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

IN THE MATTER OF:

[redacted]

Reg. No.: 2012-21475
Issue No.: 2009
Case No.: [redacted]
Hearing Date: March 1, 2012
County: Kent County

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

HEARING DECISION

This matter is before the undersigned Administrative Law Judge upon the Claimant's request for a hearing made pursuant to Michigan Compiled Laws 400.9 and 400.37, which govern the administrative hearing and appeal process. After due notice, a telephone hearing was commenced on March 1, 2012, from Lansing, Michigan. Claimant personally appeared and testified. Participants on behalf of the Department of Human Services (Department) [redacted]

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 May 2, 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 August 31, 2011, Claimant filed an application for MA and Retro-MA benefits alleging disability.

(2) On November 28, 2011, the Medical Review Team (MRT) denied Claimant's application for MA-P indicating that her impairments lacked 12

months duration. MRT granted Claimant's application for State Disability Assistance (SDA).

(3) On December 5, 2011, the department caseworker sent Claimant notice that her MA application was denied.

(4) On December 27, 2011, Claimant filed a request for a hearing to contest the department's negative action.

(5) On February 9, 2012 the State Hearing Review Team (SHRT) found Claimant was not disabled, and retained the capacity to perform her past work as a store manager. As a result, the SHRT found that based on Claimant's vocational profile (younger individual, 12th grade education, and medium work history), MA-P was denied using Vocational Rule 203.29 as a guide. (Department Exhibit B).

(6) On May 2, 2012, the SHRT again denied Claimant's application for MA/Retro-MA, indicating Claimant retained the capacity to perform her past work as a store manager, and denied her MA-P based on Claimant's vocational profile (younger individual, 12th grade education, and light work history), using Vocational Rule 202.21 as a guide. (Department Exhibit C).

(7) Claimant has a history of pancreatitis, colitis, urinary tract infection, acute renal failure, bulging discs, degenerative disc disease, bleeding ulcers, hernia, kidney infections, and kidney stones.

(8) On March 30, 2011, Claimant went to the emergency department (ED) with right flank pain and right lower quadrant pain. A CAT scan of the abdomen and pelvis was performed which showed an obstruction of the right ureter due to 0.6 cm calculus at the right ureteropelvic junction with extravasation of same fluid into perinephric space, a few diverticula were present in the sigmoid colon without evidence of acute inflammation. Urology consultation was requested and she was admitted for further evaluation and treatment and started on antibiotics. Assessment/Plan: (1) Right flank pain diagnosed with right ureteric stone and extravasation of fluid into perinephric space; (2) Electrolyte imbalance; (3) Elevated liver enzymes; (4) Hypertension; and (5) Inguinal hernia. Claimant was taken for cystoscopy with a ureteral stone. Urology placed a ureteral stent due to obstructive ureter from nephrolithiasis. She remained intubated postop. She was hypertensive, placed on a Cardene drip, and then subsequently became hypotensive. She is currently now on Levophed and was given at least 4 amps of sodium bicarb as well as some magnesium. Pulmonary Critical care consultation was obtained. Assessment: (1) Respiratory failure; (2) Septic shock, likely secondary from obstructive uropathy; and (3) Metabolic acidosis. Clinically, she has sepsis with possible disseminated intravascular coagulation. Her 2-D echocardiogram with

color flow Doppler study does reveal hyperdynamic left ventricular function with a left ventricular ejection fraction estimated at 70%. She has worsening thrombocytopenia, and abnormal coagulations. She also has worsening anemia. Urine cultures and blood cultures did show E coli. April 8, 2011, Claimant was in no apparent distress but complaining of lower extremity pain. An ultrasound was ordered and showed generalized subcutaneous edema and no other acute finding in the ankles were reported. Assessment/Plan: (1) Ureteric stone status post stenting. Claimant has been urinating without difficulty; (2) Urosepsis. Claimant has been afebrible. Leukocytosis improved; (3) Acute renal failure gradually improving; (4) Anemia. Mild decrease in hemoglobin and hematocrit, however, she is hemodynamically stable with no acute signs or symptoms of bleeding. Thrombocytopenia improving gradually; (5) Hypertension. Blood pressure currently controlled; (6) Respiratory failure. No acute issues anymore. Claimant is stable; (7) Dysphagia. Claimant was evaluated by a speech therapist. Barium swallow ordered; (8) Foot pain. This has been improved; however, she still has some discomfort and test has been unremarkable. She has no previous history of gout; (9) Encourage Claimant to get physical therapy; and (10) Disposition depends on consultant's recommendation and Claimant's progress. If her CBC continues to improve and she remained stable, anticipate discharge home once antibiotics can be switched to P.O. Claimant was discharged on April 8, 2011. (Department Exhibit A, pp 417-418, 421-618).

(9) On April 13, 2011, Claimant was admitted to the hospital with right flank pain and right lower quadrant pain. She was evaluated with a CAT scan which showed nephrolithiasis. She was seen by a Urologist and started on antibiotics for a urinary tract infection. Her liver enzymes were elevated and she was seen by GI. Her hemoglobin and hematocrit dropped and she was given 2 units of RBC. Post transfusion, her hemoglobin and hematocrit remained stable. Claimant was discharged on April 18, 2011, with a diagnoses of (1) Right flank pain, resolved; (2) Generalized aches and pain and body weakness improved; (3) Right inguinal hernia; (4) Nephrolithiasis with previous history of nephrolithiasis; (5) History of ureteric stone status post stent; (6) Disseminated intravascular coagulopathy; (7) History of respiratory distress; (8) Hypertension; (9) Deconditioning; (10) Urinary tract infection; and (11) History of urosepsis. (Department Exhibit A, pp 335-416).

(10) On May 18, 2011, Claimant went to the (ED) complaining of right flank pain. She was just recently in the hospital for removal of right double-J stent and renal calculi retrieval. Claimant has been taking her antibiotics as instructed. She has had nausea, vomiting, shortness of breath, generalized abdominal pain, chills, decreased appetite, and decreased sleep. Diagnoses: (1) Questionable narcotic-seeking behavior; (2) Right renal colic. (Department Exhibit A, pp 275-279).

(11) On May 21, 2011, Claimant was admitted to the hospital with right flank pain and some epigastric tenderness. She has mild right lower quadrant tenderness. Her creatinine was mildly elevated at 1.26, white count 7.8. Chest x-ray and VQ scan are negative. Renal ultrasound showing borderline prominence of the right medial collection system significantly improved since previous ultrasound dated 5/9/11. There was no stone noted or evidence of pancreatic inflammation. She was discharged on May 27, 2011, with diagnoses: (1) Suspected gallstone pancreatitis; (2) Nephrolithiasis status post recent stone extraction; (3) Probably pyelonephritis; (4) Deconditioning; (5) Anemia secondary to above; (6) Recent episode of sepsis with acute respiratory distress syndrome in a different state; (7) Hypertension with left ventricular hypertrophy; and (8) Status post bariatric surgery in 2000. (Department Exhibit A, pp 229-274).

(12) On May 30, 2011, Claimant was admitted to the hospital after being recently discharged on May 28, 2011, when she was admitted with gallstone pancreatitis, pyelonephritis, and also developed Clostridium difficile prior to discharge for which she was discharged on oral antibiotics. According to Claimant, after she went home, she developed nausea and vomiting with almost no oral intake and she was not even able to tolerate her oral antibiotics. She also complained of right flank and right lower quadrant abdominal pain. An initial CAT scan of the abdomen in the ED showed a moderate-sized area of focal scarring midpole of the right kidney associated with the 8 mm calcification or renal calculus close to the cortex of the kidney. Due to her intolerance to P.O. intake she was started on IV antibiotic for the C. diff. Once Claimant's electrolyte imbalances were corrected as well as after the oral intake improved, she was discharged on June 3, 2011, with diagnoses (1) Intractable nausea and vomiting, multifactorial, likely secondary to pyelonephritis and Clostridium difficile colitis; (2) Pyelonephritis with Rescherichia coli and enteroccous species; (3) Clostridium difficile colitis; (4) Non-anion gap metabolic acidosis; (5) Hypokalemia, resolved; (6) Intractable right-sided abdominal and flank pain most likely secondary to Clostidium difficile colitis; (7) History of kidney stones, and (8) Hypertension. (Department Exhibit A, pp 206-228).

(13) On June 7, 2011, Claimant went to the ED complaining that she could not afford the medications that were prescribed to her on discharge from the hospital on 6/3/11. She had no new or worsening symptoms. She stated she was running out of her pain medications. Vitals were normal with the exception of her blood pressure of 165/110. She requested a prescription for some pain medication and was written a prescription for 6 tablets of Norco. (Department Exhibit A, pp 202-205).

(14) On June 11, 2011, Claimant was admitted to the hospital with complaints of abdominal pain. She had completed a course of amoxicillin and Ceftin before this admission. During this admission, Claimant also had diarrhea associated with nausea and mild fever and chills. On this admission, her labs showed normal urinalysis. She also underwent a renal ultrasound which showed stable calcification in the right kidney upper pole. A CAT scan of the abdomen and pelvis were done to see if her symptoms were from an abscess around the kidney but it was negative. It did show an 8 mm calcification in the right kidney but it was stable and unchanged from previous CT scan. Urology was also consulted as she had a history of kidney stones. They recommended that the pain is not likely to go to her renal calculi which is stable and her urinalysis was normal. She did get IV blood pressure medications in the ED for hypertensive urgency but in the hospital her blood pressure was low so her blood pressure medications were held off during her hospital stay. Her abdominal pain was likely felt secondary to colitis. Claimant was discharged on June 23, 2011, with a diagnoses of (1) Abdominal pain secondary to Clostridium colitis; (2) Clostridium difficile colitis; (3) Acute renal insufficiency secondary to diarrhea; (4) History of nephrolithiasis; (5) History of pyelonephritis; and (6) Hypertension. (Department Exhibit A, pp 174-201).

(15) On June 20, 2011, Claimant went to the ED for evaluation of her chronic migraine. On admission, she was found to have significant dehydration with acute renal failure, as well as metabolic acidosis, which was felt to be secondary to stool loss from diarrhea. She was given IV fluids and was treated for her headache. She complained initially of dyspnea on exertion and a heavy sensation in her chest. EKG's were completed and were negative, even while she was having the discomfort. A 2-D echocardiogram was normal. Claimant has a history of multiple hospitalizations over the last 3 months, starting with the ICU stay secondary to a complicated UTI and nephrolithiasis with sepsis in Texas. She moved to Michigan and had a repeat hospitalization. She was found to have gallstone pancreatitis, pyelonephritis and Clostridium difficile colitis. She was treated for these issues and sent home, however, she returned with intractable nausea and vomiting. She was unable to tolerate her medications orally, therefore, she was admitted to complete her antibiotic course and for rehydration. She was discharged on June 23, 2011, with a diagnoses of (1) Intractable migraine headache; (2) Acute renal failure; (3) Metabolic acidosis secondary to diarrhea; (4) Recent Clostridium difficile colitis with persistent diarrhea; (5) Abdominal pain; (6) Urinary hesitancy likely related to poor urine production from dehydration; (7) Chest heaviness with dyspnea on exertion, felt to be secondary to deconditioning and generalized weakness; (8) Protein caloric malnutrition secondary to poor oral intake; (9) Generalized weakness with improvement in physical therapy; (10) Accelerated hypertension; (11) History of cholelithiasis and intensive care unit stay for complicated urinary

tract infection a few months back; (1) Elevated TSH with normal T4. (Department Exhibit A, pp 137-173).

(16) On July 26, 2011, Claimant was admitted to the hospital after going to the emergency department with right flank pain. Claimant had an elevated AST, ALT, and alkaline phosphatase. The etiology was unclear, but believed to be from previous Tylenol ingestion for the abdominal pain plus alcohol Claimant drank a few days before admission. She had a right upper quadrant ultrasound done on July 26, 2011, showing mild biliary ductal dilatation measuring 10 mm to 11 mm. She also had a CAT scan of the abdomen and pelvis on July 26, 2011, showing a stable 8 mm nonobstructing calculus in the midpole of the right kidney. No acute intraabdominal or intrapelvic abnormalities present. Fat-containing right femoral hernia incidentally noted. Her hypertension was controlled during her hospital course and her right inguinal hernia was not complicated. Claimant was discharged on July 28, 2011, with diagnoses of (1) Nephrolithiasis; (2) Acute kidney injury due to dehydration; (3) Elevated transaminase due to ingestion of Tylenol plus alcohol ingestion; (4) History of multiple transfusions; (5) Non-anion gap metabolic acidosis secondary to acute kidney injury; (6) Hypothyroidism; (7) Hypertension; and (8) Right inguinal hernia. (Department Exhibit A, pp 105-136).

(17) On August 2, 2011, Claimant went to the emergency department complaining of epigastric and left upper quadrant pain which was sharp in nature, radiating towards the back which started only 2 days after she was discharged from the hospital for pancreatitis. The lab work showed her to be in acute renal failure with a creatinine of 1.45 and she had a UTI. She was also mildly acidotic with a HCO3 of 12. She is alert but does appear anxious and uncomfortable. She was admitted to the hospital. On August 3, 2011, an esophagogastroduodenoscopy and biopsy was performed. Endoscopic diagnosis was marginal ulcers, possibly responsible for nausea and S/P Roux en Y gastric bypass. On August 6, 2011, Claimant was improved and stable for discharge. Discharge Diagnoses: (1) Epigastric pain with nausea and vomiting with positive marginal ulcers on esophagogastroduodenoscopy; (2) Hypokalemia; (3) Urinary tract infection; (4) Acute renal failure secondary to dehydration, resolved; (5) Elevated liver function tests; (6) Hypertension; and (7) History of Clostridium difficile. (Department Exhibit A, pp 70-104).

(18) On August 14, 2011, Claimant was seen in the emergency room complaining of a migraine, flank pain and tooth pain. She has just recently been discharged from the hospital for the same complaints. Regarding her migraine and flank pain, she stated that this is not the worst pain she has ever experienced and just wants some pain control. Claimant was afebrile with an elevated blood pressure of 155/114. She went for a CT which did not demonstrate any obvious abnormalities. It was felt Claimant

could continue to treat herself at home, especially as she was sleeping when examined. She did not have any significant abnormalities of her lab findings in addition to a reassuring clinical exam. She was discharged in stable condition. (Department Exhibit A, pp 61-69).

(19) On August 22, 2011, Claimant went to the ED complaining of off and on abdominal pain since May. She was admitted from August 2 to August 6 with epigastric pain with nausea and vomiting. She had positive marginal ulcers seen on the esophagogastroduodenoscopy and was noted to have slightly elevated liver functions at that time. She was discharged at that time with Norco. She has not had any hematemesis but has epigastric pain that radiates to her back. Claimant's CT was negative and she was discharged home. (Department Exhibit A, pp 51-60).

(20) On August 24, 2011, Claimant went to the ED complaining of right flank pain for the past 5 days. Claimant stated that she was seen in the ED 2 days ago and was told she had a urinary tract infection and possibly a kidney infection and if she got to worse, to come back to the hospital. Claimant also has a bulging inguinal hernia. She agreed to be sedated for the reduction, and was discharged in stable condition. (Department Exhibit A, pp 46-50).

(21) On August 29, 2011, Claimant went to the ED for flank pain radiating to the groin. Claimant appeared uncomfortable. Her blood pressure was 166/108. She does have a right inguinal hernia. However, the size is difficult to assess secondary to the significant redundant skin in the area. History of nephrolithiasis and pain persisting despite antibiotic treatment for urinary tract infection. This is possibly secondary to hydronephritis versus nephrolithiasis. A recent CT scan from 8/22/11, shows a nonobstructing 8 mm calculus in the right kidney. Another CT scan will be run. Epigastric pain. Claimant has a history of pancreatitis along with chronic nausea, vomiting and anorexia for 3 days. Lipase will be checked and a lipid panel run. Macrocytic anemia is likely secondary to malabsorption of B12 status post gastric bypass. Recent hospitalization and intensive care unit stay for sepsis. CT scan imaging of the abdomen and pelvis shows no obvious intra-abdominal or pelvic process other than the small fat containing right inguinal hernia. Because there were obstructive symptoms, the hernia was treated with pain control. Claimant had a CT abdomen and pelvis with IV contrast done which showed no acute intraabdominal or pelvic process. Exam is stable. She also had an MRI of the lumbar spine which showed degenerative disc disease and mild disk bulging within the lumbar spine. Claimant also had an MRI of the thoracic spine down which showed mild degenerative changes in the thoracic spine. Claimant was discharged on August 31, 2011 with diagnoses of (1) Right flank pain, unclear etiology, workup negative. Claimant does have some narcotic-seeking behavior; (2) Elevated liver

function tests, unclear etiology, workup negative in the past, improving; (3) Right inguinal hernia, reducible, seen by general surgery; (4) History of recurrent urinary tract infections with history of urosepsis; (5) History of nephrolithiasis; (6) History of recurrent Clostridium difficile; (7) Chronic nausea and vomiting. (Department Exhibit A, pp 16-45).

(22) On September 6, 2011, Claimant underwent a medical examination on behalf of the department. Claimant's current diagnosis included deconditioning and a right inguinal hernia. The examining physician found Claimant's condition was improving and she was expected to return to work on December 15, 2011. The physician found Claimant had no mental limitations. Claimant was limited to lifting less than 10 pounds frequently, and no more than 20 pounds occasionally during 1/3 of an 8-hour day, and standing/walking for at least 2 hours a day, and able to sit for 6 hours a day. Claimant was not limited on using her arms, for simple grasping, reaching, pushing/pulling, and fine manipulation, or her feet and legs to operate foot/leg controls. (Department Exhibit A, pp 283-284).

(23) On September 17, 2011, Claimant was admitted to the hospital after going to the ED complaining of right lower quadrant pain. She had an x-ray of her kidneys, ureters and bladder (KUB) done. The KUB showed a kidney stone in the right upper lobe of the kidney. She also was adequately controlled for pain with a Dilaudid IV. Also, during her presentation, the exam showed that she had a right inguinal hernia. Surgery was consulted and found the hernia was not strangulated and was reducible. Claimant was discharged on September 20, 2011, with diagnoses (1) Urolithiasis; (2) Inguinal hernia; (3) Hypertension; (4) Euthyroid sick syndrome; (5) Marginal ulcer, stable; (6) History of migraines, stable. (Department Exhibit A, pp 311-328).

(24) On October 6, 2011, Claimant went to the emergency department for a left elbow injury after a fall. There was no acute fracture on the x-ray. No joint effusion present. There did appear to be some subcutaneous edema about the medial aspect of the distal arm and proximal forearm. She had a normal noncontrast CT of the head. An MRI of the brain showed no acute infarction. Brain volume and ventricle size were within normal limits. Claimant states that after taking Neurontin, she started feeling dizzy. She complained of losing her balance, an inability to think, depressive symptoms and crying spells for no good reason since taking this medication. Today when she got up she became ataxic, fell on her right side and hit her head and left arm on the door. On walking she is mildly ataxic and the finger-to-nose test is mildly disturbed on the right side. At this point she is not ambulating safely and will be admitted. She was discharged on October 8, 2012, with diagnoses of (1) Dizziness, ataxia, emotional lability, much improved; (2) Elevated AST, ALT, and alkaline phosphatase, clearly trending down; (3) Hypochloremic chronic metabolic

acidosis stable; (4) Macrocytosis; (5) Hypertension; (6) Fall, leading to a bruised left elbow; (7) History of hypothyroidism; and (8) Gastroesophageal Reflux Disease (GERD). (Department Exhibit A, pp 677-702).

(25) On October 24, 2011, Claimant went to the ED complaining of right-sided flank pain. Slight sweats and chills with this as well. Claimant has a history of kidney stones, renal stones, elevated blood pressure, gastric ulcers, pancreatitis and an inguinal hernia. She appeared to be in pain. Ultrasound of kidneys and ureters was negative. No stones or hydronephrosis noted. Claimant's blood pressure was elevated. (Department Exhibit A, pp 670-676).

(26) On November 18, 2011, a CAT scan of Claimant's abdomen showed a new 2 mm calculus at the upper pole of the right kidney. Peripheral to this is a stable 8 mm calculus in the right kidney. The right kidney remains atrophic with probably cortical scarring. There is no left nephrolithiasis. No ureteral calculi and no evidence for obstructive uropathy. (Department Exhibit A, p 669).

(27) On November 21, 2011, Claimant went to the ED complaining of abdominal pain over the past three days. She also had some increased nausea and vomiting as well. She states she took approximately 45 to 50 Tylenol tablets over the course of a day to take away the pain. Claimant denies suicidal ideation and states she had no idea of the potentially severe side effects of a Tylenol overdose. She was admitted to the hospital. An ultrasound of Claimant's kidneys and bladder showed no change in appearance. No hydronephrosis is appreciated. Again noted is some scarring and volume loss in the right kidney and a parenchymal calcification measuring 8 mm. An ultrasound of the right upper quadrant found no liver mass was seen. The liver was normal in size, echogenicity and configuration. No dilation of the intrahepatic bile duct was seen. The internal diameter of the proximal portion of the common bile duct is 1 cm, which is borderline dilated as for a postcholecystectomy patient, and is currently changed compared to prior exam from 7/26/11. There is a right inguinal hernia noted approximately 3 to 5 cm diameter. The hernia is reducible with some effort, although this does cause Claimant some moderate discomfort. Serum acetaminophen level during the time of admission showed she had a slightly elevated acetaminophen blood level of 70.2 with upper limit of normal being 30.0. Claimant does have a history of kidney stones and had a CAT scan of her abdomen as an outpatient which showed she had a stone in the kidney but no ureteral lithiasis. She was discharged on November 24, 2011, with a diagnoses of (1) Tylenol overdose, resolved without any Campylobacter coli; (2) Hypertension, stable; (3) Migraine, stable; (4) Hyperthyroidism, stable; (5) Gastroesophageal reflux disease (GERD); (6) Chronic nausea and

vomiting, controlled; and (7) Inguinal hernia, stable. (Department Exhibit A, pp 637-668).

(28) On December 5, 2011, Claimant was at her physician's office being evaluated for chronic pain, when it was noted that she was hypertensive and was sent to the ED. Her blood pressure was well over 200 systolic. She was given a 20 mg dose and then a 40 mg dose of Labetalol and then 20 mg of hydralazine. On recheck, her blood pressure had decreased to approximately 170 systolic. She had also received Vicodin for pain control. Claimant's chest x-ray and EKG were normal and blood work that had also been performed was within normal limits. The clinic chief was contacted to discuss the case. The chief stated that this was typical for Claimant, and that when she is hospitalized she is given the same dosage of blood pressure medications that she has at home and she has excellent control of her blood pressure, but once she is sent home, her hypertension returns. Noncompliance was suspected. Therefore, no changes were made in her medication and Claimant was stable and improved and sent home. (Department Exhibit A, pp 626, 629-636).

(29) On December 21, 2011, Claimant's chest x-rays were compared to the x-rays taken on 12/5/11, and showed no evidence of acute cardiopulmonary disease or significant interval change. The lower thoracic and upper lumbar spine was poorly visualized and aortic dissection could not be excluded on the scoliosis plain films. There was minimal levocurvature of the upper lumbar spine and a mild pelvic and shoulder tilt with the left hip and shoulder higher than the right. This could be seen with the leg length discrepancy. (Department Exhibit A, pp 620-621).

(30) At the time of the hearing, Claimant was 46 years old with a [redacted], birth date; was 5'2" in height and weighed 174 pounds.

(31) Claimant is a high school graduate. Her work history includes being a store manager.

(32) 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).

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 December 2010. 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 pancreatitis, colitis, urinary tract infection, acute renal failure, bulging discs, degenerative disc disease, bleeding ulcers, hernia, kidney infections, and kidney stones.

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 Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, 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 pancreatitis, colitis, urinary tract infection, acute renal failure, bulging discs, degenerative disc disease, bleeding ulcers, hernia, kidney infections, and kidney stones.

Listing 1.00 (musculoskeletal system), Listing 3.00 (respiratory system), Listing 4.00 (cardiovascular system), Listing 5.00 (digestive system), Listing 6.00 (genitourinary impairments), and Listing 9.00 (endocrine 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 work as a store manager. In light of Claimant's testimony, and in consideration of the Occupational Code, Claimant's prior work is classified as unskilled, light work.

Claimant testified that she is able to walk short distances, cannot stand for any amount of time, can sit for approximately 30 minutes and can lift/carry approximately 2 pounds. The objective medical evidence notes limitations in lifting no more than 10 pounds, and no standing/walking for more than 2 hours a day. 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 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 46 years old and was, thus, considered to be a younger individual for MA-P purposes. Claimant has a high school 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 Claimant to the Department to present proof that 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 pancreatitis, colitis, urinary tract infection, acute renal failure, bulging discs, degenerative disc disease, bleeding ulcers, hernia, kidney infections, and kidney stones. The objective medical evidence notes limitations in sitting, standing, walking, lifting and carrying. 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 sedentary 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 201.21**,** it is found that 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 is 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: 5/23/12

Date Mailed: 5/23/12

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