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

IN THE MATTER OF:

[redacted]

Reg. No.:	2014 33560
Issue Nos.:	2009
Case No.:	[redacted]
Hearing Date:	July 30, 2014
DHS County:	Wayne County DHS (18)

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, a three-way telephone hearing was held on July 30, 2014, from Detroit, Michigan. Participants on behalf of Claimant included the Claimant. A witness, [redacted]rt, also appeared on behalf of the Claimant. Participants on behalf of the Department of Human Services (Department) included [redacted], Medical Contact Specialist.

ISSUE

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

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 January 15, 2014, the Claimant submitted an application for public assistance seeking MA-P and retro MA-P benefits (November 2013).

2. On February 4, 2014, the Medical Review Team ("MRT") found the Claimant not disabled. (Exhibit 1)

3. The Department notified the Claimant of the MRT determination on February 11, 2014.

4. On March 26, 2014, the Department received the Claimant's written request for hearing.

5. On May 3 2014, the State Hearing Review Team ("SHRT") found the Claimant not disabled. (Exhibit 2)

6. An Interim Order was issued July 30, 2014. The new evidence was received by the undersigned and reviewed.

7. The Claimant alleges physical disabling impairments due to cerebral vascular hemorrhage, right-sided weakness and headaches.

8. The Claimant has not alleged any mental disabling impairment.

9. At the time of hearing, the Claimant was 49 years old with an [redacted] birth date; Claimant is now 50. Claimant is 5'7" in height; and weighed 165 pounds.

10. The Claimant completed the 11th grade and attended special education classes.

11. The Claimant's past work was landscaping, transmission repair and manufacturing work.

12. The Claimant's impairments have lasted or are expected to last 12 months duration or more.

CONCLUSIONS OF LAW

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

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.

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program purusant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

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 impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3 to Step 4. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

As outlined above, the first step looks at the individual's current work activity. In the record presented, the Claimant is not involved in substantial gainful activity and, therefore, is not ineligible for disability benefits under Step 1.

The severity of the Claimant's alleged impairment(s) is considered under Step 2. The Claimant 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 mean 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 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 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).

The Claimant alleges physical disabling impairments due to headaches, cerebral hemorrhage with ongoing right sided weakness, both upper and lower extremities with memory loss and hypertension.

Claimant has not alleged any mental disabling impairments, although he was examined for mental status secondary to his brain injury.

A summary of the medical evidence follows.

The Claimant was seen for a consultative mental status examination on September 13, 2014. The examiner noted that the Claimant was an accurate historian without evident tendency to exaggerate or minimize symptoms. The Claimant was diagnosed as history of alcohol abuse/dependence per Claimant subsequently denied, depression and antisocial personality disorder. Prognosis was fair. Ability to manage funds was given a tentative approval. The GAF score was 55. A mental residual functional capacity assessment was also administered. The Claimant was markedly limited in his ability to carry out detailed instructions. The Claimant was not significantly limited in the ability to remember locations and work like procedures or ability to understand and remember one of two-step instructions and to carry out simple one of two-step instructions. The Claimant was moderately limited in his ability to maintain attention and concentration for extended periods, as well as the ability to perform activities within a schedule, maintain regular attendance and be punctual within customary tolerances. The Claimant was moderately limited in his ability to sustain an ordinary routine without supervision the Claimant was evaluated as having the ability to make simple work-related decisions and work in coordination with or proximity to others without being distracted by. The

Claimant was moderately limited in his 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. The remainder of his abilities with regard to social interactions and adaptation were moderately limited.

The Claimant's neurologist completed a medical examination report on September 13, 2014, at which time he noted the Claimant was stable, and notes right-sided weakness developing after an automobile collision while on a bicycle. The doctor evaluated the Claimant as occasionally capable of lifting less than 10 pounds. No limitations were noted with regard to standing or sitting. The Claimant was capable of using his left hands and arms, and only his left foot to operate foot controls. The examiner noted that the medical findings which supported the limitations were based on right-sided motor weakness. The Claimant was able to meet his needs in the home. The physical examination noted that the Claimant had difficulty moving his elbow on the right side, the notes indicated he was slow in movement. Claimant did not have the full range of motion of his right knee, ankle or wrist. His flexion on the right hand was slow as was the extension. The Claimant was noted as capable of standing with a cane and that he could carry light weight with left hand. He could pick up a coin, and open the door with his left hand. He could squat and arise from squatting with the help of a cane, and needed help getting on and off the examining table, and could climb stairs with the help of the cane. The Claimant could not heel/ toe walk or tandem walk, and his gate was limited to three or four steps only.

The Claimant was seen by his doctor on August 7, 2014, at which time the assessment noted hypertension, motor vehicle accident head injury and cerebral hemorrhage. The notes indicate that the patient still has significant weakness of right upper and lower extremities. He has been evaluated by neurology, based on neurological evaluation disability papers filed in in detail.

The Claimant was seen on July 28, 2014 with complaints of right hand numbness and right leg pain, and numbness since CVA in November 2013. The doctor noted alcohol abuse, cerebral hemorrhage and neuropathy as the assessments.

At an examination in June 2014, the Claimant's doctor noted alcohol abuse and recommended counseling to quit alcohol and tobacco. Patient fully understood, but is not motivated.

The Claimant was seen on May 6, 2014 for a checkup after a three-year hiatus. A medical examination report that was incomplete was submitted by [redacted], the Claimant's neurologist. It notes that Claimant walks with a cane with right-sided weakness and right-sided visual deficiency. On June 19, 2014, the Doctor indicated his

assessment was left basal ganglion hemorrhage with right-sided weakness. Claimant was started on the Neurotin.

On August 7, 2014 the Claimant's family practice doctor completed a medical examination report. The current diagnosis was basal ganglion hemorrhage, right-sided weakness, and hypertension with history of smoking. The doctor notes that it takes a long time for the Claimant to dress and walks with slow gait, etc. The Claimant was rated as stable and the following limitations were imposed -- the Claimant was capable of lifting less than 5 pounds occasionally and never 10 pounds; the Claimant could sit for about six hours in an eight-hour day; and the use of an assistive device cane was medically necessary. The Claimant could perform simple grasping, pushing/pulling, and fine manipulation with the left hand only. The doctor noted mental limitations regarding concentration, retention and memory as well as writing.

The Claimant was examined in a consultative exam on March 19, 2014. The examiner noted the Claimant ambulates with a normal gait which is not unsteady, lurching or unpredictable. He does use a cane when outside the house, cane was prescribed in December 2013 following his cerebral hemorrhage. He appears stable in standing, sitting and supine positions. The examiner also noted the Claimant was somewhat speech impaired. There was weakness noted in the right upper extremity which would grade as a 4/5, compared to 5/5 on the left. Grip strength was noted weaker on the right than the left hand, but was graded as normal bilaterally. Claimant was able to write with the dominant hand and pick up coins with either hand without difficulty. The right lower extremity was graded 4/5, compared to 5/5 on the left. The Claimant was noted to be hyperreflexic on the right side of his body and would grade his upper and lower extremity reflexes, on the right is 3/4 compared 2/4 on the left. The Claimant is unable to walk on heels, or walk on toes, perform tandem gait, squat or bend. He does appear to have some balance issues. He has fallen three times in the past year. The impression was status post basal ganglia hemorrhage, secondary to trauma, with right-sided weakness, secondary to the hemorrhage and out of control hypertension. The summary concluded that the Claimant's upper and lower extremities have normal function and range of motion; however, he does have right-sided weakness. He also has difficulty with changing positions and problems with his balance. The Claimant does seem capable of non-strenuous tasks with a minimum of walking and standing. The Claimant's ability to perform work-related activities such as bending, stooping, lifting, walking, crawling, squatting, carrying and traveling, as well as pushing and pulling heavy objects, is at least moderately impaired due to the finding above. The Claimant could stand only 10 minutes based on the limitations imposed by this examiner.

The Claimant was examined in a consultative mental status examination on March 20, 2014. The Claimant was noted as having clear speech, but was a poor historian confusing facts, dates and events. A slow gait was noted with a slight limp. The

Claimant attended high school, where he completed the 11th grade with a history of special education. The exam was summarized as follows--closed head injury noted and reported drooling, patient carries handkerchief to wipe drool, short-term memory, loses train of thought and demonstrates variable processing speed. The patient's problems are also physical. The examiner indicated no difficulty in the patient's ability to comprehend and carry out simple directions, and perform repetitive routines simple tasks. There is mild difficulty in the patient's ability to comprehend complex tasks. The patient is able to carry out complex tasks with physical limitations. The patient could benefit from MRS involvement due to his special education history. The diagnostic analysis indicated cognitive impaired, alcohol dependence not in full remission, with fair judgment and insight, and motivation within normal limits. The activity of daily living requires extra time and rest periods due to medical conditions, pain, movement and forgetfulness. The prognosis was good.

When completing his application for disability assistance, the person assisting the Claimant noted that during the evaluation the patient was reaching for objects that were not present. He walked with a limp, demonstrated poor awareness and attention, and required frequent redirection.

The Claimant was hospitalized for seven days in November 2013 due to a intracerebral hemorrhage. The Claimant presented with right-sided weakness and slurred speech likely secondary to hypertension. An MRI showed minimal chronic ischemic changes. At the time of the discharge, the records notes no significant disability despite symptoms; able to carry out all usual duties and activities. An echocardiogram was performed to determine if intra cardiac shunting was required. The ejection fraction was in the range of 55%-60%. An MRI of the brain was conducted a 4 cm area of early subacute hemorrhage within the left basal ganglia, and corona radiate with surrounding edema, and mass effect with typical appearance of hypertensive hemorrhage with chronic ischemic changes.

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

Claimant has testified to the following limitations and abilities. The Claimant can walk approximately less than one block and can stand only 15 to 20 minutes. The Claimant can sit for an hour but has numbness on his right side. The Claimant needs assistance

with showering and dressing, and has difficulty pulling his shirt on and must sit to put his pants on. The Claimant suffers with dizziness and severe headaches. The Claimant does not bend at the waist because he tends to fall. The Claimant has a medically prescribed use of a cane. During the hearing, the undersigned observed that the Claimant's speech was very slurred. The Claimant also has no ability to go up and downstairs.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The Claimant asserts disabling impairments due to headaches, slurred speech, and cerebral hemorrhage, with ongoing right sided weakness in both upper and lower extremeties, with memory loss, seizures and hypertension. As regards the alleged physical limitations, Listing 11.00 Neurological Disorders was reviewed; however, the medical evidence of seizures was not fully documented. At the time of the hearing, however, the Claimant's witness at the hearing credibly testified that the Claimant recently had a seizure with convulsions lasting 15 minutes in her presence and was taken to an emergency room. Listing 11.04 Central Nervous system Vascular Accident was also reviewed. Ultimately, it was determined based upon the medical evidence and the Claimant's testimony of his condition, that the Claimant has demonstrated that he meets Listing 11.04 or its medical equivalent. Therefore, it is determined that the Claimant is disabled at Step 3 with no further analysis required.

Assuming arguendo that further analysis was required and that the Claimant was not disabled at Step 3, it would be determined that the Claimant is no longer capable given his current physical and mental limitations, from performing medium to heavy past relevant work, including landscaping, transmission repair and manufacturing work. Likewise, the Claimant would be found disabled at Step 5 as well, as several of his doctors place him at less than sedentary.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Claimant disabled for purposes of the MA –P benefit program.

DECISION AND ORDER

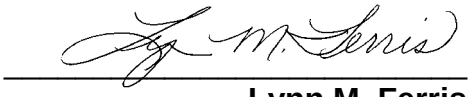
Accordingly, the Department's determination is REVERSED.

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 re-register and process the Claimant's application for MA-P dated January 15, 2014 and retro application for November 2013, and determine Claimant's non-medical eligibility if it has not already done so.

2. The matter shall be reviewed in October 2015.

3. The Department shall advise the Claimant of its determination in writing.



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

Date Signed: October 28, 2014

Date Mailed: October 28, 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.

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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]