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

IN THE MATTER OF:

[redacted]

Reg. No.: 14-011341
Issue No.: 2009
Case No.: [redacted]
Hearing Date: October 29, 2014
County: ALLEGAN

ADMINISTRATIVE LAW JUDGE: Colleen Lack

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; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, a four-way telephone hearing was held on October 29, 2014, from Lansing, Michigan. Participants on behalf of Claimant included [redacted], the Claimant, and [redacted], Authorized Hearing Representative. Participants on behalf of the Department of Human Services (Department) included [redacted], Assistant Attorney General, [redacted], Family Independence Manager, and [redacted], Eligibility Specialist.

During the hearing, Claimant waived the time period for the issuance of this decision, in order to allow for the submission of additional medical evidence. The evidence was received and reviewed.

ISSUE

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

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 February 20, 2014, Claimant applied for Medicaid (MA-P) and retroactive MA-P.

2. On June 11, 2014, the Medical Review Team (MRT) found Claimant not disabled.

3. On June 19, 2014, the Department notified Claimant of the MRT determination.

4. On September 9, 2014, the Department received Claimant's timely written request for hearing.

5. Claimant alleged disabling impairments including back pain; osteoarthritis in knees, shoulders, and neck; hand problems, diabetes, chronic obstructive pulmonary disease (COPD), sleep apnea, congestive heart failure (CHF), naval hernia, and depression.

6. At the time of hearing, Claimant was [redacted] years old with a [redacted], birth date; was 5'1" in height; and weighed 245 pounds.

7. Claimant has an Associate's Degree in business and work history including shift manager at pizza hut.

8. Claimant's impairments have lasted, or are expected to last, continuously for a period of 12 months or longer.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Human Services Bridges Administrative Manual (BAM), Department of Human Services Bridges Eligibility Manual (BEM), and Department of Human Services Reference Tables Manual (RFT).

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Family Independence Agency) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

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 CFR 416.913. 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 (i.e. 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 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 three to step four. 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 416.945(a)(1). An individual's residual functional capacity assessment is evaluated at both steps four and five. 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).

As outlined above, the first step looks at the individual's current work activity. In the record presented, the Claimant is not involved in substantial gainful activity. Therefore, Claimant is not ineligible for disability benefits under Step 1.

The severity of the Claimant's alleged impairment(s) is considered under Step 2. The Claimant 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 416.920(a)(4)(ii); 20 CFR 416.920(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 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921(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 disabling impairments including back pain; osteoarthritis in knees, shoulders, and neck; hand problems, diabetes, chronic obstructive pulmonary disease (COPD), sleep apnea, congestive heart failure (CHF), naval hernia, and depression. While some older medical records were submitted and have been reviewed, the focus of this analysis will be on the more recent medical evidence.

Claimant was hospitalized [redacted], for acute hypoxic and hypercarbic respiratory failure, COPD exacerbation, bronchial alveolitis, essential hypertension, restrictive lung disease, morbid obesity, and diabetes mellitus type II.

[redacted] office visit records document diagnosis and treatment for multiple conditions, including CHF, obstructive sleep apnea, diabetes, hypertension, lumbago, restrictive lung disease, and morbid obesity. A [redacted] office visit record, in part, documents that Claimant is to continue use of 2 liters oxygen.

[redacted] office visit records document diagnosis and treatment for multiple conditions, including CHF, hypertension, lumbago, restrictive lung disease, and obstructive sleep apnea. The [redacted], office visit note, in part, documents that Claimant still needed oxygen at night and part of the day. Claimant was awaiting insurance to be able to afford further testing. The [redacted], office visit note, in part,

documents that Claimant the CHF was doing well with minimal swelling, but Claimant still needed oxygen when lying down.

A [redacted], bilateral knee x-ray showed bilateral tricompartmental osteoarthritis and lateral patellar tilt.

A [redacted], cervical spine x-ray showed moderate mid to lower cervical disc degenerative changes.

A [redacted], history and physical documents an evaluation for left and right knee pain. Claimant reported she has had the pain for at least 8 years. X-rays showed bone on bone osteoarthritis of the medial compartment of the right knee and less significant degenerative changes of the left knee.

A [redacted], progress note documented evaluation for snoring and excessive daytime sleepiness. A [redacted], sleep study documented moderate obstructive sleep apnea and hypoxemia.

Claimant was hospitalized [redacted], for right knee osteoarthritis, COPD, hypertension, diabetes, sleep apnea, and asymptomatic acute postoperative blood loss anemia. Claimant underwent right knee total arthroscopy and acellular tissue graft right knee. Occupational therapy records indicate Claimant was to be discharged to a nursing home for short term rehabilitation.

An [redacted], progress note, in part, indicated Claimant was doing well since discharge from the hospital, but did twist her knee the other day at the nursing home. Claimant was to continue physical therapy for knee range of motion, strengthening, and gait training.

[redacted], office visit records documented diagnosis and treatment of multiple conditions including COPD, osteoarthritis of knees, umbilical hernia, hypertension, lumbago, restrictive lung disease, cervical degenerative disc disease, obstructive sleep apnea, and diabetes. A [redacted], record, in part, addressed follow up on the heart condition. Claimant reported symptoms are poorly controlled and she still uses oxygen at night for shortness of breath and only occasionally during the day. Claimant had been unable to exercise due to severe knee problems. A [redacted], record, in part, documented the Claimant's knee is improving, range of motion in increasing, she is in occupational and physical therapy daily, and will need left knee replacement done when she recovers from the right knee. Claimant was still in a nursing home for subacute rehab.

Nursing home records documented Claimant was admitted on [redacted], and discharged home on [redacted].

A [redacted], progress note documented that Claimant had been unable to wean from ambulatory aids and physical therapy met with some difficulty in range of motion. Due to transportation issues, Claimant was having in-home physical therapy. There is an inconsistent physical examination finding that Claimant ambulates well

without ambulatory aids, no limp. However, the instructions once again state Claimant is to continue in-home physical therapy for knee range of motion, strengthening, and gait training.

Home health care records for [redacted] were also submitted. An [redacted] record documents that Claimant was temporarily discharged because she was scheduled for a right knee surgical release on [redacted], [redacted] then planned to resume physical therapy. The [redacted], record, in part, notes a waddling type gait with short stride length, unable to achieve single leg stance on either leg, as well as use of a 4-wheel walker due to a tendency for either knee giving way unexpectedly.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, Claimant has presented medical evidence establishing that she does have some limitations on the ability to perform basic work activities. The medical evidence has established that the 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, or can be expected to last, continuously for twelve months; therefore, the Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The evidence confirms recent diagnosis and treatment of CHF, hypertension, COPD, restrictive lung disease, obstructive sleep apnea, morbid obesity, diabetes, lumbago, cervical degenerative disc disease, bilateral knee osteoarthritis, and depression.

Based on the objective medical evidence, considered listings included: 1.00 Musculoskeletal System. The medical records document that Claimant meets or equals the criteria for Listing 1.02 A, major dysfunction of a joint, with involvement of one major peripheral weight-bearing joint, in this case knees, resulting in inability to ambulate effectively. The records document severe bilateral knee osteoarthritis. The early 2014 medical records note that Claimant did not have insurance, which would affect her ability to obtain treatment and testing. Therefore, it is expected that the early 2014 records focused on the heart and lung conditions from the [redacted] hospitalization. Claimant did report joint pain as far back as [redacted]. It is expected that the severe knee osteoarthritis was not an acute or recently developed condition at the time of the [redacted], x-ray. Further, morbid obesity has been documented since at least [redacted], which would be a relevant factor for limitations and functional ability related to the bilateral knee osteoarthritis. The records show Claimant underwent total replacement of the right knee first, because it was in worse condition. Claimant was discharged to a nursing home. Claimant then had in home physical therapy, with a brief stoppage for a right knee surgical release scheduled for [redacted]. The records further show that Claimant will still need a left knee total replacement once there has been sufficient recovery from the right knee surgery. The medical evidence was

sufficient to meet the intent and severity requirements of listing 1.02A, or its equivalent. Accordingly, the Claimant is found disabled at Step 3.

However, even if the analysis were to continue, Claimant would also be found disabled at Step 5 due to her combination of impairments since at least [redacted] With a sedentary exertional level residual functional capacity, Claimant could not perform her past work, which required lifting at the medium exertional level. In consideration of the Claimant's age, education, work experience, RFC, and using the Medical-Vocational Guidelines [20 CFR 404, Subpart P, Appendix II] as a guide, specifically Rule 201.14, Claimant would be found disabled.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Claimant disabled for purposes of the MA benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is **REVERSED**.

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE OF MAILING OF THIS DECISION AND ORDER:

1. Initiate a review of the application dated February 20, 2014, for MA-P and retroactive MA-P, if not done previously, to determine Claimant's non-medical eligibility. The Department shall inform Claimant of the determination in writing. A review of this case shall be set for February 2016.

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

Colleen Lack
Administrative Law Judge
for Nick Lyon, Interim Director
Department of Human Services

Date Signed: **3/02/2015**

Date Mailed: **3/02/2015**

CL/hj

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]