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: 2009-34721
Issue No: 2009
Case No: [redacted]
Load No: [redacted]
Hearing Date:
November 3, 2009
Wayne 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 November 3, 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)?

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 May 1, 2009, claimant filed an application for Medical Assistance benefits alleging disability.

(2) On July 10, 2009, the Medical Review Team denied claimant's application stating that claimant could perform prior work.

(3) On July 20, 2009, the department caseworker sent claimant notice that his application was denied.

(4) On July 29, 2009, claimant filed a request for a hearing to contest the department's negative action.

(5) On September 21, 2009, the State Hearing Review Team again denied claimant's application stating in its analysis and recommendation: The claimant has hearing loss but the auditory testing does not meet program or listing level. His blood pressure was elevated at a recent examination but his heart catheterization showed no major occlusive disease. He had diminished breath sounds. Gait was slow but without an assistive device. The claimant reports dizziness and should avoid working around dangerous moving machinery and unprotected heights. The claimant's impairments do not meet/equal the intent or severity of a Social Security listing. The medical evidence of record indicates that the claimant retains the capacity to perform any job that does not require working around dangerous moving machinery and unprotected heights. Therefore, based on the claimant's vocational profile of advanced age at 55, high school equivalent education and a history of unskilled work, MA-P is denied using Vocational Rule 204.00(H) as a guide. Retroactive MA-P was considered in this case and is also denied.

(6) Claimant is a 55-year-old man whose birth date is [redacted]. Claimant is 5'10" tall and weighs 220 pounds. Claimant has a GED and is able to read and write and does have basic math skills.

(7) Claimant last worked March 2009 as a [redacted] cab driver. Claimant has also worked as a self-employed home repair person, as a truck driver, as a school bus driver, and as a manager at [redacted]

(8) Claimant alleges as disabling impairments: cardiomyopathy, chest pain, anxiety, dizziness, hypertension, cardio obstructive pulmonary disease, depression, arthritis, headaches, back pain, hearing loss and ringing in his ear and itching, as well as right arm numbness.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the MA program pursuant to MCL 400.10, *et seq.*, and MCL 400.105. Department policies are found in the Program Administrative Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM).

Pursuant to Federal Rule 42 CFR 435.540, the Department of Human Services uses the federal Supplemental Security Income (SSI) policy in determining eligibility for disability under the Medical Assistance program. Under SSI, disability is defined as:

> ...the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.... 20 CFR 416.905

A set order is used to determine disability. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience is reviewed. If there is a finding that an individual is disabled or not disabled at any point in the review, there will be no further evaluation. 20 CFR 416.920.

If an individual is working and the work is substantial gainful activity, the individual is not disabled regardless of the medical condition, education and work experience. 20 CFR 416.920(c).

If the impairment or combination of impairments do not significantly limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. Age, education and work experience will not be considered. 20 CFR 416.920.

Statements about pain or other symptoms do not alone establish disability. There must be medical signs and laboratory findings which demonstrate a medical impairment.... 20 CFR 416.929(a).

> ...Medical reports should include –
>
> (1) Medical history.
>
> (2) Clinical findings (such as the results of physical or mental status examinations);
>
> (3) Laboratory findings (such as blood pressure, X-rays);
>
> (4) Diagnosis (statement of disease or injury based on its signs and symptoms).... 20 CFR 416.913(b).

In determining disability under the law, the ability to work is measured. An individual's functional capacity for doing basic work activities is evaluated. If an individual has the ability to perform basic work activities without significant limitations, he or she is not considered disabled. 20 CFR 416.994(b)(1)(iv).

Basic work activities are the abilities and aptitudes necessary to do most jobs. Examples of these include --

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting. 20 CFR 416.921(b).

Medical findings must allow a determination of (1) the nature and limiting effects of your impairment(s) for any period in question; (2) the probable duration of the impairment; and (3) the residual functional capacity to do work-related physical and mental activities. 20 CFR 416.913(d).

Medical evidence may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of the impairment(s), including your symptoms, diagnosis and prognosis, what an individual can do despite impairment(s), and the physical or mental restrictions. 20 CFR 416.927(a)(2).

All of the evidence relevant to the claim, including medical opinions, is reviewed and findings are made. 20 CFR 416.927(c).

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability.... 20 CFR 416.927(e).

A statement by a medical source finding that an individual is "disabled" or "unable to work" does not mean that disability exists for the purposes of the program. 20 CFR 416.927(e).

When determining disability, the federal regulations require that several considerations be analyzed in sequential order. If disability can be ruled out at any step, analysis of the next step is 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 March 2009. Claimant is not disqualified from receiving disability at Step 1.

The objective medical evidence on the record indicates that a [redacted] examination of [redacted] indicates that on [redacted] claimant was 5'10" tall and weighed 225 pounds. His vision with glasses was 20/25 on the right and 20/40 on the left. He was right-handed. He was well-developed and well-nourished. He was in no respiratory distress. HEENT: Fundi were not visualized. External ocular movements were

normal. He had slight difficulty hearing but normal conversation of voice. Throat was clear, no exudate. Tongue was midline. No thyroid enlargement. Chest: The chest was symmetrical. There was expiratory delay. Breath sounds were diminished. Heart: Normal sinus rhythm. Blood pressure was 144/96, 158/100. He was advised about the blood pressure. There was no murmur, gallop, or edema. Peripheral pulses were full and equal. Abdomen: There were no masses. Nervous System: His gait was slow without aid. Biceps, triceps, knee jerks, and ankle jerks were normal. He had no difficulty getting on and off the examining table. There was no incoordination. Light touch sensation was diminished over the right arm. Vibration sense was intact at the ankles. He was unable to walk on his heels and toes because of his back pain. He was able to perform a half squat. His grip was 8 kg and 22 kg on the left. He was able to pick up coins with both hands. He was status post fracture of the right arm as well as surgery on the right forearm with persistent aching and paresthesias. He had chronic low back pain. He had cardio obstructive pulmonary disease. He had hearing loss and dizziness and he had hypertension. He had chest pains with the cause undetermined. Angina pectoris could not be excluded based upon the information currently available. (pp. 36-37) In the lumber spine flexion he had 0-70 degrees and extension he had 0-10 degrees. The right lateral flexion was 0-15 degrees and the left lateral flexion was 0-10 degrees. He had normal shoulder range of motion. In the elbow the flexion on the right was 10-140 and 10-150 and extension he had 10 degrees. Supination was normal. Pronation was normal. (p. 38)

A Medical Examination Report dated [redacted] indicates that claimant had fatigue and chest pain and that he was short of breath and had a history of cardio obstructive pulmonary disease. He was 5’10” tall and weighed 225 pounds. His blood pressure was 160/100 and he was right-hand dominant. He had musculoskeletal weakness and he was anxious at times but he was

neurologically normal. His abdomen was normal and his HEENT was normal. The clinical impression was that he was deteriorating and that he could stand or walk at least 2 hours in an 8-hour day. He could occasionally lift less than 10 pounds, but never lift 10 pounds or more and he could use both of his upper extremities for simple grasping, reaching, pushing/pulling, and fine manipulating and could operate foot and leg controls with both feet and legs. He had sustained concentration mental limitations and he was anxious at times. (pp. 7-8)

A Medical Examination Report on [redacted] indicates that claimant was overweight and he had nasal dryness, decreased hearing, some sensorial hearing loss, and in his musculoskeletal area his right and left trigger points were tender trapezius and tender occipital. He had Romberg to the left. An audiogram showed findings of sensoineural hearing loss. He was 5'10" tall and weighed 228 pounds. He was diagnosed with dizziness, cervical myalgia, sensoineural hearing loss, and ringing in the ears. The clinical impression was that he was stable and that he could frequently lift 20 pounds and occasionally lift 25 pounds, but never lift 50 pounds or more. He did not need an assistive device for ambulation and it was stated that he should refrain from driving until his dizziness resolved and also limit frequent head motions to the right and left. The claimant's Romberg was abnormal and he had no mental limitations. (pp. 9-10)

An ear, nose, and throat consultation report dated [redacted] indicates that claimant was 5'10" tall and weighed 228 pounds. His BMI was 32.71. His blood pressure was 138/96. The general examination revealed the claimant was well-developed, well-nourished, alert, did not appear acutely ill, cooperative, and appeared well groomed. There were no apparent lesions or rashes and he was able to communicate verbally without assistance or devices. The examination of the ears revealed the auricles were of normal size, shape, and location without

scars, lesions, or masses. The TMs were of normal color, clarity with good mobility without retraction or fluid, ears canals were free of otorrhea, foreign bodies, debris, and cerumen and tuning forks showed decreased hearing. The examination of the nose revealed mucous membrane dryness, the inferior turbinates had no hypertrophy, congestion, or enlargement. There was no hypertrophy or polypoid degeneration of the middle turbinate, no septal deviations. There was no hyper or hypernasality. There was no nasal discharge and normal nasal airflow bilaterally without obligate mouth breathing. The examination of the head/neck revealed trigger points in the right, tender trapezius in the left and right, tender occipital, injected with ½ cc of Kenalog missed with ½ of Marcaine 0.5%. The head was normocephalic and the anterior cervical triangle had no masses, lesions, or lymphadenopathy. The posterior cervical triangle had no masses, lesions, or lymphadenopathy. There was no submandibular tenderness, hypertrophy, or erythema. The thyroid had no palpable nodules or thyromegaly. Trachea was midline without crepitus. The parotid glands were non-tender with no palpable masses and the face appeared normal with no lesions, masses, or discoloration. The examination of the lymphatic system revealed no palpable submandibular, submental, pre or post-auricular nodes. There were no palpable cervical nodes. There were no palpable supraclavicular nodes and no palpable infraclavicular lymphadenopathy. The examination of the respiratory systems revealed there were clear breath sounds bilaterally without stertor or stridor, with a normal respiratory rate without effort. There was symmetrical chest expansion, no rales, no rhonchi, and no wheezing. The diagnoses were dizziness and giddiness, status—chronic uncontrolled; unspecified cervical myalgia, status—chronic uncontrolled; and unspecified hearing loss, sensoineural, status—chronic uncontrolled. (pp. 13-14)

On [redacted], claimant was admitted for chest pain. The claimant's ejection fraction according to the stress test was 49% and showed some evidence of ischemic changes. The claimant was put on chest pain protocol and he was scheduled to have cardiac catheterization which he had and came back in fairly good shape. The cardiologist did clear the claimant to be discharged and he was put on intravenous steroids. He was counseled extensively regarding smoking cessation. (p. 17)

A physical examination of [redacted] indicates that claimant's blood pressure was 140/80, pulse was 72, respirations were 18 and non-labored, and he was afebrile. He weighed 224 pounds with a BMI of around 30. His general appearance was well-developed. His skin was warm and dry. Head and eyes: pupils were equal, round, and reactive to light and accommodation. Extraocular movements were intact. Mouth, pharynx, and teeth showed good oral hygiene. In the neck there was no jugular venous distention. Thyroid was not palpable. There were faint bilateral carotid bruits. The lungs were clear. The heart has regular rhythm, S1 and S2 were normal, S4 present, and S3 present. There was left ventricular heave, no thrills. There was a soft systolic murmur, mitral and tricuspid insufficiency and there was a faint aortic outflow tract murmur. In the peripheral vascular area, pulses were intact with no bruits. The abdomen was soft, non-tender, bowel sounds were present, no mass, bruits, or organomegaly. Joints, back, muscles, and bones had no deformity. No neurological findings and the mental status was alert and oriented. In the extremities there was a normal examination of the extremities. Edema was trace. Gait, motor, and sensory: there were no focal motor or sensory deficits. Gait was not assessed. Hemoglobin and hematocrit were normal at 16 and 47. Platelet count was 185,000. He had classical angina with markedly abnormal MPI with a low ejection fraction of 47% and quite high end-systolic volume of over 80. There was no clinical congestive

heart failure and myocardial infarction was ruled out. (p. 21) Claimant's assessment was that his prior MPI was quite abnormal with cardiomegaly, low ejection fraction, and elevated end-systolic volume. (p. 22) Claimant was diagnosed with non-ischemic dilated cardiomyopathy, ejection fraction of 40%. No major occlusive disease in the left main, left anterior ascending, circumflex, and right coronary artery system. Elevated left filling pressures. No evidence of mitral insufficiency and no evidence of aortic stenosis or insufficiency. (p. 24)

An [redacted] echocardiogram revealed an ejection fraction of 35% - 40% and borderline concentric hypertrophy. Left ventricle was moderately dilated. Mitral, aortic, tricuspid, and pulmonic were anatomically normal. EKG done on [redacted] and [redacted] revealed no acute change. (p. 29)

The State Hearing Review Team determined that claimant could work pursuant to Vocational Rule 204.00(H) as a guide which states that the residual functional capacity to perform heavy work or very work includes the functional capacity for work at the lesser functional levels as well and represents substantial work capability for jobs in the national economy at all skill and physical demand levels.

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. This Administrative Law Judge finds that claimant has established that he does have a severe impairment or combination of impairments which have lasted or will last the durational requirement of 12 months or more or could result in death as he does have cardiomyopathy and ischemic changes and an ejection fraction of 49% at page 17 of the medical reports and then he had a heart catheterization showing non-ischemic dilated cardiomyopathy

with an ejection fraction of 40%. (pp. 23-24) Claimant is not disqualified from receiving disability at Step 2.

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, claimant testified on the record that he does have a driver's license and he drives every couple of days to the store which is about a half a mile away. Claimant is able to cook everyday and cooks things like chicken and he does baked goods. Claimant does grocery shop every two weeks with his wife who does the driving for him because he is usually dizzy and he cleans his house by loading the dishwasher and running the vacuum. Claimant testified that he can walk one block, stand for 15 minutes at a time, and sit for 2 hours at a time. Claimant testified that he can shower and dress himself, but do it slowly. Claimant testified that he cannot squat or bend at the waist and he cannot tie his shoes or touch his toes. Claimant testified the heaviest weight he can carry is 5-10 pounds and that he is right-handed and that his right arm is basically useless because he does have reduced range of motion of the back and elbow and diminished sensation in his right arm where he had a previous fracture. Claimant testified that his level of pain on a scale from 1 to 10 without medication is an 8 and with medication is a 5. Claimant testified that he does continue to smoke 3 cigarettes per day and has cut down. Claimant testified that he also quit drinking in April 2009. Claimant testified that in a typical day he gets up and makes a sandwich and watches television and then goes up stairs and lies down because he gets headaches.

The Administrative Law Judge finds that claimant can probably not currently perform his prior work. Claimant should not be driving because he was a cab driver and he does have dizziness. Therefore, this Administrative Law Judge finds that 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 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 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 light or sedentary tasks if demanded of him. However, claimant is of advanced age and he is a high school graduate and he had unskilled work which means that he is disabled pursuant to Medical-Vocational Rule 202.04 as he cannot currently perform his vocationally relevant past work and he has a history of unskilled work experience or he has skills that are not readily transferable to a significant wage or semi-skilled or skilled work that is within the individual's functional capacity. This Administrative Law Judge finds that claimant meets the definition of medically disabled and 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 claimant meets the definition of medically disabled under the Medical Assistance Program as of the May 1, 2009 application date.

Accordingly, the department's decision is REVERSED. The department is ORDERED to initiate a review of the May 1, 2009 Medical Assistance application, if it has not already done so, to determine if all other non-medical eligibility are met. The department shall inform the

claimant of the determination in writing and shall also determine whether or not claimant has a retroactive Medical Assistance application for purposes of this decision.

The department is also ORDERED to conduct a medical review of claimant's condition in November 2010. At that time, the department shall assist claimant in providing updated medical information from a cardiologist as well as audiology testing, and a complete physical examination.

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

Date Signed:_ February 2, 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: