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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-004150
Issue No.: 2009
Case No.: [redacted]
Hearing Date: May 6, 2015
County: Wayne (17)

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 May 6, 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 Health and Human Services (DHHS) included [redacted], medical contact worker.

ISSUE

The issue is whether DHHS 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 44-45).

4. On [redacted], DHHS denied Claimant's application for MA benefits and mailed a written notice informing Claimant of the denial.

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

6. As of 4/2014, Claimant was eligible for MA benefits.

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

8. Claimant alleged disability based on restrictions related to vision loss, high blood pressure, angina, seizures, and cardiac restrictions.

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 3-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 (October 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 (July 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 DHHS 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 DHHS regulations. BEM 260 (July 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.

Hospital records from February 2014 were not presented. Physician treatment records from August 2014 noted that Claimant reported that he was hospitalized for 4 days because of a seizure.

Physician office visit notes (Exhibits 39-41; A18-A20) dated August 6, 2014 were presented. It was noted that Claimant presented with left-sided chest pain and a headache. Claimant reported his chest pain occurred 1-2 times per week over last 6-7 months. Physical examination findings were normal. Diagnoses of benign HTN, chest pain of unknown etiology, and cerebral infarction were noted. Claimant's blood pressure was 214/90. A plan to send patient to the ER was noted.

ECG results (Exhibits 42; A21) dated [redacted] were presented. An abnormal ECG was noted.

Spirometry pre-test results (Exhibits 43; A22) dated [redacted] were presented. Claimant's best FVC was 2.39, noted to be 56% of predicted. Claimant's best FEV1 was 1.53, 51% of predicted. An impression of probable restriction was noted. Further examination was noted as recommended.

A Medical Examination Report (Exhibits A-A2) dated [redacted] was presented. The form was completed by a family medicine physician with a 1-appointment history of treating Claimant. Claimant's condition was noted as deteriorating. Diagnoses of chest pain and CVA were noted. It was noted that Claimant took no medications. It was noted that Claimant can meet household needs. The examining physician opined that Claimant was restricted to about 6 hours of sitting per 8 hour workday; standing restrictions were not noted. Claimant's physician opined that Claimant was restricted from performing the following repetitive actions: pushing/pulling, simple grasping, fine manipulating, reaching, and operating leg/foot controls. Claimant was restricted from any lifting/carrying.

Hospital documents (Exhibits A23-A64) from an admission dated [redacted] were presented. It was noted that Claimant presented with complaints of dyspnea, edema, and chest pain. It was noted that Claimant was not taking his medication because of financial restrictions. Ongoing tobacco abuse was noted. A chest radiology report noted newly found right pleural effusion (compared to February 2014 radiology). Claimant was initially placed on a nitroglycerine drip. An ejection fraction of 25-30% was noted following left ventriculogram result; an impression of non-ischemic cardiomyopathy was noted. A plan to treat Claimant with ACE inhibitors, beta-blockers, diuretics (possibly) was noted. It was noted that Claimant had renal failure. It was noted that Claimant may need defibrillator if ventricle function does not improve. It was noted that Claimant underwent left-sided heart catheterization. Noted discharge diagnoses included upper right DVT, HTN (better controlled), non-ischemic cardiomyopathy, improved acute CKD, CHF, pleural effusion, history of CVA, and seizure. A discharge date of October 20, 2014 was noted.

Physician office visit notes (Exhibits A15-A17) dated [redacted] presented. It was noted that Claimant presented for ongoing HTN treatment. It was noted that Claimant's blood pressure was 140/72.

Physician office visit notes (Exhibits A12-A14) dated [redacted] were presented. It was noted that Claimant presented for ongoing HTN treatment. It was noted that Claimant's INR was 2.3. A cardiology referral for coagulation management was noted. Claimant's HTN was described as decreased, with mild symptoms. Exacerbating factors included emotional stress, missed medication, exertion, and diet noncompliance. Tobacco use and obesity were noted as active problems. Claimant's blood pressure was noted as 150/80.

Physician office visit notes (Exhibits A3-A6) dated [redacted] were presented. It was noted that Claimant was s/p left heart catheterization. Claimant's HTN was described as decreased, with mild symptoms. It was noted that Claimant missed cardiology appointment and that Claimant might be noncompliant with Coumadin and blood pressure medication. Tobacco use and obesity were noted as active problems. Claimant's blood pressure was noted as 190/94. Impressions of HTN, CHF, hyperlipidemia, and CAD were noted.

It was not disputed that Claimant was approved for Healthy Michigan Plan benefits since April 2014. Claimant's AHR only seeks a determination of disability for the months before Claimant's HMP eligibility.

Presented documents did not verify any medical treatment for Claimant from before August 2014. Claimant's AHR testified that he possessed hospital records from Claimant for February 2014 and asked to submit the records after the hearing. Claimant's AHR was given until the end of the hearing date to submit Claimant's hospital records dated February 2014; no records were presented.

Physician treatment records referenced that Claimant was hospitalized for four days in February 2014 due to a seizure. Claimant testimony did not indicate ongoing difficulties due to a seizure. Subsequent seizure treatment was not verified. The absence of seizure treatment verification justifies finding that Claimant does not have a restrictions related to a seizure.

Presented records failed to verify that Claimant had any other medical treatment before August 2014. Accordingly, it is found that Claimant is not disabled from before August 2014 due to a lack of medical evidence. As Claimant only seeks MA benefits from February 2014 and March 2014, it is found that DHHS properly denied Claimant's MA eligibility for the months of February 2014 and March 2014.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that DHHS properly denied Claimant's MA benefit application dated [redacted] based on a determination that Claimant is not disabled.

The actions taken by DHHS are **AFFIRMED**.

Christian Gardocki
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Signed: **5/13/2015**

Date Mailed: **5/13/2015**

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]