

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.: 2009-750  
Issue No.: 2009/4031  
Case No.: [REDACTED]  
Load No.: [REDACTED]  
Hearing Date:  
February 4, 2009  
Macomb County DHS (36)

ADMINISTRATIVE LAW JUDGE: Colleen M. Mamelka

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Claimant's request for a hearing. After due notice, a hearing was conducted from Sterling Heights, Michigan on Wednesday, February 4, 2009. The Claimant appeared and testified. The Claimant was represented by [REDACTED] of [REDACTED]. [REDACTED] appeared on behalf of the Department.

At the Claimant's request, the record was extended to allow for the submission of additional medical documentation. The records were received, reviewed, entered as Exhibit B and forwarded to the State Hearing Review Team for consideration. On December 21, 2008, the SHRT found the Claimant not disabled. This matter is now before the undersigned for a final determination.

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of the Medical Assistance ("MA-P") and State Disability Assistance ("SDA") programs?

FINDINGS OF FACT

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

1. The Claimant submitted a public assistance application seeking MA-P and SDA benefits on May 28, 2008.
2. On August 22, 2008, the Medical Review Team (“MRT”) determined the Claimant was not disabled for purposes of the MA-P and SDA programs. (Exhibit 1, pp. 1, 2)
3. On September 15, 2008, the Department sent an eligibility notice to the Claimant informing her that the MA-P and SDA benefits were denied. (Exhibit 3)
4. On September 22, 2008, the Department received the Claimant’s Request for Hearing protesting the denial of benefits. (Exhibit 4)
5. On October 10, 2008 and December 21, 2009, the State Hearing Review Team (“SHRT”) found the Claimant was not disabled. (Exhibit 4)
6. The Claimant’s alleged physical disabling impairments are due to bilateral knee pain, arthritis, degenerative disc disease, high blood pressure, seizure disorder, and HIV.
7. The Claimant asserts mental disabling impairments due to depression and anxiety.
8. At the time of hearing, the Claimant was 45 years old with a [REDACTED] birth date; was 5’ 1” in height; and weighed approximately 165 pounds.
9. The Claimant has a limited education with some vocational training with a work history as a nurse aide and janitor.

CONCLUSIONS OF LAW

The Medical Assistance (“MA”) program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department of

Human Services (“DHS”), formally known as the Family Independence Agency, 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”).

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) 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 recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CFR 413.913 An individual’s subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a) Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.92

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant’s pain; (2) the type/dosage/effectiveness/side effects of any medication the applicants takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant’s pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3) The applicant’s pain must be assessed to determine the extent of his or her

functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2)

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1) The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (i.e. age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need evaluate subsequent steps. 20 CFR 416.920(a)(4) If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4) If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from step three to step four. 20 CFR 416.920(a)(4); 20 CFR 416.945 Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1) An individual's residual functional capacity assessment is evaluated at both steps four and five. 20 CFR 416.920(a)(4) In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv) In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a) An impairment or combination of impairments is not severe if it does not significantly limit an

individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a) The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6)

In addition to the above, when evaluating mental impairments, a special technique is utilized. 20 CFR 416.920a(a) First, an individual's pertinent symptoms, signs, and laboratory findings are evaluated to determine whether a medically determinable mental impairment exists. 20 CFR 416.920a(b)(1) When a medically determinable mental impairment is established, the symptoms, signs and laboratory findings that substantiate the impairment are documented to include the individual's significant history, laboratory findings, and functional limitations. 20 CFR 416.920a(e)(2) Functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. *Id.*; 20 CFR 416.920a(c)(2) Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality is considered. 20 CFR 416.920a(c)(1) In addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of functional limitation. 20 CFR 416.920a(c)(3) The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4) A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. *Id.* The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. *Id.*

After the degree of functional limitation is determined, the severity of the mental impairment is determined. 20 CFR 416.920a(d) If severe, a determination of whether the impairment meets or is the equivalent of a listed mental disorder. 20 CFR 416.920a(d)(2) If the severe mental impairment does not meet (or equal) a listed impairment, an individual's residual functional capacity is assessed. 20 CFR 416.920a(d)(3)

As outlined above, the first step looks at the individual's current work activity. An individual is not disabled regardless of the medical condition, age, education, and work experience, if the individual is working and the work is a substantial, gainful activity. 20 CFR 416.920(a)(4)(i) In the record presented, the Claimant is not involved in substantial gainful activity therefore is not ineligible for disability under Step 1.

The severity of the Claimant's alleged impairment(s) is considered under Step 2. The Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b) An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c) Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b) Examples 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.

*Id.* The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen*, 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 citing *Farris v Sec of Health and Human Services*, 773 F2d 85, 90 n.1 (CA 6, 1985) An impairment qualifies as non-severe only if, regardless of a claimant's age, education, or work experience, the impairment would not affect the claimant's ability to work. *Salmi v Sec of Health and Human Services*, 774 F2d 685, 692 (CA 6, 1985)

In the present case, the Claimant alleges physical disability on the basis of bilateral knee pain, arthritis, degenerative disc disease, high blood pressure, seizure disorder, and HIV. The Claimant asserts mental disabling impairments due to depression and anxiety. In support of her claim, some older medical records from 2006 and 2007 were submitted which documented treatment for a left arm abscess, knee pain, anxiety, and seizures.

On or about [REDACTED], the Claimant presented to the hospital after experiencing a seizure at home. The Claimant was treated and subsequently discharged on [REDACTED] [REDACTED] after no further seizure activity.

On [REDACTED], a Medical Examination Report was completed on behalf of the Claimant. The current diagnosis was seizures of unknown etiology. The physical examination was normal and the Claimant's condition was listed as improving. The Claimant was found able to occasionally lift/carry less than 10 pounds; able to stand and/or walk at least 2 hours in an 8 hour workday; able to perform repetitive actions with all extremities; and did not require an assistive device for ambulation. The Claimant did not have any mental limitations.

On [REDACTED] and [REDACTED], the Claimant attended an orthopedic evaluation. The physical examination documented moderate effusion of the right knee with some instability. X-rays revealed considerable degenerative changes, mostly in the medial joint, but also in the patellofemoral joint. The Claimant was noted as possibly needing knee replacement surgery in the future.

On [REDACTED], a Medical Examination Report was completed on behalf of the Claimant. The current diagnoses were listed as HIV positive, bilateral knee pain, hypercholesterol, hypertension, seizure, coronary artery disease, and myocardial infarction. The Claimant's condition was listed as deteriorating and she was limited to occasionally lifting/carrying of less than 10 pounds; and standing and/or walking less than 2 hours during an 8 hour workday with sitting at less than 6 hours during this same time span. Assistive device was not required and the Claimant was able to perform repetitive actions with all extremities. The Claimant did not have any mental limitations.

On [REDACTED], an initial psychiatric assessment was performed. The Claimant presented with anxiety issues which developed after she was confirmed HIV positive. The diagnoses were major depressive disorder, recurrent, severe without psychosis. The Claimant's Global Assessment Functioning ("GAF") was 53.

In support of her claim, the Claimant submitted psychiatric records which document the Claimant's bi-weekly therapy and medication compliance.

On [REDACTED], the Claimant was treated at the emergency room for pain relating to her degenerative arthritis. The Claimant was given a dose of Norco and a prescription for Naprosyn and 10 Vicodin (noting that two days prior she was prescribed 30 Vicodin from a different hospital).



On [REDACTED], a medication review was performed which documented the Claimant's current level of functioning as worse resulting in an adjustment in her medication regime.

The [REDACTED] medication review found the Claimant's current level of functioning as better (noting that that particular day was worse) resulting in an increase in prescribed treatment.

On [REDACTED], the Claimant presented to the emergency room with complaints of pain. The Claimant was treated with pain medication with a discharge diagnosis of acute osteoarthritis of the right knee.

On [REDACTED], a medication review was performed which documented the Claimant's current level of functioning as worse resulting in an adjustment in her medication regime.

On [REDACTED], a psychiatric medication review noted the Claimant's medication compliance however her current level of functioning was worse which resulted in an increase in her prescribed treatment.

On [REDACTED], a Psychiatric/Psychological Examination Report was completed on behalf of the Claimant. The diagnoses were major depressive and panic disorders. The Claimant's Global Assessment Functioning ("GAF") was 50. On this same date, a Mental Residual Functional Capacity Assessment was completed on behalf of the Claimant. The Claimant was found markedly limited in 12 of the 20 factors. The Claimant's level of functioning was noted as worse however there was no adjustment in prescribed treatment.

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the

Claimant has presented medical evidence establishing that she does have some physical and mental limitations on her ability to perform basic work activities. The medical evidence has established that the Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, the Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The Claimant has alleged physical disabling impairments due to bilateral knee pain, arthritis, degenerative disc disease, high blood pressure, and seizures.

Listing 1.00 defines musculoskeletal system impairments. Disorders of the musculoskeletal system may result from hereditary, congenital, or acquired pathologic processes. 1.00A Impairments may result from infectious, inflammatory, or degenerative processes, traumatic or developmental events, or neoplastic, vascular, or toxic/metabolic diseases. 1.00A Regardless of the cause(s) of a musculoskeletal impairment, functional loss for purposes of these listings is defined as the inability to ambulate effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment, or the inability to perform fine and gross movements effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment. Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. 1.00B2b(1) Ineffective ambulation is defined generally as having insufficient lower extremity function to permit independent ambulation without the use of a hand-held assistive device(s) that

limits the functioning of both upper extremities. (Listing 1.05C is an exception to this general definition because the individual has the use of only one upper extremity due to amputation of a hand.) *Id.* To ambulate effectively, individuals must be capable of sustaining a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living. 1.00B2b(2) The individual must have the ability to travel without companion assistance to and from a place of employment or school. . . . *Id.*

Categories of Musculoskeletal include:

- 1.02 Major dysfunction of a joint(s) due to any cause: Characterized by gross anatomical deformity (e.g. subluxation, contracture, bony or fibrous ankylosis, instability) and chronic joint pain and stiffness with signs of limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With:
- A. Involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in inability to ambulate effectively as defined in 1.00B2b; or
  - B. Involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, wrist, hand), resulting in inability to perform fine and gross movements effectively a defined in 1.00B2c

In order to meet a musculoskeletal listing, the impairment must present a major dysfunction and an extreme loss of function of both upper and/or lower extremities. In this case, the objective findings document considerable degenerative changes in the Claimant's right knee as well as bilateral knee pain. Evidence also documents degenerative arthritis. Ultimately, the objective medical findings are insufficient to meet the intent and severity requirement of a listed impairment within 1.00, specifically 1.02, therefore the Claimant cannot be found disabled, or not disabled, under this listing.

The Claimant asserts physical disabling impairments due to high blood pressure with previous myocardial infarction and coronary artery disease. Listing 4.00 defines cardiovascular impairment in part, as follows:

. . . any disorder that affects the proper functioning of the heart or the circulatory system (that is, arteries, veins, capillaries, and the lymphatic drainage). The disorder can be congenital or acquired. Cardiovascular impairment results from one or more of four consequences of heart disease:

- (i) Chronic heart failure or ventricular dysfunction.
- (ii) Discomfort or pain due to myocardial ischemia, with or without necrosis of heart muscle.
- (iii) Syncope, or near syncope, due to inadequate cerebral perfusion from any cardiac cause, such as obstruction of flow or disturbance in rhythm or conduction resulting in inadequate cardiac output.
- (iv) Central cyanosis due to right-to-left shunt, reduced oxygen concentration in the arterial blood, or pulmonary vascular disease.

An uncontrolled impairment means one that does not adequately respond to the standard prescribed medical treatment. 4.00A3f In a situation where an individual has not received ongoing treatment or have an ongoing relationship with the medical community despite the existence of a severe impairment, the disability evaluation is based on the current objective medical evidence. 4.00B3a If an individual does not receive treatment, an impairment that meets the criteria of a listing cannot be established. *Id.* Hypertension (high blood pressure) generally causes disability through its effect on other body systems and is evaluated by reference to specific body system(s) affected (heart, brain, kidneys, or eyes). 4.00H1 Hypertension, to include malignant hypertension, is not a listed impairment under 4.00 thus the effect on the Claimant's other body systems were evaluated by reference to specific body parts.

In the record presented, the Claimant medical records document hypertension and prior treatment for myocardial infarction, however the record is devoid of any end organ damage or

resulting treatment. Ultimately, the Claimant's medical record does not support a finding that the Claimant's physical impairment(s) are "listed impairments" or equivalent to a listed impairment detailed above. 20 CFR 416.920(a)(4)(iii) According to the medical evidence alone, the Claimant's physical impairment(s) do not meet or equal the requirements within Listing 4.00 thus she cannot be found to be disabled for purposes of the Medical Assistance program.

The Claimant alleges physical disabling impairment due to seizures. Listing 11.00 discusses adult neurological disorders. The criteria for epilepsy are applied only if the impairment persists despite the fact the individual is compliant with the antiepileptic treatment. 11.00A The severity of frequently occurring seizures is evaluated in consideration of the serum drug levels. *Id.* Blood drug levels should be evaluated in conjunction with all other evidence to determine the extent of compliance. *Id.* Listing 11.02 defines the requirements of convulsive epilepsy. To meet this listing, documentation providing a detailed description of a typical seizure pattern, including all associated phenomena, occurring more frequently than once a month, in spite of at least three months of prescribed treatment with daytime episodes (loss of consciousness and convulsive seizures) or nocturnal episodes manifesting residuals which interfere significantly with activities during the day. To meet Listing 11.03, an individual's nonconvulsive epilepsy must be documented by detailed description of a typical seizure pattern including all associated phenomena, occurring more frequently than once weekly despite at least 3 months of prescribed treatment with alteration of awareness or loss of consciousness. Additionally, documentation of transient postictal manifestations of unconventional behavior or significant interference with activity during the day is required.

The record presented establishes that the Claimant suffers from seizures however these same records establish that the last treatment for this impairment was in [REDACTED] with

no further activity. Ultimately, the objective medical documentation is insufficient to meet the intent and severity requirement of a listed impairment within Listing 11.00. Accordingly, the Claimant cannot be found disabled under this listing.

The Claimant asserts mental disabling impairments due to anxiety and depression. Listing 12.00 encompasses adult mental disorders. The evaluation of disability on the basis of mental disorders requires documentation of a medically determinable impairment(s) and consideration of the degree in which the impairment limits the individual's ability to work, and whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. 12.00A The existence of a medically determinable impairment(s) of the required duration must be established through medical evidence consisting of symptoms, signs, and laboratory findings, to include psychological test findings. 12.00B The evaluation of disability on the basis of a mental disorder requires sufficient evidence to (1) establish the presence of a medically determinable mental impairment(s), (2) assess the degree of functional limitation the impairment(s) imposes, and (3) project the probable duration of the impairment(s). 12.00D The evaluation of disability on the basis of mental disorders requires documentation of a medically determinable impairment(s) and consideration of the degree in which the impairment limits the individual's ability to work consideration, and whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. 12.00A The severity requirement is measured according to the functional limitations imposed by the medically determinable mental impairment. 12.00C Functional limitations are assessed in consideration of an individual's activities of daily living; social functioning; concentration, persistence, or pace; and episodes of decompensation. *Id.*

Listing 12.04 defines affective disorders as being characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Generally, affective disorders involve either depression or elation. The required level of severity for these disorders are met when the requirements of both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:
  - a. Anhedonia or pervasive loss of interest in almost all activities; or
  - b. Appetite disturbance with change in weight; or
  - c. Sleep disturbance; or
  - d. Psychomotor agitation or retardation; or
  - e. Decreased energy; or
  - f. Feelings of guilt or worthlessness; or
  - g. Difficulty concentrating or thinking; or
  - h. Thoughts of suicide; or
  - i. Hallucinations, delusions, or paranoid thinking; or
2. Manic syndrome characterized by at least three of the following:
  - a. Hyperactivity; or
  - b. Pressure of speech; or
  - c. Flight of ideas; or
  - d. Inflated self-esteem; or
  - e. Decreased need for sleep; or
  - f. Easy distractability; or
  - g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
  - h. Hallucinations, delusions, or paranoid thinking; or
3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive

syndromes (and currently characterized by either or both syndromes)'

AND

B. Resulting in at least two of the following:

1. Marked restriction on activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. 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.

Listing 12.06 defines anxiety related disorders where anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders. The required level of severity for these disorders are met when the requirements in both A and B are satisfied, or when the requirements in both A and C are satisfied.

A. Medically documented findings of at least one of the following:



1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:
  - a. Motor tension; or
  - b. Autonomic hyperactivity; or
  - c. Apprehensive expectation; or
  - d. Vigilance and scanning; or
2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or
3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or
4. Recurrent obsessions or compulsions which are a source of marked distress; or
5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;

AND

- B. Resulting in at least two of the following:
1. Marked restriction of activities of daily living; or
  2. Marked difficulties in maintaining social functioning; or
  3. Marked difficulties in maintaining concentration, persistence, or pace; or
  4. Repeated episodes of decompensation, each of extended duration.

OR

- C. Resulting in complete inability to function independently outside the area of one's home.

In this case, medical evidence documents that the Claimant received treatment for anxiety, panic disorder, and depression. The Claimant is currently involved in therapy, prescribed treatment, and her GAF for the period from [REDACTED] and forward was 50-53. This score results in moderate/severe symptoms or moderate/serious difficulty in social, occupational, or school functioning. The Psychiatric/Psychological Examination Report finds the Claimant markedly limited in 12 of the 20 factors, noting her current level of functioning was worse. Conversely, other records note no mental limitations. Ultimately, the records are insufficient to meet the necessary criteria to establish the intent and severity requirement thus the Claimant cannot be found disabled, or not disabled, under this listing.

The record also documents the Claimant's treatment for HIV. Listing 14.08 defines human immunodeficiency virus infection. To meet this listing, an individual must provide supporting documentation of the diagnosis and one of the following:

A. Bacterial infections:

1. Mycobacterial infection (for example, caused by *M. avium-intracellulare*, *M. kansasii*, or *M. tuberculosis*) at site other than the lungs, skin, or cervical or hilar lymph nodes, or pulmonary tuberculosis resistant to treatment; or
2. Nocardiosis; or
3. *Salmonella* bacteremia, recurrent non-typhoid; or
4. Multiple or recurrent bacterial infections, including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment three or more times in a 12-month period.

OR

B. Fungal infections:

1. Aspergillosis; or
2. Candidiasis involving the esophagus, trachea, bronchi, or lungs, or at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or
3. Coccidioidomycosis, at a site other than the lungs or lymph nodes; or
4. Cryptococcus, at a site other than the lungs (for example, cryptococcal meningitis); or

5. Histoplasmosis, at a site other than the lungs or lymph nodes; or
6. Mucormycosis; or
7. *Pneumocystis* pneumonia or extrapulmonary *Pneumocystis* infection.

OR

C. Protozoan or helminthic infections:

1. Cryptosporidiosis, isosporiasis, or microsporidiosis, with diarrhea lasting for 1 month or longer; or
2. Strongyloidiasis, extra-intestinal; or
3. Toxoplasmosis of an organ other than the liver, spleen, or lymph nodes.

OR

D. Viral infections:

1. *Cytomegalovirus* disease (documented as described in 14.00F3b (ii)) at a site other than the liver, spleen, or lymph nodes; or
2. Herpes simplex virus causing:
  - a. Mucocutaneous infection (for example, oral, genital, perianal) lasting for 1 month or longer; or
  - b. Infection at a site other than the skin or mucous membranes (for example, bronchitis, pneumonitis, esophagitis, or encephalitis); or
  - c. Disseminated infection; or
3. Herpes zoster:
  - a. Disseminated; or
  - b. With multidermatomal eruptions that are resistant to treatment; or
4. Progressive multifocal leukoencephalopathy.

OR

E. Malignant neoplasms:

1. Carcinoma of the cervix, invasive, FIGO stage II and beyond; or
2. Kaposi's sarcoma with:
  - a. Extensive oral lesions; or
  - b. Involvement of the gastrointestinal tract, lungs, or other visceral organs; or
3. Lymphoma (for example, primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkin's lymphoma, Hodgkin's disease); or

4. Squamous cell carcinoma of the anal canal or anal margin.

OR

F. Conditions of the skin or mucous membranes (other than described in B2, D2, or D3, above), with extensive fungating or ulcerating lesions not responding to treatment (for example, dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal *Candida*, condyloma caused by human *Papillomavirus*, genital ulcerative disease).

OR

G. HIV encephalopathy, characterized by cognitive or motor dysfunction that limits function and progresses.

OR

H. HIV wasting syndrome, characterized by involuntary weight loss of 10 percent or more of baseline (computed based on pounds, kilograms, or body mass index (BMI)) or other significant involuntary weight loss as described in 14.00F5, and in the absence of a concurrent illness that could explain the findings. With either:

1. Chronic diarrhea with two or more loose stools daily lasting for 1 month or longer; or
2. Chronic weakness and documented fever greater than 38°C (100.4°F) for the majority of 1 month or longer.

OR

I. Diarrhea, lasting for 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding.

OR

J. One or more of the following infections (other than described in A-I above). The infection(s) must either be resistant to treatment or require hospitalization or intravenous treatment three or more times in a 12-month period.

1. Sepsis; or
2. Meningitis; or
3. Pneumonia; or
4. Septic arthritis; or
5. Endocarditis; or

6. Sinusitis documented by appropriate medically acceptable imaging.

OR

- K. Repeated (as defined in 14.00I3) manifestations of HIV infection, including those listed in 14.08A-J, but without the requisite findings for those listings (for example, carcinoma of the cervix not meeting the criteria in 14.08E, diarrhea not meeting the criteria in 14.08I), or other manifestations (for example, oral hairy leukoplakia, myositis, pancreatitis, hepatitis, peripheral neuropathy, glucose intolerance, muscle weakness, cognitive or other mental limitation) resulting in significant, documented symptoms or signs (for example, severe fatigue, fever, malaise, involuntary weight loss, pain, night sweats, nausea, vomiting, headaches, or insomnia) and one of the following at the marked level:
  1. Limitation of activities of daily living.
  2. Limitation in maintaining social functioning.
  3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

In this case, the Claimant's objective medical records confirms the Claimant has HIV however her CD4 count and/or viral load were not known nor was there any treatment for any opportunistic infections. At this time, the Claimant's objective medical documentation does not meet the intent and severity requirement of Listing 14.08. Listings 3.00 (respiratory system) and 5.00 (digestive system) were also considered and found not applicable. Accordingly, the Claimant's eligibility under Step 4 is considered. 20 CFR 416.905(a).

The fourth step in analyzing a disability claim requires an assessment of the Claimant's residual functional capacity ("RFC") and past relevant employment. 20 CFR 416.920(a)(4)(iv) An individual is not disabled if he/she can perform past relevant work. *Id.*; 20 CFR 416.960(b)(3) Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1) Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is

not considered. 20 CFR 416.960(b)(3) RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands (exertional requirements, i.e. sitting, standing, walking, lifting, carrying, pushing, or pulling) are considered nonexertional. 20 CFR 416.969a(a) In considering whether an individual can perform past relevant work, a comparison of the individual's residual functional capacity with the demands of past relevant work. *Id.* If an individual can no longer do past relevant work the same residual functional capacity assessment along with an individual's age, education, and work experience is considered to determine whether an individual can adjust to other work which exists in the national economy. *Id.* Examples of non-exertional limitations or restrictions include difficulty function due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi) If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2) The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.*

Over the past 15 years, the Claimant worked as a nurse's aide and janitor with a short stint at a fast food restaurant. In light of the foregoing, and in consideration of the Occupational Code, the Claimant's past relevant work is considered unskilled, light work.

The Claimant testified that she can lift/carry 5 pounds; walk less than a block with assistance; stand for short periods of time; and experiences difficulty bending and squatting. The medical documentation restrictions are the equivalent to less than sedentary with mental limitations noted. If the impairment or combination of impairments does not limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. 20 CFR 416.920 In consideration of the Claimant's testimony, medical records, and current limitations, it is found that the Claimant is not able to return to past relevant work thus the fifth step in the sequential evaluation is required.

In Step 5, an assessment of the individual's residual functional capacity and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v) At the time of this writing, the Claimant was 46 years old thus considered a younger individual for MA-P purposes. The Claimant has a limited education with some vocational training. Disability is found disabled if an individual is unable to adjust to other work. *Id.* At this point in the analysis, the burden shifts from the Claimant to the Department to present proof that the Claimant has the residual capacity to substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be

used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

In the record presented, the total impact caused by the combination of medical problems suffered by the Claimant must be considered. In doing so, it is found that the Claimant's physical and mental impairments have a major effect on her ability to perform basic work activities. That being stated, it is found that the Claimant retains the physical and mental abilities to perform the full range of activities for sedentary work as defined in 20 CFR 416.967(a). Although the Medical Examination Report limits the Claimant to less than sedentary restrictions, these restrictions are not inconsistent with the objective medical evidence. 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 416.927 After review of the entire record and in consideration of the Medical-Vocational Guidelines [20 CFR 404, Subpart P, Appendix II], specifically 201.18, and finding no contradiction with the Claimant's mental impairments, it is found that the Claimant is not disabled for purposes of the MA-P program at Step 5.

The State Disability Assistance ("SDA") program, which provides financial assistance for disabled persons, was established by 2004 PA 344. DHS administers the SDA program pursuant to MCL 400.10 et seq. and Michigan Administrative Code ("MAC R") 400.3151 – 400.3180. Department policies are found in PAM, PEM, and PRM. A person is considered disabled for SDA purposes if the person has a physical or mental impairment which meets federal SSI disability standards for at least ninety days. Receipt of SSI or RSDI benefits based



on disability or blindness, or the receipt of MA benefits based on disability or blindness (MA-P) automatically qualifies an individual as disabled for purposes of the SDA program.

In this case, the Claimant is found not disabled for purposes of the Medical Assistance (“MA-P”) program, therefore the Claimant’s is found not disabled for purposes of continued SDA benefits.

DECISION AND ORDER

The Administrative Law Judge, based upon the findings of fact and conclusions of law, finds the Claimant not disabled for purposes of the Medical Assistance program and the State Disability Assistance program.

It is ORDERED:

The Department’s determination is AFFIRMED.

*Colleen M. Mamelka*

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Colleen M. Mamelka  
Administrative Law Judge  
For Ishmael Ahmed, Director  
Department of Human Services

Date Signed: 1/19/2010

Date Mailed: 1/19/2010

**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 the Circuit within 30 days of the receipt 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.

CMM/jlg

cc:

