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

IN THE MATTER OF:

[redacted]

Reg. No.: 2013 52402
Issue No.: 2009
Case No.: [redacted]
Hearing Date: November 4, 2013
County: Wayne County DHS (82)

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

HEARING DECISION

Following Claimant's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice and in person hearing was held on November 4, 2013, from Detroit, Michigan. Participants on behalf of Claimant included the Claimant. [redacted], the Claimant's Authorized Hearing Representative also appeared. Participants on behalf of the Department of Human Services (Department) included [redacted], Assistance Payments Worker.

ISSUE

Whether the Department properly determined that Claimant is not "disabled" for purposes of the Medical Assistance (MA-P) program?

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 October 26, 2012, Claimant applied for MA-P and retro MA-P (September 2012).

2. On December 4, 2012, the Medical Review Team denied Claimant's request.

3. The Department sent the Claimant's AHR a notice of the Notice of Case Action dated March 18, 2013 denying the Claimant MA-P application. Exhibit 1

4. On March 18, 2013 Claimant's AHR submitted to the Department a timely hearing request. Exhibit 2.

5. August 19, 2013 the State Hearing Review Team ("SHRT") found the Claimant not disabled and denied Claimant's request.
6. An Interim Order was issued on January 9, 2014 transmitting new evidence to the SHRT. On March 21, 2014 the SHRT found the Claimant not disabled and denied the Claimant's request.
7. Claimant at the time of the hearing was 48 years old with a birth date of [redacted]. Claimant was 5'6" and weighed 190 pounds.
8. Claimant completed education through the 9th grade and completed a GED.
9. Claimant has employment history working for as a mechanic including exhaust systems, various machine repair work, as an auto technician, manufacturing industrial molds, roofing, and as a truck parts clerk.
10. Claimant's limitations have lasted for 12 months and are expected to continue for 12 months or more.
11. Claimant alleges physical disabling impairments due to high blood pressure, chronic heart failure, obesity, dizziness and shortness of breath, and uncontrolled diabetes. .
12. The Claimant has alleged mental disabling impairments due to depression and chronic alcohol use.
13. Claimant has significant limitations on physical activities.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by the Title XIX of the Social Security Act, 42 USC 1396-1396w-5, and is implemented by 42 CFR 400.200 to 1008.59. The Department of Human Services (formerly known as the Family Independence Agency) administers the MA program pursuant to MCL 400.10 and MCL 400.105.

Pursuant to Federal Rule 42 CFR 435.540, the Department uses the Federal Supplemental Security Income (SSI) policy in determining eligibility for disability under MA-P. Under SSI, 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 set order is used to determine disability. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience are reviewed. If there is a finding that an individual is disabled or not disabled at any point in the review, there will be no further evaluation. 20 CFR 416.920.

Medical evidence may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of the impairment(s), including symptoms, diagnosis and prognosis, what an individual can do despite impairment(s), and the physical or mental restrictions. 20 CFR 416.927(a)(2).

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability. 20 CFR 416.927(e).

For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph (B) of the listings for mental disorders (descriptions of restrictions of activities of daily living, social functioning; concentration, persistence or pace; and ability to tolerate increased mental demands associated with competitive work). 20 CFR, Part 404, Subpart P, Appendix 1, 12.00(C).

The residual functional capacity is what an individual can do despite limitations. All impairments will be considered in addition to ability to meet certain demands of jobs in the national economy. Physical demands, mental demands, sensory requirements and other functions will be evaluated. 20 CFR 416.945(a).

To determine the physical demands (exertional requirements) of work in the national economy, we classify jobs as sedentary, light, medium and heavy. These terms have the same meaning as they have in the Dictionary of Occupational Titles, published by the Department of Labor. 20 CFR 416.967.

Pursuant to 20 CFR 416.920, a five-step sequential evaluation process is used to determine disability. An individual's current work activity, the severity of the impairment, the residual functional capacity, past work, age, education and work experience are evaluated. If an individual is found disabled or not disabled at any point, no further review is made.

The first step is to determine if an individual is working and if that work is "substantial gainful activity" (SGA). If the work is SGA, an individual is not considered disabled regardless of medical condition, age or other vocational factors. 20 CFR 416.920(b).

Secondly, the individual must have a medically determinable impairment that is "severe" or a combination of impairments that is "severe." 20 CFR 404.1520(c). An impairment or combination of impairments is "severe" within the meaning of regulations if it significantly limits an individual's ability to perform basic work activities. An impairment or combination of impairments is "not severe" when medical and other evidence establish only a slight abnormality or a combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work. 20 CFR 404.1521; Social Security Rulings (SSRs) 85-28, 96-3p, and 96-4p. If the claimant does not have

a severe medically determinable impairment or combination of impairments, he/she is not disabled. If the claimant has a severe impairment or combination of impairments, the analysis proceeds to the third step.

The third step in the process is to assess whether the impairment or combination of impairments meets a Social Security listing. If the impairment or combination of impairments meets or is the medically equivalent of a listed impairment as set forth in Appendix 1 and meets the durational requirements of 20 CFR 404.1509, the individual is considered disabled. If it does not, the analysis proceeds to the next step.

Before considering step four of the sequential evaluation process, the trier must determine the claimant's residual functional capacity. 20 CFR 404.1520(e). An individual's residual functional capacity is his/her ability to do physical and mental work activities on a sustained basis despite limitations from his/her impairments. In making this finding, the trier must consider all of the claimant's impairments, including impairments that are not severe. 20 CFR 404.1520(e) and 404.1545; SSR 96-8p.

The fourth step of the process is whether the claimant has the residual functional capacity to perform the requirements of his/her past relevant work. 20 CFR 404.1520(f). The term past relevant work means work performed (either as the claimant actually performed it or as is it generally performed in the national economy) within the last 15 years or 15 years prior to the date that disability must be established. If the claimant has the residual functional capacity to do his/her past relevant work, then the claimant is not disabled. If the claimant is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth step.

In the fifth step, an individual's residual functional capacity is considered in determining whether disability exists. An individual's age, education, work experience and skills are used to evaluate whether an individual has the residual functional capacity to perform work despite limitations. 20 CFR 416.920(e).

Claimant alleges physical disabling impairments due to high blood pressure, chronic heart failure, obesity, dizziness and shortness of breath, and uncontrolled diabetes. The Claimant has alleged mental disabling impairments due to depression and chronic alcohol use.

A summary of the claimant's medical evidence presented at the hearing and the new evidence presented follows.

The Claimant was seen in the Emergency Room on September 13, 2013 due to chest pain around the left shoulder. The Claimant was not admitted and the examining doctor concluded pain experienced was likely musculoskeletal. Myocardial infarction was ruled out. The examiner who was familiar with the Claimant's cardiac condition noted that it was important for the Claimant to undergo implantable cardioverter defibrillator implantation. The Diagnosis was congestive heart failure, arteriosclerotic heart disease, peripheral artery disease, diabetes mellitus, cardiomyopathy, alcohol abuse, angina

class III, ischemic cardiomyopathy, unstable angina, dyspnea, cardiomyopathy alcoholic.
On December 17, 2013 the Claimant reported to the hospital with chest pain on left side of chest radiating to the back with shortness of breath. The Claimant was admitted to be monitored. An x-ray of the chest showed no cardiac enlargement. The claimant was discharged home with atypical chest pain.

On March 17, 2013 the Claimant was seen in the emergency room for chest pain. The Claimant arrived by ambulance. Claimant had an abnormal EKG and was discharged home in stable condition and was to follow up with VA in week to recheck electrolytes.

On February 27, 2013 the Claimant was admitted for a three day hospital stay due to squeezing chest pain radiating to shoulder which was not relieved by nitroglycerin. The Claimant had a heart catheterization and noted chronic changes found in right coronary artery, with no further intervention.

On October 27, 2012 the claimant reported to the hospital with severe chest pain (8 out of 10) radiating to the left arm. No discharge information was available.

On September 23, 2012 the Claimant reported to the hospital with chronic cough which occurs frequently and has been worsening. The Claimant was admitted for a three day stay. Symptoms are aggravated by activity and supine position. Symptoms include shortness of breath, fever, rhinorrhea, and wheezing. A dilated cardiomyopathy was performed and notes global hypokinesia and decreased thickening. The left ventricle ejection fraction is 26%. The assessment was pneumonia, congestive heart failure, arteriosclerotic heart disease, peripheral artery disease diabetes mellitus, cardiomyopathy and alcohol abuse. A cardiology consult was conducted that indicated ischemic cardiomyopathy, congestive heart failure, [redacted] function class III, ejection fraction 15% patent stent. At the time patient was told that he must take him medication and stop alcohol, and if ejection fraction did not improve he would be a candidate for cardioverter defibrillator implantation. The discharge summary noted that the patient has been extremely non-compliant with his medications. During the hospitalization he had a cardiac catheterization while hospitalized which showed an ejection fraction of 15%.

On October 5, 2012 the claimant was tested for pulmonary embolism. The impression was no CT evidence of pulmonary embolism. Increased infiltrate and atelectasis at both lungs with small bilateral pleural effusions, prominent mediastinal lymph nodes. The CT was compared with prior studies, in September 2012. There was mild cardiac enlargement without significant congestion without evidence of acute intrathoracic process at this time.

On October 21, 2012 the claimant was admitted for a one day stay due to shortness of breath diagnosed as dyspnea. An x-ray of chest showed stable cardiomegaly, stable hyperinflation, no airspace disease, pneumothorax or effusion.

On December 21, 2012 a consultative examination was performed. The exam noted that Claimant noted ejection fraction of 15% which was not documented, and questioned in light of that fact whether the Claimant could stand, bend stoop, carry, push or pull. The exam noted some reduced range of motion in lumbar spine. Harsh breath sounds were noted but no wheezing. No murmurs were noted. A page of the exam may have been missing. The Claimant also had a psychological mental status examination. The diagnoses were probable alcohol dependence, panic disorder, dysthymic disorder and a GAF of 50-55. Prognosis is poor if he continues drinking.

Here, Claimant has satisfied requirements as set forth in steps one, two of the sequential evaluation as he is not employed and is not currently working and his impairments have met the Step 2 severity requirements.

In addition, the Claimant's impairments do meet a listing as set forth in Appendix 1, 20 CFR 416.926. Listings 4.02 Chronic Heart Failure requires the following to meet the listing.

4.02 *Chronic heart failure* while on a regimen of prescribed treatment, with symptoms and signs described in 4.00D2. The required level of severity for this impairment is met when the requirements in *both A and B* are satisfied.

A. Medically documented presence of one of the following:

1. Systolic failure (see 4.00D1a(i)), with left ventricular end diastolic dimensions greater than 6.0 cm or ejection fraction of 30 percent or less during a period of stability (not during an episode of acute heart failure); or

2. Diastolic failure (see 4.00D1a(ii)), with left ventricular posterior wall plus septal thickness totaling 2.5 cm or greater on imaging, with an enlarged left atrium greater than or equal to 4.5 cm, with normal or elevated ejection fraction during a period of stability (not during an episode of acute heart failure);

AND

B. Resulting in one of the following:

1. Persistent symptoms of heart failure which very seriously limit the ability to independently initiate, sustain, or complete activities of daily living in an individual for whom an MC, preferably one experienced in the care of patients with cardiovascular disease, has concluded that the performance of an exercise test would present a significant risk to the individual; or

2. Three or more separate episodes of acute congestive heart failure within a consecutive 12-month period (see 4.00A3e), with evidence of fluid retention (see 4.00D2b (ii)) from clinical and imaging assessments at the time of the episodes, requiring acute extended physician intervention such as hospitalization or emergency

room treatment for 12 hours or more, separated by periods of stabilization (see 4.00D4c); or

3. Inability to perform on an exercise tolerance test at a workload equivalent to 5 METs or less due to:

a. Dyspnea, fatigue, palpitations, or chest discomfort; or

b. Three or more consecutive premature ventricular contractions (ventricular tachycardia), or increasing frequency of ventricular ectopy with at least 6 premature ventricular contractions per minute; or

c. Decrease of 10 mm Hg or more in systolic pressure below the baseline systolic blood pressure or the preceding systolic pressure measured during exercise (see 4.00D4d) due to left ventricular dysfunction, despite an increase in workload; or

d. Signs attributable to inadequate cerebral perfusion, such as ataxic gait or mental confusion.

In the present case, Claimant has been diagnosed with high blood pressure, chronic heart failure, obesity, dizziness and shortness of breath, knee pain and chronic Kidney disease(stage 3). Claimant credibly testified to the following symptoms and abilities: the Claimant could not walk more than a couple of blocks slowly, and was required to stop due to shortness of breath. The Claimant could stand 5 to 10 minutes and sit only 5 to 10 minutes due to hip pain. The Claimant indicated that he could carry 10 pounds but only for a short distance. He also indicated that he was experiencing diabetic neuropathy with pain and numbness.

The medical evidence of record indicates that since 2012 the Claimant has had a chronic heart failure diagnosis, and the two most recent hospitalizations, resulted in stenting and catheterization and that the Claimant's ejection fraction was15%. The Claimant's [redacted] is a level III which is indicative of serious problems and functional limitations due to aheart condition and provides: Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (20–100m), Comfortable only at rest.. The Claimant also requires insertion of an implantable cardioverter defibrillator implantation. The Claimant has also had several catheterizations. The medical evidence presented demonstrates that Listing 4.02 or its medical equivalent, A(1) systolic failure is met.

It is noted that the Claimant continues to consume alcohol and smoke, the records do indicate that he has cut down on both. It is also determined that although the Claimant continues alcohol is not deemed material as Claimant's current heart condition would not significantly improve with complete alcohol cessation as the chronic heart failure condition and 15% ejection fraction would persist.

Based upon these functional limitations and the medical evidence presented it is determined that the Claimant has demonstrated that Listing 4.02 or its medical

equivalent is met and therefore is found disabled at Step 3 with no further analysis required.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that Claimant is medically disabled as of August 2012.

Accordingly, the Department's determination is ☐ AFFIRMED ☒ REVERSED.

☒ THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE OF MAILING OF THIS DECISION AND ORDER:

1. The Department shall process the October 25, 2012 application for Medical Assistance and retro active application for Medical Assistance (September 2012 and shall determine the Claimant's non medical eligibility for benefits including Michigan residency.

2. The Department shall complete a review of this case in April 2015.

Lynn M. Ferris
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: April 17, 2014

Date Mailed: April 17, 2014

NOTICE OF APPEAL: The claimant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely Request for Rehearing or Reconsideration was made, within 30 days of the receipt date of the Decision and Order of Reconsideration or Rehearing Decision.

Michigan Administrative Hearing System (MAHS) 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. MAHS 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 (60 days for FAP cases).

A Request for Rehearing or Reconsideration may be granted when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion;

- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the client;
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The Department, AHR or the claimant must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date the hearing decision is mailed.

The written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

If submitted by mail, the written request must be addressed as follows:

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

LMF/tm

cc: [redacted]