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

IN THE MATTER OF:

	Reg. No.:	15-009994
	Issue No.:	2009
	Case No.:	
	Hearing Date:	July 22, 2015
	County:	Wayne-District 18

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

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 telephone hearing was held on July 22, 2015, from Detroit, Michigan. Participants on behalf of Claimant included Claimant; , Claimant's boyfriend; and , authorized hearing representative with , Claimant's authorized hearing representative (AHR), who participated via 3-way telephone conference. Participants on behalf of the Department of Health and Human Services (Department) included , Medical Contact Specialist.

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional records, some of which were provided when the record closed on September 22, 2015. The matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

Did the Department properly determine that Claimant was not disabled for purposes of the Medical Assistance (MA-P) 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. On May 14, 2014 application, Claimant submitted an application for public assistance seeking MA-P benefits, with a request for retroactive coverage to February 2014.

2. On June 3, 2014, the Medical Review Team (MRT) found Claimant not disabled (Exhibit A, pp. 1-3).

3. On June 3, 2015, the Department sent the AHR, Claimant's authorized representative, a Benefit Notice denying the application based on MRT's finding of no disability (Exhibit A, pp. 41-42).

4. On June 18, 2015, the Department received the AHR's timely written request for hearing (Exhibit A, p. 43).

5. Claimant alleged disabling impairment due to Crohn's disease, hypothyroidism, ileostomy abscesses, depression, anxiety, and insomnia.

6. At the time of hearing, Claimant was [redacted] with a [redacted] birth date; she was [redacted] in height and weighed [redacted].

7. Claimant is a high school graduate with an associate's degree.

8. Claimant has an employment history of clerical work.

9. 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 Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Health and 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 Department of Human Services) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

MA-P benefits are available to disabled individuals. BEM 105 (January 2014), p. 1; BEM 260 (July 2014), pp. 1-4. Disability for MA-P purposes is 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). To meet this standard, a client must satisfy the requirements for eligibility for Supplemental Security Income (SSI) receipt under Title XVI of the Social Security Act. 20 CFR 416.901.

To determine whether an individual is disabled for SSI purposes, the trier-of-fact must apply a five-step sequential evaluation process and consider the following:

(1) whether the individual is engaged in SGA;
(2) whether the individual's impairment is severe;
(3) whether the impairment and its duration meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404;
(4) whether the individual has the residual functional capacity to perform past relevant work; and
(5) whether the individual has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work.

20 CFR 416.920(a)(1) and (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).

In general, the individual has the responsibility 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, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 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, are insufficient to establish disability. 20 CFR 416.927(d).

Step One

As outlined above, the first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Claimant has not engaged in SGA activity during the period for which assistance might be available. Therefore, Claimant is not ineligible under Step 1 and the analysis continues to Step 2.

Step Two
Under Step 2, the severity of an individual's alleged impairment(s) is considered. If the individual does not have a severe medically determinable physical or mental impairment that meets the duration requirement, or a combination of impairments that is severe and meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for MA-P means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 12 months. 20 CFR 416.922.

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). 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); see also *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985). Basic work activities means the abilities and aptitudes necessary to do most jobs, including (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b).

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the *de minimus* standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs v Bowen,* 880 F2d 860, 862-863 (CA 6, 1988), citing *Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28. If such a finding is not clearly established by medical evidence or if the effect of an impairment or combination of impairments on the individual's ability to do basic work activities cannot be clearly determined, adjudication must continue through the sequential evaluation process. *Id.*; SSR 96-3p.

In the present case, Claimant alleges disabling impairment due to Crohn's disease, hypothyroidism, ileostomy abscesses, depression, anxiety, and insomnia. The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

Claimant has a history of Crohn's and hypothyroid disease. She had a total proctocolectomy in 2000 with end ileostomy, with one revision in 2002. Since then she

had multiple bouts of Crohn's disease exacerbation leading to peri-stomal abscesses and fistulas. (Exhibit A, p. 19; Exhibit 2, p. 54.)

Claimant was hospitalized from March 7, 2014 to March 10, 2014 for an abscess at her ileostomy. Her ileostomy bag was refashioned to incorporate the drainage form the abscess into it. Claimant was discharged home on Augmentin. (Exhibit A, p. 10; Exhibit 1, pp. 19-33.)

From April 11, 2014 to April 14, 2014, Claimant was hospitalized for continued drainage of pus from the stomal site with increased pain and tenderness in that site. She indicated that she had completed the Augmentin course, as well as an additional 10 day course of Bactrim and Levaquin prescribed to her, but she continued to have drainage from the abscess into her ileostomy bag. There was some irrigation of the site to decrease inflammation and scarring. It was noted that Claimant's Crohn's disease was in relatively good control. (Exhibit A, pp. 8-15.)

On May 5, 2014, Claimant went to her doctor complaining of pain at the abscess sites. The ileostomy site was tender but intact. Three openings were observed on the superior part of the stoma; the openings drained pus, blood and perhaps stools. Erythema was witnessed around the ileostomy with purulent drainage. There were no obvious signs of infection but the findings were consistent with the possibility of an enterocutaneous fistula. (Exhibit A, pp. 26-29; Exhibit 2, pp. 5-9.)

Claimant was hospitalized from June 5, 2014 to June 15, 2014 for a scheduled ileostomy resection and relocation from right to left. Claimant was found to have Crohn's ileitis with peri-stomal fistulization and chronic abscess cavity and scarring of proximal jejunum loop to the ileostomy site. On June 13, 2014, she underwent a CT-guided drainage of a pelvic abscess by interventional radiology. She weighed 200 pounds on June 12, 2014 (Exhibit 2, pp. 3-4, 19-20, 23-34.)

From July 11, 2014 to July 20, 2014, Claimant was hospitalized after going to the emergency department complaining of nausea, vomiting, and pelvic/perineal pain. A CT of the abdomen and pelvis showed interval decrease in size, no intestinal obstruction, and persistent presacral and right lower quadrant fluid collection. The abscess was drained. Claimant's pain could be due to cellulitis in the perineal area or from residual pelvic abscess but was deemed unlikely related to a Crohn's exacerbation. Claimant had a new opening in the skin near the colostomy, with pus draining from it. (Exhibit 2, pp. 41-83.)

On July 24, 2014, Claimant's doctor reported an abscess observed next to the new stoma. A drain continued to have drainage. (Exhibit 2, pp. 84-86). The drain was removed July 30, 2014 (Exhibit 2, pp. 87-92.)

On August 12, 2014, Claimant's doctor noted that Claimant's abdominal pain had improved but a fistula next to the stoma was draining somewhat purulent material and had a purple hue to the borders (Exhibit 2, pp. 93-96).

From August 20, 2014 to August 29, 2014, Claimant was hospitalized with worsening abdominal and para-rectal pain. A CT scan showed intra-abdominal abscess with fistulas. She was diagnosed with peri-stoma fistula with a pyoderma gangrenosum despite a prolonged antibiotic course. She was started on IV antibiotics, the abscess was drained, and the drain was left in place. She weighed 180 pounds. She was discharged with instructions for continued oral antibiotic use. (Exhibit 2, pp. 97-139, 302-303.) The drain was removed September 29, 2014 (Exhibit 2, p. 14).

On October 23, 2014, five small fistula openings were observed just to the left of the stoma with erythema surrounding. She was referred to dermatology for evaluation of possible of pyoderma gangrenosum. (Exhibit A, pp. 32-33; Exhibit 2, pp. 153-158). It was subsequently determined that the ulcerations were pyoderma gangrenosum (Exhibit 2, pp. 158-165).

At the November 11, 2014 office visit, no new or changing lesions were observed (Exhibit 2, pp. 166-169). Claimant received ongoing treatment for ulcerations on the stoma on the left side of her abdomen on November 13, 2014; December 2, 2014 (Exhibit 2, pp. 166-169, 172)

On December 3, 2014, Claimant was prescribed prednisone for the pyoderma gangrenosum. (Exhibit A, pp. 34-37.)

On December 30, 2014, Claimant reported to her doctor that her ostomy bag had dislodged more often (Exhibit 2, p. 179).

At her January 2, 2015 office visit, Claimant reported a considerable improvement in the pyoderma gangrenosum after taking azithromycin to treat bronchitis, which continued at the January 29, 2015 visit, with the result that the prednisone dosage was reduced (Exhibit 2, pp. 187-188). The pyoderma gangrenosum was worse at the February 13, 2015 office visit (Exhibit 2, p. 189). At the April 24, 2015 office visit, Claimant reported she had no gastrointestinal issues but her pyoderma gangrenosum occasionally acted up. (Exhibit 2, pp. 206-211.) The pyoderma gangrenosum continued to improve on May 14, 2015 (Exhibit 2, p. 212), but the June 23, 2015 notes show it started to weep when Claimant reduced prednisone dosage (Exhibit 2, p. 222). On August 7, 2015, Claimant reported no Crohn's symptoms (Exhibit 2, pp. 250-254).

The June 5, 2015 office progress notes show that Claimant's weight was 229 pounds, an increase from the 180 pounds shown on October 23, 2014 due to her steroid use (Exhibit 2, pp. 154, 214, 231). The June 14, 2015 progress notes showed that Claimant experienced occasional blurry vision and that she felt depressed and anxious (Exhibit 2, p. 212).

On July 22, 2015, Claimant participated in a sleep study which concluded that she had moderate to severe SDB (sleep disordered breathing) (hypopneas) with moderate to severe/loud snoring (Exhibit 2, p. 234). She was diagnosed with moderate obstructive sleep apnea (Exhibit 2, pp. 247-249).

An August 5, 2015 lumbar sacral spine showed moderate L5-S1 degenerative disc disease and mild bilateral L5-S1 degenerative facet joint disease (Exhibit 2, p. 307).

In consideration of the de minimus standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Claimant suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 12 months. Therefore, Claimant has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step Three

Step 3 of the sequential analysis of a disability claim requires a determination of whether the individual'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 an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

Based on the medical evidence in this case, listings 5.06 (inflammatory bowel disease (IBD)), 12.04 (affective disorders) and 12.06 (anxiety-related disorders) were considered. The medical evidence fails to establish that Claimant's impairments meet, or equal, a listing under 12.04 or 12.06. A listing under 5.06 must be documented by endoscopy, biopsy, appropriate medically acceptable imaging, or operative findings with:

> **A.** Obstruction of stenotic areas (not adhesions) in the small intestine or colon with proximal dilatation, confirmed by appropriate medically acceptable imaging or in surgery, requiring hospitalization for intestinal decompression or for surgery, and occurring on at least two occasions at least 60 days apart within a consecutive 6-month period.
>
> OR
>
> **B.** Two of the following despite continuing treatment as prescribed and occurring within the same consecutive 6-month period:
>
> > 1. Anemia with hemoglobin of less than 10.0 g/dL, present on at least two evaluations at least 60 days apart; or
> > 2. Serum albumin of 3.0 g/dL or less, present on at least two evaluations at least 60 days apart; or
> > 3. Clinically documented tender abdominal mass palpable on physical examination with abdominal pain or cramping that is not completely controlled by prescribed narcotic medication, present on at least two evaluations at least 60 days apart; or
> > 4. Perineal disease with a draining abscess or fistula, with pain that is not completely controlled by prescribed narcotic medication, present on at least two evaluations at least 60 days apart; or

> 5. Involuntary weight loss of at least 10 percent from baseline, as computed in pounds, kilograms, or BMI, present on at least two evaluations at least 60 days apart; or
> 6. Need for supplemental daily enteral nutrition via a gastrostomy or daily parenteral nutrition via a central venous catheter.

In this case, Claimant was diagnosed with Crohn's disease resulting in a total proctocolectomy with end ileostomy in 2000 and a revision in 2002. Beginning March 2014, Claimant had multiple peri-stomal abscesses and fistulas. Despite a second ileostomy resection and relocation in June 2014, she continued to experience abscesses and fistulas and, as a result, she was hospitalized on five occasions in 2014: March 7, 2014 to March 10, 2014; April 11, 2014 to April 14, 2014; June 5, 2014 to June 15, 2014 (for the resection/relocation surgery); July 11, 2014 to July 20, 2014; and August 20, 2014 to August 29, 2014. On October 23, 2014, five small fistula openings were observed just to the left of the stoma with erythema surrounding. The abscesses involved purulent drainage. Claimant experienced nausea, vomiting, and pelvic/perineal pain in connection with the abscesses. Additionally, beginning August 2014, she had pyoderma gangrenosum around the fistulas, which continued as of June 23, 2015. Although the abscess and fistulas are around Claimant's stoma on her abdomen, not her perineal region, Claimant's condition equals the severity of the listing under 5.06(B)(4).

Additionally, the record shows that Claimant weighed ███ pounds on June 18, 2014, just after her resection/relocation surgery, and ██████ as of August 19, 2014 and October 23, 2014 (Exhibit 2, pp. 35, 98, 154). Therefore, Claimant had a 10% involuntary weight loss from the 200 pounds on June 18, 2014 as reflected in the August 19, 2014 progress notes and this weight loss continued more than 60 days, as evidenced by her weight on October 23, 2014. Therefore, Claimant's condition satisfied listing 5.06(B)(5). It is noted that, although Claimant experienced a ██ pound weight gain between November 2014 and May 2015, this gain was attributed to her long-term steroid use to treat her condition.

Because Claimant's impairments meet or equal the required level of severity under 5.06(B)(4) and (5), occurred during the same 6-month period, and were not controlled despite treatment, Claimant's impairments meet, or equal, the severity of a listing under 5.06. Therefore, Claimant is disabled under Step 3 and no further analysis is required. The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Claimant disabled for purposes of the MA-P benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is REVERSED.

THE DEPARTMENT IS ORDERED TO BEGIN DOING 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. Process Claimant's May 14, 2014 MA-P application, with request for retroactive coverage to February 2014, to determine if all the other non-medical criteria are satisfied and notify Claimant of its determination;

2. Supplement Claimant for lost benefits, if any, that Claimant was entitled to receive if otherwise eligible and qualified;

3. Review Claimant's continued eligibility in March 2016.

Alice C. Elkin
Administrative Law Judge
for Nick Lyon, Director
epartment of Health and Human Services

Date Signed: **10/8/2015**

Date Mailed: **10/8/2015**

ACE / tlf

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: