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: 2009-16380
Issue No: 2009
Case No: [redacted]
Load No:
Hearing Date:
May 6, 2009
Oakland 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 May 6, 2009. 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 retroactive Medical Assistance (retro MA-P)?

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 8, 2008, claimant filed an application for Medical Assistance and retroactive Medical Assistance benefits alleging disability.

(2) On January 12, 2009, the Medical Review Team denied claimant's application stating that claimant could perform other work.

(3) On January 20, 2009, the department caseworker sent claimant notice that her application was denied.

(4) On January 30, 2009, claimant filed a request for a hearing to contest the department's negative action.

(5) On April 6, 2009, the State Hearing Review Team again denied claimant's application stating that claimant was capable of performing her past work as a waitress and the medical opinion was considered in light of CFR 416.927.

(6) The hearing was held on May 6, 2009. 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 May 11, 2009.

(8) On May 20, 2009, the State Hearing Review Team again denied claimant's application stating that claimant was capable of performing other work in the form of light work per 20 CFR 416.967(b) pursuant to Medical-Vocational Rule 202.20 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, high school education, MA-P is denied using Vocational Rule 202.20 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) Claimant is a 47-year-old woman whose birth date is [redacted]. Claimant is 5' 3" tall and weighs 219 pounds. Claimant recently gained 30 pounds. Claimant attended the 12th grade and does have a GED. Claimant is able to read and write and does have basic math skills.

(10) Claimant last worked July 2008 as a waitress. Claimant has also worked doing clerical work.

(11) Claimant alleges as disabling impairments: diabetes mellitus, neuropathy, carpal tunnel syndrome, plantar fasciitis, arthritis and hip problems, sciatica, trigger finger and depression.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the MA program pursuant to MCL 400.10, *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.
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> (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 July 2008. Claimant is not disqualified from receiving disability at Step 1.

The objective medical evidence on the record indicates that on [redacted], a MRI of the lumbar spine was performed with intravenous contrast. There was a minimally bulging L4-L5 intervertebral disc. No disc herniation was identified. Significant central canal or neural foraminal stenosis was not identified. The height of the vertebral bodies and the intervertebral disc spaces appeared normal. There was mild dextroscoliosis of the lumbar spine which may be positional in nature. (Page A, New Material)

An emergency department visit of [redacted], indicates that claimant had a temperature of 98.9 degrees Fahrenheit. She was alert and oriented x4. Her affect was appropriate and she was in no respiratory distress. Her blood glucose was 176 mg. On [redacted], claimant was again alert and oriented x4. Her affect was appropriate. She was in no respiratory distress. On [redacted], claimant presented with a fall and some bilateral leg numbness. At that time claimant was 62" tall and weighed 225 pounds. Her BMI was 41. There was a diagnostic radiology test performed on [redacted] with a transverse view of the pelvis as well as two views of the left hip. There was no acute pelvic fracture. The left hip was unremarkable. No acute fracture or dislocation. The impression was a normal left hip. There was another diagnostic radiology test done [redacted] which included an AP and abducted view of the left hip. These demonstrated no evidence of fracture, dislocation or other significant bone or joint abnormality. The impression was no acute abnormality.

A [redacted], medical report indicates that claimant was a 47-year-old female who appeared her stated age. She was 63" tall and 232 pounds. Her temperature was 99 degrees Fahrenheit and the pulse rate was 112 per minute. The respiratory rate was 20 per minute. The blood pressure was 110/80 in a sitting position. She was obese and well built and well nourished, and did not appear acutely ill or in any acute distress. She used a cane but was able to walk

without it but she did limp. Her skin was within normal limits. Finger counting was present on both hands. Funduscopic examination was negative. There was a narrowing of lower opening of the throat. The head was normocephalic. The color of the face was normal. Visual acuity: far vision without glasses right 20/30 and left 20/none and near vision without glasses right 20/70 and the left 20/none. Neck was within normal limits. There was hyperresonance on percussion and slight expiratory wheezing of the left lung in supine position. There were diminished breath sounds. There was normal sinus rhythm with no murmurs. The abdomen was soft and obese with a suprapubic operational scar. The liver, spleen and kidneys were not palpable. There was no tenderness, hernias or audible abdominal bruit. The bowel sounds were normal. There was + edema with good pulses in the extremities. In the musculoskeletal system the examination of the cervical, dorsal and lumbosacral spines clinically did not reveal any striking abnormalities. There was no paraspinal muscle tenderness or spasm. The motions of the lumbosacral spine were as follows: forward flexion 0-80 degrees, backward extension 0-10 degrees, lateral flexion 0-15 degrees, lateral rotation 0-15 degrees. Straight leg raise test was 70 degrees on the right and 70 degrees on the left. Examination of the upper and lower extremities did reveal Tinel and Phalen were positive. Full range of motion of both wrists, bilateral 1st MP 0-70 degrees. Left hip internal rotation was 0-35 degrees. In the neurological examination, the claimant was cooperative and oriented to time, place and person. There was no memory loss. The claimant was right-handed. The grip strength was 20 pounds on the right and 75 pounds on the left. The cerebellar functions were tested. The gait was abnormal with an antalgic and limping left leg. She was able to walk on toes and heels. There was no tremor, nystagmus or ataxia noted. The Romberg test was negative. Finger-to-finger-to-nose was negative. Heel-to-shin was negative. The higher cerebral cortical functions, including speech and understanding were normal. All the cranial nerves

appeared to be intact. There was no localized muscle wasting, twitching, atrophy, paralysis, or involuntary movements. Pinprick, light touch, temperature, and vibration senses were diminished in the right leg below the right knee and in the whole left leg. Deep tendon reflexes were normal. Knee jerks and ankle jerks were normal. Babinski test was negative. The diagnosis was type 2 diabetes mellitus, carpal tunnel syndrome, neuropathy, sleep apnea mild on a c-pap machine, and mild chronic obstructive pulmonary disease. (Pages 68-69, Medical Reports)

On [redacted], neurological examination indicates that claimant was 5' 1" tall and weighed 224 pounds. Her blood pressure was 137/85 and her pulse was 99. Claimant was awake, alert and oriented to name, date and place. Carotids were 2/4 bilaterally as were superficial temporal pulses. The neck was supple and had full range of motion. There was no significant temporomandibular or occipital notch tenderness. Recall was 3/3 at both one and five minutes. Attention span, fund of knowledge, and language skills were within normal limits. Motor examination showed strength to be 5/5 bilaterally in both upper and lower extremities. There were absent Achilles reflexes. Reflexes were 2+ otherwise. There were no Babinski's of Hoffmann's signs. Gait was of normal station. There was no pronator drift. There was no atrophy or fasciculations seen. Tone was normal. There were no signs of frontal release. Her sensory examination showed diminished sensation to pinprick and vibratory sensation it the lower extremities, left more so than right to about the level of the knees. Romberg's sign was negative with the eyes closed. The cerebellar examination showed finger-to-nose and rapid alternating movements and heel-to-shin to be intact. In her cranial nerve examination showed cranial nerve I not tested. Cranial nerve II discs are sharp. There was no papilledema. Visual fields were full. Cranial nerves III, IV, and VI extraocular muscles were intact. Pupils were equal and reactive to light accommodation. Cranial nerve V muscles of mastication were intact. Cranial nerve VII

facial expression was intact. Cranial nerve VIII air conduction is greater than bone conduction and was non-lateralizing. Cranial nerve IX and X gag and soft palate were intact. Cranial XI sternocleidomastoid and trapezius were intact. Cranial nerve XII tongue protrudes midline. In her general physical impression her head was normocephalic. There was no evidence of trauma, battle's or raccoon's sign. ENT was within normal limits. Neck, negative Spurling's sign was noted. Heart had regular rate and rhythm. Lungs were clear to auscultation. Abdomen was soft and bowel sounds were noted. Extremities were without gross deformity. Vasculature, superficial temporal arteries were 2/4 bilaterally. Carotids were 2/4 bilaterally without bruits. Radials were 2/4 bilaterally. Dorsalis pedis and posterior tibialis were 2/4 bilaterally. In summary, she had diabetic sensory motor polyneuropathy. She was advised to quit smoking. (Pages 71-72)

A Medical Examination Report at page 7 indicates that claimant was 5' 4" and 228 pounds and had a blood pressure of 124/80 on [redacted] examination date. Her examination areas were normal except that she was obese and she had tenderness in the hips with range of motion. She had Phalen's in the right hand and left patellar reflex and she had a depressed mood. The clinical impression was that claimant was deteriorating but had no limitations either mentally or physically. (Pages 7-8)

A [redacted] Medical Examination Report indicates that claimant was normal in all areas of examination and weight 225 pounds and had blood pressure of 120/60. She was diagnosed with sleep apnea and the clinical impression was that she was improving and had no limitations either physical or mental. (Pages 9-10)

A Medical Examination Report from [redacted] indicates that claimant was again normal in all areas of examination except she was obese and had problems with her Achilles reflexes. She was 5' 1" tall and 229 pounds and her blood pressure was 151/86 and she was

right- hand dominant and she had 20/20 vision in both eyes. The clinical impression was that claimant was stable and she could lift 10 pounds occasionally, less than 10 pounds frequently; and never lift 20 pounds or more. She could stand or walk less than two hours in an eight hour day. She did not need assistive devices for ambulation. She could use both of her upper extremities for simple grasping, reaching, pushing/pulling, and fine manipulating and use both legs and feet for operating foot and leg controls. She did not have any mental limitations. (Pages 11-12)

At Step 2, claimant has the burden of proof of establishing that she has a severely restrictive physical or mental impairment that has lasted or are expected to last for the duration of at least 12 months. There is no objective clinical medical evidence in the record that claimant suffers a severely restrictive physical or mental impairment. Claimant has reports of pain in multiple areas of her body; however, there are no corresponding clinical findings that support the reports of symptoms and limitations made by the claimant. The DHS-49s in the file indicate that most of claimant's examination areas are normal with the exception of some neuropathy. The clinical impression of most of the forms is that she is stable although one stated that she is deteriorating; however, the only finding made is that claimant experiences tenderness in her musculature. There is no medical finding that claimant has any muscle atrophy or trauma, abnormality or injury that is consistent with a deteriorating condition. In short, the DHS-49s have restricted claimant from tasks associated with occupational functioning based upon claimant's reports of pain (symptoms) rather than medical findings. Reported symptoms are an insufficient basis upon which a finding that claimant has met the evidentiary burden of proof can be made. This Administrative Law Judge finds that the medical record is insufficient to establish claimant has a severely restrictive physical or mental impairment. There is no evidence on the record

indicating claimant suffers mental limitations resulting from her reportedly depressed state. Claimant testified that she is depressed because of her finances and her medical condition. There is no mental residual functional capacity assessment in the record. The evidentiary record is insufficient to find that claimant suffers a severely restrictive mental impairment. For these reasons, this Administrative Law Judge finds that claimant has failed to meet her burden of proof at Step 2. Claimant must be denied benefits at this step based upon her failure to meet the evidentiary burden.

If claimant had not been denied at Step 2, the analysis would proceed to Step 3 where the medical evidence of claimant's condition does not give rise to a finding that she would meet a statutory listing in the code of federal regulations.

Claimant testified that she lives with her husband and has no children under 18 who live with her. They are surviving on claimant's unemployment compensation benefits. Claimant testified that she does have a driver's license but she doesn't drive, she only gets rides and that she cooks four times per week and cooks things like chicken and eggs. Claimant testified that she can walk a half a block and that her cane is prescribed by a doctor and she can stand for 10 minutes and sit for 10-15 minutes at a time. Claimant testified that she can shower and dress herself and the heaviest weight she can carry is a gallon of milk. Claimant testified that she is right-handed and that her level of pain on a scale from 1 to 10 without medication is an 8 and with medication is a 5/6. Claimant testified that she needs help getting on her socks and shoes and that she smokes a pack of cigarettes every two days and her doctor has told her to quit and she is not in a smoking cessation program. Claimant testified that in a typical day she sits on the couch, takes a shower, then tries to cook, watches TV and takes a nap. Claimant testified that she is not able to have sex.

If claimant had not already been denied at Step 2, this Administrative Law Judge would have to deny her again at Step 4 based upon her ability to perform her past relevant work. Claimant could work as a waitress or especially could work in a clerical capacity as a clerical capacity does not require strenuous physical exertion. There is no medical evidence upon which this Administrative Law Judge could find that claimant is unable to perform clerical work which she has engaged in, in the past. Therefore, if claimant had not already been denied at Step 2, she would be denied again 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 her prior jobs.

At Step 5, the burden of proof shifts to the department to establish that claimant does not have residual functional capacity.

The residual functional capacity 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.

Sedentary work. Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 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. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. 20 CFR 416.967(a).

Light work. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the 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.... 20 CFR 416.967(b).

Claimant has submitted insufficient objective medical evidence that she lacks the residual functional capacity to perform some other less strenuous tasks than in her prior employment or that she is physically unable to do light or sedentary tasks if demanded of her. Claimant's activities of daily living do not appear to be very limited and she should be able to perform light or sedentary work even with her impairments. Claimant does retain bilateral manual hand dexterity. Claimant has failed to provide the necessary objective medical evidence to establish that she has a severe impairment of combination of impairments which prevent her from performing any level of work for a period of 12 months. The claimant's testimony as to her limitations indicates that she should be able to perform light or sedentary work.

Claimant testified on the record that she does have depression.

For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph (B) of the listings for mental disorders (descriptions of restrictions of activities of daily living, social functioning; concentration, persistence, or pace; and ability to tolerate increased mental demands associated with competitive work).... 20 CFR, Part 404, Subpart P, App. 1, 12.00(C).

There is insufficient objective medical/psychiatric evidence contained in the file of depression or a cognitive dysfunction that is so severe that it would prevent claimant from working at any job. Claimant was able to answer all the questions at the hearing and was responsive to all the questions. Claimant was oriented to time, person and place during the hearing. Claimant is also not in compliance with her treatment program as she continues to smoke despite the fact that her doctor has told her to quit.

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).

Claimant's complaints of pain, while profound and credible, are out of proportion to the objective medical evidence contained in the file as it relates to claimant's ability to perform work. Therefore, this Administrative Law Judge finds that the objective medical evidence on the record does not establish that claimant has no residual functional capacity. Claimant is disqualified from receiving disability at Step 5 based upon the fact that she has not established by objective medical evidence that she cannot perform light or sedentary work even with her impairments. Under the Medical-Vocational guidelines, a younger individual (age 47), with a high school education and an unskilled work history, who is limited to light work is not considered disabled.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the department has appropriately established on the record that it was acting in compliance with department policy when it denied claimant's application for Medical Assistance and retroactive Medical Assistance benefits. The claimant should be able to perform a

wide range of light or sedentary work even with her impairments. Claimant is disqualified from receiving disability benefits at Step 2, Step 3, Step 4, and Step 5. The department has established its case by a preponderance of the evidence.

Accordingly, the department's decision is AFFIRMED.

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

Date Signed: June 24, 2009

Date Mailed: June 25, 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]