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

IN THE MATTER OF:

[redacted]

Reg. No.: 2014-33978
Issue No.: 2009
Case No.: [redacted]
Hearing Date: July 31, 2014
County: Macomb (36)

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 31, 2014, from Sterling Heights, Michigan. Participants included the above-named Claimant. [redacted], Claimant's wife, testified on behalf of Claimant. [redacted] testified and appeared as Claimant's authorized hearing representative (AHR). Participants on behalf of the Department of Human Services (DHS) included [redacted], Hearings Facilitator.

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 (see Exhibits 12-32), including retroactive MA benefits from 11/2013.

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 33-34).

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 reliance on Disability Determination Explanation and Medical-Vocational Rule 202.14.

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

8. During the hearing, both parties waived the right to receive a timely hearing decision.

9. During the hearing, the record was extended 30 days for Claimant to submit a hip radiology report and Medical Examination Reports; an Interim Order Extending the Record was subsequently mailed to both parties.

10. On 10/1/14, the Michigan Administrative Hearings System received 284 pages of documents concerning Claimant's allegation of disability.

11. As of the date of the administrative hearing, Claimant was a 51 year old male with a height of 6'1'' and weight of 236 pounds.

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

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

14. Claimant alleged disability based on impairments and issues including dyspnea, cardiac problems, and hip pain.

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*., 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 testified that he tried working for 3 days in 6/2014. Claimant testified that he had to quit his job because he was not physically capable. Claimant stated he was paid $150 for his 3 days. Claimant's testimony was credible and unrefuted. 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.

An analysis typically begins with a summary of the relevant submitted medical documentation. In the present case, a procedural issue must first be addressed.

Claimant's AHR was given 30 days from the date of hearing to submit specific medical documents. At the end of the 30 day period, MAHS received no additional documents. Approximately 62 days after the date of hearing, MAHS received 284 pages of documents, most of which were not requested. Apparently, DHS sent the documents because the envelope in which the documents arrived listed a return address for the DHS office.

It is extraordinarily tempting to reject all of the documents as untimely submitted. Such an outcome would be unfair to Claimant, particularly because documents presented at the hearing insufficiently verified a claim of disability. This is known because that decision was already written when the new documents arrived.

It is equally tempting to reject all of the documents that were not listed as part of the original interim order. Again, out of respect for Claimant's claim, this course of action will not be undertaken. The allowance of tardily submitted and unrequested documents may not hold true for the next time these circumstances arise.

Hospital documents (Exhibits 45-137; 2-16 – 2-105; 2-195 – 2-284) from an admission dated [redacted] were presented. It was noted that Claimant presented with complaints of extreme chest pain, nausea, and vomiting, ongoing for 3 days. It was noted that Claimant had not seen a physician in 10 years. Claimant was admitted with acute anterior wall myocardial infarction. Claimant was catheterized shortly after admission when an occlusion of a large diagonal branch was discovered. Following a successful angioplasty, Clamant was noted to have severe coronary vessel disease. Quadruple bypass surgery was performed on [redacted]. It was noted that Claimant's condition improved following surgery. Noted discharge diagnoses included myocardial infarction, malignant hypertension, tobacco abuse, s/p CABGx4, postoperative anemia due to blood loss, respiratory failure, and atelectasis. Discharge instructions noted that Claimant required home care due to deconditioning; a review of the need for services would occur every two months. A 6 week restriction to 5 pounds of lifting was noted. A discharge date of [redacted] was noted.

A Medical Examination Report (Exhibits 9-10) dated [redacted] was presented. The form was completed by an internal medicine physician with an approximate 5 month history

of treating Claimant. Claimant's physician listed diagnoses of coronary artery disease (CAD), congestive heart failure (CHF), and a-fib. An impression was given that Claimant's condition was stable. It was noted that Claimant needs assistance with household chores.

Hospital documents (Exhibits A1-A42; 2-107 – 2-194) from an admission dated 3/28/14 were presented. It was noted that Claimant presented with complaints of heart palpitation accompanied by light-headedness, dyspnea, and fatigue. It was noted that an ECG was abnormal though Claimant had normal sinus rhythm. It was noted that Claimant was admitted based on his medical history. It was noted that Claimant did not have a-fib or demonstrate any concerning symptoms. Claimant was discharged on [redacted].

A Medical Examination Report (MER) (Exhibits 2-12 - 2-13) dated [redacted] was presented. The form was completed by a family medicine physician with an approximate 2 month history of treating Claimant. Claimant's physician listed diagnoses of right hip degeneration and osteoarthritis. An impression was given that Claimant's condition was deteriorating. It was noted that Claimant can meet household needs.

A Medical Examination Report (Exhibits 2-14 – 2-15) dated [redacted] was presented. The form was completed by an internal medicine physician with an approximate 18 month history of treating Claimant. Claimant's physician listed diagnoses of CAD and CHF. Mild edema was noted in a physical examination. An impression was given that Claimant's condition was deteriorating. It was noted that Claimant cannot meet household needs though no explanation was given to what needs Claimant was unable to meet.

At the time of Claimant's hospitalization in 11/2013, it was noted that Claimant was a tobacco smoker. Claimant credibly testified that he quit smoking after he was discharged. Thus, a disability evaluation need consider Claimant's noncompliance with medical treatment.

Claimant testified that he has ambulation and lifting restrictions due to dyspnea. Claimant's testimony is consistent with his medical history. The records established that Claimant's restrictions began no later than 11/2013, the month of quadruple bypass surgery and the first month where MA benefits are sought. 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 chronic pulmonary insufficiency (Listing 3.02) was considered based on Claimant's complaints of dyspnea. The listing was rejected due to a lack of respiratory testing evidence.

A listing for chronic heart failure (Listing 4.02) was considered. The listing was rejected because of the absence of evidence of the following: inability to perform an exercise test, three or more episodes of acute congestive heart failure or a conclusion that an exercise test poses a significant risk to Claimant's health.

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

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 he performed construction work for 15 years before his heart attack. Claimant testified that his work required heavy lifting which he is no longer able to perform. Claimant's testimony was consistent with presented records. It is found that Claimant cannot perform past employment and 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.

In 3/2014, Claimant's cardiologist provided specific restrictions (see Exhibit 10). Claimant's physician opined that Claimant was restricted as follows over an eight-hour workday, less than 2 hours of standing and/or walking, and less than 6 hours of sitting. Claimant's physician opined that Claimant was restricted to occasional lifting/carrying of less than 10 pounds, never 10 pounds or more. The restrictions are consistent with a finding that Claimant is unable to perform light employment.

The Medical Examination Report asks physicians to state the basis for any stated restrictions. Claimant's physician did not list any medical findings to support the stated restrictions. This consideration raises doubts about the provided restrictions.

Claimant's cardiologist's restrictions do not necessarily verify Claimant's restrictions for the full 12 month period following surgery. Claimant's cardiologist listed Claimant's restrictions in the fourth month following bypass surgery. Though Claimant's condition was noted as stable, it is likely that a degree of medical improvement and reduction in restrictions would have occurred in the following months. Overall, the evidence was not persuasive in establishing that Claimant is unable to perform light employment.

In a MER dated [redacted] Claimant's internal medicine physician opined that Claimant was restricted as follows: over an eight-hour workday, less than 2 hours of standing and/or walking, and less than 6 hours of sitting. The findings are consistent with an inability to perform any type of employment. The physician appeared to base the restrictions on Claimant's cardiac history as only cardiac diagnoses were noted.

The MER asks the physician to list medical findings that support the limitations. Claimant's physician also failed to list medical findings to support stated restrictions. This consideration lessens the persuasiveness of the stated restrictions.

It was established that Claimant underwent highly invasive surgery for multiple heart problems. Presented records were not suggestive that Claimant had notable complications since surgery. One precautionary hospital admission was verified, however, notable symptoms were not verified. Treatment records were not presented. Overall, the cardiac documentation was suggestive that Claimant was capable of sustaining the exertion of light employment at some point within the 12 months following bypass surgery.

In a MER dated [redacted], Claimant's family medicine physician opined that Claimant was restricted as follows over an eight-hour workday, less than 2 hours of standing and/or

walking, and less than 6 hours of sitting. Claimant was restricted to occasional lifting of 50 pounds or more.

During the hearing, the record was extended, in part, for Claimant to submit radiology documents to support ambulation restrictions. No radiology reports were provided. The absence of hip radiology makes it highly tempting to find that Claimant is capable of performing light employment. Despite the absence of radiology, some support for ambulation and sitting restrictions was verified.

Claimant's physician noted that decreased range of hip motion was the basis for standing and sitting restrictions. The physician also noted that Claimant's right quad was atrophied. It was not stated whether Claimant's right quad atrophy was reversible. Presumably, Claimant's leg muscle loss was a symptom of a sedentary lifestyle following bypass surgery. There was no evidence that nerve damage or other conditions caused the atrophy. Thus, Claimant's leg atrophy is likely reversible with exercise.

Quadruple bypass surgery, restricted hip motion, an atrophied quad and trace leg edema were verified. It is also notable that three different physicians found Claimant to have limited standing ability though none of the three presented compelling support for the restriction. Though presented records failed to verify respiratory testing or hip radiology, sufficient evidence to infer that Claimant is restricted to sedentary employment was presented.

Based on Claimant's exertional work level (sedentary), age (approaching advanced age), education (high school with no direct entry into skilled employment), 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 11/2013;
(2) evaluate Claimant's benefit eligibility 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: 10/24/2014

Date Mailed: 10/24/2014

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]