STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:
[redacted]

Reg. No: 2010-44528
Issue No: 2009
Case No: [redacted]
Load No: [redacted]
Hearing Date:
September 2, 2010
Ingham County DHS

ADMINISTRATIVE LAW JUDGE: Ivona Rairigh

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon claimant's request for a hearing. After due notice, an in-person hearing was held on September 2, 2010. Claimant personally appeared and testified. Claimant was represented by [redacted].

ISSUE

Did the Department of Human Services (the department) properly deny claimant's application for Medical Assistance (MA-P) and retro MA?

FINDINGS OF FACT

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

(1) On February 16, 2010, claimant filed an application for Medical Assistance and retro MA benefits alleging disability.

(2) On April 21, 2010, the Medical Review Team denied claimant's application stating that claimant could perform other work.

(3) On April 26, 2010, the department caseworker sent claimant notice that his application was denied.

(4) On July 23, 2010, claimant filed a request for a hearing to contest the department's negative action.

(5) On August 4, 2010, the State Hearing Review Team also denied claimant's application stating he was capable of performing light work per 20 CFR 416.967(b) and Vocational Rule 202.21.

(6) Claimant is a 43 year old man whose birthday is [redacted]. Claimant is 6' tall and weighs 323 pounds. Claimant completed 12 grade and can read, write and do basic math. Claimant also has cooking skills.

(7) Claimant states that he last worked in 2007 cooking at a restaurant for 4 months, job that ended when he passed out while working. Claimant has also worked in other numerous restaurants, as a factory line worker, and in janitorial services.

(8) Claimant lives with his mother who helps him financially and also receives food stamps. Claimant has a driver's license but does not drive as he falls asleep while doing so, does not cook due to fatigue, and goes grocery shopping only with family as it is hard for him to breathe and get around.

(9) Claimant alleges as disabling impairments congestive heart failure, shortness of breath, muscle problems, high blood pressure and high cholesterol.

(10) Claimant has applied for Social Security disability and been denied, and is appealing the denial.

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 Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Program Reference Manual (RFT).

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, that being a five-step sequential evaluation process for determining whether an individual is disabled (20 CFR 404.1520(a) and 416.920(a)). The steps are followed in order. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience is reviewed. If it is determined that the claimant is or is not disabled at a step of the evaluation process, the evaluation will not go on to the next step.

At Step 1, the Administrative Law Judge must determine whether the claimant is engaging in substantial gainful activity (20 CFR 404.1520(b) and 416.920(b)). Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. "Substantial work activity" is work activity that involves doing significant physical or mental activities (20 CFR 404.1572(a) and 416.972(a)). "Gainful work activity" is work that is usually done for pay or profit, whether or not a profit is realized (20 CFR 404.1572(b) and 416.972(b)). Generally, if an individual has earnings from employment or self-employment above a specific level set out in the regulations, it is presumed that he/she has demonstrated the ability to engage in SGA (20 CFR 404.1574, 404.1575, 416.974, and 416.975). If an individual engages in SGA, he/she is not disabled regardless of how severe his/her physical or mental impairments are and regardless of his/her age, education, and work experience. If the individual is not engaging in SGA, the analysis proceeds to the second step.

At Step 2, the Administrative Law Judge must determine whether the claimant has a medically determinable impairment that is "severe" or a combination of impairments that is "severe" (20 CFR 404.1520(c) and 416.920(c)). An impairment or combination of impairments is "severe" within the meaning of the regulations if it significantly limits an individual's ability to perform basic work activities. An impairment or combination of impairments is "not severe" when medical and other evidence establish only a slight abnormality or a combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work (20 CFR 404.1521 and 416.921; Social Security Rulings (SSRs) 85-28, 96-3p, and 96-4p). If the claimant does not have a severe medically determinable impairment or combination of impairments, he/she is not disabled. If the claimant has a severe impairment or combination of impairments, the analysis proceeds to the third step.

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). 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).

At Step 3, the Administrative Law Judge must determine whether the claimant's impairment or combination of impairments meets or medically equals the criteria of an impairment listed in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525, 404.1526, 416.920(d), 416.925, and 416.926). If the claimant's impairment or combination of impairments meets or medically equals the criteria of a listing and meets the duration requirement (20 CFR 404.1509 and 416.909), the claimant is disabled. If it does not, the analysis proceeds to the next step.

Before considering Step 4 of the sequential evaluation process, the Administrative Law Judge must first determine the claimant's residual functional capacity (20 CFR 404.1520(e) and 416.920(e)). An individual's residual functional capacity is his/her ability to do physical and mental work activities on a sustained basis despite limitations from his/her impairments. In making this finding, all of the claimant's impairments, including impairments that are not severe, must be considered (20 CFR 404.1520(e), 404.1545, 416.920(e), and 416.945; SSR 96-8p).

Next, the Administrative Law Judge must determine at step four whether the claimant has the residual functional capacity to perform the requirements of his/her past relevant work (20 CFR 404.1520(f) and 416.920(f). The term past relevant work means work performed (either as the claimant actually performed it or as it is generally performed in the national economy) within the last 15 years or 15 years prior to the date that disability must be established. In addition, the work must have lasted long enough for the claimant to learn to do the job and have been SGA (20 CFR 404.1560(b), 404.1565, 416.960(b), and 416.965). If the claimant has the residual functional capacity to do his/her past relevant work, the claimant is not disabled. If the claimant is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth and last step.

At the last step of the sequential evaluation process (20 CFR 404.1520(g) and 416.920(g), the Administrative Law Judge must determine whether the claimant is able to do any other work considering his/her residual functional capacity, age, education, and work experience. If the claimant is able to do other work, he/she is not disabled. If the claimant is not able to do other work and meets the duration requirements, he/she is disabled.

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).

At Step 1, claimant is not engaged in substantial gainful activity and testified that he has not worked since year 2007. Claimant is not disqualified from receiving disability at Step 1.

At Step 2, in considering the claimant's symptoms, whether there is an underlying medically determinable physical or mental impairment(s)-i.e., an impairment(s) that can be shown by medically acceptable clinical and laboratory diagnostic techniques-that could reasonably be expected to produce the claimant's pain or other symptoms must be determined. Once an underlying physical or mental impairment(s) has been shown, the Administrative Law Judge must evaluate the intensity, persistence, and limiting effects of the claimant's symptoms to determine the extent to which they limit the claimant's ability to do basic work activities. For this purpose, whenever statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not substantiated by objective medical evidence, a finding on the credibility of the statements based on a consideration of the entire case record must be made.

The objective medical evidence on the record includes the [redacted] hospital follow up of [redacted] which states that the claimant has extensive cardiovascular history including multiple myocardial infarctions and ischemic cardiomyopathy. Claimant also has a history of medical noncompliance and has been rehospitalized several times this summer after stent closure after stopping his Plavix. Claimant was also hospitalized in March, 2009 for congestive heart failure and significant cardiomyopathy. Claimant did not have complaints of further chest pain or heaviness on this visit, and he is not experiencing shortness of breath. He denies dizziness or palpitations, and has had no claudication, muscle weakness, or cough. Claimant runs out of Plavix frequently and cannot afford to pay for his own medication. Claimant was in no acute distress and his blood pressure was 102/60 with heart rate 60 and regular. His cardiovascular status remains stable, but guarded, as he continues to have difficulty with affording his medications, especially Plavix.

[redacted] letter from [redacted] is advising the claimant they will no longer serve as his physicians due to his failure to follow the prescribed plan of care. Letter states that the claimant had five follow up appointments at their office June 5, 2009 through October 20, 2009 and failed to keep or cancelled all of them. Claimant has also been non-compliant with his medication and lab blood draws. Claimant's cardiac medications will be refilled through November 30, 2009 and emergent care provided until this date.

Hospital admission of January, 2010 was for claimant's complaints of chest pain. Discharge diagnoses was that of coronary artery disease with known history of left anterior descending coronary artery disease status post plain balloon angioplasty in [redacted], ischemic cardiomyopathy with [redacted] with a left ventricular ejection fraction of approximately 30 percent, status post implantable cardioverter-defibrillator implantation, hypertension, and dyslipidemia.

[redacted] evaluation of [redacted] states that the claimant is being seen for a follow up regarding his history of ischemic cardiomyopathy. He is not having any chest pain or significant dyspnea, and his only complaint is that he is having some significant lower extremity edema and his legs feel tight. Claimant's weight is definitely up, from 288 to 306 pounds. Claimant was put on increased Lasix last time he was seen but obviously not much progress is being made with his fluid retention. Claimant's renal function is ok. Assessment is that of ischemic cardiomyopathy. Claimant's excess weight is likely fluid and he is being referred to the infusion center for some IV diuretic regimen to hopefully get some fluid off him and make him feel better.

Claimant was in the hospital on February 6, 2010 with chest pain from jail he was in. He has a history of noncompliance and multiple visits to the hospital for chest pain. Impression was that of chest pain related to acute coronary syndrome. Claimant's EKG showed a normal sinus rhythm and his chest pain eventually stopped.

April 8, 2010 Echocardiogram Report states that the claimant's left ventricular systolic function is moderately reduced with the left ventricular ejection fraction estimated at 27%. Right ventricular function is also reduced.

Thoracic Cardiovascular Institute evaluation of June 11, 2010 states that the claimant is doing excellent clinically and he is not having any chest pain or shortness of breath. He has had no palpitations, no racing heart-beat sensations, no lightheadedness, and no syncope.

Medical evidence has clearly established that claimant has an impairment (or combination of impairments) that has more than a minimal effect on claimant's work activities. See Social Security Rulings 85-28, 88-13, and 82-63. Claimant's impairment has lasted 12 months. Claimant therefore meets his burden of proof at Step 2 and analysis continues.

At Step 3 the trier of fact must determine if the claimant's impairment (or combination of impairments) is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. This Administrative Law Judge finds that the claimant's medical record will support a finding that claimant's impairment(s) is a "listed impairment" or equal to a listed impairment, that of 4.00, Cardiovascular System. Accordingly, claimant can be found to be disabled based upon medical evidence alone. 20 CFR 416.920(d). No further analysis is needed.

It is noted that the claimant has been noncompliant with his medical treatment, and part of this is his failure to take prescribed medications, one of them Plavix. However, it is obvious from the record that the claimant has no means of paying for his medication, so noncompliance cannot be considered against the claimant.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the department improperly denied claimant's MA and retro MA application.

Accordingly, the department's decision is REVERSED. Department shall:

1. Process claimant's disputed February 16, 2010 MA and retro MA application and grant him any such benefits he is otherwise eligible for (i.e. meets financial and non-financial eligibility requirements).

2. Notify the claimant in writing of this determination.

3. Review claimant's ongoing MA eligibility in December, 2011, at which time updated medical information is to be obtained. Claimant must comply with all prescribed medical treatment and medical instructions, as failure to do so may lead to termination of MA benefits.

SO ORDERED.

/s/_____
Ivona Rairigh
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: December 22, 2010

Date Mailed: December 22, 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.

IR/tg

cc: [redacted]