STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS & RULES
FOR THE DEPARTMENT OF HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

SOAHR Docket No. 2008-25680 REHD
DHS Req. No: 2008-22502

[redacted]

Claimant
_____/

ORDER OF RECONSIDERATION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 24.287(1) and 1993 AACS R 400.919 upon the request of the Claimant.

ISSUE

Did the Administrative Law Judge err in his denial of Claimant's eligibility for Medical Assistance (MA-P) and Retro Medical Assistance (Retro MA-P)?

FINDINGS OF FACTS

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

1. On June 12, 2008, Administrative Law Judge (ALJ) Janice Spodarek issued a Hearing Decision in which the ALJ upheld the Department of Human Services' (DHS) denial of the Claimant's May 25, 2006, application for MA-P and Retro MA-P.

2. On July 15, 2008, the State Office of Administrative Hearings and Rules (SOAHR) for the Department of Human Services received a Request for Rehearing/Reconsideration submitted by the Claimant's representative [redacted]

3. On September 11, 2008, SOAHR granted the Claimant's Request for Rehearing/Reconsideration and issued an Order for Reconsideration.

4. Findings of Fact 1-20 from the Hearing Decision, mailed on June 16, 2008, are hereby incorporated by reference.

CONCLUSIONS OF LAW

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 Family Independence Agency (FIA or agency) administers the MA program pursuant to MCL 400.10, *et seq*., and MCL 400.105; MSA 16.490 (15). Agency 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 435.50, the Family Independence Agency 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

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 a recovery and/or medical assessment of ability to do work-related activities or ability to reason and to make appropriate mental adjustments, if a mental disability is being alleged, 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908 and 20 CFR 416.929. By the same token, a conclusory statement by a physician or mental health professional that an individual is disabled or blind is not sufficient without supporting medical evidence to establish disability. 20 CFR 416.929.

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 does 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 aptitude necessary to do most jobs. Examples of these include –

> (1) Physical functions such as walking, standing, sitting, lifting, pushing, 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).

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

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

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 reflects 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).

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).

If an individual fails to follow prescribed treatment which would be expected to restore their ability to engage in substantial gainful activity without good cause, there will not be a finding of disability… 20 CFR 416.994 (b)(4)(iv).

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).

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 <u>not</u> 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, §§ 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 ALJ correctly found that the Claimant is not ineligible for disability because he was not substantially gainfully employed. (*See Finding of Fact 12 of the June 12, 2008, Hearing Decision)*. The ALJ correctly considered the Claimant's disability at Step 2.

On May 25, 2006, the Claimant applied for MA-P and Retro MA-P. On September 21, 2006, the Medical Review Team (MRT) reviewed the Claimant's application and medical file and found the Claimant was not disabled. The MRT denied MA-P because the Claimant did not have a severe impairment which had lasted or was expected to last 12 months or more.. Retro MA-P was also denied. The MRT noted that the Claimant was engaging in substance abuse. On March 14, 2007, the State Hearing and Review Team (SHRT) found the Claimant was not disabled and denied the Claimant's application for MA-P because the medical evidence of the record did not document a severe mental/physical impairment(s) that would last or were expected to last for 12 continuous months or more. Retro MA-P was reviewed and denied. The SHRT found that the Claimant had a history of active substance abuse. On December 21, 2006, SOAHR received the Claimant's request for hearing. A hearing on the matter was convened on May 1, 2007. The record was held open to receive new medical information from the Claimant. Subsequently the Claimant submitted new medical

information and that information was forward to SHRT. On December 11, 2007 the SHRT issued a second decision in which it found that the Clamant was not disabled. SHRT found that the Claimant did not have severe impairment which lasted or was expected to last 12 continuous months. The SHRT also found that the Claimant had a history of substance abuse. On July 15, 2008, SOAHR received the Claimant's request for rehearing/ reconsideration. On September 11, 2008, SOAHR granted the Claimant's Request for Rehearing/Reconsideration and issued an Order for Reconsideration.

The Claimant alleges the following impairments: chest pain, bulging discs in her back, fibromyalgia, emphysema, depression and anxiety.

On November 17, 2005, the Claimant was admitted to [redacted] with complaints of mood swings, anger control problems and anxiety. The Claimant was given a DSM IV Axis I diagnosis of Major Depression, severe, recurrent chronic without psychotic feature, adjustment disorder with depressed mood and anxiety, pain medication and cocaine dependence rule out alcohol abuse versus dependence.

On November 21, 2005, the Claimant was discharged with a referral to [redacted]. She was told to limit her use of pain medication, keep her appointments and abstain from cocaine use.

On August 10, 2005, [redacted]., completed a physical examination of the Claimant. [redacted] indicated in his progress notes that the Claimant presented with complaints of law back and shoulder pain. [redacted] indicated that his impression was that the Claimant had chronic mid and low back pain, radiating to the buttocks, chronic neck pain with radiation to the shoulders, bilateral sacroillititis, fibromyalgia, myfascial pain syndrome, narcotic dependence, history of ulcerative colotitis with ilestomy in placed since 1985 and anxiety and depression. Department Exhibit pp 30-31.

[redacted] indicated in his report that the Claimant's August 10, 2005, urine screen came back negative for all substances included benzodiazepines and opiates. [redacted] indicted in his report that the Claimant was talking numerous medications and her drug screen results were not consistent with the Claimant's use of prescribed medications. [redacted] also wrote a note addendum in which he indicated that he wrote the Claimant a script for Vicodin and the Claimant took the prescription to the [redacted] faxed a copy of the script to [redacted]. The Claimant prescription had been altered by writing 7.5 after the word Vicodin. [redacted] indicated that 7.5 is for extra strength Vidcodin and he did not prescribe that medication to the Claimant. [redacted] indicated that he would no longer fill any more prescription for narcotics for the Claimant. Department exhibit p 31.

On [redacted], [redacted] completed a physical examination of the Claimant. The Claimant presented with complaints of chest pain. [redacted] diagnosed

the Claimant with Atypical chest pain with chronic pain syndrome, low TSH and history of migraine and fibromyalgia. [redacted] admitted the Claimant for telemetry to rule out myocardial infraction.

On February 25, 2006, the Claimant under went an EKG. [redacted]., indicated in her report that the Claimant had sinus tachycardia and advised further testing. Department exhibit p 20

On February 26, 2006, the Claimant underwent a chest x-ray. [redacted] reviewed the results and concluded that the Claimant's chest x-rays were normal. Department Exhibit p 19.

On February 26, 2006, the Claimant underwent a second EKG. [redacted] read the results and concluded that the Claimant had a normal EKG and all differences with the February 25, 2006, EKG had been resolved. Department Exhibit p 18.

On February 27, 2006, the Claimant under went a Nuclear Stress test. [redacted] read the EKG results. [redacted] found that the Claimant had a normal cardiolite study with a normal ejection fraction. Department Exhibit p 17.

On February 27, 2006, the Claimant was discharged from [redacted] with a diagnosis of chest pain most likely musculoskeletal. [redacted] indicated in her Discharge Summary that that Claimant reported chest pain during her entire admission with no change her the Claimant's enzymes, EKG, telemetry. The Claimant did report pain relief through the use of Dilaudid. Department Exhibit p 15.

On August 16, 2006, the Claimant underwent an EKG. [redacted] read the results and found that there was no change from the February 26, 2006 EKG. Claimant's exhibit p A-28.

On August 16, 2006, the Claimant underwent abdominal x-rays. [redacted] read the results and found that the x-rays were normal with no bowel obstruction found. Claimant's exhibit p A 27.

The consistent and supported medical evidence presented shows that the Claimant was admitted to the hospital in November of 2005, and again in February 2006. In May 2006, the Claimant submitted an application for MA-P with Retro coverage to February 2006. The Medicaid evidence shows that the Claimant's November 2005, admission was the result of a deterioration in her mental condition which was due in part to her use of illicit drugs. In February 2006, the Claimant was admitted to the hospital after complaining of chest pain. The medical evidenced presented shows and all testing showed that that Claimant had a normal heart function. The Claimant was discharged with a diagnosis of chest pain most likely musculoskeletal.

The incomplete medical evidence provided show that despite the Claimant's November 2005, and February 2006, hospital admission there is insufficient evidence to conclude that the Claimant had an impairment or combination of impairments which significantly limited her ability to engage in basic work. Therefore, the Claimant impairments were non-severe. In addition, the sparse and incomplete medical information does not show that the Claimant had a severe impairment or combination of impairments which lasted or were expected tot last for 12 continuous months. The mere fact that the Claimant was admitted to the hospital in November 2005, and again in February 2006, does not mean that the Claimant's impairments meet the social security disability severity or duration requirements The Claimant's medically determined exertional and non-extertional mental impairments were non-severe impairments that would not significantly limit the Claimant's ability to engage in basic work activities for 12 continuous months or more. The ALJ correctly found that the Claimant was not disabled at Step 2. A finding of a severe impairment at Step 2 is a *de minimus* standard and the ALJ correctly considered the Claimant's eligibility at step 3.

The Claimant may be found disabled at Step 3 if the Claimant's physical or mental impairments meet or equal the requirements for the Social Security listings. The Claimant's impairments of chest pain, bulging discs in her back, fibromyalgia, emphysema, depression and anxiety could arguably meet or equal the requirements of listings, 1.04 Disorders of the Spine, 3.00 Respiratory System. 4.00 Cardio vascular and 12.0 Mental Disorders. Currently there is no Social Security listing for Fibromyalgia.

The medical information provided does not provide a definitive diagnosis for the Claimant's back problem. The Claimant failed to provide medical evidence from an acceptable medial source which documents that nature and extent of her alleged back impairment. Therefore, it is not possible to determine whether or not the Claimant's alleged back impairments meets or equals the requirements of listing 1.04.

The medical information provided does not provide a definitive diagnosis for the Claimant's alleged respiratory problem. The Claimant failed to provide medical evidence from an acceptable medial source which documents that nature and extent of her alleged emphysema. Therefore, it is not possible to determine whether or not the Claimant's alleged respiratory impairment meets or equals the requirements of listing 3.00.

The medical information provided does provide a definitive diagnosis for the Claimant's alleged cardiovascular problem. The Claimant provided medical evidence from an acceptable medial source which documents that nature and extent of her alleged cardiovascular condition. The Medical information obtained during her February 2006, hospital admission shows that the Claimant has a normal chest x-ray, normal enzymes, normal EKG, and normal stress test. The medical evidence provided clearly shows that there is no evidence that the Claimant has a cardiovascular condition. Therefore, the

Claimant's alleged cardiovascular impairment does not meets or equal the requirements of listing 4.00.

The medical information provided does provide a definitive diagnosis for the Claimant's alleged mental condition. The Claimant provided medical evidence from an acceptable medial source which documents that nature and extent of her alleged mental condition. The Medical information obtained during her November 2005, hospital admission shows that the Claimant was depressed and anxious. She was admitted, treated with medication and discharged with a DSM IV Axis I diagnosis of Major Depression, severe, recurrent chronic without psychotic feature, adjustment disorder with depressed mood and anxiety, pain medication and cocaine dependence rule out alcohol abuse versus dependence.

The medical evidence provided clearly shows that there is evidence that the Claimant has a mental condition. However, the Claimant's mental condition neither meets, nor equals the requirements of listing 12.04 Affective Disorders or 12.06 Anxiety related disorders. The medical evidence does not document that the Claimant's mental condition meets or equal the requirements of listing 12.04 B or C and does not documents that the Claimant's mental condition meets or equals listing 12.06 B or C. No evidence was provided that the Claimant has experienced any of the following :Marked restriction of activities of daily living; marked difficulties in maintaining social functioning;. marked difficulties in maintaining concentration, persistence, or pace; repeated episodes of decompensation, each of extended duration; complete inability to function independently outside the area of one's home: a residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or a current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

Currently there is no Social Security listing for Fibromyalgia. The medical documentation, provided by the Claimant indicates that that the Claimant had a history of Fibromyalgia. No evidence was provided that the Claimant's treating physician applied the American College of Rheumatology (ACR) guidelines for the diagnosis of fibromyaglia and gave the Claimant a diagnosis of Fibromyalgia.

In [redacted], the Court agreed that fibromyalgia is an "elusive" and "mysterious" disease. It has no known cause and no known cure. Its symptoms include severe musculoskeletal pain, stiffness, fatigue, and multiple acute tender spots at various fixed locations on the body. [redacted]. Furthermore, Courts have recognized that "fibromyalgia is a disabling impairment and that 'there are no objective tests which can conclusively confirm the disease.'" [redacted].

The Court in [redacted] stated further that proper diagnoses of fibromyalgia can be "well-supported by medically acceptable clinical and laboratory diagnostic techniques." [redacted]. The clinical signs and symptoms to support a fibromyalgia diagnosis under the [redacted] guidelines. A diagnosis of fibromyaglia must include widespread pain in four quadrants of the body and requires pain in at least 11 of the 18 specified tender points of the body. [redacted]. Given the nature of the disease, the treating physical must "have done all that can be medically done to diagnose [Claimant's] fibrositis and to support his opinion of disability." [redacted].

Unlike, the [redacted] case, the present case there is very little medical evidence to support the diagnosis of fibromyalgia for the Claimant. The objective medical evidence from the medical reports indicates that the Claimant's treating physician indicated the Claimant had a fibromyalgia. With no support medical documentation. The Claimant's treating physician' diagnosis of fibromyalgia is not supported by accepted clinical and laboratory diagnostic testing to determine the presence of fibromyalgia. The Claimant's treating physician did not do "all that was medically" possible to diagnose the Claimant with the fibromyalgia .Therefore, medical evidence presented is not sufficient to find that the Claimant had fibromyaglia.

The ALJ correctly found that the Claimant's alleged physical and mental impairments did not meet or equal the requirements of a social security listing. The ALJ correctly proceeded to Step 4.

At Step 4, the Claimant's residual functional capacity and past relevant work are considered. The Claimant's past relevant reported work was unskilled work as a home health care aide and waitress. This type of work is considered to be light/sedentary, unskilled work. 20 CFR § 416. 968 states "..unskilled work is work which needs little or no judgment to do simple duties that can be learned on the job in a short period of time." The ALJ found that the Claimant's past relevant work was unskilled work and that the Claimant did not have the residual functional capacity to perform her former work. The ALJ erred when she did not identify the Claimant's medically determined exertional and non extertional limitations. The medical evidence provided is devoid of opinions from acceptable medical sources regarding the Claimant's extertional and non extertional impairments. Neither the Claimant, nor the Claimant representative provided a physician completed DHS-49 form or similar medical documentation which details the Claimant's limitations. The medical documentation provided is devoid of any information which provides an opinion from an acceptable medical source regarding the claimant's limitations. The burden is on the Claimant to provide medically determined evidence of her limitations. While it is possible the Claimant has some limitations she failed to provide any evidence of her limitations. The Claimant's November 2005, admission and DSM IV Axis diagnosis is evidence that she has a mental disorder, but there is no evidence regarding the extent to which that condition limits her residual functional

capacity to perform her former work. Therefore, the ALJ incorrectly found that the Claimant did not have the residual functional capacity to perform her former work and incorrectly found the Claimant was not ineligible at Step 4. I find that the medical evidence presented shows that the Claimant is able to perform her former work and she is ineligible for disability at Step 4. Despite this finding the analysis will continue to step 5.

At Step 5, the Department has the burden of establishing that despite the Claimant's limitations, she has the residual functional capacity to perform work in the national economy. Residual Functional Capacity is defined as what the Claimant can do despite his limitations. Residential Functional Capacity also includes an assessment of the Claimant's physical and mental abilities.

The physical demands of jobs in the national economy are classified as sedentary, light, medium, heavy, or very heavy. The more physically demanding classification includes all less demanding classifications. For example, a classification of very heavy includes all other less physically demanding classifications. Sedentary work is defined as work which involves the lifting of no more than 10 lbs at a time and the occasional lifting or carrying of files, ledgers, small tools, and similar items. Sedentary work presumptively includes sitting but also includes some necessary walking and standing.

Light work involves the lifting of no more than 20 lbs at any time and the frequent lifting or carrying of objects weighting less than 10 lbs. Light work may involve significant walking or standing. Absent a loss of dexterity or other limiting factors, typically those who can do light work can do sedentary work.

Medium work involves lifting objects of 50 lbs or less with frequent lifting or carrying of objects, which weigh 25 lbs or less. A person who can do medium work can typically do light and sedentary work.

Heavy work involves the lifting of 100 lbs or less with frequent lifting of objects weighting 50 lbs or less. Persons who can do heavy work typically can do medium, light, and sedentary work.

Very heavy work involves the lifting of objects over 100 lbs and the frequent carrying or lifting of objects weighting 50 lbs or more. A person who can do very heavy work typically can do heavy, medium, light, and sedentary work.

The person claiming a physical disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for a recovery and/or medical assessment of ability to do work-related activities. 20 CFR

416.913. A conclusory statement, by a physician that an individual is disabled without supporting medical evidence, is not sufficient to establish disability. 20 CFR 416.929.

The medical evidence presented shows that the Claimant is a 46-year-old individual with less than a high school education and past work history of light, unskilled work.

The consistent and supported medical evidence presented shows that the Claimant was admitted to the hospital in November of 2005, and again in February 2006. In May 2006, the Claimant submitted an application for MA-P with Retro coverage to February 2006. The medical evidence shows that the Claimant' November 2005, admission was the result of a deterioration in her mental condition which was due in part to her use of illicit drugs. In February 2006, the Claimant was admitted to the hospital after complaining of chest pain. The medical evidenced presented and testing showed that that Claimant had a normal heart function. The Claimant was discharged with a diagnosis of chest pain most likely musculoskeletal. The Claimant had no medically determined or documented limitations in walking, standing, lifting, bending, or sitting. The Claimant had no medically determined or documented limitations in her ability to use her hands, arms or feet during work related activities.

The medical evidence shows that in November 2005, the Claimant was given a DSM IV Axis I diagnosis of Major Depression, severe, recurrent chronic without psychotic feature, adjustment disorder with depressed mood and anxiety, pain medication and cocaine dependence rule out alcohol abuse versus dependence. No evidence was provided which shows that the Claimant sought or was being treated for a mental condition prior or subsequent to the Claimant's November 2005, admission. This is good evidence that the Claimant's mental condition was severe only immediately, before, during and after her brief admission. Given the limited duration of the Claimant's mental impairment, it is not likely that her mental condition would limit the Claimant's mental ability to engage in light or sedentary work.

The evidence presented shows that the Claimant has the residual functional capacity to perform light and sedentary work. According to vocational rules 202.17 and 201.24, given the Claimant's vocational profile, the Claimant is not disabled.. 20 CFR Pt. 404, Subpt. P, App.2. Therefore, the Claimant is not disabled at Step 5

The medical evidence presented shows that prior to the Claimant's November 2005, hospital admission the Claimant was actively using illicit drugs. In Finding of Fact 18, the ALJ detailed the contents of a November 17, 2005, Discharge Summary. The ALJ incorrectly concluded on page 11 of the Hearing Decision that the Claimant's use of illicit drugs rendered the Claimant ineligible for disability. Federal regulations at 20 CFR 916.935 provide in pertinent part:

> (a) *General.* If we find that you are disabled and have medical evidence of your drug addiction or alcoholism, we must determine whether your drug addiction or alcoholism is

> a contributing factor material to the determination of disability, unless we find that you are eligible for benefits because of your age or blindness.
>
> (b) *Process we will follow when we have medical evidence of your drug addiction or alcoholism.* (1) The key factor we will examine in determining whether drug addiction or alcoholism is a contributing factor material to the determination of disability is whether we would still find you disabled if you stopped using drugs or alcohol.
>
> (2) In making this determination, we will evaluate which of your current physical and mental limitations, upon which we based our current disability determination, would remain if you stopped using drugs or alcohol and then determine whether any or all of your remaining limitations would be disabling.
>
> (i) If we determine that your remaining limitations would not be disabling, we will find that your drug addiction or alcoholism is a contributing factor material to the determination of disability.
>
> (ii) If we determine that your remaining limitations are disabling, you are disabled independent of your drug addiction or alcoholism and we will find that your drug addiction or alcoholism is not a contributing factor material to the determination of disability.
>
> 20 CFR 416.935

The medical evidence presented shows that the Claimant's exterinal and non-extertional limitations would not prevent the Claimant from performing her former work or other light and sedentary work. Therefore, if the Claimant ceased using illicit drugs the Claimant's remaining limitations would not be disabling. Because the Claimant's remaining limitations are not disabling the Claimant may not be found disabled independent of her use of illicit drugs. Simply put, if the Claimant's use of illicit drugs may only be material if the Claimant is found to have other disabling limitations. The evidence shows that the Claimant's limitations were not found disabling. If the Claimant stopped using illicit drugs she still would be found not disabled. Therefore, the ALJ

erred when she found that the Claimant's illicit drug use was material to her determination that the Claimant was not disabled.

The MRT, SHRT and the ALJ determined that the Claimant was not disabled and was ineligible for Retroactive MA-P. PAM 115 provides the standard Retro MA-P eligibility requirements. A Claimant is eligible for Retro MA-P if the Claimant:

- meets all financial and nonfinancial eligibility factors in that month, and
- has an unpaid medical expense incurred during the month, or

  Note: Do **not** consider bills that the person thinks may be paid by insurance as paid bills. It is easier to determine eligibility sooner rather than later.
- has been entitled to Medicare Part A.

PAM 115, pp. 8-9.

Because the MRT, SHRT, and ALJ found that the Claimant was not disabled for each of the three (3) months prior to the date of her application for MA-P, the Claimant is ineligible for Retro MA-P. Therefore, the MRT, SHRT and the ALJ correctly denied Retro MA-P.

DECISION AND ORDER

This Administrative Law Judge, based on the above findings of fact and conclusion of law, decides that the Administrative Law Judge did not err when she found that the Claimant was not disabled.

IT IS THEREFORE ORDERED that:

The Administrative Law Judge's decision mailed June 16, 2008, is AFFIRMED

Martin D. Snider
Administrative Law Judge
for Michigan Department of Human Services

[redacted]
Order of Reconsideration
SOAHR Docket No. 2008-25680 REHD
DHS Req. No: 2008-22502

cc: [redacted]

Date Signed: 7/22/2009
Date Mailed: 7/22/2009

***** NOTICE *****

The Appellant may appeal this Rehearing Decision to Circuit Court within 30 days of the mailing of this Rehearing Decision.