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

IN THE MATTER OF:

[redacted]

Reg. No: 2011-38691
Issue No: 2009
Case No: [redacted]
Hearing Date:
October 11, 2011
Monroe 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 Claimant's request for a hearing received on June 23, 2011. After due notice, a telephone hearing was held on October 11, 2011. Claimant, represented by [redacted], personally appeared and testified.

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional medical evidence. The new evidence was forwarded to the State Hearing Review Team ("SHRT") for consideration. On December 16, 2011, the SHRT found Claimant was not disabled. This matter is now before the undersigned for a final decision.

ISSUE

Whether the Department of Human Services (the department) properly denied 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 September 24, 2010, Claimant applied for MA-P and Retro-MA.

(2) On April 6, 2011, the Medical Review Team (MRT) denied Claimant's MA application stating Claimant's non-severe impairment lacks duration of 12 months in accord with 20 CFR 416-909. (Department Exhibit A, pages 4-5).

(3) On April 6, 2011, the department caseworker sent Claimant notice that her application was denied.

(4) On June 23, 2011, Claimant filed a request for a hearing to contest the department's negative action.

(5) On July 18, 2011 and December 16, 2011, the State Hearing Review Team (SHRT) upheld the denial of MA-P and Retro-MA stating Claimant's condition was improving or expected to improve within 12 months from the date of onset. Therefore, MA, Retro-MA and SDA were denied due to lack of duration. (Department Exhibit B, page 1; Department Exhibit C, page 1).

(6) Claimant has a history of problems with her left leg, hip and back, seizures, gastroesophageal reflux disease (GERD), irritable bowel syndrome (IBS), short term memory loss, seizures, chronic obstructive pulmonary disease (COPD), anxiety and depression.

(7) On July 14, 2007, an x-ray showed Claimant's gall bladder was normal, with nonobstructing right renal stones and a subcentimeter right renal cyst. (Claimant Exhibit A, page 24).

(8) On July 3, 2010, Claimant was admitted to the hospital. She was seen in the emergency room on 7/1/10 with cough, congestion, dizziness, chest pain and shortness of breath. She had a history of anxiety, depression, seizure disorder and continued smoking. Chest x-ray was done. She also had a CT of the head done which was essentially normal and was sent home. She came back two days later with symptoms getting progressively worse. This time she was markedly tachycardic. Potassium was 2.5. White count was 20,000. Chest x-ray showed at least bilateral pneumonia. She had trouble breathing and was given IV steroids and IV antibiotics. Pulmonary was consulted. She had been sick for the past four days. She denied any sore throat. No history of hypertension, myocardial infarction, or congestive cardiac failure. No asthma, emphysema or pneumonia. She had peptic ulcer disease. No acid reflux, hepatitis or hiatal hernia. No stroke. She does have remote history of seizures and migraine headaches. No TIA. No history of diabetes or thyroid disease. She has anxiety and depression. No dementia. No bipolar disorder. She has some discomfort in her chest, on a scale of 1-10 it has been a 6. Lungs: had dullness to percussion bilaterally. No wheezing. Air exchange was very poor. Cardiovascular: Marked tachycardia. Diagnosis: Bilateral pneumonia, possible septicemia, hypokalemia, respiratory distress, history of smoking, anxiety and depression, history of seizure disorder and migraine headaches. She was admitted and started on IV antibiotics and aerosol treatments. (Department Exhibit A, pages 18-20).

(9) On July 4, 2010, Pulmonary Medicine did a consult for evaluation and management of pneumonia. She was seen in the emergency room about

three days ago and was told that she had a urinary tract infection and she came back again last night because of cough and increasing shortness of breath. She had a low grade fever as well. She denied any productive sputum. In the emergency room, her chest x-ray showed bilateral infiltrates which prompted the pulmonary consultation. Impression: Bilateral pneumonia, some coagulation abnormalities and low bicarbonate. The plan at this time would be to continue broad-spectrum antibiotic. (Department Exhibit A, page 22).

(10) On July 8, 2010, Claimant was discharged from the hospital. She was admitted on July 3, 2010, and had been seen in the emergency room two days prior to admission. She had an extensive work up done and was sent home. She came back with trouble breathing. She was found to have bilateral pneumonia with a white count of 20,000. Pulmonary had a consult with her. Her respiratory status was declining. She was admitted to the intensive care unit and the pneumonia care pathway was followed. She was on a 100% rebreather mask for several days. She had to be put on steroids and aerosol treatments in addition to the IV antibiotics. She was then transferred out to the medical floor. She was put on pulmonary toilet. She was given some Lasix IV push because of the respiratory distress. She desired to go home on July 8, 2010, since Pulmonary cleared. Her white count had come down to 12,000. Potassium was low, which was replaced. Chest x-ray showed improvement in the pneumonia. She did not have any arrhythmias. She had been encouraged to quit smoking. Final diagnosis: Bilateral pneumonia, hypokalemia, respiratory distress and failure, anxiety disorder, chronic pain, opioid and benzodiazepine dependence, chronic obstructive pulmonary disease (COPD). (Department Exhibit A, pages 14-17, 23-56).

(11) On September 19, 2010, Claimant went to the emergency room complaining of lower back pain and was diagnosed with a lumbosacral sprain. She was prescribed Tordol and Norflex and discharged in stable condition. (Claimant Exhibit A, pages 42-47).

(12) On January 6, 2011, Claimant was admitted to the hospital for cystoscopy and instillation of Rimso with Decadron, Heparin and Xylocaine. (Claimant Exhibit A, page 36-41).

(13) On January 27, 2011, Claimant's CT abdomen and pelvis showed nonobstructing right renal calculi with no evidence of hydronephrosis or hydroureter. Limited evaluation of the lower abdomen and pelvis without intravenous or oral contrast. (Claimant Exhibit A, page 35).

(14) On April 11, 2011, an x-ray of Claimant's abdomen showed fecal stasis, no obstruction and a redemonstration of right renal calculi. A chest x-ray showed no acute process. (Claimant Exhibit A, pages 25, 34).

(15) On April 13, 2011, Claimant went to the emergency department complaining of chest pain that radiated to the back. An IV was started and Ativan, Morphine and Tovadol was administered. Pain decreased. Chest x-ray showed no CT evidence for pulmonary embolus or aortic dissection. Possible nodule right thyroid lobe. She was discharged in stable condition. (Claimant Exhibit A, pages 26-33, 35).

(16) On May 22, 2011, Claimant went to the emergency department complaining of abdominal pain for the past four days and nausea. She was diagnosed with acute pyelonephritis. She was given an IV and had labs drawn. She was administered Zogram, Tarado and released with a prescription for Loraquin and instructions to follow-up with her physician. (Claimant Exhibit A, pages 11-23).

(17) On June 10, 2011, Claimant was admitted to the hospital with pain and discomfort in the right loin area. An x-ray revealed four stones in the lower pole calyx of the right kidney. She was admitted for extracorporeal shockwave lithotripsy (ESWL). (Claimant Exhibit A, pages 5-10).

(18) Claimant is a [redacted] woman whose birthday is [redacted]. Claimant is 5'4" tall and weighs 130 lbs. Claimant completed her GED and was a house painter for [redacted]. Claimant last worked during the summer of 2003.

(19) Claimant had applied for Social Security disability at the time of the hearing.

CONCLUSIONS OF LAW

The Medical Assistance ("MA") program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department, (DHS or department), 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").

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). The person claiming a physical or mental disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to

establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and, (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (e.g., age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4). If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3 to Step 4. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

As outlined above, the first step looks at the individual's current work activity. In the record presented, Claimant is not involved in substantial gainful activity and testified that she has not worked since the summer of 2003. Therefore, she is not disqualified from receiving disability benefits under Step 1.

The severity of the individual's alleged impairment(s) is considered under Step 2. The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b). An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b). Examples 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. *Id.*

The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). An impairment qualifies as non-severe only if, regardless of a claimant's age, education, or work experience, the impairment would not affect the claimant's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985).

In the present case, Claimant alleges disability due to problems with her left leg, hip and back, seizures, gastroesophageal reflux disease (GERD), irritable bowel syndrome (IBS), short term memory loss, seizures, chronic obstructive pulmonary disease (COPD), anxiety and depression.

On July 3, 2010, Claimant was admitted to the hospital and diagnosed with bilateral pneumonia, septicemia, hypokalemia, respiratory distress. She had trouble breathing and was given steroids and antibiotics by IV. She was discharged in stable condition on July 8, 2010 after her chest x-ray showed improvement in the pneumonia and her white count had come down. Diagnosis at discharge was bilateral pneumonia, hypokalemia,

respiratory distress and failure, anxiety disorder, chronic pain, opioid and benzodiazepine dependence and chronic obstructive pulmonary disease. She was encouraged to quit smoking.

On September 19, 2010, Claimant went to the emergency room for a lubosacaral sprain and was prescribed Tordol and Norflex and released in stable condition.

On January 6, 2011, Claimant was admitted to the hospital for cystoscopy and instillation of Rimso with Decadron, Heparin and Xylocaine. On January 27, 2011l, a cat scan of Clamaint's abdomen showed nonobstructing right renal calculi with no evidence of hydronephrosis or hydroureter.

On April 11, 2011, an x-ray of Claimant's abdomen showed no obstruction. Her chest x-ray on April 13, 2011, showed no acute process and no CT evidence for pulmonary embolus or aortic dissection.

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the Claimant has presented some limited medical evidence establishing that she does have some physical limitations on her ability to perform basic work activities. The medical evidence has established that the Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, the Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The Claimant has alleged physical disabling impairments due to problems with her left leg, hip and back, seizures, gastroesophageal reflux disease (GERD), irritable bowel syndrome (IBS), short term memory loss, seizures, chronic obstructive pulmonary disease (COPD), anxiety and depression.

Listing 1.00 (musculoskeletal system), Listing 3.00 (respiratory system), Listing 6.00 (genitourinary impairments), Listing 11.00 (neurological) and Listing 12.00 (mental disorders) were considered in light of the objective evidence. Based on the foregoing, it is found that Claimant's impairment(s) does not meet the intent and severity requirement of a listed impairment; therefore, Claimant cannot be found disabled at Step 3. Accordingly, Claimant's eligibility is considered under Step 4. 20 CFR 416.905(a).

The fourth step in analyzing a disability claim requires an assessment of the individual's residual functional capacity ("RFC") and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if he/she can perform past relevant work. *Id*.; 20 CFR 416.960(b)(3). Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for

the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s) and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

To determine the physical demands (exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967. Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). 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. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b). Even though 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. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.* Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.* Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.* Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands (exertional requirements, e.g., sitting, standing, walking, lifting, carrying, pushing, or pulling) are considered nonexertional. 20 CFR 416.969a(a). In considering whether an individual can perform past relevant work, a comparison of the individual's residual functional capacity to the demands of past relevant work must be made. *Id.* If an individual can no longer do past relevant work, the same residual functional capacity assessment along with an individual's age, education, and work experience is considered to determine whether an individual can adjust to other work which exists in the national economy. *Id.* Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (e.g., can't tolerate dust or fumes); or

difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2). The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.*

Claimant's prior work history consists of painting houses for 20 years and customer service for 6 years. In light of Claimant's testimony, and in consideration of the Occupational Code, Claimant's prior work is classified as unskilled, medium work.

Claimant testified that she is able to walk short distances and can lift/carry approximately 5 pounds. The medical evidence does not contain any restrictions. If the impairment or combination of impairments does not limit an individual's physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. 20 CFR 416.920. In consideration of the Claimant's testimony, medical records, and current limitations, Claimant cannot be found able to return to past relevant work. Accordingly, Step 5 of the sequential analysis is required.

In Step 5, an assessment of the individual's residual functional capacity and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v) At the time of hearing, Claimant was 45 years old and was, thus, considered to be a younger individual for MA-P purposes. Claimant has a GED. Disability is found if an individual is unable to adjust to other work. *Id.* At this point in the analysis, the burden shifts from the Claimant to the Department to present proof that the Claimant has the residual capacity to substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). The age for younger individuals (under 50) generally will not seriously affect the ability to adjust to other work. 20 CFR 416.963(c).

In this case, the evidence reveals that Claimant suffers from to problems with problems with her left leg, hip and back, seizures, gastroesophageal reflux disease (GERD), irritable bowel syndrome (IBS), short term memory loss, seizures, chronic obstructive pulmonary disease (COPD), anxiety and depression. The objective medical evidence does not list any limitations. In light of the foregoing, it is found that Claimant maintains the residual functional capacity for work activities on a regular and continuing basis which includes the ability to meet the physical and mental demands required to perform

at least light work as defined in 20 CFR 416.967(a). After review of the entire record using the Medical-Vocational Guidelines [20 CFR 404, Subpart P, Appendix II] as a guide, specifically Rule 202.20, it is found that the Claimant is not disabled for purposes of the MA-P program at Step 5.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Claimant not disabled for purposes of the MA-P benefit programs.

Accordingly, it is ORDERED:

The Department's determination is AFFIRMED.

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

Date Signed: 1/10/12

Date Mailed: 1/10/12

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