonary disorder (COPD), sleep apnea, seizures, restless leg syndrome (RLS), coronary artery disease (CAD).

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.*, p. 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.*, p. 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 2013 monthly income limit considered SGA for non-blind individuals is $1,040. The 2014 monthly income limit considered SGA for non-blind individuals is $1,070.

Claimant testified that she recently worked for 2 days at a party store. Claimant stated that she performed work such as cashier and stock. Claimant stated that she could not continue the standing and had to quit due to anxiety. Claimant testified that she had no other employment. 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.

Hospital documents (Exhibits 8-21) from an admission dated [redacted] were presented. It was noted that Claimant presented with complaints of nausea and vomiting following a fall. It was noted that Claimant's medical history included questionable seizures which have not been medically documented. It was noted that a chest x-ray demonstrated acute COPD exacerbation. Claimant developed COPD exacerbation and was treated with Albuterol. It was noted that an echocardiogram demonstrated normal systolic function and mild mitral and aortic regurgitation. Claimant's ejection fraction was 60%. It was noted that an EEG revealed no evidence of seizure. A recommendation was made for a gastric emptying study; it was noted that Claimant refused the study. It was noted that dehydration probably caused Claimant to fall; a recommendation to follow-up with neurology was noted.

Hospital documents (Exhibits 55-66) from an admission dated [redacted] were presented. It was noted that Claimant presented with complaints of chest pain that began while at rest. The hospital course of action was not apparent. A discharge date of 1[redacted] was noted.

Hospital documents (Exhibits 30-54) from an admission dated [redacted] were presented. It was noted that Claimant presented with complaints of slurred speech, left-sided tingling, numbness, and imbalance. A list of 17 medications was noted as taken by Claimant. A brain MRI/MRA neck was noted to show no infarct or stenosis or cerebellar ectopia. Claimant's chest discomfort was noted to be most likely caused by COPD/asthma exacerbation. A recent echocardiogram was noted to be normal. An assessment of mild CAD was noted following cardiac tests. A "questionable" history of cerebrovascular accident was noted.

Hospital documents (Exhibits 67-79) from an admission dated [redacted] were presented. It was noted that Claimant presented with complaints of chest pain and dyspnea. It was noted that Claimant was a tobacco smoker. It was noted that a chest x-ray was suspicious for lingular pneumonia. Discharge diagnoses of COPD and pneumonia were noted. A discharge date of [redacted] was noted.

Hospital documents (Exhibits 80-91) from an admission dated [redacted] were presented. It was noted that Claimant presented with complaints of chest pain and dyspnea. It was noted that a chest x-ray showed resolution of pneumonia. It was noted that Claimant was suspected to have sleep apnea based on a report of loud snoring. Claimant

received various breathing treatments and IV steroids. A diagnosis of COPD exacerbation was noted. Claimant received medication for ongoing treatment of HTN, non-obstructive CAD, neuropathy, GERD, and depression. A discharge date of was noted.

Hospital documents (Exhibits 22-29) from an admission dated were presented. It was noted that Claimant presented with complaints of left-side tingling, loss of balance, and slurred speech. It was noted that Claimant had similar symptoms after a reported stroke that occurred a few months ago. It was noted that Claimant's speech returned to normal after 2 hours. It was noted that Claimant smoked 1 pack per day. Claimant's last seizure was noted to be 1.5 years ago. A CT of Claimant's head was performed; an impression of no acute intracranial abnormality was noted. Claimant's lungs were noted to be clear and heart was noted as stable. A carotid doppler noted an unspecified right carotid artery blockage of less than 29%; a left carotid artery blockage was noted to be between 30-49%. A diagnosis of acute bronchitis with asthma and/or COPD was noted.

Hospital documents (Exhibits 92-102) from an admission dated were presented. It was noted that Claimant presented with complaints of chest pain, back pain, and dyspnea. It was noted that Claimant improved with breathing treatment. It was noted that Claimant ran out of inhaler medication two days before admission. A diagnosis of COPD exacerbation was noted. A discharge date of was noted.

Hospital documents (Exhibits 103-119) from an admission dated were presented. It was noted that Claimant presented with complaints of dyspnea. It was noted that Claimant had middle right lobe pneumonia and was given "around the clock" IV steroids and nebulized bronchodilator. It was noted that Claimant's breathing improved and that she was weaned off of oxygen. A primary discharge diagnosis of acute respiratory failure was noted. The following active diagnoses were also noted: nicotine dependence, obesity, HTN, and chronic pain syndrome. A discharge date of was noted.

Hospital documents (Exhibits 120-129) from an admission dated were presented. It was noted that Claimant presented with complaints of increasing dyspnea over the past 3 days. It was noted that Claimant was an obese one pack per day smoker. It was noted that Claimant's chest x-ray was consistent with pneumonia. It was noted that Claimant received high dose steroids. A primary discharge diagnosis of acute on chronic respiratory failure was noted. A discharge date of was noted.

Hospital documents (Exhibits 130-145) from an admission dated were presented. It was noted that Claimant reported chest pain. It was also noted that reported a particularly severe headache after taking nitro. It was noted that Claimant was an ongoing pack per day smoker. It was noted that an EKG showed no new ST-T changes. It was noted that a stress myocardial perfusion was performed; results were noted to be negative for reversible ischemia. A new diagnosis of diabetes mellitus (type

II) was noted. It was noted that Claimant's headache improved after receiving morphine and fiorcet. A discharge date of was noted.

Hospital documents (Exhibits 146-162) from an admission dated were presented. It was noted that Claimant presented with complaints of cough and dyspnea, ongoing for 3 days. It was noted that Claimant was an ongoing pack per day smoker. It was noted that Claimant could normally walk long distances without dyspnea, but now she is down to 40 feet. It was noted that Claimant reported that her inhalers did not offer relief. It was noted that Claimant received albuterol and nebulizer treatments. It was noted that Claimant was to start CPAP therapy for sleep apnea. It was noted that Claimant received prednisone, Azithromycin and NMT treatments. Noted chronic problems included the following: HTN, dyslipidemia, mild CAD, depression, RLS, left extremity neuropathy, tobacco abuse, and diabetes. A discharge date of was noted.

Hospital documents (Exhibits 173-215) from an admission dated were presented. It was noted that Claimant presented with complaints of chest pain after trying to push her husband's car out of the snow. It was noted that acute kidney failure resolved with IV fluids. It was noted that a CT of Claimant's chest revealed multifocal opacities throughout both lungs. It was noted that Claimant had a severe sepsis infection which contributed to low blood pressure. It was noted that Claimant received COPD medications. It was also noted that Claimant was offered smoking cessation advice and that Claimant was not interested in quitting at that time. It was noted that Claimant would likely require oxygen at discharge. It was noted that an EKG was suggestive of constrictive heart physiology. A discharge date of was noted.

Hospital documents (Exhibits 163-172) from an admission dated were presented. It was noted that Claimant presented with complaints of malaise, body aches, and headache. It was noted that Claimant took her blood pressure medication despite low blood pressure. Noted discharge diagnoses included dehydration, acute kidney failure, and acute bronchitis. Discharge documents noted that Claimant's kidney function improved with IV fluids.

Hospital documents (Exhibits A1-A4; A10-A17) from an admission dated were presented. It was noted that Claimant presented with complaints of chest pain. It was noted that Claimant became hypoxic with an oxygen saturation of 88%. It was noted that Claimant was placed on a heparin drip. It was noted that Claimant felt better after oxygen treatment. A discharge date of was noted.

Hospital documents (Exhibits A5-A9; A18-A35) from an admission dated were presented. It was noted that Claimant was taken by ambulance from her physician's office after being found to be hypoxic. It was noted that Claimant's blood gas measured 61 mmhg with normal bicarbonate level. It was noted that Claimant was thought to have experienced COPD exacerbation but Claimant's breathing did not improve with breathing treatments. It was noted that Claimant's breathing improved after she

received IV Narcan. It was noted that Claimant reported neck pain following a fall earlier in the day; a CT of Claimant's head and cervical spine revealed no abnormal findings. A diagnosis of depression/anxiety exacerbated by recent bereavement was noted. Other discharge diagnoses included acute hypercapnic respiratory failure, acute bronchitis, HTN, depression, back pain, and nicotine addiction.

Hospital documents form 2/2014 noted an assessment of possible opiate overdose; it was also noted that Claimant denied taking any opiate medication. A drug screening verified opiate use. Consideration was given to factoring Claimant's apparent misreporting. There was no evidence of opiate abuse in other medical records; this is suggestive of an isolated incident. The incident could be explained by a tragedy experienced by Claimant. Hospital documentation noted that Claimant's son passed away that week. The trauma of a child's death is a compelling excuse for Claimant's isolated giving of misinformation.

Hospital radiology documents (Exhibits A36-A43; A46-A47) dated [redacted] were presented. It was noted that x-rays of Claimant's lumbar revealed moderate degenerative changes at L4-L5 and S5-S1; facet arthropathy and possible stenosis were noted. It was noted that x-rays were taken of Claimant's cervical spine. An impression of minimal anterolisthesis and minimal disc space narrowing was noted. It was noted that a CT of Claimant's head was performed; an impression of minimal change from a previous study was noted.

Hospital documents (Exhibits A59-A66) from an admission dated [redacted] were presented. Diagnoses of acute COPD exacerbation, history of deep vein thrombosis, and pneumonia were noted. Noted active problems included the following: sleep apnea, acid reflux, allergy, depression, COPD exacerbation, hyperlipidemia, hyper-intensive disorder, seizure, transient cerebral ischemia, chest pain, anxiety, and TIA. A slew of active medications were noted.

The presented evidence verified diagnoses and treatment for COPD, respiratory failure, and back pain. The evidence also verified that Claimant suffered at least one stroke.

Claimant testified that she is restricted in walking, lifting/carrying, and standing. Claimant's testimony was consistent with the presented medical documentation. Medical documentation also established that Claimant's restrictions have lasted since 11/2013, the first month that Claimant seeks MA benefits. It is found that Claimant has a severe impairment and the analysis may proceed 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.

A listing for spinal disorders (Listing 1.04) was considered based on Claimant's back pain complaints. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root.

A listing for chronic pulmonary insufficiency (Listing 3.02) was considered based on recurring complaints of dyspnea. The listing was rejected due to a lack of respiratory testing evidence.

Cardiac-related listings (Listing 4.00) were considered based on Claimant's cardiac treatment history. Claimant failed to meet any cardiac listings.

A listing for sleep apnea (Listing 3.10) was considered. The listing was rejected due to a failure to meet the requirements of Listings 3.09 or 12.02.

It is found that Claimant failed to establish meeting a SSA listing. Accordingly, the analysis moves to step four.

The fourth step in analyzing a disability claim requires an assessment of the Claimant's residual functional capacity (RFC) and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if it is determined that a claimant can perform past relevant work. *Id.*

Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

Claimant testified that she recently attempted employment as a party store clerk. Claimant testified that her primary duty was to ring-up customers. Claimant testified that she only lasted 2 days before having to quit due to anxiety and standing difficulties.

Claimant testified that her last full-time employment was in 2003, as a machine operator for a factory. Presumably, Claimant's employment was mostly standing.

Claimant testified that she worked part-time in 2003 for a department store. Claimant testified that her primary job duty was stocking dairy shelves.

Claimant testified that she also worked in the early 2000s as a grocery store cashier and as a factory line operator. Claimant's testimony suggested that both jobs required long periods of standing and a modest degree of lifting.

Claimant testified that she is unable to perform the lifting/carrying or standing required of past employment. Claimant's testimony was consistent with presented records. Accordingly, the analysis may proceed to step five.

In the fifth step in the process, the individual's RFC in conjunction with his or her age, education, and work experience, are considered to determine whether the individual can engage in any other substantial gainful work which exists in the national economy. SSR 83-10. While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

To determine the physical demands (i.e. exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967. The definitions for each are listed below.

Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b) Even though weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additionally limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.*

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.*

Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.*

Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id.*

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands are considered nonexertional. 20 CFR 416.969a(a). Examples of non-exertional limitations include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i)-(vi) If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2)

The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.* In using the rules of Appendix 2, an individual's circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, is compared to the pertinent rule(s).

Given Claimant's age, education and employment history a determination of disability is dependent on Claimant's ability to perform light employment. Social Security Rule 83-10 states that the full range of light work requires standing or walking, off and on, for a total of approximately 6 hours of an 8-hour workday.

Physician statements of specific restrictions were not presented. Specific restrictions can be inferred based on the presented medical evidence.

Claimant had numerous hospital encounters related to breathing restrictions. Hospital documents were suggestive that Claimant was vulnerable to respiratory failure. This finding is consistent with Claimant's stroke history and multiple incidents of hypoxia. Claimant's susceptibility to respiratory failure is suggestive of an inability to perform light employment.

Radiological evidence also established moderate degenerative changes and a small degree of stenosis. Claimant's back restrictions are indicative of back pain that would make lifting/carrying difficult.

Medical records also established problems of restless leg syndrome, artery blockage, neuropathy, and sleep apnea. Claimant also credibly testified that she has recurring

seizures. When taken together, the medical evidence sufficiently verified that Claimant is unable to perform light employment.

Based on Claimant's exertional work level (sedentary), age (approaching advanced age), education (high school), employment history (semi-skilled with no known transferrable skills), Medical-Vocational Rule 201.14 is found to apply. This rule dictates a finding that Claimant is disabled. Accordingly, it is found that DHS improperly found Claimant to be not disabled for purposes of MA benefits.

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 11/2013;
(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 benefits.

The actions taken by DHS are **REVERSED**.

Christian Gardocki
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: **9/17/2014**

Date Mailed: **9/17/2014**

CG / hw

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: