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

IN THE MATTER OF:

[redacted]

Reg. No.: 2014-31449
Issue No.: 2009
Case No.: [redacted]
Hearing Date: July 17, 2014
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 July 17, 2014, 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) 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 [redacted], Claimant applied for MA benefits.

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 9-10).

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 (see Exhibit 7).

6. On [redacted], SHRT determined that Claimant was not a disabled individual, in part, by determining that Claimant did not have a severe impairment (see Exhibits 90-91).

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

8. During the hearing, the record was verbally extended by 30 days to allow Claimant additional time to submit additional treatment records for scoliosis; an Interim Order Extending the Record was subsequently mailed.

9. On [redacted] Claimant submitted additional medical documents (Exhibits B1-B36).

10. As of the date of the administrative hearing, Claimant was a 57 year old female with a height of 5'7'' and weight of 140 pounds.

11. Claimant's highest education year completed was the 10th grade.

12. As of the date of the administrative hearing, Claimant was an ongoing Health Michigan Plan recipient, effective 7/2014.

13. Claimant alleged disability based on impairments and issues including scoliosis and hypertension.

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.

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 record was extended 30 days from the date of hearing to allow Claimant to submit additional documents. Claimant submitted records approximately 40 days after the date of hearing. Though Claimant's submission was tardy, the records were factored in the disability determination. The analysis will begin with a summary of the relevant submitted medical documentation.

Hospital documents (Exhibits 68-90) from an admission dated [redacted] were presented. The documents did not relate to Claimant.

Hospital documents (Exhibits 22-67) from an admission dated [redacted] were presented. It was noted that Claimant presented with complaints of abdominal pain and dyspnea, ongoing for one day. It was noted that Claimant was a half pack per day smoker for 25 years. It was noted that a CT scan of Claimant's abdomen revealed edema of multiple loops of the small bowel; the CT scan was described as negative (see Exhibit 45) though bowel thickening was noted (see Exhibit B2). It was noted on that Claimant's abdominal pain improved and that she felt better though it was noted that Claimant could reproduce pain with flexion and rotation of her torso. On [redacted], it was noted that Claimant complained of mild abdominal pain and leg pain when walking. An impression of acute abdominal pain and uncontrolled HTN were noted. Discharge documents were not presented. A discharge date of [redacted] was noted.

Hospital documents (Exhibits A1-A30) from an admission dated [redacted] were presented. It was noted that Claimant presented with complaints of intermittent chest pain (3-4/10), ongoing for 2 days. It was noted that Claimant's pain was relieved by rest. It was noted that Claimant ran out of medications four days prior. Discharge documents were not presented, but a discharge date of [redacted] was noted. It was noted that a stress test was performed; no abnormalities were noted. Impressions of HTN, acute coronary syndrome, and tobacco abuse were noted.

Hospital documents (Exhibits B28-B36) from an encounter dated [redacted] were presented. It was noted that Claimant presented with complaints of right-sided chest

pain, ongoing for 1 day. Other complaints included weakness, myalgias, and cough. A past medical history of COPD and backache was noted. It was noted that a stress test performed in 2/2014 showed "essentially normal stress". It was noted that Claimant's complaints were not believed to be cardiac-related. It was noted that Claimant failed to follow-up with a physician at last hospitalization. A chest x-ray was noted to show no acute cardiopulmonary process. Diagnoses of acute chest pain, upper respiratory infection and myalgias were noted.

Hospital documents (Exhibits B1-B27) from an admission dated [redacted] were presented. It was noted that Claimant presented with complaints of tarry stool and abdominal pain, ongoing for 1 day. Claimant's blood pressure was noted to be 217/114. An assessment of dyspepsia was noted. Recommendation of a proton pump inhibitor was noted. It was noted that lab results were normal (see Exhibit B19). It was noted that Claimant felt much better the day after admission. A discharge date of [redacted] was noted. A discharge prescription of omeprazole was noted.

Claimant alleged that she has walking and lifting restrictions related to scoliosis. Claimant testified that her back pain caused her to quit employment as a caregiver in 2009. Claimant testified that she hadn't received back treatment since quitting her job.

The only apparent complaint of back pain in initially submitted records was a reference to back pain in Claimant's medical history (See Exhibits A15 and B29). Treatment for back pain was not verified.

Some cardiac treatment was verified. Cardiac testing was noted as normal. Acute coronary syndrome was noted; "acute" is suggestive of a one-time problem. The only references to cardiac treatment suggested that Claimant's complaints are non-cardiac in nature. Insufficient evidence was suggestive of restrictions related to heart performance.

Presented records suggested that Claimant has recurring dyspnea and ambulation problems related to hypertension. Hospital notes implied that Claimant was medication noncompliant at the time of her 2/2014 hospitalization. The evidence was suggestive that Claimant is asymptomatic when medication compliant.

Claimant's 10/2013 abdomen pain hospitalization also referenced "acute" pain. A later diagnosis of dyspepsia tended to verify a more permanent problem for Claimant. A diagnosis of dyspepsia is insufficient to infer that Claimant has restrictions in performing basic work activities.

Claimant's multiple hospitalizations failed to establish any lengthy restrictions to Claimant's performance of basic work activities. Accordingly, Claimant did not establish having a severe impairment and it is found that DHS properly denied Claimant's MA application.

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 and SDA benefit application dated [redacted] 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: 9/16/2014

Date Mailed: 9/16/2014

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]