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: 2009-31939
Issue No: 2009; 4031
Case No: [redacted]
Load No: [redacted]
Hearing Date:
September 17, 2009
Genesee 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 September 17, 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 April 28, 2009, claimant filed an application for Medical Assistance and retroactive Medical Assistance benefits alleging disability.

(2) On May 26, 2009, the Medical Review Team denied claimant's application stating that claimant could perform other work.

(3) On June 5, 2009, the department caseworker sent claimant notice that her application was denied.

(4) On June 17, 2009, claimant filed a request for a hearing to contest the department's negative action.

(5) On August 19, 2009, the State Hearing Review Team again denied claimant's application stating that it had insufficient evidence and requested a [redacted] internal medicine examination by September 18, 2009.

(6) The hearing was held on September 17, 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 20, 2009.

(8) On October 27, 2009, the State Hearing Review Team again denied claimant's application stating that claimant is capable of performing other work pursuant to Medical-Vocational Rule 203.21 and stated that this may be consistent with past relevant work. However, there is no detailed description of past work to determine this. In lieu of denying benefits as capable of performing past work, a denial to other work based on a Vocational Rule will be used.

(9) Claimant is a 50-year-old woman whose birth date is [redacted] Claimant is 5' 2" tall and weighs 177 pounds. Claimant is a high school graduate and has one semester of college. Claimant is able to read and write and does have basic math skills.

(10) Claimant last worked in 2006 as a cook. Claimant worked from 1979 to 2006 for the State of Michigan in mental health as a home healthcare person.

(11) Claimant receives [redacted] in State Disability Assistance benefits every two week and also Food Assistance Program benefits and lives in Section 8 housing and is single with no children under 18 who live with her.

(12) Claimant alleges as disabling impairments: depression, back problems, carpal tunnel syndrome in wrists and hands, back injury in [redacted], heart disease, congestive heart failure (3 heart attacks in [redacted]), asthma, cardio obstructive pulmonary disease, and hypertension.

CONCLUSIONS OF LAW

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. The Department of Human Services (DHS or department) administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. Department policies are found in the Program Administrative Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM).

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 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 2006. Claimant is not disqualified from receiving disability at Step 1.

The objective medical evidence on the record indicates that a [redacted] examination indicates that on physical examination, claimant was a 50-year-old African American female. She was 5' 2" and weighed 174 pounds. Vision without glasses in the right eye is 20/20 and in the left eye is 20/20. Her grip on the right was 24 kilograms; left was 16 kilograms per Jamar dynamometer. She is right-handed. She could pick up a coin with her right hand and left hand. Her blood pressure was 138/80. HEENT: The pupils reacted to light and accommodation equally. There was no rise in jugular venous pressure. The neck was supple. There was no thyromegaly. There was no lymphadenopathy. Chest: The lungs were clear to auscultation and percussion bilaterally. There were no wheezing, rales, or rhonchi heard at the time of the examination. Cardiovascular: Examination of the heart revealed regular sinus rhythm without gallop or murmur. Heart rate was 68 per minute. Abdomen: The abdomen was soft and non-tender. There was no rebound or guarding. Extremities: There was no pedal edema. Peripheral pulses were felt bilaterally. Neurological: The claimant was alert and oriented x3. Cranial II through VI were grossly intact. Deep tendon reflexes were within normal limits. Gait and sensation were intact. Straight leg raising was negative. Musculoskeletal: Fine and gross dexterities, in the form of opening a jar, buttoning clothes, writing legible, picking up a coin, and tying shoelaces, were well preserved. The claimant is right-handed. There was no motor or sensory deficit. She could get on and off the table and in and out of the chair without

any assistance. She could ambulate in the room without any assistance. She could walk on her toes and heels. There was no muscle atrophy noted. Claimant's range of motion chart indicates that claimant was normal in all areas of examination.

A Medical Examination Report indicates on [redacted], claimant was normal in all areas of examination except that she had some shortness of breath in her respiratory and her ejection fraction was 30% and she had cardiomyopathy and acute DVT, PVT. The clinical impression was that she was improving and she had no mental limitations. (pp. 1-2)

A [redacted] evaluation indicates that claimant had acute congestive cardiac failure secondary to systolic dysfunction with ejection fraction of 55%, hypertension, diabetes mellitus, and dyslipidemia. Claimant was admitted and put on congestive heart failure protocol. She condition improved and she was discharged home in good general condition. (p. 3)

On [redacted], the clinical impression was that claimant was deteriorating and she could never lift any weight. She could stand or walk less than 2 hours in an 8-hour workday and she could sit less than 6 hours in an 8-hour workday. She could not use her upper extremities for simple grasping, reaching, pushing/pulling, or fine manipulating on the date of examination.

An [redacted] admission indicates that claimant had cardiomyopathy with an ejection fraction of 30%, status post cardio pulmonary resuscitation and intubation, cardio obstructive pulmonary disease, diabetes, iron deficiency anemia, acute upper extremity DVT and non-sustained ventricular tachycardia. She was in ICU for a couple of days and got extubated. She was managed for her diabetes, cardio obstructive pulmonary disease, hypertension, and congestive heart failure. She was started on anti-coagulation for her new DVT and was loaded with Amiodarone for her SVT. Her blood pressure was 101/56. Pulse was 82. Respirations were

16. Temperature was 37.2. Her blood sugar was running okay. She was walking around on [redacted]. Her INR on the day was 1.4. Her rhythm was sinus rhythm. Her chest was clear to auscultation. She was discharged home with a medication regime and asked to follow up with her doctor within a week. (p. 8)

A Medical Examination Report from the cardiologist dated [redacted] indicated that claimant was normal in all areas of examination. She was 5' 1" tall and weighed 175 pounds. Her blood pressure was 88/62. The clinical impression was that she was stable. She could occasionally lift 20 pounds or less and frequently lift 10 pounds or less. She could stand or walk at least 2 hours of an 8-hour day and sit less than 6 hours in an 8-hour day. She could use both of her upper extremities for simple grasping, reaching, pushing/pulling, and fine manipulating and could operate foot and leg controls with both feet and legs. She was taking 11 medications and had no mental limitations. She had a Class III functional capacity which indicates that patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain. Her therapeutic classification was Class C – patients with cardiac disease with ordinary physical activity should be moderately restricted and whose more strenuous efforts should be discontinued. (p. 11)

Claimant had an echocardiogram dated [redacted] which indicated her left ventricular chamber was enlarged with severe decrease in left systolic function. Calculated left ventricular ejection was 30%. There was left atrial enlargement. Right ventricular chamber was mildly enlarged with mild decrease in right ventricular systolic function. Mitral value was sclerotic with moderate mitral regurgitation. Tricuspid valve showed moderately tricuspid regurgitation. There was moderate pulmonary hypertension with calculated systolic pulmonary artery pressure of 50

MMHG. Pulmonic valve with trace pulmonic regurgitation. Aorta valve with trace aortic regurgitation. No evident intracardiac masses, thrombus, or vegetations noted. No pericardial effusion noted. (pp. 13-14)

A [redacted] examination indicated that an MRI of the lumbar spine in [redacted] showed facet arthropathy at L4-L5 and disc desiccation at L5-S1 with some protrusion to the left at that level. She had hypertension and diabetes. She was on metformin and hydrochlorothiazide. She was found to be in acute distress. She was pleasant and well-built. Head and neck examination revealed normal range of motion, no meningeal signs and no tenderness on palpation of the cervical spine or cervical paraspinal muscles. There were no carotid bruits on auscultation. The cardiac exam revealed regular rate and rhythm without murmur, rub or gallops. The higher cortical function and mental status was normal. The claimant was found to be awake, alert, and oriented to person, place, and time and answered all questions appropriately. Affect was normal. Recent and remote memory was also normal. Speech and language function were normal with no evidence with dysarthria or dysphasia. Repetition, naming, and comprehension were normal. Cranial nerve examination showed sharp discs with normal vasculature on funduscopy. Visual fields were full. Pupils were equal, round, and reactive to light and accommodation. Extraocular movements were intact bilaterally. There were no ptosis or nystagmus noted. No facial asymmetry was noted. Hearing was intact to finger rub. The pallet raised symmetrically. Uvula was midline. Sternocleidomastoid and trapezii were 5/5. Tongue protruded in the midline without evidence of atrophy or fasciculation. On motor examination the strength was 5/5 in the upper and lower extremities in a symmetrical fashion with normal tone and bulk throughout. No fasciculations were noted. The sensory examination revealed hypesthesia to pinprick and median sensory distribution bilaterally. On coordination testing there

was no dysmetria on finger-to-nose or heel-to-shin testing. No tremor was noted. Reflexes were diffusely hypoactive with ankle jerks and brachioradialis reflexes being absent bilaterally. Both plantars were flexor. There was marked spasm of on the lumbosacral paraspinal muscles. Positive facet-loading signs and negative SLR bilaterally. Gait was normal without evidence of ataxia and s negative Romberg. EMG testing of the upper extremities showed evidence of bilateral carpal tunnel syndrome of moderate severity. No cervical radiculopathy. (pp. 159-160)

An electromyographic report indicates that claimant had an abnormal study with electrodiagnostic evidence of bilateral median mononeuropathies at the wrists (carpal tunnel syndrome) of moderate severity without active denervation in either abductor pollicis brevis muscle. There was no electrodiagnostic evidence of bilateral upper extremity plexopathy or radiculopathy. (p. 161)

An internal medicine Medical Examination Report dated [redacted] indicates that the clinical impression was that claimant's condition was deteriorating. She could never lift any weight. She could stand or walk less than 2 hours of an 8-hour workday and sit less than 6 hours of an 8-hour workday. She could not use her upper extremities for simple grasping, reaching, pushing/pulling, or fine manipulating and could not operate foot and leg control and had no mental limitations. (pp. 133-134)

Another Medical Examination Report indicated that claimant had back pain and lumbar radiculopathy and on [redacted], she was normal in areas of examination except that she had pain on straight leg raising and couldn't climb stairs. She had normal hearing and visual acuity. She had normal gait with pain medication and normal musculature. The clinical impression was that the claimant was deteriorating and she could stand or walk less than 2 hours of an 8-hour workday and sit less than 6 hours of an 8-hour workday. She could occasionally lift

less than 10 pounds but never lift 10 pounds or more. She could use her upper extremities for simple grasping, reaching, pushing/pulling, or fine manipulating as well as operating foot and leg control and she had no mental limitations. (pp. 144-145)

Claimant testified on the record that she does not cook, grocery shop, or clean her home and that her friend does all those things for her. Claimant testified that she can walk a half a block and she gets dizzy and has shortness of breath. She can stand for 10 minutes and sit for 20 minutes at a time. She can shower and dress herself. Claimant testified that she can't squat because her legs are bad and she has pain in her back, but she can bend over slowly. Claimant testified that she can tie her shoes but she cannot touch her toes. Claimant testified that the heaviest weight she can carry is 20 pounds, and 10 pounds on a repetitive basis and that she is right-handed and that her hands and arms have carpal tunnel syndrome. Claimant testified that her level of pain on a scale from 1 to 10 without medication is a 10 and with medication is a 5. Claimant testified that she smoked a pack of cigarettes a day until May 2009. Claimant stopped drinking alcohol occasionally two years before the hearing. Claimant testified that in a typical day she gets up at 6:30 a.m., drinks coffee, and watches the news, goes to the bathroom, showers, fixes her cereal which is oatmeal, and then takes her medications, watches television 12 hours a day and reads.

A Physical Residual Functional Capacity Assessment in the record indicates that claimant has not established functional limitations and that a [redacted] MRI of the lumbar spine showed facet arthropathy at L4-L5 and disc desiccation at L5-S1 with some protrusion to the left. On [redacted] an EMG was abnormal with mild bilateral L5 and left S1 polyradiculopathies without denervation. On [redacted] she was doing well without complaints of parenthesis or pain in her hands. Spasm of lumbosacral paraspinal muscles,

antalgic gait. On [redacted], vision not corrected 20/20 OU, grip strength on the right 24 kg, left 16 kg. Blood pressure was 138/80. Gait and sensation were intact. Negative straight leg raising. No motor or sensory deficit. Slight limitation of lumbar. Diabetes controlled with medication. The determination of claimant's statement regarding her condition is partially credible although the MRI showed arthritic changes and the EMG was abnormal and she had normal grip strength and a normal gait with no sensory deficits. A September 18, 2009 medical report indicates that claimant had a history of dizziness. She had no blurred vision but she was ambulatory and waiting for a pacemaker for irregular rhythm to her heart.

At Step 2, the objective medical evidence on the record indicates that claimant has established that she does have a severe impairment or combination of impairments which has lasted or will last the durational requirement of 12 months or more.

At Step 3, claimant's impairments do not rise to the level necessary to be specifically listed as disabling as a matter of law.

At Step 4, this Administrative Law Judge finds that claimant probably not work as a cook or as a mental health home healthcare aid with her impairments. Claimant does have a 30% ejection fraction and is waiting for a pacemaker for her heart. In addition, claimant does have diabetes and hypertension which are only controlled through medication. Claimant also has adult onset asthma and for the first time had an asthma attack in [redacted]. Therefore, this Administrative Law Judge finds that claimant could probably not perform her prior work given her combination of impairments. The Administrative Law Judge will not disqualify claimant from receiving disability 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).

In the instant case, although claimant does have heart problems, diabetes, hypertension, and back problems as well as carpal tunnel syndrome, her medical reports indicate that she had 5/5 strength in her upper and lower extremities. This Administrative Law Judge finds that claimant has provided 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. Once claimant receives her pacemaker and improves her heart ejection fraction as well as gets her asthma under control, claimant may then develop some residual functional capacity. This Administrative Law Judge finds that based upon the combination of claimant's impairments, claimant has established that she is disabled for purposes of Medical Assistance and State Disability Assistance benefits as of the April 28, 2009 application date.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that claimant has established that she is disabled for purposes of Medical Assistance and State Disability Assistance benefits as of the April 28, 2009 application date as well as the retroactive months of January, February, and March 2009.

Accordingly, the department's decision is REVERSED. The department is ORDERED to reinstate claimant's April 28, 2009 Medical Assistance and retroactive Medical Assistance application, if it has not already done so, to determine if all other non-medical eligibility criteria are met. The department shall inform the claimant of the determination in writing and shall also determine whether or not claimant has continued to receive State Disability Assistance benefits and if she has not, to pay to claimant any benefits to which she is entitled.

In addition, the department is ORDERED to conduct a medical review of claimant's impairments in November 2010. At that time, the claimant and department shall provide updated

cardiology reports as well as updated complete physical and updated psychological evaluations and any updated treatment notes from the years 2009-2010.

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

Date Signed: January 28, 2010

Date Mailed: February 2, 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]