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

IN THE MATTER OF:

[redacted]

Reg. No.: 14-018360
Issue No.: 2009
Case No.: [redacted]
Hearing Date: January 22, 2015
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, a telephone hearing was held on January 22, 2015, from Detroit, 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] medical contact worker.

ISSUE

The issue is whether DHS properly denied Claimant's Medical Assistance (MA) eligibility 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 1-2).

4. On [redacted], DHS denied Claimant's application for MA benefits and mailed written notice (see Exhibits 4-6) informing Claimant of the denial.

5. On [redacted], Claimant's AHR requested a hearing disputing the denial of MA benefits (see Exhibit 3).

6. As of the date of the administrative hearing, Claimant was a 63 year old male.

7. Claimant has not earned substantial gainful activity since before the first month of benefits sought.

8. Claimant's highest education year completed was the 12th grade, via general equivalency degree.

9. Claimant has a history of semi-skilled employment, with no known transferrable job skills.

10. Claimant alleged disability based on restrictions related to back fractures.

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, a three-way telephone 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*. 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.

SGA means a person does the following: performs significant duties, 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 SGA. *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 2014 monthly income limit considered SGA for non-blind individuals is $1,070.

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 analysis will begin with a summary of presented medical documentation.

Various physician office documents (Exhibits 92-96) from 2013 were presented. It was noted that Claimant received treatment for high cholesterol, a cold, bronchitis, and sinusitis. The documents were accompanied by lab results (Exhibits 97-101) and chest radiology (Exhibit 102), neither of which were notable.

A physician office visit document (Exhibit 90) dated [redacted] was presented. It was noted that Claimant reported ongoing high blood pressure readings. A plan to start Lisinopril was noted.

A physician office visit document (Exhibit 89) dated [redacted] was presented. It was noted that Claimant received ongoing treatment for HTN.

Hospital documents (Exhibits 23-33; 48-88) from an admission dated [redacted] were presented. It was noted that Claimant presented with severe back, hip, and buttocks pain after falling 4 feet off of a ladder. It was noted that radiology demonstrated L1 vertebra fracture with 30% loss of height, L3 compression fracture, hyper-intense T2 signal, mild desiccation of all lumbar discs, moderate spinal canal stenosis at L3-L4 with disc material abutting the exiting L3 nerve root, suspected impingement of the L4 nerve root, among other abnormalities. It was noted that Claimant underwent T11-L3 fusion surgery. Post-surgery, it was noted that pain limited Claimant's ambulation to several steps. It was noted that Claimant underwent physical and occupational therapy. Claimant was noted to have a FIM score of 91 at his final conference (a FIM score of 91 is indicative that Claimant was able to independently complete daily activities). Claimant's strength was noted to be 5/5 in all extremities. It was noted that Claimant was prescribed Vicodin for home pain control. A past medical history of arthritis in the hands and depression was noted. Noted discharge diagnoses included lumbar vertebra fracture, uncontrolled HTN, dizziness, diastolic CHF, and urinary retention. A discharge date of [redacted] was noted.

An x-ray report of Claimant's lumbar (Exhibits 24) dated [redacted] was presented. An impression of persistent compression fracture at L1 and progressive loss of vertical height was noted.

An x-ray report of Claimant's thoracic spine (Exhibits 36) dated [redacted] was presented. An impression of fracture deformity at L1 was noted.

An internal medicine examination report (Exhibits 15-22) dated [redacted] was presented. The report was noted as completed by a consultative physician. It was noted that Claimant reported multiple falls after taking Lopressor to treat HTN. It was noted that Claimant wore a semi-rigid brace and used a walker for ambulation. It was noted that Claimant was observed to have a slow gait. Reduced lumbar flexion and hip forward flexion were noted. A need for a walking aid was noted.

A CT report of Claimant's thoracic spine (Exhibits B3-B4) dated [redacted] was presented. An impression of thoracic spondylosis was noted.

A CT report of Claimant's lumbar (Exhibits A4; B1-B2) dated [redacted] was presented. A burst L1 vertebral fracture with progressing height loss (40%) was noted. Mild degenerative changes were noted throughout Claimant's lumbar (compared to radiology from 3/2014). Suspected impingement of exiting L4 and L5 nerve roots was noted.

Physician office visit documents (Exhibits A1-A2) dated [redacted] were presented. It was noted that Claimant reported flu-like symptoms, ongoing for 3 days. Moderate breathing difficulty was noted. Medications for Norco and Valium were noted as continued to treat back pain. A diagnosis of COPD was noted.

Neurologist office visit documents (Exhibits B5-B7) dated [redacted] were presented. It was noted that Claimant's lumbar had unspecified range of motion limits due to pain. Tenderness of the lumbar was noted. A plan of follow-up radiology for possible discontinuation of the back brace was noted.

Claimant testified that he has ongoing ambulation and lifting restrictions stemming from broken vertebrae. Claimant's testimony was fairly consistent with presented records. It was verified that approximately four months following fusion surgery, Claimant still experienced pain, likely due to nerve root impingement and had a need to use a walker. It was also verified that seven months following surgery, Claimant still required narcotic medication.

It is found that Claimant established significant impairment to basic work activities for a period longer than 12 months. Accordingly, it is found that Claimant established having a severe impairment and the disability analysis may move to Step 3.

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.

Claimant's most prominent impairment appears to be back pain. Spinal disorders are covered by Listing 1.04 which reads:

> **1.04** ***Disorders of the spine*** (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the cauda equina) or the spinal cord. With:
>
> A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy

with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine);
OR
B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours;
OR
C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b.

Claimant testified that he was unable to pursue physical therapy following surgery due to his DHS-issued health insurance denying payment. Claimant's testimony was credible, in light of post-surgery radiology which tended to verify aggravation of spinal problems. Nerve root impingement was suspected at multiple vertebra, stenosis at multiple vertebra was noted, and degeneration was noted throughout Claimant's lumbar.

Claimant testified that he was restricted to walking only a few steps before needing to stop due to lumbar pain. Claimant's testimony was consistent with his relatively old age (63 years old), injury (multiple spinal fractures), and lack of medical improvement. Though Claimant appears capable of independently performing ADLs, his ambulation appears to be severely restricted.

It is likely that Claimant's ambulation will improve; however, it is not likely to improve to the point of effective ambulation. Though claudication and muscle strength loss was not verified, Claimant is found to be incapable of effectively ambulating.

It is found that Claimant meets Listing 1.04 (c) and is therefore a disabled individual. Accordingly, it is found that DHS improperly denied Claimant's MA application by finding that Claimant was not a disabled individual.

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 perform the following actions:

(1) reinstate Claimant's MA benefit application dated [redacted];
(2) evaluate Claimant's eligibility for 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 Nick Lyon, Interim Director
Department of Human Services

Date Signed: **2/6/2015**

Date Mailed: **2/6/2015**

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 48909-8139

cc: [redacted]