STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

[redacted]

[redacted]
Ingham County DHS

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the claimant's request for a hearing. After due notice, a telephone hearing was held on August 31, 2011. Claimant personally appeared and testified.

ISSUE

Whether 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 December 6, 2010, Claimant applied for MA-P and Retro-MA benefits.

(2) On February 14, 2011, the Medical Review Team (MRT) denied Claimant's application for MA and Retro-MA stating Claimant is capable of performing past relevant work pursuant to 20 CFR 416.920(f).

(3) On February 18, 2011, the department caseworker mailed Claimant notice that his application was denied.

(4) On May 16, 2011, Claimant filed a request for a hearing to contest the department's negative action. (Request for a Hearing).

(5) On June 7, 2011, the State Hearing Review Team (SHRT) upheld the denial of MA-P and Retro-MA benefits stating Claimant retains the

residual functional capacity to perform a wide range of medium exertional work. (Department Exhibit B, page 1).

(6) On September 1, 2011, Claimant submitted new medical documentation and the records were forwarded to the State Hearing Review Team for review.

(7) On October 4, 2011, the State Hearing Review Team (SHRT) upheld the denial of MA-P and Retro-MA benefits stating Claimant retains the residual functional capacity to perform a wide range of light work. (Department Exhibit C, pages 1-2).

(8) Claimant has a history of unstable angina, hyperglycemia, hyperlipidemia, hypertension, diabetes mellitus type 2 insulin dependent, dyslipidemia, acute kidney injury, proteinuria, deep vein thrombosis (DVT), myocardial infarction, coronary artery disease, arteriovenous (AV) fistula and a PTCA intracoronary stent.

(9) On November 18, 2010, Claimant was admitted to the hospital with severe stabbing mid retrosternal chest pain. He stated he had been having chest pain on and off for the last several weeks. He had recently had a stress test performed which was within normal limits but this was the worst that his symptoms had ever become. He did have nausea and vomiting and EKG changes with some questionable ST elevation as well as T-wave inversions in the inferior leads. A cardiac catheterization procedure was performed at which time he had percutaneous coronary intervention (PCI) and two drug-eluting stents were placed into his right coronary artery (RCA). He tolerated the procedure well, but he did have some right groin pain. His left main was normal, LAD had mild luminal irregularities, left circumflex gave off an OM with diffuse coronary artery disease, distal segment had tandem 70% lesion, up to 50% stenosis in a small second OM branch, LVEF was 50%-55% with normal wall motion. An ultrasound was done that showed anteriovenous (AV) fistula and also ultrasound findings were suggestive of deep vein thrombosis (DVT). Discharged on November 20, 2011, diagnosed with unstable angina, chest pain syndrome, coronary artery disease, deep vein thrombosis, diabetes mellitus type 2, hyperglycemia, hypertension and dyslipidemia. Discharge medications: Aspirin, Coreg, Monpril, Nitroglycerin, Lantus, Apresoline, Zocor and Plavix. (Department Exhibit A, pages 7-11, 41-51).

(10) On November 20, 2010, Claimant was admitted to the hospital for right groin pain postop day #2. Pain starts in the medial part of his right leg and radiates up into the right lower quadrant of the abdomen. Duplex ultrasound showed a deep vein thrombosis (DVT) and possible anteriovenous (AV) fistula. Heparin drip was started in the emergency department. CT of the abdomen and pelvis showed contrast extravasation from the right common femoral artery extending 2.3 x 1.8 cm fluid collection just medial to the common femoral artery and anterior

to the femoral vein. This is consistent with a arteriovenous fistula. There is thrombus within the common femoral vein and its tributaries inferior to the level of the AV fistula. A right lower extremity arteriovenous duplex preliminary report showed an acute occluding DVT of the right common femoral artery, questionable fistula of the distal external iliac artery, which appears to connect to the external iliac vein. There is a nonoccluding DVT present in the distal external iliac vein. EKG showed some T-waive inversion inferiorly. Cardiac enzymes were subsequently negative. He is being treated for DVT. At discharge on November 24, 2010, he was diagnosed with coronary artery disease, deep vein thrombosis, diabetes, hypertension and dyslipidemia. Discharge medications: Aspirin, Coreg, Monopril, Apresoline, Plavix, Metformin, Nitro, Coumadin and Lovenox. (Department Exhibit A, pages 52-64).

(11) On November 26, 2010, Claimant returned to the hospital, postop day #8 status post right heart catheterization with stent placement, recently admitted on November 20, 2010, for a DVT in his right common femoral vein as well as thrombus in his distal external iliac vein. He presented complaining of increased swelling and pain in that leg with a subtherpeutic INR of 1.3 from a lab draw earlier today. Radiology performed on November 21, 2010, shows: Arteriovenous (AV) fistula rising from the anterior aspect of the right common femoral artery and communicates with the common femoral vein. Thrombus within the common femoral vein and its tributaries inferior to the level of the AV fistula. Assessment and Plan: Deep venous thrombosis, status post heart catheterization. Claimant will be admitted to D Service and started on heparin drip per DVT protocol. (Department Exhibit A, pages 14-17).

(12) On November 27, 2010, Claimant was admitted for right lower extremity swelling. He had extensive DVT and was under anticoagulated with an INR of 1.3. He was restarted on heparin and made slow and steady progress. Once his INR was up to 1.9, he was fit to be discharged. Discharged on November 29, 2010, diagnosed with right lower extremity deep vein thrombosis with recurrence of swelling and some pain, now resolved, under coagulation in terms of Coumadin, coronary heart disease, diabetes mellitus type 2, hypertension and hyperlipdemia. Discharge medications: Aspirin, Coreg, Monopril, Hydralazine, Plavix, Metformin, Nitroglycerin and Coumadin. (Department Exhibit A, pages 12-13).

(13) On December 10, 2010, Claimant was seen by his doctor for a follow up after being discharged from the hospital on December 2, 2010. After his heart catheter he developed a right DVT and possibly a femoral AV fistula. He complained of trouble getting up from sitting, and pain in his thigh. His right leg was very painful and tender to the touch. He his still having difficulty with swelling in hip area. Current medications: Aspirin 325 mg 1 tab QD, Carvedilol 12.5 mg 1 tab twice daily, Coumadin 7.5 mg 1 UAD, Coumadin 6 mg 1 tab daily, Coumadin 1 mg 1-3 QU, Fosinopril Sodium 10

mg 1 tab daily, hydralazine HCL 10 mg 1 tab QID, Lantus 10U, Nitrostat .4mg, Plavix 75 mg 1 tab daily, and Simvastatin 40 mg, 1 tab daily. (Department Exhibit A, pages 21-25).

(14) On December 21, 2010, Claimant was discharged from the hospital after being admitted on December 20, 2010, for atypical chest pain. He came into the hospital with nausea, episodes of vomiting and chest pain. EKG showed no acute changes. Cardiac enzymes were negative. His INR was subtherapeutic, apparently at 7.5 mg it overshot the therapeutic level and he has dropped back to 5. His INR is now 1.67. A medicine consultation was obtained and they put him on Lantus. The case manager was in the process of evaluating whether this medication is covered by his insurance. At this time, no further cardiac testing will be done. Claimant was given a lab slip to have his INR drawn in 2 days with those results faxed to his primary care physician. Recommend follow up with primary care physician and if he returns to the hospital, given his multiple medical issues, admitting him to medicine service was recommended. (Department Exhibit A, pages 25-26).

(15) On February 1, 2011, Claimant was seen at the Thoracis Cardiovascular Institute for follow-up on his coronary artery disease. He has premature coronary heart disease and is status-post percutaneous intervention on his right coronary artery with two drug-eluting stents in November 2010. Subsequently, he presented back to Ingham Regional with right groin pain and was found to have a DVT as well as a possible pseudoaneurysm and a possible arterial venous fistuala. When seen by cardiovascular surgeons, there was no clear evidence for fistula. He was treated with anticoagulation for his DVT which did not worsen his swelling in the groin and hence he was discharged. Today he is reporting episodes of chest pain that occur randomly. His wife told the doctor that he is waking up in the middle of the night and vomits and this has been happening recurrently. Impression: Coronary Heart Disease: Chest pain is random and he presented with similar symptoms the end of December while in the hospital and was discharged. The doctor did not think it was cardiac in etiology. It could be gastroesophageal reflux disease (GERD) related given he is on Aspirin, Plavix and Warfarin. Prescribed Pepcid and ordered a nuclear stress test. Peripheral Arterial Disease: the right femoral artery is relatively feeble compared to the left femoral artery pulse. He does not have any typical symptoms of claudication. (Claimant Exhibit A, page 1-4).

(16) On February 17, 2011, Claimant completed a Regadenoson Cardiovascular Stress Test. Claimant experienced no arrhythmia. Impression: This is a non-diagnostic (due to baseline abnormalities) response to IV Regadenoson with accentuation of baseline abnormalities in anterior leads. (Claimant Exhibit A, page 5).

(17) On March 1, 2011, Claimant returned to the Thoracis Cardiovascular Institute for a follow up. The nuclear stress test was completely normal. The Pepcid Claimant was prescribed at the last visit appeared to have improved his symptoms to some degree. He continues to have episodes that wake him in the night, sweating and occasional vomiting and has more frequent episodes of nausea. Impressions: Epigastric and chest discomfort: this almost certainly sounds like gastroesophageal reflux disease. He has persistent nausea and occasional episodes of vomiting associated with heartburn type symptoms, worse when in bed. Ideally, he should probably be referred to a gastroenterologist for possible endoscopy, but at this time, the doctor decided to prescribe Protonix to avoid proton pump inhibitors in patients who are on Plavix due to drug interference. Given his symptoms, his doctor warned of the small risk of in-stent thrombosis. (Claimant Exhibit A, pages 6-10).

(18) On March 26, 2011, Claimant was admitted to the hospital for chest pain. Discharge diagnosis: Atypical chest pain; Coronary artery disease with history of PCI with stents to his right coronary artery, left coronary, left anterior descending in November of 2010; Right chronic deep venous thrombus seen in right femoral vein; acute kidney injury; diabetes mellitus type 2; hypertension-resistant. EKG revealed some mild T-wave abnormalities in inferior leads, otherwise normal. Chest x-ray showed the heart was not enlarged. There was no mediastinal mass. No inflitrate or vascular congestion. Physical exam was unremarkable in that his symptoms were very different from his previous presentation prior to stenting. He admits to depression over his current life/medical affairs, is somewhat fixated on his pain, complaining of spinal pain and receiving pain killers. Stress testing was indeterminate. The nuclear stress test revealed normal perfusion, normal imaging with no evidence of infarct or ischemia. His insulin was increased for better control of his diabetes and his Lisinopril and his Coreg were maximized for improved blood pressure. He admits to chest tightness and stabbing for 2 days which has been constant, worse at rest, better with exertion. Also admits to a chronic sharp chest pain that goes to his back since his cardiac cath. He also states that it can sometimes radiate to his neck, spine and the right side of his head. He admits to chronic dyspnea on exertion since his heart attack and palpitations occurring last night. Denies any orthopnea, murmurs or PND. Positive for diabetes mellitus type 2, insulin dependent, uncontrolled. Discharged on March 29, 2011, in stable condition. His vitals include blood pressure of 140/70, heart rate of 86, respiratory rate 18, oxygenating 97% on room air. (Department Exhibit A, pages 8-14, Department Exhibit B, page 35).

(19) On March 26, 2011, Claimant underwent a treadmill test showing sinus rhythm is present with early repolarization, poor R-wave progression, T-wave inversion in III and aVF, possibly representing underlying left ventricular hypertrophy, although not diagnostic of the same. Resting blood pressure 156/98. At peak exercise, blood pressure is 226/100.

Maximum heart rate 134. The test was discontinued because of end protocol (blood pressure). There was no significant EKG change at peak exercise and heart rate was submaximal. Impression: Indeterminate response to exercise at 6 mets with a generally hypertensive response to exercise with a submaximal heart rate. Clinical correlation is recommended. (Department Exhibit A, page 10).

(20) On March 26, 2011, Claimant had a consult regarding medicine management. Claimant's daily medications include Hydralazine, Lisinopril, Carvedilol, Lipitor, Coumadi, Aspirin, Lantus, Plavix and Pepcid. Claimant has had diabetes since the age of 20 and currently his diabetes is uncontrolled and insulin depending in addition to his hypertension, hyperlipidemia, coronary heart disease, history of DVT and a history of myocardial infarction and stents in November 2010 in addition to an acute kidney injury and subtherapeutic INR. He has been on an ACE inhibitor since November 2010 and he has also had a heart catheterization. (Department Exhibit B, pages 17-19).

(21) On March 26, 2011, Claimant had a consult for his acute kidney injury. Renal ultrasound was reviewed showing bilaterally enlarged kidneys with increased echogenicity bilaterally. No GERD. Assessment and Plan: Acute kidney injury, possibly due to increased glucosuria and osmotic diuresis with this, along with continued use of angiotensin converting enzyme inhibitors and nonsteroidal anti-inflammatories. In terms of chronic renal component, urine protein creatinine ratio of 0.4 grams does point to early proteinuria. This was also confirmed by fairly enlarged kidneys bilaterally in a diabetic patient with poor glucose control and increased echogenicity bilaterally. (Department Exhibit B, pages 20-22).

(22) On March 27, 2011, a renal/retroperitoneal ultrasound of the urinary bladder and kidneys showed the prevoid urinary bladder was without focal wall abnormality. No significant postvoid urinary bladder residual was demonstrated. The kidneys were visualized and mildly lobulated though smoothly marginated. No hydronephrosis was seen nor was there cystic or contour deforming solid renal mass identified. The renal cortex is echogenic bilaterally. This is nonspecific but can be seen with medical renal disease. Impressions: Negative sonographic appearance of the urinary bladder. The kidneys are borderline to mildly prominent in size. They are echogenic. This is nonspecific but can be seen with medical renal disease. No hydronephrosis or mass was identified. (Department Exhibit B, pages 36-37).

(23) On April 11, 2011, Claimant was evaluated by a neurologist. Claimant was hospitalized on March 31, 2011 where he was diagnosed with proteniuria. He experienced a myocardial infarction and needed a stent placement in the right coronary vessel in Autumn 2010. Complicating the presentation was a DVT to the right leg high in his thigh. An arterial venous (AV) fistula developed in the right groin where he had the cardiac

catheterization. This region is continuously swollen and painful to the touch. Though he was given a treadmill stress test recently, he had to stop the test due to intense pain developing in his right thigh and causing hypertension. Claimant was crying during the interview from fear of his medical problems and depression. The right upper thigh near the groin is swollen where he has the AV fistula. The right thigh in this region measures 66 cm and the left thigh is 64 cm in circumference. A bruit was not heard with the stethoscope over the right fistula. Conclusion: Uncontrolled diabetes, now insulin dependent. Target organ in the heart and kidneys with recurring chest pain that the physicians are trying to ascertain if it is due to angina. There is an AV fistula in the right upper thigh. This makes him prone to vascular symptoms downstream from the fistula in addition to a number of other complications. He did not complain of claudication but he is at risk for this with exercise. He likely has not exercised enough so far for this to become a problem since he has been symptomatic with chest pain. (Department Exhibit B, pages 2-4).

(24) On July 12, 2011, Claimant was seen at the emergency department for complaints of chest pain that began yesterday which he described as squeezing and tightness, followed by nausea, vomiting and pain down his left arm which felt like it was falling asleep. He tried walking to see if it would go away, but he became nauseous and lightheaded, so he went to lie down. Pain is also exacerbated by deep breaths. Reports a 20 pound weight gain, positive fatigue, weakness and chills. Reports positive lightheadedness and dizziness. Reports some blurriness in vision. Positive for angina, palpitations and shortness of breath. Positive for nausea and vomiting. He reports claudication as he has a chronic deep vein thrombosis in this right upper leg in the superficial femoral vein. Positive for diabetes and depression with suicidal ideation. Blood pressure 180/93. Chest x-ray was unremarkable. Heart was normal size, no mediastinal mass, no infiltrate or vascular congestion. EKG sinus rhythm with a ventricular rate of 80, possible septal infract and inferior T wave changes that may be due to ischemia. Assessment and Plan: Atypical chest pain. There is no evidence of acute coronary syndrome as of yet. The atypical chest pain may be secondary to the hypertensive urgency. Hypertensive urgency, idiopathic. He will be offered a psychiatric consult and one on one. Urinalysis is consistent with possible nephritic syndrome with elevated glucose, protein, ketones and red blood cells present. (Department Exhibit A, pages 18-20).

(25) On July 13, 2011, Claimant saw a doctor for follow up after his visit to the emergency department last night for chest pain. He states he woke up Monday with left-sided chest pain that radiated down his left arm, associated with nausea and vomiting and shortness of breath. He states that he wakes up every day with some nausea. However, Monday morning was different because he had the chest pain associated with it. He tried to go about his day and ignore the pain, but the pain lasted until the next day. Tuesday, he came into the ER and after receiving

nitroglycerin and morphine, the pain went away. No anxiety, positive depression. EKG shows a rate of 80, normal sinus rhythm, with Q-waves in V1 and V2, T wave inversions in lead 3 and AVF. There is poor R progression compared to previous, with Q waves intermixed. Assessment and plan: Chest pain that occurred when the patient woke from sleep. It was substernal, left sided and was associated with nausea, vomiting and shortness of breath. The patient states it was only relieved by getting nitroglycerin and morphine in the ED, is atypical in that it began during sleep and lasted greater than 24 hours. His cardiac enzymes were negative x3. The EKG showed an old infarct and the chest pain is now gone. He has known reflux disease for which Pecid did not help. He had been told he needs an EGD and colonoscopy for these atypical symptoms. However, he is having difficulty having the EGD done because he is on Coumadin for his DVT in November 2010. The chest pain is nonischemic in nature. He needs to follow up with a gastroenterologist. High blood pressure, elevated at this time. (Department Exhibit A, pages 15-17, 21-24).

(26) Claimant is a 34 year old man whose birthday is [redacted]. Claimant is 6'2" tall and weighs 268 lbs. Claimant is a high school graduate with auto mechanic certification. He was last employed as a janitor in May 2010.

(27) Claimant has applied for Social Security disability and his application was pending at the time of the hearing.

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 Reference Tables 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 one, 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 two, 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 three, 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 four 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 2010. Therefore, Claimant is not disqualified from receiving disability at Step 1.

At Step 2, in considering 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 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 Claimant's symptoms to determine the extent to which they limit 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.

At Step 2, the objective medical evidence of record shows Claimant had a myocardial infarction requiring the surgical placement of two drug-eluting stints in his right coronary

artery and hospitalization. The finding of a severe impairment at Step 2 is a *de minimus* standard. This Administrative Law Judge finds that Claimant established that at all times relevant to this matter Claimant suffered side effects from the surgical placement of two stents which would affect his ability to do substantial gainful activity. Therefore, the analysis will continue to Step 3.

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 Claimant's medical record will not support a finding that Claimant's impairment(s) is a "listed impairment" or equal to a listed impairment. Accordingly, Claimant cannot be found to be disabled based upon medical evidence alone. 20 CFR 416.920(d).

At Step 4, Claimant's past relevant employment was working as a janitor and security guard for the past ten years. At Step 4, the objective medical evidence of record is sufficient to establish that Claimant has severe impairments that have lasted or are expected to last 12 months or more and prevent him from performing the duties required from his past relevant employment for 12 months or more. Accordingly, Claimant is qualified to receive disability at Step 4.

The Administrative Law Judge will continue to proceed through the sequential evaluation process to determine whether or not Claimant has the residual functional capacity to perform other jobs.
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, the burden of proof shifts to the department to establish that Claimant has the residual functional capacity to do substantial gainful activity. 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. See discussion at Step 2 above. Findings of Fact 13-26.

In Claimant's case, the intensity, severity and chronicity of the pain and medication side-effects he describes is consistent with the objective medical evidence presented. Claimant credibly testified that his daily vomiting is secondary to the medications he is currently taking in an attempt to manage his coronary artery disease. He also has chest pain with and without exertion and has been hospitalized five times for chest pain since his surgery in November 2010 and July 2011. His neurosurgeon noted that while Claimant did not complain of claudication at his April 2011 evaluation, Claimant was at risk for this with exercise. Claimant testified that his is unable to exercise due to the deep vein thrombosis and arteriovenous fistula in his right leg and hypertension, as evidenced by his discontinued stress test.
Therefore, after careful review of Claimant's medical record and the Administrative Law Judge's personal interaction with Claimant at the hearing, this Administrative Law Judge finds that Claimant's exertional and non-exertional impairments render Claimant unable to engage in a full range of even sedentary work activities on a regular and continuing basis. 20 CFR 404, Subpart P. Appendix 11, Section 201.00(h). See Social Security Ruling 83-10, *Wilson v Heckler*, 743 F2d 216 (1986). The department has failed to provide vocational evidence which establishes that Claimant has the residual functional capacity for substantial gainful activity and that, given Claimant's age, education and work experience, there are a significant number of jobs in the national economy which the Claimant could perform despite Claimant's limitations. Accordingly, this Administrative Law Judge concludes that Claimant is disabled for purposes of the MA program. Consequently, the department's denial of his December 6, 2010, MA/retro-MA application cannot be upheld.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides the department erred in determining Claimant is not currently disabled for MA/retro-MA eligibility purposes.

Accordingly, the department's decision is REVERSED, and it is ORDERED that:

1. The department shall process Claimant's December 6, 2010 MA/retro-MA application and shall award him all the benefits he may be entitled to receive, as long as he meets the remaining financial and non-financial eligibility factors.

/s/
Vicki L. Armstrong
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: 10/17/11

Date Mailed: 10/17/11

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.

VLA/ds