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

IN THE MATTER OF:

[redacted]

Reg. No.: 2012-65444
Issue No.: 2009
Case No.: [redacted]
Hearing Date: October 11, 2012
County: Berrien

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 October 11, 2012. Claimant personally appeared and testified. The department was represented by Family Independence Manager [redacted] and Assistant Payments Worker [redacted].

ISSUE

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

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 December 29, 2011, Claimant filed an application for MA and Retro-MA benefits alleging disability.

(2) On July 9, 2012, the Medical Review Team (MRT) denied Claimant's application for MA-P and Retro-MA indicating that he was capable of performing other work pursuant to 20 CFR 416.920(f). (Department Exhibit A, pp 1-2).

(3) On July 12, 2012, the department sent out notice to Claimant that his application for Medicaid had been denied.

(4) On July 17, 2012, Claimant filed a request for a hearing to contest the department's negative action.

(5) On January 13, 2013, the State Hearing Review Team (SHRT) upheld the denial of MA-P and Retro-MA benefits indicating Claimant retains the capacity to perform light work. (Depart Ex. B).

(6) Claimant has a history of type 1 diabetes, arthritis, hernia, high blood pressure, asthma, dyspnea, and vision loss in his right eye.

(7) On July 20, 2011, Claimant saw his primary care physician for back pain. His physician reviewed the MRI which showed significant deformities of T1-T2 with degenerative disc changes throughout the spine but no herniated discs. He was assessed with severe pain, slight anxiety, and diabetes mellitus. (Dept Ex. D, p 77).

(8) On September 19, 2011, Claimant was diagnosed with Keratoconus, the right eye greater than the left. He had more distortion on the right eye and a corneal transplant was recommended. (Dept Ex. A, p 12).

(9) On November 7, 2011, Claimant's treating physician completed a Diabetes Residual Functional Capacity Assessment. Claimant was diagnosed as a brittle diabetic, with chronic left knee pain, arthritis in his right ankle, diabetic neuropathy resulting in decreased vision, chronic back pain, and central canal stenosis in the cervical spine. His prognosis was poor. Claimant had symptoms of fatigue, general malaise, extremity pain and numbness, difficulty walking, muscle weakness, episodic vision blurriness, retinopathy, frequency of urination, excessive thirst, abdominal pain, insulin shock/coma, hyper/hypoglycemic attacks, central canal stenosis, radiculopathy, and sensitivity to light, heat or cold. The treating physician opined that Claimant constantly experiences severe symptoms associated with diabetes that interfere with his attention and concentration. The physician added that Claimant is incapable of even "low stress" jobs based on his severe generalized pain, uncontrolled blood sugars and decreased vision. Based on Claimant's impairments, the physician indicated Claimant can walk no more than 100 feet, sit no more than 20 minutes, stand no more than 10 minutes and sit/stand no more than 2 hours of an 8 hour day. The physician opined that Claimant would have to take unscheduled breaks during an 8-hour workday every 15 minutes, and rest for an hour before returning to work. Claimant was limited to rarely lifting less than 10 pounds, with no twisting, stooping, bending, crouching, climbing of ladders or stairs. The physician also indicated that Claimant had significant limitations in reaching, handling or fingering. Claimant also had additional limitations of no over the head work, no lifting more than 10 pounds, no repetitive movement, and Claimant would be unable to view a computer due to his diabetic retinopathy. (Dept Ex. A, pp 14-18).

(10) On December 21, 2011, Claimant was hospitalized for observation concerning his heart. An abdominal ultrasound revealed hepatic steatosis and/or hepatocellular disease. The liver is at the top limits of normal in size to slightly enlarged. There was also mild thickening of the gallbladder wall with a positive sonographic Murphy sign. A CT of the abdomen and pelvis with contrast showed no acute CT intra-abdominal or pelvic abnormalities. There was a stable small left adrenal nodule and an umbilical hernia. Also observed was a new tiny pericardial effusion. The head CT without contrast revealed a questionable area of low attenuation in the right frontal lobe versus motion artifact. A small to moderately sized right maxillary sinus retention cyst or polyp was also noted. (Dept Ex. D, pp 89-91).

(11) On January 5, 2012, Claimant presented to his primary care physician for follow-up of his diabetes. He has type 1 diabetes mellitus. His disease course has been fluctuating. Hypoglycemia symptoms include nervousness/anxiousness. Associated symptoms include blurred vision, foot paresthesias, polyuria and visual changes. Hypoglycemia complications include hospitalization and nocturnal hypoglycemia. Symptoms are worsening. Diabetic complications include impotence, peripheral neuropathy, PVD and retinopathy. Current diabetic treatment includes injections. He is compliant with treatment some of the time. His home blood glucose trend is fluctuating dramatically. His vision is blurred. He has abdominal pain, polyuria, impotence, back pain, joint swelling and arthralgias. His is nervous/anxious. (Dept Ex. D, pp 64-65).

(12) On January 23, 2012, Claimant saw his primary care physician for back pain. This is a chronic problem. The pain is present in the thoracic spine (head, neck, shoulders all the way to lower back). The pain radiates to bilateral upper arms to all fingertips on both sides. His hands go numb. The pain goes down from his neck to hips to both legs. His fasting blood sugar is running at 235. He is diagnosed as a brittle diabetic. (Dept Ex. D, pp 58-59).

(13) On February 18, 2012, Claimant underwent a medical examination by the Disability Determination Service. Claimant's chief complaints were diabetes, high blood pressure, kidney problems, neck, back, and knee pain. He was currently taking oral agents as well as insulin for his diabetes. He described fairly poor glycemic control which was also noted in the medical records. He reported that his blood sugars can vary from a low of 50 to as high as 200-300. He stated he has hypoglycemic episodes which he usually treats himself by taking honey. He walked with a slightly wide based gait. Visual acuity was 20/70 on the right and 20/20 on the left. There was some early evidence of peripheral neuropathy with diminished ankle reflexes although no current motor weakness or sensory changes were noted. His blood pressure was in the pre-hypertensive

range. During the examination, there was some degree of active bronchospasm with expiratory wheezing. The examining physician noted that Claimant coughed frequently throughout the exam. There also appeared to be some restrictive disease as noted in previously performed pulmonary function studies. Claimant also reported a history of discomfort involving several joints. He reported tenderness with movement in the knees, shoulders, lumbar and cervical spines. With respect to the neck and lower back, there did not appear to be evidence of nerve root impingement, although he reported occasional neck referred pain initiating headaches. (Dept Ex. B, pp 3-8).

(14) On March 31, 2012, Claimant underwent a pulmonary function test by the Disability Determination Service. The results indicated Claimant had reduced FVC and FEV1 indicating mild restriction and mild obstruction. (Dept Ex. A, pp 5-6, 8).

(15) On September 12, 2012, x-rays of Claimant's left knee showed early degenerative joint and bone changes primarily involving the medial compartment. No acute left knee bone abnormality was seen. (Dept Ex. D, p 2).

(16) On October 9, 2012, the x-ray of Claimant's right ankle indicated no acute right ankle bony abnormalities. There was a large medial malleolus osteophyte versus calcific tendinosis. The findings were suggestive of an old calcaneal fracture. There was also a small calcaneal spur and mild narrowing of the medial joint space. The x-rays of Claimant's left ankle showed no acute ankle bony abnormalities except for a possible small old avulsion fracture. (Dept Ex. D, pp 10, 15).

(17) On October 10, 2012, the MRI of Claimant's left knee revealed mild cartilage thinning and irregularity in the medial compartment without full-thickness tear. There was also a small amount of knee joint fluid. The MRI of Claimant's right knee showed a tear involving the posterior horn of the medial meniscus, with a 6 to 7 mm gap (a few meniscus fibers appeared intact at the posterior aspect). There was also mild bowing of the ACL fibers, which appeared grossly intact. In addition there was moderate-sized knee joint effusion, a tiny Baker's cyst, and moderate medial compartmental cartilage thinning /irregularity. (Dept Ex. D, pp 1, 13-14).

(18) On October 23, 2012, the MRI of Claimant's left ankle showed no suspicious marrow suggesting recent or actively healing fracture, osseous inflammation or necrosis. There were minimal osteoarthritic changes at posterior subtalar, talonavicular and tibiotalar articulations, end also at a few other hindfoot and midfoot articulations. There was also a suspected small plantar calcaneal bony spur with minimal adjacent muscular edema,

minimal appendicitis might be considered. Major ligamentous structures about ankle appeared essentially intact. The MRI of Claimant's right ankle revealed edema within the sinus Tarsi. Also a probable old tear of the anterior talofibular ligament and degenerative changes at the tarsometatarsal joints. (Dept Ex. D, p 3, 11).

(19) Claimant is a 49 year old man whose birthday is [redacted]. Claimant is 5'11" tall and weighs 328 lbs. Claimant completed the eleventh grade and last worked in 2007 as a truck driver.

(20) 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, decrease in vision, uncontrolled blood sugars and other non-exertional symptoms he describes are consistent with the objective medical evidence presented. Consequently, great weight and credibility must be given to his 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 2007; 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 his 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 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 his past relevant work because the rigors of working as a truck driver are completely outside the scope of his 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 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 a significant numbers of jobs in the national economy which Claimant could perform despite his limitations. Accordingly, this Administrative Law Judge concludes that Claimant is disabled for purposes of the MA program. Consequently, the department's denial of his December 29, 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 December 29, 2011 MA/Retro-MA application, and shall award him all the benefits he may be entitled to receive, as long as he meets the remaining financial and non-financial eligibility factors.

2. The department shall review Claimant's medical condition for improvement in March, 2014, unless his 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 his 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: February 26, 2013

Date Mailed: February 27, 2013

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.

Claimant may request a rehearing or reconsideration for the following reasons:

- A rehearing **MAY** be granted if there is newly discovered evidence that could affect the outcome of the original hearing decision.
- A reconsideration **MAY** be granted for any of the following reasons:

  - misapplication of manual policy or law in the hearing decision,
  - typographical errors, mathematical error, or other obvious errors in the hearing decision that effect the substantial rights of the claimant:
  - the failure of the ALJ to address other relevant issues in the hearing decision.

Request must be submitted through the local DHS office or directly to MAHS by mail at

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P. O. Box 30639
Lansing, Michigan 48909-07322

VLA/las

cc: [redacted]