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

IN THE MATTER OF:

Reg. No.: 2013-24564
Issue No.: 2009
Case No.:
Hearing Date: May 1, 2013
County: St. Joseph

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 May 1, 2013, from Lansing, Michigan. Claimant personally appeared and testified. Participants on behalf of the Department of Human Services (Department) included Eligibility Specialist and Assistance Payment Supervisor

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 July 29, 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?

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 16, 2012, Claimant filed an application for MA-P and Retro-MA benefits alleging disability.

(2) On January 4, 2013, the Medical Review Team (MRT) denied Claimant's application for MA-P and Retro-MA indicating that she was capable of performing other work. (Depart Ex. A, pp 29-30).

(3) On January 11, 2013, the department caseworker sent Claimant notice that her application was denied.

(4) On January 17, 2013, Claimant filed a request for a hearing to contest the department's negative action.

(5) On March 18, 2013, the State Hearing Review Team (SHRT) found Claimant was not disabled and retained the capacity to perform a wide range of sedentary, unskilled work. (Depart Ex. B, pp 1-2).

(6) Claimant has a history of degenerative disc disease, status post left knee replacement, diabetes and bipolar disorder.

(7) Claimant is a 47 year old woman whose birthday is [redacted] Claimant is 5'6" tall and weighs 250 lbs. Claimant completed the ninth grade.

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

CONCLUSIONS OF LAW

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

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

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to

relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and, (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

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

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920 (a)(4). 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 CF R 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 she has not worked in the last 15 years. Therefore, she 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 degenerative disc disease, needs left knee replacement, diabetes and bipolar disorder.

On January 30, 2012, Claimant went to community mental health for a medication review. Her psychomotor activity was normal. She was pleasant on interaction. Her mood was depressed and her affect was sad. Her thought form was normal. She denied psychotic features. Diagnosis: Axis I: Posttraumatic Stress Disorder (PTSD); Generalized Anxiety Disorder; Major Depression, recurrent, moderate; Poly-substance abuse in remission; Bereavement; Axis III: Obesity; Hysterectomy; Appendectomy; Gall bladder removal; Borderline diabetic; Bad back; Axis IV: Health issue in family members; Axis V: GAF=45.

On March 16, 2012, Claimant presented for a medication review. Claimant was pleasant on interaction. Her mood was depressed. Her affect was angry when talking about her alleged molestation. She stated she has lots of mixed emotions and this makes her anxious. Her thought form was goal directed, relevant, coherent and logical. She acknowledged hearing voices. She denied seeing things. Diagnosis: Axis I: Posttraumatic Stress Disorder; Generalized Anxiety Disorder; Major Depression,

recurrent, moderate; Poly-substance abuse in remission; Bereavement; Axis III: Obesity; Hysterectomy; Appendectomy; Gall bladder removal; Borderline diabetic; Bad back; Axis IV: Recent loss of a friend; Fighting disability; Axis V: GAF=45.

On April 10, 2012, Claimant presented to the emergency room with dyspnea. She appeared anxious and was in mild respiratory distress with anxiety and trachypnea (observed by staff with no apparent duress, talking on her phone with no shortness of breath, moving about freely, then moments later requesting pain medications and uncontrolled symptoms). She was oriented to person, place and time. A CTA showed no evidence of pulmonary embolism. The chest x-ray revealed no evidence of acute cardiopulmonary pathology. She was discharged with a diagnosis of acute exacerbation of COPD and pleurisy.

On June 5, 2012, Claimant presented to the emergency department with chest pain and a cough. She appeared in moderate distress. She was diagnosed with bronchitis, prescribed Atrovent and Xopenex and discharged in stable condition.

On July 24, 2012, Claimant underwent a medical evaluation on behalf of the department. Claimant's chief complaints were right hearing loss, hard time breathing, back pain, neck pain, degenerative disc disease and bulging discs. The examining physician opined that Claimant did appear to have moderate chronic bronchitis with associated obstructive disease. She appeared mildly dyspneic and was not on inhaler therapy. She had some mild lower extremity edema and her blood pressure was mildly elevated. She had tenderness in her lower lumbar spine and weakness in her left leg which she stated intermittently goes out on her. She had difficulty doing orthopedic maneuvers due to balance issues. Clinically, there were no radicular symptoms. She reported a history of domestic violence from which she sustained hearing loss in her right ear. There were no other focal neurological deficits. Claimant reported a history of anxiety and her mental affect was mildly depressed although it appeared to be more reactionary and was not contributing to her clinical symptoms. Overall, the physician found that her degree of impairment was mild to moderate and she had the potential for some element of remediability over time.

On August 28, 2012, Claimant presented to the emergency department stating she was kicked in the back while breaking up a fight. X-rays of her thoracic spine showed no traumatic findings and minimal degenerative change. X-rays of her lumbar spine were unremarkable. X-rays of her bilateral knees demonstrated no evidence of fracture or effusion. There was mild to moderate degenerative changes noted.

On September 23, 2012, Claimant went to the emergency department complaining of hip pain from an altercation an week before. X-rays of her left knee and right and left hips were unremarkable.

On September 27, 2012, Claimant had an MRI of her left knee for lateral knee pain for the past three months. There was free edge blunting of the body segment of the lateral meniscus and a degenerative signal without focal tearing of the medial meniscus.

There was also cartilage loss greatest in the medial and patello femoral compartments with an associated moderate effusion. In addition, there was a moderate Baker's cyst likely leaking along the medial head of the gastrocnemius.

On October 14, 2012, Claimant's knees were x-rayed for pain after a fall. The left knee found no fracture, no suspicious bone lesion. There was no joint malalignment and only a tiny joint effusion with no significant degenerative changes. The right knee showed no fracture or suspicious bone lesion. There was no joint malalignment and no significant degenerative changes. X-ray of the lumbar spine revealed no fracture or subluxation. The x-ray of the pelvis was unremarkable.

On October 16, 2012, Claimant underwent a pulmonary function test. Her Forced Expiratory Volume (FEV1) was 1.54, 1.56 and 1.29 before bronchodilator and 1.67, 0.76 and 0.59 after bronchodilator. Claimant is 65 inches tall. Her Forced Vital Capacity (FVC) was 2.14, 2.00 and 1.71 before bronchodilator and 1.92, 1.88 and 1.80 after bronchodilator.

On December 26, 2012, an x-ray of Claimant's left knee after twisting it was unremarkable.

On January 8, 2013, Claimant presented to the emergency room complaining of injuring her left knee. Claimant was in severe pain. She was alert and oriented to person, place and time and in no acute distress. She had moderate tenderness in her left knee and mild swelling located in the lateral collateral ligament. No limitation in range of motion. She had a limping gait. Labs, x-rays and EMG were negative. Claimant was noted to already be taking Norco for her pain. She was discharged in stable condition and diagnosed with a probable sprained left knee.

On January 16, 2013, Claimant underwent an MRI of her left knee. AP weightbearing views of both knees as well as lateral weightbearing and sunrise view of the left knee were obtained and compared to a previous dated 1/8/13. There was a joint effusion and mild tricompartmental osteoarthristis seen. There were no fractures or dislocations demonstrated and no osteolytic or osteoblastic lesions seen.

On January 24, 2013, Claimant presented to the emergency room after sliding down 12 stairs carrying a sofa. Claimant was in pain and crying. Claimant had muscle spasm in her upper thoracic spine and pain with movement in her left shoulder. Left shoulder x-ray was unremarkable. The cervical spine x-ray showed no acute fracture. The x-ray of her head revealed no acute intracranial findings. Claimant was discharged in stable condition with a diagnosis of a contusion in her shoulder region.

On March 26, 2013, Claimant saw her treating physician for left knee pain. She had painful to palpation and range of motion. She appeared in no apparent distress. She had good strength and range of motion of all extremities. Deep tendon reflexes were normal. She had no sensory or motor deficits. Her prescription for Vicodin was refilled.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, Claimant has presented some limited medical evidence establishing that she does have some physical limitations on her ability to perform basic work activities. The medical evidence has established that Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. Claimant has alleged physical and mental disabling impairments due to degenerative disc disease, needs left knee replacement, diabetes and bipolar disorder.

Listing 1.00 (musculoskeletal system), Listing 3.00 (respiratory system), Listing 9.00 (endocrine system) and Listing 12.00 (mental disorders), were considered in light of the objective evidence.

Regarding the musculoskeletal system, Claimant had multiple x-rays and MRI's over the past 18 months. The x-ray of her head showed no acute intracranial findings. X-rays of her pelvis and left shoulder were unremarkable. The cervical spine x-ray showed no acute fracture. There were some minimal degenerative changes noted on the thoracic x-ray. X-rays of her chest, left hip and lumbar spine were unremarkable. The right knee x-ray showed no significant degenerative changes. The x-ray of her left knee showed a tiny joint effusion. Despite Claimant's testimony that she needed a left knee replacement, there was nothing in the medical records supporting that assertion.

While Claimant did not mention COPD or emphysema, there were some medical records concerning the diagnosis. To meet Listing 3.02(B) for chronic obstructive pulmonary disease with a height of 65 inches, Claimant's FVC must be equal to or less than 1.45. Here, Claimant's FVC test scores were 2.14, 2.00 and 1.71 before bronchodilator and 1.92, 1.88 and 1.80 after bronchodilator. As a result, Claimant does not meet Listing 3.02(B). To meet Listing 3.02(A), Claimant's FEVI must be equal to or less than 1.25. As evidenced by her before bronchodilator FEV1 test scores of 1.54, 1.56 and 1.29, and after bronchodilator scores of 1.67, 0.76 and 0.59, Claimant may meet the listing. However, it was noted during the testing that Claimant was uncooperative and did not exert her best efforts. Claimant had used her ProAir inhaler at 3:30AM on the day of testing and during the testing she insisted that she could not do the testing standing up – so she sat. She had lots of wheezing, however, it appeared to be exaggerated symptoms.

Furthermore, the only records concerning diabetes mentioned "borderline diabetes," as opposed to the severe diabetes she testified to having. Claimant also stated she had bipolar disorder, however the only diagnoses regarding her mental impairments in her

medical records diagnosed her with posttraumatic stress disorder, depression and anxiety.

As a result, and based on the foregoing, it is found that Claimant's impairment(s) does not meet the intent and severity requirement of a listed impairment; therefore, Claimant cannot be found disabled at Step 3. Accordingly, Claimant's eligibility is considered under Step 4. 20 CFR 416.905(a).

The fourth step in analyzing a disability claim requires an assessment of the individual's residual functional capacity ("RFC") and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if he/she can perform past relevant work. *Id.*; 20 CFR 416.960(b)(3). Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s) and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

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.

In Step 5, an assessment of the individual's residual functional capacity and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v). At the time of hearing, Claimant was 47 years old and was, thus, considered to be a younger individual for MA-P purposes. Claimant has a ninth grade education. Disability is found if an individual is unable to adjust to other work. *Id.* At this point in the analysis, the burden shifts from Claimant to the Department to present proof that Claimant has the residual capacity to substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). The age for younger individuals (under 50) generally will not seriously affect the ability to adjust to other work. 20 CFR 416.963(c).

In this case, the evidence reveals that Claimant suffers from degenerative disc disease, needs a left knee replacement, diabetes and bipolar disorder. The objective medical evidence notes no physical or mental limitations. In light of the foregoing, it is found that Claimant maintains the residual functional capacity for work activities on a regular and

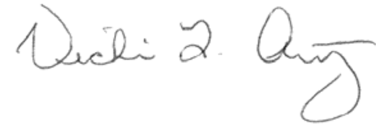
continuing basis which includes the ability to meet the physical and mental demands required to perform at least sedentary work as defined in 20 CFR 416.967(a). After review of the entire record using the Medical-Vocational Guidelines [20 CFR 404, Subpart P, Appendix II] as a guide, specifically Rule 201.18, it is found that Claimant is not disabled for purposes of the MA-P program at Step 5.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Claimant not disabled for purposes of the MA-P 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: August 14, 2013

Date Mailed: August 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 erro r, 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: