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FOR THE DEPARTMENT OF HUMAN SERVICES
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IN THE MATTER OF:

SOAHR Docket No. 2008-32432 REHD
DHS Req. No: 2008-32415

[redacted]

Claimant

_____

RECONSIDERATION DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 24.287(1) and 1993 AACS R 400.919 upon the request of the Claimant.

ISSUE

Did the Administrative Law Judge err when she found that the Claimant was disabled and eligibility for Medical Assistance (MA-P), and Retroactive Medical Assistance (Retro 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 22, 2008, Administrative Law Judge (ALJ) Marlene Magyar issued a Hearing Decision in which the ALJ reversed the Department of Human Services (DHS) denial of the Claimant's April 29, 2005, application for MA-P and SDA.

2. On September 29, 2008, the State Office of Administrative Hearings and Rules (SOAHR) for the Department of Human Services received a Request for Rehearing/Reconsideration.

3. On November 20, 2008, SOAHR granted the DHS Request for Rehearing/Reconsideration and issued an Order for Reconsideration.

4. Findings of Fact 1-16 from the Hearing Decision, mailed on September 23, 2008, excluding Findings of Fact 8, 9 and 10 ,are hereby 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 400.105; 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. 20 CFR 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.

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 <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, §§ 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 correctly found that the Claimant is not ineligible for disability because she was not substantially gainfully employed. (*See Finding of Fact 2 of the September 22, 2008, Hearing Decision)*. The ALJ correctly considered the Claimant's disability at Step 2.

On April 26, 2005, the Claimant applied for MA-P and Retro MA-P. On June 2, 2005, the Medical Review Team (MRT) reviewed the Claimant's application and medical file and found the Claimant was not disabled. The MRT denied MA-P because the Claimant did not have severe impairment which had lasted or was expected to last for 12 continuous months.

On August 11, 2006, the State Hearing and Review Team (SHRT) found the Claimant was not disabled and denied the Claimant's application for MA-P and Retro MA- P.

On December 14, 2006, a hearing was convened and the hearing record was held open to receive new medical information. The evidence in the record shows that the Claimant was given a hearing where the Claimant was given the opportunity to present medical evidence and contest the DHS determination that the Claimant was not disabled

Subsequently, on March 20, 2007, the Claimant's medical file was returned to SHRT with new medical information.

On April 16, 2007, the State Hearing and Review Team (SHRT) once again found the Claimant was not disabled and denied the Claimant's application for MA-P because the Claimant had the residual functional capacity to perform a wide range of unskilled medium work.

On May 31, 2007, ALJ Ivona Rairigh issued an Order of Dismissal which dismissed the Claimant's request for hearing. ALJ Rairigh concluded that the Claimant's request for

hearing was not submitted within 90 day of the mailing of the DHS notice of denial. This Order was issued after and not before the December 16, 2006 hearing, after the hearing record was open to receive new medical information and after the SHRT reviewed the new medical information and concluded the Claimant was not disabled.

On June 12, 2007, SOAHR received the Claimant's request for rehearing/reconsideration. On July 18, 2007, SOAHR issued an Order of Dismissal of the Claimant's request for rehearing/reconsideration.

Subsequently, the Claimant appealed the Order of Dismissal to the [redacted]. On April 15, 2008, the [redacted] issued an order remanding the case back to SOAHR. The Order of Remand directed SOAHR to reinstate the hearing request and schedule a hearing on the substantive issue whether or not the claimant was disabled. A new hearing was ordered despite the fact that a hearing had been convened on December 16, 2006, and hearing record already existed on the issue of disability. In order to comply with the remand order SOAHR scheduled a second disability hearing with a second ALJ. The [redacted], in it's order, failed to recognize that ALJ Rairigh's May 31, 2007, Order of Dismissal was issued after the Claimant was given a disability hearing, was allowed to submit additional medical information and after that medical information was considered by the SHRT in its April 16, 2007 decision.

On August 19, 2008, ALJ Magyar convened a hearing and began a second disability hearing record with the same medical information which had been submitted before the December 2006, hearing and before the April 16, 2007 SHRT decision. During the hearing the Claimant submitted new medical information which the Claimant believed had not been reviewed by the SHRT. On August 20, 2008, the ALJ sent the Claimant's medical information to SHRT for a third review.

On August 21, 2008, the SHRT for the third time found that the Claimant was not disabled and denied the Claimant's application for MA-P because the Claimant had the residual functional capacity to perform a wide range of unskilled medium work.

On September 22, 2008, ALJ Magyar issued a Hearing Decision in which she reversed the DHS decision that the Claimant was not disabled. On September 29, 2008, SOAHR received the DHS request for rehearing/reconsideration. On November 20, 2008, SOAHR issued an Order of Reconsideration which granted the DHS request.

The Claimant alleges the following impairments: Post laminectomy for excision of an intra spinal lesion, T9 vertebroplasty compression fracture, chronic back pain, GERD muscle weakness and spasm. The medical evidence presented shows that on [redacted], the Claimant was admitted to [redacted] for a laminectomy for excision of intra spinal lesion other than neoplasm, extradural thoracic. Department Exhibit p 113. The Admission Summary indicates that the Claimant's presenting

problems were five month history of numbness and tingling in her lower extremities. On January 13, 2005, the Claimant was discharged with a return to work date of April 1, 2005. The discharge report indicates that the Claimant underwent spinal angiogram and embolization of the T9 lesion without complications. Her discharge was noted to be " routine". Department exhibit p 112.

On [redacted], the Claimant's physician, [redacted], indicated in her office notes "this is a 6-week post radiological procedure for an aggressive thoracic T9 hemangioma which was treated with absolute alcohol. Amanda has been doing noticeably better since then. She really feels quite well. Has still a little bit of residual weakness but clearly is improving on a regular basis. She had an MRI done recently which demonstrates that there is no further impingent on the thecal sac or neural foramina but it sill look like she is going to need a second procedure… The issue that comes up today is that she has problems with her insurance that will need to get into and investigate..". Department exhibit p 91,

The medical records submitted by the Claimant do not include a report which details the MRI results referenced by [redacted] in her [redacted], note.

On [redacted], the Claimant was admitted to [redacted]. According to the Discharge Summary completed by [redacted], the Claimant was admitted with a presenting problem of T9 compression fracture and ostenecrosis at levels T8 and T10 vertebral bodies. [redacted] performed a selective embolism of artery and Kyphoplasty. The operative and post operative summaries indicate that "the patient tolerated the procedure well. Post surgically, she was transferred over to neurosurgical floor. On post operative exam, the patient had good strength in bilateral lower extremities. On post operative CT scan, the patient had nice placement of cement. The patient continued to do well and she was discharged home in good condition." Claimant's exhibit B

The post operative CT scan results referenced by [redacted] in the Discharge Summary were not included in the medical records provided by the Claimant. The medical records provided by the Claimant do include one post operative MRI scan result. On June 29, 2005, the Claimant underwent a MRI scan of her spine at [redacted] provided a radiology consultative report. [redacted] indicated in his report that the examination was a follow-up to vertebral hemangioma status post kyphoplasty and embolization. [redacted] compared the [redacted], results with the [redacted], MRI results. [redacted] indicated that:

> In comparison with a prevision examination on 02/19/05 there have been intervening kyphoplasties performed at the T8, T9 and T10 levels. There has been an interval evolution of a mild lower thoracic kyphosis with apex at the T9 level. The sagittal AP diameter of the osseous spinal canal appears to remain within normal limits but there is persistent enhancing paraspinous soft tissue mass with epicenter at

> the T 9 level more prominent on the left and similar to the previous study of 02/19/05… There is and obliteration of the T-8-9 and T9-10 disc spaces but the T7-8 and T10-11 discs appear normal in appearance. The remaining vertebrate , disc spaces and posterior elements all appear normal and the thoracic thecal sac and content appear normal above and below the T- 9 level. Department Exhibit 2 p13.

The 2005 post-operative medical documentation is sparse. There is no post-operative medically determined evidence which supports a finding that the Claimant's pre-operative physical limitations associated with her back impairment lasted continued for 12 continuous months or were expected to last for 12 continuous months. The Claimant provided no evidence that she had physical limitations as the result of her January or May 2005, surgeries which lasted or were excepted last for 12 continuous months. Therefore, even if the medical evidence indicated that the Claimant's back impairment significantly limited her ability to engage in basic work there is insufficient evidence to conclude that those arguably severe limitations met the 12 months disability determination duration requirement. In addition, the Claimant indicated in two [redacted] sheets that she was employed and working for [redacted] prior to her September 2006, admissions. This information indicates that sometime after the Claimant's May 2005, surgery and before her 2006, hospital admissions and surgery, the Claimant had returned to work.

The medical evidence shows that the Claimant had an impairment of her gallbladder/liver which was totally unrelated to her back impairment. On February 27, 2006, the Claimant underwent an ultrasound of the abdomen in response to her complaints of upper quadrant pain and jaundice. [redacted] indicated in his report that the Claimant's liver appeared hyperchoic. [redacted] impression was Cholelithiais.

On February 28, 2006, the Claimant underwent a MR of her abdomen. [redacted], [redacted]., indicated in his report that the Claimant's liver, pancreas, spleen, adrenals, kidneys, and bowel look unremarkable. [redacted] indicated that his impression was Choledocholithaisis with two gall stones in the dilated common hepatic duct, normal-appearing gall balder and common bile duct.

On [redacted], the Claimant was admitted to [redacted] due to upper quadrant pain. The admission diagnosis was obstructive jaundice. [redacted] indicated in his Discharge Summary that the Claimant had a fibrotic stenosis of the common bile duct. A stent was successfully placed and the Claimant was discharged on March 5, 2006.

On [redacted], the Claimant's treating physical [redacted] [redacted] completed a DHS-49 Medical Examination Report. [redacted] indicated on this form

that the Claimant was normal in all examination areas. [redacted] indicated that Claimant's condition was improving with a return to work date of March 31, 2006. [redacted] indicated on page two of the report that the Claimant could frequently list 25 lbs and occasionally 50 lbs or more, could stand and/or walk 6 hours in an 8 hours day and had full use of her hands arms leg and feet. The physical limitation noted on page two of the report are inconsistent with the information provided on page one. There is no supporting medically determined evidence which supports [redacted] opinion with regard to the Claimant's physical limitations. [redacted] indicated in his report "Pt was disabled totally until hemagioma was txd. She is currently not disabled". Department Exhibit 3 pp.2-3.

On August 7, 2006, the Claimant was admitted to [redacted]. [redacted] indicated in his admission report that the Claimant was suffering from Cholethiasis choedocholithiasis (gull stones). [redacted] scheduled laparoscopic cholecystectomy and common duct exploration surgery for [redacted]. On [redacted] completed the Discharge Summary. [redacted] indicated in this report that the Claimant Discharge diagnosis was choledocholithiasis with removal of the choledocholithiasis and gall bladder and acute pancreatitis with abdominal peritonitis. [redacted] indicated that the surgery was successful and the Claimant was sent home in satisfactory condition. The operative and post-operative reports were not provided by the Claimant and are not part or the record. It is not clear why this information was not submitted by the Claimant.

On [redacted], the Claimant was admitted to [redacted] for further evaluation and treatment of a sub hepatic abscess. [redacted] completed the Admission Summary. Claimants Exhibit p 4. The Claimant was discharged on September 11, 2006.

On [redacted], the Claimant was readmitted to [redacted] because of increased drainage from her drainage tube in her right abdomen. The admission summary indicated that the Claimant's admission diagnosis was status post cholecystectomy and sub hepatic abscess. [redacted] indicated in his [redacted], report that the Claimant was diagnosed with cellulitis of the abdomen. On [redacted], the Claimant was discharged from [redacted] with a discharge diagnosis of sub hepatic abscess, post cholecystectomy and T-tube placement. [redacted] completed the Discharge Summary. Claimant's exhibit p 20.

On [redacted], the Claimant indicated on a [redacted] Patient information sheet that she was employed with [redacted].

On [redacted], the Claimant indicated on a [redacted] report that she was employed with [redacted]. Claimant's Exhibit p 21.

On [redacted], surgeon, completed a DHS 49 Medical Examination Report. [redacted] indicated in the form that he last examined the Claimant in [redacted]. [redacted] diagnosed the Claimant's condition as persistent abscess with pertuaneous drainage tube. [redacted] indicated in page one of the form that, save the Claimant's abdomen, the Claimant was normal in all other examination areas. On page two of this report [redacted] indicated that the Claimant could frequently lift 20 lbs, could stand and/or walk about 6 hours in an 8-hour's day, could use both hands and arms for grasping, reaching, pushing/pulling and fine manipulation and could use both arms and legs for the operation of foot and leg controls. The Claimants abscess was being treated with antibiotics.

On [redacted], completed a DHS-49 Medicaid Evaluation Report. [redacted] indicated in this report that the Claimant was normal in all major body areas except the Claimant's abdominal area. The report indicated that the Claimant had a drain in the right sub hepatic area to drain an abscess. [redacted] indicated that the Claimant could frequently lift less than 10 lbs ,could stand and/or walk less than 2 hours per day in a 6-hours day, and could use both hands and arms for grasping, reaching pushing, pulling and fine manipulation. The doctor indicated that the Claimant could use neither of her feet or legs to operate foot or leg controls. The physical limitations listed on page two of this report are not consistent with the information provided on page one of the reports. Medical information which is internally inconsistent and not supported by other medically determined evidence cannot be given any weight.

The medical evidence shows that the onset of the Claimant's liver and gall bladder impairment was March 2006. There is no evidence that this impairment had an onset date earlier than March 2006. The medical evidence shows that the Claimant's intra spinal lesion and fractured vertebrae were successfully treated in January and May 2005. While the Claimant may have had physical imitations following her January and May 2005, surgery the Claimant failed to provide medical opinions from qualified sources which detailed and supported each opinion regarding the Claimant's post-surgical physical limitations. [redacted] indicated in his [redacted], report that he examined the Claimant on [redacted], (Claimant was born on October 4, 1981) and then again on [redacted]. This is good evidence that [redacted] had not established an ongoing treatment relationship with the Claimant and his review and assessment of the Claimant's condition was limited and not entitled to controlling weight.

The evidence provided in the January 2, 2007, Medical Examination Report completed by [redacted] indicated that as of [redacted], five months after her [redacted], and [redacted], surgery, the Claimant had a sub hepatic abscess and was being treated with antibiotics. [redacted] opined that the Claimant's sub hepatic abscess created exertional limitations in the Claimant's hands, arms, feet and legs. There is no medical evidence that the Claimant had any medically determined impairment of her hands,

arms, feet, and legs. The Claimant's alleged physical limitations as noted by [redacted] are inconsistent with the Claimant's diagnosed condition and are not support by medically determined evidence. In addition, the alleged limitations noted were only for the period from March 2006 to January 2007. The Claimant provided no medically determined evidence which adequately and consistently documents that the Claimant had exertional limitations which lasted or were expected to last 12 continuous months from March 2006. Therefore, there is insufficient evidence to conclude the Claimant's arguably severe liver/gall bladder impairments lasted or were expected to last for 12 continuous months from March 2006.

The medical evidence shows that the Claimant had a back impairment and liver or gall bladder impairment both of which required several hospitalizations. There is no medically determined evidence that these impairments were related impairments. Each impairment had a unique etiology and resulted in a separate distinct diagnosis and treatment regime. Federal regulations at 20 CFR 416. 922 provide that two or more unrelated impairments may not be combined to meet the 12 months disability duration requirement. These regulations provide in pertinent part

> a) *Unrelated severe impairments.* We cannot combine two or more unrelated severe impairments to meet the 12-month duration test. If you have a severe impairment(s) and then develop another unrelated severe impairment(s) but neither one is expected to last for 12 months, we cannot find you disabled, even though the two impairments in combination last for 12 months.
>
> (b) *Concurrent impairments.* If you have two or more concurrent impairments which, when considered in combination, are severe, we must also determine whether the combined effect of your impairments can be expected to continue to be severe for 12 months. If one or more of your impairments improves or is expected to improve within 12 months, so that the combined effect of your remaining impairments is no longer severe, we will find that you do not meet the 12-month duration test. 20 CFR 416.922

Regulations at 20 CRF 416.923 provide further information regarding disability determinations which involved multiple impairments.

> In determining whether your physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under the law, we will consider the combined effect of all of your impairments without regard to whether any such

> impairment, if considered separately, would be of sufficient severity. If we do find a medically severe combination of impairments, the combined impact of the impairments will be considered throughout the disability determination process. If we do not find that you have a medically severe combination of impairments, we will determine that you are not disabled (see §§416.920 and 416.924). 20 CFR 416.923

There is no medical evidence that the Claimant had concurrent impairments and the combination of those impairments continued or was expected to continue for 12 continuous months. ALJ Magyar erred when she combined the Claimant's unrelated impairments and concluded that the combination of the Claimant's impairments lasted or were expected to last 12 continuous months. The medical evidence shows that Claimant impairments neither individually, nor in combination had lasted, nor were expected to last 12 continuous months or more. The Claimant's vertebral hemangioma and liver/gallbladder impairments significantly limited the Claimant's ability to perform basic work and therefore, were severe impairments. However neither of those impairments, nor the combination of those impairments met the disability durational requirement.

The ALJ erred when she found that the Claimant was disabled at Step 2. A finding of a severe impairment at Step 2 is a *de minimus* standard and the ALJ correctly considered the Claimant's eligibility at step 3.

The Claimant may be found disabled at Step 3 if the Claimant's physical or mental impairments meet or equal the requirements for the Social Security listings. The Claimant's impairment of vertebral hemangioma status post kyphoplasty and embolization could arguably meet or equal a Social Security Administration disability listing.

The medical evidenced presented shows that on [redacted], the Claimant was admitted to [redacted] for a laminectomy for excision of intra spinal lesion other than neoplasm, extradural thoracic. Department Exhibit p 113. The Admission Summary indicates that the Claimant's presenting problems were five month history of numbness and tingling in her lower extremities. On January 13, 2005, the Claimant was discharged with a return to work date of April 1, 2005. The discharge report indicates that the Claimant underwent spinal angiogram and embolization of the T9 lesion without complications. Her discharge was noted to be "routine". Department exhibit p 112

On [redacted], the Claimant was admitted to [redacted]. According to the Discharge Summary completed by [redacted], the Claimant was admitted with a presenting problem of T9 compression fracture and ostenecrosis at levels T8 and T10 vertebral bodies. [redacted] performed a selective embolism of artery and Kyphoplasty.

The operative and post-operative summaries indicate that “the patient tolerated the procedure well. Post surgically, she was transferred over to neurosurgical floor. On post operative exam, the patient had good strength in bilateral lower extremities. On post operative CT scan, the patient had nice placement of cement. The patient continued to do well and she was discharged home in good condition.”. Claimant’s exhibit B

The Claimant may be found disabled if the Claimant’s spine impairment meets or equals the requirements for listing 1.04. Listing 1.04 provides the listing requirements for Disorders of the Spine:

> **1.04 Disorders of the Spine** (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet, and vertebral fracture), resulting in compromise of a nerve root (including the cauda equina) or the spinal cord. With:
>
> A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine);
>
> OR
>
> B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by sever burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours;
>
> OR
>
> C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00(B)(2)(b).

The medical documentation provided shows that the Claimant had an intra spinal lesion which was successfully treated with surgery. The evidence also shows that the Claimant’s T9 compression fracture and ostenecrosis at levels T8 and T10 vertebral bodies. It was successfully surgically treated. The medical evidence presented shows

that the post-surgically condition of the Claimant's spine did not meet nor equal the requirements of listing 1.04.

Listing 1.04C is met or equaled if the Claimant has the required condition and that condition resulted in an inability to effectively ambulate. Listing 1.00 (B)(2)(b) defines ambulation as follows:

> (1) Definition. Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. Ineffective ambulation is defined generally as having insufficient lower extremity functioning (see 1.00J) to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities. (Listing 1.05C is an exception to this general definition because the individual has the use of only one upper extremity due to amputation of a hand.)
>
> (2) To ambulate effectively, individuals must be capable of sustaining a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living. They must have the ability to travel without companion assistance to and from a place of employment or school. Therefore, examples of ineffective ambulation include, but are not limited to, the inability to walk without the use of a walker, two crutches or two canes, the inability to walk a block at a reasonable pace on rough or uneven surfaces, the inability to use standard public transportation, the inability to carry out routine ambulatory activities, such as shopping and banking, and the inability to climb a few steps at a reasonable pace with the use of a single hand rail. The ability to walk independently about one's home without the use of assistive devices does not, in and of itself, constitute effective ambulation

The evidence provided shows that post-surgery the Claimant was unable to ambulate effectively However the Claimant did regain her ability to ambulate effectively within 12 months of her surgery. There is no evidence that the Claimant was not ambulating effectively in December 2005.The Claimant's spinal impairments do not meet or equal listing 1.04 A, B, or C.

The Claimant's liver impairment could arguably meet or equal the requirements of listing 5.00. The requirements for listing 5.00 and 5.05 are as follows:

5.00 Digestive System

A. *What kinds of disorders do we consider in the digestive system?* Disorders of the digestive system include gastrointestinal hemorrhage, hepatic (liver) dysfunction, inflammatory bowel disease, short bowel syndrome, and malnutrition. They may also lead to complications, such as obstruction, or be accompanied by manifestations in other body systems.

B. *What documentation do we need?* We need a record of your medical evidence, including clinical and laboratory findings. The documentation should include appropriate medically acceptable imaging studies and reports of endoscopy, operations, and pathology, as appropriate to each listing, to document the severity and duration of your digestive disorder. Medically acceptable imaging includes, but is not limited to, x-ray imaging, sonography, computerized axial tomography (CAT scan), magnetic resonance imaging (MRI), and radionuclide scans. *Appropriate* means that the technique used is the proper one to support the evaluation and diagnosis of the disorder. The findings required by these listings must occur within the period we are considering in connection with your application or continuing disability review.

C. How do we consider the effects of treatment?

1. Digestive disorders frequently respond to medical or surgical treatment; therefore, we generally consider the severity and duration of these disorders within the context of prescribed treatment.

2. We assess the effects of treatment, including medication, therapy, surgery, or any other form of treatment you receive, by determining if there are improvements in the symptoms, signs, and laboratory findings of your digestive disorder. We also assess any side effects of your treatment that may further limit your functioning.

3. To assess the effects of your treatment, we may need information about:

a. The treatment you have been prescribed (for example, the type of medication or therapy, or your use of parenteral (intravenous) nutrition or supplemental enteral nutrition via a gastrostomy);

b. The dosage, method, and frequency of administration;

c. Your response to the treatment;

d. Any adverse effects of such treatment; and

e. The expected duration of the treatment.

4. Because the effects of treatment may be temporary or long-term, in most cases we need information about the impact of your treatment, including its expected duration and side effects, over a sufficient period of time to help us assess its outcome. When adverse effects of treatment contribute to the severity of your impairment(s), we will consider the duration or expected duration of the treatment when we assess the duration of your impairment(s).

5. If you need parenteral (intravenous) nutrition or supplemental enteral nutrition via a gastrostomy to avoid debilitating complications of a digestive disorder, this treatment will not, in itself, indicate that you are unable to do any gainful activity, except under 5.07, short bowel syndrome (see 5.00F).

6. If you have not received ongoing treatment or have not had an ongoing relationship with the medical community despite the existence of a severe impairment(s), we will evaluate the severity and duration of your digestive impairment on the basis of the current medical and other evidence in your case record. If you have not received treatment, you may not be able to show an impairment that meets the criteria of one of the digestive system listings, but your digestive impairment may medically equal a listing or be disabling based on consideration of your residual functional capacity, age, education, and work experience.

5.05 Chronic liver disease, with:

A. Hemorrhaging from esophageal, gastric, or ectopic varices or from portal hypertensive gastropathy, demonstrated by endoscopy, x-ray, or other appropriate medically acceptable imaging, resulting in hemodynamic instability as defined in 5.00D5, and requiring hospitalization for transfusion of at least 2 units of blood. Consider under disability for 1 year following the last documented transfusion; thereafter, evaluate the residual impairment(s).

OR

B. Ascites or hydrothorax not attributable to other causes, despite continuing treatment as prescribed, present on at least 2 evaluations at least 60 days apart within a consecutive 6-month period. Each evaluation must be documented by:

1. Paracentesis or thoracentesis; or

2. Appropriate medically acceptable imaging or physical examination and one of the following:

a. Serum albumin of 3.0 g/dL or less; or

b. International Normalized Ratio (INR) of at least 1.5.

OR

C. Spontaneous bacterial peritonitis with peritoneal fluid containing an absolute neutrophil count of at least 250 cells/mm3.

OR

D. Hepatorenal syndrome as described in 5.00D8, with on of the following:

1. Serum creatinine elevation of at least 2 mg/dL; or

2. Oliguria with 24-hour urine output less than 500 mL; or

3. Sodium retention with urine sodium less than 10 mEq per liter.

OR

E. Hepatopulmonary syndrome as described in 5.00D9, with:

1. Arterial oxygenation (PaO2) on room air of:

a. 60 mm Hg or less, at test sites less than 3000 feet above sea level, or

b. 55 mm Hg or less, at test sites from 3000 to 6000 feet, or

c. 50 mm Hg or less, at test sites above 6000 feet; or

2. Documentation of intrapulmonary arteriovenous shunting by contrast-enhanced echocardiography or macroaggregated albumin lung perfusion scan.

OR

F. Hepatic encephalopathy as described in 5.00D10, with 1 and either 2 or 3:

1. Documentation of abnormal behavior, cognitive dysfunction, changes in mental status, or altered state of consciousness (for example, confusion, delirium, stupor, or coma), present on at least two evaluations at least 60 days apart within a consecutive 6-month period; and

2. History of transjugular intrahepatic portosystemic shunt (TIPS) or any surgical portosystemic shunt; or

3. One of the following occurring on at least two evaluations at least 60 days apart within the same consecutive 6-month period as in F1:

a. Asterixis or other fluctuating physical neurological abnormalities; or

b. Electroencephalogram (EEG) demonstrating triphasic slow wave activity; or

c. Serum albumin of 3.0 g/dL or less; or

d. International Normalized Ratio (INR) of 1.5 or greater.

OR

G. End stage liver disease with SSA CLD scores of 22 or greater calculated as described in 5.00D11. Consider under a disability from at least the date of the first score.

The medical evidence presented shows the following: On [redacted], the Claimant was admitted to [redacted] due to upper quadrant pain. The admission diagnosis was obstructive jaundice. [redacted] indicated in his Discharge Summary that the Claimant had a fibrotic stenosis of the common bile duct. A stent was successfully placed and the Claimant was discharged on March 5, 2006.

On [redacted], the Claimant was admitted to [redacted]. [redacted], indicated in his admission report that the Claimant was suffering from Cholethiasis choedocholithiasis (gull stones). [redacted] scheduled laparoscopic cholecystectomy and common duct exploration surgery for [redacted]. On [redacted] completed the Discharge Summary. [redacted] indicated in this report that the Claimant Discharge diagnosis was choledocholithiasis with removal of the choledocholithiasis and gall bladder and acute pancreatitis with abdominal peritonitis. [redacted] indicated that the surgery was successful and the Claimant was sent home in satisfactory condition. The operative and post-operative reports were not provided by the Claimant and are not part or the record. It is not clear why this information was not submitted by the Claimant.

On [redacted], the Claimant was admitted to [redacted] for further evaluation and treatment of a sub hepatic abscess. [redacted] completed the Admission Summary. Claimants Exhibit p 4. The Claimant was discharged on September 11, 2006.

On [redacted], the Claimant was readmitted to [redacted] because of increased drainage from her drainage tube in her right abdomen. The admission summary indicated that the Claimant's admission diagnosis was status post cholecystectomy and sub hepatic abscess. [redacted] indicated in his [redacted], report that the Claimant was diagnosed with cellulitis of the abdomen. On [redacted], the Claimant was discharged from [redacted] with a discharge diagnosis of sub hepatic abscess, post cholecystectomy and T-tube placement. [redacted] completed the Discharge Summary. Claimant's exhibit p 20.

The medical evidence presented shows that the Claimant's gallbladder/liver impairment did not meet or equal the requirements of listing 5.00 or 5.04. The ALJ correctly found

that the Claimant's alleged physical impairments did not meet or equal the requirements of a social security listing. The ALJ correctly proceeded to Step 4.

At Step 4, the Claimant's residual functional capacity and past relevant work are considered. The Claimant's past relevant reported work was unskilled work as a home health care aide and waitress. This type of work is considered to be light/sedentary, unskilled work. 20 CFR § 416. 968 states "..unskilled work is work which needs little or no judgment to do simple duties that can be learned on the job in a short period of time."

The Claimant provided her past work history on the FIA- 49-F. The information provided shows that the Claimant had past relevant work as a cashier, babysitter, direct care worker, child care provider and teacher's assistant. The Claimant indicated that she last worked in December 2004. I find that the Claimant's past relevant work was light and sedentary work.

The medical evidence presented shows that in January 2005 and May 2005, the Claimant's intra spinal lesion and fractured vertebrae were successful treated. The June 2005, MRI results confirmed that the Claimant's intra spinal lesion and fractured vertebrae had been successfully treated. The medical information from June 2005 to March 2006, was not provided. The ALJ indicated in Finding of Fact 8 in her Hearing Decision that the Claimant progressed through physical therapy from wheelchair to full weight bearing but no medically determined evidence was found in the record to support this conclusion.

There is no medical opinion in the record regarding the Claimants physical limitations until May 2006. On [redacted], the Claimant's treating physician [redacted], Family Practitioner, completed a DHS-49 Medical Examination Report. [redacted] indicated on this form that the Claimant was normal in all examination areas. [redacted] indicated that Claimant's condition was improving with a return to work date of March 31, 2006. [redacted] indicated on page two of the report that the Claimant could frequently list 25 lbs and occasionally 50 lbs or more, could stand and/or walk 6 hours in an 8 hours day and had full use of her hands arms leg and feet. The physical limitation noted on page two of the report are inconsistent with the information provided on page one. There is no supporting medically determined evidence which supports [redacted] opinion with regard to the Claimant's physical limitations. [redacted] indicated in his report "Pt was disabled totally until hemagioma was txd. She is currently not disabled". Department Exhibit 3 pp.2-3.

Given the absence of medically determined evidence regarding the Claimant's physical limitations for the period May 2005 to May 2006, I must find that the Claimant had the residual functional capacity to perform her former light and sedentary work for the period June 2005 to March 2006.

In March 2006, the Claimant was admitted to the hospital for treatment of gall stones. ALJ Magyar found in Finding of Fact 10 in her Hearing Decision that the Claimant had a bile duct stent placed in February 2006, and in March 2006, the Claimant was treated for gall stone and in May 2006, the Claimant had her gall bladder removed. According to the Medical records the Claimant was evaluated at [redacted] in late [redacted], with surgery in March 2006. There is no medical evidence in the record which indicates that the Claimant had a bile duct stent placed in February 2006. In fact, the medical evidence shows that the Claimant was still undergoing testing the last week of February 2006 and surgery was first performed on March 4, 2006. The Claimant was discharged March 5, 2006. On [redacted], the Claimant's treating physician, examined the Claimant and indicated that she could return to work on March 31, 2006.

The medical evidence shows that in September 2006 the Claimant began having additional gallbladder symptoms which were treated surgically. On September 6, 2006, the Claimant indicated on a [redacted] sheet that she was employed with [redacted]. On September 13, 2006, the Claimant indicated on a [redacted] report that she was employed with [redacted]. Claimant's Exhibit p 21. It appears from this evidence that this Claimant sometime after March 2006, had returned to her former work.

On [redacted], surgeon, completed a DHS 49 Medical Examination Report. [redacted] indicated in the form that he last examined the Claimant in [redacted], and [redacted] diagnosed the Claimant's condition as persistent abscess with pertuaneous drainage tube. [redacted] indicated in page one of the form that, save the Claimant's abdomen, the Claimant was normal in all other examination areas. On page two of this report [redacted] indicated that the Claimant could frequently lift 20 lbs, could stand and/or walk about 6 hours in an 8-hour day, could use both hands and arms for grasping, reaching, pushing/pulling and fine manipulation and could use both arms and legs for the operation of foot and leg controls. The Claimants abscess was being treated with antibiotics.

The medical evidence shows that the Claimant was able to perform her former work from March 2006 to December 6, 2006.

On [redacted], completed a DHS-49 Medicaid Evaluation Report. [redacted]. [redacted] indicated in this report that the Claimant was normal in all major body areas except the Claimant's abdominal area. The report indicated that the Claimant had a drain in the right sub hepatic area to drain an abscess. [redacted] indicated that the Claimant could frequently lift less than 10 lbs, could stand and/or walk less than 2 hours per day in a 6-hour day, and could use both hands and arms for grasping, reaching pushing, pulling, and fine manipulation. The doctor indicated that the Claimant could use neither of her feet or legs to operate foot or leg controls. The physical limitations listed on page two this report are not consistent with the information provided on page

one of the report. Medical information which is internally inconsistent and not supported by other medically determined evidence cannot be given any weight.

The [redacted] medical opinion from [redacted] and the [redacted], medical opinion from [redacted] regarding the Claimant's physical limitations are completely inconsistent. [redacted] report and opinion are internally consistent and consistent with other medically determined evidence. The [redacted], opinion from [redacted] is internally inconsistent and is not consistent with other medically determined evidence. Therefore, I find that [redacted] opinion is given greater weight. The Claimant did have the residual functional capacity to perform her former light and sedentary work from December 21, 2006, forward.

ALJ Magyar erred when she concluded that the Claimant did not have the residual functional capacity to perform her former work. The Claimant is ineligible for disability at Step 4. Despite this finding the Claimant's disability will be considered at Step 5.

At Step 5, the Department has the burden of establishing that despite the Claimant's limitations, she has the residual functional capacity to perform work in the national economy. Residual Functional Capacity is defined as what the Claimant can do despite his limitations. Residential Functional Capacity also includes an assessment of the Claimant's physical and mental abilities.

The physical demands of jobs in the national economy are classified as sedentary, light, medium, heavy, or very heavy. The more physically demanding classification includes all less demanding classifications. For example, a classification of very heavy includes all other less physically demanding classifications. Sedentary work is defined as work which involves the lifting of no more than 10 lbs at a time and the occasional lifting or carrying of files, ledgers, small tools, and similar items. Sedentary work presumptively includes sitting but also includes some necessary walking and standing.

Light work involves the lifting of no more than 20 lbs at any time and the frequent lifting or carrying of objects weighting less than 10 lbs. Light work may involve significant walking or standing. Absent a loss of dexterity or other limiting factors, typically those who can do light work can do sedentary work.

Medium work involves lifting objects of 50 lbs or less with frequent lifting or carrying of objects, which weigh 25 lbs or less. A person who can do medium work can typically do light and sedentary work.

Heavy work involves the lifting of 100 lbs or less with frequent lifting of objects weighting 50 lbs or less. Persons who can do heavy work typically can do medium, light, and sedentary work.

Very heavy work involves the lifting of objects over 100 lbs and the frequent carrying or lifting of objects weighting 50 lbs or more. A person who can do very heavy work typically can do heavy, medium, light, and sedentary work.

The person claiming a physical disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for a recovery and/or medical assessment of ability to do work-related activities. 20 CFR 416.913. A conclusory statement, by a physician that an individual is disabled without supporting medical evidence, is not sufficient to establish disability. 20 CFR 416.929.

The medical evidence presented shows that the Claimant is a 28-year-old individual with a high school education and three years of college and past work history of light, unskilled work.

The medical evidence shows that the Claimant was admitted to the hospital in January and May 2005. The Claimant's intra spinal lesion and fractured vertebrae were successfully treated. In late February 2006, the Claimant was evaluated for upper quadrant pain. In March 2006, she was hospitalized for gall bladder surgery. In August 2006, the Claimant began to experience symptom of liver dysfunction. In September 2006, her gall bladder was removed and drain was placed. She subsequently experienced an infection and a sub hepatic abscess formed. This condition was treated with additional hospitalizations and ultimately was resolved through antibiotics. The medical evidence presented shows that after her 2005 surgeries, and her March 2006 onset of her liver impairment, the Claimant had the residual functional capacity to perform her former work. In May 2006, the Claimant's treating physician indicated that the Claimant could return to work March 31, 2006. In December 2006, the Claimant's treating surgeon indicated that the Claimant had minimal exertional limitations. Given [redacted] medical opinion the Claimant did have the residual functional capacity to perform other light and sedentary work in the national economy. ALJ Magyar erred when she concluded that the Claimant had no residual functional capacity .

The evidence presented shows that the Claimant has the residual functional capacity to perform light and sedentary work. According to vocational rules 202.20 and 201.27, given the Claimant's vocational profile, the Claimant is not disabled.. 20 CFR Pt. 404, Subpt. P, App.2. Therefore, the Claimant is not disabled at Step 5 .The ALJ (Magyar) erred when she found that the Claimant lacked the residual functional capacity to perform light and sedentary work.

The MRT, SHRT, and this have ALJ determined that the Claimant was not disabled and was ineligible for Retroactive MA-P. PAM 115 provides the standard Retro MA-P eligibility requirements. A Claimant is eligible for Retro MA-P if the Claimant:

•

- meets all financial and nonfinancial eligibility factors in that month, and
- has an unpaid medical expense incurred during the month, or
  Note: Do **not** consider bills that the person thinks may be paid by insurance as paid bills. It is easier to determine eligibility sooner rather than later.
- has been entitled to Medicare Part A.

PAM 115, pp. 8-9.

Because the MRT, SHRT, and this ALJ have found that the Claimant was not disabled for each of the three (3) months prior to the date of her application for MA-P, the Claimant is ineligible for Retro MA-P.

DECISION AND ORDER

This Administrative Law Judge, based on the above findings of fact and conclusion of law, decides that Administrative Law Judge Magyar erred when she found that the Claimant was disabled.

IT IS THEREFORE ORDERED that:

The Administrative Law Judge's Hearing Decision mailed, September 23, 2008 is REVERSED

/s/
Martin D. Snider
Administrative Law Judge
for Michigan Department of Human Services

cc: [redacted]

Date Signed: October 12, 2009
Date Mailed: October 12, 2009

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