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: 2010-25637
Issue No: 2009/4031
Case No: [redacted]
Load No:
Hearing Date:
April 22, 2010
Alpena 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, a telephone hearing was held on April 22, 2010.

ISSUE

Whether claimant has established disability for Medical Assistance (MA) 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) January 4, 2010, claimant applied for MA, retroactive MA, and SDA.

(2) February 25, 2010, the Medical Review Team (MRT) denied claimant's application. Department Exhibit A.

(3) March 1, 2010, the department sent claimant written notice that the application was denied.

(4) March 8, 2010, the department received claimant's timely request for hearing.

(5) March 24, 2010, the State Hearing Review Team (SHRT) denied claimant's application. Department Exhibit B.

(6) April 22, 2010, the telephone hearing was held.

(7) Claimant asserts disability based on impairments caused by mental illness, poor vision, carpal tunnel syndrome, back pain, stroke, spastic right hip, neuralgia, migraine headache, hepatitis, and multiple sclerosis.

(8) Claimant testified at hearing. She is 45 years old, 5'7" tall, and weighs 158 pounds. Claimant completed high school and LPN training. She has a current license. Claimant is able to read, write, and perform basic math. She has a driver's license and is able to drive, but prefers often not to due to nerves and vision issues. Claimant cares for her needs at home.

(9) Claimant's past relevant employment has been as an LPN.

(10) June 27, 2008, claimant underwent an MRI of the cervical spine and a report was prepared that states the following: some narrowing of the fifth interspace with localized degenerative changes and bulges of the annulus. Department Exhibit A, pg 63. April 4, 2008, claimant underwent MRI of the brain and a report was prepared that states the following: unenhanced and enhanced MRI imaging scans of the brain demonstrate several white matter lesions, which are unchanged since February 20, 2007. None of these appear to enhance. Department Exhibit A, pg 64. April 21, 2008, claimant was examined by a neurologist and a letter was prepared. In pertinent part, the letter indicates that claimant's mental status was sharply intact to detailed history; normal language function. Visual fields are full to

confrontation. Extraocular movements are intact without nystagmus. No INO is present. No APD is noted. On funduscopy, discs are flat without pallor bilaterally. Facial sensation and strength is intact and symmetric. Palate elevates symmetrically. Tongue protrudes in the midline. Sternocleidomastoid and trapezius strength was full. Motor has normal bulk and normal tone throughout. There is 5/5 strength proximal and distally in all four extremities. No pronator drift nor fixation satelliting is appreciated. Patient does have very subtle head titubation and a fine high frequency tremor of her arms which appears most consistent with an essential tremor. Deep tendon reflexes are slightly brisk but likely still 2+ and symmetric in the bilateral upper extremities, but normal 2+ and symmetric in bilateral lower extremities. Downgoing toes to Plantars stimulation bilaterally. Sensory is intact to light touch, proprioception and a vibratory sensation on a graded tuning four times four extremities. Normal smooth eye pursuits. No truncal ataxia. Mild tremor of the arms, although dysmetria of truncal ataxia with fine finger movements and finger nose finger maneuvers. Gait is normal casual gait, normal heel walking and toe walking. Tandem walk is performed with subtle difficulties. Normal casual gait. Doctor's impression is right handed patient with longstanding history of migraine headaches treated with medication. Abnormal findings on the MRI white matter lesions are nonspecific in appearance, shape, location and size. We see no change in period of one year. Department Exhibit A, pgs 54-62.

(11) During 2009, claimant frequently visited her family physician complaining of neuralgia, headache, loss of peripheral vision, and painful feet at night. Treatment notes taken an August 7, 2009 visit indicate that claimant is alert, oriented x 3, well-developed, and in no acute distress. Neck demonstrates no decrease in suppleness. Extraocular movements and pupils are normal. Pharynx is normal fair. Lymph nodes are normal. Heart sounds are normal. Sensation

abnormalities were noted when light was flashed in the eyes—right side and teary eyes. Reflexes were normal. Assessment was trigeminal neuralgia. Doctor prescribed medication. Department Exhibit , pg 18-19; 20-21;; 22-31.

(12) June 13, 2008, claimant presented to emergency room complaining of an accident in which she twisted her right ankle. Examination revealed minimal swelling over the anterolateral malleous area. No ecchymosis or erythema. She has good dorsiflexion and Plantar flexion however this does cause her some discomfort. X-rays revealed a negative x-ray. Diagnosis was acute right ankle sprain. Department Exhibit A, pgs 100-101. September 2, 2008, claimant presented to emergency room complaining of pain in the right knee following an accident on the previous day. Physical examination revealed mild swelling, erythema over the right upper knee cap area. Full range of motion of the knee. No pain with varies and vagus stress in the knee. X-rays revealed a negative x-ray. Diagnosis was acute right knee contusion. Department Exhibit A, pgs 98-99. ECG performed March 18, 2008, revealed normal sinus rhythm, normal ECG. Department Exhibit A, pg 95.

(13) September 16, 2009, claimant presented to emergency room complaining of pain to the low back after a fall that took place approximately six weeks prior. Objective examination revealed no obvious deformity; no swelling, ecchymosis, or abrasions. On palpation, no crepitus or step off. Claimant reports pain over the lumbar spine as well as the sacroiliac joints bilaterally. She was able to stand and ambulate without difficulty. Deep tendon reflexes are normoactive in Patellar and Achilles regions bilaterally. Straight leg raising is negative for sciatic bilaterally. Lumbosacral spine films and AP of pelvis are negative. Department Exhibit A, pgs 133-135.

(14) Ophthalmology exam on February 19, 2009, indicates that visual fields are stable with no further loss and that claimant has unspecified visual field defect. February 25, 2009, claimant was again examined by an ophthalmologist and a report was prepared. Visual complaints on report consist of Hepatitis C, stroke, migraines, hypertension, bipolar disorder, and bronchitis. Doctor indicates complaints of loss of visual field. Doctor indicates that visual field testing was conducted and a visual field defect was ruled out. Visual acuity without correction was 20/100 and 20/200. Department Exhibit A, pgs 140-148.

(15) November 17, 2008, claimant underwent a psychiatric evaluation and a narrative report was prepared. Objective findings were as follows: mood depressed and anxious with no symptoms evident of increased anxiety. Affect was congruent to mood. Patient denies any feelings of self harm. Psychomotor activity was calm. Psychotic signs were denied. Cognition appeared appropriate, alert, and oriented to all spheres. AXIS I diagnoses were bipolar I disorder, mixed type, severe; marijuana dependence; amphetamine abuse, in remission; history of periluteal dysphoria. GAF was assessed at 44. Department Exhibit A, pgs 159-161. In June, 2009, claimant underwent a second psychiatric evaluation that indicated same diagnoses and similar objective findings with the exception of patient reports having some paranoia and hallucinations. GAF was assessed at 40. Department Exhibit A, pgs 162-164.

(16) March 20, 2009, physician treatment records indicate that claimant has carpal tunnel syndrome, worsening. Department Exhibit A, pg 28.

(17) October 27, 2009, claimant visited her physician complaining of right knee pain and “charlie horses.” Doctor’s assessment is curvature of the spine and nonallopathic lesions of the sacral region. Doctor does not indicate objective findings regarding the knee. Doctor indicates plan of treating condition with medication. Department Exhibit A, pgs 18-19.

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 –
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> (1) Medical history.
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> (2) Clinical findings (such as the results of physical or mental status examinations);
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> (3) Laboratory findings (such as blood pressure, X-rays);
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> (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;
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> (2) Capacities for seeing, hearing, and speaking;
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> (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 has bilateral carpal tunnel syndrome. The record contains no objective medical evidence to establish that claimant has severe limitations or impairments because of this condition. The objective medical evidence of record indicates that claimant has nonspecific white matter lesions of the brain that are unchanged since 2007. Claimant's neurologic exam is within normal limits. The claimant has hepatitis. The record contains no objective evidence to establish that claimant has severe impairments due to this condition. The objective medical evidence of record indicates that claimant has a nonspecific visual field loss. Claimant's visual acuity does not rise to the level to be considered disabling. Claimant has right knee pain and cramping. The duration and severity of

this condition is not established. Claimant has some degenerative disc disease in her back. As stated above, neurologic exam is within normal limits. Claimant has long history of severe migraine headaches. Finding of Fact 10-17.

At Step 2, the objective medical evidence of record indicates that claimant has bipolar disorder, marijuana dependence, and amphetamine abuse, in remission. GAF is established at 40 indicative of some impairment in reality testing and/or serious symptoms or difficulties. Finding of Fact 15; DSM IV, 1994, R.

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 as an LPN. See discussion at Step 2 above. The objective medical evidence of record would appear to establish that due to claimant’s mental illness, she doe not retain the functional capacity to work as an LPN.

At Step 4, the objective medical evidence of record is 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 not disqualified from receiving disability at Step 4. Finding of Fact 9-17.

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 10-17.

At Step 5, the objective medical evidence of record is sufficient to establish that claimant retains the residual functional capacity to perform simple, light work activities. Considering claimant's Vocational Profile (younger individual, high school graduate or more, history of skilled work) and relying on Vocational Rule 202.21, 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.

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).

> 2004 PA 344, Sec. 604, establishes the State Disability Assistance program. It reads in part:
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> Sec. 604 (1) The department shall operate a state disability assistance program. Except as provided in subsection (3), persons eligible for this program shall include needy citizens of the United States or aliens exempt from the Supplemental Security Income citizenship requirement who are at least 18 years of age or emancipated minors meeting one or more of the following requirements:
>
> (a) Recipient of Supplemental Security Income, Social Security or Medical Assistance due to disability or 65 years of age or older.
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> (b) A person with a physical or mental impairment which meets federal SSI disability standards, except that the minimum duration of the disability shall be 90 days. Substance abuse alone is not defined as a basis for eligibility.

(c) A resident of an adult foster care facility, a home for the aged, a county infirmary, or a substance abuse treatment center.

(d) A person receiving 30-day post-residential substance abuse treatment.

(e) A person diagnosed as having Acquired Immunodeficiency syndrome (AIDs).

(f) A person receiving special education services through the local intermediate school district.

(g) A caretaker of a disabled person as defined in subdivision (a), (b), (e), or (f) above.

(2) Applicants for and recipients of the State Disability Assistance program shall be considered needy if they:

(a) Meet the same asset test as is applied to applicants for the Family Independence Program.

(b) Have a monthly budgetable income that is less than the payment standard.

(3) Except for a person described in subsection (1)(c) or (d), a person is not disabled for purposes of this section if his or her drug addiction or alcoholism is a contributing factor material to the determination of disability. 'Material to the determination of disability' means that, if the person stopped using drugs or alcohol, his or her remaining physical or mental limitations would not be disabling. If his or her remaining physical or mental limitations would be disabling, then the drug addiction or alcoholism is not material to the determination of disability and the person may receive State Disability Assistance. Such a person must actively participate in a substance abuse treatment program, and the assistance must be paid to a third party or through vendor payments. For purposes of this section, substance abuse treatment includes receipt of inpatient or outpatient services or participation in Alcoholics Anonymous or a similar program. 1995 PA 156, Sec. 605.

(4) A refugee or asylee who loses his or her eligibility for the federal Supplemental Security Income program by virtue of exceeding the maximum time limit for eligibility as delineated in Section 402 of Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, 8 U.S.C. 1612, and who otherwise meets the eligibility criteria under this section shall be eligible to receive benefits under the State Disability Assistance program.

After careful examination of the record and for reasons discussed at Steps 2and 5 above, the Administrative Law Judge decides that claimant does not have severe impairments that prevent all work for 90 days or more. Therefore, claimant does not qualify for SDA based on disability and the department properly denied his application

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that claimant has not established disability for Medical Assistance and State Disability Assistance.

Accordnigly, the department's action is, hereby, UPHELD.

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

Date Signed: July 2, 2010

Date Mailed: July 6, 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]