[redacted]

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.: 2008-17496
Issue No.: 2009, 4031
Case No.: [redacted]
Load No.: [redacted]
Hearing Date:
September 2, 2008
Wayne County DHS [redacted]

ADMINISTRATIVE LAW JUDGE: Judith Ralston Ellison

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, the Claimant appeared at a hearing held on September 2, 2008 at the Department of Human Service (Department) in Wayne County.

The closing date was waived' and Interim Order was issued for additional medical records. Medical records were received by the State Hearing Review Team (SHRT); and the application was denied. The matter is now before the undersigned for final decision.

ISSUES

Whether the Department properly determined the Claimant is "not disabled" for purposes of Medical Assistance based on disability (MA-P) and State Disability Assistance program?

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 July 10, 2007 the Claimant applied for MA-P and SDA.

(2) On March 6, 2008 the Department denied the application; and on March 26, 2009 the SHRT guided by Vocational Rule 201.27, denied the application finding the impairment did not preclude unskilled sedentary work.

(3) On April 4, 2008 the Claimant filed a timely hearing request protesting the determination of the Department.

(4) Claimant's date of birth is [redacted]; and the Claimant is forty-seven years of age.

(5) Claimant completed grade 11 and GED; and can read and write English and perform basic math.

(6) Claimant last worked in 2004 as a janitor at [redacted]; and then was incarcerated until [redacted]

(7) Claimant has alleged a medical history of left foot infection beginning while incarcerated, right and left ulcers on bottom/sides of feet with difficulty walking; and wearing non-weight bearing rocker shoe, osteomylitis in both feet and neuropathy in feet and hands for five years, hypertension with right/left retinopathy, shortness of breath at night, diabetes and bladder frequency and depression and taking Paxil for one year.

(8) [redacted], in part:

> HISTORY: GSW in [redacted], three bullets, left arm, chronic back pain, hypertension, DM with blood sugars 80-480.
>
> CURRENT DIAGNOSIS: High Cholesterol on medications now. Foot ulcers bilaterally. Hypertension. Left/right foot osteomylitis.
>
> HT: 69", WT 295 pounds, BP 162/84, Visual acuity best corrected right 20/200, left 20/50.
>
> NORMAL FINDINGS: General, HEENT, Respiratory, Cardiovascular, Abdominal, Mental.
>
> FINDINGS: Obesity, Musculoskeletal range of motion 45. Bandage around left foot.

CLINICAL IMPRESSION: Stable.

PHYSICAL LIMITATIONS: Limited and expected to last 90 and over. Lifting/carrying up to 20 pounds 1/3 of 8-hour day; stand and/or walk less than 2 hours in 8-hour day; sit about 6-hours in 8 hour day; use of both hands/arms for simple grasping, reaching, pushing/pulling, fine manipulating; no use of either feet/legs for operating foot controls. No medical need for walking aid.

FINDING ABOVE LIMITATIONS: Ulcers left foot plantar surface with bandage change daily. No Mental limitations with history of depression. Medications glucophage micromax, catapres, lasix, anti-biotic lotion.

MEDICAL NEEDS: Pt is non-ambulatory; and needs daily bandage change left foot. [redacted]. DE 1, pp. 4-6

(9) [redacted], in part:

[redacted]: Presented with ulcer. Physical Examination: Well nourished, well developed, no acute distress, no deformities, normal grooming and hygiene. Cardiovascular: No clubbing, venous status dermatitis, normal hair growth left/right leg, edema, varicosities, Capillary refill less than 3 seconds toes 1-5 bilateral. Warm toes to tibial tubercle. Left and right radial pulse 2/4, left and right posterior tibial pulses, left and right dorsalis pedic pulse 2/4.

Findings: Ulcer, forefoot, plantar left foot. Wagner grade 2 resolved lateral incision 6mm diameter with 4mm depth, good capillary bleeding identified, granular base, hyperkeratosis and serous drainage. Diagnosis: Ulcer of part of foot. Diabetic neuropathy type II. Instructions: debridment full thickness to bleeding base and redressed with garamycin and gauze to continue. Accommodate insole full time. Stay off foot, no excessive walking. [redacted]. DE N, pp. 1-2.

[redacted]: Currently undergoing continued therapy and wound care for left chronic foot ulcerations and infection. He was hospitalized last month for cellulites and abscess with risk of sepsis and loss of limb due to diabetes. Suffers from hammertoe deformities with contracted MPJs and friction callous to left plantar of foot with low grade neuropathy due to diabetes. Callus results in ulceration, infections and persistent pain. Ulcer is still

> open. Weight bearing in Cam shoe with daily dressings being provided by [redacted] and [redacted]. DE N, pp. 3.
>
> [redacted] Diagnosed with diabetes in [redacted]; and used both insulin and pills. Blood sugars have been 130-140. Developed foot ulcers in prison in [redacted]. Diagnosed with osteomylitis in left foot and on prolonged oral anti-biotics. Ulcers healed in prison before release in [redacted]. But have re-occurred on left foot. Sees podiatrist and has daily dressing changes. Takes Vicodin for pain. Hospitalized in [redacted] and had left foot surgery. EMG and nerve conduction studies diagnosed diabetic neuropathy.
>
> PHYSICAL EXAMINTION: Vital signs: HT 72", WT: 275, BP 130/80. Visual acuity with glasses right eye 20/200 and 20/40 left eye. HEENT, Neck, Lungs, Abdomen, Musculoskeletal, Nervous system: [all within normal limits.] Except: Tenderness right shoulder with range of motion less than normal. Right foot has riding of right littlie toes over fourth toe. Left foot reveals use of surgical shoe. Scar left sole with small ulcer sole of left foot with dressing to cover. Gait: Walks with limp left side. Unable to walk on heels, tiptoes or tandem. Unable to squat. Both knee and ankle reflexes are absent. Plantar reflex missing left side. Light touch is decreased over both feet.
>
> IMPRESSION: recurrent left foot ulceration. Left foot pain. Diabetic neuropathy. Chronic right shoulder pain with decreased range of motion. Based on today's examination, the Pt should be able to work seated. Limitations with standing and walking secondary to left foot ulceration as well as diabetic neuropathy. Should sit after standing for 30 minutes. Good hand grip and can use hands for manipulation. No limits in hearing or speaking. [redacted]. DE N, pp. 4-8.

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 400.1 *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).

Federal regulations require that the department use the same operative definition for "disabled" as used for Supplemental Security Income (SSI) under Title XVI of the Social Security Act. 42 CFR 435.540(a)

"Disability" is:

> . . . the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months . . . 20 CFR416.905

In determining whether an individual is disabled, 20 CFR 416.920 requires the trier of fact to follow a sequential evaluation process by which current work activity; the severity of impairment(s); residual functional capacity, and vocational factors (i.e., age, education, and work experience) are assessed in that order. A determination that an individual is disabled can be made at any step in the sequential evaluation. Then evaluation under a subsequent step is not necessary.

First, the trier of fact must determine if the individual is working and if the work is SGA. 20 CFR 416.920(b) In this case, under the first step, Claimant testified to not performing SGA since 2004. Therefore, the Claimant is not disqualified from MA at step one in the evaluation process.

Second, in order to be considered disabled for purposes of MA, a person must have a "severe impairment" 20 CFR 416.920(c). A severe impairment is an impairment which significantly limits an individual's physical or mental ability to perform basic work activities. Basic work activities mean the abilities and aptitudes necessary to do most jobs. Examples 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)

The purpose of the second step in the sequential evaluation process is to screen out claims lacking in medical merit. The court in *Salmi v Sec'y of Health and Human Servs*, 774 F2d 685 (6th Cir 1985) held that an impairment qualifies as "non-severe" only if it "would not affect the claimant's ability to work," "regardless of the claimant's age, education, or prior work experience." *Id.* At 691-92 Only slight abnormalities that minimally affect a claimant's ability to work can be considered non-severe. *Higgs v Bowen*, 880 F2d 860, 862 (6th Cir. 1988); *Farris v Sec'y of Health & Human Servs*, 773 F2d 85, 90 (6thCir 1985)

In this case, the Claimant has presented sufficient medical evidence to support a finding that Claimant has more than minimal physical limitations that would affect abilities to perform basic work activities more than minimally. See finding of facts 8-9. There were no medical records that established mental impairments that prevented basic work activities. See finding of facts 8-9

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's impairment is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. Based on the hearing record, the undersigned finds that the Claimant's medical record does not support findings that the Claimant's impairments are "listed impairment(s)" or equal to a listed impairment. 20 CFR 416.920(a) (4) (iii) According to the medical evidence, alone, the Claimant can not be found to be disabled.

The medical records establish decreased range of motion of the right shoulder, right toe deformities, left foot ulcerations, best corrected right eye vision of 20/200, loss of right and left knee and ankle reflexes and loss of sensation of the right and left feet. See finding of fact 9.

Appendix I, Listing of Impairments (Listing) discusses the analysis and criteria necessary to a finding of a listed impairment. Listing 1.00 *Musculoskeletal System* discusses that the medical records must establish the severity and intent of the listing; and under this listing is loss of function. [redacted] opines that the Claimant can perform a sitting job; and that with his upper extremities the actions of fine and gross motor movements can be performed. There was no loss of strength in the upper extremities.

In this case, this Administrative Law Judge finds the Claimant is not disabled at the third step for purposes of the Medical Assistance (MA) program because the medical records do not establish the intent and severity of Listing 1.00. Sequential evaluation under step four or five is necessary. 20 CFR 416.905

In the fourth step of the sequential evaluation of a disability claim, the trier of fact must determine if the Claimant's impairment(s) prevents Claimant from doing past relevant work. 20 CFR 416.920(e) Residual functional capacity (RFC) will be assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what you can do in a work setting. RFC is the most you can still do despite your limitations. All the relevant medical and other evidence in your case record applies in the assessment. See 20 CFR 416.945.

Claimant's past relevant work was performing janitorial services in 2004. The medical records established partial upper extremity function but lower extremity function was impaired. Thus the Claimant cannot return to past relevant work as a janitor. Further, given the medical

records and the establishment of decreased range of motion of the right shoulder, right toe deformities, left foot ulcerations, best corrected right eye vision of 20/200, loss of right and left knee and ankle reflexes and loss of sensation of the right and left feet; the undersigned decides the Claimant cannot return to any other work at the present time. Based on the medical record evidence, the undersigned decides the Claimant is "disabled" at step four because he cannot return to past relevant work or return to other work with the established multiple impairments.

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 1939 PA 280, as amended. The Department of Human Services (formerly known as the Family Independence Agency) administers the SDA program pursuant to MCL 400.1 et seq., and MAC R 400.3151-400.3180. Department policies are found in the Program Administrative Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM).

A person is considered disabled for purposes of SDA if the person has a physical or mental impairment which meets federal SSI disability standards for at least ninety days. Receipt of SSI or RSDI benefits based on disability or blindness or the receipt of MA benefits based on disability or blindness (MA-P) automatically qualifies an individual as disabled for purposes of the SDA program. Other specific financial and non-financial eligibility criteria are found in PEM 261.

In this case, there is sufficient evidence to support a finding that Claimant's impairments meet the disability requirements under SSI disability standards or prevent past relevant work and other work for ninety days. This Administrative Law Judge finds the Claimant is "disabled" for purposes of the SDA program.

DECISION AND ORDER

The Administrative Law Judge, based on the findings of fact and conclusions of law, decides that the Claimant is "disabled" for purposes of the Medical Assistance based on disability and State Disability Assistance programs.

It is ORDERED; the Department's determination in this matter is REVERSED.

. Accordingly, The Department is ORDERED to initiate a review of the July 2007 application to determine if all other non-medical eligibility criteria are met. The Department shall inform Claimant of its determination in writing. Assuming Claimant is otherwise eligible for program benefits, the Department shall review Claimant's continued eligibility for program benefits in March 2010.

__/s/_____
Judith Ralston Ellison
Administrative Law Judge
For Ishmael Ahmed, Director
Department of Human Services

Date Signed: _04/01/09__

Date Mailed: _04/01/09___

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.

JRE/jlg

cc: [redacted]