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

IN THE MATTER OF:

Reg. No: 2011-49243
Issue No: 2009
Case No:
Hearing Date:
November 22, 2011
Kalamazoo 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. After due notice, a telephone hearing was held on November 22, 2011. Claimant, represented by of L&S Associates, 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 March 23, 2012, 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 December 17, 2010, Claimant filed an application for MA and Retro-MA benefits back to November 2010, alleging disability.

(2) On April 20, 2011, the Medical Review Team (MRT) denied Claimant's application for MA-P and Retro-MA indicating that she was capable of performing other work, pursuant to 20 CFR 416.920(f).

(3) On May 14, 2011, the department caseworker sent Claimant notice that her application was denied.

(4) On August 9, 2011, Claimant filed a request for a hearing to contest the department's negative action.

(5) On October 5, 2011, the State Hearing Review Team (SHRT) found Claimant was not disabled. (Department Exhibit B, pp 1-2).

(6) Claimant has a history of reflex sympathetic dystrophy (RSD), diverticulitis, migraines, back pain, and heart disease.

(7) On December 22, 2009, Claimant underwent a psychological evaluation. She used a cane to help her walk and maintain balance. She stated that she has used the cane off and on for about 10 years and uses it when she has not taken her medication, if her legs are in pain, or if she has problems falling. She indicated that her depression and anxiety developed in the past year due to stress from her physical conditions. At this time, the psychologist found that Claimant's depression and anxiety did not appear to be interfering with her daily functioning. She had been taking Xanax for the past couple of months, which has been helpful. It is recommended that the disability office refer Claimant to an appropriate medical specialist to determine her degree of disability. Diagnostic Impressions: Axis I: Adjustment Disorder with Mixed Anxiety and Depressed Mood; Axis V: GAF=65. (Department Exhibit A, pp 33-38).

(8) On November 5, 2010, Claimant was evaluated by the Disability Determination Service. Claimant's chief complaints were back pain, reflex sympathetic dystrophy, arthritis, and heart disease. The exam showed Claimant did have some mild findings of degenerative arthritis to her knees and some mild diminished range of motion in the left hip. She had tenderness over both sacroiliac joints, but the physician did not find any evidence of reflex sympathetic dystrophy today. Claimant did have moderate difficulty doing a squat due to pain and had mild difficulty standing as she refused to hop. Claimant walked with a guarded gait but did not need an assistive device at this point. She is on supportive care with anti-inflammatories and antispasmodics. She did have an element of paravertebral spasm today. Injection treatments to her back may be of benefit. There was no finding of cardiopulmonary disease today. Her blood pressure was mildly elevated. She appeared compliant on her current medical treatment. She apparently has had a normal stress test, and at this point, further monitoring would be indicated. (Department Exhibit A, pp 26-32).

(9) On November 21, 2010, Claimant was admitted to the hospital with chest pain and pain radiating down her right arm. Her chest x-ray showed a

normal heart size and revealed a left midlung pulmonary nodule approximately 8 mm that was not present on the 12/3/03 x-ray. Stress test revealed a normal exam. The electrocardiogram and myocardial perfusion response to lexiscan was negative for ischemia. The left ventricular wall motion was normal with a calculated ejection fraction of 77 percent. No chest pain with infusion. Claimant was discharged on November 22, 2010, with instructions to follow-up with her primary physician. (Department Exhibit A, pp 51-116).

(10) On December 2, 2010, an x-ray of the lung nodule revealed a benign calcified granuloma. Claimant was informed she had a benign nodule. (Department Exhibit A, p 145).

(11) On December 28, 2010, Claimant went to the emergency room for knee pain after falling twice. Her left knee was swollen and her range of motion was limited. The x-ray showed a possible fracture of medial tibial plateau. It was noted that correlation with CAT scan should be considered. A knee immobilizer was applied and she was discharged on December 29, 2010. On December 30, 2010, there was a new or additional finding on the x-ray of Claimant's left knee showing a fracture. Claimant's was called and a message left advising her to return the call. Her family physician was also notified of the x-ray results. (Claimant Exhibit A, pp 41-57).

(12) On January 4, 2011, Claimant had an x-ray of her left knee which revealed suspected mild early degenerative changes of the medial tibiofemoral compartment, incompletely characterized, and moderate joint effusion. (Department Exhibit A, pp 143-144).

(13) On January 16, 2011, Claimant went to the emergency department complaining of back pain and left hip pain radiating down her thigh. She reported she had taken Oxycodone. She had difficulty walking and was nauseous. She had no neurological defects. She had good strength and sensation. Claimant was administered Toradol, Valium and Dilaudid and discharged with instructions to follow up with her primary physician. (Department Exhibit A, pp 117-133).

(14) On February 22, 2011, Claimant was admitted to the hospital complaining of chest pain. Chest x-ray found no interval change and a stable calcified granulomoa in the lateral left lung. Clear lungs, normal heart and mediastinum, no pleural abnormality, no new findings when compared to x-ray taken on 12/2/10 and 11/21/10. Claimant was discharged on February 23, 2011, and instructed to follow-up with her primary physician. (Claimant Exhibit A, pp 6-40).

(15) On March 21, 2011, Claimant was admitted to the hospital with a diagnosis of 1) Presyncope: questionable psychosomatic; 2) Bilateral

lower extremity weakness with severe pain with history of reflex sympathetic dystrophy; 3) Hypertension; 4) Tobacco abuse; 5) Deep vein thrombosis prophylaxis; 6) History of chronic back pain, diverticulosis, and hypertension. Chest x-ray compared with 2/22/11 and 11/21/10, revealed normal heart size and pulmonary vascularity and a benign calcified granuloma in her left lung. No infiltrates or effusions. Claimant's lumbar spine x-ray showed possible right renal lithiasis with no acute lumbar spine findings. The CAT scan of Claimant's head was normal. The laboratory results were normal to include cardiac enzymes, basic metabolic profile and complete blood count. Her echocardiogram showed normal left ventricular function, ejection fraction 60 percent. Claimant was discharged on March 22, 2011, with instructions to follow-up with her primary physician. Discharge diagnosis was 1) Chronic pain syndrome; 2) Overmedication with central acting medications; 3) Polypharmacy; 4) Chronic narcotics use; 5) Tobacco addiction; 6) Hypertension, and 7) Reflex sympathetic dystrophy. (Claimant Exhibit A, pp 4-5, 58-84).

(16) On May 12, 2011, Claimant saw her primary physician for a recheck of her reflex sympathetic dystrophy and renewal of her pain medication. Claimant has had numerous operations on her knees mostly on the left where she has chronic pain issues. She has been taking Oxycodone 30 mg up to 4 a day and it is pretty well controlled. She uses Valium for a muscle relaxant. She has a history of trouble sleeping, hypertension, migraine headaches, and hypercholesterolemia. Her prescriptions were renewed. (Claimant Exhibit C, p 5).

(17) On October 21, 2011, Claimant went to the emergency department after falling and hitting her head, back and right elbow. Claimant had a gait disturbance. She had weakness and balance problems related to her reflex sympathetic dystrophy. Claimant appeared mildly anxious as well as having mild discomfort secondary to pain. A left elbow x-ray showed no evidence of fracture or dislocation. No evidence of soft tissue swelling. She was discharged from the emergency department after relief of her pain and instructed to take her home medications as prescribed. (Claimant Exhibit B, pp 3-4).

(18) On October 26, 2011, Claimant went to the emergency department complaining of severe right-sided flank pain. She stated that she fell and was having pain and some palpitations. Claimant was in no severe distress and did not have any other severe injuries that were identified. Claimant's physical exam was unremarkable. Claimant's EKG demonstrated a sinus tachycardia without any acute St-T wave MI. Heart rate was 102. PR interval was 174, QTC was 437 milliseconds. There was no evidence of myocardial infarction. CAT scan of the abdomen and pelvis showed no renal or ureteral calculi notes; colonic diverticulosis with no signs of diverticulitis, and diffuse fatty infiltration of the liver. There

were no abnormal findings. Claimant received 1 milligram of Dilaudid and was discharged home. (Claimant Exhibit B, pp 1-2, 6-7).

(19) Claimant is a 46 year old woman whose birthday is February 11, 1966. Claimant is 5'2" tall and weighs 168 lbs. Claimant completed a high school equivalent education and has not worked since 2008.

(20) Claimant was appealing the denial of Social Security disability benefits 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 CF R 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, the Claimant is not involved in substantial gainful activity and testified that she has not worked since May 2009. 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 reflex sympathetic dystrophy (RSD), diverticulitis, migraines, back pain, and heart disease.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). 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 reflex sympathetic dystrophy (RSD), diverticulitis, migraines, back pain, and heart disease.

Listing 1.00 (musculoskeletal system), Listing 4.00 (cardiovascular system), Listing 8.00 (skin disorders), and Listing 11.00 (neurological) 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, the 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 work as a telemarketer and trainer, line worker and home health aid. In light of Claimant's testimony, and in consideration of the Occupational Code, Claimant's prior work is classified as semi-skilled, medium work.

Claimant testified that she is able to walk short distances and can lift/carry approximately 6 pounds. The objective medical evidence notes limitations in walking and squatting. 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, the Claimant was 45 years old and was, thus, considered to be a younger individual for MA-P purposes. Claimant has a high school equivalent education and some college education. 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 reflex sympathetic dystrophy (RSD), diverticulitis, migraines, back pain, and heart disease. The objective

medical ev idence not es some limitations in wa lking and hopping. In lig ht of the foregoing, it is found t hat Cla imant maintains the resid ual functional capacit y for work activities on a regular and continuing basis which includes the ability to meet the physical and mental demands required to perf orm at least sedentary work as defined in 20 CFR 416.967(a_). After review of the entire re cord using the Medical- Vocational Guidelines [20 CFR 404, Subp art P, Appendix II] as a guide, specifically Rule 201.21 , 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 the 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:_April 10, 2012______

Date Mailed:_April 10, 2012______

NOTICE: Administrative Hearings may or der a rehearing or reconsideration on either its own motion or at t he request of a party within 30 days of the mailing date of this Decision and Order. Administrative Hear ings will not orde r a rehearing or reconsideration on the Department's mo tion where the final decis ion 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 Decis ion and Order or, if a ti mely request for rehearing was made, within 30 days of the receipt date of the rehearing decision.

VLA/ds

cc: