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

IN THE MATTER OF:

[redacted]

Reg. No.: 2012-28633
Issue No.: 2009
Case No.: [redacted]
Hearing Date: April 17, 2012
County: Genesee 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 April 17, 2012, from Lansing, Michigan. Claimant, represented by [redacted], personally appeared and testified. Participants on behalf of the Department of Human Services (Department) included [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 21, 2012, the SHRT found Claimant was not disabled. This matter is now before the undersigned for a final decision.

ISSUE

Whether the Department of Human Services (the department) properly denied Claimant's application for Medical Assistance (MA-P) and Retro-MA?

FINDINGS OF FACT

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

(1) On July 7, 2011, Claimant filed an application for MA and Retro-MA benefits alleging disability.

(2) On August 19, 2011, the Medical Review Team (MRT) denied Claimant's application for MA-P and Retro-MA indicating that she was capable of performing other work, pursuant to 20 CFR 416.920(f).

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

(4) On January 6, 2012, Claimant filed a request for a hearing to contest the department's negative action.

(5) On March 9, 2012, and May 21, 2012, the State Hearing Review Team (SHRT) found Claimant was not disabled. (Department Exhibit B, pp 1-2; Department Exhibit C, pp 1-2).

(6) Claimant has a history of chronic obstructive pulmonary disease (COPD), asthma, acute coronary syndrome, coronary artery disease, status post percutaneous transluminal coronary angioplasty (PTCA), myocardial infarction, drug-eluting stents to the circumflex and right coronary artery in 2006, a known right bundle branch block, left catheterization in June 2009 that showed patent stents, normal left main and left anterior descending and ejection fraction of 55%, hypertension, hyperlipidemia, chest, back and lower leg pain, and mild emphysema.

(7) On January 19, 2009, Claimant saw her cardiologist for a consultation regarding her coronary artery disease, shortness of breath, and palpitations. Apparently, she had PTCA and stenting of the right coronary artery in January of 2006. Her EKG revealed sinus bradycardia, rate 49 beats per minute, right bundle branch block. Claimant was scheduled for cardiac echocardiography to evaluate her left ventricular function for risk stratification and pulmonary artery pressure; also, a stress Myoview to evaluate for progression of coronary artery disease. She will return for follow-up after the above tests are completed for further recommendations. (Claimant Exhibit A, pp 13-14).

(8) On February 15, 2009, Claimant was evaluated by her cardiologist. Her treadmill stress test revealed a good exercise capacity, normal blood pressure response to exercise, and no exercise-induced chest pain or ischemic ST segment changes. In summary, Claimant has an uncontrolled lipid profile. She has just recently started on Zocor. She has had no side effects to medications. She will have a lipid profile in three months and follow-up in six months with echocardiography to evaluate left ventricular function and pulmonary artery pressure. She received a prescription for nitroglycerin. (Claimant Exhibit A, pp 9-10).

(9) On June 15, 2009, Claimant was evaluated by a cardiologist for a posthospital discharge follow-up visit. She was recently admitted with

acute coronary syndrome. A myocardial infarction was ruled out and she was discharged home for follow-up. She admits to episodes of shortness of breath, chest fluttering, and chest tightness. She has a history of coronary artery disease and prior PTCA and stenting of right coronary artery in 2006. She was diagnosed with angina, palpitations, and shortness of breath. She will be scheduled for a cardiac catheterization to evaluate her coronary anatomy and possible further intervention. (Claimant Exhibit A, pp 7-8).

(10) On November 23, 2009, Claimant underwent a pulmonary function test which showed a severe obstructive pattern with good response to bronchodilators which was consistent with asthma. (Department Exhibit A, pp 60-65).

(11) On June 12, 2011, Claimant was admitted to the hospital for chest pain. Her pain was associated with mild diaphoresis and occasional palpitations. She had a history previously of a myocardial infarction and coronary artery disease. She underwent acute coronary syndrome protocol, stress testing and a heart catheterization. Her chest x-ray was negative. Her EKG showed sinus rhythm, sinus bradycardia in the 50s with a right bundle branch block with no acute changes. On June 14, 2011, a myocardial perfusion with Persantine was performed which showed a small apical posterior reversible defect. No other pertusion defect. Left ventricular ejection fraction was 70% with normal left ventricle wall motion. On June 16, 2011, a left heart catheterization, left coronary angiogram and left ventriculogram were performed based on her positive stress test and chest pain. Findings: Left main was short and had 20% ostial lesion. All her coronaries were small vessel. Left anterior descending artery at 30% midsegment stenosis. Diagonal branch was patent and normal angiographically. Obtuse marginal system was patent and normal angiographically. Right coronary artery was patent and normal angiographically except for the area inside the stent. There was a 10% in-stent restenosis. Left ventriculogram revealed ejection fraction of 65%. Final Impression: Mild nonobstructive coronary artery disease. She was discharged on June 17, 2011, on Metoprolol, Trazodone, Zanaflex, Simvastatin, Naproxen, Amlodipine, Colace, Aspirin, and Mylanta, Tylenol, and nitroglycerin as needed. She will follow-up in the next week or two. (Department Exhibit A, pp 72-110).

(12) On January 30, 2012, Claimant went to her primary care physician and was diagnosed with localized joint pain in her shoulder, herpes zoster (shingles), and a thoracic strain and was prescribed Acyclovir, Prednisone, and Triamcinolone Acetonide ointment. (Claimant Exhibit B, pp 47-48).

(13) On February 17, 2012, Claimant saw her primary care physician and was diagnosed with joint pain, localized in the shoulder, and a thoracic sprain and prescribed Cyclobenzaprine and Tramadol. (Claimant Exhibit B, pp 45-46).

(14) On February 22, 2012, Claimant went to see her primary care physician who upon examination sent her to the emergency department with chest pain. She appeared to be in mild distress. The chest pain got better in the emergency room with the administration of aspirin and nitroglycerin. EKG showed normal sinus rhythm, rate of 77 with right bundle branch block. She was diagnosed with unstable angina. She was negative for myocardial infarction with troponins negative x4. She had recent left heart catheterization in June 2011 which showed mild nonobstructive coronary artery disease with no intervention. She was currently chest pain free with no recurrences. No additional workup was provided at the time. If she continued to have chest pain, will repeat nuclear stress test or other workup. She has a history of coronary artery disease, myocardial infarction with history of angioplasty and stents, all stable. She has a history of hypertension but her blood pressure was slightly low, which may have been causing her feeling of lightheadedness. Her Metroprolol will be decreased. Her chronic obstructive pulmonary disease was stable, as was her history of right bundle block. (Claimant Exhibit B, pp 1-14, 43-44).

(15) On February 27, 2012, Claimant saw her primary care physician and was diagnosed with acute conjunctivitis and a urinary tract infection. She was prescribed Ciproflaxin and Tobramycin Sulfate and instructed to seek medical advice if worsening symptoms or concerns, or no prompt resolution of symptoms in 4-7 days. (Claimant Exhibit B, pp 41-42).

(16) On March 30, 2012, Claimant was seen by her primary care physician for shoulder pain, herpes, acute thoracic back pain, and chronic bronchitis with acute exacerbation. Palpatory findings along the thoracic spine included bilateral muscle spasms, left-sided muscles spasms, and right-sided muscle spasms. Claimant was diagnosed with a thoracic strain and chronic bronchitis with acute exacerbation and prescribed Acyclovir, Prednisone, Cephalexin, and Triamcinolone Acetonide ointment. (Claimant Exhibit B, pp 37-40).

(17) Claimant is a 52 year old woman whose birthday is [redacted]. Claimant is 4'11" tall and weighs 110 lbs. Claimant completed high school.

(18) Claimant had applied for Social Security disability benefits at the time of the hearing.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department, (DHS or department), pursuant to MCL 400.10 *et seq.* and MCL 400.105. Department policies are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM), and the Reference Tables Manual (RFT).

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a). The person claiming a physical or mental disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and, (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (e.g., age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In Claimant's case, the ongoing palpitations, shortness of breath 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 not 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 2006; 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 and mental 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 medical findings, that Claimant cannot return to her past relevant work because the rigors of working as an assistant manager at a Dollar Store which included unloading trucks and stocking shelves, are completely outside the scope of her physical and mental 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 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 Claimant has the residual functional capacity for substantial gainful activity.

After careful review of Claimant's 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). Based on Claimant's vocational profile (approaching advance age, Claimant is 52, has a 12th grade education and an

unskilled work history), this Administrative Law Judge finds Claimant's MA and Retro/MA approved using Vocational Rule 201.12 as a guide. Consequently, the department's denial of her July 7, 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 July 7, 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 June, 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.

It is SO ORDERED.

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

Date Signed: 6/12/12

Date Mailed: 6/12/12

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