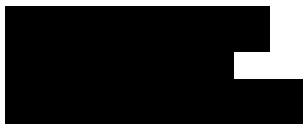


STATE OF MICHIGAN  
MICHIGAN ADMINISTRATIVE HEARING SYSTEM  
ADMINISTRATIVE HEARINGS FOR THE  
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:



Reg. No: 2011-38706  
Case No: [REDACTED]  
Issue: 2009  
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 20, 2011. After due notice, an in-person hearing was held on October 11, 2011. Claimant and his representative, [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 15, 2011, the SHRT found Claimant was disabled, but denied Retro-MA. 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 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 January 14, 2011, Claimant applied for MA-P, Retro-MA and SDA.
- (2) On May 3, 2011, the Medical Review Team (MRT) approved Claimant's SDA and denied Claimant's MA and Retro-MA indicating Claimant's physical or mental impairments lacked 12-months duration. (Department Exhibit A, pages 1-2).
- (3) On June 17, 2011, the department caseworker sent Claimant notice that his application was denied.

- (4) On June 20, 2011, Claimant filed a request for a hearing to contest the department's negative action.
- (5) On July 16, 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 light unskilled work. (Department Exhibit B, page 1).
- (6) On December 15, 2011, SHRT approved Claimant's MA application based on his vocational profile of 55 years old, a high school education and a history of light exertional, unskilled unemployment, using Vocational Rule 202.04. SHRT denied Claimant's Retro-MA application using Vocational Rule 202.13 as a guide from 12/2010, the requested date of retroactive MA. (Department Exhibit C, pages 1-2).
- (7) Claimant has a history of congestive heart failure, coronary artery disease, chronic atrial fibrillation, severe depression, morbid obesity, acute renal failure, pancreatitis, pleural effusion, pulmonary infiltrates, and hypertension.
- (8) On January 12, 2009, Claimant went to the hospital for shortness of breath and bilateral extremity swelling. Blood pressure was 190/100. He was admitted for acute chronic congestive heart failure and chronic congestive heart failure exacerbation. He had 3 to 4+ edema in both lower extremities, pitting type, with diffuse purple dark discoloration of the skin. The skin did not appear warm to the touch. Feet were cool to the touch and atrophic. Capillary fill time, both feet, was delayed at about 8 seconds. Chest x-rays showed evidence of congestive heart failure. EKG showed atrial fibrillation. Echocardiogram done on 8/1/06 showed suboptimal study. Ejection fraction was estimated around 40%. The 2-D echocardiogram showed multiple wall motion abnormalities. Left ventricular ejection fraction was mildly reduced to 45%. Mild mitral and tricuspid regurgitation with estimated pulmonary hypertension at 38 mmHg. He was assessed with chronic congestive heart failure, likely acute, possibly diastolic, likely also worsened by atrial fibrillation with rapid ventricular rate and chronic renal insufficiency and hypertensive urgency. Claimant was asked to remain in the hospital an additional day, but refused. He was instructed to follow-up with his physician. He was discharged on January 20, 2009. (Department Exhibit C, pages 7-25).
- (9) On December 11, 2010, Claimant was admitted to the hospital through the emergency room because of findings consistent with congestive heart failure. He had applied for a security job and during the physical examination was sent to the emergency room due to shortness of breath and irregular heartbeat. He was treated during his admission for atrial fibrillation, congestive heart failure, hypertension, severe depression, and

incidental findings of asymptomatic pancreatitis with elevation of amylase and lipase. Random glucose was 91, BUN 22, creatinine 1.1, and serum electrolytes were abnormal for hypokalemia of 3.4 and hypochloremia of 108. In addition, his alkaline phosphatase was elevated at 311 and his urinalysis was positive for urobilinogen and leukocyte esterase test. His electrocardiogram revealed atrial fibrillation with ventricular rate of 98 per minute and minimal nonspecific intraventricular conduction delay with flattened T waves in limb leads. His PA and lateral chest x-rays reported as "extremely limited examination" with the findings of right lower lobe consolidation and right-sided pleural effusion, as well as infiltrate in left lower lobe base. He had an abdominal and pelvic ultrasound, the report of which was positive for peripancreatic changes suspicious of developing pancreatitis, fatty changes of the liver, cholelithiasis with layering gallstones within the dependent calculi, and nonspecific retroperitoneal lymph nodes with follow-up recommendation for re-evaluation and a left lower lobe nodule measuring 1.4 cm, consistent with "developing atelectasis." Under therapy with intravenous diuretic therapy for congestive heart failure, his eGFR was 74% on admission and declined to 48%, consistent with acute renal failure, and as such diuretic therapy was temporarily withheld and subsequently resumed at lower doses to avoid compromising renal function. His last chest x-ray obtained on the last day of admission prior to discharge reported moderate right-sided pleural effusion along with associated nonspecific right basilar parenchymal opacity representing an infectious process versus compressive atelectasis. His echocardiogram revealed concentric left ventricular hypertrophy with a slight dilation, inferior wall akinesis, septal hypokinesis, with an ejection fraction of the left ventricle estimated at 35% plus/minus 5%, along with dilated left atrium and a slightly dilated right atrium, and a cardiac Doppler was abnormal for mild tricuspid and mitral regurgitation with mild pulmonary hypertension estimated at 30-35 mm of pulmonary systolic pressure. He was discharged on coated aspirin 325 mg daily, Coreg 6.25 mg tablet 1-1 ½ tablets BID, Cardizem CD 240 mg daily, Coumadin therapy, and follow-up INR/PT, Celexa 10 mg QAM, Zestril 2.5 mg daily, Lasix 40 mg QAM, Ativan 0.5 mg Q12 hours PRN for severe anxiety, and Ambien 5 mg nightly PRN for insomnia. Final diagnosis: Chronic diastolic and systolic congestive heart failure superimposed by exacerbation and acute systolic congestive heart failure; Ischemic cardiomyopathy suggested by segmental myocardial dysfunction and low ejection fraction of 35% plus/minus 5%, contributing to the congestive heart failure; Coronary artery disease suggested by echocardiogram and contributing to the low ejection fraction; Chronic atrial fibrillation, contributing to congestive heart failure; Severe depression, treated and improved; Morbid obesity; Acute renal failure, monitored and improved to be followed up; Early developing pancreatitis, monitored and improved, to be followed up; Pleural effusion, pulmonary infiltrates and/or atelectasis, to be followed up by repeat chest x-ray and chest CT if

necessary; Pulmonary hypertension and mild mitral and tricuspid regurgitation; and Hypertension, monitored and treated. (Department Exhibit A, pages 29-96).

- (10) On December 22, 2010, Claimant was discharged. His follow-up chest x-rays were taken prior to discharge and compared to his 12/16/10 x-rays. Overall, there was no significant interval change. Again seen was a somewhat loculated right pleural effusion, moderate in size. There was associated right basilar parenchymal opacity. This was nonspecific and may represent an infectious process. No new confluent infiltrates. There was an exaggerated thoracic kyphosis with a focal wedging of the T10 vertebral body. There were thick anterior flowing osteophytes consistent with diffuse idiopathic skeletal hyperostosis. Superimposed degenerative changes were seen at multiple levels. Redemonstrated was a fracture deformity of the left clavicular head. (Department Exhibit A, page 97).
- (11) On May 25, 2011, Claimant underwent a psychological evaluation by the Michigan Disability Determination Service. The psychologist noted Claimant's hand tremors, his low mood and that his affect was flat. Claimant was diagnosed with Depressive Disorder and Generalized Anxiety Disorder with a GAF of 53. His prognosis was fair to guarded. The psychologist indicated that in the work place, his mood and physical health issues could be impacted negatively if not provided the necessary support and treatments. Some work restrictions may be required. (Department Exhibit C, pages 3-6).
- (12) Claimant is a 55 year old man whose birthday is [REDACTED]. Claimant is 6'3" tall and weighs 220 lbs. Claimant graduated high school and completed two years of college. He last worked as a security guard in September 2010.
- (13) Claimant was appealing the denial for Social Security disability 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).

In Claimant's case, the ongoing chest pain, shortness of breath and other non-exertional symptoms he describes are consistent with the objective medical evidence presented.



**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

■ [REDACTED]