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

IN THE MATTER OF:

[redacted]

Reg. No.: 2013-6013
Issue No.: 2009; 4031
Case No.: [redacted]
Hearing Date: March 5, 2013
County: Kalkaska

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, an in-person hearing was commenced on March 5, 2013, at the Kalkaska County DHS office. Claimant, represented by [redacted], personally appeared and testified. Participants on behalf of the Department of Human Services (Department) included Family Independence Specialist [redacted] [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 20, 2012, the SHRT found Claimant was not disabled. This matter is now before the undersigned for a final decision.

ISSUE

Did the Department of Human Services (DHS) properly deny Claimant's Medical Assistance (MA), Retro-MA and State Disability Assistance (SDA) application?

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 June 7, 2012, Claimant filed an application for MA/Retro-MA and SDA benefits alleging disability.

2. On August 6, 2012, the Medical Review Team (MRT) denied Claimant's application for MA/Retro-MA indicating he was capable of performing other work. SDA was denied due to lack of duration. (Depart Ex. A, pp 47-48).

3. On August 13, 2013, the department caseworker sent Claimant notice that his application for MA/Retro-MA and SDA had been denied.

4. On October 11, 2012, Claimant filed a request for a hearing to contest the department's negative action.

5. On December 19, 2012, the State Hearing Review Team (SHRT) found Claimant was not disabled and retained the capacity to perform light exertional tasks of a repetitive nature. (Depart Ex. B, pp 1-2).

6. Claimant had applied for Social Security disability benefits at the time of the hearing.

7. Claimant is a 38 year old man whose birthday is [redacted]. Claimant is 6'0" tall and weighs 210 lbs.

8. Claimant does not have an alcohol/drug abuse problem or history. Claimant smokes a pack of cigarettes over three days. Claimant has a nicotine addiction.

9. Claimant does not have a driver's license based on a previous conviction.

10. Claimant has a tenth grade education.

11. Claimant is not currently working. Claimant last worked in March, 2012.

12. Claimant alleges disability on the basis of degenerative disc disease, deep vein thrombosis, pulmonary embolus, leukocytosis, anxiety, insomnia, neural foraminal stenosis, lumbar radiculopathy and neuropathy.

13. On April 2, 2012, Claimant saw his treating physician for chronic anxiety. He had also recently injured his back lumbar area and had pain radiating into his left foot. He has had chronic numbness in the lateral aspect of both feet for the past year. On examination, he has positive straight leg raise on the left. MRI was scheduled. He was assessed with chronic anxiety, currently stable with Xanax, insomnia, acute low back pain with lumbar radiculopathy with a suspected herniated disc and chronic numbness in both feet. (Dept Ex. A, pp 72-73).

14. On April 10, 2012, an MRI of Claimant's lumbar spine without contrast showed interval development of a moderate annular tear at the L4-L5 level in the posterolateral disc on the left side with subsequent mild left neural foraminal stenosis. Findings not evidenced on the prior 2/26/11 study. Stable appearance to mild degenerative changes at L5-S1 with stable mild left neural foraminal stenosis. (Dept Ex. A, pp 70-71).

15. On April 13, 2012, Claimant presented to the emergency department with left calf pain. He was found to have thrombus in the left lower extremity as well as pulmonary embolism and admitted to the hospital. He was started on Arixta and Warfarin. Claimant was referred to his treating physician with a suggestion of lifelong anticoagulation given that this was his second thromboembolism. He was discharged on April 14, 2012, a diagnosis of venothromboembolism with pulmonary embolism and left posterior tibial vein thrombus. (Dept Ex. A, pp 180-193).

16. On April 16, 2012, Claimant went to the emergency department with left sided chest pain down the whole left side of his chest and down his left arm. He was coughing and had dark colored sputum. He was still having severe leg pain but that pain was stable. An IV was established and he was given Dilaudid. Chest x-rays showed no acute pulmonary disease. He INR was still subtherapeutic at 1.4 and he was admitted to the hospital. On April 17, 2012, Claimant still had significant pain on the left side of his chest and a repeat CT scans showed a largely resolved pulmonary embolism with mild residual subsegmental thrombus, much improved from three days ago. Claimant was informed that his chest CTA had improved. He was given a dose of Toradol and another dose of Dilaudid and discharged home in stable condition with a diagnosis of acute chest pain with recent pulmonary embolism. (Dept Ex. A, pp 172-179).

17. On April 26, 2012, Claimant presented to the emergency department with right lower quadrant abdominal pain. He was found to have a negative CT scan, but marked leukocytosis as 23,000. He was transferred to the observation unit for serial abdominal examinations, IV hydration and pain control. On April 27, 2012, Claimant was discharged in improved condition with a diagnosis of abdominal pain of uncertain etiology, leukocytosis, history of deep venous thrombosis, and a pulmonary embolism currently anticoagulated on Coumadin, therapeutic at 3.4. (Dept Ex. A, pp 159-171).

18. On April 28, 2012, Claimant went to the emergency department complaining of a sudden onset of chest discomfort on the left side. There was a pleuritic component to it. He was anxious. A CT of the chest was done to ensure there was no recurrence of a pulmonary embolism and there was none. Claimant was given Dilaudid and Ativan. He did not feel comfortable going home. He was hospitalized with a subtherapeutic INR of 1.9. He was risk stratified for observation status. Overnight he continued to have chest pain which was resolved with Dilaudid. He was given Lovenox to bridge overnight with a repeat INR on April 29, 2012 of 4.9. Ultimately, the CT scan was repeated, which showed almost complete resolution of any filling defects. He also had a stress test which was unremarkable for any acute muscular or regurgitant problems or any ischemic changes. He was reassured that the clot in the leg would be slowly resolving and that the CT scan showed it was almost completely resolved and his cardiac evaluation was negative. He was discharged

with a diagnosis of anterior chest wall pain, history of a recent pulmonary embolus, and recent deep venous thrombosis. (Dept Ex. A, pp 123-158).

19. On May 14, 2012, Claimant saw his treating physician for follow-up of his left leg deep vein thrombosis complicated by bilateral pulmonary embolus. He was symptomatic at the appointment. He is on chronic Coumadin. His INR yesterday was 2.9, one week ago previously it had been over 4. He also has a history of chronic back pain. His last MRI demonstrated an annular tear with some mild left neuroforaminal compromise. He also has a history of leukocytosis. (Dept Ex. A, pp 59-60).

20. On June 4, 2012, Claimant followed up with his primary care physician for his abnormal INR. Last week his INR was 3.3. His dose was decreased to 7.5 mg daily. His INR this date was 1. He admitted to missing two doses of Coumadin last week which explained his low INR. Claimant was in no distress and did not appear uncomfortable. Diagnosis was chronic back pain secondary to disc disease, DVT on Coumadin and subtherapeutic INR. (Dept Ex. A, pp 57-58).

21. On June 13, 2012, Claimant went to the emergency department complaining of severe pain from his posterior pelvis, buttock on down. He has a history of chronic back problems and thromboembolic disease. He stated he was concerned that a blood clot was causing the symptoms. He also has chronic numbness in the lateral sides of both feet. He underwent a bilateral lower extremity Dopplers which was negative for DVT. He was diagnosed with exacerbation of chronic back pain with suspected sciatica, prescribed Dilaudid and Flexeril and discharged. (Dept Ex. A, pp 120-121).

22. On June 27, 2012, Claimant's treating physician completed a medical examination of Claimant. Claimant is diagnosed with degenerative disc disease, pulmonary embolism and deep vein thrombosis. Claimant had decreased range of motion in lumbar spine and positive straight leg raise. His last MRI was abnormal, revealing an annular tear. Claimant's physician opined that Claimant's condition was deteriorating. (Dept Ex. A, pp 45-56).

23. On July 15, 2012, Claimant was brought to the emergency department. He was dizzy and lightheaded. He stated he was achy all over and his back pain was getting worse. He continues to smoke and stated he was cutting back, but halfway through his visit, he was agitated and required a nicotine patch. He did start throwing up when he arrived and has been mildly nauseated throughout. He was alert and oriented. A CT scan showed no acute intracranial pathology. An abdominal series was also obtained which showed no acute abnormalities. He was diagnosed with acute viral syndrome with dehydration and discharged home. (Dept Ex. A, pp 27-29).

24. On August 1, 2012, Claimant went to the emergency department complaining of stomach problems. He stated he was having vomiting and severe upper abdominal pain. He was having pain with breathing and was short of breath. He was alert and oriented and in general, in good spirits. His white count was elevated at 14.3, but he has some chronic leukocytosis and he has had CT's in the past with leukocytosis and the CT's have been negative. He was diagnosed with acute gastritis and acute constipation secondary to narcotic pain medications. He was discharged in stable condition. (Dept Ex. A, pp 19-20).

25. On August 16, 2012, Claimant presented to the emergency department complaining of a headache. Claimant had been in the emergency department a month ago for dizziness and had a CT scan that was negative. He stated he quit smoking and that could be a contributing factor. Claimant was in no acute distress. His mood and affect were normal. CBC showed an elevated white count of 12.3. This was consistent with previous readings. It looked like he had chronic leukocytosis. He was discharged in improved condition. (Claimant Ex. A, pp 12-13).

26. On September 10, 2012, Claimant underwent a Mental Status Examination on behalf of the department. Claimant sat calmly in his chair and did not appear to be nervous or restless during the examination. He walked with a normal gait. He was polite and cooperative. He appeared to have low average cognitive ability although no formal testing was conducted. Reality contact was fair. His ability for insight was adequate. It was unclear if he was exaggerating or minimizing his symptoms. His thinking was goal directed and organized. When asked about hallucinations, he stated that he frequently has them. However, it is not clear that the experience that he describes constitutes hallucinations. He said that he often thinks he hears someone say something when no one is around. He denies that the voices give commands or say anything in particular. He thinks that he sometimes sees things that other people don't see. He has had passive suicidal thinking but has never had a plan and does not think that he would ever attempt suicide. He noted a diminished appetite. He stated that he has never slept well. He presented with a normal range of affect. He said that he frequently has panic attacks. His panic attacks are triggered by general stress but he pointed to his relationship with his son's mother as a major stressor in his life. He stated he often feels nervous and restless. His memory and fund of general information was limited. His ability to concentrate was fair. The psychologist opined that Claimant would be able to understand and follow both simple and complex instructions. His ability to interact and communicate with coworkers and authority figures may be limited by difficulty remaining calm in stressful situations. His ability to manage a normal amount of stress is diminished by anxiety. Problem solving and judgment are limited by personality features. Diagnoses: Axis I: Anxiety

Disorder; Panic Disorder without Agoraphobia; Alcohol Dependence in full sustained remission; Axis II: Antisocial Personality Traits; Axis IV: Psychosocial stressors are moderate including chronic pain, unresolved child abuse issues; Axis V: GAF=50. Prognosis is fair. Due to a history of substance abuse issues, he would need help managing his benefit funds. (Dept Ex. B, pp 3-8).

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by 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 (DHS or department) 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 Bridges Reference Manual (RFT).

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. The Department of Human Services (DHS or department) administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. Department policies are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Bridges Reference Manual (RFT).

Statutory authority for the SDA program states in part:

> (b) A person with a physical or mental impairment which meets federal SSI disability standards, except that the minimum duration of the disability shall be 90 days. Substance abuse alone is not defined as a basis for eligibility.

In order to receive MA benefits based upon disability or blindness, claimant must be disabled or blind as defined in Title XVI of the Social Security Act (20 CFR 416.901). DHS, being authorized to make such disability determinations, utilizes the SSI definition of disability when making medical decisions on MA applications. MA-P (disability), also is known as Medicaid, which is a program designated to help public assistance claimants pay their medical expenses. Michigan administers the federal Medicaid program. In assessing eligibility, Michigan utilizes the federal regulations.

Relevant federal guidelines provide in pertinent part:

> "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.

The federal regulations require that several considerations be analyzed in sequential order:

> . . . We follow a set order to determine whether you are disabled. We review any current work activity, the severity of your impairment(s), your residual functional capacity, your past work, and your age, education and work experience. If we can find that you are disabled or not disabled at any point in the review, we do not review your claim further. 20 CFR 416.920.

The regulations require that if disability can be ruled out at any step, analysis of the next step is not required. These steps are:

1. If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or your age, education, and work experience. 20 CFR 416.920(b). If no, the analysis continues to Step 2.

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 416.909(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 that meets the duration requirement? If no, the analysis continues to Step 4. If yes, MA is approved. 20 CFR 416.920(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. Sections 200.00-204.00(f)?

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? This step considers the residual functional capacity, age, education, and past work experience to see if the client can do other work. If yes, the analysis ends and the client is ineligible for MA. If no, MA is approved. 20 CFR 416.920(g).

At application Claimant has the burden of proof pursuant to:

> . . . You must provide medical evidence showing that you have an impairment(s) and how severe it is during the time you say that you are disabled. 20 CFR 416.912(c).

Federal regulations are very specific regarding the type of medical evidence required by claimant to establish statutory disability. The regulations essentially require laboratory or clinical medical reports that corroborate claimant's claims or claimant's physicians' statements regarding disability. These regulations state in part:

> Medical reports should include --
>
> (1) Medical history.
>
> (2) Clinical findings (such as the results of physical or mental status examinations);
>
> (3) Laboratory findings (such as ultrasounds, X-rays);
>
> (4) Diagnosis (statement of disease or injury based on its signs and symptoms). 20 CFR 416.913(b).

Statements about your pain or other symptoms will not alone establish that you are disabled; there must be medical signs and laboratory findings which show that you have a medical impairment. 20 CFR 416.929(a). The medical evidence must be complete and detailed enough to allow us to make a determination about whether you are disabled or blind. 20 CFR 416.913(d).

> Medical findings consist of symptoms, signs, and laboratory findings:
>
> (a) **Symptoms** are your own description of your physical or mental impairment. Your statements alone are not enough to establish that there is a physical or mental impairment.
>
> (b) **Signs** are anatomical, physiological, or psychological abnormalities which can be observed, apart from your statements (symptoms). Signs must be shown by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomena which indicate specific psychological abnormalities e.g., abnormalities of behavior, mood, thought, memory, orientation, development, or perception. They must also be shown by observable facts that can be medically described and evaluated.

> (c) **Laboratory findings** are anatomical, physiological, or psychological phenomena which can be shown by the use of a medically acceptable laboratory diagnostic techniques. Some of these diagnostic techniques include chemical tests, electrophysiological studies (electrocardiogram, electroencephalogram, etc.), roentgenological studies (X-rays), and psychological tests. 20 CFR 416.928.
>
> It must allow us to determine --
>
> (1) The nature and limiting effects of your impairment(s) for any period in question;
>
> (2) The probable duration of your impairment; and
>
> (3) Your residual functional capacity to do work-related physical and mental activities. 20 CFR 416.913(d).

Information from other sources may also help us to understand how your impairment(s) affects your ability to work. 20 CFR 416.913(e). You can only be found disabled if you are unable 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. See 20 CFR 416.905. Your impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. 20 CFR 416.927(a)(1).

Applying the sequential analysis herein, Claimant is not ineligible at the first step as Claimant is not currently working. 20 CFR 416.920(b). The analysis continues.

The second step of the analysis looks at a two-fold assessment of duration and severity. 20 CFR 416.920(c). This second step is a *de minimus* standard. Ruling any ambiguities in Claimant's favor, this Administrative Law Judge (ALJ) finds that Claimant meets both. The analysis continues.

The third step of the analysis looks at whether an individual meets or equals one of the Listings of Impairments. 20 CFR 416.920(d). Claimant does not. The analysis continues.

The fourth step of the analysis looks at the ability of the applicant to return to past relevant work. This step examines the physical and mental demands of the work done by Claimant in the past. 20 CFR 416.920(f).

In this case, Claimant has a history of less than gainful employment. As such, there is no past work for Claimant to perform, nor are there past work skills to transfer to other work occupations. Accordingly, Step 5 of the sequential analysis is required.

The fifth and final step of the analysis applies the biographical data of the applicant to the Medical Vocational Grids to determine the residual functional capacity of the applicant to do other work. 20 CFR 416.920(g).

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 a careful review of the credible and substantial evidence on the whole record, 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).

It is noted that the law does not recognize lifestyle choices such as Claimant's—including smoking, obesity, lack of exercise, and lack of work as statutorily disabling. However, most individual who make these choices eventually reach a state where they have irreversible medical problems which will continue to exist even if that individual changes their lifestyle choices such as losing weight, exercising, stopping the nicotine and drug addiction(s), etc.

In this case, Claimant's treating physician opined that Claimant is disabled based on his decreased range of motion in the lumbar spine, positive straight leg raise and his abnormal MRI showing an annular tear. Because Claimant's treating physician's opinion is well supported by medically acceptable clinical and laboratory diagnostic techniques, it has controlling weight. 20 CFR 404.1527(d)(2). This evidence, as already noted, does rise to statutory disability.

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 and SDA eligibility purposes.

Accordingly, the department's decision is **REVERSED**, and it is ORDERED that:

1. The department shall process Claimant's June 7, 2012, MA/Retro-MA and SDA 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 June, 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.

It is SO ORDERED.

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

Date Signed: June 12, 2013

Date Mailed: June 13, 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 mailing 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]