STATE OF MICHIGAN STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ADMINISTRATIVE HEARINGS FOR THE DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

Claimant

Reg. No:2007-09765Issue No:2009Case No:1000Load No:1000Hearing Date:1000September 4, 20071000Kalamazoo County DHS

ADMINISTRATIVE LAW JUDGE: Jay W. Sexton

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9; and MCL 400.37 upon claimant's request for a hearing. After due notice, an in-person hearing was held in Kalamazoo on September 4, 2007. Claimant personally appeared and testified under

oath. Claimant was represented at the hearing by

The department was represented by Patricia Daniel (FIS)

Claimant requested additional time to submit new medical evidence. Claimant's medical evidence was sent to the State Hearing Review Team (SHRT) on October 5, 2007 and October 18, 2007. Claimant waived the timliness requirement so that her new medical evidence could be reviewed by SHRT. After SHRT's second disability denial, the Administrative Law Judge made the final decision below.

<u>ISSUE</u>

(1) Did claimant establish a severe mental impairment expected to preclude her from substantial gainful work **continuously** for one year (MA-P)?

(2) Did claimant establish a severe physical impairment expected to preclude her from substantial gainful work **continuously** for one year (MA-P)?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

(1) Claimant is a MA-P/retro applicant (October 18, 2006) who was denied by SHRT

(May 7, 2007 and November 26, 2007) due to claimant's failure to establish an impairment which meets the severity and duration requirements.

(2) Claimant's vocational factors are: age—45; education –high school diploma; post high school education—received an

); work experience—did production work for textile systems, worked as a

kitchen aide for a local community college.

(3) Claimant has not performed Substantial Gainful Activity (SGA) since she was a

production worker for textile systems in 2006.

(4) Claimant has the following unable-to-work complaints:

- (a) Back dysfunction, with pain;
- (b) Left knee goes out;
- (c) Severe depression.
- (5) SHRT evaluated claimant's medical evidence as follows:

OBJECTIVE MEDICAL EVIDENCE (MAY 5, 2007):

Claimant sustained a jaw fracture 7/13/2006 and had surgery for repair of the fracture (pages 84). Claimant was admitted at that time due to her alcohol intoxication and overall medical problems (page 76). She was discharged home 7/17/2006 with antibiotics, but claimant failed to take the antibiotics. On 7/20/2006, claimant was admitted due to right submandibular abscess (pages 84-85. She had aspiration pneumonia requiring intubation and tracheostomy (page 4).

On 9/15/2006, claimant was admitted again due to acute pancreatitus (pages 43-44). She had laproscopic colecystecomy (page 4). In 11/2006, claimant had an open rotator cuff repair on the left shoulder (page 4).

On 11/12/2006, claimant presented to the ER due to abdominal pain. Her shoulder pain seemed to be getting better. However, she did report occasional excruciating shoulder pain (page 6). On exam, her left shoulder was tender. The wound looked healed with on signs of infection. There was mild soreness of the left shoulder. She was actually able to move it and range of motion was acceptable, although painful (page 7).

ANALYSIS: Claimant had a jaw fracture in 7/2006 and infection/abscess because she had not taken her antibiotics. She had complications and required endotracheal intovation and tracheostomy. She did recover from that. In 9/2006 she had acute pancreatitis and laparoscopic cholecystectomy. She recovered from that. In 11/2006 she had rotator cuff on her left shoulder. On 11/12/2006, she went to ER due to abdominal pain. Her shoulder wound was healed with no signs of infection. She had soreness, but was actually able to move it. It is assumed that she recover from this surgery.

SUPPLEMENTAL MEDICAL EVIDENCE (November 26, 2007

NEWLY SUBMITTED INFORMATION:

Emergency room records of 5/21/07 indicate the claimant was treated for back pain a result of being hit in the back with fists. She had some tenderness, however, no motor or sensory deficit and range of motion was normal. (Page 469.)

Hospital records of 6/04/07 indicate the claimant was treated for chest pain after an argument with her boyfriend. Cardiac testing was within normal limits.

Hospital records of 6/07/07 indicate the claimant was treated for an assault. CT scans of the brain and face were normal with the exception of a left soft tissue injury.

Hospital records of 9/03/07 indicate the claimant was treated for back pain, abdominal pain, diarrhea, and nausea. Exam was otherwise normal.

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(6) Claimant performs the following Activities of Daily Living (ADLs): dressing, bathing, cooking and dishwashing. Claimant was hospitalized 5x in 2006 and 4x in 2007.

(7) Claimant has a valid driver's license and drives an automobile approximately 10 times per month. Claimant is not computer literate.

(8) The following medical records are persuasive:

See the SHRT summary of medical evidence at paragraph #5, above.

(9) The probative medical evidence does not establish an acute mental condition that is expected to prevent claimant from performing all customary work functions for the required period of time. The February 23, 2007 psychiatric evaluation states that claimant was very angry, agitated, flighty with ideations and mania, along with racing thoughts. Poor concentration was evident. Judgment and insight were limited. The psychiatrist provided the following diagnosis: Bipolar mood disorder, NOS; prior post traumatic stress disorder. Axis V/GAF—30. There is no evidence that claimant has been receiving on-going therapy. No evidence in the record that she is taking her psychotropic medications, as ordered. Claimant did not submit a DHS-49D or DHS-49E to establish her mental residual functional capacity.

(10) The probative medical evidence does not establish an acute physical condition that is expected to prevent claimant from performing all customary work functions. The medical records show that she was discharged from the hospital with the following diagnosis: History of coronary artery disease, status post stent placement; hypothyroidism; history of hypertension; history of asthma; recent shoulder fractures, status post surgical repair; recent jaw fracture. All of these conditions were successfully treated, according to the medical evidence.

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(11) Claimant recently applied for Federal disability benefits with the Social Security Administration. Recently, the Social Security Administration denied her application. Claimant filed a timely appeal.

CONCLUSIONS OF LAW

CLAIMANT'S POSITION

Claimant position is summarized in the Hearing Request as follows:

Claimant was hospitalized in July of 2006 status-post assault with bilateral mandibular fractures and readmitted due to abscess formation resulting in bilateral interstitial infiltrates and respiratory failure. Claimant was also treated for hypothyroidism, hypertension, and psychological disorder.

Claimant has a history of coronary artery disease with stent placement.

DEPARTMENT'S POSITION

The department thinks that claimant has normal Residual Functional Capacity (RFC).

The department that the medical evidence of record does not document a mental/physical impairment that significantly limits claimant's ability to perform basic work activities. The department denied MA-P eligibility based on claimant's failure to establish an impairment which meets the department's severity and duration requirements.

Claimant has been treated for a number of impairments that were brief in duration and improved significantly with treatment.

LEGAL BASE

The Medical Assistance (MA) program is established by Title XIX of the Social Security

Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department

of Human Services (DHS or department) administers the MA program pursuant to MCL 400.10,

et seq., and MCL 400.105. Department policies are found in the Program Administrative

Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual

(PRM).

"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.

...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.

...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).

...[The impairment]...must have lasted or must be expected to last for a continuous period of at least 12 months. We call this the duration requirement. 20 CFR 416.909.

...If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience. 20 CFR 416.920(c).

[In reviewing your impairment]...We need reports about your impairments from acceptable medical sources.... 20 CFR 416.913(a).

...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).

...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).

...[The record must show a severe impairment] which significantly limits your physical or mental ability to do basic work activities.... 20 CFR 416.920(c).

...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 blood pressure, X-rays);
- (4) Diagnosis (statement of disease or injury based on its signs and symptoms).... 20 CFR 416.913(b).

...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).

...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).

...Evidence that you submit or that we obtain may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions. 20 CFR 416.927(a)(2).

When determining disability, the federal regulations require that several considerations

be analyzed in sequential order. If disability can be ruled out at any step, analysis of the next

step is <u>not</u> required. These steps are:

- Does the client perform Substantial Gainful Activity (SGA)? If yes, the client is ineligible for MA. If no, the analysis continues to Step 2. 20 CFR 416.920(b).
- 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 416.920(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? If no, the analysis continues to Step 4. If yes, MA is approved. 20 CFR 416.290(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. 20 CFR 416.920(e).
- 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? If yes, the analysis ends and the client is ineligible for MA. If no, MA is approved. 20 CFR 416.920(f).

Claimant has the burden of proof to show by a preponderance of the medical evidence

in the record that her mental/physical impairments meet the department's definition of disability

for MA-P purposes. PEM 260. "Disability," as defined by MA-P standards is a legal term

which is individually determined by consideration of all factors in each particular case.

<u>STEP 1</u>

The issue at Step 1 is whether claimant is performing Substantial Gainful Activity (SGA). If claimant is working and is earning substantial income; she is not eligible for MA-P.

SGA is defined as the performance of significant duties over a reasonable period of time for pay, or engaging in work of a type generally performed for pay. PRM Glossary, Page 34.

The medical/vocational evidence of record shows that claimant is not currently

performing SGA.

Therefore, claimant meets the Step 1 disability requirements.

<u>STEP 2</u>

The issue at Step 2 is whether claimant has impairments which meet the SSI definition of severity/duration.

A severe impairment is defined as a verified medical condition which totally precludes substantial employment. Duration means the severe impairment is expected to last for twelve continuous months or result in death. SHRT found that claimant does not meet the severity and duration requirements.

Therefore, claimant does not meet the Step 2 disability requirements.

<u>STEP 3</u>

The issue at Step 3 is whether claimant meets the Listing of Impairments in the SSI regulations. Claimant does not allege that she meets any of Listings.

Therefore, claimant does not meet the Step 3 disability requirements.

<u>STEP 4</u>

The issue at Step 4 is whether claimant is able to do her previous work. Claimant previous worked on a production job.

There is no medical evidence to establish that claimant is unable to return to her previous job as a production worker. Claimant has normal residual functional capacities based on the entire medical record.

Therefore, claimant does not meet the Step 4 disability requirements.

<u>STEP 5</u>

The issue at Step 5 is whether claimant has the Residual Functional Capacity (RFC) to do other work.

For purposes of this analysis, we classify jobs as sedentary, light, medium and heavy. These terms are defined in the published by the

at20 CFR 416.967.

The medical/vocational evidence of record establishes that claimant is able to perform substantial gainful activity. This includes the ability to perform light/sedentary work. Claimant's vocational profile shows a younger individual (age 45) with a high school diploma and an associate's degree. She has a work history of production work.

The medical/vocational evidence of record when taken as a whole shows that claimant is able to perform work as a ticket taker at a theatre, as a parking lot attendant and as a greeter at

. However, the medical record shows that claimant has not been compliant with her psychotropic medications. Claimant's failure to take her medications, as directed, exacerbates her mental impairments.

During the hearing, claimant testified that a major impediment to her return to work was her left shoulder dysfunction in combination with her pain. Evidence of pain, alone, is insufficient to establish disability for MA-P purposes.

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The Administrative Law Judge concludes that claimant's testimony about her pain is credible, but out of proportion to the objective medical evidence as it relates to claimant's ability to work.

In summary, the Administrative Law Judge is not persuaded that claimant is totally unable to work based on her mental impairments in combination with her left shoulder dysfunction. Claimant currently performs many activities of daily living, drives an automobile, and has an active social life. (She lives at a shelter). Also, claimant has an associate's degree. The evidence of record suggests that claimant is currently able to perform substantial gainful activity.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides claimant does not meet the MA-P disability requirements under PEM 260. Claimant is not eligible for MA-P, at this time, based on Step 5 of the sequential analysis, as enumerated above.

Accordingly, the department's denial of claimant's MA-P/SDA application is, hereby, AFFIRMED.

SO ORDERED.

<u>/s/</u>

Jay W. Sexton Administrative Law Judge for Ismael Ahmed, Director Department of Human Services

Date Signed: August 10, 2009

Date Mailed: <u>August 11, 2009</u>

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NOTICE: Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative Hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt date of the rehearing decision.

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