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

IN THE MATTER OF:

Reg. No.:	15-007239
Issue No.:	2009
Case No.:	
Hearing Date:	June 10, 2015
County:	Wayne (31)

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 June 10, 2015, from Detroit, Michigan. Participants included the above-named Claimant. testified and appeared as Claimant's authorized hearing representative (AHR). Participants on behalf of the Department of Health and Human Services (DHHS) included , specialist.

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 , Claimant applied for MA benefits, including retroactive MA benefits from March 2014.

2. Claimant's only basis for MA benefits was as a disabled individual.

3. On an unspecified date, the Medical Review Team (MRT) determined that Claimant was not a disabled individual.

4. On , DHHS denied Claimant's application for MA benefits and mailed a Health Care Coverage Determination Notice (Exhibits 88-89) informing Claimant's AHR of the denial.

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

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

7. During the hearing, Claimant and MDHHS waived the right to receive a timely hearing decision.

8. During the hearing, the record was extended 10 days to allow Claimant and MDHHS to submit documents verifying Claimant's Social Security Administration history; an Interim Order Extending the Record was subsequently mailed to both parties.

9. Neither party presented additional documents.

10. As of the date of the administrative hearing, Claimant was a 49 year old male.

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

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

13. Claimant has a history of unskilled employment, with no known transferrable job skills.

14. Claimant alleged disability based on restrictions related to diagnoses of a torn rotator cuff and back 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).

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.

MDHHS approved Claimant for MA benefits, effective April 2014. Claimant limited his dispute to MA eligibility for March 2014.

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.

Before a medical analysis is undertaken, consideration was given to finding that SSA already determined that Claimant was not disabled for March 2014. Had SSA issued a "final' denial (see BEM 260) concerning Claimant's disability for March 2014, that denial would be binding on MDHHS.

Claimant testimony suggested that he applied for disability-related benefits from SSA before applying for MA benefits. It was not disputed that SSA denied his claim of disability. Specific months of application and denial were not verified. The SSA denial would only be binding if Claimant's application was before March 2014 and the denial occurred after March 2014. Claimant's testimony was not certain enough to determine the dates of application or denial. The record was extended 10 days for each side to present evidence of Claimant's SSA application history. Neither side presented evidence of Claimant's previous SSA applications and/or dates of denial. Presented evidence was insufficient to determine if a SSA determination of non-disability is binding on MDHHS. A medical analysis to determine if Claimant is disabled will proceed.

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 (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 initially testified that he had not worked since July 2013. During the hearing, Claimant was asked about MDHHS check stubs (Exhibit 74) and a Verification of Employment (Exhibits 72-73) which indicated that Claimant worked in February 2014 and March 2014. Claimant testified that he was asked similar questions by the unemployment agency while maintaining that he had not worked since July 2013. After further questioning, Claimant relented and conceded that he worked for approximately 3 weeks in 2014.

Claimant then insisted that he had not worked since March 2014. Later in the hearing, MDHHS alleged that Claimant also worked briefly in September 2014. MDHHS provided

information about Claimant's employer and income. After MDHHS discovered the income, Claimant then "remembered" that he had worked in September 2014.

A hospital document dated March 12, 2014 noted that Claimant worked in a steel mill and for a cleaning service (Exhibit 57). Claimant only conceded having one job at the time.

Despite Claimant's challenges in testifying accurately about his employment history, presented evidence did not establish that Claimant's monthly income since March 2014 exceeded SGA standards. 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 evidence.

Hospital documents (Exhibits 32-47) from an encounter dated [redacted] were presented. It was noted that Claimant presented with complaints of neck and shoulder pain, ongoing for 2 days. It was noted that Claimant received Valium and Toradol. An impression of back spasm and neck strain was noted. It was noted that Claimant felt much better and was discharged.

Hospital documents (Exhibits 48-65) from an encounter dated [redacted] were presented. It was noted that Claimant presented with complaints of ongoing neck and shoulder pain. It was noted that a CT scan of Claimant's neck revealed a collection of retropharyngeal fluid. An assessment of discitis with retropharyngeal abscess and C5-C6 stenosis was noted. Claimant was noted to be positive for Salmonella. It was noted that Claimant underwent an urgent I&D (incision and drainage) and discectomy of C5-C6. It was noted that Claimant reported "great improvement" in discomfort. It was noted that Claimant underwent physical therapy and that had no difficulty with walking the halls or stairs. A recommendation of 8 weeks of antibiotics was noted. A need for lifelong antibiotic treatment was noted. It was noted that Claimant was "completely pain-free" at discharge. A discharge date of [redacted] was noted.

Physician office visit notes (Exhibits A3-A5) dated [redacted] were presented. It was noted that Claimant complained of left shoulder pain. It was noted that the shoulder was repaired 1½ years earlier. A prescription for Tramadol was noted. Mild shoulder tenderness to palpation was noted. Resisted external rotation was noted to reveal "weakness effort related".

Physician office visit notes (Exhibits A6-A11) dated [redacted] were presented. It was noted that Claimant had a rotator cuff tear. The age of Claimant's tear was noted to be indeterminate. An impression of successful left shoulder arthrocentesis without evidence of immediate complication was noted following shoulder radiology. An impression of pain persistence was noted. An impression of Claimant's loss of arm use when away from his side was noted.

A Medical Examination Report (Exhibits A1-A2) dated [redacted] was presented. The form was completed by an orthopedic physician with an approximate 21 month history of treating Claimant. A diagnosis of rotator cuff rupture and repair were noted. It was noted that Claimant was scheduled for left shoulder surgery. It was noted that Claimant can meet household needs. Claimant's physician opined that Claimant was restricted to frequent lifting of 20 pounds and occasional lifting/carrying of 25 pounds, never 50 pounds or more. Claimant was restricted from performing repetitive right arm actions

(though it is assumed that the physician intended to restrict Claimant's left shoulder). Standing and sitting restrictions were not identified.

Presented documents verified that Claimant had emergency back surgery in March 2014 due to salmonella poisoning. Claimant presented treatment documents from March 2014, however, follow-up treatment documents were not presented. Statements of "great improvement" and "completely pain-free" are indicative that Claimant had no ongoing restrictions. This conclusion is further supported by a statement that Claimant was ambulating without difficulties.

Hospital documents identified a need for ongoing infection treatment. A need for treatment and monitoring is not a restriction to performing basic work activities.

Claimant testified that he has two rotator cuff tears. Medical documents from April 2015 and May 2015 verified that Claimant has a left rotator cuff tear. Medical evidence of a right rotator cuff tear was not presented. Presented records verified that Claimant had surgery in 2013, however, problems with surgery were not verified until several months after Claimant applied for MA benefits.

Claimant testified that he was scheduled for an upcoming shoulder surgery. During the hearing, Claimant was asked why he did not seek surgery sooner. Claimant could not explain.

Presented medical records verified that Claimant experienced a severe neck infection in March 2014. Presented records failed to demonstrate any related restrictions expected to last 12 months or longer.

Claimant verified a rotator cuff tear as of April 2015. The treatment was verified after MDHHS denied Claimant's application and is essentially irrelevant to determining whether MDHHS properly denied Claimant's MA application.

Based on the presented evidence, Claimant failed to establish having a severe impairment. Accordingly, it is found that MDHHS properly denied Claimant's MA application.

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 [redacted], [redacted] including retroactive benefits from March 2014, 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: 6/26/2015
Date Mailed: 6/26/2015

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: