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

IN THE MATTER OF:

Reg. No.: 201415586
Issue No.: 2009
Case No.: [redacted]
Hearing Date: March 19, 2014
County: Wayne (15)

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

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, a telephone hearing was held on March 19, 2014 from Detroit, Michigan. Participants on behalf of Claimant included Claimant and [redacted], Claimant's daughter. Participants on behalf of the Department of Human Services (Department) included [redacted], Medical Contact Worker.

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional records. The records were received, reviewed, and forwarded to the State Hearing Review Team (SHRT) for consideration. On June 11, 2014, this office received the SHRT determination which found Claimant not disabled. This matter is now before the undersigned for a final determination.

ISSUE

Did the Department properly determine that Claimant was not disabled for purposes of the Medical Assistance (MA-P) benefit program?

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On July 26, 2013, Claimant submitted an application for public assistance seeking MA-P benefits, with request for retroactive coverage to May 2013.

2. On November 15, 2013, the Medical Review Team (MRT) found Claimant not disabled.

3. On November 21, 2013, the Department sent Claimant a Notice of Case Action denying the application based on MRT's finding of no disability.

4. On November 27, 2013, the Department received Claimant's timely written request for hearing.

5. On February 6, 2014 and June 5, 2014, SHRT found Claimant not disabled.

6. Claimant alleged physical disabling impairment due to stroke and left side weakness.

7. Claimant alleged mental disabling impairments due to depression.

8. At the time of hearing, Claimant was [redacted] years old with a [redacted], birth date; she was [redacted] in height and weighed [redacted] pounds.

9. Claimant has an [redacted] grade education and an employment history of work as a janitor, home health aide, and factory worker.

10. Claimant's impairments have lasted, or are expected to last, continuously for a period of 12 months or longer.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Family Independence Agency) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

Department policies are found in the Department of Human Services Bridges Administrative Manual (BAM), Department of Human Services Bridges Eligibility Manual (BEM), and Department of Human Services Bridges Reference Tables (RFT).

MA-P benefits are available to disabled individuals. BEM 105 (January 2014), p. 1; BEM 260 (July 260); BEM 261 (July 2013), p. 1. In order to receive MA benefits based upon disability, Claimant must be disabled as defined in Title XVI of the Social Security Act. 20 CFR 416.901. Disability for MA-P purposes 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).

In order to determine whether or not an individual is disabled, federal regulations require application of a five-step sequential evaluation process. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider (1) whether the individual is engaged in substantial gainful activity (SGA); (2) whether the individual's impairment is severe; (3) whether the impairment and its duration meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) whether the individual has the residual functional capacity to perform past relevant work; and (5) whether the individual has the residual functional capacity and vocational factors (based on age, education and work experience) to 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 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).

In general, the individual has the responsibility to establish a disability 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, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. 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, are insufficient to establish disability. 20 CFR 416.927(d).

Step One

As outlined above, the first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is substantial gainful activity (SGA), then the individual must be considered as not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Claimant has not engaged in SGA activity during the period for which assistance might be available. Therefore, Claimant is not ineligible under step 1 and the analysis continues to step 2.

Step Two

Under step 2, the severity of an individual's alleged impairment(s) is considered. If the individual does not have a severe medically determinable physical or mental impairment that meets the duration requirement, or a combination of impairments that is severe and meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 12 months. 20 CFR 416.922.

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 416.920(a)(4)(ii); 20 CFR 416.920(c). 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); see also *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921(b). Examples include (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b).

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. A disability claim obviously lacking in medical merit may be dismissed. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may 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). However, under the *de minimus* standard applied at step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs* at 862.

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 alleges physical disability due to stroke and left side weakness.

On July 22, 2013, Claimant awoke with left-sided weakness, left facial droop and right eye pain. She went to the hospital and was admitted. On admission, she tested positive for cocaine and opiates, and her blood pressure was 220/120. A CT of Claimant's brain showed bilateral frontal cortical hypodensities, likely representing acute ischemic infarct, hypodense lesion of the superior midline nasopharynx, and chronic

small vessel ischemic changes, and an MRA of her head showed findings consistent with acute/subacute infarction in the vascular territory of the superior division of the right MCA and white matter and chronic ischemic changes. Based on these tests and her history, Claimant was diagnosed with cerebral vascular accident (CVA) resulting from accelerated hypertension due to medication noncompliance and cocaine use.

A speech language pathology consultation concluded that Claimant had mild spastic dysarthria, left neglect affecting reading and writing, and mild oral dysphagia and recommended speech therapy following discharge. A transthoracic echocardiogram report showed (i) normal LV ejection fraction; (ii) normal left ventricular cavity size; (iii) impaired relaxation pattern of LV diastolic filling; (iv) normal right ventricular size and global RV systolic function; and (v) normal pulmonary artery systolic pressure. A transesophageal echocardiogram report showed (i) hyperdynamic LV ejection fraction; (ii) normal left ventricular cavity size and mildly increased LV wall thickness; (iii) normal right ventricular size and global RV systolic function; (iv) no evidence of any intracardia shunt with rest, abdominal pressure and coughing; (v) normal aortic root, ascending aorta and aortic arch; and (vi) no cardiac source of embolism. An MRA of the neck showed mild to moderate stenosis of the carotid bulbs bilaterally measuring 45% on the right side and 46% on the left side. While in the hospital, Claimant was treated for urinary tract infection, and her hypertension was controlled.

Claimant was discharged to in-patient rehabilitation on July 29, 2013 with a post-admission evaluation note that there had not been any significant change in her overall functional status since the time of preadmission screening, but there was a reasonable potential for functional improvement with three-hours of daily therapy. In rehab, her diagnosis was listed as acute ischemic infarction in the right insula, precentral and postcentral gyri with left facial, upper and lower extremity weakness. She was discharged from rehab to family on August 14, 2013.

In a July 24, 2013 medical exam report, the resident doctor listed Claimant's diagnosis as middle cerebral artery (MCA) stroke. She noted that Claimant had marked weakness in her left arm, with grip at 2/5, bicep at 3/5 and deltoid at 2/5; weakness in her left leg, with her hip flexor at 4-/5 and dorsi/plantar flexion at 4-/5; and left facial droop, with the ability to close her left eye but affected speech, cheek and tongue-biting, and weakness. The doctor concluded that Claimant had the following limitations: she could occasionally lift up to 20 pounds but never more and using only her right arm; she could sit up to 4 hours daily but could not stand or walk; she would be able to use only her right hand and arm to grasp, reach, push/pull and manipulate and her right foot and leg to operate foot and leg controls. The doctor noted that Claimant needed extensive physical occupation; her status was stable, and her prognosis showed she could improve with treatment.

On October 8, 2013, Claimant was hospitalized to rule out a new stroke after she complained of worsening of the left-sided weakness and numbness from her July 2013 stroke. A brain MRI did not reveal any new stroke. A head CT showed no acute intracranial abnormality but evolution of previously known right frontoparietal infarct with wallerian degeneration of the corticospinal tract on the right. An echocardiogram showed (i) ejection fraction estimated to be 69%; (ii) normal left ventricular cavity size; (iii) normal pattern of LV diastolic filling; (iv) normal right ventricular size and normal global RV systolic function; (v) no evidence of any intracardiac shunt with rest, Valsalva and coughing; and (vi) normal pulmonary artery systolic pressure. After she significantly improved and returned to her baseline, she was discharged in fair condition. It was noted that from her physical exam at discharge that she had mild left upper and lower extremity weakness; left face and upper and lower extremity numbness; and left upper and lower extremity ataxias. It was also noted that she walked with a cane and a left leg brace.

On October 24, 2013, Claimant was seen at the hospital emergency department complaining of coughing and headaches. She was diagnosed with pharyngitis and discharged.

On October 30, 2013, Claimant participated in a physical consultative exam requested by the Department and a report was prepared. Claimant informed the doctor that she continued to suffer from headaches, dizziness and blurred vision since her stroke. The doctor noted that Claimant used a cane, wore an ankle-foot orthosis, and had a limp on the left side. She had weakness against resistance in the left upper and left lower extremities, with strength 4/5 on the left and 5/5 on the right. Claimant was able to get on the examination table slowly but unable to tandem walk, heel walk or toe walk. Her ability to squat was limited. Straight leg raise while sitting was 0-90 on the right and 0-80 on the left. Abduction of shoulders was 0-150 on the right and 0-140 on the left. Flexion of the knees was 0-150 on the right and 0-140 on the left. The doctor concluded that Claimant continued to have weakness, slurred speech, and mild expressive aphasia.

On November 16, 2013, Claimant participated in a physical consultative exam requested by the by the Social Security Administration and a report was prepared. The doctor noted that Claimant walked with a severe left-sided limp and ataxic gait and wore a left leg brace due to a foot drop. He also noted that she used a cane for balance and weakness issues. Claimant complained of occasional headaches since her stroke, with some associated nausea and visual auras.

In conducting the physical exam, the doctor noted that Claimant's speech was clear. She had moderate difficulty getting on and off the exam table and severe difficulty heel and toe walking, squatting and hopping. The doctor noted limited range of motion in the

lumbar spine, with flexion limited to 60 degrees, extension limited to 20 degrees. All other range of motion was intact and full. The straight leg raise was positive on the right and decreased on the left. She had full dexterity with her right hand but had mild difficulty picking up a coin, buttoning and opening a door with the left hand. The doctor found strength of 5/5 in the right upper and lower extremities and 4/5 in the left upper and lower extremities, with decreased sensation in the left side of the body including the left facial area, left arm and left lower extremity. Reflexes were normal.

The doctor concluded that Claimant had a history of ischemic stroke with left-sided weakness and lower back pain with straight leg positive on the left. Claimant was able to complete all task asked with moderate to severe difficulty due to left sided weakness. Grip strength was slightly decreased on the left, and Claimant used an assistive device for ambulation, which was required secondary to balance and weakness.

Claimant's record also showed evidence of impairments due to mental condition.

On December 13, 2013, a handwritten psychological evaluation showed that Claimant was diagnosed with major depressive disorder recurrent severe and crack cocaine dependency. The mental status examination showed that Claimant was appropriately dressed, with good hygiene. She was cooperative. Her affect was blunted; her speech was clear.

A March 24, 2014 mental residual functional capacity assessment indicated that Claimant was moderately limited with respect to (i) the ability to remember locations and work-like procedures; (ii) the ability to understand and remember one or two-step instructions; (iii) the ability to carry out simple, one [or] two-step instructions; (iv) the ability to carry out detailed instructions; (v) the ability to maintain attention and concentration for extended periods; (vi) the ability to interact appropriately with the general public, (vii) the ability to get along with co-workers or peers without distracting them or exhibiting behavioral extremes; (viii) the ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness; (ix) the ability to be aware of normal hazards and take appropriate precautions; (x) the ability to travel in unfamiliar places or use public transportation; and (xi) the ability to set realistic goals or make plans independently of others.

Claimant was identified as markedly limited in (i) the ability to understand and remember detailed instructions; (ii) the ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; (iii) the ability to sustain an ordinary routine without supervision; (iv) the ability to work in coordination with or proximity to others without being distracted by them; (v) the ability to make simple work-related decisions; (vi) the ability to complete a normal workday and worksheet without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods; (vii) the

ability to ask simple questions or request assistance; (viii) the ability to accept instructions and respond appropriately to criticism from supervisors; and (ix) the ability to respond appropriately to change in the work setting.

In consideration of the *de minimis* standard necessary to establish a severe impairment under step 2, the foregoing medical evidence is sufficient to establish that Claimant suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 12 months. Therefore, Claimant has satisfied the requirements under step 2, and the analysis proceeds to step 3.

Step Three

Step 3 of the sequential analysis of a disability claim requires a determination if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920(a)(4)(iii). If an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

The evidence shows diagnosis of, and treatment for, stroke with left-sided weakness. With respect to this diagnosis, Listing 11.00 (neurological), specifically 11.04 (central nervous system vascular accident), was considered. An impairment meets the severity of a listing under 11.04 when the central nervous system vascular accident is accompanied by one of following more than 3 months post-vascular accident: A. sensory or motor aphasia resulting in ineffective speech or communication; or B. significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station. "Persistent disorganization of motor function" means paresis or paralysis, tremor or other involuntary movements, ataxia and sensory disturbances which occur singly or in various combinations. Listing 11.00C. The assessment of impairment depends on the degree of interference with locomotion and/or interference with the use of fingers, hands and arms. Listing 11.00C.

In this case, Claimant had two consultative physical examinations, both more than three months after her stroke, both showing limitations in Claimant's motor function in both left extremities. In the October 30, 2013 exam ordered by the Department, the doctor noted that Claimant used a cane, wore an ankle-foot orthosis of the left foot, and had a limp on the left side. She had weakness against resistance in the left upper and left lower extremities, with strength 4/5. He noted that she was able to get on the examination table slowly but unable to tandem-,heel-, or toe-walk. Her ability to squat was limited. Straight leg raise while sitting was 0-80 on the left. Abduction of the left shoulder was 0-140. Flexion of the left knee was 0-140. The doctor concluded that Claimant continued to have weakness, slurred speech, and mild expressive aphasia.

In the November 16, 2013 exam requested by the by the Social Security Administration, the doctor noted that Claimant walked with a severe left-sided limp and ataxic gait and wore a left leg brace due to a foot drop. He also noted that she used a cane for balance and weakness issues. In conducting the physical exam, the doctor noted that Claimant's speech was clear. She had moderate difficulty getting on and off the exam table and severe difficulty heel and toe walking, squatting and hopping. The doctor noted limited range of motion in the lumbar spine, with flexion limited to 60 degrees, extension limited to 20 degrees. All other range of motion was intact and full. The straight leg raise was positive on the right and decreased on the left. The doctor found strength of 4/5 in the left upper and lower extremities, with decreased sensation in the left side of the body including the left facial area, left arm and left lower extremity. He noted she had mild difficulty picking up a coin, buttoning and opening a door with the left hand. He noted that she was able to complete all tasks asked but with moderate to severe difficulty due to left sided weakness.

The two consultative reports were sufficient to show that Claimant's stroke resulted in impairments with respect to two extremities, her left leg and left arm, and that the severity of these impairments was sufficient to meet a listing under 11.04(B). Accordingly, Claimant is disabled 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 Claimant disabled for purposes of the MA-P benefit program.

Accordingly, the Department's determination is REVERSED.

THE DEPARTMENT IS ORDERED TO BEGIN DOING 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. Process Claimant's July 26, 2013, MA application, with request for retroactive coverge to May 2013, to determine if all the other non-medical criteria are satisfied and notify Claimant of its determination;

2. Supplement Claimant for lost benefits, if any, that Claimant was entitled to receive if otherwise eligible and qualified;

3. Review Claimant's continued eligibility in August 2015.

Alice C. Elkin
Administrative Law Judge
For Maura Corrigan, Director
Department of Human Services

Date Signed: July 2, 2014

Date Mailed: July 2, 2014

NOTICE OF APPEAL: A party may appeal this Hearing Decision in the circuit court in the county in which he/she resides or has its principal place of business in the State, or the circuit court in Ingham County, within 30 days of the receipt date.

A party may request a rehearing or reconsideration of this Hearing Decision from the Michigan Administrative Hearing System (MAHS) within 30 days of the mailing date of this Hearing Decision, or MAHS may order a rehearing or reconsideration on its own motion.

MAHS may grant a party's Request for Rehearing or Reconsideration 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 party requesting a rehearing or reconsideration 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 this Hearing Decision is mailed.

A written request may be faxed or mailed to MAHS. If submitted by fax, 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

ACE/tlf

2014-15586/ACE

cc: [redacted]