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

IN THE MATTER OF:

MAHS Reg. No.:	15-017462
Issue No.:	2009
Agency Case No.:	
Hearing Date:	November 19, 2015
County:	Wayne (17)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

Following Petitioner'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 November 19, 2015, from Detroit, Michigan. Petitioner appeared and was represented by of . The Michigan Department of Health and Human Services (MDHHS) was represented by , hearing facilitator.

ISSUE

The issue is whether MDHHS properly denied Petitioner's Medical Assistance (MA) eligibility for the reason that Petitioner 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 April 24, 2014, Petitioner applied for MA benefits, including retroactive MA benefits from March 2014 (see Exhibits 10-11).

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

3. On July 8, 2015, the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibits 16-18).

4. On July 13, 2015, MDHHS denied Petitioner's application for MA benefits and mailed an Application Eligibility Notice (Exhibits 163-164; 3-4) informing Petitioner and his authorized representative of the denial.

5. On September 17, 2015, Petitioner's authorized hearing representative (AHR) requested a hearing disputing the denial of MA benefits.

6. As of the date of the administrative hearing, Petitioner was a 58-year-old male.

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

8. Petitioner's highest education year completed was the 12th grade (via equivalency degree).

9. Petitioner has no employment history from the last 15 years.

10. Petitioner alleged disability based on restrictions related to chronic obstructive pulmonary disorder (COPD), osteoarthritis, coronary artery disease (CAD), obstructive sleep apnea (OSA), and various body pains.

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 Bridges Administrative Manual (BAM), Bridges Eligibility Manual (BEM), and Reference Tables Manual (RFT).

Prior to a substantive analysis of Petitioner's hearing request, it should be noted that Petitioner's AHR noted special arrangements in order to participate in the hearing; specifically, a 3-way telephone hearing was requested. Petitioner'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 Petitioner'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

It was not disputed that Petitioner is an SSI recipient. The approval of SSI benefits only establishes disability back to the date Petitioner was found to be disabled by the Social Security Administration. It was not disputed that Petitioner was found to be disabled by the Social Security Administration as of March 2015. Thus, Petitioner's approval for SSI benefits fails to address whether Petitioner was disabled from March 2014 through February 2015. The analysis will proceed to determine if Petitioner was disabled during this time period. Accordingly, Petitioner may not be considered for Medicaid eligibility without undergoing a medical review process which determines whether Petitioner is a disabled individual. *Id.*, p. 2.

Generally, state agencies such as MDHHS 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 MDHHS 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 CFR 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. The 2015 monthly income limit considered SGA for non-blind individuals is $1,090.

Petitioner credibly denied performing any employment since the date of the MA application; no evidence was submitted to contradict Petitioner's testimony. Based on the presented evidence, it is found that Petitioner 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 Petitioners 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 Petitioner'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 documents (Exhibits 45-47) from an admission dated September 14, 2011, were presented. It was noted that Petitioner presented with complaints of breathing difficulties, ongoing for 10 days. A history of alcohol abuse was noted. It was noted that Petitioner's oxygen saturation level was 92% while in the emergency room. Petitioner was shown to have hypoxia and subsequently sedated and intubated. Petitioner testified that he was essentially placed into a coma until he could breathe independently. Petitioner's breathing and vital signs improved through various medications and treatments which included physical therapy due to Petitioner's weakness. Noted discharge diagnoses included acute COPD exacerbation, uncontrolled HTN, and alcohol abuse. A discharge date of September 28, 2011 was noted.

Hospital documents (Exhibits 60-61) dated July 2, 2012, were presented. It was noted that Petitioner presented with complaints of dyspnea, ongoing for 5 days.

Hospital documents (Exhibits 39-41; 48-53) from an admission dated October 2, 2012, were presented. It was noted Petitioner presented with complaints of right-sided chest pain, ongoing for 2 days. It was noted Petitioner received NMTs (presumed to mean nebulizer mist treatments) and IV steroids. Treatment for right-sided abdominal hernia and gallstone removal was noted. Noted discharge diagnoses included acute COPD exacerbation, rib pain, abdominal hernia, alcohol abuse, HTN, and cholelithiasis. A discharge date of October 12, 2012 was noted.

Hospital documents (Exhibits 42-44; 54-59) from an admission dated March 19, 2014, were presented. It was noted that Petitioner presented with complaints of dyspnea, worse over the last 3 days. A chest x-ray was noted to show no acute process. It was noted that Petitioner received various medications and his breathing improved. Noted discharge diagnoses included acute COPD exacerbation, bronchitis, and ETOH abuse. A discharge date of March 21, 2014 was noted.

Physician office visit notes (Exhibit 118-119) dated May 13, 2014, were presented. It was noted that Petitioner had not been seen in several years. Petitioner reported for a follow-up to pneumonia, diagnosed 6-8 weeks earlier. A chest x-ray was noted to be normal.

Physician office visit notes (Exhibits 153-156) dated May 13, 2014, were presented. A history of COPD, chronic pain, and radiculopathy was noted. Various medications were prescribed.

Physician office visit notes (Exhibits 151-152) dated May 14, 2014, were presented. Assessments included HTN, CAD, gout, COPD, chronic pain, alcohol withdrawal, and bee allergy issues.

Orthopedist office notes (Exhibits 76-77) dated June 2, 2014, were presented. Petitioner reported back, leg, and hip problems since a motorcycle accident. Petitioner reported he takes 6 Norco tablet per day. Impressions of left hip osteoarthritis, back osteoarthritis, and spinal stenosis were noted.

Physician office visit notes (Exhibits 148-150) dated June 12, 2014, were presented. Assessments included HTN, CAD, COPD, chronic pain, alcohol withdrawal, and allergic rhinitis.

Physician office visit notes (Exhibits 79-84; 110-113) dated June 23, 2014, were presented. It was noted that Petitioner reported dyspnea with exertion. A moderate restriction on activities was reported. A NYHA Class III severity was noted. It was noted Petitioner drinks 6-8 beers per day, with an occasional shot of cognac to help him sleep. Diagnoses of COPD and sleep-related breathing disorder were noted. Prescriptions of Flonase and Todorza were noted. It was noted Petitioner was recommended to reduce alcohol consumption.

Orthopedist office notes (Exhibits 74-75) dated July 1, 2014, were presented. “All kinds of pain issues” were noted as reported. It was noted Petitioner’s pain improved with use of Oxycodone.

A Pulmonary Function Interpretation (Exhibit 121-123) dated July 7, 2014, was presented. An interpretation of a mild reversible obstructive ventilatory defect was noted. Petitioner’s FVC was noted to be 4.58 (99% of predicted). Petitioner’s best FEV1 ws 3.02 (80% of predicted).

Physician office visit notes (Exhibits 85-87; 106-107) dated July 8, 2014, were presented. It was noted Petitioner completed a 6 minute walk. A conclusion that Petitioner did not need supplemental oxygen was noted.

Physician office visit notes (Exhibits 88-91; 116-117) dated July 24, 2014, were presented. It was noted Petitioner reported ongoing dyspnea, triggered by minimal activity. It was noted that pulmonary testing revealed obstruction with significant air trapping. Ongoing medications were prescribed, along with a 15 day taper of prednisone.

Physician office visit notes (Exhibits 145-147) dated August 1, 2014, were presented. Assessments included HTN, gout, CAD, COPD, colon polyps, allergic rhinitis, and obesity.

Physician office visit notes (Exhibits 92-96; 108-109) dated August 14, 2014, were presented. It was noted Petitioner reported ongoing dyspnea with exertion. Ongoing medication treatment was noted.

Sleep testing documents (Exhibits 124-133) dated August 28, 2014, were presented. An impression of mild sleep apnea, corrected with CPAP therapy was noted.

Orthopedist office notes (Exhibits 72-73) dated September 2, 2014, were presented. Petitioner was noted to have reported ongoing right hip, neck, and back pain. Restricted left hip, lumbar, and bilateral knee ranges of motion were noted.

Physician office visit notes (Exhibits 142-144) dated September 1, 2014, were presented. It was noted Petitioner sought removal of a skin lesion on his back.

A Stress Echocardiogram Report (Exhibit 102) dated September 12, 2014, was presented. It was noted Petitioner achieved a peak of 7 METs. The test was stopped due to fatigue. An ejection fraction of 60% was noted.

Physician office visit notes (Exhibits 140-141) dated 9/318/14, were presented. Assessments of Vitamin D deficiency and HTN were noted.

Orthopedist office notes (Exhibits 70-71) dated September 30, 2014, were presented. It was noted ongoing right hip, neck, and back pain. Severe pain was noted with internal and external right hip motion.

Physician office visit notes (Exhibits 114-115) dated October 14, 2014, were presented. Ongoing dyspnea was noted as reported. It was noted that Petitioner's activities were not limited.

Physician office visit notes (Exhibits 137-139) dated October 16, 2014, were presented. Petitioner reported reducing alcohol consumption to twice per week. Assessments for HTN, colon polyps, CAD, gout, and allergic rhinitis were noted. Various medications were noted as prescribed.

Orthopedist office notes (Exhibits 68-69; 78) dated October 30, 2014, were presented. It was noted Petitioner reported ongoing right hip pain and difficulty with ambulation. An antalgic gait was noted. Right hip range of motion was noted to be restricted. It was noted Petitioner underwent a right hip bursa lidocaine/Depo-Medrol injection.

Orthopedist office notes (Exhibits 66-67) dated November 25, 2014, were presented. It was noted Petitioner was doing better following hip injections into the bursa. A need for a weight loss program was noted.

Physician office visit notes (Exhibits 97-101; 104-105; A1-A6) dated January 20, 2015, were presented. It was noted Petitioner missed several appointments to get a CPAP.

Petitioner reported dyspnea with most activities. It was noted Petitioner could not walk for long distances. Alcoholism was noted to be active. COPD with acute exacerbation and acute bronchitis, and OSA were noted. A complete pulmonary function test was planned.

Physician office visit notes (Exhibits 134-136) dated January 15, 2015, were presented. It was noted Petitioner sought a prescription of Viagra for erectile dysfunction. It was noted Petitioner complained of neuropathy since a drug-induced coma in 2001.

Orthopedist office notes (Exhibits 64-65) dated January 27, 2015, were presented. It was noted Petitioner reported pulmonary difficulties in performing recommended exercises. It was noted Petitioner was morbidly obese. Weight loss was noted to be very important. Motor strength was noted to globally be 5/5. Impressions of bilateral hip bursitis and back pain with stenosis were noted. A recommendation for Petitioner to see his physician for pulmonary treatment was noted.

A Pain Assessment (Exhibit 62) and rehabilitation physician office notes (Exhibit 63) dated February 24, 2015, were presented. The assessment was signed by a physician that was not listed on Petitioner’s reported treatment history (see Exhibits 22-23). Current problems included back, hip, neck, and foot pain. Petitioner was reported to have severe pain, based on an MRI. It was noted Petitioner’s pain would interfere with at least 2/3 of his day. Petitioner’s pain was expected to cause at least 2 absences per month due to symptoms and/or required treatment.

Spirometry test results (Exhibits A7-A10) dated February 25, 2015, were presented. Petitioner’s best FEV1 following bronchodilator was noted to be 2.69 (78% of predicted). Petitioner’s best FVC following bronchodilator was 4.71 (97% of predicted). An interpretation of a moderate obstructive lung defect was noted, confirmed by decrease in flow rate at peak flow. It was noted testing demonstrated good response to bronchodilator.

Physician office visit notes (Exhibits A10-A16) dated April 23, 2015, received ongoing COPD treatment. It was noted that dyspnea does not limit Petitioner’s activities. Normal gait, normal strength, and no neurological abnormalities were noted in the physical examination. Problems included asthma, alcoholism, emphysema, and COPD.

Physician office visit notes (Exhibits A17-A24) dated May 12, 2015, were presented. It was noted that Petitioner reported prescribed medications did not improve his breathing. It was noted Petitioner reported he still did not have a CPAP machine.

Physician office visit notes (Exhibits A25-A31) dated August 13, 2015, were presented. It was noted Petitioner was not interested in getting a machine for OSA. Petitioner reported daily episodes of breathlessness.

An internal medicine examination report (Exhibits 32-38) dated June 2, 2015, was presented. The report was noted as completed by a consultative physician. Petitioner reported complaints of sleep apnea, asthma, and HTN. Petitioner reported ongoing back pain related to a 1998 motorcycle accident. It was noted Petitioner had no difficulty standing from a chair or getting on the examination table. Mild-to-moderate tenderness was noted along the thoracic spine. It was noted Petitioner walked with mild limping and did not require the use of a cane. Diagnoses were noted for OSA, COPD (mild to moderately severe), HTN (under control), degenerative disease of the cervical spine and lumbar spine; degenerative disease of the hip, and obesity. It was noted Petitioner was a lifelong smoker until quitting in 2011. Standing, bending, stooping, carrying, pushing, and pulling were noted as performed, though with lumbar pain. Reduced ranges of motion were noted in all lumbar, cervical spine, and right hip motions. Right knee flexion, right shoulder abduction, and right shoulder forward flexion motions were also noted to be limited.

A Medical Examination Report (Exhibits A32-A33) dated September 24, 2015, was presented. The form was completed by an orthopedic physician with an approximate 5-year history of treating Petitioner. Petitioner's physician listed diagnoses of back pain, left hand pain, and osteoarthritis; an illegible diagnosis was also listed. Current medications included oxycodone. An impression was given that Petitioner's condition was stable. A positive straight leg raising test was noted. It was noted that Petitioner can meet household needs.

A Pain Assessment (Exhibit A34) dated September 24, 2015, was presented. It was noted Petitioner would be absent at least 2 times per month, either due to treatment or symptoms. It was noted Petitioner's pain would interfere with Petitioner's concentration and/or attention approximately 1/3 to 2/3 of the time. Left extremity weakness and decreased ranges of motion were noted. A positive straight leg raising test was noted.

Petitioner testified he was in a motorcycle accident in 1998. Petitioner testified the accident caused a closed-head injury, right hip fracture, ruptured spleen, 11 broken ribs, and several broken vertebrae. Petitioner testified he was hospitalized for 14-15 days. Petitioner testified he has ongoing body pain related to the accident. Petitioner testified he has had several hernias since the accident. Petitioner's testimony was generally consistent with what he was told a consultative examiner (see Exhibit 32).

Petitioner testified he has ongoing respiratory restrictions. Petitioner testified he can walk about 14 stairs before he has to use an inhaler or nebulizer. Petitioner testified he sometimes has breathing problems when he awakes. Petitioner testified his breathing is more difficult in cold weather. Petitioner's testimony was generally consistent with presented medical history which established significant medical treatment for breathing complaints.

A history of OSA was established. Petitioner testified he has still not obtained a CPAP. A diagnosis of mild OSA, treatable with a CPAP was noted. Petitioner's "no interest" in

pursuing a CPAP is material noncompliance concerning the recognition of OSA as a severe impairment.

Presented evidence sufficiently verified multiple complaints and treatments for spinal and hip pain. The evidence sufficiently established that Petitioner was impaired over the disputed period from March 2014 through February 2015.

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

The third step of the sequential analysis requires a determination whether the Petitioner'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 Petitioner's impairments are listed and deemed to meet the 12 month requirement, then the Petitioner is deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step.

A listing for joint dysfunction (Listing 1.02) was considered based on various diagnoses of joint problems. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively or that Petitioner is unable to perform fine and gross movements with both upper extremities.

A listing for spinal disorders (Listing 1.04) was considered based on Petitioner's various back pain complaints. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root.

A listing for chronic pulmonary insufficiency (Listing 3.02) was considered based on Petitioner's complaints of dyspnea. The listing was rejected due to spirometry testing failing to meet listing levels.

A listing for sleep apnea (Listing 3.10) was considered. The listing was rejected due to a failure to meet the requirements of Listings 3.09 or 12.02.

Cardiac-related listings (Listing 4.00) were considered based on a diagnosis of CAD. Petitioner failed to meet any cardiac listings.

A listing for peripheral neuropathies (Listing 11.14) was factored based on Petitioner's claim of neuropathy, related to a history of broken vertebrae. The listing was rejected due to a failure to establish significant and persistent disorganization of motor function in two extremities.

A listing for organic mental disorders (Listing 12.02) was considered based on a diagnosis of closed-head injury. This listing was rejected due to a failure to establish marked psychological restrictions or a mental disorder of 2 years duration that imposes more than a minimal limitation on Petitioner's ability to perform basic work activities.

A listing for inflammatory arthritis (Listing 14.09) was considered based on diagnoses of osteoarthritis. The presented medical records were insufficient to establish that Petitioner has an inability to ambulate effectively, perform fine and gross movements, or suffers inflammation or deformities with a diagnosis of ankylosing spondylitis or other spondyloarthropathies, or suffers repeated manifestations of inflammatory arthritis.

It is found that Petitioner failed to establish meeting or equaling a SSA listing. Accordingly, the analysis moves to step four.

The fourth step in analyzing a disability claim requires an assessment of the Petitioner's residual functional capacity (RFC) and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if it is determined that a Petitioner can perform past relevant work. *Id*.

Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

Petitioner testified he has not performed employment for one single day in the last 15 years. When asked how he supported himself, Petitioner testified he has been completely financially dependent on his wives. Petitioner's testimony was not rebutted.

Without any relevant history of SGA earnings, it can only be found that Petitioner cannot return to employment resulting in SGA. Accordingly, the analysis may proceed to the final step.

In the fifth step in the process, the individual's RFC in conjunction with his or her age, education, and work experience, are considered to determine whether the individual can engage in any other substantial gainful work which exists in the national economy. SSR 83-10. While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). To determine the physical demands (i.e. exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967.

Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b) Even though weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additionally limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.*

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.*

Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.*

Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id.*

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands are considered non-exertional. 20 CFR 416.969a(a). Examples of non-exertional limitations include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (e.g. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i)-(vi) If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2)

The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.* In using the rules of Appendix 2, an individual's circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, is compared to the pertinent rule(s).

Given Petitioner’s age, education and employment history a determination of disability is dependent on Petitioner’s ability to perform medium employment. Social Security Rule 83-10 states that the full range of light work requires standing or walking, off and on, for a total of approximately 6 hours of an 8-hour workday. Medium employment requires comparable standing and walking standards, but with a heavier lifting requirement than light employment.

Physician statements of restrictions were provided. SSR 96-2p states that if a treating source's medical opinion is well-supported and not inconsistent with the other substantial evidence in the case record, it must be given controlling weight (i.e. it must be adopted). Treating source opinions cannot be discounted unless the Administrative Law Judge provides good reasons for discounting the opinion. *Rogers v. Commissioner,* 486 F. 3d 234 (6th Cir. 2007)*; Bowen v Commissioner.*

On a Medical Examination Report dated September 24, 2015, Petitioner’s orthopedist opined that Petitioner was restricted to about 2 hours of standing and/or walking over an 8 hour workday. Sitting restrictions were not listed. Petitioner was restricted to occasional lifting/carrying of less than 10 pounds, never 20 pounds or more. Petitioner’s physician opined that Petitioner was restricted from performing the following repetitive actions: bilateral reaching, bilateral pushing/pulling, and operating foot/leg control with both feet. The lifting/carrying, standing, and repetitive motion restrictions were consistent with an inability to perform medium employment. The restrictions were consistent with an inability to perform medium employment. There was some basis to disregard the physician-stated restrictions.

In response to a question asking for the stated basis for restrictions, Petitioner’s physician did not respond. An MRI was separately noted to support restrictions. An MRI report was not presented. If radiology was the sole basis to support restrictions, it should have been submitted as an exhibit.

Some justification for restrictions was presented. It was established that Petitioner has a history of taking fairly strong narcotic medication (Oxycodone and Norco). Several reduced ranges of bilateral knee, hip, and lumbar motions were noted. A positive straight leg-raising test was noted. Hip bursitis was also established within Petitioner’s medical records. All of these medical findings are consistent with pains that would limit lifting/carrying and repetitive motions.

Petitioner’s most compelling restriction was breathing restrictions. Petitioner testified he notices breathing problems when climbing stairs and when grocery shopping. Petitioner

testified vacuuming is difficult, in part, because the dust exacerbates his breathing difficulties. Petitioner testified dressing sometimes requires use of a nebulizer because he gets out of breath. Petitioner testified his walking is limited to approximately ¼ mile due to respiratory restrictions. Petitioner's testimony was generally consistent with an inability to perform medium employment.

Presented spirometry testing verified a moderate obstruction, responsive to use of a bronchodilator. A history of extensive pulmonary treatment and hospitalizations was also verified.

Petitioner's breathing restrictions were stated by his treating physician to be comparable to a NYHA Class III restriction. The restriction is indicative of someone comfortable at rest while less than ordinary physical activity causes fatigue, palpitation, dyspnea or anginal pain. The restriction is consistent with an inability to perform medium employment.

It is found that Petitioner is incapable of performing the requirements of medium employment. For purposes of this decision, it will be found that Petitioner can perform the requirements of light employment.

Based on Petitioner's exertional work level (light), age (advanced age), education (high school equivalency with no direct entry into skilled employment), employment history (none), Medical-Vocational Rule 202.04 is found to apply. This rule dictates a finding that Petitioner is disabled. Before a finding of disability is finalized, some consideration of Petitioner's ETOH abuse and medical noncompliance should be considered.

Petitioner testimony conceded he was a long-term tobacco smoker up to the time he was hospitalized in 2011. Petitioner testified he has not smoked since. Petitioner's testimony was credible and consistent with presented documents. Thus, cigarette smoking was not established to be material noncompliance by Petitioner. Despite Petitioner's cessation of cigarette smoking, there were many other areas where he did not comply with physician recommendations.

Petitioner testimony conceded he was advised by a physician to lose weight. Petitioner testified he has gained 50 pounds in the last couple years.

Petitioner testified he stopped drinking alcohol approximately March 2015. Thus, Petitioner was an alcohol abuser for the entire time he seeks disability. There was also evidence suggesting Petitioner is still an occasional alcohol drinker. Despite Petitioner's alcohol consumption, at least during the time of disputed disability, it was not established to affect ongoing restrictions.

There was ample evidence suggesting Petitioner's failure to pursue a CPAP affected sleep apnea. It is not farfetched to link Petitioner's failure to be treated for OSA to his ongoing breathing restrictions; however, Petitioner's medical history is not suggestive

that use of a CPAP would improve Petitioner's restrictions to the point where medium employment is a realistic expectation.

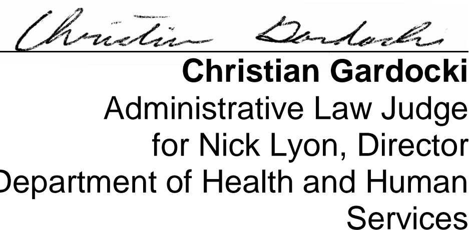
It is found that neither ETOH abuse nor medical noncompliance are material to a finding of disability. Accordingly, Petitioner is disabled and it is found that MDHHS improperly denied Petitioner's MA eligibility.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that MDHHS improperly denied Petitioner's application for MA benefits. It is ordered that MDHHS:

(1) reinstate Petitioner's MA benefit application dated April 24, 2014, including retroactive MA benefits from March 2014;
(2) evaluate Petitioner's eligibility for benefits subject to the finding that Petitioner 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 Petitioner is found eligible for future benefits.

The actions taken by MDHHS are **REVERSED**.



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

Date Signed: **11/25/2015**

Date Mailed: **11/25/2015**

CG/tm

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: