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: 2009-33443
Issue No: 2009; 4031
Case No: [redacted]
Load No: [redacted]
Hearing Date:
October 22, 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 October 22, 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 April 28, 2009, claimant filed an application for Medical Assistance and State Disability Assistance benefits alleging disability.

(2) On July 1, 2009, the Medical Review Team denied claimant's application stating that claimant could perform other work and that her impairments were non-exertional.

(3) On July 2, 2009, the department caseworker sent claimant notice that her application was denied.

(4) On July 21, 2009, claimant filed a request for a hearing to contest the department's negative action.

(5) On September 2, 2009, the State Hearing Review Team again denied claimant's application stating in its analysis and recommended decision: The objective medical evidence presented does not establish a disability at the listing or equivalence level. The collective medical evidence shows that the claimant is capable of performing a wide range of simple, medium work. The claimant's impairments do not meet/equal the intent or severity of a Social Security listing. The medical evidence of record indicates that the claimant retains the capacity to perform a wide range of simple, medium work. Therefore, based on the claimant's vocational profile of advanced age, high school graduate and a semi-skilled work history, MA-P is denied using Vocational Rule 203.15 as a guide. Retroactive MA-P was considered in this case and is also denied. SDA is denied per PEM 261 because the nature and severity of the claimant's impairments would not preclude work activity at the above stated level for 90 days.

(6) The hearing was held on October 22, 2009. At the hearing, claimant waived the time periods and requested to submit additional medical information.

(7) Additional medical information was submitted and sent to the State Hearing Review Team on November 9, 2009.

(8) On November 11, 2009, the State Hearing Review Team again denied claimant's application stating in its analysis and recommended decision: On examination the claimant had a normal gait. Grip strength was equal bilaterally. Gross and fine dexterity were bilaterally intact. A psychiatric evaluation showed that claimant had a history of substance abuse and depression.

There was no evidence of a disorder of thought process or thought content. The claimant's impairments do not meet/equal the intent or severity of a Social Security listing. The medical evidence of record indicates that the claimant retains the capacity to perform a wide range of simple, medium work. Therefore, based on the claimant's vocational profile of advanced age, high school education and a semi-skilled work history, MA-P is denied using Vocational Rule 203.15 as a guide. Retroactive MA-P was considered in this case and is also denied. SDA is denied per PEM 261 because the nature and severity of the claimant's impairments would not preclude work activity at the above stated level for 90 days.

(9) Claimant is a 59-year-old woman whose birth date is [redacted]. Claimant is 5' 10" tall and weighs 184 pounds. Claimant graduated from high school and attended college for a half a year. Claimant is able to read and write and does have basic math skills.

(10) Claimant last worked August 15, 2008 as a home healthcare provider and home health aid. Claimant has also worked as a cashier.

(11) Claimant alleges as disabling impairments: hypertension, carpal tunnel syndrome, arthritis, knee and back pain, left shoulder pain, high cholesterol, as well as depression, anxiety, and mood swings.

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 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).

At Step 1, claimant is not engaged in substantial gainful activity and has not worked since 2008. Claimant is not disqualified from receiving disability at Step 1.

The objective medical evidence on the record indicates that a physical examination on [redacted] noted her blood pressure was controlled at 120/70. (p. 7) She had a normal gait and stance. She ambulated without a cane. Her grip strength was equal bilaterally. (pp. 19-22) The mental examination report indicated that the claimant had a sad affect with crying spells. She was anxious. Her speech was spontaneous, coherent, and logical. (pp. 28-33) She was independent in activities of daily living. (pp. 9-12)

An EMG dated [redacted] showed evidence of bilateral carpal tunnel syndrome. (p. 2) An MRI dated [redacted] of the left knee showed partial ACL tear, tearing of the lateral meniscal body, the posterior horn, and body of the medial meniscus, mild MCL sprain and minimal joint effusion. (p. 15) An MRI of the left shoulder dated [redacted] showed

AC joint arthropathy, spurring, tendinosis of the rotator cuff, labral degeneration, and mild glenohumeral joint effusion with synovitis. (p. 17)

A Medical Examination Report dated [redacted] indicates that claimant was normal in all areas of examination. She was 5' 10" and weighed 183 pounds. Her blood pressure was 120/71. She was right-hand dominant and she had visual acuity best corrected in both eyes of 20/20. There was no information about claimant's ability to stand, walk, or sit but she could frequently lift 10 pounds or less and she could use her upper extremities for simple grasping, reaching, pushing/ pulling, and fine manipulating. She was determined to have some shortness of breath and palpation and she had mood problems. (pp. 7-8)

An electromyography laboratory report in the file indicates that during the EMG needle part of the test, the claimant couldn't move her arms smoothly because of severe pain but she had normal deltoid, normal biceps brachia, normal triceps on both the left and right sides. There was electrodiagnostic evidence of a bilateral medium sensory axonal neuropathy across the wrist (carpal tunnel syndrome). The claimant should consider wrist splints and modification of habits for using the hands. (p. 2) Claimant had a professional certification of disability that indicates that claimant has degenerative joint disease. (p. 21)

A psychiatric/psychological examination report in the file of [redacted] indicates that claimant has the ability to function independently. A [redacted] examination of [redacted] indicates that claimant was well-developed, well-nourished, cooperative, and in no acute distress. She was awake, alert, and oriented x3. She was dressed appropriately and answered questions very well. Her height was 5' 8-1/2" tall and she weighed 180 pounds. Her pulse was 84. Her respiratory rate was 16. Blood pressure was 174/130, 146/102, and 164/102. Visual acuity without glasses was 20/70 on the right and 20/100 on the

left. HEENT: She was normocephalic and atraumatic. Eyes: Lids were normal. There was no exophthalmos, icterus, conjunctiva, erythema, or exudates noted. PERRLA: Extraocular movements were intact. Ears: There was no discharge in the external auditory canals. No bulging erythema, perforation of the visible tympanic membrane noted. Nose: There was no septal deformity, epistaxis, or rhinorrhea. Mouth: The teeth were in fair repair. Neck: Supple. No JVD noted. No tracheal deviation. No lymphadenopathy. Thyroid was not visible or palpable. ENT: External inspection of the ears and nose revealed no evidence of acute abnormality. Respiratory System: The chest was symmetrical and equal to expansion. The lungs 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. Cardiovascular: Normal sinus rhythm. S1, S2. No rubs, murmur, or gallop. Gastrointestinal: Soft, benign, non-distended, non-tender with no guarding, rebound, palpable masses. Bowel sounds were present. Liver and spleen were not palpable. Skin: There were no significant skin rashes or ulcers. Extremities: Minimal 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, statis dermatitis, chronic leg ulcers and muscle atrophy or joint deformity or enlargement was noted. Bones and Joints: The claimant did not use a cane or aid for walking. The claimant was able to get on and off the table without difficulty Gait and stance were normal. Tandem walk, heel walk, and toe walk were done without difficulty. Able to squat to 60% of the distance and recover, and bend to 90% of the distance and recover. Grip strength was equal bilaterally. The claimant was right-handed. Gross and fine dexterity appeared bilaterally intact. Abduction of the shoulder was 0-150, flexion of the knees 0-150. Straight leg raising while lying was 0-50, while sitting was 0-90. Neurologic:

General: The claimant was alert, awake, and oriented to person, place, and time. Cranial Nerve II: Vision as stated in vital signs. III, IV, VI: No ptosis, nystagmus. PERRLA. Pupils 2 mm. bilaterally. V: No facial numbness. Symmetrical response to stimuli. VII: Symmetrical facial movements noted. VIII: Can hear normal conversation and whispered voice. IX, X: Swallowing intact. Gag reflex intact. Uvula midline. XI: Head and shoulder movement against resistance was equal. 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 that claimant had carpal tunnel syndrome primarily affecting the right side. She had a history of arthritis of her back and knees with paresthesias in the left lower extremity. Claimant has anxiety attacks and hypertension and her blood pressure was under poor control. (pp. 22-23) Claimant's range of motion tests was all normal. (pp. 23-24)

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 is 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 no corresponding clinical findings that support the reports of symptoms and limitations made by the claimant. The DHS-49, Medical Examination Report, indicates that claimant was normal in all areas but did not give any standing, walking, or sitting restrictions and did not determine a clinical impression. Claimant's physician indicates that assistive devices are not medically needed or required for ambulation. There is no medical finding that claimant has 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 that claimant has a severely restrictive physical impairment.

Claimant testified on the record that she does have depression, anxiety, and panic attacks.

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 in the record indicating claimant suffers mental limitations resulting from her reportedly depressed and anxious state. There is no mental residual functional capacity assessment in the record; however, there is a psychiatric report which indicates that claimant can perform her activities of daily living and that she is able to function without mental limitations. 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 as a cashier or to do laundry as a caregiver/home healthcare aid. There is insufficient objective 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 testified on the record that she does cook three days a week and cooks things like bacon and eggs. Claimant testified that she can walk a half a block, stand for 10-15 minutes at a time, and sit for 10 minutes at a time. Claimant testified that she can shower and dress herself, but not squat, touch her toes, or tie her shoes. Claimant testified that the heaviest weight she can carry is 5-6 pounds and she is right-handed. Claimant testified that her level of pain on a scale from 1 to 10 without medication is a 10 and with medication is a 7.

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. 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.

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, p. 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:_ March 8, 2010 ___

Date Mailed:_ March 9, 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.

LYL/vmc

cc: