

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: 2008-10924

Issue No: 2009

Case No: [REDACTED]

Load No: [REDACTED]

Hearing Date:

July 30, 2008

Saginaw County DHS

ADMINISTRATIVE LAW JUDGE: Jana A. Bachman

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 on July 30, 2008. Claimant was represented by [REDACTED]

ISSUE

Whether claimant has established disability for Medical Assistance (MA).

FINDINGS OF FACT

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

- (1) October 11, 2006, claimant applied for MA and retroactive MA.
- (2) September 12, 2007, the Medical Review Team (MRT) denied claimant's application. Department Exhibit A.
- (3) September 14, 2007, the department sent claimant written notice that the application was denied. Department Exhibit C.

(4) December 13, 2007, the department received claimant's timely request for hearing.

(5) March 17, 2008, the State Hearing Review Team (SHRT) denied claimant's application. It is noted that claimant reapplied for MA and retroactive MA on November 9, 2007, and was denied by MRT on November 9, 2007. The SHRT included the medical evidence from the second application when it evaluated claimant's MA eligibility. Department Exhibit B.

(6) July 30, 2008, the in-person hearing was held.

(7) Claimant asserts disability based on impairments caused by a motorcycle accident including broken bones, disc herniation, and closed head injury.

(8) Claimant testified at hearing. Claimant is 25 years old, 5' 10" tall, and weighs 197 pounds. Claimant completed high school and is able to read, write, and perform basic math. Claimant has a driver's license and is able to drive. Claimant cares for his needs at home.

(9) Claimant returned to work as a semi-truck driver on or about March 2008. He has worked fulltime since on or about July 2008.

(10) September 14, 2006, claimant was admitted to hospital following motorcycle accident. On admission, diagnoses were blunt trauma, T-12 burst fracture, right pulmonary contusion, and substance/abuse. Objective medical testing revealed moderate spinal stenosis at L4-L5 level due to broad-based herniated nucleus pulposus; minimal spinal stenosis due to left paracentral L5-S1 herniated nucleus pulposus. Additional objective medical testing revealed collapse of portions of the right upper lobe and right lower lobe of the lungs are noted. Claimant had a splenic contusion and right pelvic fracture and acetabulum comminuted fracture. There was cardiomegaly and pulmonary effusion. On discharge on October 10, 2006, claimant was

noted to have a mild traumatic brain injury that was stable. Claimant was transferred to a rehab program. Department Exhibit A, pgs 76-136.

(11) January 23, 2007, claimant's orthopedic surgeon completed a Medical Examination Report (DHS-49) following physical examination that took place on December 16, 2006. Doctor indicates current diagnosis of status post open reduction internal fixation of burst fracture at T12. Doctor indicates a normal physical exam with the exception of wearing a TLSO due to burst fracture and back pain. Doctor indicates claimant's condition is improving. He can frequently lift less than ten pounds. He is able to stand/walk/sit as needed. He is able to perform a full range of repetitive actions with upper extremities with the exception of pushing/pulling. He is able to operate foot and legs controls with both lower extremities. Doctor notes no mental limitations. Doctor indicates that claimant has crutches and walker and may use them when necessary. Department Exhibit A, pgs 50-51.

(12) August 15, 2007, claimant underwent an independent physical examination and functional assessment. The narrative report indicates that head is normocephalic. Pupils are equal and reactive to light and accommodation. Fundi normal. Neck is supple. No thyromegaly or lymphadenopathy. Carotid pulses are normal. No bruit. JVD not evaluated. Chest is symmetrical. Breathing is vesicular. No rales or rhonchi. Good air entry bilaterally. Percussion note is resonant. Heart sounds first and second normal. No gallop or murmur. APEX beat is in the fifth intercostal space at the midclavicular line. There is a scar on both sides of the chest from previous chest tube insertion. The abdomen is soft. No palpatal mass. No tenderness, no hernia, no ascites, no bruit. No aneurysm felt. Patient is fully conscious and oriented. Cranial nerves 2-12 are normal. Motor system shows some wasting of the right leg muscle. Plantar are both downgoing. DTRs are 2+. No sensory or motor deficit present. Patient is ambulatory,

walking with a slight limp with the right leg. He is unable to touch his toes. He is able to squat completely. Arterial pulses are normal. No varicose veins, no edema of feet. No cyanosis or clubbing present. There is a scar on the back from the mid thoracic spine to the mid lumbar spine bilaterally. Patient has scoliosis to the right and tenderness in this area. Straight leg raise test is negative bilaterally. Hand grip is 140 pounds on the right side and 130 pounds on the left side. Tinel's and Phalen's signs are negative. Patient is able to open a jar, button clothing, write legibly, pick up a coin, and tie shoelaces with either hand. The right hip has mild limitation of motion. The ankle has normal limitation of motion. X-rays of the dorsal spine shows two Harrington rods placed on either side of the spine, starting at T10-L1. It appears to be in good position. Patient has a compression factor of T12 noted in this x-ray. Doctor's conclusion is after examination and no charts available to review, it appears that patient was involved in a motorbike accident when he was drunk. He broke his T12 spine which has been operated with rod fixation. He has limitation of motion of the dorsal lumbar spine. He has wasting of the right leg as a result of the injured dorsal spine. He has a history of fracture of the right hip but has very minimal limitation of motion. His pneumothorax has been resolved and he has no lung problems. Patient had a closed head injury without any neurologic deficit. He had bilateral ankle fracture which is stable. He is walking with a limp because of the spinal injury. Department Exhibit A, pgs 24-28.

(13) December 16, 2007, claimant's orthopedic surgeon wrote a letter following physical exam that took place that same day. The letter states that patient is walking independently and has apparently given up crutches, walker, and cane on his own. Patient says that he has no pain in his ankle or hip. He states the main area that bothers him is his back. Overall, he feels he continues to improve. Physical exam reveals him to be comfortable. Skin,

circulation, and strength in the lower extremities are satisfactory. Hip movement and ankle movement do not bother him. He states he has satisfactory bowel and bladder control. X-rays of the hip revealed right acetabular fracture is overall unchanged in alignment and healing. There is some pelvis asymmetry. There may be some SI joint arthritis. Two views of the right ankle revealed fracture is stable, aligned satisfactorily, and healing. Multiple x-rays of the T12 fracture revealed essentially stable unchanged in alignment with satisfactory alignment of the internal fixation and overall stable healing, progressing satisfactorily. Patient was to continue to wear his TLSO and begin taking it off for sleeping in January and then wean himself off completely by mid February. Patient's exercise remains walking. Department Exhibit A, pgs 154-155.

(14) October 27, 2007, claimant underwent a psychiatric examination and a narrative report was prepared. Axis I diagnosis was major depressive, single episode, without psychotic features; alcohol intoxication; alcohol abuse; marijuana abuse, rule out substance induced mood disorder. Patient was apparently brought to hospital after sustaining lacerations due to ramming his head against a mirror. Wounds were healed and staples were inserted. The rest of physical exam was within the normal range. Mental status exam revealed cooperative patient with good eye contact. Hygiene and grooming were poor. Speech was normal in rate and volume. Mood is depressed with constricted affect. Patient denies any current suicidal or homicidal ideation, intent or plan. Thought processes are logical and coherent. No delusional thoughts. Patient has average IQ. Insight and judgment are fair. Department Exhibit A, pgs 5-6.

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).

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).

For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph (B) of the listings for mental disorders (descriptions of restrictions of activities of daily living, social functioning; concentration, persistence, or pace; and ability to tolerate increased mental demands associated with competitive work).... 20 CFR, Part 404, Subpart P, App. 1, 12.00(C).

If an individual fails to cooperate by appearing for a physical or mental examination by a certain date without good cause, there will not be a finding of disability. 20 CFR 416.994(b)(4)(ii).

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 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).

At Step 1, claimant has been engaged in substantial gainful activity since on or about March 2008.

At Step 2, the objective medical evidence of record establishes that claimant sustained multiple injuries and fractures in a September 2006 motorcycle accident. Claimant was hospitalized, underwent multiple surgeries, and rehabilitation treatment. In December 2007, claimant's orthopedist indicates that claimant is doing well and has no neurologic deficits. He has some muscle wasting in the right leg and some pelvic asymmetry. He reports his main problem is pain in his back. Independent physical exam that took place in August 2007 revealed that patient has limitation of motion in the dorsal lumbar spine and wasting of the right leg as a result of the injured dorsal spine. Right hip has very minimal limitation of motion. Pneumothorax and closed head injury are resolved. Bilateral ankle fracture is stable. Patient walks with a limp due to spinal injury. In December 2006, claimant's orthopedic surgeon advised claimant to walk as exercise and advised to wean off the TSLO. Doctor did not indicate severe impairments due to any physical or mental condition with the exception of inability to lift ten pounds and inability to push/pull maneuvers with his upper extremities. Patient was briefly hospitalized due to single

episode of depression and polysubstance abuse. Mental status exam was within normal limits.

Finding of Fact 10-14.

At Step 2, the objective medical evidence of record is not sufficient to establish that claimant has severe impairments that have lasted or are expected to last 12 months or more and prevent employment at any job for 12 months or more. Therefore, claimant is disqualified from receiving disability at Step 2.

At Step 3, claimant's impairments do not rise to the level necessary to be specifically disabling by law.

At Step 4, claimant's past relevant employment has been as a semi-truck driver. Claimant returned to work on or about March 2008. The objective medical evidence of record contains no indication that claimant was physically or mentally unable to return to work prior to that date. See discussion at Step 2 above. Finding of Fact 9-14.

At Step 4, the objective medical evidence of record is not sufficient to establish that claimant has functional impairments that prevent claimant, for a period of 12 months or more, from engaging in a full range of duties required by claimant's past relevant employment. Therefore, claimant is disqualified from receiving disability at Step 4.

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).

Medium work. Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work. 20 CFR 416.967(c).

Heavy work. Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work. 20 CFR 416.967(d).

At Step 5, see discussion at Step 2 above. Finding of Fact 10-14.

At Step 5, the objective medical evidence of record is sufficient to establish that claimant retains the residual functional capacity to perform at least light work activities. Considering claimant's Vocational Profile (younger individual, high school education, and history of

semi-skilled work) and relying on Vocational Rule 202.21, claimant is not disabled. Therefore, claimant is disqualified from receiving disability at Step 5.

Claimant does not meet the federal statutory requirements to qualify for disability. Therefore, claimant does not qualify for Medical Assistance based on disability and the department properly denied claimant's application.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that claimant has not established disability for Medical Assistance.

Accordingly, the department's action is, hereby, UPHELD.

/s/

Jana A. Bachman
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: May 5, 2010

Date Mailed: May 6, 2010

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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