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.: 2009-13076
Issue No.: 2009, 4031
Case No: [redacted]
Load No.: [redacted]
Hearing Date:
April 2, 2009
Wayne County DHS (49)

ADMINISTRATIVE LAW JUDGE: Colleen M. Mamelka

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Claimant's request for a hearing. After due notice, a hearing was conducted from Inkster, Michigan on April 2, 2009. The Claimant appeared and testified. The Claimant was represented by [redacted] of [redacted]. [redacted] appeared on behalf of the Department. At the Claimant's request, the record was extended to allow for the submission of additional medical records however no further records were submitted. This matter is now before the undersigned for a final determination.

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of Medical Assistance ("MA-P") and State Disability Assistance ("SDA") programs?

FINDINGS OF FACT

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

1. The Claimant submitted an application for public assistance seeking Medical Assistance ("MA-P") and State Disability Assistance ("SDA") benefits on April 27, 2006.
2. On April 27, 2007, the Medical Review Team ("MRT") deferred the disability determination in order to obtain additional medical documentation. (Exhibit 1, p. 3)
3. On May 24, 2007, the MRT determined the Claimant was not disabled for purposes of the MA-P benefits. (Exhibit 1, pp. 3, 4)
4. On December 5, 2008, the Department sent an Eligibility Notice to the Claimant informing her that she was found not disabled.
5. On December 16, 2008, the Department received the Claimant's written Requests for Hearing.
6. On February 26, 2009, the State Hearing Review Team ("SHRT") determined the Claimant not disabled based upon insufficient evidence. (Exhibit 2)
7. The Claimant's alleged physical disabling impairment(s) are due to chronic back and leg pain, osteoarthritis, asthma, diabetes, coronary artery disease, high blood pressure, GERD, and obesity.
8. The Claimant has not alleged any mental disabling impairment(s).
9. At the time of hearing, the Claimant was 50 years old with a [redacted] birth date; was 5'2" in height; and weighed 200 pounds.
10. The Claimant is a high school graduate with an employment history as a maintenance worker, general laborer, and as a waitress.
11. The Claimant's impairment(s) have lasted, or are expected to last, continuously for a period of 12-months or longer.

CONCLUSIONS OF LAW

The Medical Assistance ("MA") program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department of Human Services ("DHS"), formally known as the Family Independence Agency, 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").

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) 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 recovery and/or medical assessment of ability to do work-relate activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913 An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a) Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.929(a)

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicants takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and

(4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3) The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2)

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1) The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (i.e. age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need evaluate subsequent steps. 20 CFR 416.920(a)(4) If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4) If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from step three to step four. 20 CFR 416.920(a)(4); 20 CFR 416.945 Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1) An individual's residual functional capacity assessment is evaluated at both steps four and five. 20 CFR 416.920(a)(4) In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv)

In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a) An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a) The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6)

As outlined above, the first step looks at the individual's current work activity. An individual is not disabled regardless of the medical condition, age, education, and work experience, if the individual is working and the work is a substantial, gainful activity. 20 CFR 416.920(a)(4)(i) In the record presented, the Claimant is not involved in substantial gainful activity and last worked in 2005 therefore she is not ineligible for disability benefits under Step 1.

The severity of the Claimant's alleged impairment(s) is considered under Step 2. The Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b) An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c) Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b) Examples include:

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

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

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

6. Dealing with changes in a routine work setting.

Id. The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985) An impairment qualifies as non-severe only if, regardless of a claimant's age, education, or work experience, the impairment would not affect the claimant's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985)

In the present case, the Claimant alleges physical disability due to chronic back/leg pain, osteoarthritis, asthma, diabetes, coronary artery disease, high blood pressure, GERD, and obesity.

On [redacted], the Claimant's knees were examined due to complaints of pain. Four views of the left knee were obtained which documented the narrowing of the medial joint space with hypertrophic spurs. Spur formation was found off the tibial joint with no evidence of fracture or joint effusion. Ultimately, degenerative changes were noted. Similarly, four views of the right knee were obtained which revealed a narrowing of the medial and lateral joint spaces with hypertrophic spurring. Spurs were documented off the tibial spine along with evidence of narrowing of the patellofemoral joint with hypertrophic spurring. Moderate degenerative changes of the right knee were noted. Finally, three views of the right hip were obtained which

showed space narrowing compatible with mild degenerative change about both hips. Phleboliths were documented within the pelvis.

On [redacted], the Claimant presented to the hospital with complaints of sharp left side pain, abdominal pain, shortness of breath, chest and lower extremity joint pain. The Claimant received IV steroids and nebulizer treatments. Swelling of the right knee was noted as well as an elevated sugar value of 423. The discharge diagnoses on [redacted] were asthma exacerbation, diabetes, and leukocytosis.

On [redacted], the Claimant presented to the emergency room with complaints of chest pain, stomach cramping, and leg pain. The Claimant was treated with IV steroids and released along with prescribed medication treatment. The discharge diagnoses were acute abdominal and chest pain, chronic obesity, hypokalemia (resolved) and chronic COPD and asthma.

On [redacted], the Claimant underwent a left temporal artery biopsy due to complaints of excruciating headaches which were associated with some visual disturbance in her left eye. The post-operative diagnosis was left temporal arteritis (inflammation or infection involving an artery or arteries).

On [redacted], the Claimant presented to the emergency room with severe swelling and pain of her lower extremities as well as shortness of breath. The Claimant's admitting diagnoses were acute, severe pain, both lower extremities and congestive heart failure. Deep vein thrombosis and cerebellar tumor were of concern. A discharge summary was not submitted so it is not clear how low the Claimant remained in the hospital and what the final diagnoses were.

On [redacted], the Claimant presented to the emergency room with complaints of asthma exacerbation. The Claimant received IV steroid treatment and was diagnosed with exacerbation of asthma with vigorous coughing and probable muscle spasm and hyperventilation. The final diagnoses at discharge on or about [redacted] were asthmatic exaggeration, hypertension, coronary artery disease, diabetes mellitus, and hypercholesterolemia. The Claimant was prescribed 15 medications at discharge.

On [redacted], the Claimant's treating physician completed a Medical Examination Report on behalf of the Claimant. The current diagnoses were listed as severe osteoarthritis, hypertension, asthma and COPD. The physical examination found the Claimant's gait as unsteady requiring a cane; lower leg edema; abdominal pain; and very tender joints with calf muscle weakness. Full lifting/carrying, standing, walking, and sitting restrictions were documented as well as the Claimant's inability to perform repetitive actions with her feet and leg controls. The Claimant was able to perform repetitive actions with her hands/arms. In addition, the Claimant's severe pain and unsteady gait were documented.

On [redacted] the Claimant was admitted to the hospital after presenting to the emergency room with a boil/abscess which was treated with IV antibiotics. The Claimant was found with multiple medical problems including coronary artery disease post angioplasty within stent placement (January 2006). The Claimant's bronchial asthma was treated on an "around-the-clock" basis. The Claimant was discharged on [redacted].

On [redacted], the Claimant presented to the emergency room with complaints of chest pain, shortness of breath, and cough. A chest x-ray documented stable moderate cardiomegaly. The Claimant was given steroid IV, subsequently discharged with the diagnoses of asthma, bronchitis with cough and shortness of breath, and reproducible chest pain.

On [redacted], the Claimant underwent a left heart catheterization without complication. The Claimant was found with double vessel coronary artery disease and patent stent to mid right coronary artery with 30% in stent stenosis. On [redacted], an ultrasound of the Claimant's right groin was performed, post catheterization, which showed no pseudoaneurysm within the right groin. On [redacted], the Claimant was discharged with the diagnoses of abdominal pain and muscle spasms post catheterization noting polypharmacy.

On [redacted], the Claimant attended a cardiovascular examination. The Claimant complaints of chest discomfort were secondary to her complex medical regime. The Claimant did not have angina with excellent pulses and no claudication.

On [redacted], the Claimant attended a cardiovascular evaluation. At that time, the Claimant had been prescribed at least 24 different medications. The main concern from both a cardiac and non-cardiac standpoint was to get her medication regime optimized and stabilized.

On [redacted] and [redacted], the Claimant's blood work revealed a high white blood cell count.

On [redacted], the Claimant attended a follow-up cardiac appointment with complaints of high blood pressure and headaches. The Claimant was prescribed 18 medications. The Claimant was found with coronary artery disease with a prior revascularization with risk modification. The polypharmacy complexity was also highlighted as a concern.

On [redacted], the Claimant attended a follow-up cardiac appointment. The Claimant was found with back and lower extremity pain with higher blood pressure. Problems with her polypharmacy (17 prescribed medications) were noted however no changes were recommended by the Claimant's primary care physician. Ultimately, the Claimant's coronary artery disease was stable and her blood pressure was high.

On [redacted], the Claimant attended a follow-up cardiac appointment. Some confusion regarding the Claimant's complex medication regime was noted. The Claimant was diagnosed with coronary artery disease (stable), systemic hypertension, and dyslipidemia. The Claimant was strongly recommended to follow-up with her primary car physician to clarify the non-cardiac medications.

On [redacted], the Claimant attended a cardiovascular follow-up appointment. The physical examination documented tenderness upon palpation of the left anterior chest. The Claimant was treated for chest pain, coronary artery disease, benign hypertension, hyperlipidemia, and was instructed to return in 6 weeks.

On [redacted], the Claimant was admitted to the hospital after complaints of shortness of breath. The Claimant was diagnosed with COPD exacerbation and was started on steroid IV and breathing treatments. A chest x-ray revealed the Claimant's heart as borderline in size. A large cyst in the anterior chest, consistent with a large lung cyst, was also documented. The Claimant was stabilized and discharged on the [redacted], with the diagnoses of COPD exacerbation, diabetes, hypertension, coronary artery disease, and osteoarthritis.

On [redacted], the Claimant was seen by a cardiologist. The Claimant was diagnosed with coronary artery disease, benign hypertension, headaches, and unspecified hyperlipidemia.

On [redacted], the Claimant went to a cardiologist appointment. The Claimant's blood pressure was high and she was diagnosed with coronary artery disease, edema, and shortness of breath. The Claimant's care was documented as challenging noting the Claimant's symptoms of dyspnea and edema were likely multifactorial due to the Claimant's high blood

pressure, weight gain, deconditioning, and medication side effects. Pulmonary hypertension was not ruled out.

On [redacted], a Medical Examination Report was completed on behalf of the Claimant. The current diagnoses were listed as hypertension, urinary incontinence, hyperlipidemia, gastritis, sleep apnea, COPD, diabetes, coronary artery disease with stent placement, degenerative disc disease, and obesity. The physical examination noted an unsteady gait, pulmonary hypertension, wheezing, and edema. The Claimant's condition was listed as deteriorating and she was restricted to occasionally lifting/carrying less than 10 pounds. Standing and/or walking was limited to less than 2 hours during an 8 hour workday, with sitting limited to less than six hours during this same period. Assistive devices were not medically required although a cane was suggested. The Claimant was able to perform repetitive simple grasping and fine manipulation with both hands/arms but was unable to perform repetitive reaching, pushing, or pulling.

On [redacted], the Claimant presented to the emergency room with complaints of sharp pain. The chest x-ray confirmed cardiomegaly. The Claimant's white blood cell count was high. The Claimant was discharged and instructed to follow-up with her cardiologist. The diagnoses were atypical chest pain, diabetes, and peripheral neuropathy.

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the Claimant has presented some medical evidence establishing that she does have some physical and mental limitations on her ability to perform basic work activities. The medical evidence has established that the Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted

continuously for twelve months; therefore, the Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The Claimant has alleged physical disabling impairments due to chronic back/leg pain, osteoarthritis, asthma, GERD, coronary artery disease, high blood pressure, diabetes, and obesity.

As a preliminary matter, the Claimant suffers from Gastric Esophageal Reflux Disease ("GERD") however there were no treatment records submitted regarding this disease nor does it meet a listed impairment.

Listing 1.00 defines musculoskeletal system impairments. Disorders of the musculoskeletal system may result from hereditary, congenital, or acquired pathologic processes. 1.00A Impairments may result from infectious, inflammatory, or degenerative processes, traumatic or developmental events, or neoplastic, vascular, or toxic/metabolic diseases. 1.00A Regardless of the cause(s) of a musculoskeletal impairment, functional loss for purposes of these listings is defined as the inability to ambulate effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment, or the inability to perform fine and gross movements effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment. 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. 1.00B2b(1) Ineffective ambulation is defined generally as having insufficient lower extremity function 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.) *Id.* 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. 1.00B2b(2) They must have the ability to travel without companion assistance to and from a place of employment or school. . . . *Id.* When an individual's impairment involves a lower extremity uses a hand-held assistive device, such as a cane, crutch or walker, the medical basis for use of the device should be documented. 1.00J4 The requirement to use a hand-held assistive device may also impact an individual's functional capacity by virtue of the fact that one or both upper extremities are not available for such activities as lifting, carrying, pushing, and pulling. *Id.*

Categories of Musculoskeletal include:

1.02 Major dysfunction of a joint(s) due to any cause: Characterized by gross anatomical deformity (e.g. subluxation, contracture, bony or fibrous ankylosis, instability) and chronic joint pain and stiffness with signs of limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With:

A. Involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in inability to ambulate effectively as defined in 1.00B2b; or

B. Involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, wrist, hand), resulting in inability to perform fine and gross movements effectively a defined in 1.00B2c

* * *

1.04 Disorders of the spine (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the cauda equine) or 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 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 1.00B2b. (see above definition)

In order to meet a musculoskeletal listing, the impairment must present a major dysfunction resulting in the inability to ambulate effectively. Recent medical records state that assistive devices are not medically required but instead were suggested. Degenerative disc disease and narrowing of the medial and lateral joint spaces bilaterally is documented, as well as right knee swelling, degenerative disc disease, and osteoarthritis. Full restrictions were documented in 2006, however the [redacted] Medical Examination Report restrictions are the equivalent to sedentary. Ultimately, the Claimant may meet a listed impairment within Listing 1.00, however the record is insufficient to meet the intent and severity requirement thus the Claimant cannot be found disabled under this listing.

The Claimant has asthma. Listing 3.00 defines respiratory system impairments. Respiratory disorders, along with any associated impairment(s), must be established by medical evidence sufficient enough in detail to evaluate the severity of the impairment. 3.00A Evidence must be provided in sufficient detail to permit an independent reviewer to evaluate the

severity of the impairment. *Id.* A major criteria for determining the level of respiratory impairments that are episodic in nature, is the frequency and intensity of episodes that occur despite prescribed treatment. 3.00C Attacks of asthma, episodes of bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum), or respiratory failure as referred to in paragraph B of 3.03, 3.04, and 3.07, are defined as prolonged symptomatic episodes lasting one or more days and requiring intensive treatment, such as intravenous bronchodilator or antibiotic administration or prolonged inhalational bronchodilator therapy in a hospital, emergency room or equivalent setting. 3.00C Hospital admissions are defined as inpatient hospitalizations for longer than 24 hours. *Id.* Medical evidence must include information documenting adherence to a prescribed regimen of treatment as well as a description of physical signs. *Id.* For asthma, medical evidence should include spirometric results obtained between attacks that document the presence of baseline airflow obstruction. *Id.*

Chronic asthmatic bronchitis (Listing 3.03A) is evaluated under Listing 3.02. Chronic obstructive pulmonary disease, due to any cause, meets Listing 3.02 if medical evidence establishes that the Claimant's forced expiratory volume (in one second) is equal to or less than 1.15 (based on the Claimant's 5' 2" height). Attacks of asthma and/or episodes of bronchitis as referred to in 3.03 and 3.07, in spite of prescribed treatment, that occur at least once every 2 months or at least six times a year are considered. Each in-patient hospitalization for longer than 24 hours counts as two attacks/episodes and an evaluation of at least 12 consecutive months must be used to determine the frequency of attacks/episodes. 3.03B; 3.07B For asthma, the medical evidence should include spirometric results obtained between attacks that document the presence of baseline airflow obstruction. 3.00C In addition, Listing 3.10 defines sleep-breathing disorders.

In this case, the record documents treatment for shortness of breath and/or asthma on a least seven occasions throughout the period from January 2006 through March of 2009. A pulmonary function test was not performed (or at least not submitted for consideration). Further, the objective medical records associate the Claimant's shortness of breath with the Claimant's chest pain, as opposed to asthma. Further, due in part to polypharmacy, adherence to a medication regime is not clear. Ultimately, the record is insufficient to meet the intent and severity requirement of a listed impairment within 3.00 as detailed above.

The Claimant alleges physical disabling impairments due to coronary artery disease and high blood pressure. Listing 4.00 defines cardiovascular impairment in part, as follows:

> . . . any disorder that affects the proper functioning of the heart or the circulatory system (that is, arteries, veins, capillaries, and the lymphatic drainage). The disorder can be congenital or acquired. Cardiovascular impairment results from one or more of four consequences of heart disease:
> (i) Chronic heart failure or ventricular dysfunction.
> (ii) Discomfort or pain due to myocardial ischemia, with or without necrosis of heart muscle.
> (iii) Syncope, or near syncope, due to inadequate cerebral perfusion from any cardiac cause, such as obstruction of flow or disturbance in rhythm or conduction resulting in inadequate cardiac output.
> (iv) Central cyanosis due to right-to-left shunt, reduced oxygen concentration in the arterial blood, or pulmonary vascular disease.

An uncontrolled impairment means one that does not adequately respond to the standard prescribed medical treatment. 4.00A3f In a situation where an individual has not received ongoing treatment or have an ongoing relationship with the medical community despite the existence of a severe impairment, the disability evaluation is based on the current objective medical evidence. 4.00B3a If an individual does not receive treatment, an impairment that meets the criteria of a listing cannot be established. *Id.* Hypertension (high blood pressure) generally causes disability through its effect on other body systems and is evaluated by reference

to specific body system(s) affected (heart, brain, kidneys, or eyes). 4.00H1 Hypertension, to include malignant hypertension, is not a listed impairment under 4.00 thus the effect on the Claimant's other body systems were evaluated by reference to specific body parts.

Listing 4.02 discusses chronic heart failure. To meet the required level of severity while on a regimen of prescribed treatment the following must be satisfied:

A**.** Medically documented presence of one of the following:

1. Systolic failure (see 4.00D1a(i)), with left ventricular end diastolic dimensions greater than 6.0 cm or ejection fraction of 30 percent or less during a period of stability (not during an episode of acute heart failure); or

2. Diastolic failure (see 4.00D1a(ii)), with left ventricular posterior wall plus septal thickness totaling 2.5 cm or greater on imaging, with an enlarged left atrium greater than or equal to 4.5 cm, with normal or elevated ejection fraction during a period of stability (not during an episode of acute heart failure);

AND

B. Resulting in one of the following:

1. Persistent symptoms of heart failure which very seriously limit the ability to independently initiate, sustain, or complete activities of daily living in an individual for whom an MC, preferably one experienced in the care of patients with cardiovascular disease, has concluded that the performance of an exercise test would present a significant risk to the individual; or

2. Three or more separate episodes of acute congestive heart failure within a consecutive 12-month period (see 4.00A3e), with evidence of fluid retention (see 4.00D2b (ii)) from clinical and imaging assessments at the time of the episodes, requiring acute extended physician intervention such as hospitalization or emergency room treatment for 12 hours or more, separated by periods of stabilization (see 4.00D4c); or

3. Inability to perform on an exercise tolerance test at a workload equivalent to 5 METs or less due to:

   a. Dyspnea, fatigue, palpitations, or chest discomfort; or

b. Three or more consecutive premature ventricular contractions (ventricular tachycardia), or increasing frequency of ventricular ectopy with at least 6 premature ventricular contractions per minute; or

c. Decrease of 10 mm Hg or more in systolic pressure below the baseline systolic blood pressure or the preceding systolic pressure measured during exercise (see 4.00D4d) due to left ventricular dysfunction, despite an increase in workload; or

d. Signs attributable to inadequate cerebral perfusion, such as ataxic gait or mental confusion.

Listing 4.04 discusses ischemic heart disease. If an individual does not receive treatment, an impairment is not found however, disability may be found if another impairment in combination with the cardiovascular impairment medically equals the severity of a listed impairment or based on consideration of the individual's residual functional capacity and age, education, and work experience. 4.00B3 To meet the severity requirement of Listing 4.04 while on prescribed treatment, one of the following must be met:

A. Sign- or symptom-limited exercise tolerance test demonstrating at least one of the following manifestations at a workload equivalent to 5 METs or less:

1. Horizontal or downsloping depression, in the absence of digitalis glycoside treatment or hypokalemia, of the ST segment of at least -0.10 millivolts (-1.0 mm) in at least 3 consecutive complexes that are on a level baseline in any lead other than a VR, and depression of at least -0.10 millivolts lasting for at least 1 minute of recovery; or

2. At least 0.1 millivolt (1 mm) ST elevation above resting baseline in non-infarct leads during both exercise and 1 or more minutes of recovery; or

3. Decrease of 10 mm Hg or more in systolic pressure below the baseline blood pressure or the preceding systolic pressure

measured during exercise (see 4.00E9e) due to left ventricular dysfunction, despite an increase in workload; or

4. Documented ischemia at an exercise level equivalent to 5 METs or less on appropriate medically acceptable imaging, such as radionuclide perfusion scans or stress echocardiography.

OR

B. Three separate ischemic episodes, each requiring revascularization or not amenable to revascularization (see 4.00E9f), within a consecutive 12-month period (see 4.00A3e).

OR

C. Coronary artery disease, demonstrated by angiography (obtained independent of Social Security disability evaluation) or other appropriate medically acceptable imaging, and in the absence of a timely exercise tolerance test or a timely normal drug-induced stress test, an MC, preferably one experienced in the care of patients with cardiovascular disease, has concluded that performance of exercise tolerance testing would present a significant risk to the individual, with both 1 and 2:

1. Angiographic evidence showing:

a. 50 percent or more narrowing of a nonbypassed left main coronary artery; or

b. 70 percent or more narrowing of another nonbypassed coronary artery; or

c. 50 percent or more narrowing involving a long (greater than 1 cm) segment of a nonbypassed coronary artery; or

d. 50 percent or more narrowing of at least two nonbypassed coronary arteries; or

e. 70 percent or more narrowing of a bypass graft vessel; and

2. Resulting in very serious limitations in the ability to independently initiate, sustain, or complete activities of daily living.

In this case, the Claimant coronary artery disease with stent placement is documented, as well as continued chest pain. In review of the submitted record, it is found the record the

Claimant's heart impairment may meet a Listed impairment within 4.00 however the record is insufficient to meet the intent and severity requirement thus the Claimant cannot be found disabled, or not disabled, under this listing.

The Claimant also asserts physical disabling impairments due to diabetes. Listing 9.08 discusses diabetes mellitus and, in order to meet this Listing, an individual must also establish:

> A. *Neuropathy* demonstrated by significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C); or
>
> B. *Acidosis* occurring at least on the average of once every 2 months documented by appropriate blood chemical tests (pH or $pC0_2$ or bicarbonate levels); or
>
> C. *Retinitis proliferans;* evaluate the visual impairment under the criteria in 2.02, 2.03, or 2.04.

In this case, the Claimant's diabetes is documented however, the objective medical records do not meet the intent or severity requirement of 9.08 thus the Claimant cannot be found disabled, or not disabled under this listing.

On August 24, 1999, the Social Security Administration deleted Listing 9.09 regarding obesity from the Listing of Impairments. SSR 02-1p In conjunction, the final rule in the Federal Register deleting 9.09, added paragraphs to the prefaces of the musculoskeletal, respiratory, and cardiovascular body system listings that provide guidance regarding the potential effects obesity has in causing or contributing to impairments in those body systems. *Id.* Obesity affects the cardiovascular and respiratory systems because of the increased workload the additional body mass places on these systems. *Id.* Therefore, when determining whether an individual with obesity has a listing-level impairment or combination of impairments (and when assessing a claim at other steps of the sequential evaluation process, including when assessing an

individual's residual functional capacity) any additional and cumulative effects of obesity is considered. *Id.* The National Institute of Health (NIH) established medical criteria for the diagnosis of obesity in its *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults* (NIH Publication No. 98-4083, September 1998). SSR 02-1p These guidelines classify overweight and obesity in adults according to Body Mass Index ("BMI") which is the ratio of an individual's weight in kilograms to the square of his/her height in meters. *Id.* For adults, the *Clinical Guidelines* describe a BMI of 25-29.9 as "overweight" with obesity being 30.0 or above. *Id.* The guidelines recognize three levels of obesity. Level I includes BMIs of 30.0-34.9; Level 2 includes BMIs of 35.0-39.9; and Level 3 (termed "extreme" obesity) includes BMIs of 40.0 or above. *Id.*

In the record presented, the objective medical records documents the Claimant's obesity, which based on the Claimant's current weight, is at Level 2. That being stated, the record remains insufficient to meet the intent and severity of the Listing therefore the Claimant cannot be found disabled, or not disabled at Step 3 therefore the Claimant's eligibility is considered under Step 4. 20 CFR 416.905(a)

The fourth step in analyzing a disability claim requires an assessment of the Claimant's residual functional capacity ("RFC") and past relevant employment. 20 CFR 416.920(a)(4)(iv) An individual is not disabled if he/she can perform past relevant work. *Id.*; 20 CFR 416.960(b)(3) Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1) Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3) RFC is assessed based on impairment(s), and any related

symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

To determine the physical demands (exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967 Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a) Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b) Even though weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additionally limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.* Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c) An individual capable of performing medium work is also capable of light and sedentary work. *Id.* Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d) An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.* Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with

frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e) An individual capable of very heavy work is able to perform work under all categories. *Id.*

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands (exertional requirements, i.e. sitting, standing, walking, lifting, carrying, pushing, or pulling) are considered nonexertional. 20 CFR 416.969a(a) In considering whether an individual can perform past relevant work, a comparison of the individual's residual functional capacity with the demands of past relevant work. *Id.* If an individual can no longer do past relevant work the same residual functional capacity assessment along with an individual's age, education, and work experience is considered to determine whether an individual can adjust to other work which exists in the national economy. *Id.* Examples of non-exertional limitations or restrictions include difficulty function due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi) If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2) The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.*

The Claimant's prior work history includes employment as a maintenance worker, general laborer, and waitress. In light of the Claimant's testimony and in consideration of the Occupational Code, the Claimant's prior work is classified as unskilled, medium work.

The Claimant testified that she experiences difficulty lifting/carrying; can stand for 15 minutes with pain; can sit for approximately ½ hour; can walk short distances; and is unable to squat and/or bend. The most recent medical documentation note similar restrictions with lifting/carrying limited to less than 10 pounds; standing and/or walking less than 2 hours with sitting at less than 6 hours. Assistive devices were also suggested. If the impairment or combination of impairments does not limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. 20 CFR 416.920 In consideration of the Claimant's testimony, medical records, and current limitations, it is found that the Claimant is not able to return to past relevant work thus the fifth step in the sequential evaluation is required.

In Step 5, an assessment of the individual's residual functional capacity and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v) At the time of this writing, the Claimant, a high school graduate, was 51 years old thus considered to be closely approaching advanced age for MA-P purposes. Disability is found disabled if an individual is unable to adjust to other work. *Id.* At this point in the analysis, the burden shifts from the Claimant to the Department to present proof that the Claimant has the residual capacity to substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden.

O'Banner v Sec of Health and Human Services, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

In the record presented, the total impact caused by the combination of medical problems suffered by the Claimant must be considered. In doing so, it is found that the combination of the Claimant's physical impairments have a major effect on her ability to perform basic work activities. Although the Claimant *may* be able to perform the full range of activities for sedentary work as defined in 20 CFR 416.967(a), after review of the entire record and in consideration of the Medical-Vocational Guidelines [20 CFR 404, Subpart P, Appendix II], specifically Rule 201.12, it is found that the Claimant is disabled for purposes of the MA-P program at Step 5

The State Disability Assistance ("SDA") program, which provides financial assistance for disabled persons, was established by 2004 PA 344. DHS administers the SDA program purusant to MCL 400.10 et seq. and Michigan Administrative Code ("MAC R") 400.3151 – 400.3180. Department policies are found in PAM, PEM, and PRM. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal SSI disability standards for at least ninety days. Receipt of SSI or RSDI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness (MA-P) automatically qualifies an individual as disabled for purposes of the SDA program.

In this case, the Claimant is found disabled for purposes of the Medical Assistance ("MA-P") program, therefore the Claimant's is found disabled for purposes of continued SDA benefits.

DECISION AND ORDER

The Administrative Law Judge, based upon the findings of fact and conclusions of law, finds the Claimant disabled for purposes of the Medical Assistance program and the State Disability Assistance program.

It is ORDERED:

1. The Department's determination is REVERSED.

2. The Department shall initiate review of the April 27, 2006 application to determine if all other non-medical criteria are met and inform the Claimant and her authorized representative of the determination.

3. The Department shall supplement the Claimant any lost benefits she was entitled to receive if otherwise eligible and qualified in accordance with department policy.

4. The Department shall review the Claimant's continued eligibility in August 2010 in accordance with department policy.

__/s/_____
Colleen M. Mamelka
Administrative Law Judge
For Ishmael Ahmed, Director
Department of Human Services

Date Signed: _08/11/09_____

Date Mailed: _08/12/09_____

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

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

CMM/jlg

cc: [redacted]