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: 2010-9207
Issue No: 2009; 4031
Case No: [redacted]
Load No: [redacted]
Hearing Date:
January 27, 2010
Jackson 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, an in-person hearing was held on January 27, 2010. Claimant did not appear. Claimant was represented at the hearing by [redacted] who requested a decision be made upon the record that was contained in the file.

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 April 27, 2009, [redacted] Inc. applied for Medical Assistance and State Disability Assistance benefits on claimant's behalf.

(2) On July 23, 2009, the Medical Review Team denied claimant's application for Medical Assistance, State Disability Assistance and retroactive Medical Assistance benefits to January 2009 stating that claimant could perform other work pursuant to Medical Vocational Rule 202.21.

(3) On August 18, 2009, the department caseworker sent claimant notice that his application was denied.

(4) On August 27, 2009, claimant filed a request for a hearing to contest the department's negative action.

(5) On December 22, 2009, the State Hearing Review Team requested additional medical information in the form of a psychiatric evaluation.

(6) [redacted] did not have contact with claimant and requested that this decision be made based upon the information contained in the file. Therefore, the record is hereby closed and the decision will be made based upon the information contained in the file without obtaining an additional psychiatric evaluation because claimant is incarcerated.

(7) Claimant is a man whose birth date is [redacted] An application of September 19, 2008 was also filed on claimant's behalf, and on November 10, 2008, the Medical Review Team also denied claimant's application stating that claimant had a non-exertional impairment.

(8) Claimant alleges as disabling impairments: seizures, asthma, shortness of breath, rheumatoid arthritis, muscle pain, degenerative disc disease, depression, anxiety and panic 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 Program Administrative Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM).

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

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

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

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

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

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

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

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

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

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

> (1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;
>
> (2) Capacities for seeing, hearing, and speaking;

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

(4) Use of judgment;

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

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

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

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

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

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).

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 is incarcerated. There is no information obtained as to claimant's prior work history.

The objective medical evidence in the record indicates that claimant had a seizure disorder and is on [redacted] in addition to [redacted] three times per day. He

does not have an outpatient neurologist and he did have recurrent seizures recently. Claimant has alcoholism and alcohol problem. On June 5, 2009, claimant's alcohol level was normal and stated that he quit Alcoholics Anonymous. Claimant was diagnosed with bipolar disorder, panic disorder and pancreatitis and a history of esophageal reflux disease and a history of polysubstance abuse. On June 5, 2009, claimant was lying on the bed. He was not in respiratory distress. He looked sick. His HEENT was normcephalic and atraumatic. Examination of the eyes showed severe conjunctival hemorrhage surrounding the eyeball and visual acuity was normal. The extra ocular movement of the eyeball was normal. There was no evidence of orbital edema and no evidence of eye protrusion. Examination of the mouth, his muscles kind of dropped but there was no evidence of infection, no evidence of fetal hepatitis. No lymph nodes were palpable and there was no carotid bruit. No enlarged thyroid. His neck was supple without any tenderness or spasm. First and second heart sounds were normal.. There was no murmur. No added sounds**.** The lungs were clear bilaterally and there was no evidence of rales or wheezes. The chest wall showed a small petechiae, not clear whether they indicate venous malformation as a consequence of chronic liver disease or there because of low platlets. No distinct angiodysplasia. Abdomen soft, nontender. There was mild tenderness in the right upper quadrant. No organomegaly. Bowel sounds were normal active. Extremities had petechial rash where the patient states that it has been in place for a long time. There was no edema. No focal neurological deficits. CDC white count is 2.3. Patient's hemoglobin level was 12.5, hemotacrit was 35.25. The platlets were 56 and no bands. The metabolic panel was 30 and 136, potassium 3.2, fluoride 1.02, CO2 was 25, BUN is 9 (page 119). The marked reports were approximately 133 pages, the Administrative Law Judge figured all the information in the file. Much of the information was from 2008. A medical report as of June 4, 2008 indicates that claimant was

starting a new job at [redacted] and he was participating and receiving chiropractic care (page 22). On that day, he weighed 170 pounds. His BMI was 24 and his heart rate was 76. His blood pressure was 119/73. He was complaining about having trouble urinating and having trouble with his sciatic nerve. He had mild distress. He was normal for suffering a traumatic slip in 2005 (page 25). The doctor's slip in 2005 (page 27) indicates that claimant was treated on June 24, 2008 and he was able to return to work. An MRI of the lumbar spine indicates there was normal alignment. His discs were normal. However, there was L5 and S1 disc single reduction. Clonus medullar is normal as at an appropriate level. There is bilateral L5, spondylosis no evidence of listhesis. The Axial images from L1 through S1are performed. There is no evidence of disc herniation. Facet joints are intact. Neuroforamina are widely patented. No nerve compression is creating the impression of bilateral L5 spondylolisis without evidence of listhesis. L5-S1 disc degeneration (page 29). An EMG laboratory coordinated July 14, 2008 indicates that there was normal electrodiagnostic study at present. No absence of active lumbosacral radiculopathy or lumbo nerve entrapment syndrome or peripheral neuropathy (page 33). An MRI of the low back performed June 27, 2008 indicates that there is normal alignment. At the bilateral L5 spondylolysis without evidence of a listhesis. L5 to S1 disc herniation (page 44). Mental status examination conducted August 29, 2008 for inpatient psychiatric evaluation indicates that a 37-year-old male Caucasian appeared his stated age. He was casually groomed and dressed. Claimant was calm, cooperative and pleasant during his interview. He described his mood as lousy and angry. His affect was tearful and he started crying. Nothing is working out. He is fighting battles which he cannot win. He felt abandoned by his parents. The patient was clear, coherent and goal-directed. He is not auditory or visually paranoid delusions. He was admitted for suicidal thought and threatened to jump out of a window, if he was sent

back to the halfway house. He reported that he did not feel safe out there so he might as well kill himself. His cognition was fairly intact where he was fully away, alert and oriented to person, place, and time. He was able to tell the name of the current president and past presidents. He was able to do simple math calculations. His insight and judgment were fairly intact. He was diagnosed with depressive disorder and panic disorder by history and alcohol dependence. He was on anti-depressant medication (pages 67-68). Medical Examination Report of January 30, 2009 indicates that claimant does have dentures in the upper and lower and has some difficulty with his weight. He was well-developed and did not appear acutely ill. He had no evidence of infection with HEENT. The neck was supple with the range of motion. No jugular venous distention or spontaneous peripheral pulsations. Medical Examination Report of January 30, 2009 indicates that claimant does have dentures up front and lower half may have some difficulty based on his weight. He was well-developed, wrong nurse did not appear acutely ill [sic]. He had no evidence of infection with HEENT. The neck was supple with range of motion. No jugular venous distension or spontaneous peripheral pulsations. No carotid bruits. The lungs were fairly clear to auscultation. No rales, rhonchi, wheezes. The heart had regular rate and rhythm without gallops, reps or murmurs. The abdomen was soft, without guarding, tenderness with no mass or organomegaly. The cranial nerves 2 through 12 were grossly intact. The patient was awake, alert, cooperative in origin without spheres. He had basically normal speech. There were no focal peripheral neurological deficits. The impressions that claimant had a seizure and they increased his dosage of [redacted] (page 99). A February 1, 2009 discharge summary indicates that CT of claimant's head was negative. Instead, a study was done of the right ankle and it was probably an avulsion chip fracture involving the right tarsal navicular bone and soft tissue slowly down his right ankle. (Pages 104-105.) The EKG showed chronic tachycardia and

his heart rate came down nicely otherwise once he was given medication. The urinalysis was normal and complete metabolic panels were normal with minimally elevated sugar, valpric acid level was less than three, part of the reason why is this patient may have seized. His drug screen was negative for benzldiavepianes. Interestingly, since he has still continued on them. The impression was that he had a seizure disorder with possible subtherapeutic Dilantin level which indicates that claimant was not compliant with his medication.

At Step 2, claimant has the burden of proof of establishing that he had a severely restricted physical or mental impairment that has lasted or is expected to last for a duration of at least 12 months. There is insufficient objective clinical/medical/psychiatric evidence in the record that claimant suffers a severely restricted impairment. From the evidence indicated on the record and the medical file, claimant is a substance abuser, he is into heavy alcohol. Claimant also is a polysubstance abuser. Claimant is disqualified from receiving disability at Step 2 because he has not established a severe impairment or combination of impairments have lasted the durational requirement of 12 months or more and have kept him from working 12 months or more. This Administrative Law Judge will continue to proceed through the sequential evaluation process for the sake of argument since the Step 2 *de minimus* standard.

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

At Step 4, this Administrative Law Judge does not have a work history for claimant and he did not testify on the record because he was not present. Therefore, this Administrative Law Judge will not disqualify him at Step 4.

The Administrative Law Judge will continue to proceed with the sequential evaluation process to determine whether or not claimant has a residual functional capacity to perform some other less strenuous tasks in his prior job.

At Step 5, the burden shifts to the department to establish that claimant does not have a residual functional capacity.

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 and lacks the residual functional capacity to perform a prior job or any less strenuous task than in his prior employment. He is physically unable to do light or sedentary tasks if demanded of him. There is no objective medical evidence in the record that indicates that claimant is not independent his

activities of daily living. Claimant is currently incarcerated. Claimant has failed to provide the necessary objective medical evidence to establish that he has a severe impairment or combination of impairments which prevent him from perform any level of work for 12 months.

The Federal Regulations at 20 CFR 404.1535 speak to the determination of whether Drug Addiction and Alcoholism (DAA) is material to a person's disability and when benefits will or will not be approved. The regulations require the disability analysis be completed prior to a determination of whether a person's drug and alcohol use is material. It is only when a person meets the disability criterion, as set forth in the regulations, that the issue of materiality becomes relevant. In such cases, the regulations require a sixth step to determine the materiality of DAA to a person's disability.

When the record contains evidence of DAA, a determination must be made whether or not the person would continue to be disabled if the individual stopped using drugs or alcohol. The trier of fact must determine what, if any, of the physical or mental limitations would remain if the person were to stop the use of the drugs or alcohol and whether any of these remaining limitations would be disabling.

The information contained in the file indicates that claimant has a history of alcohol and drug abuse (DA & A Legislation), Public Law 104-121, Section 105. The law indicates that individuals are not eligible and/or not disabled with drug addiction or alcoholism as a contributing factor material to the determination of disability. After a careful review of the credible and substantial evidence on the whole record, this Administrative Law Judge finds that even if claimant were to be considered disabled based upon his impairments, he is not disabled based on the DA & A Legislation because the substance abuse is material to the alleged disability.

Under Medical Vocational Guidelines, an individual (age 38) with a high school education and unskilled work history is limited to light work is not considered disabled. This Administrative Law Judge has also determined that based upon the fact that claimant did not appear for the hearing and did not testify, there is insufficient objective information contained in the file to determine that the claimant is 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, age 55 or older. PEM Item 261, page 1. Because the claimant does not meet the definition of disabled for the MA-P program, because the evidence of record has not established 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.

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 by the necessary competent, material or substantial evidence on the whole 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.

The department's information contained in the file that claimant should be able to perform a wide range of light or sedentary work with his impairments. Based upon the information above, claimant's impairments are nonsevere and do not meet the duration and there is some indication that claimant was noncompliant with his medication. The department establishes that the 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 02, 2010

Date Mailed: June 3, 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.

LYL/tg

cc: [redacted]