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

IN THE MATTER OF:

[redacted]

Reg. No.: 2012-64944
Issue No.: 2009
Case No.: [redacted]
Hearing Date: October 24, 2012
County: Marquette

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

HEARING DECISION

This matter is before the undersigned Administrative Law Judge upon 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 October 24, 2012, from Lansing, Michigan. Claimant, represented by [redacted] of [redacted] personally appeared and testified. Participants on behalf of the Department of Human Services (Department) included Family Independence Manager [redacted] and Eligibility Specialist [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 April 23, 2013, 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 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 April 20, 2011, Claimant applied for MA-P and Retro-MA benefits.

(2) On March 29, 2012, the Medical Review Team (MRT) denied Claimant's MA/Retro-MA application indicating Claimant was capable of performing other work, pursuant to 20 CFR 416.920(f). SDA was denied due to lack of duration. (Department Exhibit A, pp 9-10).

(3) On April 4, 2012, the department caseworker sent Claimant notice that his application was denied.

(4) On July 9, 2012, Claimant filed a request for a hearing to contest the department's negative action.

(5) On August 28, 2012, the State Hearing Review Team (SHRT) upheld the denial of MA-P and Retro-MA benefits indicating Claimant retains the capacity to perform past work as a manager. SDA was denied because the information in the file was inadequate to ascertain whether the claimant is or would be disabled for 90 days. (Department Exhibit B, pp 1-2).

(6) Claimant has a history of diabetes, pancreatitis, and hypertension.

(7) Claimant is a 53 year old man whose birthday is [redacted]. Claimant is 5'6" tall and weighs 168 lbs. Claimant completed high school and last worked in September, 2010.

(8) Claimant was appealing the denial of Social Security disability 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). 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 he has not worked since September, 2010. Therefore, he 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 diabetes, pancreatitis, and hypertension.

On December 15, 2010, Claimant presented to the emergency room with hypertension and heavy alcohol use. He was started on IV fluids. An ultrasound was recommended because the etiology was most likely alcohol related and probably also associated with hypertriglyceridemia. The ultrasound showed some pancreatic dilatation, but there was no evidence of any stone in the common bile duct. His potassium and creatinine were high. On 12/17/10, Claimant was confused and tremulous and it was felt he had gone into the DT's. He was oriented 2/3. He was hypoxic with a saturation of 85% on room air and a chest x-ray showed bilateral infiltrates. It was felt that he may be developing pneumonia and he was started back on Zithromax and Unasyn. He was also noted to be developing jaundice with elevated liver function tests, possibly related to chronic hepatitis, possible pancreatic edema. On the evening of 12/18/10, Claimant became increasingly agitated requiring manpower one-on-one nursing care, repeated doses of Ativan with minimal sedation resulting. He began hallucinating and was climbing out of his bed and felt to be a danger to himself. At that point he required intubation for sedation. He was then transferred to intensive care in another hospital.

On December 19, 2010, Claimant was admitted to the hospital already intubated and sedated and breathing on his own. Claimant's primary care physician called the hospital because Claimant was in the DT's and they were concerned about giving him Ativan due to possibly precipitating respiratory arrest. Due to having elevated

triglycerides in the past, and having pancreatitis, the Propofol was stopped and he was started on Ativan. Claimant was discharged in stable condition on 12/30/10 and encouraged to go to alcohol rehab. Discharge diagnoses: Alcohol dependence and severe withdrawal (delirium tremens); Encephalopathy, secondary to alcohol dependence and residual medication effects, with delirium tremens; Pancreatitis, recurrent, with exacerbation upon hospitalization, with no necrosis. Requiring pancreatic enzyme replacement on discharge; Type 2 diabetes, Alc 6.9, but requiring moderate amounts of insulin during his hospitalization; Chronic obstructive pulmonary disease; Moderate malnutrition, improving; Hypertension; Urinary tract infection on this hospitalization which was treated with Cipro, resolved.

On September 6, 2011, Claimant was admitted to the hospital after an all terrain vehicle accident, with traumatic injury to pancreatic pseudocyst, alcoholism, and diabetes mellitus. He had struck a pole while riding an all terrain vehicle and had lain on the ground for a few hours. When EMS got to him, he was activated as a level one trauma code. His GCS score was 15 and his pressures responded well to fluid bolus. He underwent CT scans of the head, C spine, chest, abdomen, and pelvis, as well as thoracic and lumbar spine. His only injury was a large pancreatic pseudocyst measuring approximately 15 x 5 centimeters with a slight traumatic rupture of that cyst. There was some bleeding adjacent to the stomach with no other evidence of acute traumatic injury. No obvious fractures in the lumbar or thoracic spine. He was admitted for monitoring of the traumatic injury to the pancreatic pseudocyst in case he developed pancreatic peritonitis and required surgery. Claimant was seen by the traumatic brain injury team due to his loss of consciousness, headache, and initial dizziness. The TBI team did not feel that he needed any further management of his concussion and that discharge to a rehab facility for alcoholism was a good place to start. Claimant was discharged on 9/8/11 to an inpatient rehabilitation facility.

On December 2, 2011, Claimant underwent an independent medical evaluation to determine his current level of psychological functioning in relationship to significant health problems, mental health history, and substance abuse problems. Claimant stated he is seeking disability benefits due to both his chronic health conditions (diabetes, hypertension, depression) along with his substance abuse history. He stated that he has had several hospitalizations related to his diabetes, and that he was in his primary care physician's office that morning for evaluation due to complications with his diabetes. He indicated that he went into a diabetic coma on December 14, 2010, and was hospitalized until December 28, 2010. He indicated that he was experiencing some ongoing depression symptoms. He reported a history of depression that included pharmacotherapy and psychotherapy. He is prescribed Citalopram and Xanax. He reported persistent sadness, daily fatigue, depressed mood, difficulty concentrating, and having little interest in things that he used to enjoy. He also described some intermittent appetite disturbance and sleep disturbance. His report of symptoms was consistent with depression along with accompanying anxiety. The examining psychologist opined that Claimant also has a number of problematic health behaviors. His use of alcohol certainly caused a negative impact on his mood, and may have led to some problems with his diabetes and pancreatitis. He has demonstrated poor diabetes management that has included his acknowledging poor monitoring of his blood sugars and insulin intake. His overall prognosis is fair, and certainly will improve as he adheres to

improving his compliance behavior related to his diabetes, and hypertension, and maintains his sobriety, and stops smoking. The psychologist opined that Claimant would not be able to maintain full-time competitive employment at this point given his health complications, along with his mood symptoms. Diagnosis: Axis I: Depressive disorder; Anxiety disorder; Nicotine dependence; Alcohol dependence; Axis III: Diabetes, hypertension, and chronic pain; Axis V: GAF=60.

On January 29, 2012, Claimant underwent a medical evaluation on behalf of the department. Claimant's chief complaints were diabetes, pancreatitis, and high blood pressure. The diabetes appears to have been due to pancreatic injuries due to gall stones as well as traumatic injuries in the past. His sugars remain poorly controlled around 300. His blood pressure was moderately elevated. He does complain of fatigue and diffuse arthralgias. Some of this does appear to be due to deconditioning as well as poorly controlled sugars. From a cardiopulmonary standpoint, he appeared relatively stable. There were no findings of joint destruction. The examining physician suggested aggressive sugars management and risk factor modification to avoid further decline. The physician opined that Claimant's condition is potentially controllable and he is motivated to improve his condition. His degree of impairment at this point appears mild but again, slowly declining. His prognosis appears fair.

On December 10, 2012, Claimant was admitted to the [redacted]. He was admitted on a diagnostic competency order for Homicide – Open Murder, Unlawful Imprisonment, Assault with a Dangerous Weapon, and Weapons – Felony Firearm. The referral was for a competency and criminal responsibility evaluation on the above charges. Claimant was generally cooperative during the interview. There was no psychomotor agitation or slowing. No tics, tremors or other abnormal movements observed. His speech was normal in rate, volume, and prosody. There was no response latency. He reported his mood as "pretty bad," which he attributed to his legal circumstances. He stated that his mood generally improves if he does not have to talk about his case. He described his energy level as "very low," and his sleep as "horrible," averaging a few hours of sleep a night, which he attributes to stress, depression and worries about his ex-wife. His affect was somewhat congruent with his stated mood, his affect was reactive and he appeared euthymic. With regard to thought process, he was organized and goal-directed. He denied ever experiencing visual or auditory hallucinations, paranoid/grandiose/religious delusions, thought broadcasting/withdrawal or ideas of reference. With regard to cognition, he showed no impairment of immediate or delayed recall during cognitive screening. His insight and judgment were limited to fair. Diagnosis: Axis I: Alcohol dependence; Axis III: Hypertension; Type II Diabetes Mellitus; Self-Reported history of pancreatitis; Axis IV: Moderate to severe (legal difficulties); Axis V: GAF=51. On assessment, Claimant does not present with symptoms suggestive of a substantial disorder of thought or mood. During cognitive screening, there were no impairments in the immediate or delayed recall. Based on his history, any impairment in psychosocial function is most likely related to his alcohol dependence.

On December 13, 2012, Claimant was seen for a neuropsychosocial evaluation. Claimant complained of memory problems. He said that he has had memory problems since childhood attributing this to his rocky childhood. He said he developed

safeguards by burying things if uncomfortable. In addition to the self reported tendency toward repression, he identified other neuropsychosocial risk factors including purported diabetic coma as well as subsequent incident of a diabetic black out and traumatic brain injury. Specifically, he said about a year ago in October, he hit a telephone pole while driving a four-wheeler and sustained a head injury resulting in a two-week coma. He said he was taken to the ER trauma ward for about a week at Marquette General. He did not present with symptoms of significant mood disturbance or formal thought disorder. He denied and did not appear to be experiencing perceptual anomalies such as auditory or visual hallucinations. There was no indication of disorganized thinking or delusional ideation. Furthermore, he denied such symptoms. His speech was audible, adequately articulated and of normal rate and rhythm. He maintained good eye contact, was articulate in his speech, relevant and coherent in his communications. Based on the series of tests administered, the results suggest a person with a history of drinking problems who is embittered and angry. His sensitivity and hostility in social interactions probably serves as a formidable obstacle to the development of close relationships, and thus he is likely to be withdrawn and isolated. Alcohol may be playing a functional role in helping him withdraw from such relationships or in reducing the anxiety and threat that they pose. He may likely ruminate about his life circumstances, and the urge to drink may be at the center of many of these ruminations. It is likely that there is significant impairment in social role performance that has resulted from his drinking; however, he is more likely to attribute such problems to external factors than to admit their relation to his drinking. Overall, Claimant presented as a man of average intelligence with adequate capacity for new learning and memory. He demonstrated adequate communication skills and adequate reasoning and problem-solving capabilities. Personality testing and clinical history revealed significant problems associated with probable alcohol dependence. The current findings do not reveal a mental condition that would necessarily pose an impediment to his competency to stand trial.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). In the present case, Claimant testified that he had diabetes, pancreatitis, and hypertension. It should be noted that Claimant stated during two separate medical and psychological evaluations that he was in a diabetic coma for two weeks in December, 2010, then during the second evaluation, that he was in a coma for those same two weeks due to a head injury. The medical records support neither statement. Therefore, based on the lack of objective medical evidence that the alleged impairment(s) are severe enough to reach the criteria and definition of disability, Claimant is denied at step 2 for lack of a severe impairment and no further analysis is required.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Claimant not disabled for purposes of the MA-P and Retro-MA benefit programs. Accordingly, it is ORDERED:

The Department's determination is **AFFIRMED**.

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

Date Signed: May 14, 2013

Date Mailed: May 14, 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

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cc: [redacted]