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: 2008-26177
Issue No: 2009; 4031
Case No: [redacted]
Load No:
Hearing Date:
November 5, 2008
Wayne County DHS

ADMINISTRATIVE LAW JUDGE: Landis Y. Lain

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon claimant's request for a hearing. After due notice, a telephone hearing was held on November 5, 2008. Claimant personally appeared and testified.

ISSUE

Did the Department of Human Services (the department) properly deny claimant's application for Medical Assistance (MA-P) and State Disability Assistance (SDA)?

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 December 21, 2007, claimant filed an application for Medical Assistance and State Disability Assistance benefits alleging disability.

(2) On June 2, 2008, the Medical Review Team denied claimant's application stating that claimant could perform other work pursuant to Medical-Vocational Rule 202.19.

(3) On June 6, 2008, the department caseworker sent claimant notice that his application was denied.

(4) On June 26, 2008, claimant filed a request for a hearing to contest the department's negative action.

(5) On August 6, 2008, the State Hearing Review Team again denied claimant's application stating that there was insufficient evidence and requested an eye test.

(6) The hearing was held on November 5, 2008. At the hearing, claimant waived the time periods and requested to submit additional medical information.

(7) Additional medical information was submitted and sent to the State Hearing Review Team on July 23, 2009.

(8) On July 30, 2009, the State Hearing Review Team again denied claimant's application stating that claimant is capable of performing other work in the form of light work per 20 CFR 416.967(b) and unskilled work per 20 CFR 416.968(a) pursuant to Medical-Vocational Rule 202.17 and commented that the claimant's impairments do not meet/equal the intent or severity of a Social Security listing. The medical evidence of record indicates that the claimant retains the capacity to perform a wide range of light work. Therefore, based on the claimant's vocational profile of a younger individual, with a less than high school education, MA-P is denied using Vocational Rule 202.17 as a guide. Retroactive MA-P was considered in this case and is also denied. SDA is denied per PEM 261 because the nature and severity of the claimant's impairments would not preclude work activity at the above stated level for 90 days.

(9) On the date of hearing, claimant was a 42-year-old man whose birth date is [redacted]. Claimant was 5' 8" tall and weighed 160 pounds. Claimant attended the 11th grade and has no GED. Claimant was able to read and write and did have basic math skills.

(10) Claimant last worked 2006 at [redacted] as a dishwasher and prep cook. Claimant has also worked as a barber.

(11) Claimant alleges as disabling impairments: hypertension, congestive heart failure, diabetes mellitus, vision problems, cardiac disease, anemia, cataracts, as well as muscle deterioration in the left leg, and a pacemaker defibrillator placed in [redacted].

CONCLUSIONS OF LAW

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. The Department of Human Services (DHS or department) administers the SDA program pursuant to MCL 400.10, *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).

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 –
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> (1) Medical history.
>
> (2) Clinical findings (such as the results of physical or mental status examinations);
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> (3) Laboratory findings (such as blood pressure, X-rays);
>
> (4) Diagnosis (statement of disease or injury based on its signs and symptoms).... 20 CFR 416.913(b).

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

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

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

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

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

Medical evidence may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of the impairment(s), including your symptoms, diagnosis and prognosis, what an individual can do despite impairment(s), and the physical or mental restrictions. 20 CFR 416.927(a)(2).

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

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability.... 20 CFR 416.927(e).

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

When determining disability, the federal regulations require that several considerations be analyzed in sequential order. If disability can be ruled out at any step, analysis of the next step is 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 is not engaged in substantial gainful activity and has not worked since 2006. Claimant is not disqualified from receiving disability at Step 1.

The objective medical evidence on the record indicates that an eye examination of [redacted] indicates that claimant has had blurred vision in the right eye and left eye for approximately three years. The blurred vision started gradually and occurs daily and is happening throughout the day. The condition is moderate and is associated with all activities and seems to be stable. Vision is affected. The claimant's visual acuity and intraocular pressures were as follows: OD Dva CC was 20/200 and 20/80. Claimant has diabetes with no diabetic retinopathy and he has a cataract in one eye which is visually significant. (Page A of the new information)

A [redacted] Medical Examination Report indicates that claimant was alert and cooperative. Claimant weighed 176 pounds and his blood pressure was 90/60. His height was 5' 8" tall. His vision without glasses was 20/cannot see on the left and 20/70 on the right. The doctor could not see any significant cataracts. Clinically, the claimant was not jaundiced. The claimant's gait was normal. The claimant was able to get on and off the examination table. The claimant could raise both arms above head level. HEENT: Normocephalic. External eye movements were intact. Pupils were equal and regular, reacting to light and accommodation. Fundus was intact. ENT was benign. The neck was supple. No thyromegaly. No venous engorgement. Trachea was central. No carotid bruit. The chest moved normally on either side. Respiratory movements were normal. The chest was clear to auscultation and percussion. No rhonchi or rales noted. The claimant did have a long scar over the sternal area. Cardiovascular: Heart size was normal. No audible murmur. JVD was not raised. Air entry was equal. No adventitious sounds. Trachea was midline. The abdomen was soft with no masses felt. Bowel

sounds were normal. No evidence of hernia. Spleen was not palpable. No ascites. The claimant had vague tenderness over his abdomen. Bones and Joints: Straight leg raising was equal bilaterally. All peripheral pulses were equal and good bilaterally. There was no wasting of muscles. Handgrip was equal. Nervous System: Cranial nerves II-XII were grossly intact. No gouty deformities or nodules noted. Sensory: Touch, pinprick and sensation were normal. Plantar was flexor bilaterally. Cerebellar function was normal. Motor strength was equal bilaterally. Plantar reflex was flexor. The deep tendon reflexes were 2+ in the upper and lower extremities. Heel-to-knee and finger-to-finger, finger-to-nose testing was normal. The gait was normal. No wasting of muscles. Speech and memory appeared to be normal. Orientation was normal. The claimant's general health was fairly good. No leg ulcers. The conclusion was a 43-year-old male suffering with markedly impaired vision and refraction error; diabetes mellitus, insulin dependent, fairly well controlled; chronic nonspecific abdominal pain; history of recent appendectomy; history of shortness of breath or pulmonary insufficiency. The claimant was not wheezing on exam. No evidence of congestive heart failure. (Pages F-G of the new information)

Claimant was admitted [redacted] for an acute Methicillin-sensitive staphylococcus aureus bacteremia and sepsis secondary to an infected eustachian valve (this is a fetal remnant valve that persisted and it is in the proximal portion of the inferior vena cava as enters the right ventricle). Claimant was in the hospital from [redacted] through [redacted]. In a final report from [redacted] claimant had a secondary diagnosis of type 2 diabetes, controlled; essential hypertension, controlled; and compensated systolic heart failure with implantable cardioverter defibrillator that was removed secondary to sepsis. He was stable and afebrile and his lungs were clear to auscultation. Heart had regular rate and rhythm with no

gallops, murmurs, or rubs. His abdomen was distended and mildly diffusely tender and he had trace edema. He was placed on intravenous antibiotics. (Pages F-G of the new information)

On [redacted], claimant was admitted to the hospital for left ventricular failure secondary to uncontrolled hypertension and right ventricular failure. His secondary diagnosis was eustasia valve infective endocarditis; stable coronary artery disease; stable hyperlipidemia; uncontrolled diabetes mellitus type 2; anemia of chronic disease; and uncontrolled hypertension; statin-induced myopathy, possibly from Crestor; pulmonary embolism from stable; lower extremity cellulitis; bilateral pleural effusions secondary to congestive heart failure; and infected sternal wound from coronary artery bypass graft.

On [redacted], claimant was admitted to the hospital and stayed in until [redacted] with a principal diagnosis of chest pain, ruling out acute coronary syndrome. Claimant's vital signs were blood pressure 142/84, heart rate 84, respiration rate was 18, pulse oxygen of 99%. He had no pallor or icterus on the skin. Cardiac revealed a regular rate, normal first and second heart sounds. Expansion of the chest was equal, lungs were clear, abdomen was soft and non-tender, and the extremities revealed some stable edema. He was admitted to the hospital and medical treatment of coronary artery disease and congestive heart failure continued with Lasix, ACE inhibitor, and Plavix. His previous ejection fraction was known from echocardiography and estimated at 60%. The claimant remained clinically stable without any ongoing features of sepsis. His repeat blood cultures remained negative. Infectious disease consultation was obtained. The claimant was counseled as to the importance of remaining on antibiotic therapy and discharged from the hospital.

On [redacted], claimant was admitted to the hospital. His blood sugar was very high at almost 700. The claimant stated that he had not been taking his insulin. The blood sugar was brought down with insulin and his blood pressure was controlled with hypertensive medications. The claimant underwent a stress thallium, and the stress thallium showed non-ischemic response.

On [redacted], claimant was admitted to the hospital for acute gastroenteritis, hyperglycemia, and dilated cardiomyopathy, status post coronary artery bypass grafting, status post automated internal cardial defibrillator insertion. His discharge diagnosis was uncontrolled diabetes, suppurative abscess in the chest wall, dilated cardiomyopathy, status post coronary artery bypass grafting, status post implantable cardial defibrillator insertion, and acute gastroenteritis.

On [redacted], claimant was admitted to the hospital for suspected acute coronary syndrome, uncontrolled diabetes mellitus, history of medical noncompliance, hypertension, hyperkalemia, hyponatremia, diarrhea and abdominal pain. On physical examination his blood pressure was 128/85, pulse 81, temperature 36.7, pulse oxygen 100% on room air. He was a thin 42-year-old African American male, lying in bed in moderate distress due to pain. HEENT: Normocephalic and atraumatic. He had a cataract in his left eye. His right eye was round, reactive to light and accommodation. Extraocular muscles were intact. No pallor, no icterus, no nasal discharge, and oral mucosa moist. Neck: Supple, no lymphadenopathy, trachea midline. Cardiovascular: Regular rate and rhythm, S1, S2 heard. On his chest wall he had a CABG scar with no erythema, it was clean and dry but there was a chest wall ulcer mid-sternum, no drainage. There was a holosystolic murmur loudest at the apex, grade 2/6, no radiation, and claimant also had AICD scars on the right and on the left chest. The chest wall was also tender to deep palpation in the mid-sternal area. Lungs: Clear to auscultation bilaterally. No rales, rhonchi,

crackles or wheezes. Abdomen: Soft and did have tenderness and fullness in the left upper quadrant. No guarding, no rebound, no shifting dullness. Musculoskeletal: Cold upper and lower extremities bilaterally. Radial pulses were +3/4 bilaterally. Dorsalis pedis pulses were +3/4 bilaterally. Claimant had ulcers along the left elbow and left lower extremity which were shallow ulcers, no drainage. An EKG was performed which showed unusual P axis, possible ectopic atrial rhythm, low voltage QRS, marked T wave abnormalities, consider anterolateral ischemia for long QT. Abnormal ECG, so a consult to cardiology was placed. Chest x-ray showed no acute process, no significant change from the previous chest x-ray. Abdominal x-ray was negative.

Claimant was admitted [redacted] and discharged [redacted] for chest wall abscess and chest pain. The assessment indicates that claimant had diabetes mellitus which was poorly controlled and that the claimant was not very compliant with his medicines at home and had very poor glycemic control overall and that he had hypertension which was uncontrolled on the current medication and a history of non-sustained ventricular tachycardia status post implantable cardioverter defibrillator placement.

On [redacted], the claimant was admitted to the hospital and found to have a blood pressure in the range of 160 systolic and 90 diastolic. He was started on medication for hypertension and his blood pressures were poorly controlled ranging from 180 systolic to over 200 systolic. His medication was increased and after two days it was still poorly controlled; his blood pressure was consistently over 200. He was given IV medication which immediately lowered the blood pressure into the range of 160s and 170s systolic. He was monitored for another night and his blood pressure remained lower in the 160s systolic. Three days after admission he was still stable and did not require any further IV medications and was not

symptomatic for hypertension. A 2-D echocardiogram was performed two days after admission and was significant for severe concentric hypertrophy of the left ventricle indicating that claimant's hypertension was chronically uncontrolled. He was diagnosed with acute renal insufficiency, hypertensive urgency, and ingrown toenail of the right great toe.

A chest x-ray done on [redacted] showed cardiac silhouette size was normal. Mediastinal sutures and sternal wires were present. A right-sided cardiac device was present, extending a lead into the right ventricle. The lungs were clear of a focal airspace consolidation. A linear opacity was seen in the left mid lung laterally, most likely atelectasis. There was no pneumothorax or pleural effusion.

On [redacted], claimant presented to the hospital admitting to noncompliance with medication. He denied being on narcotics; however, he was positive for opiate on his drug screen. Indications were that he continued to smoke and continued to use alcohol and continued to use narcotics that are not prescribed for him with a longstanding history of multi-substance abuse. Cocaine and marijuana tests were negative. On [redacted] claimant presented at the hospital with chest pain. On [redacted] claimant was admitted with chest pain and abdominal pain.

At Step 2, the objective medical evidence on the record indicates that claimant has established that he does have a severe impairment which has lasted for is expected to last for the duration of at least 12 months. The objective clinical medical evidence in the record indicates that claimant has been noncompliant with his medication; however, claimant testified on the record that because he doesn't have insurance, he cannot afford his medication so this Administrative Law Judge will not hold his noncompliance against him.

At Step 3, the claimant's impairments do not rise to the level necessary to be specifically listed as disabling as a matter of law.

At Step 4, claimant testified on the record that he last worked in 2006 as a dishwasher and prep cook for [redacted] and prior to that he was a barber for 10 years before his health took a turn for the worse. Claimant testified that he does cook two times per week and cooks things like baked chicken and pork chops and uses the microwave mostly. Claimant testified that he doesn't grocery shop or clean up but he does sometimes do the dishes, but he can't really get up and down stairs very well. Claimant testified that he had open heart surgery in [redacted] and he had a pacemaker and defibrillator placed. Claimant testified that he can walk 2-3 houses with a cane and that he gets dizzy. He can stand for 2-3 minutes at a time and sit for 20-30 minutes at a time. Claimant testified that he doesn't stand much because it is hard to breath and he doesn't squat because his left leg does not work well. Claimant testified that he can bend slowly at the waist and can sometimes tie his shoes, but he can't touch his toes. Claimant testified that the heaviest weight he can carry is a gallon of milk and that he is right-handed and he can't lift his arms above his head because of the placement of the defibrillator. Claimant testified that his level of pain on a scale from 1 to 10 without medication is an 8/9 and with medication is a 2/3. Claimant testified that in a typical day he wakes up and takes his medications, checks his sugar and eats and move around and walks around the house. Claimant gets fatigued and then he rests, reads, and watches television. Claimant testified he can only read if the print is large enough. This Administrative Law Judge finds that claimant could probably not perform his prior work based upon his uncontrolled diabetes, uncontrolled hypertension, and his heart problems. Claimant is not disqualified for receiving disability at Step 4.

The Administrative Law Judge will continue to proceed through the sequential evaluation process to determine whether or not claimant has the residual functional capacity to perform some other less strenuous tasks than in his prior jobs.

At Step 5, the burden of proof shifts to the department to establish that claimant does not have residual functional capacity. This Administrative Law Judge has read the entire record and it is noted that claimant has been hospitalized at least one time per month since [redacted]. In addition, claimant is just not presenting at the emergency department but is actually being retained and admitted into the hospital for at least several days during each of his hospital visits. Therefore, this Administrative Law Judge finds that claimant does not have residual functional capacity to perform even sedentary work at this time based upon his heart problems, uncontrolled diabetes, and uncontrolled hypertension. Based upon his combined impairments, claimant does meet the disability criteria for Medical Assistance and State Disability Assistance benefits as of the December 21, 2007 application date. The department is required to initiate a determination of claimant's financial eligibility for the requested benefits, if it has not previously done.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the claimant meets the definition of medically disabled under the Medical Assistance program and the State Disability Assistance program as the December 21, 2007 application date based upon his combination of impairments.

Accordingly, the department's decision is REVERSED. The department is ORDERED to initiate a review of the December 21, 2007 application, if it has not already done so, to determine if all other non-medical eligibility criteria are met. The department shall inform the claimant of the determination in writing.

The department shall conduct a medical review in August 2010, at which time the claimant shall provide updated medical information in the form of updated cardiology reports, a complete physical, a complete eye examination, and range of motion testing.

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

Date Signed: September 11, 2009

Date Mailed: September 11, 2009

NOTICE: Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative Hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the mailing of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt date of the rehearing decision.

LYL/vmc

cc: [redacted]