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

IN THE MATTER OF:

[redacted]

Reg. No.: 14-018277
Issue No.: 2009
Case No.: [redacted]
Hearing Date: January 26, 2015
County: Oakland-District 4

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, an in-person hearing was held on January 26, 2015, from Pontiac, Michigan. Participants on behalf of Claimant included the Claimant and [redacted]; Claimant's authorized hearing representative (AHR). Participants on behalf of the Department of Human Services (Department) included [redacted], Eligibility Specialist.

During the hearing, the AHR waived the time period for the issuance of this decision in order to allow for the submission of additional records. Some of the requested records were received by the interim order due date. 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 April 11, 2014, Claimant submitted an application for public assistance seeking MA-P benefits, with a request for retroactive coverage to March 1, 2014.

2. On August 20, 2014, the Department sent Claimant a Notice of Case Action denying the application because she was not under 21, pregnant, the caretaker of

a minor child in the home, over 65, blind or disabled, with a note from the specialist that Claimant had not attended a scheduled doctor's appointment or returned proof of assets.

3. On August 20, 2014, the Department sent the AHR a DHS-2565, Facility Admission Notice, advising the AHR that Claimant was denied MA because she did not attend a consultative doctor's appointment.

4. The Department subsequently became aware that Claimant did in fact attend the doctor's appointment.

5. On September 4, 2014, the Medical Review Team (MRT) found Claimant not disabled.

6. On September 4, 2014, the Department sent the AHR a Facility Admission Notice notifying it that Claimant's application was denied because of MRT.

7. On October 13, 2014; November 13, 2014; and December 16, 2014, the AHR faxed to the Department a written request for a hearing concerning the denial of Claimant's April 11, 2014 MA application, disputing MRT's finding that Claimant was not disabled.

8. Claimant alleged physical disabling impairment due to chronic artery disease; shortness of breath; diabetes mellitus; back pain; and asthma.

9. Claimant alleged mental disabling impairments due to anxiety.

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

11. Claimant attended high school through the [redacted] grade. She has training in data entry and is a certified direct care worker.

12. Claimant has an employment history of work as a direct care worker providing assistance with medication and driving, a telephone interviewer, and a customer service representative.

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

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.

As a preliminary matter, the AHR established that it faxed a request for hearing concerning the denial of Claimant's MA application to the Department on October 13, 2014; November 13, 2014; and December 16, 2014. Because the AHR was not notified by the Department of the denial of the application due to MRT's finding of no disability until it received the September 4, 2014 denial of the Facility Admission Notice, the AHR's October and November hearing requests were timely. See BAM 600 (January 2015), p. 6. The hearing proceeded to address the denial of Claimant's MA-P application due to MRT's conclusion that Claimant was not disabled.

MA-P benefits are available to disabled individuals. BEM 105 (January 2014), p. 1; BEM 260 (July 2014), pp. 1-4. Disability for MA-P purposes is defined as the inability to do any substantial gainful activity (SGA) 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). To meet this standard, a client must satisfy the requirements for eligibility for Supplemental Security Income (SSI) receipt under Title XVI of the Social Security Act. 20 CFR 416.901.

To determine whether an individual is disabled for SSI purposes, the trier-of-fact must apply a five-step sequential evaluation process and consider the following:

(1) whether the individual is engaged in 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)(1) and (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).

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 SGA, then the individual must be considered 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 for MA-P 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, including (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. A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28. If such a finding is not clearly established by medical evidence, however, adjudication must continue through the sequential evaluation process. *Id.* If the effect of an impairment or combination of impairments on the individual's ability to do basic work activities cannot be clearly determined, the sequential evaluation process should not end at Step 2; rather, it should be continued. *Id.*; SSR 96-3p.

In the present case, Claimant alleges physical disabling impairment due to chronic artery disease; shortness of breath; diabetes mellitus; back pain; asthma; and mental disabling impairment due to anxiety. The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

In 2006, Claimant had her first stent surgery. Claimant was hospitalized from June 7, 2013 to June 11, 2013 complaining of chest pain. She was found to have some transient second-degree atrioventricular block that was asymptomatic and additional workups were requested. After undergoing a heart catheterization on June 10, 2013, Claimant was found to have chronic total occlusion (CTO) and severe residual disease of the right coronary artery (RCA). Two additional stents were placed in the left circumflex. (Exhibit 5, pp. 198-222.)

Claimant returned to the hospital on July 16, 2013 complaining of chest pain and shortness of breath. She was admitted for observation until July 17, 2013. A July 16, 2013 chest x-ray showed no focal infiltrate or consolidation. (Exhibit 5, pp. 183-197.)

Claimant was hospitalized from August 27, 2013 to August 28, 2013 complaining of persistent chest pain which she complained had been ongoing since her cardiac catheterization in June 2013. A physical exam at admission showed full range of motion of both upper and lower extremities and muscle strength 5/5 in all extremities. An August 27, 2013 chest x-ray showed no evidence of an acute cardiopulmonary

process. An August 27, 2013 nuclear medicine myocardial perfusion stress test showed normal (i) Persantine myocardial perfusion scan, (ii) cardiac wall motion and (iii) left ventricular ejection fraction of 61%. (Exhibit 5, pp. 169-182.)

Claimant was hospitalized from March 6, 2014 to March 16, 2014 after complaining of chest discomfort, like a squeezing pressure, and pain radiating to the arms. Claimant's medical history of coronary artery disease, with stents in June 2013 and in 2006 following myocardial infarction, was noted. Additionally, Claimant had a past medical history of diabetes mellitus, asthma, hypertension, anxiety disorder, alcohol abuse and tobacco abuse. Claimant underwent heart catheterization on March 6, 2014 for a non ST-elevation myocardial infarction and was found to have left main with an ostial 70% stenosis and several other issues. A preoperative echocardiogram showed an ejection fraction of 50% to 55% with diastolic dysfunction, mild annular calcification of the mitral vales, trace tricuspid regurgitation, trivial mitral regurgitation, and trace pulmonic regurgitation. Claimant underwent additional preoperative testing on March 6, 2014. A consulting cardiologist concluded that, because of her non-ST elevation myocardial infarction with severe triple vessel coronary artery disease, Claimant should undergo a coronary revascularization. On March 10, 2014, Claimant underwent coronary artery bypass grafting x4 and, in connection with this procedure, intraoperative transesophageal echocardiography and endoscopic vein harvesting. Claimant's post-operative condition improved and her pain was under control at discharge on March 16, 2014. (Exhibit 5, pp. 24-27; 28-87; 105-168.)

Claimant's physical examination at the time of hospitalization showed full range of motion in both upper and lower extremities (Exhibit 5, p. 29). At admission, she admitted smoking half a pack of cigarettes daily for the past 25 years but denied illicit drug use; she stated she was a recovering alcoholic and had not drank alcohol in the last 5 years (Exhibit 5, pp. 28, 41). On March 8, 2014, Claimant was seen by a doctor concerning her diabetes who concluded that her diabetes mellitus was "totally out of control" (Appendix 5, pp. 33-35).

A March 16, 2014 chest x-ray showed postoperative changes with strands of atelectasis in the left lung and tiny residual right pleural effusion but no new complicating process (Exhibit 5, p. 53). A March 31, 2014 chest x-ray, which was compared to the March 16, 2014 x-ray, showed resolution of the right pleural effusion with residual atelectasis of the right lung base. No pneumothorax was noted. There was stable mild cardiomegaly without pulmonary vascular congestion. (Exhibit 5, pp. 23, 104.)

On April 7, 2014, Claimant returned to the hospital complaining of chest pain. Claimant's chest x-ray was stable compared to previous results. Because Claimant described her pain as superficial and she had been unable to take her postoperative pain medication because it made her nauseous, it appeared that her issue was due to uncontrolled post-surgical pain but she was admitted. It was noted that the sternotomy scar was healing well with no signs of infection and EKG was normal. (Exhibit 55, pp. 88-101.)

On April 18, 2014, Claimant returned to the hospital complaining of chest pain. A chest x-ray showed stable appearance of the chest with post-coronary artery bypass graft (CABG) changes and minor strands of scarring or atelectasis in the lingular segment of the left upper lobe and the right lung base but no acute intrathoracic process. The doctor noted that Claimant's chest pain was atypical but her blood work was normal, and her chest x-ray was unremarkable, showing no sign of pneumothorax or infectious process. (Exhibit A, pp. 193-205.)

Claimant returned to the hospital the next day, April 19, 2014, complaining that, in addition to the ongoing chest pain, she was also experiencing left arm pain. A chest x-ray showed no acute process and was unchanged from the prior day's study. Claimant's troponin levels came back elevated and the doctor concluded that she was not taking her medications correctly or was not on the correct medications for her chest pain and diabetes mellitus. Her cardiologist concluded that no acute intervention was necessary and recommended that Claimant go home and follow up with him in two days. After Claimant's drug regimen was changed, the emergency room doctor recommended a repeat troponin test, but Claimant indicated she felt better and did not want to stay. (Exhibit A, pp. 180-192.)

Claimant was hospitalized from May 15, 2014 to May 19, 2014 for chest pain and shortness of breath. At the time of admission, she was noted to have acute pulmonary edema, possibly secondary to hypertension. Shortly after coming to the emergency department, Claimant became hypoxic and, when nasal oxygen did not resolve the issue, she was immediately intubated for desaturation and pending respiratory failure. A post-intubation chest x-ray was significant for flash pulmonary edema. Because her blood sugar level was over 400, she was also placed on an insulin drip. A May 15, 2014 echocardiogram showed normal left ventricle size, normal left ventricular wall thickness, and left ventricular ejection fraction estimated at 55%. Based on EKG results, the overall impression was sinus tachycardia and ischemic changes in anterior leads. Claimant's last echo in March 2014 showed ejection fraction of 50% to 55% with diastolic dysfunction. She was discharged in stable and fair condition with active diagnoses of diabetic ketoacidosis, history of coronary artery disease, and unspecified essential hypertension. (Exhibit A, pp. 97-179.)

A July 14, 2014 stress test, compared with the August 27, 2013 study showed (i) moderate area of reversible ischemia (approximately 10% to 20% of the left ventricle) in the inferolateral wall and (ii) hypokinetic the inferolateral wall with an ejection fraction of 43% (Exhibit A, pp. 94-95).

A July 16, 2014 CT scan of the extracranial carotid and vertebrobasilar arteries showed (i) atheromatous plaque involving a short segment of left common carotid artery at the proximal to mid segment causing moderate degree of stenosis; (ii) a high degree of stenosis of approximately 70% at the origin of the left internal carotid artery from the

underlying atheromatous plaque; and (iii) redemonstration of multiple nodules of the thyroid gland, with further evaluation of the neck/thyroid gland recommended. (Exhibit A, pp. 92-93.)

On July 17, 2014, Claimant submitted to a consultative physical examination. In a report prepared in connection with the exam, the doctor noted Claimant's past medical history of coronary artery disease, two myocardial infarctions, chronic heart failure, high blood pressure, hyperlipidemia, diabetes, chronic back pain, and eczema and her past surgical history of quadruple bypass in March 2014 and stent placements in 2008 and 2012. Claimant complained of shortness of breath with minimal exertion, chest pain, and asthma. When asked about any psychiatric issues, Claimant denied any depressive symptoms. The doctor noted in her examination of Claimant's chest that it was clear to auscultation except bilateral few rhonchi and mild wheezing.

In examining Claimant's musculoskeletal system, the doctor noted that (i) Claimant had a lot of muscle spasms in the lower back area with painful range of motion; (ii) her straight leg raise was positive for 30 to 40 degrees; (iii) she had painful range of motion in both shoulders; (iv) she had no erythema or swelling and full range of motion in the cervical spine; and (v) she had full range of motion in the knees and both upper extremities. In her assessment, the doctor concluded that Claimant had coronary artery disease, a history of myocardial infarction, status post CABG; high blood pressure; hyperlipidemia; chronic back pain; asthma; questionable anxiety; insulin-dependent diabetes mellitus; history of tobaccoism. (Exhibit 5, pp. 11-13.)

On July 23, 2014 Claimant was admitted to the hospital for a cardiac catheterization for coronary artery bypass surgery, with angioplasty and stenting of the left main coronary artery and the obtuse marginal branch and angioplasty for in-stent restenosis of the distal left circumflex artery. As a result of the procedure, Claimant went (i) from 100% occlusion of the circumflex artery to 0% residual stenosis; (ii) from 80% stenosis of the obtuse marginal branch to 0% residual stenosis post-stenting; and (iii) from 70% stenosis of the proximal left anterior coronary artery to 0% residual stenosis post-stenting. The result was good left ventricular function with an estimated ejection fraction of 50% to less than 55%. (Exhibit A, pp. 52-56, 39-91.)

From August 6, 2014 to August 8, 2014, Claimant was hospitalized for a carotid angiography, left heart catheterization, placement of a distal protection device in the left internal carotid artery and angioplasty and stenting of the left carotid artery. (Exhibit A, pp. 1-38).

In consideration of the de minimus standard necessary to establish a severe impairment under Step 2 and in light of Claimant's cardiac issues beginning in June 2013, 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 will proceed to Step 3.

Step Three

Step 3 of the sequential analysis of a disability claim requires a determination as to whether 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.

Based on Claimant's allegations of chronic artery disease, shortness of breath, diabetes mellitus, neuropathy, back pain, asthma, and anxiety, Listings 1.00 (musculoskeletal system), particularly 1.04 (disorders of the spine); 3.00 (respiratory system), particularly 3.03 (asthma); 4.00 (cardiovascular system), particularly 4.04 (ischemic heart disease); 9.00 (endocrine disorders); 11.00 (neurological), particularly 11.14 (peripheral neuropathy); and 12.00 (mental disorders), particularly 12.06 (anxiety-related disorders) were considered.

The medical record presented does **not** show that Claimant's impairments meet, or are equal to, the required level of severity of any listing to be considered as disabling without further consideration. Because Claimant's physical and mental conditions are insufficient to meet, or to equal, the severity of a listing, Claimant is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Step 4, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. Impairments, and any related symptoms, may cause physical and mental limitations that affect what a person can do in a work setting. 20 CFR 416.945(a)(1). RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s) and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4). The total limiting effects of all impairments, including those that are not severe, are considered. 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicants 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).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If the limitations and restrictions imposed by the individual's impairment(s) and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b). To determine the exertional requirements, or physical demands, of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a).

> Sedentary work.
> Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.
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> Light work.
> Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, [an individual] must have the ability to do substantially all of these activities. If someone can do light work, … he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.
>
> Medium work.
> Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, … he or she can also do sedentary and light work.
>
> Heavy work.
> Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, … he or she can also do medium, light, and sedentary work.
>
> Very heavy work.
> Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If someone can do very heavy work, … he or she can also do heavy, medium, light, and sedentary work.
>
> 20 CFR 416.967.

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of nonexertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., can't tolerate

dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi).

In this case, Claimant alleges exertional and nonexertional limitations due to her impairments.

Claimant alleges exertional limitations due to her back pain, coronary artery disease, and shortness of breath. At the hearing, she testified that she could walk a block to a block and a-half before experiencing shortness of breath; she could sit ten minutes before her legs and back started to hurt; she could pick up no more than 10 pounds at a time; she could stand 10 minutes before needing to sit down; she tried to avoid stairs; she could grip and grasp; and she could bend but could not squat. She testified that she lived with her daughter, she bathed herself but was sometimes assisted by her daughters or used a chair; she could dress herself but could not tie her shoes; she was able to do some cooking and cleaning as long as she did not have to stand too long; she could shop with assistance; she could drive but preferred to let her boyfriend drive because she had problems with her attention span.

The physical examination records from her hospitalizations in August 2013 and March 2014 show full range of motion in the upper and lower extremities (Exhibit 5, pp. 5, 24-27; 28-87; 105-168). However, the doctor from the July 17, 2014 consultative exam found that, although Claimant had no erythema or swelling and full range of motion in the cervical spine, the knees and both upper extremities, she had a lot of muscle spasms in the lower back area with painful range of motion and a straight leg raise that was positive for 30 to 40 degrees (Exhibit 5, pp. 11-13). Therefore, there is medical evidence supporting Claimant's complaints of back pain.

Claimant's medical record also support ongoing issues arising from her chronic artery disease, including several stents in 2006, June 2013 and August 2014, and, in March 2014, the retroactive month for which MA is sought, quadruple bypass surgery as well as issues with uncontrolled diabetes mellitus in March 2014 and April 2014. Between March 2014 and July 2014, Claimant had numerous hospital visits and two hospitalizations. She had an incident of flash pulmonary edema and diabetic ketoacidosis in May 2014, although she was discharged in stable and fair condition. (Exhibit A, pp. 97-179.) On July 23, 2014 Claimant was admitted to the hospital for a cardiac catheterization for coronary artery bypass surgery, with angioplasty and stenting of the left main coronary artery and the obtuse marginal branch and angioplasty for in-stent restenosis of the distal left circumflex artery. As a result of the procedure, Claimant went (i) from 100% occlusion of the circumflex artery to 0% residual stenosis; (ii) from 80% stenosis of the obtuse marginal branch to 0% residual stenosis post-stenting; and (iii) from 70% stenosis of the proximal left anterior coronary artery to 0% residual stenosis post-stenting. The result was good left ventricular function with an estimated ejection fraction of 50% to less than 55%. (Exhibit A, pp. 52-56, 39-91.) In August 2014, Claimant was hospitalized for a carotid angiography, left heart

catheterization, placement of a distal protection device in the left internal carotid artery and angioplasty and stenting of the left carotid artery (Exhibit A, pp. 1-38). As a result of these procedures, Claimant's cardiac condition appears to have improved. There were no medical records admitted into the record for any ongoing cardiac issues or additional evidence of uncontrolled diabetes.

Based on the medical record presented, Claimant physical RFC to perform basic work activities was limited to less than sedentary for the period of March 2014 through August 2014. From September 2014 ongoing, Claimant's cardiac condition appears to have improved and there was no evidence that her diabetes was not controlled. However, she continued to experience back pain. Based on the record presented, for the period September 2014 ongoing, Claimant maintains the physical capacity to perform, at a minimum, sedentary work as defined by 20 CFR 416.967(a).

Claimant also alleged nonexertional limitations due to anxiety. She testified that she has anxiety attacks which last until she finds a way to soothe herself; her attention span is limited; she has no appetite but she has gained weight because of her insulin; and she takes prescription medication, which she admits help with her anxiety, and has sought therapy for her anxiety. Claimant's medical record does not support any limitations to Claimant's ability to perform basic work activities due to anxiety. Therefore, Claimant retains mild to no limitations on her mental ability to perform basic work activities due to mental impairments.

Claimant's RFC is considered at both Steps 4 and 5. 20 CFR 416.920(a)(4), (f) and (g).

Step Four

Step 4 in analyzing a disability claim requires an assessment of Claimant's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. 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).

Claimant's work history in the 15 years prior to the application consists of work as a direct care worker providing assistance with medication and driving (light, semi-skilled), a telephone interviewer (sedentary, unskilled), and a customer service representative (sedentary, unskilled).

March 2013 to August 2014

As determined in the RFC analysis above, Claimant is limited to less than sedentary work activities for the period March 2013 through August 2014 and has mild to no limitations in her mental capacity to perform basic work activities. In light of the entire

record and Claimant's RFC, it is found that Claimant was **not** able to perform past relevant work for the period March 2013 through August 2014. Accordingly, for the period March 2014 through August 2014, Claimant cannot be found disabled, or not disabled, at Step 4 and the assessment continues to Step 5.

September 2014 ongoing

For the period September 2014 ongoing, Claimant's RFC is limited to sedentary work activities and she has mild to no limitations in her mental RFC to perform basic work activities. Because Claimant's past relevant work consisted of sedentary work, for September 2014 ongoing, Claimant retains the RFC to meet the physical demands of past work. Her mental RFC does not affect her ability to perform her prior work activities. Because Claimant is capable of performing her prior work after September 2014, she cannot be considered as disabled for that period. Therefore, for September 2014 ongoing, Claimant is found **not** disabled at Step 4, and no further analysis is required for that period of time.

Step 5

In Step 5, an assessment of Claimant's RFC 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). If the individual can adjust to other work, then there is no disability. 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 RFC to obtain and maintain SGA. 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).

When the impairment(s) and related symptoms, such as pain, only affect the ability to perform the exertional aspects of work-related activities, Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix 2, 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). When a person has a combination of exertional and nonexertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination **unless** there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969a(d).

As discussed above in Step 4, Claimant is not disabled for the period September 2014 ongoing under Step 4. The issue at Step 5 is whether Claimant had, based on her age, education, and work experience, the RFC to adjust to other work for the period from March 2014 through August 2014. In this case, Claimant was [redacted] years old at the time

at issue and, thus, considered to be a younger individual (age 45-49) for purposes of Appendix 2. She went through the [redacted] grade in high school. As discussed above, for the period March 2014 through August 2014, Claimant maintained the RFC for work activities on a regular and continuing basis to meet the physical demands to perform less than sedentary work activities and has mild to no limitations on her mental ability to perform work activities. After review of the entire record, including Claimant's testimony, and in consideration of Claimant's age, education, work experience, physical as well as her physical RFC, Claimant is found **disabled** at Step 5 for purposes of MA-P benefit program from March 2013 through August 2014.

The Administrative Law Judge, based on the above findings of fact and conclusions of law finds for purposes of the MA-P benefit program that Claimant is (i) disabled for the period March 2014 through August 2014 and (ii) **not** disabled for September 2014 ongoing.

DECISION AND ORDER

Accordingly, the Department's MA-P determination is AFFIRMED IN PART with respect to its disability finding for the period September 2014 ongoing AND REVERSED IN PART with respect to its disability finding for the period March 2013 through August 2014.

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 April 11, 2014, MA application, with request for retroactive coverage to March 2014, to determine if all the other non-medical criteria are satisfied for the period March 1, 2014 to August 31, 2014 and notify Claimant of its determination; and

2. Supplement Claimant for lost benefits, if any, that Claimant was entitled to receive if otherwise eligible and qualified from March 1, 2014 to August 31, 2014.

Alice C. Elkin
Administrative Law Judge
for Nick Lyon, Interim Director
Department of Human Services

Date Signed: **3/13/2015**

Date Mailed: **3/13/2015**

ACE / tlf

NOTICE OF APPEAL: A party may appeal this Hearing Decision in the circuit court in the county in which he/she resides, 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 48909-8139

cc: [redacted]