

STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF: [REDACTED]

Claimant

Reg. No: 2008-22261

Issue No: 2009

Case No: [REDACTED]

Load No: [REDACTED]

Hearing Date:

September 24, 2008

Macomb County DHS

ADMINISTRATIVE LAW JUDGE: Jay W. Sexton

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon claimant's request for a hearing. After due notice, a telephone hearing was held in Warren on September 24, 2008. Claimant personally appeared and testified under oath.

The department was represented by Conyell Watkins (ES) and Patricia Lemon (ES).

The Administrative Law Judge appeared by telephone from Lansing.

ISSUES

(1) Did claimant establish a severe mental impairment expected to preclude her from substantial gainful work, **continuously**, for one year (MA-P)?

(2) Did claimant establish a severe physical impairment expected to preclude her from substantial gainful work, **continuously**, for one year (MA-P)?

FINDINGS OF FACT

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

(1) Claimant is an MA-P/retro applicant (February 11, 2008) who was denied by SHRT (July 1, 2008) due to claimant's ability to perform unskilled medium work. SHRT relied on Med-Voc Rule 203.18 as a guide. Claimant requests retro-MA for November and December 2007 and January 2008.

(2) Claimant's vocational factors are: age--50; education--10th grade; post-high school education--GED; work experience--surveyor, puppy adoption worker, service desk worker and substitute cashier for [REDACTED].

(3) Claimant has not performed Substantial Gainful Activity (SGA) since October 2006 when he was a surveyor who asked mall-goers their opinions on various issues.

(4) Claimant has the following unable-to-work complaints:

- (a) Status post stroke;
- (b) Right elbow pain;
- (c) Bilateral knee pain;
- (d) Status post knee surgery;
- (e) Unable to use last 3 fingers of right hand;
- (f) Received MA in 2007;
- (g) Bipolar disorder;
- (h) Depression.

(5) SHRT evaluated claimant's medical evidence as follows:

OBJECTIVE MEDICAL EVIDENCE (July 1, 2008)

A DHS-49 form, dated 9/2007, indicated claimant had asthma, osteoarthritis of the lumbar spine, right knee and both elbows, hepatitis C with no hepatic failure, depression, pre case of hypothyroidism and chronic polysubstance abuse (page 12).

An exam, dated 1/2008, showed claimant was 67½ inches tall and 151 pounds. The thyroid was not enlarged. Heart sounds were normal. Breath sounds were vesicular, with no adventitious sounds. There was a well healed surgical scar over the left ankle joint. There was no tenderness over the spine. All movements of the lumbar spine were painful, but there was no limitation of motion. Straight leg raise was 90 degrees, on both sides with complaint of pain in the right hip joint (page 2). Range of Motion (ROM) of the right hip and right knee was restricted and painful. There was no pain, swelling, limitation of motion or crepitus of any other joint. There was no wasting of the muscles around the joints. Grip was good. Claimant ambulated without any walking aid, but with a limp. There was no loss of dexterity. Power and tone sensations were normal. Reflexes were normal (page 3).

ANALYSIS:

Claimant has a history of polysubstance abuse, but reported occasional alcohol use and the last use of illegal drugs was in 2003. On exam, she had some limitation of motion and pain. But grip and dexterity were good. She could walk without assistance. Claimant should avoid heavy lifting.

(6) Claimant lives alone and performs the following Activities of Daily Living (ADLs): dressing (needs help), bathing (sometimes), cooking (sometimes), dishwashing (sometimes), light cleaning (sometimes), vacuuming (sometimes), laundry (sometimes), and grocery shopping (sometimes). Claimant uses a cane approximately 20 times a month. She does not use a walker or a wheelchair. She uses a shower stool about 4 times a month. Claimant wears a brace on her waist about 30 times a month. She wears a right hand brace about 4 times a month. Claimant was hospitalized at St. Joseph's Hospital in August 2007 to obtain treatment of a blood disorder.

(7) Claimant has a valid driver's license but does not drive an automobile. Claimant is not computer literate.

(8) The following medical/psychological records are persuasive:

- (a) A [REDACTED] narrative internist report was reviewed.

The internist provided the following history:

This patient says that she fractured the right ankle joint in 1985 and had surgery for it. Since then she has had pain and swelling of the right ankle joint. She also has pain and swelling of the left ankle joint for the last 12 years, but there is no history of any injury. She also complains of pain in the right hip joint for the last 12 years and pain in the lower part of the back for the last 12 years. She had an MRI in 1996 and was told she had a ruptured disc over the lumbar vertebrae. She had an auto accident in 1996. She had physical therapy for more than one year which improved the pain to a certain extent. The pain for the lower part of her back radiates down to the right ankle on the right side up to the knee on the left side. She said she can manage to walk without support from room to room and stand for 5 minutes. She can climb one flight of stairs, one step at a time. With change of position, she can sit for about one hour. She can lie on the bed for several hours. She cannot manage to do any household chores. She cannot lift anything from the floor or table height. She has been using a cane since July 200, both indoors and outdoors to keep pressure off the right ankle joint, hip joint and lower part of the back. She was taking Vicodin ES, but she has not been taking anything since August 2007 because of lack of money and insurance. In the year 2003, she had also been diagnosed to have Rheumatoid Arthritis.

The internist provided the following assessment, in pertinent part:

NERVOUS SYSTEM: She has been suffering from depression for the last 7 years. She was taking medication for it until August 2007 when she had to stop due to lack of money and insurance. Memory is good. No weakness, dizziness, tingling, numbness or involuntary movements.

PERSONAL HISTORY: She has been smoking 10 cigarettes a day for the last 37 years. She has used alcohol heavily in the past, but currently she drinks occasionally. She has used heroin, crack, cocaine, LSD, acid, speed and marijuana for about 33 years, but stopped in the year 2003.

The internist provided the following diagnoses:

- (1) Osteoarthritis of the knee and hip joints. Patient has functional limitations orthopedically.
- (2) Chronic alcoholism and a history of hepatitis C. Clinically, however, there is not evidence of hepatitis or hepatic failure. No abnormal physical finding noted in the abdomen during this exam.
- (3) Depression. Memory is good, she was in fair grooming and hygiene. She responded fairly well to the examining situation.
- (4) Chronic polysubstance abuse, but is currently in remission. Clinically, there is no evidence of endocarditis or peripheral neuropathy.

(9) The probative medical evidence does not establish an acute (non-exertional) mental condition expected to prevent claimant from performing all customary work functions for the required period of time. Claimant testified that she has the following mental impairments: bipolar disorder and depression. However, the medical records show only a diagnosis for depression. There is no evidence from the medical records that claimant's depression is so severe that she is totally unable to work. Also, claimant did not provide a DHS-49d or a DHS-49e to show her mental residual functional capacity.

(10) The probative medical evidence does not establish an acute (exertional) physical impairment expected to prevent claimant from performing all customary work functions for the required period of time. The medical records do show the following physical diagnosis: osteoarthritis of the knee and hip joints, chronic alcoholism and history of hepatitis C, chronic polysubstance abuse, currently in remission. The medical evidence of record does not establish the claimant's physical impairments are so severe that she is totally unable to work.

(11) Claimant recently applied for federal disability benefits with the Social Security Administration. Social Security denied her application; claimant filed a timely appeal.

CONCLUSIONS OF LAW

CLAIMANT'S POSITION

Claimant thinks she is entitled to MA-P based on the impairments listed in paragraph #4, above.

DEPARTMENT'S POSITION

The department thinks that claimant has the residual functional capacity to perform unskilled medium work.

The department thinks that claimant's impairments do not meet/equal the intent or severity of a Social Security listing.

Based on Med-Voc Rule 203.18, in combination with claimant's vocational profile [closely approaching advanced age (50), GED education and unknown work history] claimant's application for MA-P was denied.

LEGAL BASE

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the MA program pursuant to MCL 400.10, *et seq.*, and MCL 400.105. Department policies are found in the Program Administrative Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM).

Pursuant to Federal Rule 42 CFR 435.540, the Department of Human Services uses the federal Supplemental Security Income (SSI) policy in determining eligibility for disability under the Medical Assistance program. Under SSI, disability is defined as:

...the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which

can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.... 20 CFR 416.905

A set order is used to determine disability. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience is reviewed. If there is a finding that an individual is disabled or not disabled at any point in the review, there will be no further evaluation. 20 CFR 416.920.

If an individual is working and the work is substantial gainful activity, the individual is not disabled regardless of the medical condition, education and work experience. 20 CFR 416.920(c).

If the impairment or combination of impairments do not significantly limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. Age, education and work experience will not be considered. 20 CFR 416.920.

Statements about pain or other symptoms do not alone establish disability. There must be medical signs and laboratory findings which demonstrate a medical impairment.... 20 CFR 416.929(a).

...Medical reports should include –

- (1) Medical history.
- (2) Clinical findings (such as the results of physical or mental status examinations);
- (3) Laboratory findings (such as blood pressure, X-rays);
- (4) Diagnosis (statement of disease or injury based on its signs and symptoms).... 20 CFR 416.913(b).

In determining disability under the law, the ability to work is measured. An individual's functional capacity for doing basic work activities is evaluated. If an individual has the ability to

perform basic work activities without significant limitations, he or she is not considered disabled. 20 CFR 416.994(b)(1)(iv).

Basic work activities are the abilities and aptitudes necessary to do most jobs. Examples of these include --

- (1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;
- (2) Capacities for seeing, hearing, and speaking;
- (3) Understanding, carrying out, and remembering simple instructions;
- (4) Use of judgment;
- (5) Responding appropriately to supervision, co-workers and usual work situations; and
- (6) Dealing with changes in a routine work setting. 20 CFR 416.921(b).

Medical findings must allow a determination of (1) the nature and limiting effects of your impairment(s) for any period in question; (2) the probable duration of the impairment; and (3) the residual functional capacity to do work-related physical and mental activities. 20 CFR 416.913(d).

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

All of the evidence relevant to the claim, including medical opinions, is reviewed and findings are made. 20 CFR 416.927(c).

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

A statement by a medical source finding that an individual is "disabled" or "unable to work" does not mean that disability exists for the purposes of the program. 20 CFR 416.927(e).

When determining disability, the federal regulations require that several considerations be analyzed in sequential order. If disability can be ruled out at any step, analysis of the next step is not required. These steps are:

1. Does the client perform Substantial Gainful Activity (SGA)? If yes, the client is ineligible for MA. If no, the analysis continues to Step 2. 20 CFR 416.920(b).
2. Does the client have a severe impairment that has lasted or is expected to last 12 months or more or result in death? If no, the client is ineligible for MA. If yes, the analysis continues to Step 3. 20 CFR 416.920(c).
3. Does the impairment appear on a special listing of impairments or are the client's symptoms, signs, and laboratory findings at least equivalent in severity to the set of medical findings specified for the listed impairment? If no, the analysis continues to Step 4. If yes, MA is approved. 20 CFR 416.290(d).
4. Can the client do the former work that he/she performed within the last 15 years? If yes, the client is ineligible for MA. If no, the analysis continues to Step 5. 20 CFR 416.920(e).
5. Does the client have the Residual Functional Capacity (RFC) to perform other work according to the guidelines set forth at 20 CFR 404, Subpart P, Appendix 2, Sections 200.00-204.00? If yes, the analysis ends and the client is ineligible for MA. If no, MA is approved. 20 CFR 416.920(f).

The department evaluates mental illnesses a basis for disability using the following policies:

(a) **Activities of Daily Living**

...**Activities of daily living** including adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for one's grooming and hygiene, using telephones and directories, using a post office, etc. 20 CFR, Part 404, Subpart P, App. 1, 12.00(C)(1).

(b) **Social Functioning**

...**Social functioning** refers to an individual's capacity to interact independently, appropriately, effectively, and on a sustained basis with other individuals. 20 CFR, Part 404, Subpart P, App. 1, 12.00(C)(2).

Social functioning includes the ability to get along with others, such as family members, friends, neighbors, grocery clerks, landlords, or bus drivers. You may demonstrate impaired social functioning by, for example, a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, or social isolation. You may exhibit strength in social functioning by such things as your ability to initiate social contacts with others, communicate clearly with others, or interact and actively participate in group activities. We also need to consider cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority (e.g., supervisors), or cooperative behaviors involving coworkers. 20 CFR, Part 404, Subpart P, App. 1, 12.00(C)(2).

(c) **Concentration, Persistence and Pace**

...**Concentration, persistence or pace** refers to the ability to sustain focused attention and concentration sufficiently long to permit the timely and appropriate completion of tasks commonly found in work settings. 20 CFR, Part 404, Subpart P, App. 1, 12.00(C)(3).

Limitations in concentration, persistence, or pace are best observed in work settings, but may also be reflected by limitations in other settings. In addition, major limitations in this area can often be assessed through clinical examination or psychological testing. Wherever possible, however, a mental status examination or psychological test data should be supplemented by other available evidence. 20 CFR, Part 404, Subpart P, App. 1, 12.00(C)(3).

Claimant has the burden of proof to show by a preponderance of the medical evidence in the record that her mental/physical impairments meet the department's definition of disability for MA-P/SDA purposes. PEM 260/261. "Disability" is defined by MA-P/SDA standard as a legal term which is individually determined by a consideration of all factors in each particular case.

STEP 1

The issue at Step 1 is whether claimant is performing Substantial Gainful Activity (SGA). If claimant is working and is earning substantial income, she is not eligible for MA-P/SDA.

SGA is defined as the performance of significant duties over a reasonable period of time for pay. Claimants who are working, or otherwise performing Substantial Gainful Activity (SGA), are not disabled regardless of medical condition, age, education or work experience. 20 CFR 416.920(b).

The medical/vocational evidence of record shows that claimant is not currently performing substantial gainful activity.

Therefore, claimant meets the Step 1 disability test.

STEP 2

The issue at Step 2 is whether claimant has impairments which meet the SSI definition of severity/duration.

Unless an impairment is expected to result in death, it must have lasted or be expected to last for a continuous period of at least 12 months. 20 CFR 416.909.

Since the Step 2 severity and duration test is a *de minimus* requirement, claimant meets the Step 2 disability test.

STEP 3

The issue at Step 3 is whether claimant meets the Listing of Impairments in the SSI regulations. Claimant does not allege disability based on the Listings.

However, the following Listings were considered: 1.01, 1.02, 1.03, 1.04 and 1.05 (back pain, hip pain, neck pain, knee pain and arm pain). Listing 3.01 and 3.02 (breathing dysfunction).

STEP 4

The issue at Step 4 is whether claimant is able to do her previous work. Claimant previously worked as a public opinion surveyor at a mall. This was sedentary work. Claimant has also worked as a pet caretaker at a pet store (light work) and as a service desk associate and substitute cashier at [REDACTED] (sedentary work). The information in the medical records establishes that the claimant has asthma and osteoarthritis of the lumbar spine, right knee and both elbows.

However, the medical evidence does not contain any information to establish that claimant is unable to perform her previous work as a public opinion surveyor.

Since claimant is able to return to her previous work as a public opinion surveyor, she does not meet the Step 4 disability test.

STEP 5

The issue at Step 5 is whether claimant has the Residual Functional Capacity (RFC) to do other work.

Claimant has the burden of proof to show by the medical/psychiatric evidence on the record that her mental/physical impairments meet the department's definition of disability for MA-P/SDA purposes.

First, claimant alleges disability based on her mental impairments (bipolar disorder and depression). The medical evidence of record establishes that claimant has depression as well as chronic polysubstance abuse (in remission). There are no psychiatric reports to establish what claimant's residual functional mental capacity is. Claimant did not submit a DHS-49D or a DHS-49E to establish her mental residual functional capacity.

Second, claimant alleges disability based on her physical impairments (right elbow pain, bilateral knee pain and right hand/finger dysfunction). The medical evidence of record states that claimant's diagnoses are: osteoarthritis of the knee and hip joints and chronic alcoholism and a history of hepatitis C. The medical records do not establish any functional limitation due to these impairments.

During the hearing, claimant testified that a major impediment to her return to work was her spinal dysfunction and the pain in her knees. Unfortunately, evidence of pain, alone, is insufficient to establish disability for MA-P/SDA purposes.

The Administrative Law Judge concludes that claimant's testimony about her pain is profound and credible, but out of proportion to the objective medical evidence as it relates to claimant's ability to work.

In short, the Administrative Law Judge is not persuaded that claimant is totally unable to work based on her current physical and mental impairments. Claimant currently performs a significant number of activities of daily living and is able to function while living alone. The record shows that claimant is able to perform sedentary/light work (SGA). In this capacity, claimant is able to work as a ticket taker at a theater, as a parking lot attendant, or as a greeter at



Based on this analysis, the department correctly denied claimant's MA-P application based on Step 5 of the sequential analysis, as presented above.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that claimant does not meet the MA-P/SDA disability requirements under PEM 260/261.

Accordingly, the department's denial of claimant's MA-P application is, hereby, AFFIRMED.

SO ORDERED.

/s/ _____
Jay W. Sexton
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: January 19, 2010

Date Mailed: January 20, 2010

NOTICE: Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative Hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the mailing of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt date of the rehearing decision.

JWS/kgw

2008-22261/JWS

cc:

