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: 2010-17359
Issue No: 2009; 4031
Case No: [redacted]
Load No:
Hearing Date:
March 4, 2010
Grand Traverse 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 March 4, 2010. 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 January 22, 2009,, claimant filed an application for Medical Assistance and State Disability Assistance alleging disability.

(2) On April 10, 2009, the Medical Review Team denied claimant's application stating that claimant's impairments are non-exertional.

(3) On December 7, 2009, the department caseworker sent claimant notice that her application was denied.

(4) On January 15, 2010, claimant filed a request for a hearing to contest the department's negative action.

(5) On February 9, 2010, the State Hearing Review Team again denied claimant's application stating in its analysis and recommendation: the findings of a Social Security Administration Law Judge are taken into consideration and find that claimant is capable of performing only sedentary tasks. It is noted that the claimant cares for her physically and mentally disabled adult child and that the sedentary limitations may be somewhat generous. The claimant's voracity is also in question relating to psychiatric claims. The claimant in less than a year's time had a significant retelling of symptoms and abilities between two evaluations. Also, during this time the claimant fully managed the household again, caring for disabled child and to a certain extent a disabled spouse. 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 a wide range of sedentary exertional work of a simple and repetitive nature. Therefore, based on the claimant's vocational profile of 48 years, and some high school education and a history of no gainful employment, Medicaid P is denied using Vocational Rule 201.18 as a guide. Retroactive Medicaid P was considered in this case and was also denied. State Disability Assistance was not applied for by the claimant. Listings 1.04 and 12.04 and 12.06 were considered in this determination.

(6) The hearing was held on March 4, 2010. At the hearing, claimant waived the time periods and requested to submit additional medical information.

(7) Additional medical information was submitted and sent to the State Hearing Review Team on March 8, 2010.

(8) On March 12, 2010, the State Hearing Review Team again denied claimant's application stating in its analysis and recommendation: There is new evidence provided by the claimant. While the claimant did have hospitalizations related to chest pain and abdominal pain, both hospitalizations revealed no functional limitations. The new evidence does not materially alter the prior determination. 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 a wide range of sedentary of a simple and repetitive nature. Therefore, based on the claimant's vocational profile of 48 years old, less than high school education, and a history of no gainful employment, Medicaid P is denied using Vocational Rule 201.18 as a guide. Retroactive Medicaid P was considered in this case and was also denied. State Disability Assistance was applied for by the claimant. Listings 1.04, 5.01, 12.04 and 12.06 were considered in this determination.

(9) Claimant is a 48-year-old woman whose birth date is [redacted] Claimant is 5'5" tall and weighs 160 pounds. Claimant attended the 9th grade and has no GED. Claimant is able to read and write and does have basic math skills.

(10) Claimant is currently employed as a home health care aide and she earnings $[redacted] per month, taking care of her disabled daughter. Claimant's disabled daughter weighs 46 pounds and she is 100% dependent. Claimant feeds her, bathes her, clothes her, changes her diaper and transports her to her day program. Her daughter is 30 years old and totally physically and mentally disabled from birth and receives SSI in the amount of $[redacted] per month.

(11) Claimant has worked at the job for approximately 12 years. Claimant has also worked as a housekeeper at [redacted] and as a deli clerk in a grocery store.

(12) Claimant alleges as disabling impairments: herniated discs, back pain, panic disorder, irregular heart beat, prolapsed mitral valve and posttraumatic stress disorder.

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 Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) 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 Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) 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 engaged in substantial gainful activity and has been working at the same job for approximately 12 years earning $[redacted] per month for her home health care of her disabled daughter. Claimant is disqualified from receiving disability at Step 1.

The objective medical evidence on the record indicates that there are approximately 1,000 pages of medical information contained in the file. This Administrative Law Judge did read all of the entire medical file. It should be noted that claimant received an unfavorable

decision from Social Security Administration dated March 31, 2008, which indicated that claimant is capable of performing sedentary tasks. A Community Mental Health report dated October 22, 2009 indicates that claimant's mood was initially anxious for dypshoric. She denied thoughts of suicide or homicide but stated that she wished the panic attacks would go away. Insight and judgment appeared fair to good. (Page 111.) The February 9, 2010 State Hearing Review Team decision medical summary indicates that claimant is alleging disability secondary to low back pain and panic disorder. The psychiatric evaluations are pages 408 and 556. The former gives a diagnosis of anxiety disorder and claimant explicitly states they had no idea why they are in for a psychiatric evaluation as there is no issue related to a psychiatric condition. The claimant admits to being on [redacted] and [redacted] and relative to spouse having survived cancer, caring for a disabled adult child dumped on by her father-in-law. The latter evaluation claimant alleges an 18 to 24 year history of severe panic attacks and occurring up to two times a day until recently when they now occur approximately three times per week. Aside from this departure, early testimony, the remainder of the evaluation is essentially the same except for the evaluator gave her a diagnosis of panic disorder without agoraphobia and major depression. (Page 578.)

A [redacted] clinical crisis screen dated January 9, 2010 indicates that claimant's appearance was unremarkable, she was oriented to time, situation, and place. She was tense and rigid, and her speech was unremarkable. Her insight was fair. Her affect was labile. Her concentration was focused; her mood was anxious and worried and depressed. Her perceptions were unremarkable and her thoughts were organized. She was neat and clean in appearance and dressed appropriately for the weather. She denied perceptual alterations. Her thoughts were organized and logical. Her judgment and insight appeared fair. Her attention was focused. She did not appear to have any difficulties with gait, speech or gross fine movements.

Her attention was focused on the conversation at hand. She had no thoughts of homicidal but did have some vague passive thoughts of suicide. (Page 907.) A [redacted] emergency department report dated February 17, 2010 indicates that claimant was a middle aged female lying supine in no acute distress. Files per nursing triage note HEENT revealed skull is normal and cephalic. Conjunctivae and sclerae were clear. Oral phyry and exit is clear and moist. Neck is supple. No JVD or bruit. Lungs are clear to auscultation and percussion. Cardiac had regular rate and rhythm. Abdomen is schpoid. Bowel sounds were present in all four quadrants. Patient complained of pain to palpation of the abdomen even to light touch of skin; however, over the right mid-quadrant, the long border erectus but there is no palpable hernia or mass. There is no echomosis noted. Left side is begnigh. There was no guarding or rebound. There was no palpable or hepatosplenomegaly. Bowel sounds were present in all four quadrants. Negative CVAT. GU was deferred. Rectal was deferred. Extremities were unremarkable. Neurologically, the patient was intact. CDC revealed white count of 11.6, hemoglobin of .4, basic metabolic normal. Liver one profile normal. UA is unremarkable. Acute abdominal series reveals nonspecific gas pattern. Ultrasound is carried out of the right which was negative as well. ECG revealed sinus mechanism without any hyperacute ST segment changes noted. (Page 851.) Patient was given a single ejection and [redacted] and discharged home with the instructions to take [redacted] or [redacted] for pain. (Page 851.) An emergency department report dated February 16, 2010 indicates that claimant was afebrile. Vital signs were stable. General is well developed, well-nourished female in acute distress. HEENT is negative. Chest is clear to auscultation bilaterally. Heart is regular rate and rhythm. Abdomen is soft, nontender, nondistended, positive bowel sounds. Extremities are clear, no clubbing, cyanosis or edema. Pulses are 2+. Skin was negative for lesions or rashes.

Neurological examination was intact. Claimant had an MRI of the brain, C spine, CT of the head and chest all of which were negative. (Page 844.) At [redacted], medical report of February 2, 2010 indicates that claimant came to the medical center with episodes of upper chest tightness. Claimant was lying in a cart. The vital signs were stable. She was afebrile. Pulse rate was 72. Respiratory rate is 16 and blood pressure is 135/84 with a 96% pulse oximetry. There is no ectopy or cardiac monitoring. She appears to be in sinus rhythm. Skin color is good, warm and moist. Air, nose and throat are normal. Pupils are equal and reactive to light. Extraocular motions are intact. Neck is supple. Carotid pulsations are symmetrical with good upstrokes. There is no palpable and large thyroid or cervical added on to the adenopathy. Lungs are clear. Heart rate and rhythm is regular at 72 without murmur or ectopy. Abdomen is soft with active bowel sounds and nontender to palpation. The patient has no peripheral edema. EKG shows a normal sinus rhythm. No acute ischemic changes. The impression was anxiety and panic disorder. (Page 800.) Claimant testified that she can stand for half an hour, walk for half a block, sit for an hour. Claimant can shower and dress herself and touch her toes and she is careful. Claimant cannot squat or bend at the waist and stated that she has had surgery on both knees. Claimant testified her level of pain on a scale of 1 to 10 without medication is a 7 and with medication is a 2. Claimant isn't able to engage in sexual relations. Claimant is right handed and there is nothing wrong with her hands and arms and nothing wrong with her legs and feet. Claimant testified the heaviest weight she could carry is her daughter who weighs 46 pounds. Claimant testified that she does have a drivers license but her cousin takes her places and that she does cook five to six times per week and cooks things like pork chops, chicken and potatoes. Claimant testified that she grocery shops two times per week and needs help getting to the store. Claimant testified that she does do laundry, vacuum and does dusting and that she

does sew and watches television four to five hours per day. Claimant testified that on a typical day she gets up, makes breakfast, gets her daughter ready to take her to daycare program, clean or takes a nap and at 1:30 p.m. she leaves to pick up her daughter and that she feeds her daughter, eats, bathes her daughter and goes to bed.

At Step 2, the clinical impressions that claimant is stable. Claimant alleges the following mental impairments: panic attacks, depression and posttraumatic stress disorder.

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 mental residual functional capacity assessment in the record.

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 she would meet a statutory 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 her again at Step 4 based upon her ability to perform her past relevant work. There is no evidence upon which this Administrative Law Judge could base a finding that claimant is unable to perform work in which she has engaged in, in the past. Therefore, if claimant had not already been denied at Step 2, she would be denied again 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).

Claimant has submitted insufficient objective medical evidence that she lacks the residual functional capacity to perform some other less strenuous tasks than in her prior employment or that she is physically unable to do light or sedentary tasks if demanded of her. Claimant's

activities of daily living do not appear to be very limited and she should be able to perform light or sedentary work even with her impairments. Claimant has failed to provide the necessary objective medical evidence to establish that she has a severe impairment or combination of impairments which prevent her from performing any level of work for a period of 12 months. The claimant's testimony as to her limitations indicates that she should be able to perform light or sedentary work.

There is insufficient objective medical/psychiatric evidence contained in the file of depression or a cognitive dysfunction that is so severe that it would prevent claimant from working at any job. 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. 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 she has not established by objective medical evidence that she cannot perform light or sedentary work even with her impairments. Under the Medical-Vocational guidelines, a younger individual (age), with a high school education and an unskilled work history who is limited to light work is not considered disabled.

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. BEM, Item 261, p. 1. Because the claimant does not meet the definition of disabled under

the MA-P program and because the evidence of record does not establish that claimant is unable to work for a period exceeding 90 days, the claimant does not meet the disability criteria for State Disability Assistance benefits either.

The Department has established by the necessary competent, material and substantial evidence on the record that it was acting in compliance with department policy when it determined that claimant was not eligible to receive Medical Assistance and/or State Disability Assistance.

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 State Disability Assistance benefits. The claimant should be able to perform a wide range of light or sedentary work even with her 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: June 07, 2010

Date Mailed: June 8, 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/tg

cc: [redacted]