STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS & RULES
FOR THE DEPARTMENT OF HUMAN SERVICES
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IN THE MATTER OF:

SOAHR Docket No. 2007-169 REHD
DHS Req. No: 2007-00023

[redacted]

Claimant

_____/

ADMINISTRATIVE LAW JUDGE: Marya A. Nelson-Davis

REHEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9; MCL 400.37; and MAC R 400.919 upon an Order of Rehearing granted on June 13, 2008. Claimant was represented by [redacted] Claimant failed to appear at the hearing.

ISSUE

Did the department properly determine that Claimant did not meet the disability standard for Medical Assistance based on disability (MA-P)?

FINDINGS OF FACTS

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

1. On September 26, 2006, Administrative Law Judge (ALJ) Michael S. Silver issued a Decision and Order in which the ALJ upheld the Department of Human Services' (DHS) denial of the Claimant's July 25, 2005, application for MA-P and Retro MA-P benefits.

2. On October 30, 2006, the State Office of Administrative Hearings and Rules (SOAHR) for the Department of Human Services received a Request for Rehearing/Reconsideration submitted on behalf of the Claimant by [redacted].

3. Claimant was denied Federal Supplemental Security Income (SSI) benefits by the Social Security Administration (SSA). (ALJ I)

4. Findings of Fact 1-22 from the Hearing Decision, issued on September 26, 2006, are incorporated by reference.

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 Family Independence Agency (FIA or agency) administers the MA program pursuant to MCL 400.10, *et seq*., and MCL 4000.105; MSA 16.490 (15). Agency policies are found in the Program Administrative Manual (PAM), the Program Eligibility Manual (PEM), and the Program Reference Manual (PRM).

Pursuant to Federal Rule 42 CFR 435.50, the Family Independence Agency 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

The person claiming a physical or mental disability has the burden to establish it 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 a recovery and/or medical assessment of ability to do work-related activities or ability to reason and to make appropriate mental adjustments, if a mental disability is being alleged, 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908 and 20 CFR 416.929. By the same token, a conclusory statement by a physician or mental health professional that an individual is disabled or blind is not sufficient without supporting medical evidence to establish disability. 20 CFR 416.929.

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 does 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 aptitude necessary to do most jobs. Examples of these include –

> (1) Physical functions such as walking, standing, sitting, lifting, pushing, 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. 20CFR 416.921 (b).

The Residual Functional Capacity (RFC) 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 CCR 416.9677 (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 reflects 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).

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).

If an individual fails to follow prescribed treatment which would be expected to restore their ability to engage in substantial gainful activity without good cause, there will not be a finding of disability… 20 CFR 416.994 (b)(4)(iv).

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).

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 not 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 sever 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, §§ 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).

The ALJ in his September 2006, hearing decision did not address Claimant's employment status. The information provided on Claimant's FIA-49-F and in Finding of Fact 20 indicates that at the time of the May 2006 hearing the Claimant was working 16 to 20 hours per week at [redacted] per hour as a direct care worker. From December 2004 to January 2005, Claimant was employed as a waitress. Based on the evidence on the record, Claimant is not ineligible for disability at Step 1, because she was not earning enough income to be considered substantially gainfully employed at the time of her application and during the period under review. Therefore, Claimant's disability will be considered at Step 2.

On July 25, 2005, the Claimant applied for MA-P, Retro MA-P, and SDA. On August 22, 2005, the Medical Review Team (MRT) reviewed the Claimant's application and

medical file and approved SDA, but denied MA-P and Retro MA-P on the basis that Claimant's alleged impairments lacked duration. On March 6, 2006, the State Hearing Review Team (SHRT) denied Claimant's application for MA-P, and Retro MA-P on the basis that her impairment lacked duration. Claimant presented new medical information at the May 2006 hearing and after the hearing. This new medical, including Claimant's medical file, was returned to SHRT a second time for a review of new medical information. On September 8, 2006, SHRT issued a decision in which it denied MA-P and Retro MA-P. SHRT determined that Claimant retained the residual functional capacity to perform sedentary work.

Claimant submitted medical documentation which reveals the following:

> On September 11, 2000, Claimant was seen by the emergency department with a chief complaint of unresponsive. Claimant had been found unresponsive in a car and had claimed to have used a bag and a ½ of heroin. During the physical exam, it was noted that Claimant was alert and oriented x 3, and stable vital signs were present. Claimant was given a diagnosis of acute poly-drug overdose and an acute suicide attempt. Claimant was admitted to [redacted] After a physical and mental examination, the doctor concluded the following: Axis I-adjustment disorder with mixed emotional features; depressed disorder, not otherwise specified; Axis II-borderline personality traits, consider borderline disorder; Axis III-acute suicide attempt; Axis IV-psychosocial stressors-severe; and Axis V-Global Assessment of Functioning (GAF)-30. The doctor recommendations were to: continue one to one sitter x 24 hours per day; change to plastic utensils; transfer patient to [redacted] or to "inpatient psych-once"; and Claimant was medically cleared for further evaluation and treatment. (Exhibit 1, pp. 39-43)
>
> On February 3, 2002, Claimant was admitted at [redacted] with an admitting diagnosis of acute status asthmaticus. The Claimant was alert, well oriented, and had some mild respiratory distress. A chest x-ray showed no acute pathology. Upon admission to the hospital, Claimant was placed on intravenous cortical steroids along with aerosolized bronchodilators. [redacted] from the chemical-dependency unit and [redacted] of pulmonary medicine saw Claimant for a consultation. [redacted] treated the Claimant for possible withdrawal, and her symptoms improved. Also, Claimant had a gradual increase in activity. Claimant's hospital stay was uneventful, and towards the end, Claimant refused treatment. Claimant's final diagnosis was status asthmaticus, upper respiratory infection, and substance abuse with an improved condition upon discharge. (Exhibit 1, p. 44)

On February 9, 2005, Claimant was admitted to [redacted] because of increasing dyspnea on the day of admission. Admitting diagnosis was asthmaticus. Claimant had a previous history of asthma, previous hospitalization/intubations, and had a history of a [redacted] a day heroin habit. Upon physical examination, patient was in distress. Lab reports indicated a leukocytosis of 10,600 and normal hemoglobin. BUN, creatinine, and electrolytes were normal with minimal hypokalemia. Claimant was agitated and combative, requiring restraints. Claimant was placed on intravenous corticosteroids and aerosolized bronchodilators. She was given intravenous [redacted] and [redacted] because of elevated blood pressure, and a consult was requested. Claimant left the hospital against medical advice on February 12, 2005. Final diagnosis was acute exacerbation of asthma, acute drug withdrawal, and chronic substance abuse. Claimant's condition upon discharge was improved. (Exhibit 1, pp. 45 & 46)

On April 28, 2005, Claimant was admitted to [redacted] under the care of [redacted]. Claimant complained of having difficulty breathing, and that she is a heroin addict and last used on April 27, 2005. In addition, she had a history of using cocaine and other drug abuse. She became hyoptensic and was sent to the ICU. Claimant's history and physical examination revealed wheezing, lung lesions probably septic emboli, septic shock, asthma, anemia, and IV drug abuse. (Exhibit 1, p. 53)

On April 28, 2005, Consultation of patient was administered by [redacted] The impressions [redacted] drew were as follows: Claimant had acute opiate withdrawal; hypotension/tachycardia, rule out sepsis versus dehydration versus withdrawal versus other; bilateral pulmonary emboli; bilateral multiple septic emboli within the lungs; dehydration; anemia, rule out GI bleed versus other; history of asthma; and history of lung abscess. The plan for Claimant was as follows: IV fluid therapy; Empiric antibiotic therapy; no beta blockers; urine toxicity screen; a hold on all sedatives until blood pressure is stable; Cardiology consult for echo to rule out vegetations of the heart; and further recommendations were to be made following the lab results. [redacted] dictates in the discharge summary that the Claimant went in complaining of shortness of breath, a history of cocaine abuse, endocarditis, asthma, and hepatitis C. She had bilateral wheezing and systolic ejection murmur. Claimant was treated for endocarditis with septic emboli to the lung, transferred for blood, and developed worsening respiratory distress which lead to her being placed on a ventilator. The decision was made to do an EGD when the Claimant was stable. The hospital continued a course of IV antibiotics and fluids. Her diagnosis was diluresed for volume overload. It was

discussed with Cardiovascular Surgery, and no surgery was agreed upon at that time. Claimant was discharged to an extended care facility for long-term antibiotics with likely recurrent admissions as well as the possibility of reusing (she has had recurrent problems with IV drugs in the past). Claimant had a consultation with [redacted] for reasons indicated to be coffee-ground emesis. [redacted] found the following results: questionable coffee-ground emesis, could rule out peptic ulcers disease versus others; no evidence of active ongoing gastrointestinal bleeding; acute pulmonary embolism; septic pulmonary emboli; active opiate withdrawal; microcytic/hyperchromic anemia, acute/chronic, and can rule out deficiency state; polysubstance abuse; gram positive bacteremia; valvular heart disease with tri-cuspid valve degeneration, ruling out endocarditis; hepatitis C; thrombocytopenia, questioning secondary to sepsis versus hypersplenism secondary to portal hypertension; and coagulopathy secondary to Vitamin K deficiency versus intrinsic liver disease. Recommendations at that time were as follows: the patient is currently not a good candidate for esophagogastroduo-denoscopy at this point due to active opiate withdrawal; there are currently no signs of active gastrointestinal bleeding; would start [redacted] bolus time one, then [redacted] per hour; Serial hemoglobin and Hematocrit while on [redacted]; fecal occult blood testing; check iron studies, B12, Folate level, peripheral smear, LDH and Haptoglobin, rule out underlying hemolysis; and to check abdominal ultrasound, rule out ascites. (Exhibit 1, pp. 49-53)

On April 30, 2005, Claimant was seen at [redacted] and her condition was discussed with a [redacted]. Claimant's diagnosis was as follows: Axis I-polysubstance abuse dependence to opiates, cocaine, marijuana, and benzodiazepines (rule out possible substance abuse mood disorder); Axis II-deferred; Axis III-see past medical history; Axis IV-moderate to severe; Axis V-25-35. The Plan dictated was to undergo substance abuse treatment, [redacted] day, and to follow [redacted] diagnosis and treatment. (Exhibit 1, pp. 47 & 48)

On May 3, 2005, Claimant had a consultation with [redacted] due to chronic proteinuria. [redacted] assessed that Claimant had acute renal failure with creatinine going from .7 to 1.1, nonoliguric. It was determined that ossibilities could be secondary to contract nephropathy as well as the fact that she was hypotensice, causing ischemic ATN from the septic shock. The other possibilities, because of the fact that she has endocarditis, rule out any acute glomerulonephritis, although not convinced that's the case here. Proteinuria, possibly secondary to the acute renal failure was considered a possibility as well. Claimant had gram positive septicemia, and her status was post IV drug abuse as well

as multi-drug abuse. The plans/recommendations were as follows: check urine sediment; check C3, C4, and CH-50; check spot quantitative urine for protein and creatinine; repeat UA with micro, monitor electrolytes, BUN, and creatinine; check HIV status if not already done; and continue to follow the patient. (Exhibit 1, pp. 54 & 55)

On May 3, 2005, [redacted] had the Claimant go through radiology tests, which examined the chest, single frontal portable view with clinical indications of shortness of breath. The study revealed bilateral infiltrative changes throughout the lung fields, bilaterally, fibro nodular in nature, and pulmonary vascular congestion. The findings were compatible with congestive heart failure, and the possibility of underlying mass lesions could not be ruled out at that time. No evidence of any other abnormalities were noted. The impression was that there were no interval changes from previous examination. On May 3, 2005, [redacted] ordered the Claimant to have an Electrocardiograph test at [redacted]. The report diagnosis stated that the Sinus tachycardia was as 140 bpm's. There was significant right axis deviation compatible with left posterior fascicular block along with low-voltage, suggesting pulmonary pathology. There was slow r wave progression, and no previous tracing was available for comparison. (Exhibit 1, pp. 77-79)

On May 3, 2005, [redacted] ordered a renal ultrasound, and one was performed on May 4 . The left kidney was sub-optimally visualized and measured 12.5 cm in greatest dimension. There was no focal mass or hydronephrosis. The right kidney measured 12.1 cm with no focal mass or hydronephrosis. There was also abdominal ascites seen adjacent to the bilateral kidneys, and echogenic material seen within the urinary bladder which may be a reverberation artifact; however, echogenic debris could not be excluded. The impressions were that Claimant had bilateral medical renal disease, ascites, and questionable exhogenic debris within the urinary bladder. (Exhibit 1, p. 76)

On May 4, 2005, [redacted] ordered a portable chest, single view x-ray due to Claimant's shortness of breath. The chest was examined bedside, using the portable technique in a single frontal projection. A comparison was made to the prior portable chest exam on May 3rd. There was diffused nodular infiltrates seen throughout the bilateral lung fields, compatible with septic emboli. Heart size was at the upper limit for normal. The osseous thorax appeared unremarkable, and there was no significant interval change when compared to the prior study. (Exhibit 1, pp. 77 & 78)

On May 5, 2005, the Claimant was examined by [redacted] The Medical Examination report was filled on May 5 as well. Claimant was given a current diagnosis of Endocarditis. All examination areas were normal except for respiratory as well as cardiovascular. The doctor's physical impressions of the Claimant were stable. Physical limitations were listed, and the Claimant was to never perform any lifting or carrying, and could stand and/or walk less than 2 hours in an 8-hour work day. Assisted devices are not medically required, and no extremity impairments were indicated. Medical findings indicated that Claimant will need long term antibiotics, and that it is likely that she will have continued problems secondary to her heart disease.

On May 6, 2005, another portable chest, single view test was run at the order of [redacted]. Same method was performed. The study revealed bibasilar infiltrative changes and effusions, and pulmonary vascular congestion. When compared with the previous examinations, no interval changes were noted. Findings may have been compatible with congestive heart failure; however, the possibility of inflammatory disease of the chest was a diagnostic possibility. (Exhibit 1, p. 75)

On May 7, 2005, [redacted] (with the assistance of [redacted]) of the radiology department performed a right upper extremity venous ultrasound and right upper extremity PICC line placement using micro puncture access techniques. The procedure was performed at patient's bedside. The area in the right upper extremity was scanned with real-time ultrasound. An appropriate brachial vein was identified. The vein was acceded and a PICC line was inserted and advanced to approximately 44 cm. The position was reviewed on the f/u chest x-ray. The tipped lied within the right atrium, and the catheter was retracted to approximately 42 cm. Normal blood return was documented. Both ports were flushed with saline, and Claimant remained stable throughout the procedure. (Exhibit 1, pp. 73 & 74)

On May 11, 2005, Claimant was again examined for shortness of breath by [redacted] Chest was examined at bedside using the mobile x-ray machine and compared to prior studies (the last dated 5/06/05). The right PICC line remained in place; however, there was still some cardiomegaly. Claimant had a worsened cardiopulmonary status. (Exhibit 1, p. 72)

On May 11, 2005, Claimant had an abdominal ultrasound performed by [redacted] with no prior study done for comparison. The findings were suggestive of acalculus cholecystitis. There were minimal perihepatic ascites and nonvisualization of the pancreas. (Exhibit 1, pp. 63-65)

On May 12, 2005, the Claimant was seen by [redacted] at the request of [redacted]. She was being seen for cardiac evaluation because of her tricuspid valve endocarditis. This doctor stated that Claimant was sedated, but that her hospital work-ups demonstrated evidence of tri-cuspid valve vegetations. Claimant was a known heroin addict and had been using cocaine, marijuana, and other drugs. She was treated, became hypertensive, and was sent to the ICU and responded to therapy. On May 11, she developed acute respiratory distress with tachycardia. Claimant was intubated and sent back to the ICU. There was evidence of septic embolization on the chest x-ray, with pneumonia and heart failure apparent. Claimant was on a ventilator at the time of this consultation. The impressions at this time were as follows: infectious endocarditis of the tricuspid valve, probable congestive heart failure, pneumonia (secondary to septic emboli), ventilator-dependent respiratory failure (secondary to pneumonia), septic shock, polysubstance abuse, coagulopathy, and hepatitis C. The Recommendations at this time were: [redacted] current therapy; a re-check echocardiogram to assess for changes in right and left ventricular function as well as valvular status; a transesophageal echocardiography at some point in the future; probable left heart catheterization to assess Claimant's coronary anatomy; and possible surgical evaluation will need to be considered. (Exhibit 1, pp. 69-71)

On May 12, 2005, Claimant had several tests run by [redacted], [redacted]. A port chest single view was run at 3:12pm, another again at 5:42pm, and a port abdomen single view at 5:42. The first test was compared to the previous portable chest dated 5/11/05. The right PICC line remained unchanged. There was no significant interval change, the test indicated congestive heart failure, and a right PICC line was identified. The chest was re-examined at 5:42, and the doctor noted interval placement of an endotracheal tube and nasofastrtic tube. The doctor also indicated that congestive heart failure was worsening. The abdomen exam was run at 5:42, which examined the nasogastric tube. It was noted that there was an unremarkable bowel gas pattern w/ no evidence of obstruction. The osseous anatomy appeared to be within normal limits. (Exhibit 1, pp. 65 & 66)

On May 12, 2005, the Claimant also had a C.T. of the brain and the thorax due to the septic emboli and pneumonia clinical indications. The brain CT revealed no evidence of acute hemorrhage, and it was essentially an unremarkable un-enhanced and enhanced CT scan of the brain. The thorax CT scan revealed interval development of pleural effusions, consolidates and infiltrates involving all segments of the lungs. There was

also a loculated fluid collection seen in the right superior aspect of the lower lobe. Questionable filling defect seen in the right peripheral mid lung zone, which indicated pulmonary embolus. Claimant had a destructive medial rib lesion of a right lower rib, small pericardial effusion, bilateral hilar and mediastinal adenopathy, and interval placement of nasogastric tube and endotracheal tube. (Exhibit 1, pp. 61 & 62)

On May 13, 2005, the Claimant received another single view portable chest x-ray. [redacted] found there to be congestive heart failure and multiple septic emboli with improved aeration at the bilateral lungs. Dr. also observed globular cardiomegaly. Pericardial effusion is a diagnostic consideration. When compared to the prior study on 5/12/05, improved aeration of the bilateral lungs was observed. (Exhibit 1, p. 60)

On May 24, 2005, Claimant was admitted to [redacted]. She was complaining of chest pains /palpitations and was seen by [redacted] and [redacted]. Upon physical examination, [redacted] reported no physical acute distress, no respiratory distress, and normal EENT. The Claimant's CVS revealed Tachycardia. The final report revealed that the Claimant had mild cardomegaly, and there could have been mild central pulmonary vascular congestion. There were also increased lung markings bilaterally, which indicated early pulmonary edema or volume overload. It was suggested that Claimant followup with chest radiograph. (Exhibit 1, pp. 221-229)

On May 31, 2005, Claimant was admitted to [redacted] for tachycardia. Assessment and Plan at the time of admittance was that Claimant had tachycardia and a history of cardiomyopathy (Claimant was to see cardiology), a history of septic pulmonary emboli, and heroin abuse (Claimant was to continue with methadone). (Exhibit 1, pp. 99 & 100)

On May 31, 2005, [redacted] performed a cardiology consultation at [redacted] on the Claimant. [redacted] found that Claimant had endocarditis (to which treatment was in progress), pulmonary embolism, persistent left chest discomfort (probably pulmonary in origin), substance abuse, and anxiety neurosis with depressive trends. The doctor noted that Claimant will be evaluated for further treatment as the case progresses. (Exhibit 1, pp. 118-121)

On May 31, 2005, [redacted] ran tests on Claimant. The tests were negative for pulmonary embolism, but Claimant had patchy infiltrates scattered in both lungs and cardiomegaly. The examination also revealed

that Claimant did not have any deep venous thrombosis or other significant pathology. (Exhibit 1, pp. 104 & 105)

On June 1, 2005, the Claimant was seen for a mental consultation by [redacted]. Diagnostic impressions of Claimant were that she had opiate dependence, situational depression, and anxiety. [redacted] recommended that Claimant see a counselor in the [redacted] program and referred Claimant to the hospital social worker for arrangements. Claimant was advised to taper off methadone, but she said she was not ready to do that. (Exhibit 1, pp. 111 & 112)

On June 2, 2005, The Claimant was seen by [redacted]wood [redacted] for tricuspid endocarditis with probable septic pulmonary emboli. After physical examination, [redacted] assessment was as follows: tricuspid endocarditis with probable septic pulmonary emboli, questionable SVC thrombus or vegetation or fibrin sheath around the PICC line; intravenous drug abuse history; and Hepatitis C. Recommendations were that they move forward with transesophageal echo to further evaluate her tricuspid valve. The doctor agreed with the therapy for her cardiomyopathy as it seemed to be improving her condition significantly. Claimant fully understood her condition and wished to do whatever is necessary to regain her health and get back out of the hospital. (Exhibit 1, pp. 113 & 115)

On June 6, 2005, Claimant was seen by [redacted] at [redacted] for her endocarditis. After a physical exam and diagnostic studies, [redacted] noted that Claimant had tricuspid valve endocarditis on long term nafcillin treatment and a possible infected PICC line (the PICC line may have vegetation). [redacted] recommended continuing nafcillin, to maintain the PICC and await the transesophageal echocardiography. (Exhibit 1, pp. 196-198)

On June 17, 2005, Claimant was referred to [redacted] by both [redacted] and [redacted] at [redacted] The impressions were that Claimant had low cortisol levels and adrenal insufficiency. The doctors suggested starting her on H[redacted] and then tapering to [redacted] in the morning and 1[redacted] at night. There was a need for further testing. The doctors opined that the etiology could have been the use of steroids in the past or from endocarditis and vascular problems. Autoimmune process was also possible. It was determined that Claimant needed to be on Hydrocortisone with taper to oral [redacted] and reevaluated in a few months when she felt better. In addition, it was recommended that her adrenal

gland be reevaluated and see if further treatment was needed. (Exhibit 1, pp. 194 & 195)

On June 28, 2005, The Claimant was seen at [redacted] for treatment of the tachycardia and infective endocarditis. Prior to this admission, she was admitted to [redacted] and was treated for acute endocarditis accompanied by septic emboli to the lung. Claimant was treated by [redacted] underwent further investigation, and was seen by a vascular surgeon, thoracic surgeon, infectious disease specialist, and an internist. Due to Claimant's hypertension at the time, [redacted] states that studies were done and findings were suggestive of Addison's disease, and an endocrinologist started [redacted] on Claimant. Surgical intervention was discussed, but lack of insurance prevented this option at the time. Claimant was afebrile, she had not been using substances, and she was in stable condition. Claimant's second heart sound was physiologically split, and the S1 was of normal intensity. There was a murmur of mitral and tricuspid regurgitation, and the latest echocardiogram demonstrated dilated left ventricle with a reduced ejection fraction of about 30-35%. Overall, office notes indicate that Claimant was in stable condition, [redacted] bid was to be continued for tachycardia as well as Altrace 2.5 mg for the low ejection fraction, and Digitek .25 mg daily. Claimant was also taking [redacted] and [redacted] pump inhibitor on a prn basis. (Exhibit B)

On July 21, 2005, Claimant was seen at [redacted] at the [redacted] by [redacted] She was diagnosed with having endocarditis, and she was seen for pre-op testing and consultation for open heart surgery. (Exhibit 1, p. 98)

On August 26, 2005, Claimant was examined at [redacted]. An Emergency Nursing Record for Respiratory Complaints indicates that Claimant's chief complaint was a cold. The evaluation reveals that Claimant was anxious and presented moderate respiratory distress as well as some wheezing. Claimant's CVS indicated tachycardia, strong pulse, and normal cap refill. Claimant had a normal ENT inspection as well as non-tender extremities, movement in all extremities, and no pedal edema. (Exhibit C)

On November 3, 2005, [redacted], completed a medical examination report for Claimant, indicating a former and current diagnosis of endocarditis. [redacted]b writes that Claimant had respiratory asthma and cardiovascular abnormalities, consisting of endocarditis. All else was normal. The doctor's clinical impression was that Claimant's condition was deteriorating, and she had physical

limitations expected to last for more than 90 days; however, no limitations related to lifting, standing/walking, or any others were indicated on the form. Claimant was currently waiting for open heart surgery. (Exhibit A)

On January 20, 2006, Claimant had a 2-D echocardiogram, M-mode, Doppler, color Flow performed. The test was performed by [redacted] and signed by [redacted] Claimant was admitted with fever, nausea, and vomiting. The chamber size and function test results were as follows: Left ventricle- normal size, thickness and systolic function with paradoxical septal motion secondary to right ventricle volume overload and an estimated ejection fraction of 55%; Left Atrium- normal size; Right ventricle- moderately dilated; Right atrium- moderately enlarged; Vessels- normal size and relationship of great vessels; Pericardium- no evidence of pericardial effusion. The valve test results were as follows: Aortic and Mitral valves- normal appearance and function; tricuspid valve- thickening of one or more tricuspid leaflets present without tricuspid stenosis, severe tricuspid regurgitation, estimated PA systolic pressure from TR velocity is 45 mm Hg, and TR flow suspicious for elevated RA V-waves; and Pulmonic value- normal valve function. (Exhibit D5)

On May 30, 2006, the Claimant was seen for an initial visit at the [redacted] and [redacted] Claimant indicated a visit to the [redacted] to see [redacted], who started a medication regimen that had improved Claimant's condition, and Claimant was doing very well. Claimant was 7-8 weeks pregnant and stated that she was having some tiredness, but otherwise doing pretty well. Claimant complained of lower extremity swelling, and the doctor indicated this could have been due to the pregnancy. Claimant also stated that she had some shortness of breath when she walked about a block or up a flight of stairs, but overall indicated she was doing very well. The physical Examination states that generally, there was no distress, her lungs were clear, and she had tachycardia, but with a regular rhythm (normal S1, S2, and no S3 or S4). Claimant also had a loud 3-4/6 systolic murmur at the left lower sternal border increased on inspiration. Claimant's extremities were found to have very minimal pitting edema to the mid shins bilaterally. Since Claimant was pregnant, the treatment plan was to obtain a 2-D echocardiogram, and at some point, a tricuspid valve replacement was needed. No changes were made to her medications. (Exhibit D1-D4)

On August 25, 2006, Claimant was examined by [redacted] OB-GYN. [redacted] indicated in his medical examination that Claimant was a 26 year old female who had recently delivered a female baby on

> July 23, 2006. [redacted] also indicated that Claimant was diagnosed with tricuspid valve endocarditis in April of 2005. Current diagnosis indicated asthma, Bell's Palsy, Tricuspid valve endocarditis, and congestive heart failure. All examination areas were normal with the exception of respiratory and cardiovascular. [redacted] clinical impression of Claimant was that she was stable. This doctor was of the opinion that Claimant should never do any lifting or carrying of any kind; she should stand/walk less than 2 hours in an 8-hour work day; and she would be able to sit for 6 hours out of an 8-hour work day with full hand/arm/feet/leg usage in both hands and feet for repetitive actions. (Exhibits E1-E2)

Controlling weight may not be given to treating source's medical opinion unless the opinion is well supported by medically acceptable clinical and laboratory diagnostic techniques. *(SSR 96-2p: Policy Interpretation Ruling, #3)*. Even if a treating source's medical opinion is well-supported, controlling weight may not be given to the opinion unless it also is '"not inconsistent" with the other substantial evidence in the case record. *(SSR-96-2p: Policy Interpretation Ruling, #4)*. 20 CFR 416.927(d)(2) defines a "treatment relationship" as follows:

> 2) *Treatment relationship.* Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (d)(2)(i) and (d)(2)(ii) of this section, as well as the factors in paragraphs (d)(3) through (d)(6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion (emphasis added).
>
> (i) *Length of the treatment relationship and the frequency of examination.* Generally, the longer a treating source has

treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if it were from a non-treating source.

(ii) *Nature and extent of the treatment relationship.* Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a non-treating source.

(3) *Supportability.* The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for an opinion, the more weight we will give that opinion. Furthermore, because non-examining sources have no examining or treating relationship with you, the weight we will give their opinions will depend on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including opinions of treating and other examining sources.

(4) *Consistency.* Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) *Specialization.* We generally give more weight to the opinion of a specialist about medical issues related to his or

> her area of specialty than to the opinion of a source who is not a specialist.
>
> (6) *Other factors.* When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the extent to which an acceptable medical source is familiar with the other information in your case record

Claimant alleges the following impairments: Endocarditis with septic pulmonary emboli, and she has a history of substance abuse. Step 2 is a *de minimus* standard. The medical evidence in this case establishes that Claimant had a severe physical impairment that could arguably affect her ability to perform basic work activities. Therefore, the analysis will continue at Step 3.

The objective medical evidence fails to establish that Claimant had a severe impairment which met or equaled any listing found at 20 CFR, Part 404, Subpart P, Appendix 1. Therefore, the analysis continues to step 4.

Appellant reported past relevant work as a waitress. (Exhibit 1, p. 129) This ALJ agrees with the previous ALJ's determination that Appellant's physical impairment prevented her from the prolonged walking and standing that a job as a waitress requires. Therefore, the analysis continues to the last step of the sequential evaluation.

This ALJ agrees that the objective medical evidence fails to establish that Claimant was precluded from doing at least sedentary work for the period relevant to this matter. As stated above, 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. A sedentary job is defined as one which involves sitting, mainly. 20 CFR 416.967(a). The laboratory data and x-ray findings do not support a finding that Claimant was unable or expected to be unable to do sedentary work for a continuous period of at least one year. According to the most recent Medical Examination Report completed by Claimant's OB-GYN in August 2006, Claimant's physical limitations were due to her shortness of breath and tiring easily. However, the OB-GYN indicated on the Medical Examination Report that Claimant's condition was stable, and Claimant was able to use both hands/arms for simple grasping, reaching, pushing/pulling and fine manipulation; and she could use her feet/legs for operating foot/leg controls. Claimant's physical examination was normal except for her respiratory and cardiovascular exam. It was recommended that Claimant undergo a tricuspid valve replacement at some point in the

future. The most recent cardiologist's report indicates that Claimant was doing better with the exception of tricuspid regurgitation. Further, it was noted that no changes were made to Claimant's medications as she appeared to be very well compensated. At the time of the hearing, Claimant was a very young individual in her 20s who was able to work 16-20 hours a week at a group home as a direct-care worker, a job that would require more than sedentary job duties. ALJ Silver correctly concluded that Claimant's cardiology consultative report dated May 30, 2006, revealed that her blood pressure was 101/69; Claimant was in no acute distress; she had no jugular vein distension; her lungs were clear; and Claimant's heart sounds were normal, except for the systolic murmur.

Medical vocational guidelines have been developed and can be found in 20 CFR, Subpart P, Appendix 2, Section 200.00. When the facts coincide with a particular guideline, the guideline directs a conclusion as to disability. 20 CFR 416.969. Claimant was considered a young individual with a high school education and unskilled work experience. 20 CFR 416.963, 20 CFR 416.964 and 20 CFR 416.968. According to Medical Vocational Rule 201.27, a young individual with a high school education and unskilled work experience, limited to sedentary work, would be considered not disabled.

In conclusion, Claimant did not meet the standard for disability as set forth in the Social Security regulations. Accordingly, the department's MA-P determination is upheld.

DECISION AND ORDER

This Administrative Law Judge, based on the above findings of fact and conclusion of law, decides that the Administrative Law Judge Silver did not err when he found that Claimant was not disabled.

IT IS THEREFORE ORDERED that:

> The Administrative Law Judge's September 26, 2006, Hearing Decision is AFFIRMED.

/s/
Marya A. Nelson-Davis
Administrative Law Judge
for Michigan Department of Human Services

cc: [redacted]

[redacted]
Order of Reconsideration
SOAHR Docket No: 2007-169
DHS Reg No: 2006-07053

[redacted]

Date Signed: November 17, 2009
Date Mailed: November 17, 2009

*****Notice*****

The The Claimant may appeal this Rehearing Decision to Circuit Court within 30 days of the mailing of this Rehearing Decision.