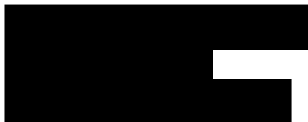
STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:



Reg. No: 2011-46848
Issue No: 2009
Case No:
Hearing Date:
November 15, 2011
Shiawassee 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, an in-person hearing was held on November 15, 2011. Claimant, and Claimant's representative , 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 January 19, 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 benefit programs?

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 April 4, 2011, Claimant filed an application for MA and Retro-MA benefits alleging disability.

(2) On June 21, 2011, the Medical Review Team (MRT) denied Claimant's application for MA-P and Retro-MA indicating that she had a non-severe impairment that lacked 12 months duration, pursuant to 20 CFR 416.909.

(3) On June 30, 2011, the department caseworker sent Claimant notice that her application was denied.

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

(5) On September 21, 2011, the State Hearing Review Team (SHRT) found Claimant had a severe impairment, but denied her application for lack of 12 month duration. On January 19, 2011, SHRT found Claimant retained the capacity to perform light work. (Department Exhibit B, pages 1-2; Department Exhibit C, pages 1-2).

(6) Claimant has a history of Marfan syndrome, dissected aorta, back pain, Dressler's syndrome, and clubbed left foot.

(7) On March 14, 2011, Claimant presented to the emergency department with progressively worsening back pain. She was seen in the emergency department three days earlier, managed as a URI with IVF, Zithromax, Zofran PO but symptoms persisted. Few hours prior to admission at the emergency department, she developed acute onset severe, stabbing 10/10 back pain at rest between her scapulae, exacerbated by deep breathing and without alleviating factors. She endorsed dyspnea, pain radiating to the chest and was constant in nature. CTA Chest revealed Type B aortic dissection. She was transferred to U of M for surgical consultation and medical management of Type B aortic dissection and admitted to Cardiothoracic Surgery. (Department Exhibit A, pp 17-18, 26-30).

(8) On March 16, 2011, Claimant was taken to the operative room for a replacement of the ascending and total arch aorta with a #24 Vasuteck graft using deep hypothermic circulatory arrest with antegrade and retrograde cerebral perfusion, bypass to the left carotid and left vertebral arteries with an 8 millimeter Vascutek graft, bypass of the innominate artery with a 10 millimeter Vascutek graft, thoracic aortic endovascular repair of the proximal descending thoracic aorta, intravascular ultrasound of the thoracic aorta. She recovered in the ICU and was extubated on operative day. Her course was notable for leukocytosis with a peak in her WBC to 36.1. The diagnostic ultrasound of the right upper extremity revealed evidence of acute deep venous thrombosis involving the internal jugular vein. She was transferred to general care on 3/21/11 for further management. She was evaluated by her cardiologist on 3/21/11. He felt that she would do better at home and given her vital signs were stable, the decision was made to discharge her home. She will follow-up with her cardiologist in one month. She was restricted to lift no greater than 10 pounds and no driving until she was seen by her cardiac surgeon at her

follow-up appointment. She was discharged March 22, 2011. (Department Exhibit A, pp 10-25, 92).

(9) On March 29, 2011, Claimant was seen in the local emergency department for evaluation of fever. A chest x-ray was taken in the emergency department and showed nonspecific bilateral subpulmonic pleural effusions. Consultation with her cardiologist determined she should be continued to be treated as an outpatient on antibiotics. (Department Exhibit A, p 16).

(10) On April 9, 2011, Claimant was seen for a consultation due to nausea and vomiting in the setting of recent ascending aorta and arch repair for dissection. She presented to outside emergency department on 4/8/11 with nausea and vomiting. CT chest, abdomen and pelvis were obtained which showed 5x4 cm anterior mediastinal fluid collection likely seroma and R>L pleural effusion. Dissection of the aorta remains stable. She was transferred to UMHS for further evaluation. She was found to have a large discrepancy between her left and right arms upon blood pressure measurement. Cardiac Surgery was consulted and concluded she was stable enough to be discharged home at this time. (Department Exhibit A, pp 31-38).

(11) On April 10, 2011, Claimant returned to the emergency department with nausea and vomiting. CT Surgery was asked to evaluate her. They reviewed the CT of her chest. They state that she has had a fever with negative workup ever since the surgery as well as leukocytosis. They feel her CT scan of the chest is stable with no postsurgical complications. They feel her symptoms are a result of gastroenteritis and they recommend no further intervention from their standpoint. Since she returned with failure of outpatient management of her persistent nausea and vomiting, she was felt best to be admitted to the observation unit for further monitoring and treatment. She has had a chronic fever and leukocytosis since the operation and all cultures have been negative. Chest CT showed interval increase in the right layering pleural effusion, with adjacent atelectasis, underlying infection is possible in the proper clinical setting. Small left pleural effusion. Minimally increased interstitial markings, may represent minimal pulmonary edema. No pneumothorax. Abdomen CT showed interval endovascular repair of the proximal descending thoracic aorta. There is linear attenuation within the left common carotid artery which may represent small dissection flap versus artifact. Redemonstration of remaining dissection flap within the descending thoracic aorta starts just distal to the endograft and extends into the right common iliac artery. There is a new large anterior mediastinal collection with thick peripheral contrast enhancement. The attenuation of collection is slightly higher than simple fluid. Interval development of moderate to large right and slightly increased small left

pleural effusions with adjacent associated atelectasis. There is patchy airspace opacity of right lower lobe concerning for infection in proper clinical setting. On April 11, 2011, Claimant failed to respond to conservative management with IV fluids and IV antiemetics, and was still not able to take p.o. She did have several brief runs of tachycardia running from 100 to 107. She was rescreened by Social Work and met inpatient criteria. (Department Exhibit A, pp 39-47).

(12) On April 13, 2011, Claimant had a new in-patient consult. Her clinical course on STX was notable for leukocytosis to 36 and all negative cultures. At the time of her 4/8/11 ED presentation, a CT chest, abdomen and pelvis were obtained which showed 5x4 cm anterior mediatinal fluid collection likely seroma and R>L pleural effusion. Her graft was found to be stable in appearance. STX evaluated her and invoked no concern for her operative site or other intrathoracic or abdominal cause for her symptoms with suspicions that her presentation was consistent with gastroenteritis. She continues to experience some ongoing pain of obscure etiology. One consideration is that the Doxycycline provoked some esophagitis/gastritis. She is overall improved and tolerating her diet well. (Department Exhibit A, pp 48-64).

(13) On April 15, 2011, Claimant still hospitalized, febrile last night. Thoracentesis was discussed for diagnosis of her fevers. X-rays on 4/14/11 showed moderately large and increasing bilateral subpulmonic pleural effusions. Compression of adjacent lung. No pulmonary edema. Mild hypoxemia likely due to large pleural effusions. Underwent IR guided right thoracentesis and 1 litre of dark fluid was aspirated from right pleural space. Feeling better since the procedure, but on 4/16/11, she had fever in the morning as well. (Department Exhibit A, pp 65-66).

(14) On April 16, 2011, Claimant was febrile again last night, back pain improved somewhat after thoracentesis, but she continues to have pain on the left side. The thoracentesis studies suggest hemothorax due to recent major vascular surgery and concern for possible secondary infection. Considering persistent fever, leukocytosis and recent graft placement, IV antibiotics were started pending results of cultures. (Department Exhibit A, pp 67-73).

(15) On April 17, 2011, Claimant's chest x-ray showed the interval development of 7mm apical pneumothorax on the right. Right pleural effusion appears only slightly less than on chest x-ray prior to thoracentesis on 4/14/11. Left pleural effusion markedly larger compared to 4/14/11 study. (Department Exhibit A, pp 73-83).

(16) On April 18, 2011, Claimant had an ultrasound guided left thoracentesis and was discharged on April 19, 2011, with diagnoses of bilateral pleural

effusions, nausea and vomiting likely due to Doxycycline and Marfans. She was discharged home in stable and improved condition under her family's care and activity restrictions of lifting no more than 10 pounds, and no driving or working until cleared by a surgeon. (Department Exhibit A, pp 84-91).

(17) On May 5, 2011, Claimant was evaluated in the Cardiac Surgery Clinic. Postoperatively, her course was complicated by leukocytosis with a WBC of 36.1. All cultures were negative. There was sternal drainage, which resolved. She had surgical anemia and depression. Psychiatry was consulted and she was cleared to go home on March 22, 2011. She completed a one-week course of Levaquin for the sternal drainage, however, she was readmitted on April 10 through April 19th for fevers, chest pain, bilateral pleural effusions, nausea, and vomiting. She had ultrasound-guided thoracentesis on the right side, April 15, 2011, and on the left side, April 18, 2011. She returned for a postoperative evaluation. Her sternum is stable. The midsternal incision is completely healed and scarred. Her heart has a regular rate and rhythm with no murmurs heard. The cardiologists' impression was she was recovering appropriately and had resolving Dressler's syndrome. She was given the okay to resume driving and should limit her lifting, pushing, and pulling to no greater than 15 pounds. A CT scan was scheduled for six months to reassess her aortic repairs, assess the endograft stent, and to determine if her native aorta is remaining stable or not. The DI Chest Endograph showed a normal heart size, bilateral small to moderate pleural effusion was noted, slightly decreased in size compared to prior examination on 4/17/11. Endograft extends from the distal arch to the mid descending aorta. Difficult to assess for pneumothorax (overexposed images for better evaluation of endograft). Increased lucency in the left apex likely related to technique. (Claimant Exhibit A, pp 13-15).

(18) On November 4, 2011, Claimant was seen in the Cardiac Surgery Clinic for a 6-month post-op visit. She was last seen in the clinic in May 2011, where her early postoperative status was stable. Her doctor recommended a 15-pound lifting restriction, maintenance of a normotensive blood pressure, and revisit with a follow-up chest CT. She has not been able to return to work, secondary to lifting restriction. The CT Angio Chest and Abdomen – Thoracic and Abdominal Aorta Protocol showed high contrast material at the proximal end of the endovascular stent medially and also superiorly outside the stent within the native excluded aorta which begins near the origin of the left subclavian artery consistent with a Type I endoleak. There is associated increased dilation of the excluded native aorta around the stent superiorly now measuring approximately 2 cm in maximum short axis diameter (previously measuring 1.6 cm). There is an interval progression of the dissection flap within the left common artery which begins just distal to the bypass graft

and extends into the neck with its distal end incompletely included on the provided images. Consider CT angiography of the neck for further evaluation. There is a very short dissection flap at the origin of the left subclavian artery, not apparent previously. There is a chronic dissection flap which begins just distal to the endovascular stent in the proximal descending aorta and extends into the proximal right common iliac artery with a mild 2 mm increase in the diameter of the descending aorta and upper abdominal aorta as compared to prior examination in April 2011. There is a residual 1.8 cm cystic lesion within the anterior mediastinum which has significantly decreased in size as compared to prior exam likely representing a resolving postsurgical seroma. Close attention to this area is recommended on subsequent exams. Recommendation at present includes obtaining a carotid Doppler ultrasound to further evaluate the status of the left carotid artery, and evidence of new dissection. Claimant was to resume low-dose metroprolol given her mild tachycardia and maintain the lifting restriction of 15 to 20 pounds. (Claimant Exhibit A, pp 5-12).

(19) On November 11, 2011, Claimant was seen in the Vascular Surgery Clinic. She has a past medical history significant for Marfan's disease. She underwent replacement of the ascending aorta and arch in March 2011, with a Vascuteck graft with bypass to the left common carotid and left vertebral arteries as well as bypass to the innominate artery and TEVAR of the proximal descending thoracic aorta for acute and chronic type aortic dissection. As of November 4, 2011, a CT scan showed a left carotid dissection that was noted to have increased. She reported dizziness and tongue numbness with quick neck movements occurring approximately two to three times a week. She also complains of right hand tingling of intermittent nature that has been present since her surgery last March. A bilateral carotid duplex study was performed and showed a non-flow-limiting dissection of the left carotid extending from the proximal common carotid to the proximal internal carotid, 0.84 centimeters distal to the bifurcation. Velocities in the distal common carotid measured 234/31 centimeters for second. (Claimant Exhibit A, pp 1-4).

(20) At the time of the hearing, Claimant was 24 years old with a [redacted] birth date; was 5'5" in height and weighed 100 pounds.

(21) Claimant is a high school graduate. Her work history includes working as an aid providing in-home direct care the past four years.

(22) 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 the 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 (formerly known as the Family Independence Agency) 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).

Under the Medicaid (MA) program:

> "Disability" is:
>
> ...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.

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 limitations in light of the objective medical evidence presented. 20 CFR 416.929(c)(94).

> In determining whether you are disabled, we will consider all of your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with objective medical evidence, and other evidence. 20 CFR 416.929(a).
>
> Pain or other symptoms may cause a limitation of function beyond that which can be determined on the basis of the anatomical, physiological or psychological abnormalities considered alone. 20 CFR 416.945(e).
>
> In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings and statements about how your symptoms affect you. We will then determine the extent to which your alleged functional limitations or restrictions due to pain or other symptoms can reasonably

> be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work. 20 CFR 416.929(a).
>
> Since symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you may submit about your symptoms. 20 CFR 416.929(c)(3).
>
> Because symptoms such as pain, are subjective and difficult to quantify, any symptom-related functional limitations and restrictions which you, your treating or examining physician or psychologist, or other persons report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account in reaching a conclusion as to whether you are disabled. 20 CFR 416.929(c)(3).
>
> We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your treating, examining or consulting physician or psychologist, and observations by our employees and other persons. 20 CFR 416.929(c)(3).
>
> Your symptoms, including pain, will be determined to diminish your capacity for basic work activities to the extent that your alleged functional limitations and restrictions due to symptoms, such as pain, can reasonably be accepted as consistent with the objective medical evidence and other evidence. 20 CFR 416.929(c)(4).

In Claimant's case, the ongoing pain and other non-exertional symptoms she describes are consistent with the objective medical evidence presented. Consequently, great weight and credibility must be given to her testimony in this regard.

When determining disability, the federal regulations require that several considerations be analyzed in sequential order. If disability can be ruled out at any step, analysis of the next step is <u>not</u> required. These steps are:

1. Does the client perform Substantial Gainful Activity (SGA)? If yes, the client is ineligible for MA. If no, the analysis continues to Step 2. 20 CFR 416.920(b).

2. Does the client have a severe impairment that has lasted or is expected to last 12 months or more or result in death? If no, the client is ineligible for MA. If yes, the analysis continues to Step 3. 20 CFR 416.920(c).

3. Does the impairment appear on a special listing of impairments or are the client's symptoms, signs, and laboratory findings at least equivalent in severity to the set of medical findings specified for the listed impairment? If no, the analysis continues to Step 4. If yes, MA is approved. 20 CFR 416.290(d).

4. Can the client do the former work that he/she performed within the last 15 years? If yes, the client is ineligible for MA. If no, the analysis continues to Step 5. 20 CFR 416.920(e).

5. Does the client have the Residual Functional Capacity (RFC) to perform other work according to the guidelines set forth at 20 CFR 404, Subpart P, Appendix 2, Sections 200.00-204.00? If yes, the analysis ends and the client is ineligible for MA. If no, MA is approved. 20 CFR 416.920(f).

Claimant has not been employed since March 2011; consequently, the analysis must move to Step 2.

In this case, Claimant has presented the required medical data and evidence necessary to support a finding that Claimant has significant physical limitations upon her ability to perform basic work activities.

Medical evidence has clearly established that Claimant has an impairment (or combination of impairments) that has more than a minimal effect on Claimant's work activities. See Social Security Rulings 85-28, 88-13, and 82-63.

In the third step of the sequential consideration 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. This Administrative Law Judge finds that the Claimant's medical record will not support a finding that Claimant's impairment(s) is a "listed impairment" or equal to a listed impairment. See Appendix 1 of Subpart P of 20 CFR, Part 404, Part A. Accordingly, Claimant cannot be found to be disabled based upon medical evidence alone. 20 CFR 416.920(d).

In the fourth step of the sequential consideration of a disability claim, the trier of fact must determine if the claimant's impairment(s) prevents claimant from doing past relevant work. 20 CFR 416.920(e). It is the finding of this Administrative Law Judge, based upon the medical evidence and objective physical findings that Claimant cannot return to her past relevant work because the rigors of working as an in-home direct care

provider are completely outside the scope of her physical abilities given the medical evidence presented.

In the fifth step of the sequential consideration of a disability claim, the trier of fact must determine if the claimant's impairment(s) prevents claimant from doing other work. 20 CFR 416.920(f). This determination is based upon the claimant's:

(1) residual functional capacity defined simply as "what can you still do despite you limitations?" 20 CFR 416.945;

(2) age, education, and work experience, 20 CFR 416.963-.965; and

(3) the kinds of work which exist in significant numbers in the national economy which the claimant could perform despite his/her limitations. 20 CFR 416.966.

See *Felton v DSS* 161 Mich. App 690, 696 (1987). Once claimant reaches Step 5 in the sequential review process, claimant has already established a *prima facie* case of disability. *Richardson v Secretary of Health and Human Services,* 735 F2d 962 (6th Cir, 1984). At that point, the burden of proof is on the state to prove by substantial evidence that the claimant has the residual functional capacity for substantial gainful activity.

After careful review of Claimant's extensive 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 significant numbers 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 her April 14, 2011 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 April 14, 2011 MA/Retro-MA application, and shall award her all the benefits she may be entitled to receive, as long as she meets the remaining financial and non-financial eligibility factors.

2. The department shall review Claimant's medical condition for improvement in January 2014, unless her Social Security Administration disability status is approved by that time.

3. The department shall obtain updated medical evidence from Claimant's treating physicians, physical therapists, pain clinic notes, etc. regarding her continued treatment, progress and prognosis at review.

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

Date Signed: 1/23/12

Date Mailed: 1/23/12

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

cc:
Shiawassee County DHS

DHS-DDS
V. Armstrong