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

SOAHR Docket No. 2008-30612REHD
DHS Reg. No: 2008-30415

[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 he determined the Claimant was not disabled for Medical Assistance (MA-P) and retro Medical Assistance (retro MA-P)?

FINDINGS OF FACTS

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

1. On August 12, 2008, ALJ William Sundquist issued a Hearing Decision in which the ALJ affirmed the Department of Human Services' (DHS) denial of the Claimant's July 31, 2006, applications for MA-P and retro MA-P.

2. On September 11, 2008, the State Office of Administrative Hearings and Rules (SOAHR) for the Department of Human Services received a request for Rehearing/Reconsideration submitted by the Claimant's representative [redacted]

3. On September 22, 2008, SOAHR granted the Claimant's request for reconsideration and issued an Order for Reconsideration.

4. Findings of Fact 1 and 2 from the Hearing Decision, mailed on August 14, 2008,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 4000.105; MSA 16.490 (15). Agency policies are found in the Program Administrative Manual (PAM), the Program Eligibility Manual (PEM), and the Program Reference Manual (PRM).

Pursuant to Federal Rule 42 CFR 435.50, the Family Independence Agency uses the federal Supplemental Security Income (SSI) policy in determining eligibility for disability under the Medical Assistance program. Under SSI, disability is defined as:

> …the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months…
>
> 20 CFR 416.905

The person claiming a physical or mental disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for a recovery and/or medical assessment of ability to do work-related activities or ability to reason and to make appropriate mental adjustments, if a mental disability is being alleged, 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908 and 20 CFR 416.929. By the same token, a conclusory statement by a physician or mental health professional that an individual is disabled or blind is not sufficient without supporting medical evidence to establish disability. 20 CFR 416.929.

A set order is used to determine disability. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience is reviewed. If there is a finding that an individual is disabled or not disabled at any point in the review, there will be no further evaluation. 20 CFR 416.920.

If an individual is working and the work is substantial gainful activity, the individual is not disabled regardless of the medical condition, education, and work experience. 20 CFR 416.920(c).

If the impairment or combination of impairments does not significantly limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. Age, education, and work experience will not be considered. 20 CFR 416.920.

Statements about pain or other symptoms do not alone establish disability. There must be medical signs and laboratory findings, which demonstrate a medical impairment…20 CFR 416.929(a).

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

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

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

> (1) Physical functions such as walking, standing, sitting, lifting, pushing, reaching, carrying or handling;
> (2) Capacities for seeing, hearing, and speaking;
> (3) Understanding, carrying out, and remembering simple instructions;
> (4) Use of judgment;
> (5) Responding appropriately to supervision, co-workers and usual work situations; and
> (6) Dealing with changes in a routine work setting. 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 416.920(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 the Claimant not ineligible for disability at Step 1 because the Claimant had not been engaged in substantial gainful activity since June, 2006 (*See page 5 of the August 12, 2008, Hearing Decision*). The Claimant is not disqualified from receiving disability at Step 1. The ALJ properly considered the Claimant's eligibility at Step 2.

On December 5, 2007, the DHS MRT completed a review of the Claimant's eligibility for MA-P and retro MA-P. On December 5, 2007, the MRT determined that the Claimant was not disabled and was not eligible for MA-P and retro MA-P. On June 24, 2008, the SHRT issued a decision in which it found that the Claimant was not disabled. After the Claimant presented additional medical information at his hearing, the SHRT issued a second decision on July 31, 2008, in which it again found that the Claimant was not disabled. The SHRT determined that that the Claimant's impairments did not meet or equal a listing. The SHRT further determined that the Claimant did not have a severe impairment or combination of impairments and lacked the requisite duration of impairment to be found disabled.

On [redacted] the Claimant was admitted to [redacted] with complaints of severe abdominal pain, nausea, and vomiting. Department exhibit p. 178.

On [redacted], [redacted]., performed a CT scan of the Claimant's abdomen and pelvis with contrast. [redacted] stated that there was an extensive inflammatory process in the lower abdomen and upper pelvic region. The inflammation was diagnosed as a possible acute appendicitis that has perforated with rupture.

Sigmoid diverticula, small bowel ileus, and calcifications of the prostate gland were also noted. Claimant's exhibit B 7.

On [redacted], the [redacted] performed an exploratory laparotomy, appendectomy, and drainage of appendiceal abscess complex and interloop abscess during which the Claimant's appendix was removed. [redacted] stated that the Claimant tolerated the procedure well and the prognosis was guarded. Claimant's exhibit B 1.

On [redacted], three portable chest x-rays were performed on the Claimant. [redacted] performed the first procedure, noting no active pulmonary disease. A nasogastric tube and left central catheter line were placed between the procedures. [redacted] performed the second procedure. [redacted], noted cardiomegaly from the test, and further stated that the nasogastric tube and left central catheter line were adequately placed. [redacted] performed the third procedure. [redacted] noted no active pulmonary disease, and also stated that the nasogastric tube and left central catheter line were adequately placed. Claimant's exhibit B 3-5.

On [redacted], a portable chest x-ray was performed on the Claimant by [redacted] noting no active pulmonary disease and adequate placement of the nasogastric tube and left central catheter line. Claimant's exhibit B 8.

On [redacted], posteroanterior and lateral projections of the chest were done by [redacted]. The chest was found to be normal. Claimant's exhibit B 9.

On June 19, 2007, a CT angiogram of the Claimant's pulmonary arteries was performed with nonionic intravenous contrast and coronal reconstructions. [redacted] stated that no pulmonary embolus was found. Bibasilar atelectatic and/or infiltrative change was seen. Also, a few scattered small lymph nodes were noted in the mediastinum. Claimant's exhibit B 10.

On [redacted], a portable chest x-ray was performed by [redacted] to affirm the status of the nasiogastric tube and left central catheter line. Claimant's exhibit B 11.

On [redacted], a CT scan of the Claimant's abdomen and pelvis was performed by [redacted] determined that the Claimant had a probable fatty liver, and/or hepatocellular disease; a fluid-fluid level within the gallbladder, which was suggestive of chronic cholecystic disease; and resolving inflammatory changes around the abdomen, with no discrete abscess identified. Claimant's exhibit B 12.

On [redacted], [redacted] performed a posteoranterior and later chest scan, noting that the heart and lungs were unremarkable. Claimant's exhibit B 13.

On [redacted], the Claimant was discharged from [redacted] with diagnoses of acute peritonitis, ruptured appendix, and interloop abscess; hypertension; hyperlipidema; chronic obstructive pulmonary diseases; atrial fibrillation; and a past history of head injury. Department exhibit p. 10.

On [redacted], the Claimant was transferred to the [redacted] system for care and physical therapy. Claimant's exhibit C 1.

On [redacted], the Claimant was examined by [redacted] found benign prostate enlargement. Claimant's exhibit C 26.

On [redacted], the Claimant was discharged from [redacted] system. [redacted] identified discharge diagnoses of: wound care following appendectomy and peritonitis; generalized weakness secondary to recent surgery; paroxysmal atrial fibrillation; depression; benign prostatic hypertrophy; and arthritis of the right, first metatarsophalangeal joint. The claimant was discharged with the following instructions and medications:

(1) Citalopram 40 mg – take one half tablet once a day for depression.
(2) Diltiazem 120 mg SA capsule – one a day for abnormal atrial fibrillation.
(3) Ibuprofen 600 mg – one tablet twice a day for arthritis.
(4) Recommendation of one baby aspirin per day to thin the blood and prevent coronary artery disease.
(5) Regular diet.
(6) Continue regular activities as tolerated.

Claimant's exhibit C 1-3.

On [redacted], the Claimant was examined by [redacted] and found to have hallux limitus/rigidus in his right foot. The right lower extremity was determined to be approximately half an inch shorter than the left. Custom insoles were prescribed by [redacted]. Claimant's exhibit C 25.

On October 1, 2007, the Claimant underwent a CT lumbar spine examination. [redacted]. [redacted] found a wedging of the T12; spinal stenosis at L4-L5 with possible superimposed left paracentral herniated disc; bilateral foramina narrowing with bulging annulus fibrosis and mild stenosis at L3-L4; and a bulging disc with a prominent facet joint arthropathy at L5-S1. Claimant's exhibit C 30.

On October 5, 2007, the Claimant's DHS-49 Medical Examination Report form was completed by a medicaid advocate.

On [redacted], the Claimant was examined by [redacted] and found to have a traumatic optic neuropathy and presbyopia. Polycarbonate bifocals were prescribed for full time wear. Department exhibit p. 62.

On [redacted], the Claimant was admitted to [redacted] after developing confusion. The Claimant underwent a CT scan of his brain without intravenous contrast enhancement. [redacted] indicated in his report that there could be a small aneurysm and suggested a CT scan of the brain with intravenous contrast enhancement. Department exhibit p. 10.

On January 31, 2008, the Claimant underwent a CT scan of his brain with intravenous contrast enhancement. [redacted] stated in his report that a 6mm sized aneurysm was found at the junction between the left internal carotid artery and the middle cerebral artery. [redacted] also stated that there was likely some acute thrombosis in the middle cerebral artery, but there was no obvious acute intracranial hemorrhage, and there were no enhancing lesions. Department exhibit p. 11.

On [redacted], [redacted] examined the Claimant's chest in posteroanterior and lateral projections, finding that it was unremarkable. Department exhibit p. 12.

On [redacted] the Claimant was transferred from [redacted] in [redacted]. Department exhibit p. 19.

On January 31, 2008, the Claimant underwent a CT scan of the head and neck at [redacted]. [redacted]. The Claimant was shown to have a 5mm left internal carotid artery aneurysm. Department exhibit p. 31.

On February 1, 2008, the Claimant underwent a further posteroanterior and later view chest exam which was found to be negative. Department exhibit p. 32.

On February 1, 2008 the Claimant underwent an examination of his eye for a foreign body. No foreign bodies or fractures were found in the orbits. Department exhibit p. 32.

On February 1, 2008, a transesophageal echocardiogram was performed on the Claimant's heart whereby [redacted] found the left and right ventricles and atriums to be normal in size and function. There was no finding of any cardioembolic source in the study. Department exhibit p. 25.

On February 2, 2008, an MRI of the brain was performed with and without contrast on the Claimant. A 5mm left internal carotid aneurysm was noted, along with a mild right inferior frontal encephalomalacia. Department exhibit p. 33.

On February 2, 2008, the Claimant was discharged from [redacted] with instructions to gradually return to normal activity. Department exhibit p. 38.

On [redacted], the Claimant underwent a cervical and cerebral angiogram which was interpreted by [redacted] found that the Claimant had an aneurysm which arose from the left internal carotid artery at its terminus. The aneurysm measured approximately 5.3 mm in width. The neck of the aneurysm appeared to incorporate the left anterior cerebral artery, and measured approximately 4.4 mm. [redacted]. [redacted] also noted that there was a tiny daughter aneurysm arising from the superolateral portion of the aneurysm. There was only minimal athermoatous disease at the left carotid bifurcation. Claimant exhibit G 2-3.

The medical evidence presented shows that the Claimant was admitted to the [redacted] on [redacted] with abdominal pain and nausea and was diagnosed with appendicitis with peritonitis. After having an exploratory laparotomy procedure which removed his perforated appendix, he remained at the [redacted] for further care until he was discharged on June 26, 2007, with diagnoses of acute peritonitis, ruptured appendix, and interloop abscess; hypertension; hyperlipidema; chronic obstructive pulmonary diseases; atrial fibrillation; and a past history of head injury.

The Claimant then entered the [redacted] system for further care on [redacted], and remained there until he was discharged on August 1, 2007 with diagnoses of paroxysmal atrial fibrillation; depression; benign prostatic hypertrophy; and arthritis of the right, first metatarsophalangeal joint.

The Claimant later underwent examinations of his right foot, spine, and right eye which showed medical impairments due to deformity or previous accidents.

On [redacted], the Claimant was admitted to [redacted] with confusion and was subsequently diagnosed with a left internal carotid artery aneurysm, which was confirmed upon the Claimant's transfer to [redacted] of [redacted] in [redacted] on the same date. This diagnosis was also confirmed in subsequent tests as late as July 1, 2008.

The medical evidence presented shows that most of the Claimant's impairments, other than certain chronic conditions, have been or are being treated. Furthermore, those other chronic conditions and impairments are not of the severe nature that they have or would be expected to prevent the Claimant from having the ability to perform basic work for 12 consecutive months or more. The medical evidence presented shows then, that the Claimant has the ability to perform basic work functions. Therefore, the Claimant failed to provide sufficient evidence to establish that he had a severe impairment or combination of impairments that lasted or was expected to last 12 consecutive months or more. The finding of a severe impairment at Step 2 is a diminimus standard, so although the ALJ correctly found that the Claimant was not disabled at Step 2, he erred in not proceeding to Step 3.

At Step 3, the Claimant's impairment of a left internal carotid artery aneurysm does not meet or equal the requirements of listing 4.00, Cardiovascular System, and specifically listing 4.10, Aneurysm of aorta or major branches. Listings 4.10 and 4.00H6 provide in pertinent part:

> **4.10 Aneurysm of aorta or major branches**, due to any cause (e.g., artherosclerosis, cystic medial necrosis, Marfan syndrome, trauma), demonstrated by appropriate medically accepted imaging, with dissection not controlled by prescribed treatment (see 4.00H6).
>
> **H. Evaluating other cardiovascular impairments**
>
> 6. *When does an aneurysm have "dissection not controlled by prescribed treatment," as required under 4.10?* An aneurysm (or bulge in the aorta or one of its major branches) is *dissecting* when the inner lining of the artery begins to separate from the arterial wall. We consider the dissection not controlled when you have persistence of chest pain due to progression of the dissection, an increase in the size of the aneurysm, or compression of one or more branches of the aorta supplying the heart, kidneys, brain, or other organs. An aneurysm with dissection can cause heart failure, renal (kidney) failure, or neurological complications. If you have an aneurysm that does not meet the requirements of 4.10 and you have one or more of these associated conditions, we will evaluate the condition(s) using the appropriate listing.

The medical evidence presented shows that the Claimant's aneurysm is not associated with "dissection not controlled by prescribed treatment" in that it has not caused or created any of the conditions listed in 4.10H6. Therefore, the impairment does not meet or equal the listing and does not show that the claimant is disabled.

Also at Step 3, the Claimant's back impairments do not meet or equal the requirements of 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 equine) or the spinal cord. With:

A. Evidence of nerve root compression characterized by neuro-automatic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated 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 severe 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 evidence presented shows that on [redacted], the Claimant underwent a CT lumbar spine examination. [redacted] found a wedging of the T12; spinal stenosis at L4-L5 with possible superimposed left paracentral herniated disc; bilateral foramina narrowing with bulging annulus fibrosis and mild stenosis at L3-L4; and a bulging disc with a prominent facet joint arthropathy at L5-S1. Claimant's exhibit C 30.

However, this documentation was not accompanied by any other documentation of conditions or limitations caused by back impairments which would allow any of the Claimant's impairments to meet or equal the listing.

Because none of the Claimant's impairments meet or equal applicable listings, the Claimant is not found disabled at Step 3 and the analysis continues to Step 4.

According to the Claimant's 49-F and the Hearing Decision, the Claimant was formerly a non-working factory supervisor from 1987 to 1999. In 2002, the Claimant was employed as a satellite television technician. From April to June of 2006, the Claimant was employed as a used automobile salesmen. Department exhibit p. 142. The Claimant's former work was light work.

On October 5, 2007, the Claimant's DHS-49 Medical Examination Report was completed by a medicaid advocate. A medicaid advocate is not considered an acceptable medical source. Furthermore, the medical evidence presented does not adequately describe any limitations placed on the Claimant due to his impairments. The burden at Step 4 is on the Claimant to produce medical evidence from medically acceptable sources that show his impairments prevent him from performing his former work. In this instance, that burden has not been met. Therefore, the Claimant has the residual functional capacity to perform his former work, and is thusly ineligible for disability at Step 4.

Despite this finding, the ALJ may have completed the sequential analysis by considering the Claimant's eligibility at Step 5.

At Step 5, the Department has the burden of establishing that despite the Claimant's limitations, he 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. Residual 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 pounds 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 pounds at a time and the frequent lifting or carrying of objects weighing less than 10 pounds. 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 the lifting of objects of 50 pounds or less with frequent lifting or carrying of objects which weigh 25 pounds or less. A person who can do medium work can typically do light and sedentary work. Heavy work involves the lifting of 100 pounds or less with frequent lifting of objects weighing 50 pounds or less. People who can do heavy work can typically do medium, light, and sedentary work. Very heavy work involves the lifting of objects weighing 100 pounds or more and the frequent carrying or lifting of objects weighing 50 pounds or more. A person who can do very heavy work can typically do heavy, medium, light, and sedentary work.

The evidence presented shows that the Claimant is a 58-year-old individual who has a high school education and past light, semi-skilled work experience. The objective medical evidence in the record does not show that the Claimant's physical limitations are so severe that those limitations would prevent the Claimant from performing light or sedentary work. Given the Claimant's vocational profile, the applicable vocational rules render the Claimant not disabled. 20 CFR Pt. 404, Subpt. P, App. 2(202.07).

Also, because the Claimant was not found disabled for each of the three months prior to the date of his application, he was ineligible for retro MA-P. Therefore, the MRT, the SHRT, and the ALJ all correctly denied retro MA-P.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Administrative Law Judge's decision mailed August 14, 2008, is AFFIRMED.

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

cc: [redacted]

Date Signed: July 29, 2009
Date Mailed: July 30, 2009

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