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: 2009-24733
Issue No: 2009; 4031
Case No: [redacted]
Load No: [redacted]
Hearing Date:
July 28, 2009
Macomb 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 28, 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 November 14, 2008, claimant filed an application for Medical Assistance and State Disability Assistance benefits alleging disability.

(2) On February 23, 2009, the Medical Review Team denied claimant's application stating that claimant could perform her prior work.

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

(4) On April 24, 2009, claimant filed a request for a hearing to contest the department's negative action.

(5) On June 13, 2009, the State Hearing Review Team again denied claimant's application stating that claimant is capable of performing other work and commented that the claimant retains the physical residual functional capacity to perform sedentary work. The claimant's past work was sedentary. Therefore, the claimant retains the capacity to perform her past job as an office manager. MA-P is denied per 20 CFR 416.920(e). Retroactive MA-P was considered in this case and is also denied. SDA is denied per PEM 261 due to the capacity to perform past relevant work.

(6) Claimant is a 57-year-old woman whose birth date is [redacted]. Claimant is 5' 3" tall and weighs 146 pounds. Claimant attended the 10th grade and has no GED. Claimant is able to read and write and does have basic math skills.

(7) Claimant alleges as disabling impairments: rheumatoid arthritis, heart disease, cardio obstructive pulmonary disease (COPD), coronary artery disease, a double heart bypass, two heart attacks in [redacted], leg swelling, right side nerve damage, a quadruple bypass in [redacted], constant pain in her joints, and migraines.

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 2007. Claimant is not disqualified from receiving disability at Step 1.

The objective medical evidence on the record indicates that on a Medical Examination Report of [redacted], claimant was well-developed, well-nourished, cooperative, and in no

acute distress. She was awake, alert, and oriented x3. The claimant was dressed appropriately and answered questions fairly well. Vital signs: Her height was 5’ 3”, weight 139 pounds, pulse 73, respiratory rate 16, blood pressure 92/64, visual acuity without glasses was 20/70 on the right and 20/70 on the left. Vision with glasses was right eye 20/25 and left eye 20/20. HEENT: Normocephalic/atraumatic. EYES: Her lids were normal. There was no exophthalmos, icterus, conjunctiva, erythema, or exudates noted. PERRLA: Extraocular movements were intact. EARS: No discharge in the external auditory canals. No bulging erythema, no perforation of the visible tympanic membrane noted. NOSE: There was no septal deformity, epistaxis, or rhinorrhea. MOUTH: The teeth were in fair repair. The neck was supple. No JVD noted. No tracheal deviation. No lymphadenopathy. Thyroid was not visible or palpable. The external inspection of the ears and nose revealed no evidence of acute abnormality. The respiratory system, the chest was symmetrical and equal to expansion. Lung fields were clear to auscultation and percussion bilaterally. There were no rales, rhonchi, or wheezes noted. No retractions noted. No accessory muscle usage noted. No cyanosis noted. There was no cough. In the cardiovascular, there was normal sinus rhythm, S1, and S2. No rubs, murmur, or gallop. The gastrointestinal revealed a soft, benign, non-distended abdomen, non-tender with no guarding, rebound, or palpable masses. Bowel sounds were present. Liver and spleen were not palpable. On the skin, there were no significant skin rashes or ulcers. In the extremities, there were no obvious spinal deformity, swelling, or muscle spasm noted. Pedal pulses were 2+ bilaterally. There was no calf tenderness, clubbing, edema, varicose veins, brawny erythema, statis dermatitis, chronic leg ulcers, muscle atrophy, joint deformity or enlargement was noted. In the bones and joints, the claimant did not

use a cane or an aid for walking. She was able to get on and off the table without difficulty. Gait and stance were normal. Tandem walk, heel walk, and toe walk were done without difficulty. She was able to squat to 100% of the distance and recover, and bend to 100% of the distance and recover. Grip strength was equal bilaterally. The claimant was right-handed. Gross and fine dexterity appeared bilaterally intact. Finger-to-nose test was done without difficulty. Flexion of the knees was 0-150. The right hand grip was 4+/5. The right shoulder abduction was limited to 100 degrees and right hand range of motion was restricted in the PIP and DIP of the right hand, as described in the range of motion sheet. Straight leg raising test while lying was 0-50 and while sitting was 0-90. Neurologically, the claimant was alert, awake, oriented to person, place, and time. The cranial nerve II—vision as stated in vital signs, III, IV, and VI—no ptosis or nystagmus. Pupils were 2 mm bilaterally. Fundi not visualized. V—no facial numbness. Symmetrical response to stimuli. VII—symmetrical face movement noted. VIII—could hear normal conversation in whispered voice. IX and X –swelling was intact. Gag reflexes intact. Uvula was midline. XI—head and shoulder movement against resistance were equal. XII—no sign of tongue atrophy. No deviation with protrusion of tongue. Sensory functions were intact to sharp and dull gross testing. Motor exam revealed fair muscle tone without flaccidity, spasticity, or paralysis. Cerebellar—finger-to-nose was done very well. The impression was that claimant had coronary artery disease and has had two myocardial infarctions. She had a coronary artery bypass graft x2 as well as coronary stents. Her ejection fraction last documented at 40%. She did complain of exertional shortness of breath on walking for half a block. She did have chest pain but that was chest wall pain which was worse on coughing and breathing and felt like soreness.

On examination there was no clinical evidence of congestive heart failure. She was also diagnosed with peripheral vascular disease and had bilateral carotid endarterectomy. She did complain on swelling in her legs off and on and her feet feel cold and numb sometimes but she did have good pedal pulses bilaterally. She was diagnosed with rheumatoid arthritis and complained of aches and pains in her joints. She did complain of stiffness. Her right hand finger joints had decreased range of motion. Her grip strength on the right hand was limited to 4+/5. Her right shoulder had decreased abduction of 100 degrees. COPD—she did complain of shortness of breath and has been a smoker. She does use an inhaler, but she uses it only occasionally. She denied any chronic cough or wheezing. She had a respiratory infection only once in the last one year (pp. 7-8).

A Medical Examination Report in the file indicates that on [redacted] claimant was 5’ 4” tall and weighed 144 pounds. Her blood pressure was 98/70 and she was right-hand dominant. The clinical impression was that claimant was improving and that she could never lift any weight. She could do simple grasping and fine manipulating with her left hand and arm and could do reaching with both, but could not do pushing/pulling with either. Claimant could not operate foot and leg controls and did not need assistive devices for ambulation. She was diagnosed with severe coronary artery disease (pp. 22-23).

A Physical Residual Functional Capacity Questionnaire in the file indicates that the claimant is incapable of even low stress jobs. She can sit for 10-15 minutes at a time and can stand 5-10 minutes at a time and can sit or walk less than two hours in an eight-hour workday. Claimant would need to take unscheduled breaks during an eight-hour workday and could rarely lift less than 10 pounds, rarely look down, rarely look up, and rarely hold her head in a static

position. Claimant could never twist, crouch/squat, climb ladders, or climb stairs, but could stoop or bend. Claimant had limitations in reaching, handling, and fingering (pp. 27-28).

A medical imaging and diagnostic radiology test dated [redacted] indicates that claimant had a moderate left pleural effusion. The interpretation of the report was that there was a moderate left pleural effusion. No pneumothorax was identified. Surgical changes were seen in the right upper thorax. Coronary artery bypass graft was performed. The cardiomediastinal silhouette was not enlarged. The bones were intact. There was note of bilateral breast implants (p. 30).

Another CT of chest dated [redacted] indicates no pulmonary embolism or aortic dissection. There was moderate atherosclerosis of the thoracic aorta and moderate left pleural effusion with compressive atelectasis of the left lower pulmonary lobe. The left implant and collapsed right breast implant. Right middle pulmonary lobe nodule. Follow-up was recommended. Neoplasm should be considered. Correlation with any outside CT of the chest was recommended (p. 32).

A medical report of [redacted] indicates that claimant had neuropathic pain in the right upper extremity and that in her right shoulder and right hand there was some reduced range of motion. The DIP and PIP joints had reduced motion in them. She was not able to go to therapy. She wanted to do a home exercise program. Her right shoulder flexed to 160, abducted to 160, and external rotation 80, and internal rotation 90. Digits two, three, four, and five had edema and she needs to work on flexibility of those joints (p. 36).

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 objective clinical medical evidence in the record that claimant does

suffer from coronary artery disease and has had two heart attacks and that she does have rheumatoid arthritis and some limitation in her right hand. Therefore, this Administrative Law Judge finds that claimant has established that she does have a severe impairment or combination of impairments which have lasted for the duration of 12 months.

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

At Step 4, claimant testified on the record that she can walk a half a block, stand for 10-15 minutes at a time, and sit for 10-15 minutes at a time. Claimant is able to bend at the waist and is able to shower and dress herself, but cannot tie her shoes or touch her toes and cannot easily squat. Claimant testified that she can carry two pounds and that she is right-handed and that her right hand doesn't grip and her arm won't go up and down. 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 stated that she quit smoking two packs of cigarettes a day in 2008. Claimant testified that she has a migraine for about five days straight and usually gets 2-3 a month or every other week. Claimant testified that in a typical day she reads stories to her grandkids and watches television two hours a day. She takes her medication which makes her unable to function and she usually eats and sleeps. Claimant testified she was in the hospital [redacted] with chest pains and in [redacted] with chest pains. The May admission was for three days and the June admission was for 24 hours.

The Administrative Law Judge finds that claimant has established that she can probably no longer perform any of her prior work. Claimant does not retain bilateral manual hand dexterity because of her rheumatoid arthritis. Although she does have 4+/5 grip strength, she

does have some limitations in her right hand and her right arm. Claimant is right-hand dominant. Therefore, claimant is not disqualified 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).

This Administrative Law Judge finds that claimant has submitted sufficient objective medical evidence that she lacks the residual functional capacity to perform some other less strenuous tasks than in her prior employment. Although claimant may be able to do some sedentary work, she does not retain bilateral manual hand dexterity. Therefore, claimant has established based upon a combination of her impairments, the coronary artery disease, rheumatoid arthritis, migraines, and some right side nerve damage that she is disabled for purposes of Medical Assistance and State Disability Assistance benefit eligibility.

This Administrative Law Judge finds that the department is required to initiate a determination of claimant's financial eligibility for the requested benefits, if not previously done.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the claimant meets the definition of medically disabled under the Medical Assistance program and the State Disability Assistance program as of the November 14, 2008 application date based upon a combination of impairments.

Accordingly, the department's decision is REVERSED. This Administrative Law Judge finds that based upon claimant's advanced age and limited or less education with a maximum sustained work capability limited to light work would be disabled pursuant to Medical-Vocational Rule 202.10 and she would also be disabled pursuant to Medical-Vocational Rule 201.02 based upon her advanced age, limited or less education, and skilled and semi-skilled work. The department is ORDERED to initiate a review of the November 14, 2008 Medical Assistance and State Disability Assistance benefit 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.

A medical review will be conducted of claimant's condition in September 2010. At that time, the department shall assist claimant in gathering updated medical information from her cardiologist as well as updated medical reports and an updated DHS-49 and Residual Functional Capacity Assessment.

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

Date Signed: September 16, 2009

Date Mailed: September 17, 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]