STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF: [redacted]

Claimant

Reg. No: 2007-19636
Issue No: 2009
Case No: [redacted]
Load No:
Hearing Date:
December 17, 2008
Wayne County DHS

ADMINISTRATIVE LAW JUDGE: Landis Y. Lain

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, a telephone hearing was held on December 17, 2008.

ISSUE

Did the Department of Human Services (the department) properly deny claimant's application for Medical Assistance (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) On September 1, 2006, claimant filed an application for Medical Assistance and retroactive Medical Assistance benefits for the months of June, July and August 2006.

(2) On November 15, 2006, the Medical Review Team denied claimant's application stating that claimant could perform other work.

(3) On November 27, 2006, the department caseworker sent claimant notice that his application was denied.

(4) On [redacted], claimant committed suicide by an intraoral gunshot wound.

(5) On March 23, 2007, [redacted] filed an application for a hearing to contest the department's negative action.

(6) [redacted] were appointed as personal representative on [redacted] under the authority for personal representative signed by [redacted].

(7) On October 12, 2007, the State Hearing Review Team (SHRT) denied claimant's application stating in its analysis and recommendation: that claimant died [redacted] due to suicide by an intraoral gunshot wound. There is no evidence in the file to document a significant heart problem. He presented to the hospital multiple times in [redacted] due to seizures. There is limited information but there was question of possible drug seeking behavior. His neurological examinations were basically within normal limits. He reported shortness of breath but breath sounds were clear and a breathing test in the file did not show program severity. He was reported to have anxiety and depression on several occasions. However, there were no mental health records. The mental status information in the file did not show severe depression at the time. Therefore, the claimant would not have been approved for SSI benefits prior to his death in [redacted]. The claimant's impairments did not meet/equal the intent or severity of a Social Security listing prior to his death. The medical evidence of record indicated that the claimant would have retained the capacity to perform simple unskilled medium work avoiding unprotected heights and dangerous moving machinery. Therefore, based on the claimant's vocational profile of a younger individual, 12th grade education and unskilled work, MA-P is

denied using Vocational Rule 203.28 as a guide prior to his death. Retroactive MA-P was considered in this case and is also denied.

(8) The hearing was held on December 17, 2008. At the hearing, claimant's representative presented additional medical information to submit to the State Hearing Review Team for review.

(9) On January 27, 2009, the State Hearing Review Team approved claimant as equaling listing 12.04 beginning [redacted]. Prior to that his condition would have been a denial based on his ability to perform light work that did not involve working around dangerous heights or machinery pursuant to Medical-Vocational Rule 202.20 which was used as a guide. The State Hearing Review Team commented that the claimant died as the result of a self-inflicted gunshot wound. While the medical records do not indicate a disabling mental impairment it would be reasonable to assume the claimant's mental condition was of a disabling nature as much as one month before his suicide. A mental status performed in [redacted] reported findings of his mental status to be within normal limits. He received treatment for several other medical impairments for which medical records do not indicate an impairment of disabling severity. He had a history of seizures and began having breakthrough seizures; however, he was not always compliant with medication and did not have an ongoing treating neurologist.

(10) Claimant was [redacted] at the date of his death. His birth date was [redacted].

(11) Claimant alleged as disabling impairments: chest pain, sarcoidosis, anxiety, and distant history of a head injury as well as seizures and back pain.

CONCLUSIONS OF LAW

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).

Claimant's representative has requested that claimant be found to be disabled from [redacted] through [redacted], the date of his death.

Pursuant to Federal Rule 42 CFR 435.540, the Department of Human Services uses the federal Supplemental Security Income (SSI) policy in determining eligibility for disability under the Medical Assistance program. Under SSI, disability is defined as:

> ...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

A set order is used to determine disability. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience is reviewed. If there is a finding that an individual is disabled or not disabled at any point in the review, there will be no further evaluation. 20 CFR 416.920.

If an individual is working and the work is substantial gainful activity, the individual is not disabled regardless of the medical condition, education and work experience. 20 CFR 416.920(c).

If the impairment or combination of impairments do not significantly limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. Age, education and work experience will not be considered. 20 CFR 416.920.

Statements about pain or other symptoms do not alone establish disability. There must be medical signs and laboratory findings which demonstrate a medical impairment.... 20 CFR 416.929(a).

> ...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).

In determining disability under the law, the ability to work is measured. An individual's functional capacity for doing basic work activities is evaluated. If an individual has the ability to perform basic work activities without significant limitations, he or she is not considered disabled. 20 CFR 416.994(b)(1)(iv).

Basic work activities are the abilities and aptitudes necessary to do most jobs. Examples of these include --

> (1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;
>
> (2) Capacities for seeing, hearing, and speaking;
>
> (3) Understanding, carrying out, and remembering simple instructions;
>
> (4) Use of judgment;
>
> (5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting. 20 CFR 416.921(b).

Medical findings must allow a determination of (1) the nature and limiting effects of your impairment(s) for any period in question; (2) the probable duration of the impairment; and (3) the residual functional capacity to do work-related physical and mental activities. 20 CFR 416.913(d).

Medical evidence 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 the impairment(s), including your symptoms, diagnosis and prognosis, what an individual can do despite impairment(s), and the physical or mental restrictions. 20 CFR 416.927(a)(2).

All of the evidence relevant to the claim, including medical opinions, is reviewed and findings are made. 20 CFR 416.927(c).

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).

A statement by a medical source finding that an individual is "disabled" or "unable to work" does not mean that disability exists for the purposes of the program. 20 CFR 416.927(e).

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:

1. 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).

During the time in question, claimant was not employed and therefore was not disqualified from receiving disability at Step 1.

The objective medical evidence in the record indicates that the claimant presented to the hospital [redacted] due to shortness of breath, chest pain and subjective fever. His symptoms were non-specific and cardiac enzymes were negative. His Dilantin level was subtherapeutic. He was noted to have a history of depression but no suicidal ideation or intent (page 46).

The claimant presented to the hospital [redacted] because he passed out. It was thought to be probably secondary to breakthrough seizures. His medications were switched (pages not numbered).

A consultative examination dated [redacted] showed the claimant had a history of chest pain, chronic shortness of breath, seizures and arthritis (pages 6 and 7). On exam he was alert and oriented x3 dressed appropriately and answered questions fairly well. His blood pressure was 126/92. Lung fields were clear. There were no rales, rhonchi or wheezes (page 8). There was no spinal deformity, swelling, muscle spasm, muscle atrophy, joint deformity, edema,

clubbing, varicose veins, brawny erythema or statis dermatitis are noted. Gait was slow. Grip strength was equal bilaterally. Gross and fine dexterity appeared intact bilaterally (page 9).

The claimant was admitted [redacted] due to a syncopal event or seizure. He had a previous 2D echocardiogram which was normal and showed a normal ejection fraction of 65 percent. Carotid Doppler's were done and showed mild to moderate plaque in the distal common carotid artery. He had normal CT scan of the brain (pages not numbered).

The claimant was admitted again [redacted] to [redacted] due to breakthrough seizures. His medications were adjusted. No anticonvulsant levels were provided in the records. He had a breathing test and his FEV was 83 percent of normal (pages not numbered).

The claimant was admitted again on [redacted] to [redacted] for breakthrough seizures most likely secondary to subtherapeutic valproic acid levels.

On [redacted] the claimant was admitted again for breakthrough seizures. He noted to have possible drug seeking behavior. He is typically seizure free during his hospitalizations. Neurological exam was within normal limits. A mental status exam indicated that his depression has gotten worse due to increased stressors. He lost his house, he lost his truck, and he is living with his fiancé's sister. His speech is clear. Thought processes were normal. There was no evidence of a thinking disorder, psychosis, delusions or hallucinations. He was noted to have a history of major depression. His discharge diagnosis also included opiate dependency.

On [redacted], the claimant was admitted due to a fall he believed to have been possibly after a seizure. One consult indicated his medications had been restarted. There was no anticonvulsant. There was no anticonvulsant levels in the records provided.

The claimant was admitted [redacted] to [redacted] after he stated he had approximately three seizures. During his admission he had multiple episodes of what he claimed were seizure-like activity. He was evaluated multiple times. He had generalized shaking. He had

a negative EEG for any seizure-like activity. He was seen many times resting and sleeping. When physicians would enter the room he would begin to shake. There was a question of whether there was some drug seeking behavior. It was felt that his tremors might be secondary to anxiety with a possible component of bipolar disorder. One consultant indicated breakthrough seizures were due to poor compliance. He reported he had run out of one medication.

The claimant was admitted again [redacted] and there several notes made of noncompliance. One of the secondary diagnoses was unspecified drug dependence and personal history of noncompliance with medical treatment. A DHS-49 in the file indicates that claimant had examination areas which were normal in all areas except for diffuse abdominal pain which was resolved by [redacted] and neck range of motion 2/2 with pain. The DHS-49 indicated that claimant's condition was improving and that he could never lift any weight and could not stand or walk less than 2 hours in an 8 hour day and that needed a soft collar c-spine for comfort but that he could use his upper extremities for both simple grasping, reaching, pushing and pulling and fine manipulating but not operating foot and leg controls because he had significant neck pain.

A report from [redacted] dated [redacted] indicates that on neurological examination claimant was awake and alert, oriented in person, place and time and situation. His attention span had improved. His speech was normal and he had no dysarthria. His pupils were symmetric and reactive to light. There was no papilledema. Extraocular movements were full. There was no nystagmus. Face was symmetrical. Hearing was normal. Tongue is in midline. There is no pronator drift. Strength is 5/5 bilaterally. Reflexes are symmetric. Plantar responses are flexor. Sensory is normal. Finger to nose coordination is normal. Claimant's gait was abnormal secondary to pain on the back and radiculopathy (Claimant's Exhibits C, pages 1 and 2).

At Step 2, claimant has the burden of proof of establishing that he had a severely restrictive physical or mental impairment that lasted or was expected to last for a duration of at least 12 months.

There is insufficient objective clinical medical evidence in the record that claimant suffered a severely restrictive physical or mental impairment until his suicide in [redacted]. Claimant had reports of pain in multiple areas of his body; however, there are no corresponding clinical findings that will support the reports or symptoms and limitations made by the claimant. This Administrative Law Judge cannot give weight to the treating physician's DHS-49 as it is internally inconsistent. The DHS-49 indicates that examinations areas are normal with the exception of the musculoskeletal area where he had range of motion 2/2 with pain and diffuse abdominal pain which was resolved. Claimant was expected to improve and the clinical impression was that he was improving. He had a soft collar for his c-spine for comfort (pages 100 and 101). An internal medical examination of [redacted] indicated that claimant was well-developed, well-nourished, cooperative and in no acute distress. He was awake and alert and oriented x3, dressed appropriately and answered questions fairly well. He was 5' 9" and 200 pounds. His pulse was 72. His respiratory rate was 16. His blood pressure was 126/92. Visual acuity without glasses was 20/20 on the right and 20/30 on the left but blurry without glasses. He does not wear glasses. Claimant was normocephalic/atraumatic. His eyelids were normal. There was no exophthalmos, icterus, conjunctival erythema or exudates noted. Extraocular movements were intact. There was no discharge in the external auditory canal. No bulging erythema. Corporation of the vestal tympanic membrane noted. There was no septal deformity, epistaxis or rhinorrhea. Teeth were in fair repair. Neck was supple. No JVD was noted, no tracheal deviation. No lymphadenopathy. Thyroid was not visible or palpable. External inspection of the ears and nose revealed no evidence of acute abnormality. For respiratory systems, the chest was

symmetrical and equal to expansion. The lung fields were clear to auscultation and percussion bilaterally. There were no rales, rhonchi or wheezes noted. No retractions noted. No accessory muscle usage noted, no cyanosis noted. There was no cough. For cardio vascular systems, normal sinus rhythms S1-S2, no rubs, murmur or gallop. For gastrointestinal, colon was soft, benign, non-distended, non-tender with no guarding, rebound, palpable masses. Bowel sounds were present. Liver and spleen were not palpable. Claimant had no significant skin rashes or ulcers. In his extremities there was no obvious deformity, swelling or muscle spasm noted. Pedal pulses were 2+ bilaterally. There is no calf tenderness, clubbing, edema, varicose veins, brawny erythema, statis dermatitis, chronic leg ulcers and no muscle atrophy or joint deformity or enlargement were noted. In terms of claimant's bones and joints, claimant did not use a cane or aid for walking. He had a slight limp on the right side. Gait was slow. He was unable to do tandem walk, heel walk, toe walk or squat. He was able to bend to 40 percent of the distance and recover. Grip strength was equal bilaterally. He was right handed. Gross and fine dexterity appear bilaterally intact. Finger to nose test was done without difficulty. Abduction of the shoulders was 0 to 120. Flexion of the knees was 0 to 120. Straight leg raising while lying was 0 to 20 on the right and 0 to 30 on the left, while sitting 0 to 90. Claimant was alert, awake and oriented to person, place and time. Cranial nerves to vision as stated and vital signs, 3, 4 and 6 ptosis, nystagmus. Pupils 2 millimeters bilaterally. No facial numbness. Symmetrical response to stimuli. Symmetrical facial movements noted. Could hear normal conversation and whispered voice. Swelling intact. Gag reflex intact. Uvula midline. Head and shoulder movement against resistance were equal. There was no sign of tongue atrophy. No deviation with protrusion of the tongue. It was intact to sharp and dull cross testing. Revealed fair muscle tone without flaccidity, spasticity or paralysis. Finger to nose test done very well. He had a slight limp on his right side (pages 6-10).

This Administrative Law Judge finds that the clinical impression was that claimant was improving and there was no medical finding that claimant had any muscle atrophy or trauma, abnormality or injury that was consistent with a deteriorating condition. Reported symptoms are an insufficient basis upon which a finding that claimant has met the evidentiary burden of proof can be made.

There was no mental residual functional capacity assessment in the record. There was no evidence in the record indicating claimant suffered mental limitations resulting from his reportedly depressed state. The evidentiary record was insufficient to find that claimant suffered a severely restrictive mental impairment.

At Step 2, the objective medical evidence on the record indicated that claimant had not established that he had a severe impairment or combination of impairments which had lasted or would last the durational requirement of 12 months or more or that had kept him from working for 12 months or more. Up until he committed suicide, claimant did not have any severe symptoms, either mental or physical. Claimant must be denied benefits at Step 2 based upon his failure to meet the evidentiary burden.

If claimant had not been denied at Step 2, the analysis would proceed to Step 3 where the medical evidence of claimant's condition does not give rise to a finding that claimant would meet the statutory listing in the code of federal regulations until shortly before his death where upon he would be approved as equaling 12.04 beginning [redacted].

If the claimant had not already been denied at Step 2, this Administrative Law Judge would have to deny him at Step 4 based upon his ability to perform his past relevant work. Claimant's past relevant work was as a sales person. There was no evidence in the record to indicate that claimant could not perform his past relevant work and that his mental and physical condition were so severe that it would not allow him to perform his past relevant work.

At Step 5, the burden of proof shifts to the department to establish that claimant did not have residual functional capacity.

The residual functional capacity is what an individual can do despite limitations. All impairments will be considered in addition to ability to meet certain demands of jobs in the national economy. Physical demands, mental demands, sensory requirements and other functions will be evaluated.... 20 CFR 416.945(a).

To determine the physical demands (exertional requirements) of work in the national economy, we classify jobs as sedentary, light, medium and heavy. These terms have the same meaning as they have in the *Dictionary of Occupational Titles*, published by the Department of Labor... 20 CFR 416.967.

Sedentary work. Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 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. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. 20 CFR 416.967(a).

Light work. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the 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.... 20 CFR 416.967(b).

Claimant had submitted insufficient medical evidence that he lacks the residual functional capacity to perform some other less strenuous tasks than in his prior employment or that he was physically unable to do light or sedentary tasks if demanded of him. Claimant's activities of daily living were not given to this Administrative Law Judge, however his areas of

examination were normal and therefore he should have been able to perform his prior work pursuant Medical-Vocational Rule 202.20 and therefore he was limited to light work. Claimant indicated that he suffered depression.

There was insufficient objective medical/psychiatric evidence contained in the file of depression or a cognitive dysfunction that is so severe that it would have prevented claimant from working at any job. Claimant was disqualified from receiving disability at Step 5 based upon the fact that he had not established by objective medical evidence that he could not perform light or sedentary work even with his impairments. The claimant had normal mental status examinations and was oriented to person, time and place during all of the examinations.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the department appropriately established on the record that it was acting in compliance with department policy when it denied claimant's application for Medical Assistance and retroactive Medical Assistance benefits. The claimant would have been able to perform a wide range of light or sedentary work even with his impairments. The department has established its case by a preponderance of the evidence. However, since claimant did kill himself on [redacted], this Administrative Law Judge will find that he was at least depressed enough to kill himself in the month of [redacted] and therefore may have also been depressed in [redacted] and he is approved for Medical Assistance benefits from [redacted] to [redacted] at the time of his death.

Accordingly, the department's decision is partially REVERSED. The department is ORDERED to reinstate claimant's Medical Assistance application and open an ongoing Medical

Assistance case for the months of [redacted] and [redacted] if claimant was otherwise eligible at that time.

/s/
Landis Y. Lain
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: February 12, 2009

Date Mailed: February 13, 2009

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 mailing 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.

LYL/vmc

cc: [redacted]