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

IN THE MATTER OF:

[redacted]

MAHS Reg. No.: 15-020086
Issue No.: 2009
Agency Case No.: [redacted]
Hearing Date: January 14, 2016
County: Alpena

ADMINISTRATIVE LAW JUDGE: Vicki Armstrong

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; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, an in-person hearing was held on January 14, 2016, from Alpena, Michigan. The Petitioner was represented by [redacted] of [redacted]. The Department was represented by Assistance Payment Worker [redacted] and Assistance Payment Supervisor [redacted].

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the Medical Assistance (MA) 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 March 27, 2015, Claimant applied for MA disability benefits.

2. On [redacted], Claimant presented to the emergency department at the advice of her primary care physician. Claimant was admitted to the hospital with severe acute diabetic ketoacidosis with severe dehydration, acute rhabdomyolysis and an acute non-ST elevation myocardial infarction with a history of hypertension. Echocardiogram and stress test were abnormal. The stress test revealed peri-infarct reversible ischemia in inferior wall, inferior wall infarct and an ejection fraction of 73%. She was also diagnosed with left lower lobe versus lingular pneumonia based on the x-ray from March 23, 2015. Claimant was transferred from [redacted] to [redacted] on March 29, 2015 for heart catheterization. Discharge diagnosis was non-ST-elevation myocardial infarction, coronary artery disease, diabetes mellitus – type 1, resolved diabetic ketoacidosis, resolved hydration, resolved pneumonia, anemia thought

secondary to lower gastrointestinal (GI) blood loss following anticoagulation, hypertriglyceridemia, and morbid obesity. (Dept Ex. 45-176).

3. On [redacted], Claimant was admitted to [redacted] in Flint with an acute non-ST elevated myocardial infarction. Secondary diagnoses included pneumonia, status post below knee amputation, diabetes, hypertension, obesity, history of cerebrovascular accident and tobacco use. On March 31, 2015, Claimant underwent left heart cardiac catheterization, coronary angiogram and left ventriculogram. Claimant was assessed with three-vessel coronary artery disease involving right coronary artery equals 90% distal, left anterior descending equals 30% and left circumflex equals 20%. Normal left ventricular systolic function with calculated ejection fraction of 58%. The cardiologist indicated Claimant will need medical therapy and she will have PTCA and stent placement to right coronary artery. (Dept Ex. A, pp 177-208).

4. On July 9, 2015 Claimant underwent a Medical Examination by her treating physician. Claimant is diagnosed with type 2 diabetes – insulin dependent, history of a heart attack, high blood pressure, hyperlipidemia and depression. Her medical records indicate she has had poorly controlled diabetes since at least July, 2013. (Dept Ex. A, pp 217-225).

5. On July 29, 2015, Claimant underwent a medical evaluation by an independent physician paid for by the Department. The physician indicated Claimant has diabetes. She has had a cerebrovascular accident and myocardial infarction in the past. Her blood pressure was borderline elevated. There were no findings of heart failure. She did not have any residual focal neurological deficits but did complain of problems with memory which was thought to be more due to her loss of consciousness due to diabetes, than to the cerebrovascular accident. The physician noted that aggressive sugar management would be indicated to avoid any further deterioration or sequel. (Dept Ex. A, pp 244-246).

6. On August 20, 2015, the Department mailed Claimant a Health Care Coverage Determination notifying Claimant her application for MA disability had been denied. (Dept Ex. A, pp 7-12).

7. On October 21, 2015, Claimant's Authorized Hearing Representative (AHR) submitted a hearing request contesting the Department's negative action.

8. On December 20, 2015, Claimant was admitted to the hospital with a diagnosis of acute diabetic ketoacidosis (DKA), diabetes mellitus-type 1, obesity, tobacco abuse, history of alcoholism and chronic back pain. She has a history of hypertension, chronic low back pain, diabetes mellitus with multiple hospitalizations, obesity and depression. She was admitted to the intensive care unit and DKA protocol was initiated. On December 22, 2015, Claimant was about to discharge and left against medical advice. (Claimant Ex. pp 1-15).

9. Claimant had applied for Social Security disability benefits at the time of the hearing.

10. Claimant is a 52 year old woman whose birthday is [redacted].

11. Claimant is 5'5" tall and weighs 226 lbs.

12. Claimant quit drinking two years ago. She currently smokes half a pack of cigarettes a day.

13. Claimant has a driver's license but is afraid to drive because she is a brittle diabetic and never knows when her sugar is going to spike.

14. Claimant has a high school education.

15. Claimant has never worked outside the home.

16. Claimant alleges disability on the basis of depression, hypertension, obesity, chronic low back pain, hyperlipidemia, acute diabetic ketoacidosis (DKA), insulin dependent diabetes, coronary artery disease, acute myocardial infarction, cerebral artery occlusion, post stenting, anemia, and pneumonia.

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

18. Claimant's complaints and allegations concerning her impairments and limitations, when considered in light of all objective medical evidence, as well as the record as a whole, reflect an individual who is so impaired as to be incapable of engaging in any substantial gainful activity on a regular and continuing basis.

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 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.

In order to receive MA benefits based upon disability or blindness, claimant must be disabled or blind as defined in Title XVI of the Social Security Act (20 CFR 416.901). DHS, being authorized to make such disability determinations, utilizes the SSI definition of disability when making medical decisions on MA applications. MA-P (disability), also is known as Medicaid, which is a program designated to help public assistance claimants pay their medical expenses. Michigan administers the federal Medicaid program. In assessing eligibility, Michigan utilizes the federal regulations.

Disability is the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905.

The federal regulations require that several considerations be analyzed in sequential order:

> . . . We follow a set order to determine whether you are disabled. We review any current work activity, the severity of your impairment(s), your residual functional capacity, your past work, and your age, education and work experience. If we can find that you are disabled or not disabled at any point in the review, we do not review your claim further. 20 CFR 416.920.

The regulations require that if disability can be ruled out at any step, analysis of the next step is not required. These steps are:

1. If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or your age, education, and work experience. 20 CFR 416.920(b). If no, the analysis continues to Step 2.

2. Does the client have a severe impairment that has lasted or is expected to last 12 months or more or result in death? If no, the client is ineligible for MA. If yes, the analysis continues to Step 3. 20 CFR 416.909(c).

3. Does the impairment appear on a special Listing of Impairments or are the client's symptoms, signs, and laboratory findings at least equivalent in severity to the set of medical findings specified for the listed impairment that meets the duration requirement? If no, the analysis continues to Step 4. If yes, MA is approved. 20 CFR 416.920(d).

4. Can the client do the former work that he/she performed within the last 15 years? If yes, the client is ineligible for MA. If no, the analysis continues to Step 5. Sections 200.00-204.00(f)?

5. Does the client have the Residual Functional Capacity (RFC) to perform other work according to the guidelines set forth at 20 CFR 404, Subpart P, Appendix 2, Sections 200.00-204.00? This step considers the residual functional capacity, age, education, and past work experience to see if the client can do other work. If yes, the analysis ends and the client is ineligible for MA. If no, MA is approved. 20 CFR 416.920(g).

At application Claimant has the burden of proof pursuant to:

> . . . You must provide medical evidence showing that you have an impairment(s) and how severe it is during the time you say that you are disabled. 20 CFR 416.912(c).

Federal regulations are very specific regarding the type of medical evidence required by claimant to establish statutory disability. The regulations essentially require laboratory or clinical medical reports that corroborate claimant's claims or claimant's physicians' statements regarding disability. These regulations state in part:

> Medical reports should include --
>
> (1) Medical history.
>
> (2) Clinical findings (such as the results of physical or mental status examinations);
>
> (3) Laboratory findings (such as ultrasounds, X-rays);
>
> (4) Diagnosis (statement of disease or injury based on its signs and symptoms). 20 CFR 416.913(b).

Statements about your pain or other symptoms will not alone establish that you are disabled; there must be medical signs and laboratory findings which show that you have a medical impairment. 20 CFR 416.929(a). The medical evidence must be complete and detailed enough to allow us to make a determination about whether you are disabled or blind. 20 CFR 416.913(d).

Information from other sources may also help us to understand how your impairment(s) affects your ability to work. 20 CFR 416.913(e). You can only be found disabled if you are unable to do any substantial gainful activity by reason of any medically determinable

physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months. See 20 CFR 416.905. Your impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. 20 CFR 416.927(a)(1).

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability. 20 CFR 416.927(e).

Applying the sequential analysis herein, Claimant is not ineligible at the first step as Claimant is not currently working. 20 CFR 416.920(b). The analysis continues.

The second step of the analysis looks at a two-fold assessment of duration and severity. 20 CFR 416.920(c). This second step is a *de minimus* standard.

The medical information indicates that Claimant suffers from depression, hypertension, obesity, chronic low back pain, hyperlipidemia, acute diabetic ketoacidosis (DKA), insulin dependent diabetes, coronary artery disease, acute myocardial infarction, cerebral artery occlusion, post stenting, anemia, and pneumonia. Ruling any ambiguities in Claimant's favor, this Administrative Law Judge (ALJ) finds that Claimant meets duration and severity. The analysis continues.

The third step of the analysis looks at whether an individual meets or equals one of the Listings of Impairments. 20 CFR 416.920(d). Claimant does not. The analysis continues.

Claimant has been medically described as morbidly obese, which condition likely exacerbates her impairments.

> Obesity is a medically determinable impairment that is often associated with disturbance of the respiratory system, and disturbance of this system can be a major cause of disability in individuals with obesity. The combined effects of obesity with respiratory impairments can be greater than the effects of each of the impairments considered separately. Therefore, when determining whether an individual with obesity has a listing-level impairment or combination of impairments, and when assessing a claim at other steps of the sequential evaluation process, including when assessing an individual's residual functional capacity, adjudicators must consider any additional and cumulative effects of obesity. Listing 3.00(I).

The fourth step of the analysis looks at the ability of the applicant to return to past relevant work. This step examines the physical and mental demands of the work done by Claimant in the past. 20 CFR 416.920(f). In this case, Claimant has no work history. As such, there is no past work for Claimant to perform, nor are there past work skills to transfer to other work occupations. Accordingly, Step 5 of the sequential analysis is required.

The fifth and final step of the sequential consideration of a disability claim, the trier of fact must determine if the claimant's impairment(s) prevents claimant from doing other work. 20 CFR 416.920(f). This determination is based upon Claimant's:

(1) residual functional capacity defined simply as "what can you still do despite you limitations?" 20 CFR 416.945;

(2) age, education, and work experience, 20 CFR 416.963-.965; and

(3) the kinds of work which exist in significant numbers in the national economy which the claimant could perform despite his/her limitations. 20 CFR 416.966.

See *Felton v DSS* 161 Mich. App 690, 696 (1987). Once Claimant reaches Step 5 in the sequential review process, Claimant has already established a *prima facie* case of disability. *Richardson v Secretary of Health and Human Services,* 735 F2d 962 (6th Cir, 1984). At that point, the burden of proof is on the state to prove by substantial evidence that Claimant has the residual functional capacity for substantial gainful activity.

Claimant credibly testified that she has a limited tolerance for physical activities and is unable to stand or sit for lengthy periods of time. Claimant reported her diabetes is uncontrolled, and was hospitalized in December, 2015 for acute diabetic ketoacidosis. She was also hospitalized in March, 2015 for acute diabetic ketoacidosis and a heart attack. Claimant's treating physician and the hospital records from her multiple hospitalizations note that Claimant's diabetes is uncontrolled.

After careful review of Claimant's medical records and the Administrative Law Judge's personal interaction with Claimant at the hearing, this Administrative Law Judge finds that Claimant's exertional and non-exertional impairments render Claimant unable to engage in a full range of even sedentary work activities on a regular and continuing basis. 20 CFR 404, Subpart P. Appendix 11, Section 201.00(h). See Social Security Ruling 83-10; *Wilson v Heckler*, 743 F2d 216 (1986). Based on Claimant's vocational profile (approaching advance age, Claimant is 52, with a high school education and no work history), this Administrative Law Judge finds Claimant's MA/Retro-MA benefits are approved using Vocational Rule 201.12 as a guide. Consequently, the Department's denial of her March 27, 2015, MA/Retro-MA application cannot be upheld.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides the Department erred in determining Claimant is not currently disabled for MA/Retro-MA eligibility purposes.

Accordingly, the Department's decision is **REVERSED**, and it is ORDERED that:

1. The Department shall process Claimant's March 27, 2015, MA/Retro-MA application, and shall award her all the benefits she may be entitled to receive, as long as she meets the remaining financial and non-financial eligibility factors.

2. The Department shall review Claimant's medical condition for improvement in January, 2016, unless her Social Security Administration disability status is approved by that time.

3. The Department shall obtain updated medical evidence from Claimant's treating physicians, physical therapists, pain clinic notes, etc. regarding her continued treatment, progress and prognosis at review.

It is SO ORDERED.

Vicki Armstrong
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Mailed: **1/19/2016**

VLA/las

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]