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

IN THE MATTER OF:

[redacted]

Reg. No.: 2012-29128
Issue No.: 2009
Case No.: [redacted]
Hearing Date: April 11, 2012
County: Kalamazoo

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, a telephone hearing was held on April 11, 2012. Claimant, her sister, and three daughters, 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 June 1, 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 September 19, 2011, Claimant filed an application for MA and Retro-MA benefits alleging disability.

(2) On December 6, 2011, the Medical Review Team (MRT) denied Claimant's application for MA-P indicating that she was capable of performing other work, pursuant to 20 CFR 416.920(f).

(3) On January 13, 2012, the department caseworker sent Claimant notice that her application was denied.

(4) On January 30, 2012, Claimant filed a request for a hearing to contest the department's negative action.

(5) On March 12, 2012, and June 1, 2012, the State Hearing Review Team (SHRT) found Claimant was not disabled. (Department Exhibit B, p 1; Department Exhibit C, p 1).

(6) Claimant has a history of seizures, rheumatoid arthritis, bipolar disorder, migraines, degenerative disc disease, chronic obstructive pulmonary disease (COPD), chronic back and hip pain, asthma, dyslipidemia, attention deficit disorder (ADD), restless leg syndrome, post traumatic stress disorder and anxiety.

(7) On September 5, 2011, Claimant went to the emergency department complaining of shortness of breath. She denied any chest or abdominal pain. She had expiratory wheezing with some questionable crackles in the right base. The examining physician was concerned Claimant may have reactive airway disease versus bronchitis versus pneumonia. She was given a breathing treatment which significantly improved her wheezing, although there were still some questionable rales in the right base. Her EKG showed a normal sinus rhythm and an incomplete right bundle branch block. Final diagnosis was bronchitis, suspected possible early pneumonia and reactive airway disease. (Department Exhibit A, pp 197-200).

(8) On September 7, 2011, Claimant was admitted to the hospital for persistent chest pain with no history of coronary artery disease. Claimant had a cardiac catheterization in 2/2011 that showed an ejection fraction of 50% and normal cardiac arteries at that time. A heart catheterization was performed. The borderline EKG showed sinus bradycardia and an incomplete right bundle branch block. Her chest CT showed she had 2 subcentimeter nodules along the surface of the minor fissure within the right middle lobe, one measuring 7 mm and the other 4 mm. There was some concern that the nodules in the right middle lobe possibly represented metastasis and another progress study in 3 months was recommended. Claimant did not have any pulmonary artery embolism or thoracic aortic aneurysm or dissection. She was discharged on September 9, 2011, with a postoperative diagnosis of nonobstructive coronary heart disease and normal left ventricular systolic function. (Department Exhibit A, pp 183-196).

(9) On September 22, 2011, Claimant saw her primary care physician for follow-up after her latest hospital admission for chest pain. She was

admitted to the hospital and underwent a cardiac catheterization that was normal. They did find that she had bronchitis and also noted that she had some pulmonary nodules on the CT angiogram. She had blood work done in the hospital which was unremarkable except for her cholesterol. Her triglycerides were very elevated at 388, cholesterol was 29, HDL 22, and LDL 109. (Department Exhibit A, pp 179-180).

(10) On October 5, 2011, Claimant was admitted to the hospital for episodes of losing consciousness. She had a history of a seizure disorder as a child. Her abnormal EEG showed a few occasions of single sharp wave-like activity emanating from the left central and parietal head region. Similar activity was seen in the right mid and posterior temporal head region as well. State of drowsiness was also observed during which left central parietal questionable abnormalities were also seen. (Department Exhibit A, pp 389-401).

(11) On December 9, 2011, Claimant saw her rheumatologist for follow-up. Claimant was having pain from her shoulder blade down the right side of her back to the right buttocks. The x-rays of her lumbar spine revealed an L5 limbus vertebra and some facet joint hypertrophy from L4-S1. Her cervical spine x-rays showed osteophyte formation at C3-C6, mild disc space narrowing at C5-C7, moderate left neuroforaminal narrowing at C4-C5, and mild right neural foraminal narrowing at C3-C4. (Department Exhibit A, pp 345-347, 354).

(12) On December 28, 2011, Claimant underwent a psychological evaluation by the Disability Determination Service. Claimant's prognosis was guarded and it was noted that she would definitely benefit from psychological and psychiatric intervention. Claimant appeared to be socially anxious and to have limited social skills. Claimant was clearly depressed and such symptoms would interfere with her ability to work with others on a sustained basis. Furthermore, she appeared capable of managing simple and repetitive tasks but would have difficulties with detailed or complex tasks. She appeared excessively sensitive to common stressors and would likely not manage work stressors adequately. Diagnoses: Axis I: Bipolar disorder; Posttraumatic Stress disorder; Axis V: GAF=45. (Department Exhibit B, pp 3-9).

(13) On January 19, 2012, Claimant went to the emergency department with severe lower back pain and some radiation around both sides of her back to the front of her abdomen. Claimant was tearful and mildly tachycardic. Her pulse improved with analgesia. Her back was tender in both paraspinous areas in the lumbar region. A CT abdomen with contrast showed a mild fatty infiltration of the liver and a 12 mm stable splenic hypodensity probably a hemangioma or other benign lesion. There was subtle soft tissue haziness surrounding the origin of the superior

mesenteric artery. This was new in comparison to her prior examination on 10/13/11. It was nonspecific and could represent some mild edema, contusion, or perhaps retroperitoneal fibrosis. There may be some minimal narrowing at the origin which raised the possibility of vasculitis. The CT of the pelvis showed lower thoracic spine degenerative disc disease with spurring. She was treated with analgesics and antinauseants and advised to follow-up with her primary care physician and released. (Department Exhibit A, pp 330-336).

(14) On January 26, 2012, Claimant saw her neurologist for follow-up. Claimant was started on Depakote ER at her previous visit on 12/14/11. She was also scheduled for a 24-hour ambulatory EEG which was completed on 1/4/12. This revealed moderately independent single sharp wave activity in both parecentral and parietal head regions, more so in the left. She stated that she had been taking Depakote ER 500 mg twice a day and Valporic acid 250 mg twice a day, making the dose 750 mg twice a day. Claimant stated that she is still having seizures, but not as many. This was confirmed by her husband. Her brother also has epilepsy. Claimant's serum Depakote level was within the normal range, but she was still having spells. The examining physician noted that a further increase in Depakote might result in toxicity. Therefore, Claimant was prescribed Keppra to replace Depakote. (Department Exhibit A, pp 369-383).

(15) On March 15, 2012, Claimant went to the emergency room with breakthrough seizures three times the day before. She was admitted for observation and seen by a neurologist who recommended increasing the Keppra dosage to 2000 mg. Claimant remained seizure free and was discharged home with instructions to follow up with her neurologist. Claimant's discharge diagnosis was Seizure disorder with breakthrough seizures, bipolar disorder, anxiety, COPD, and attention deficit disorder. (Department Exhibit A, pp 138-143).

(16) On March 17, 2012, Claimant was seen at the emergency department after a seizure at home. She did not bite her tongue, but there's a question whether she lost control of her bladder. She had a workup for this previously in the past and was admitted last week for "breakthrough seizures." She stated she has several seizures a week. (Department Exhibit A, pp 134-135).

(17) On March 21, 2012, Claimant was seen by her neurologist for follow-up of her complex partial seizure disorder with secondary generalization. She had potential epileptogenicity in both parietal and parecentral head regions. Claimant stated that two days ago she had three seizures in one day while on Keppra 750mg twice a day. She was taken to Borgess Medical Center Emergency Department where the dose was increased to

1000 mg twice a day. Her last seizure was yesterday, and was quite hard and lasted about ten minutes. (Department Exhibit A, pp 136-137, 367-368).

(18) On March 28, 2012, Claimant was seen by her primary care physician for follow-up of her seizures and migraine headaches. Claimant had been hospitalized after three seizures in a row occurred. She began having terrible head pain yesterday, after about a 15-minute seizure. Diagnosis: Classic migraine headache with aura and seizure disorder. Claimant was prescribed Lortab. (Department Exhibit A, pp 402-403).

(19) Claimant is 46 years old with a [redacted] birth date. She is 5'2" in height and weighs 142 pounds.

(20) Claimant completed the eleventh grade. Her work history includes 16 years of house keeping and janitorial work.

(21) 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 October, 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 a janitor and house keeper 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 your 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 September 19, 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 September 19, 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.

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

Date Signed: 6/22/12

Date Mailed: 6/22/12

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