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

IN THE MATTER OF:

[redacted]

Reg. No.: 14-006304
Issue No.: 2009
Case No.: [redacted]
Hearing Date: October 14, 2014
County: Wayne-District 35

ADMINISTRATIVE LAW JUDGE: Vicki Armstrong

HEARING DECISION

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to the Claimant's Authorized Hearing Representative's (AHR) timely Request for Rehearing/Reconsideration of the Hearing Decision generated by the assigned Administrative Law Judge (ALJ) at the conclusion of the hearing conducted on October 14, 2014, and mailed on October 16, 2014, in the above-captioned matter.

The Rehearing and Reconsideration process is governed by the Michigan Administrative Code, Rule 400.919, *et seq.*, and applicable policy provisions articulated in the Bridges Administrative Manual (BAM), specifically BAM 600, which provide that a rehearing or reconsideration must be filed in a timely manner consistent with the statutory requirements of the particular program or programs that is the basis for the claimant's benefits application, and **may** be granted so long as the reasons for which the request is made comply with the policy and statutory requirements.

This matter having been reviewed, an Order Granting Reconsideration was mailed on November 5, 2014.

ISSUE

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

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. Findings of Fact No. 1 through 5 under Registration Number 14-006304 are incorporated by reference.

2. On October 14, 2014, a hearing was held resulting in a Hearing Decision mailed on October 16, 2014, which found Claimant was not disabled.

3. On October 30, 2014, Claimant's authorized representative requested reconsideration/rehearing.

4. The Request for Rehearing/Reconsideration was GRANTED.

CONCLUSIONS OF LAW

In the instant case, Claimant requested rehearing/reconsideration asserting misapplication of policy that would impact the outcome of the original hearing decision.

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).

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability. 20 CFR 416.927(e).

As outlined above, the first step looks at the individual's current work activity. In the record presented, Claimant last worked in October, 2010, and is not involved in substantial gainful activity. Therefore, she 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 recent right above the knee amputation, acute kidney injury, sepsis, ileostomy, colostomy, abdominal mass, congestive heart failure, type II diabetes, peripheral arterial disease, perinephric abscesses, bowel obstruction, hypotension, degenerative disc disease, chronic back pain, diverticulosis, arthritis, lymphadenopathy, large ventral hernia, grade 1 anterolisthesis of L4 on L5, urinary tract infection, hematoma of left kidney, pneumonia, diabetes, hypertension, chronic low back pain, peripheral neuropathy, restless leg syndrome, microcytic anemia, hyponatremia, hypokalemia, morbid obesity, polydipsia and leukocytosis.

On [redacted], Claimant presented with knee pain and muscle aches in an office visit to her primary care physician. The pain was localized to the left thigh, right thigh, left shin, right shin leg, left and right hip. Associated symptoms include arthralgias. She was positive for arthralgias, limb pain (bilateral leg pain) and leg edema daily. She had an antalgic gait. Pain noted on palpation at the medial joint line, over the superior patella and anteriorly. She had limited active range of motion with flexion. She was diagnosed with bilateral knee pain and muscle aches and given an osteoarthritis handout.

On [redacted], Claimant saw her primary care physician for generalized pain. The pain was localized to the right shoulder, left knee, right knee and left food leg. It began two weeks ago. Associated symptoms included joint pain, chronic back pain, joint stiffness, limb pain and left leg edema. She had decreased range of motion with right shoulder flexion and extension, pain with right shoulder flexion, extension, internal rotation and external rotation in addition to pain with bilateral knee flexion and extension, left lower leg edema. She was diagnosed with lower limb edema, with possible deep vein thrombosis. The physician was unable to do Doppler due to lack of insurance coverage.

On [redacted], Claimant presented to her primary care physician with leg swelling. The swelling was episodic and of mild intensity. She had chronic back and limb pain and trace pedal edema.

On [redacted], Claimant saw her primary care physician complaining of constipation for the past week. The constipation was accompanied by abdominal pain, cramping, and nausea. Claimant was prescribed Tigan.

Claimant was admitted to the hospital on [redacted], with diarrhea, vomiting, pneumonia, a lower urinary tract infection, and a hematoma of the left kidney. While in the hospital she was diagnosed with new onset diabetes mellitus. A CAT scan was performed which suggested a 6.1 x 5.5 fluid collection near the left kidney consistent with acute to subacute hemorrhage. She was started on antibiotics for the UTI and pneumonia and transferred to the medial floor. Claimant was discharged on [redacted].

On [redacted], she followed up with her primary care physician and complained of fatigue since being released from the hospital. Claimant stated it was difficult to maintain sleep and she was waking after only 2-3 hours, averaging 5-6 hours a night. Claimant had mild pedal edema, diarrhea and polyuria. Claimant was diagnosed with elevated fasting glucose and a urinary tract infection. She was given a free style glucometer and scheduled to return in two weeks.

On [redacted], Claimant saw her primary care physician complaining of increased thirst. Glucose was PT 147/mg. She was diagnosed with polydipsia, and prescribed a blood by glucose monitoring device.

On [redacted], Claimant was assessed for rehabilitative needs and therapies. She was recently admitted to the hospital for hypotension and an abdominal abscess. She ultimately underwent an above the knee amputation due to a bowel ischemia that required the amputation. She developed decubitus ulcer and acute kidney injury. She has been hospitalized since February, 2014, and also reports a left phrenic abscess. She also developed sepsis and required ileostomy due to her abdominal mass and a colostomy. Once she was stabilized she required continued medical management and subacute rehabilitation and was transferred to a nursing home. She was assessed with multiple medical comorbidities including: multifactorial gait impairment; balance and transfer deficits, recent right above the knee amputation, history of bowel ischemia, decubitus ulcers, hypotension, and multiple abdominal abscesses, history of sepsis, poor exertional tolerance, and decreased manual muscle strength. The physician opined that Claimant's rehabilitation potential is guarded.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). Based on the medical evidence, Claimant has presented medical evidence establishing that she does have some physical and mental limitations on her ability to perform basic work activities. The medical evidence has established that Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, Claimant is not disqualified from receipt of MA-P benefits under Step 2 and the ALJ erred in finding otherwise.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The evidence confirms treatment/diagnoses of hypertension, back pain, osteoarthritis of both knees, hypoxemic respiratory failure, hyperglycemia, gastroesophageal reflux disease, chronic obstructive pulmonary disease and paranoid schizophrenia, cocaine abuse, alcohol abuse, cannabis abuse, pneumonia, bipolar disorder, schizophrenia, depression with psychotic features.

Listing 1.00 (musculoskeletal system), Listing 3.00 (respiratory system), Listing 4.00 (cardiovascular system) and Listing 12.00 (mental disorders) were considered in light of the objective evidence. Based on the foregoing, it is found that Claimant's impairment(s) do not meet the intent and severity requirement of a listed impairment; therefore, Claimant cannot be found disabled at Step 3. Accordingly, the Claimant's eligibility is considered under Step 4. 20 CFR 416.905(a).

The fourth step in analyzing a disability claim requires an assessment of the individual's residual functional capacity ("RFC") and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if he/she can perform past relevant work. *Id*.; 20 CFR 416.960(b)(3). 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 are 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.

This step examines the physical and mental demands of the work done by Claimant in the past. 20 CFR 416.920(f). Claimant's past work history is that of a desk top publisher and as such, Claimant would be unable to perform the duties associated with her past work. Likewise, Claimant's past work skills will not transfer to other occupations. Accordingly, Step 5 of the sequential analysis is required.
The fifth and final step of the sequential consideration of a disability claim, the trier of fact must determine if the claimant's impairment(s) prevents claimant from doing other work. 20 CFR 416.920(f). This determination is based upon Claimant's:

> (1) residual functional capacity defined simply as "what can you still do despite you limitations?" 20 CFR 416.945;
>
> (2) age, education, and work experience, 20 CFR 416.963-.965; and
>
> (3) the kinds of work which exist in significant numbers in the national economy which the claimant could perform despite his/her limitations. 20 CFR 416.966.

See *Felton v DSS* 161 Mich. App 690, 696 (1987). Once Claimant reaches Step 5 in the sequential review process, Claimant has already established a *prima facie* case of disability. *Richardson v Secretary of Health and Human Services,* 735 F2d 962 (6th Cir, 1984). At that point, the burden of proof is on the state to prove by substantial evidence that Claimant has the residual functional capacity for substantial gainful activity.

After careful review of Claimant's medical records and the Administrative Law Judge's personal interaction with Claimant at the hearing, this Administrative Law Judge finds that Claimant's non-exertional impairments render Claimant unable to engage in a full range of even sedentary work activities on a regular and continuing basis. 20 CFR 404, Subpart P. Appendix 11, Section 201.00(h). See Social Security Ruling 83-10; *Wilson v Heckler*, 743 F2d 216 (1986). Based on Claimant's vocational profile (advanced age, Claimant is 55, with a high school education and an semi-skilled work history), this Administrative Law Judge finds Claimant's MA/Retro-MA benefits are approved using Vocational Rule 201.06 as a guide.

As a result, the ALJ's determination which found Claimant not disabled at Step 2 (non-severe impairment), Step 3 (meets an impairment listing), and Step 4 (residual functional capacity and past employment) are VACATED and the Department's determination which found Claimant is not disabled is **REVERSED**.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, it is determined that the Administrative Law Judge erred in affirming the Department's determination which found Claimant not disabled.

Accordingly, it is ORDERED:

1. The ALJ's Hearing Decision mailed on October 16, 2014, under registration Number 14-006304 which found Claimant not disabled is VACATED.

2. The Department's determination which found Claimant not disabled is **REVERSED**.

3. The Department shall initiate processing of the January 9, 2014, application to include any applicable requested retroactive months, to determine if all other non-medical criteria are met and inform Claimant of the determination in accordance with Department policy.

4. The Department shall supplement for any lost benefits (if any) that Claimant was entitled to receive if otherwise eligible and qualified in accordance with Department policy.

5. The Department shall review Claimant's continued eligibility in December, 2015, in accordance with Department policy.

IT IS SO ORDERED.

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

Date Signed: **12/8/2014**

Date Mailed: **12/8/2014**

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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 48909-8139

cc: