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

IN THE MATTER OF:

[redacted]

Reg No.: 2012-54262
Issue No.: 2009
Case No.: [redacted]
Hearing Date: April 30, 2012
Oakland County DHS (04)

ADMINISTRATIVE LAW JUDGE: Colleen M. Mamelka

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 hearing was held in Pontiac Michigan on Monday, April 30, 2012. The Claimant appeared and testified. The Claimant was represented by [redacted] of L & S Associates, Inc. Participating on behalf of the Department of Human Services ("Department") was [redacted].

During the hearing, the Claimant waived the time period for the issuance of this decision, in order to allow for the submission of additional medical evidence. The records were received, reviewed, and forwarded to the State Hearing Review Team ('SHRT") for consideration. On August 22, 2012, this office received the SHRT determination which found the Claimant not disabled. This matter is now before the undersigned for a final decision.

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of the Medical Assistance ("MA-P") benefit program?

FINDINGS OF FACT

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

1. The Claimant submitted an application for public assistance seeking MA-P benefits, retroactive to January 2011, on April 27, 2011.

2. On June 24, 2011, the Medical Review Team ("MRT") found the Claimant not disabled. (Exhibit 1, pp. 1, 2)

3. The Department notified the Claimant of the MRT determination.

4. On August 31, 2011, the Department received the Claimant's written request for hearing. (Exhibit 2)

5. On March 20th and August 16, 2012, the SHRT found the Claimant not disabled. (Exhibit 3)

6. The Claimant alleged physical disabling impairments due to neck pain, shoulder and elbow pain, knee pain, low back pain with radiculopathy, asthma, high blood pressure, gastroesphogeal reflux disease ("GERD"), and chronic pain.

7. The Claimant has not alleged any mental disabling impairment(s).

8. At the time of hearing, the Claimant was 48 years old with a March 31, 1964 birth date; was 5'1" in height; and weighed 178 pounds.

9. The Claimant is a high school graduate with some vocational training with an employment history as a daycare worker, beautician, and cashier.

CONCLUSIONS OF LAW

The Medical Assistance program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department of Human Services, formerly known as the Family Independence Agency, 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 Bridges Reference Tables ("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 CFR 416.913. 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 (i.e. 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 three to step four. 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 416.945(a)(1). An individual's residual functional capacity assessment is evaluated at both steps four and five. 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 therefore is not ineligible for disability benefits under Step 1.

The severity of the Claimant's alleged impairment(s) is considered under Step 2. The Claimant 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 416.920(a)(4)(ii); 20 CFR

416.920(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 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921(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, the Claimant alleges disability due to neck pain, shoulder and elbow pain, knee pain, low back pain with radiculopathy, asthma, high blood pressure, gastroesophageal reflux disease ("GERD"), and chronic pain.

In support of her claim, some older records from 2010 were submitted which document treatment/diagnoses, despite prescribed treatment, asthma, bronchitis, hypertension, arthritis, hyperlipidemia, cervical disc disease, lumbar pain, high cholesterol, and GERD.

On [redacted] the Claimant presented to the emergency room with complaints of cough and lumbar/neck pain. The diagnoses were bronchitis, hypertension, and lumbar/cervical pain.

On [redacted], the Claimant was prescribed medication for asthma control and to reduce pain.

On [redacted], the Claimant was admitted to the hospital with complaints of breathing difficulties with cough. The Claimant was given IV steroids along with breathing treatments. The Claimant was discharged on January 22, 2011 with the diagnoses of acute hypoxemic respiratory failure, acute exacerbation of asthma, hypertension, tobacco abuse, constipation, chronic anemia, and leukocytosis secondary to steroids.

On [redacted], the Claimant was treated via emergency room for lumbar/cervical pain and asthma.

On [redacted], the Claimant was prescribed medication to control her asthma and reduce her pain.

On [redacted] the Claimant presented to the emergency room with complaints of asthma exacerbation and joint/ lumbar pain. The diagnoses were cervical/lumbar arthritis, asthma, and hyperlipidemia.

On [redacted], a Medical Examination Report was completed on behalf of the Claimant. The current diagnoses were asthma, hypertension, and hyperlipidemia. The physical examination noted an abnormal echocardiogram, asthma, hypertension, joint, lumbar, and neck pain, cervical disc fusion. The Claimant was in stable condition and able to meet her needs in the home.

On [redacted] the Claimant was diagnosed in the emergency room with early bronchitis, asthma, and cervical/lumbar arthritis.

On [redacted] the Claimant was diagnosed with chronic obstructive pulmonary disease ("COPD"), asthma, hyperlipidemia, and cervical/lumbar arthritis.

On [redacted] the Claimant sought emergent care for chest pain and palpitations. The diagnoses were bronchial asthma and cervical and lumbar arthritis.

On [redacted], the Claimant sought emergent care for bronchitis. The diagnoses were asthma, hypertension, and cervical/lumbar arthritis.

On [redacted] the Claimant sought treatment for chest pain. The diagnoses were bronchial asthma, hypertension, and cervical/lumbar arthritis.

On [redacted] the Claimant sought emergent care for lumbar/neck pain and stiffness. The diagnoses were severe arthritis on the right, hyperlipidemia, asthma, and cervical/lumbar arthritis.

On [redacted], the Claimant presented to the hospital with complaints of shortness of breath. The physical examination was positive for wheezing. The diagnoses were asthma, hyperlipidemia, and cervical/lumbar arthritis.

On [redacted], the Claimant sought treatment for vomiting and neck pain. The diagnoses were hypertension and cervical pain.

On [redacted] the Claimant presented to the hospital with complaints of chest pain, shortness of breath, cough, abdominal pain, and lumbar/cervical pain. The diagnoses were GERD, dysphagia, chronic pain, and asthma.

On [redacted] the Claimant presented to the hospital with complaints of wheezing. An echocardiogram was abnormal noting probable anterior infarct. The diagnoses were (in part) asthma and cervical and lumbar arthritis.

On [redacted], the Claimant presented to the emergency room with complaints of shortness of breath with cough and joint and back pain. The diagnoses were asthma/bronchitis, cervical and lumbar arthritis, and a BMI of 33.

On [redacted] the Claimant presented to the emergency room with complaints of shortness of breath with cough. The Claimant was treated and discharged with the diagnoses of hypertension, shortness of breath, and cervical and lumbar arthritis.

On [redacted], a Medical Examination Report was completed on behalf of the Claimant. The current diagnoses were asthma, high cholesterol, cervical disc herniation, positive H- pylori, hypertension, and history of cervical and lumbar surgery. The physical examination revealed chronic cervical and lumbar pain, asthma, shortness of breath, chest pain, rotator cuff surgery, and ulna nerve/cervical fusion. The Claimant's condition was deteriorating, limiting her to lifting/ carrying less than 10 pounds; standing and/or walking less than 2 hours in an 8 hour workday; sitting at 6 hours during this same time frame; and unable to perform repetitive actions with her upper extremities.

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 medical evidence establishing that she does have 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 minimus* 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 Claimant's impairment, or combination of impairments, is listed in

Appendix 1 of Subpart P of 20 CFR, Part 404. The evidence confirms treatment/diagnoses of lumbar pain, shoulder pain, neck pain, asthma, bronchitis, cervical disc disease, hypertension, hyperlipidemia, chronic anemia, GERD, COPD, and arthritis.

Listing 3.00 defines respiratory system impairments. Respiratory disorders, along with any associated impairment(s), must be established by medical evidence sufficient enough in detail to evaluate the severity of the impairment. 3.00A. Evidence must be provided in sufficient detail to permit an independent reviewer to evaluate the severity of the impairment. *Id.* A major criteria for determining the level of respiratory impairments that are episodic in nature, is the frequency and intensity of episodes that occur despite prescribed treatment. 3.00C. Attacks of asthma, episodes of bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum), or respiratory failure as referred to in paragraph B of 3.03, 3.04, and 3.07, are defined as prolonged symptomatic episodes lasting one or more days and requiring intensive treatment, such as intravenous bronchodilator or antibiotic administration or prolonged inhalational bronchodilator therapy in a hospital, emergency room or equivalent setting. 3.00C.

Obesity is a medically determinable impairment that is often associated with disturbance of the musculoskeletal and respiratory system and may be a major cause of disability. 1.00Q; 3.00I

Listing 3.03 provides in relevant part:

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B. Attacks (as defined in 3.00C), in spite of prescribed treatment and requiring physician intervention, occurring at least once every 2 months or at least six times a year. Each in-patient hospitalization for longer than 24 hours for control of asthma counts as two attacks, and an evaluation period of at least 12 consecutive months must be used to determine the frequency of attacks.

In this case, the evidence shows that the Claimant was hospitalized in [redacted] for 5 days due to asthma exacerbation and respiratory failure. The evidence confirms adherence to prescribed treatment. Since discharge, the Claimant was treated in the emergency room for her chest pain/asthma approximately 14 times over a 16 month period. In [redacted] the Claimant's primary care provider noted the Claimant's condition was deteriorating. In light of the foregoing, and in consideration of the multiple hospitalizations despite prescribed treatment, the Claimant's impairments meet, or are the medical equivalent thereof, a listed impairment within 3.00 as discussed above. Accordingly, the Claimant is found disabled at Step 3 with no further analysis required.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law finds the Claimant disabled for purposes of the MA-P benefit program.

Accordingly, it is ORDERED:

1. The Department's determination is REVERSED.

2. The Depar tment shall initiate pr ocessing of the April 27, 20 11 application, retroactive to January 2011, to determine if all other non-medical criteria ar e met in accordance with Department policy.

3. The Department shall notify t he Claimant and her Authorized Hearing Representative of the determination in accordance with Department policy.

4. The Department shall supplement for lo st benefits (if any) that the Claimant was entitled to receiv e if otherwise elig ible and qualified in acc ordance with Department policy.

5. The Department shall revi ew th e Cla imant's continu ing eligibility in October 2013 in accordance with Department policy.

Colleen M. Mamelka

Colleen M. Mamelka
Administrative Law Judge
For Maura Corrigan, Director
Department of Human Services

Date Signed: September 12, 2012

Date Mailed: September 12, 2012

NOTICE: Michigan Administrative Hearing Syst em (MAHS) may order a rehearing or reconsideration on either its own motion or at the request of a par ty within 30 days of the mailing date of this Dec ision and Order . MAHS will not or der 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. (60 days for FAP cases)

The Claimant may appeal the Decision and Order to C ircuit Court within 30 days of the receipt of the Dec ision and Order or, if a ti mely request for rehea ring was made, within 30 days of the receipt date of the rehearing decision.

Claimant may request a rehearing or reconsideration for the following reasons:

- A rehearing **MAY** be granted if there is newly discovered evidence that could affect the outcome of the original hearing decision.
- A reconsideration **MAY** be granted for any of the following reasons:

  - misapplication of manual policy or law in the hearing decision,
  - typographical errors, mathematical error, or other obvious errors in the hearing decision that effect the substantial rights of the claimant:
  - the failure of the ALJ to address other relevant issues in the hearing decision.

Request must be submitted through the local DHS office or directly to MAHS by mail at

Michigan Administrative Hearings
Re consideration/Rehearing Request
P. O. Box 30639
Lansing, Michigan 48909-07322

CMM/cl

cc: [redacted]
Oakland County DHS (04)/DHS-1843
[redacted]
C. Mamelka