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: 2009-16817
Issue No: 2009
Case No: [redacted]
Load No:
Hearing Date:
May 21, 2009
Ingham 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, an in-person hearing was held on May 21, 2009. Claimant personally appeared and testified. Claimant was represented at the hearing by [redacted]

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 October 28, 2008, claimant filed an application for Medical Assistance and retroactive Medical Assistance benefits alleging disability.

(2) On November 24, 2008, the Medical Review Team denied claimant's application stating that claimant's impairments lacked duration.

(3) On November 26, 2008, the department caseworker sent claimant notice that his application was denied.

(4) On February 19, 2009, claimant filed a request for a hearing to contest the department's negative action.

(5) On April 13, 2009, the State Hearing Review Team again denied claimant's application stating that it had insufficient information and requested a mental status examination.

(6) The hearing was held on May 21, 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 October 13, 2009.

(8) On October 16, 2009, the State Hearing Review Team again denied claimant's application stating in its analysis and recommendation: The claimant was admitted in [redacted] and [redacted] due to suicide attempts by overdose. The claimant has a history of substance abuse. He admits to continued alcohol use. In [redacted] the claimant was very anxious and had a flat affect. However, his thought processes were well organized and there was no evidence of a thought disorder. He reported hallucinations when he was depressed. The psychologist had indicated he could not do IQ testing due to the claimant's intense anxiety; however, IQ testing was no requested. The claimant's findings were basically unremarkable. Public Law 104-121 is cited due to materiality of drug and alcohol abuse. 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 simple, unskilled work. In lieu of detailed work history, the claimant will be returned to other work. Therefore, based on the claimant's vocational profile of a younger individual, high school equivalent education and a history of unskilled work, MA-P is denied using Vocational Rule 204.00(H) as a guide. Retroactive MA-P was considered in this case and is also denied.

(9) Claimant is a 41-year-old man whose birth date is [redacted]. Claimant is 6' 1" tall and weighs 210 pounds. Claimant attended the 9th grade and has a GED and four semesters of college where he studied architecture. Claimant is able to read and write and does have basic math skills.

(10) Claimant last worked as a carpenter which is a job he had for approximately fifteen years.

(11) Claimant receives Food Assistance Program benefits and the Adult Medical Program.

(12) Claimant alleges as disabling impairments: shortness of breath, attention deficit disorder, depression, a bipolar disorder, a bad left shoulder and a separated clavicle, panic and anxiety attacks which occur daily and last for 15-20 minutes at a time. Claimant also alleges blackouts, schizophrenia, and psychotic episodes.

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 –
>
> (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 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;
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> (2) Capacities for seeing, hearing, and speaking;
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> (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 2008. Claimant is not disqualified from receiving disability at Step 1.

The objective medical evidence on the record indicates that claimant had a suicide attempt on [redacted] and reattempted suicide on [redacted] by taking all of his Geodon and Depakote tablets. His laboratory data indicated that his sodium was 144, potassium was 3.8, chloride was 112, bicarb was 24, anion gap of 8, BUN of 5, creatinine of 0.9. glucose of 93, ammonia 120, calcium 7.1, albumin of 3.0, ALT 21, AST 16, alk phos of 39, bilirubin total of 0.6, valproic acid of 50.6, white count 5.4, hemoglobin 13.6, hematocrit 41.2, platelets 191,000. No radiological imaging available on the chart. Serial EKGs have been reviewed with recent QTC interval of 411 and also 401 today, as of [redacted]. The claimant was watched with one-on-one supervision. IV hydration was initiated and psychiatry was consulted. The alcohol withdrawal pathway was instituted and three ammonia levels were checked with Lactulose management. Calcium was replaced. (p. 15)

On [redacted] a mental status examination indicates claimant was oriented to person, place, and situation. He was generally cooperative. His mood was described as depressed and anxious. His affect was consistent with his reported mood. He described that he had a war going on inside his head. He denied any specific auditory or visual hallucinations, but talked of two sides of himself, a good side and a bad side, that were constantly vying for his attention. He also

mentioned that he could have difficulty with paranoia at times. His mood was described as depressed. The claimant was anxious at times. His thought content and thought processes were as noted above. He had some recent suicidal ideation, although he denied any specific plan to harm himself at present. He says that the suicidal thoughts are intermittent and he has had them on a long-term basis. His insight was fair. He was interested in getting out of the hospital as quickly as possible and had not followed through with any treatment opportunities in the past. (p. 12) Claimant had no acute medical problems, but he had a GAF at the time of admission of 20, and the highest in the past year of 40-50. He was diagnosed with bipolar affective disorder, also anxiety disorder not otherwise specified, alcohol dependence, and cocaine abuse.

On physical examination of [redacted], claimant was a well-developed, well-nourished male. His blood pressure was 120/70, pulse was 80, and temperature was 98. Head, eyes, ears, nose, and throat were within normal limits with respect to ears, nose, throat, back, and lymphatic system. Carotids were clear. Thyroid was normal. Chest was clear to auscultation and percussion. Heart showed regular rhythm, no murmurs or gallops. Abdomen was soft with no organomegaly. Bowel sounds were present. No bruits. Genitourinary showed normal male, no hernia. Musculoskeletal showed consequences of a separated left shoulder as a result of a 4-wheeler accident. There was slight swelling in the left forearm over a superficial vein, but otherwise normal range of motion and strength in all extremities. Neurologic showed normal vibration, reflexes, and light touch. Gait and balance were normal. His laboratory data was remarkable for superficial thrombus within the forearm at the site of a previous IV with no retained foreign body. He had a history of hypertension. No specific treatment was indicated at that time. (p. 8)

A Medical Needs form in claimant's file at page B3 indicates the claimant was ambulatory, that he did not need special transportation or he did not need someone to accompany him to his medical appointments and he didn't have a medical for assistance with any of his personal care activities.

A [redacted] medical report indicates that claimant was admitted to the emergency room. He arrived at triage and his vital signs showed blood pressure of 129/73, heart rate of 127, respiratory rate 18, saturation was 98% by four liters nasal cannula and no temperature was recorded. The chief complaint was logged as a drug overdose and suicide attempt. Claimant had told [redacted] that he toke 25 Seroquel and had a pint of vodka. He had a second physical examination and his blood pressure was 103/55, heart rate 116, respiratory rate 16, saturation was 92% on room air, and his temperature was 98.7. He was sedated and seemed non-ill and non-toxic. He was unable to cooperate fully and smelled of alcohol. His HEENT was atraumatic and normocephalic. Pupils were 2.5 mm, equal, round, and reactive to light. Unable to assess for extraocular motility secondary to the claimant's sedation but there was no obvious scleral icterus or exophthalmos. Sclerae were non-icteric and there was no exophthalmos noted. Oropharyngeal tissue was blackened with charcoal; unable to fully visualize the oral cavity. Mucous membranes however did appear dry but native dentition appeared in acceptable repair. The neck had no JVD; unable to assess range of motion secondary to claimant sedation. Cardiovascular: S1 and S2 were appreciated without murmur, gallop, heave, rub, or thrill. Respiratory: Lungs were clear to auscultation bilaterally without palpable fremitus, word dyspnea, or use of accessory muscles. Abdomen: Bowel sounds were present. Abdomen was soft and non-tender without masses or organomegaly noted. Neurologic: Cranial nerves II through XII were grossly intact. Motor strength was 5/5 on both the upper and lower extremities

bilaterally. Speech was slurred and large non-intelligible; unable to assess for claimant's orientation due to sedation. The claimant was oriented to person, place, and time. The claimant appeared irritable but unable to do full assessment due to sedation. His skin was warm and dry with rashes or secondary excoriations. There was no clubbing, cyanosis, or pedal edema. Laboratory investigations done through the emergency room showed a 12-lead EKG without comparison study. There was sinus tachycardia at a rate of 117 with normal axis, normal intervals, and no pathological Q-waves. (pp. 4-5)

A psychological evaluation done on [redacted] indicated that claimant was oriented to time, person, and place. He could recall four digits forward and four digits backward. He could recall two out of three objects after a three-minute time lapse. The claimant knew his birthday and could easily name five recent past presidents. During the administration of many items associated with sensorium and mental capacity, he indicated he was having a hard time focusing. He exhibited low average capabilities for general fund of information. He could easily name five large cities, five currently famous people, but only one current event. He completed Serial 7's without mistake. He exhibited average capabilities for abstract reasoning. He stated that the proverb, "The grass is greener on the other side of the fence," meant, "Things look better." He stated that the proverb, "Don't cry over spilled milk," meant, "Don't sweat the small stuff." In similarities and differences the claimant indicated that a bush and a tree were alike in that they both have leaves. He indicated that they were different in size. He exhibited low average capabilities for social judgment and comprehension. He stated that if he found a stamped, addressed envelope in the street, he would mail it. He stated that is were the first person in a theater to discover a fire, he would yell fire and get out. Claimant had intense levels of anxiety during the examination. He indicated he was having a hard time focusing and

demonstrated significant psychomotor agitation. He reportedly has lost a number of jobs due to depression and panic attacks. He also reported a history of drinking on the job. It appeared that he has a severe impairment in his capacity to interact appropriately and effectively with coworkers and supervisors, and to adapt to changes in the work setting. The impression was bipolar disorder, panic disorder without agoraphobia, alcohol dependence, cocaine abuse in full sustained remission, and attention deficit hyperactivity disorder. His GAF was 48 and he would be unable to manage his own funds and his prognosis was very poor. (New Information pp. 2-4)

At Step 2, claimant has the burden of proof of establishing that he has a severely restrictive physical or mental impairment that has lasted or is expected to last for the duration of at least 12 months. There is insufficient objective clinical medical/psychiatric evidence in the record that claimant suffers a severely restrictive physical or mental impairment. Claimant basically has no physical impairments. There is no medical finding that claimant has any muscle atrophy or trauma, abnormality or injury that is consistent with a deteriorating condition. Claimant testified on the record that he does have panic attacks, bipolar disorder, attention deficit disorder, depression, schizophrenia, and psychotic episodes.

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).

The objective psychiatric evidence in the file indicates that claimant has had some suicide attempts, but is oriented to time, person, and place, and if he refrained from drinking and drug

abuse, he would have a more positive prognosis. The evidentiary record is insufficient to find that claimant suffers a severely restrictive mental impairment.

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. In addition, based upon the claimant's medical reports, it is documented that claimant had heavy use of alcohol as well as drug abuse which would have contributed to his physical and any alleged mental problems.

For these reasons, this Administrative Law Judge finds that claimant has failed to meet his burden of proof at Step 2. Claimant must be denied benefits at this step based upon his 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 he would meet a statutory listing in the code of federal regulations.

If claimant had not already been denied at Step 2, this Administrative Law Judge would have to deny him again at Step 4 based upon his ability to perform past relevant work as a carpenter. There is insufficient objective medical evidence upon which this Administrative Law Judge could base a finding that claimant is unable to perform work which he has engaged in, in the past. Therefore, if claimant had not already been denied at Step 2, he would again be denied at Step 4.

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

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

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 he lacks the residual functional capacity to perform some other less strenuous tasks than in his prior employment or that he is physically unable to do light or sedentary tasks if demanded of him. Claimant did

testify on the record that he catches the bus one time per week to the library and it's a five minute bus ride. He cooks two times a week and cooks things like pasta and grilled chicken. Claimant testified that he cleans his room by picking up his bed and vacuuming. Claimant testified that he walk with no limits, stand with no limits, and sit with no limits. Claimant testified that he is able to squat, bend at the waist, shower and dress himself, touch his toes, and tie his shoes. Claimant can lift fifty pounds and with his right shoulder he can lift over 100 pounds. He is right-handed and he does have arthritis and his hands hurt when it's damp or cold. Claimant testified he has no physical problems and no physical pain. He does continue to smoke a pack to a half a pack of cigarettes per day and his doctor has told him to quit and he's not in a smoking cessation program. He did cocaine March 19, 2009 and he used to drink a case of beer every day and he quit drinking nine months before the hearing.

Claimant is not in compliance with his treatment program as he does continue to smoke despite the fact that his doctor has told him to quit and he just recently stopped drinking and also did cocaine March 19, 2009.

If an individual fails to follow prescribed treatment which would be expected to restore their ability to engage in substantial activity without good cause, there will not be a finding of disability.... 20 CFR 416.994(b)(4)(iv).

The Federal Regulations at 20 CFR 404.1535 speak to the determination of whether Drug Addiction and Alcoholism (DAA) is material to a person's disability and when benefits will or will not be approved. The regulations require the disability analysis be completed prior to a determination of whether a person's drug and alcohol use is material. It is only when a person meets the disability criterion, as set forth in the regulations, that the issue of materiality becomes

relevant. In such cases, the regulations require a sixth step to determine the materiality of DAA to a person's disability.

When the record contains evidence of DAA, a determination must be made whether or not the person would continue to be disabled if the individual stopped using drugs or alcohol. The trier of fact must determine what, if any, of the physical or mental limitations would remain if the person were to stop the use of the drugs or alcohol and whether any of these remaining limitations would be disabling.

Claimant's testimony and the information contained in the file indicate that claimant has a history of alcohol, drug, and tobacco abuse. Applicable hearing is the Drug Abuse and Alcohol (DA&A) Legislation. The law indicates that individuals are not eligible and/or are not disabled where drug addiction or alcoholism is a contributing factor material to the determination of disability. After a careful review of the credible and substantial evidence on the whole record, this Administrative Law Judge finds that even if claimant did meet the disability determination standards, he wound not meet the statutory disability definition under the authority of the DA&A Legislation because his substance abuse is material to his alleged impairment and his alleged disability.

Under the Medical-Vocational guidelines, a younger individual (age 41), 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 his impairments. The claimant should be able to perform his past work if he refrains from drinking and taking drugs. 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: January 6, 2010

Date Mailed: January 7, 2010

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]