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: 2009-14955
Issue No: 2009; 4031
Case No: [redacted]
Load No: [redacted]
Hearing Date:
May 28, 2009
Wayne County DHS

ADMINISTRATIVE LAW JUDGE: Landis Y. Lain

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 on May 28, 2009. Claimant personally appeared and testified.

ISSUE

Did the Department of Human Services (the department) properly deny claimant's application for Medical Assistance (MA-P) and State Disability Assistance (SDA)?

FINDINGS OF FACT

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

(1) On July 24, 2008, claimant filed an application for Medical Assistance and State Disability Assistance benefits alleging disability.

(2) On November 6, 2008, the Medical Review Team denied claimant's application stating that claimant could perform other work.

(3) On December 4, 2008, the department caseworker sent claimant notice that her application was denied.

(4) On February 2, 2009, claimant filed a request for a hearing to contest the department's negative action.

(5) On March 30, 2009, the State Hearing Review Team again denied claimant's application stating that claimant is capable of performing past work as a cashier and can perform light work per 20 CFR 416.967(b) and unskilled work per 20 CFR 416.968(a) and the medical opinion is considered in light of CFR 416.927.

(6) Claimant is a 52-year-old woman whose birth date is [redacted]. Claimant is 5' 8" tall and weighs 198 pounds. Claimant attended the 11th grade and has a GED and is able to read and write and does have basic math skills.

(7) Claimant last worked 2006 at [redacted] as a crew line member. Claimant has also worked at [redacted] as a cashier and stock person and at a nursery school.

(8) Claimant alleges as disabling impairments: depression, diabetes mellitus and neuropathy in her hands, feet and legs.

CONCLUSIONS OF LAW

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. The Department of Human Services (DHS or department) administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. Department policies are found in the Program Administrative Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM).

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 <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, 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).

At Step 1, claimant is not engaged in substantial gainful activity and has not worked since 2006. Claimant is not disqualified from receiving disability at Step 1.

The objective medical evidence on the record indicates that a medical report from [redacted] indicates that claimant was well-developed, well-nourished, cooperative and in no acute distress. Claimant was awake, alert and oriented x3. The claimant was dressed appropriately and answered questions fairly well. Her height was 5' 6-3/4". Weight was 178 pounds. Pulse was 88. Respiratory rate was 17. Blood pressure was 140/80, 150/86 and 140/84. Visual acuity without glasses was 20/40 on the right and 20/100 on the left. Her HEENT was normocephalic/atraumatic. Eyes and ears were normal. There was no exophthalmos, icterus, conjunctiva, erythema or exudates noted. Extraocular movements were intact. There was no discharge in the external auditory canals. No bulging erythema, perforation of the visible tympanic membrane noted. In the nose there was no septal deformity, epistaxis or rhinorrhea. In the mouth the teeth were in fair repair. The neck was supple. No JVD noted. No tracheal deviation. No lymphadenopathy. Thyroid was not visible or palpable. External inspection of ears and nose revealed no evidence of acute abnormality. The chest was symmetrical and equal to expansion. The lung fields were clear to auscultation and percussion bilaterally. There were no rales, rhonchi or wheezes noted. No retractions noted. No accessory muscle usage noted, no cyanosis noted. There was no cough. In the cardiovascular there was normal sinus rhythm, S1

and S2. There were no rubs, murmur or gallop. In the gastrointestinal the abdomen was soft, benign and non-distended. It was non-tender with no guarding, rebound or palpable masses. Bowel sounds were present. Liver and spleen were not palpable. No significant skin rashes or ulcers. There was mild tenderness to palpation in the lower lumbar area. No obvious spinal deformity, swelling or muscle spasm noted. Pedal pulses were 2+ bilaterally. There was no calf tenderness, clubbing, edema, varicose veins, brawny erythema, stasis dermatitis, chronic leg ulcers and muscle atrophy or joint deformity or enlargement was noted. In the bones and joints the claimant did not use a cane or aid for walking. She was able to get on and off of the table without difficulty and her gait and stance was normal. Her tandem walk, heel and toe walk were done without difficulty. She was able to squat 40% of the distance and recover, and bend to 60% of the distance and recover. Grip strength was equal bilaterally. The claimant was right-handed. Gross and fine dexterity appeared bilaterally intact. Finger to nose test was done without difficulty. Abduction of the shoulders was 0-150. Flexion of the knees was 0-150. Straight leg raise while lying was 0-50, while sitting 0-90. Neurologically, the claimant was alert, awake and oriented to person, place and time. Cranial nerve II: vision as stated in vital signs. III, IV and VI: no ptosis, nystagmus. PERRLA: pupils were 2 mm bilaterally. Nerve V: no facial numbness. Symmetrical response to stimuli. Nerve VII: symmetrical facial movements noted. Nerve VIII: can hear normal conversation and whispered voice. Nerves IX and X: swallowing intact. Gag reflex intact. Uvula was midline. Nerve XI: head and shoulder movement against resistance were equal. Nerve XII: no sign of tongue atrophy. No deviation with protrusion of tongue. Sensory functions: intact to sharp and dull gross testing. Motor exam: revealed fair muscle tone without flaccidity, spasticity or paralysis. The impression was diabetes which stated the claimant had a history of diabetes on Glucovance and insulin dependent. Her blood sugar was poorly controlled

at 395 to 500+. Claimant had a history of diabetic neuropathy with prescription for Amitriptyline. Claimant had hypertension and is currently on medication. Her blood pressure was borderline controlled. She also had hyperlipidemia and she was currently on Crestor at that time. (Pages 30-32)

An initial psychiatric evaluation dated [redacted], indicates that claimant has no previous psychiatric symptoms or treatment and no history of manic or psychotic symptoms. Claimant admitted to smoking cannabis and drinking alcohol about once a month. She stated alcohol and drugs were not a problem for her. Claimant was diagnosed with major depressive disorder, single episode, unspecified and started on Lexapro. She only had mild restrictions on her activities of daily living and it stated that she does have marked difficulties in maintaining social functioning and marked deficiency in concentration, persistence and pace resulting in frequent failure to complete tasks in a timely manner.

A Medical Examination Report dated [redacted] indicates that claimant's condition is deteriorating as a clinical impression and that she can occasionally lift 10 pounds or less and never lift 20 pounds or more. Claimant can stand or walk less than two hours in an eight hour day and she can sit less than six hours in an eight hour day. She did use a cane for an assistive device for ambulation and she could use her upper extremities for simple grasping and reaching but not for pushing/pulling and fine manipulating. She had some problems with sustained concentration. (Page 13) There is a [redacted] report from [redacted] which indicates that claimant was alert and cooperative. Claimant weighed 191 pounds. Her blood pressure was 110/70. Her weight was 5' 7-1/2". Vision without glasses was 20/100 on the left and 20/40 on the right and 20/30 bilaterally. Clinically, the claimant was not jaundiced. The claimant's gait was normal. The claimant was able to get on and off the examination table.

The claimant could raise both arms above head level. Her HEENT: she was normocephalic. External eye movements were intact. Pupils were equal and regular, reacting to light and accommodation. Fundus was intact. ENT was benign. Neck was supple. No thyromegaly. No venous engorgement. Trachea was central. No carotid bruit. Chest: the chest moved normally on either side. Respiratory movements were normal. The chest was clear to auscultation and percussion. No rhonchi or rales noted. In the cardiovascular area heart size was normal. There was no audible murmur. JVD was not raised. Air entry was equal. No adventitious sounds. Trachea was midline. The abdomen was soft with no masses felt. Bowel sounds were normal. No evidence of hernia. Spleen was not palpable. No ascites. Bones and joints: straight leg raise was equal bilaterally. All peripheral pulses were equal and good bilaterally. There was no wasting of muscles. Hand grip was equal. Nervous system: cranial nerves II-XII were grossly intact. No gouty deformities or nodules noted. Sensory: touch, pinprick and sensation were normal. Plantar was flexor bilaterally. Cerebellar function was normal. Muscle strength was equal bilaterally. The deep tendon reflexes were 2+ on the upper and lower extremities. Heel-to-knee and finger-to-finger and finger-to-nose testing was normal. The gait was normal. No wasting of muscles. Speech and memory appeared to be normal. Orientation was normal. The claimant's general health is good. No leg ulcers. (Pages 3 and 4 of the Medical Reports)

At Step 2, claimant has the burden of proof of establishing that she has a severely restrictive physical or mental impairment that has lasted or are expected to last for the duration of at least 12 months. There is insufficient objective clinical medical evidence in the record that claimant suffers a severely restrictive physical or mental impairment. Claimant has reports of pain in multiple areas of her body; however, there are limited corresponding clinical findings that support the reports of symptoms and limitations made by the claimant. This Administrative Law

Judge finds that there is no medical finding of any muscle atrophy or trauma, abnormality or injury that is consistent with a deteriorating condition. In short, claimant has restricted herself from tasks associated with occupational functioning based upon her reports of pain (symptoms) rather than medical findings. Reported symptoms are an insufficient basis upon which a finding that claimant has met the evidentiary burden of proof can be made. This Administrative Law Judge finds that the medical record is insufficient to establish claimant has a severely restrictive physical impairment.

There is no evidence in the record indicating claimant suffers mental limitations resulting from her reportedly depressed state. There is no mental residual functional capacity assessment in the record. The evidentiary record is insufficient to find that claimant suffers a severely restrictive mental impairment. For these reasons, this Administrative Law Judge finds that claimant has failed to meet her burden of proof at Step 2. Claimant must be denied benefits at this step based upon her failure to meet the evidentiary burden.

If claimant had not been denied at Step 2, the analysis would proceed to Step 3 where the medical evidence of claimant's condition does not give rise to a finding that she would meet a statutory listing in the code of federal regulations.

If claimant had not already been denied at Step 2, this Administrative Law Judge would have to deny her again at Step 4 based upon her ability to perform her past relevant work. Claimant's past relevant work was light or sedentary as a cashier/stock person. There is no medical evidence upon which this Administrative Law Judge could base a finding that claimant is unable to perform work in which she has engaged in, in the past. Therefore, if claimant had not already been denied at Step 2, she would be denied again at Step 4.

The Administrative Law Judge will continue to proceed through the sequential evaluation process to determine whether or not claimant has the residual functional capacity to perform some other less strenuous tasks than in her prior jobs.

At Step 5, the burden of proof shifts to the department to establish that claimant does not have residual functional capacity.

The residual functional capacity 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.

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. 20 CFR 416.967(a).

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.... 20 CFR 416.967(b).

Claimant has submitted insufficient objective medical evidence that she lacks the residual functional capacity to perform some other less strenuous tasks than in her prior employment or that she is physically unable to do light or sedentary tasks if demanded of her. Claimant's activities of daily living do not appear to be very limited and she should be able to perform light or sedentary work even with her impairments. Claimant has failed to provide the necessary objective medical evidence to establish that she has a severe impairment of combination of impairments which prevent her from performing any level of work for a period of 12 months. The claimant's testimony as to her limitations indicates that she should be able to perform light or sedentary work.

The claimant testified on the record that she does have depression.

For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph (B) of the listings for mental disorders (descriptions of restrictions of activities of daily living, social functioning; concentration, persistence, or pace; and ability to tolerate increased mental demands associated with competitive work).... 20 CFR, Part 404, Subpart P, App. 1, 12.00(C).

There is insufficient objective medical/psychiatric evidence contained in the file of depression or a cognitive dysfunction that is so severe that it would prevent claimant from working at any job. In addition, claimant was able to answer all the questions at the hearing and was responsive to the questions. Claimant was oriented to time, person and place during the hearing. Claimant's complaints of pain, while profound and credible, are out of proportion to the objective medical evidence contained in the file as it relates to claimant's ability to perform work. Therefore, this Administrative Law Judge finds that the objective medical evidence on the record does not establish that claimant has no residual functional capacity. Claimant is

disqualified from receiving disability at Step 5 based upon the fact that she has not established by objective medical evidence that she cannot perform light or sedentary work even with her impairments.

The department's Program Eligibility Manual contains the following policy statements and instructions for caseworkers regarding the State Disability Assistance program: to receive State Disability Assistance, a person must be disabled, caring for a disabled person or age 65 or older. PEM, Item 261, page 1. Because the claimant does not meet the definition of disabled under the MA-P program and because the evidence of record does not establish that claimant is unable to work for a period exceeding 90 days, the claimant does not meet the disability criteria for State Disability Assistance benefits either.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the department has appropriately established on the record that it was acting in compliance with department policy when it denied claimant's application for Medical Assistance, retroactive Medical Assistance and State Disability Assistance benefits. The claimant should be able to perform a wide range of light or sedentary work even with her impairments. The department has established its case by a preponderance of the evidence.

Accordingly, the department's decision is AFFIRMED.

/s/______________________________
Landis Y. Lain
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed:___June 29, 2009___

Date Mailed:___June 30, 2009___

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.

LYL/vmc

cc: