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: 2009-26899
Issue No: 2009
Case No: [redacted]
Load No:
Hearing Date:
August 12, 2009
Midland 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 August 12, 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 January 14, 2009, claimant filed an application for Medical Assistance and retroactive Medical Assistance benefits alleging disability.

(2) On February 17, 2009, the Medical Review Team denied claimant's application stating that claimant's condition did not meet duration.

(3) On February 25, 2009, the department caseworker sent claimant notice that her application was denied.

(4) On May 20, 2009, claimant filed a request for a hearing to contest the department's negative action.

(5) On July 1, 2009, the State Hearing Review Team again denied claimant's application stating that claimant's impairments lacked duration per 20 CFR 416.909 and commented that the medical evidence of record indicates that the claimant's condition is improving or is expected to improve within 12 months from the date of onset or from the date of surgery. Therefore, MA-P is denied due to lack of duration under 20 CFR 416.909. Retroactive MA-P was considered in this case and is also denied. SDA is denied per PEM 261 as the impairment(s) would not preclude all work for 90 days.

(6) Claimant is a 43-year-old woman whose birth date is [redacted]. Claimant is 5' 2" tall and weighs 110 pounds. Claimant recently lost 60 pounds. Claimant is a high school graduate and is able to read and write and does have basic math skills.

(7) Claimant last worked in 2008 as a dispatcher. The claimant has also worked as a customer service representative and as a furniture store manager.

(8) Claimant is currently receiving unemployment compensation benefits in the amount of [redacted] biweekly.

(9) Claimant alleges as disabling impairments: confusion, gastrointestinal bleed, a broken collar bone, peripheral vascular disease, malabsorption of nutrients, headaches, weakness, restless leg syndrome, a hypoactive thyroid, as well as substance abuse.

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;

(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 <u>not</u> required. These steps are:

1. Does the client perform Substantial Gainful Activity (SGA)? If yes, the client is ineligible for MA. If no, the analysis continues to Step 2. 20 CFR 416.920(b).

2. Does the client have a severe impairment that has lasted or is expected to last 12 months or more or result in death? If no, the client is ineligible for MA. If yes, the analysis continues to Step 3. 20 CFR 416.920(c).

3. Does the impairment appear on a special listing of impairments or are the client's symptoms, signs, and laboratory findings at least equivalent in severity to the set of medical findings specified for the listed impairment? If no, the analysis continues to Step 4. If yes, MA is approved. 20 CFR 416.290(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 has a medical history that is significant for bariatric surgery approximately nine years ago. On [redacted], claimant was diagnosed as having delirium due to gastrointestinal bleeding, overdose on multiple medications, polysubstance abuse including alcohol abuse in early remission, benzodiazepine and opiate abuse, as well as anemia, status post proximal small bowel acute bleed, history of hypothyroidism, status post ventral hernia repair, status post bariatric surgery approximately six years ago, and chronic abdominal pain. (pp. 465-467)

On [redacted], claimant was admitted and her general physical examination was that she was a young female who was currently obtunded. Her vital signs were stable. She was afebrile. Her sclerae were anicteric. Her oral mucosa was dry with some old blood on her lips. Her neck was supple. Her chest was clear bilaterally. Her heart sounds 1 and 2 were heard and

they were normal. Her abdomen was full and soft, mildly tender in the epigastric region, but there was no rebound, tenderness, or guarding. Bowel sounds were present and they were normal. The scars from her previous surgery appeared intact without incisional hernias. In the extremities, there was no edema or cyanosis. Her initial hemoglobin was 7.4, hematocrit of 21.8, platelet count of 337,000, and her white count was 5.7. Claimant was transfused with two units of packed red blood cells. She was admitted with mental status changes secondary to drug overdose and gastrointestinal bleed. (p. 464)

On [redacted], claimant received an upper endoscopy with findings that she had mild esophagitis, status post bariatric surgery, but normal upper endoscopy otherwise. (p. 462)

In [redacted], claimant had a pulmonary embolism and left upper extremity thrombus which was resolved. (p. 352) On physical examination of [redacted], claimant was a well-developed woman who appeared to be in no acute distress. Her sclerae were anicteric, no lymphadenopathy. Her chest was regular. Her heart was regular. Her abdominal examination revealed no masses and she had gastrointestinal bleeding with uncertain etiology and abdominal pain of uncertain etiology. (p. 350) On [redacted], claimant had a normal left ventricular systolic function with an ejection fraction of 65% with normal left ventricular diastolic function. No pericardial effusion and had mild pulmonary hypertension. (p. 348) On [redacted], it was determined that claimant's previously seen venous thrombosis in the left upper extremity on study of [redacted] appeared to have resolved completely. There was no evidence of thrombus in the left upper extremity. (pp. 333-334)

On [redacted], claimant was admitted for chronic abdominal pain, headache, and generalized weakness. On physical examination, her temperature was 98.8, pulse 79, respiratory rate 18, and blood pressure 122/59. Saturation was 99% on room air. She was a 42-year-old

female. She was awake. She was mildly obese. She had a somewhat flattened affect. She answered questions appropriately. Her head was normocephalic and atraumatic. Her pupils were 4 mm. There were reactive bilaterally. Extraocular movements were intact. Heart was regular without murmur. Lungs were clear. Her chest wall was non-tender with the exception of any right lower ribs, midway between the sternum and the midaxillary area. She had an area of reproducible tenderness to palpation. In the abdomen there was no flank pain. Her belly was soft and non-tender. She had stretch marks present from significant weight loss after the gastric bypass. Her extremities were without edema. There was no calf tenderness or Homan's sign. Neurologically, she had 5/5 strength in bilateral upper and lower extremities. No focal sensory deficits. Head CT was within normal limits. No acute bleed. CBC showed a white count of 5.9. Hemoglobin was adequate at 14.5. MCV and MCH were high consistent with macrocytosis. Hematocrit was 42.7 and platelets were 210,000. Chemistries were essentially normal. BUN was 9 with a creatinine of .7. Magnesium and phosphorous were normal. (p. 302)

On [redacted], claimant was determined to have Vitamin B-12 deficiency anemia and receives B-12 injections monthly as an outpatient. Her hemoglobin was stable. (p. 275)

An admission of [redacted] indicates that claimant has a history of pancreatitis but denied drinking alcohol. Her blood pressure was 149/97, pulse 89, respirations 20, temperature 98.2 orally. Oxygen saturation was 100% on room air. She was alert and oriented x3. Her skin was warm, dry, and intact without rash or lesions. Her HEENT was normocephalic and atraumatic. Pupils were equal, round, and reactive. Her neck was supple. Her chest had regular rate and rhythm, no murmurs, rubs, or gallops. Lungs were clear to auscultation bilaterally. The abdomen had positive bowel sounds, was soft and non-distended. She did have some pain to palpation in the epigastrium and right upper quadrant area. Her back was normal to inspection.

No CVA tenderness. In her extremities there was no clubbing, cyanosis, or edema. Her strength was 5/5 and sensation was intact throughout. Her admitting diagnosis was pancreatitis. Her final diagnosis was abdominal pain, bowel obstruction, GI bleed ruled out, a history of gastric bypass surgery, chronic anxiety, alcohol abuse, anemia—chronic, B-12 deficiency, and previous colonoscopy was unremarkable. (p. 246)

A [redacted] admission indicated that claimant has a social history of a heavy drinker of vodka up to a fifth of a day and quit two months before July 2008 and went to detox. She was assessed with acute pancreatitis. She had anemia with macrocytosis and was given Vitamin B-12. She had malabsorption status post gastric bypass. She had hypothyroidism. Her TSH appeared to be okay. She has alcohol dependence. (p. 244)

A hospitalization of [redacted], indicates claimant had pancreatitis, abdominal pain, and alcohol abuse. She was requested to refrain from alcohol indefinitely. As of the [redacted] admission, claimant had been off vodka for three months but started drinking the Monday before her hospitalization and she drank three-quarters of a bottle of vodka. (p. 221)

A hospital admission of [redacted] indicates that claimant had a blood pressure of 131/72, pulse 77, respirations 16, temperature 97.4, saturating 100% on room air. She was a middle-aged woman appearing older than her stated age with a flat affect. She did not appear to be acute distress. Her HEENT was normocephalic and atraumatic. Eyes trailed appropriately. Nares were patent. Mucous membranes were moist. Her heart, S1 and S1 were appreciated. No murmurs or rubs. Her lungs were clear to auscultation bilaterally. She had tenderness on the right side of her ribs. No erythema, no edema, and no bruising. Her abdomen was soft with mild left upper quadrant tenderness. Her CBC showed hemoglobin 13.1 and it was generally within normal limits. Vitamin B-12 was up at 971. Folate was 9.2 which was normal. Pregnancy test

was negative. Comprehensive metabolic panel was normal except for calcium was low at 8.1, albumin low at 2.3, and total protein low at 5.2 which was better than her previous in September 2008. AST was elevated at 53. Lipase level was elevated at 59 which was better than in September when she was in the hospital for pancreatitis. Amylase level was 39, magnesium 2.0, and phosphorous 3.2. EKG was done and showed a normal sinus rhythm with a rate of 76 beats per minute. Chest x-ray showed no acute intrathoracic process. (p. 203)

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 is expected to last for the duration of at least 12 months. There is insufficient 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. There is no medical finding that claimant has any muscle atrophy or trauma, abnormality or injury that is consistent with a deteriorating condition. Claimant does have some gastrointestinal bleeding and pain; however, she does continue to drink. Claimant testified that she does drink one to two times per week and usually drinks a pink of vodka. She does have malabsorption problems because of her prior bypass surgery, but she does take Vitamin B-12 shots which help with her anemia. If claimant refrained from drinking alcohol, she would not be considered disabled at Step 2.

In addition, claimant does receive unemployment compensation benefits. In order to receive unemployment compensation benefits under the federal regulations, a person must be monetarily eligible, they must be totally or partially unemployed, they must have an approvable job separation, and they must meet certain legal requirements which include being physically and mentally able to work, being available for and seeking work, and filing a weekly claim for

benefits on a timely basis. This Administrative Law Judge finds that claimant has not established that she has a severe impairment or combination of impairments which have lasted or will last the durational requirement of 12 months or more or have kept her from working for a period of 12 months or more. Claimant did last work in 2008. Claimant does continue to receive unemployment compensation benefits as of the date of hearing.

There is insufficient objective medical evidence/psychiatric evidence on the record indicating that claimant suffers mental limitations resulting from her reported depressed state. Claimant did testify on the record that she does have no mental impairments. 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.

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's past relevant work was sedentary and light. As a dispatcher, grocery manager, and customer service representative, claimant's employment did not require strenuous physical exertion. There is insufficient medical evidence upon which this Administrative Law Judge could base a finding that claimant is unable to perform work in 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 work 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 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.

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 information contained in the file indicate that claimant has a history of chronic alcohol abuse. Applicable hearing is the Drug Abuse and Alcohol (DA&A) Legislation, Public Law 104-121, Section 105. 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 record, this Administrative Law Judge finds that claimant does not meet the statutory disability definition under the authority of the DA&A Legislation because her substance abuse is material to her alleged impairments and alleged disability. Even if claimant were to be considered disabled, based upon her condition, she would not be held as disabled based upon the fact that she does have continued alcohol abuse.

Claimant testified on the record that she does have chronic pain, but no mental impairments.

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 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 she had heavy use of alcohol which would have contributed to her physical and any alleged mental problems. In addition, claimant was able to answer all the questions at the hearing and was responsive to the questions. Claimant was oriented to time, person and place during the hearing. 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. In addition, claimant did testify that she does receive some relief from her pain medication. 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 43), 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. The claimant is not in compliance with her treatment program, as she does continue to drink alcohol 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 activity without good cause, there will not be a finding of disability.... 20 CFR 416.994(b)(4)(iv).

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: September 23, 2009

Date Mailed: September 24, 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]