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: 2009-23690
Issue No: 2009; 4031
Case No: [redacted]
Load No: [redacted]
Hearing Date:
July 15, 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 July 15, 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 State Disability Assistance (SDA)?

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, State Disability Assistance, and retroactive Medical Assistance benefits for the month November 2008, alleging disability.

(2) On February 18, 2009, the Medical Review Team approved claimant for State Disability Assistance benefits from December 2008 through May 2009 and denied claimant's application for Medical Assistance stating that claimant's impairments lacked duration.

(3) On March 2, 2009, the department caseworker sent claimant notice that his application was denied.

(4) On April 2, 2009, claimant filed a request for a hearing to contest the department's negative action.

(5) On July 8, 2009, the State Hearing Review Team again denied claimant's application stating that claimant's impairments lacked duration per 20 CFR 416.909.

(6) Claimant is a 54-year-old man whose birth date is [redacted]. Claimant is 6' tall and weighs 176 pounds. Claimant recently lost 30 pounds. Claimant attended the 12th grade and has no GED, but is able to read and write and does have basic math skills.

(7) Claimant last worked June 2008 at [redacted] as a chauffeur. Claimant testified that he left the job because he couldn't see to drive. The claimant testified that he also worked as a general contractor, as a cashier and stock person.

(8) Claimant receives the Adult Medical Program and State Disability Assistance benefits.

(9) Claimant alleges as disabling impairments: glaucoma, macular degeneration, coronary artery disease, hearing problems, hepatitis C, a pacemaker and defibrillator, two stents, two clogged arteries, and two heart attacks in [redacted].

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 June 2008. Claimant is not disqualified from receiving disability at Step 1.

The objective medical evidence on the record indicates that on [redacted] claimant had a bilateral coronary angiography and deployment of Impella percutaneous left ventricular assist device, a direct stenting of the left anterior descending, supravalvular aortography, a selective right common femoral artery angiography, and a right heart catheterization. Claimant was found to have a history of ischemic cardiomyopathy with an ejection fraction of 10%, hepatitis C, and had severe three-vessel coronary artery disease and a

required CABG. Claimant tolerated the procedures well with no complications and remained hemodynamically stable. He remained with low blood pressure throughout the procedures with systolic pressures in the 80s to 90s. (Pages 3-4)

A Medical Examination Report at pages 11 and 12 of the medical information indicates that claimant had a general appearance of fatigue and pain level in the back. Claimant had macular degeneration and diabetes mellitus, and he was wheezing, and had cardio obstructive pulmonary disease in his respiratory system. He had edema and PDD in the cardiovascular system and he had mild ascites, hepatitis C positively active in the abdominal area. He had lumbar spine tenderness and he had low vibration sensation in the lower extremity and he was depressed and anxious. He was 6' 1" tall and weighed 183 pounds and his blood pressure 102/90 and he was right-hand dominant. His visual acuity was 20/30 in the right eye and 20/25 in the left eye. The clinical impression was that claimant was deteriorating and that he could frequently lift less than 10 pounds, stand and/or walk less than two hours in an eight-hour day and sit less than six hours in an eight-hour day. Claimant could not use either hand or arm for simple grasping, reaching, pushing/pulling, and fine manipulating and he could not operate foot and leg controls with either foot or leg. Claimant had some anxiety and some attention deficit. (Pages 11-12)

On [redacted], claimant was admitted and his physical examination vitals included a height of 6', weight 175 pounds. Temperature was 98.2. Respirations were 24, pulse was 88, and blood pressure was 99/63. Pulse oximetry was 97% on room air. Claimant was a 52-year-old Caucasian male in no acute distress. He was sleeping on initial approach but easily aroused. His pupils were equal and reactive with extraocular movements intact. Conjunctivae were clear. Sclerae were anicteric. Ears, nose, and throat: Mucus membranes were moist without

erythema or exudate. Lips, teeth, and gums were in adequate repair. Hearing was within normal limits. The neck was supple with no JVD, no thyromegaly, no carotid bruits, trachea was midline. In the respiratory system bilateral lungs were essentially clear to auscultation, although slightly diminished at bases. There were no crackles or rales noted on exam. In the cardiovascular area S1-S2 had regular rate and rhythms, no skips, gallops, or murmurs noted. No peripheral edema noted. Pedal pulses were palpable. The breast exam was deferred. Gastrointestinal: His abdomen was distended but soft, no masses were palpated. Bowel sounds were positive in all four quadrants. There was no guarding or rebound. On his skin he had a large ecchymotic area from the groin extended to the right thigh from the previous catheterization site during the last hospitalization. There was no hematoma evidenced. His genitourinary examination was deferred. Lymphatics: There was no cervical lymphadenopathy. In the musculoskeletal area he was moving all extremities. He did complain and had slightly limited range of motion to the right lower extremity secondary to the ecchymotic area. Psychiatrically, he was awake, alert, and oriented x3. Recent and remote memory was intact. He did get agitated at times during the exam and attributed this to his recent insomnia. In the neurological area his cranial nerves II through XII were intact with no focal deficits noted. Plantar reflexes were downgoing. His EKG revealed normal sinus rhythm with possible left atrial enlargement, possible inferior infarct, and anterior infract, age undetermined, unchanged from previous EKG. The impression was hypotension, leukocytosis, congestive heart failure, ascites, diabetes, and chronic pain syndrome. (Page 14) Claimant was released to his home the next day and placed on a cardiac 1800 ADA diet.

A cardiac catheterization was performed on [redacted]. Claimant was admitted November 18, 2008 with new onset ascites secondary to congestive heart failure and shortness of

breath. On physical examination his temperature was 97.8 degrees, heart rate was 105, respiratory rate was 18, pulse oximetry was 99% on room air, and blood pressure was 117/88. He was a well-developed, well-nourished 52-year-old male in no acute distress. Pupils were equal and reactive to light. Sclerae were non-icteric. Hearing was within normal limits. Oropharynx was clear. His neck was supple without JVD or thyromegaly. Lungs were clear to auscultation. There was no chest tenderness. In the cardiovascular system, he had regular rate and rhythm, normal S1, normal S2. There was no murmur or gallop. There was no peripheral edema. His abdomen was distended and firm with hyperactive bowel sounds and there was right CVA tenderness. His skin was clean, dry, and intact. Muscle strength was 5/5 of all four extremities. Claimant was alert and oriented x3 without focal deficits. (Page 17) An echocardiogram conclusion dated November 20, 2008 indicates that claimant had thickening of the aortic root and the aortic leaflets with adequate opening. No gradient across the valve. There was increased E-point separation, mitral annulus calcification, thickened mitral leaflets indicative of a reduced cardiac output state with diastolic dysfunction as well as decreased compliance. Pulmonic valve was not seen. Tricuspid valve appeared to be normal. Left atrial dilatation, left ventricular dilatation. Right atrial dilatation and right ventricular dilatation. Ejection fraction was 14%, globally decreased with a flattened akinetic septum. Trace of posterior pericardial effusion, at least mild diastolic dysfunction as well. A whiff of aortic insufficiency, moderate mitral regurgitation, mild to moderate tricuspid regurgitation, mild pulmonary insufficiency, and mild pulmonary hypertension. Globally decreased left ventricular ejection fraction of around 14% with a flattened akinetic septum. (Pages 22-23)

Claimant had a left and right heart catheterization on [redacted]. There was mid LAD 80% stenosis at the large septal branch. Diag 2 was medium-sized vessel with a proximal

90% stenosis. The left circumflex coronary artery circumflex was a medium-sized vessel with ostial OMI 90%. Right coronary artery was 100% in the mid with grade III left to right collaterals. Left ventriculography LV showed an ejection fraction of 10% with an EDP of 25 mmHg. There was evidence of apical filling defect consistent with a thrombus. No gradient across the aortic valve. The conclusion was three-vessel coronary artery disease, mild pulmonary hypertension, severely depressed cardiac output, severely depressed LV function, as well as apical filling defect, likely thrombus. (Pages 24-25)

Claimant had a Mental Residual Functional Capacity Assessment which indicates that claimant was moderately limited in a few areas but there was no evidence of limitation in most categories and he was not significantly limited in another area. Claimant was only moderately limited in the ability to maintain attention and concentration for extended periods, the ability to work in coordination with and proximity to others without being distracted by them, the ability to complete a normal workday and worksheet without interruptions from psychologically-based symptoms, and to perform at a consistent pace without an unreasonable number and length of rest periods. Claimant was alleged to be suffering from anxiety and depression due to severe medical conditions. (Pages 34-35)

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. In the instant case, this Administrative Law Judge finds that claimant did have a severe impairment; however, once claimant had a heart catheterization his condition has been stabilized and his impairments do not meet duration. The Administrative Law Judge cannot give weight to the treating physician’s DHS-49 as it is internally inconsistent. The other objective medical information indicates that claimant has the ability to use both his upper and

lower extremities and has 5/5 strength. On the DHS-49, the document indicates that claimant cannot even do simple grasping or fine manipulating with his hands. This is inconsistent with the objective medical information contained in the file. 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-49 has restricted claimant from tasks associated with occupational functioning based upon claimant's reports of pain (symptoms) rather than medical findings. The DHS-49 indicates that claimant can stand or walk less than two hours in an eight-hour day and sit less than six hours in an eight-hour day. This information indicates that claimant should be able to perform at least sedentary work even with his impairments. 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 that claimant has a severely restrictive physical impairment.

There is insufficient objective medical/psychiatric evidence in the record indicating claimant suffers mental limitations resulting from his reportedly depressed state.

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 a Mental Residual Functional Capacity Assessment in the record which indicates that claimant has no evidence of limitation in most categories and has only moderate limitations in four categories and he has no marked limitations in any category. The evidentiary record is insufficient to find that claimant suffers a severely restrictive mental impairment. 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. 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. This Administrative Law Judge finds that claimant does not meet any 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. Claimant's past relevant work was sedentary as he was a [redacted] chauffeur. Claimant has also worked as a cashier. Neither of these positions requires strenuous physical exertion, and there is insufficient objective medical evidence upon which this Administrative Law Judge could base a finding that claimant is unable to perform work that 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 testified on the record that he can walk 40-50 feet, stand for two minutes at a time, and sit for five minutes to a half an hour at a time. Claimant testified that he can squat but he can't get back up and he can bend waist, but cannot shower and dress himself or tie his shoes or touch his toes. Claimant testified that the heaviest weight he can carry is 10 pounds and that he is right-handed and he can't lift his hands and arms because he has a pacemaker. However, there is no indication in the file that claimant has a pacemaker or defibrillator placed in his heart.

Claimant does have stents, but there is no evidence of pacemaker. Claimant testified that his level of pain on a scale from 1 to 10 is a 6 with medication.

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 at least sedentary tasks if demanded of him. Claimant's activities of daily living do not appear to be very limited as he does cook one time per week and he does do dishes and pick up after himself. The claimant's testimony as to his limitations indicates that he should be able to perform light or sedentary work even with his impairments.

Claimant testified on the record that he does continue to smoke a pack of cigarettes every three days and his doctor has told him 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). Claimant is not in compliance with his treatment program, as he continues to smoke despite the fact that he does have heart problems.

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 he has not established by objective medical evidence that he cannot perform light or sedentary work even with his impairments.

The department's Program Eligibility Manual contains the following policy statements and instructions for caseworkers regarding the State Disability Assistance program: to receive State Disability Assistance, a person must be disabled, caring for a disabled person or age 65 or older. PEM, Item 261, page 1. Because the claimant does not meet the definition of disabled under the MA-P program this Administrative Law Judge finds that the evidence of record does not establish that claimant continues to be disabled for a period beyond May 2009. The claimant does not meet the disability criteria for State Disability Assistance benefits either

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, retroactive Medical Assistance and continued State Disability Assistance benefits beyond May 2009. The claimant should be able to perform a wide range of light or sedentary work even with his impairments. 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: August 20, 2009

Date Mailed: August 20, 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]