STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

[redacted]

Reg No. 200924353
Issue No. 2009
Case No. [redacted]
Load No. [redacted]
Hearing Date: August 4, 2009
Van Buren County DHS

ADMINISTRATIVE LAW JUDGE: Jana A. Bachman

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 4, 2009. Claimant was represented by [redacted]

ISSUE

Whether claimant has established disability for Medical Assistance (MA).

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. October 3, 2008, claimant applied for MA, retroactive MA, and SDA.

2. November 19, 2008, the Medical Review Team (MRT) denied claimant's MA and retroactive MA application. Department Exhibit A.

3. January 15, 2009, the department sent claimant written notice that the MA and retroactive MA application was denied. Department Exhibit C.

4. April 14, 2009, the department received claimant's timely request for hearing.

5. June 9, 2009, the State Hearing Review Team (SHRT) denied claimant's MA and retroactive MA application. Department Exhibit B.

6. August 4, 2009, the in-person hearing was held. Prior to the close of the record, claimant requested the record be left open for additional medical evidence. Claimant waived the right to a timely hearing decision. May 4, 2010, the SHRT again denied claimant's application. SHRT Decision, 5-4-2010.

7. Claimant asserts disability based on impairments caused by burns to his left arm, neck, chest, hypertension, depression, anxiety, and attention deficit disorder.

8. Claimant testified at hearing. Claimant is 27 years old, 5'9" tall, and weighs 160 pounds. Claimant completed ninth grade and a GED. Claimant is able to read, write, and perform basic math. Claimant's driver's license is revoked. Claimant cares for his needs at home.

9. Claimant's past relevant employment has been in factory work.

10. July 21, 2008, claimant was admitted to hospital after suffering burns over 18 percent of his body involving face, neck, chest, and left arm. Claimant also had an inhalation injury. Claimant underwent burn treatment, including skin grafts. September 10, 2008, claimant was transferred to a rehabilitation facility. Department Exhibit A, pgs 34-35. On admission at the rehab facility, physical examination revealed extensive burns involving ears, face, neck, upper arms, and chest with manifested extensive erythematous changes and extensive scarring. The scarring and grafting sites at the upper anterior chest and upper arm regions erythematous appearance of the cheeks were evident. Donor sites of the thighs were healed up. Tracheotomy to remove site was open, was approximately closed to 1 cm in diameter. He had normal strength in both upper extremities, but strength in the lower extremities was 3/5 bilaterally. No sensory deficit was evident. Babinski was equivocal. Deep tendon reflexes were normal and symmetrical. Over the course of treatment, burn sites, erythematous changes, graft sites, and scarring remained stable and unchanged. There was no evidence of skin infection. Tracheotomy to removal site has completely been closed uneventfully. PEG tube was removed and the area has completely healed up. Claimant has started on a regular diet the morning of his discharge. A psychologist and consultation with

psychiatrist was conducted. Impression was anxiety disorder, mood disorder, marijuana abuse, antisocial personality disorder features. It was recommended patient continue counseling at local mental health facility. Claimant had suffered from diarrhea but that was resolved with medication. Claimant was discharged September 23, 2008. Department Exhibit A, pgs 505-506.

11, April 25, 2009, claimant underwent an independent medical examination and a narrative report was prepared that indicates in pertinent part: there was a 22 cm surgical scar noted in the lower abdomen just above the umbilicus to the symphysis pubis. There were also skin graft harvest sites over the anterior abdominal wall below the xyphoid. There were known to be extensive burn scars over the anterior chest from approximately the level of the nipples into both axula and up to the roughly angle of the jaw and the neck. There was a burn scar noted in the left dorsum of the hand and in the proximal left forearm. Visual acuity was 20/20 without corrective lenses in each eye. Pupils were equal and reactive to light. Neck was supple with no masses or thyromegaly. No bruits were appreciated over the carotid arteries. There was no jugular venous distension. Chest diameter is grossly normal. Breath sounds were of a normal intensity. There are no wheezes, rales, or rhonchi. Accessory muscles are not used. Heart had no clip or murmur and no S3 or S4. Heart does not appear to be enlarged. No orthopnea was noted. Abdominal contour was normal with no organomegaly or masses. There was no evidence of ascites. Bowel sounds were normal. There was no clubbing or cyanosis detected. Peripheral pulses were intact. Feet were warm and of normal color. There were no foraminal bruits. There was no peripheral edema or varicose veins. There was stasis, dermatitis or ulcerations. There was no joint instability, enlargement, or effusion. Grip strength remained intact with dexterity unimpaired. Patient could pick up a coin, button clothing, and open a door. Patient had no difficulty getting on and off the exam table, no difficulty heel and toe walking and no difficulty squatting. Range of motion in the joints were reduced in the cervical spine and the shoulder. Claimant Exhibit A, pgs B1-B4.

12. April 7, 2009, claimant underwent a psychological evaluation and a narrative report was prepared. During exam, claimant appeared to have adequate contact with reality and showed no evidence of psychomotor agitation or retardation. Stream of mental activity was spontaneous and adequately organized. Claimant denied hallucinations, persecutions, obsessions, thoughts controlled by others, unusual powers, and suicidal ideation. Claimant stated that he has problems with being sleepless. Claimant appeared fatigued

> and dysphoric throughout the interview. He was oriented x 3. Cognitive functions appeared to be within normal limits. Examiner opined that claimant was likely to have marked difficulty interacting appropriately with others in public and with coworkers and supervisors in the workplace due to factors associated with his depression, anxiety, and antisocial personality disorder. AXIS I diagnoses were history of drug and alcohol abuse, dysthymic disorder, and generalized anxiety disorder. AXIS II diagnoses was antisocial personality disorder. GAF was assessed at 52. Claimant Exhibit A, pgs C1-C7.

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).

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).

If an individual fails to cooperate by appearing for a physical or mental examination by a certain date without good cause, there will not be a finding of disability. 20 CFR 416.994(b)(4)(ii).

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 so is not disqualified from receiving disability at Step 1.

At Step 2, the objective medical evidence of record indicates that claimant suffered burns over 18 percent of his body, specifically the upper body during July 2008. He was hospitalized for a period of time and then was in a rehabilitation center. He was released from inpatient medical care on September 23, 2008. Independent physical exam that took place during April 2009 revealed claimant to have burn scars on his upper body. He had reduced range of motion in the cervical spine, shoulders, and to a lesser extent the elbows. Grip strength was well maintained and claimant could walk normally without the use of assistive device. He did not have difficulty with orthopedic maneuvers. During his hospitalization, claimant was diagnosed with anxiety, depression, and antisocial personality. During April 2009, claimant underwent an independent psychological examination that revealed a history of drug and alcohol abuse, dysthymic disorder, and generalized anxiety disorder. Doctor opined claimant also had antisocial personality disorder. GAF was assed at 52, indicative of moderate difficulties or symptoms. Doctor opined that claimant was likely to have marked difficulty interacting with others in public and with coworkers and supervisors in the workplace. However, no medical history of psychiatric treatment history documenting long-term difficulties were submitted into the record. The objective medical evidence of record does not support that claimant has had or will have marked difficulties getting along with others. Accordingly, the objective medical evidence will be given the greater legal weight. Finding of Fact 10-12; DSM IV 1994 R.

At Step 2, the objective medical evidence of record is not sufficient to establish that claimant has severe impairments that have lasted or are expected to last 12 months or more and prevent employment at any job for 12 months or more. Therefore, claimant is disqualified from receiving disability at Step 2.

At Step 3, claimant's impairments do not rise to the level necessary to be specifically disabling by law.

At Step 4, claimant's past relevant employment has been in factory work. See discussion at Step 2 above. Finding of Fact 9-12.

At Step 4, the objective medical evidence of record is not sufficient to establish that claimant has functional impairments that prevent claimant for a period of 12 months or more from engaging in a full range of duties required by claimant's past relevant employment. Therefore, claimant is disqualified from receiving disability at Step 4.

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).

Medium work. Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work. 20 CFR 416.967(c).

Heavy work. Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work. 20 CFR 416.967(d).

At Step 5, see discussion at Step 2 above. Finding of Fact 8-12.

At Step 5, the objective medical evidence of record is sufficient to establish that claimant retains the residual functional capacity to perform at least light, unskilled activities. Considering claimant's vocational profile (younger individual, limited

education, and history of unskilled work) and relying on Vocational Rule 202.17, claimant is not disabled. Therefore, claimant is disqualified from receiving disability at Step 5.

Claimant does not meet the federal statutory requirements to qualify for disability. Therefore, claimant does not qualify for Medical Assistance based on disability and the department properly denied claimant's application.

DECISION AND ORDER

The Administrative Law Judge, based upon the clear and convincing evidence, decides that claimant has not established disability for Medical Assistance.

Accordingly, the department's actions are, hereby, UPHELD.

/s/
Jana A. Bachman
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: January 7, 2010

Date Mailed: January 11, 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 receipt 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.
JAB/db

cc: [redacted]