

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: 2009-10851  
Issue No: 2009; 4031  
Case No: [REDACTED]  
Load No: [REDACTED]  
Hearing Date:  
April 23, 2009  
Sanilac County DHS

ADMINISTRATIVE LAW JUDGE: Jay W. Sexton

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon claimant's request for a hearing. After due notice, a telephone hearing was held on April 23, 2009 in Sandusky. Claimant personally appeared and testified under oath.

The department was represented by Linda Courter (General Services Program Manager).

The Administrative Law Judge appeared from telephone from Lansing.

Claimant requested additional time to submit new medical evidence. Claimant's new medical evidence was mailed to the State Hearing Review Team (SHRT) on April 23, 2009. Claimant waived the timeliness requirement so her new medical evidence could be reviewed by SHRT. After SHRT's second disability denial, the Administrative Law Judge issued the decision below.

ISSUES

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

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

FINDINGS OF FACT

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

(1) Claimant is an MA-P/SDA/retroactive applicant (August 15, 2008) who was denied by SHRT (February 10, 2009) due to claimant's ability to perform light unskilled work under 20 CFR 416.967(b). SHRT relied on Med-Voc Rule 202.20 as a guide. Claimant requests retro MA for May, June and July 2008.

(2) Claimant's vocational factors are: age—46; education—high school diploma; post high school education—Associate's degree from [REDACTED] (majoring in [REDACTED]); work experience—church secretary, self-employed dog groomer.

(3) Claimant has not performed substantial gainful activity since 2005 when she worked as a church secretary.

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

- (a) Rheumatoid lyme disease;
- (b) Uses oxygen 24/7;
- (c) Rheumatoid arthritis;
- (d) Fibromyalgia;
- (e) Diabetes;
- (f) Anxiety disorder.

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

OBJECTIVE MEDICAL EVIDENCE ([REDACTED])

SHRT decided that claimant was able to perform light unskilled work. SHRT evaluated claimant's eligibility using the SSI listings at 20 CFR 404, Subpart P, Appendix. SHRT decided that claimant does not meet any of the applicable listings. SHRT denied disability based on 20 CFR 416.967(b) and 20 CFR 416.968(a).

(6) Claimant lives with her husband and performs the following Activities of Daily Living (ADLs): dressing, bathing, cooking (sometimes), light cleaning, and laundry. Claimant uses a cane three times a month and a walker (sometimes). She uses the shower stool three times a month. Claimant does not use a wheelchair and does not wear braces. Claimant received inpatient hospital services since [REDACTED] for pneumonia and rheumatoid lung disease.

(7) Claimant has a valid driver's license and drives an automobile approximately three times a month. Claimant is computer literate. Claimant has on-the-job secretarial training and an Associates degree.

(8) The following medical records are persuasive:

- (a) A [REDACTED] Medical Examination Report (DHS-49) was reviewed. The physician provided the following diagnoses: diabetes mellitus and bronchial spasms.

The physician reported that claimant is totally unable to lift any weight. He did not report any limitations in claimant's ability to stand, walk or sit. He recommended that claimant use a cane or a walker. He reported that claimant was totally unable to do simple grasping, reaching, pushing/pulling or fine manipulating. He reports that claimant is totally unable to do any work with foot controls.

The physician reported that claimant has no mental limitations.

- (b) A [REDACTED] physician note was reviewed. The physician states as follows:

Symptoms: Claimant has diabetes mellitus, occasional bronchospasms. Her lungs are better. We talked about finishing out her antibiotics. Her CRX looked better. She has not mentioned any cough.

\* \* \*

- (c) A [REDACTED] [REDACTED] consultation was reviewed.

The consulting physician reported the following background:

Claimant is a 46-year-old white female with a history of rheumatoid arthritis, who comes in with about two weeks worth of increasing respiratory complaints. They include chest tightness, wheezing and cough, coughing up some yellow phlegm and light fever and chills. She has been getting over the last two weeks. She finally came in to the Emergency Room where she was evaluated and diagnosed as having pneumonia.

The consulting physician provided the following assessment:

- (1) Bilateral pneumonia;
- (2) History of rheumatoid arthritis, with possible methotrexate lung;
- (3) History of fibromyalgia;
- (4) History of depression;
- (5) History of restless leg syndrome;
- (6) History of anxiety.

(e) A [REDACTED] cardiac test was reviewed. The cardiologist provided the following conclusions:

- (1) The patient seems to be in sinus rhythm with some sinus tachycardia present.
- (2) Aortic, mitral and tricuspid valve morphology appears to be normal.
- (3) Right atrial, right ventricle, left atrial and left ventricular dimension is normal. There is mild hypertrophy of the left ventricular systolic function is preserved, ejection fraction is around 60%.
- (4) The old pericardial effusion present.
- (5) L wave, continuous wave and color Doppler shows mild mitral and mild tricuspid regurgitation present. Right ventricular peak systolic pressure is around 41 meters of mercury, suggestive of mild pulmonary hypertension.

\* \* \*

(e) A [REDACTED] [REDACTED] discharge summary was reviewed. The physician provided the following discharge diagnosis:

- (1) Acute severe bilateral pneumonia.
- (2) Bilateral pulmonary fibrosis (rheumatoid lung).
- (3) Acute respiratory failure.
- (4) Sinus tachycardia.
- (5) Rheumatoid arthritis.
- (6) Fibromyalgia with acute flare-up.
- (7) Restless leg syndrome.
- (8) Generalized anxiety.
- (9) Reactive leukocytosis from steroids.
- (10) Hyperglycemia from steroids.

\* \* \*

(f) A [REDACTED] [REDACTED] Psychiatric evaluation was reviewed.

The psychiatrist provided the following history:

Claimant reports she has been having bouts of depression which have gotten worse and recently she reports doing something stupid and ‘she states that she got upset, just wanted to be able to sleep and took several pills. These pills included Klonopin. She states that her husband became worried as he was unable to rouse her, she was so drowsy.

\* \* \*

Claimant reports that she has depressive symptoms related to her multiple medical issues. She notes that when she has a difficult week in terms of the pain related to arthritis and fibromyalgia, then her depression gradually worsens. She has been unable to get proper treatment for these conditions due to the fact she does not have insurance. She states that she did see a rheumatologist, who told her there was nothing else she could do as the patient does not have insurance and she became very upset with this rheumatologist. She notes that it is difficult for her to go from being somebody who had a lot of money and good insurance to being financially strapped and having no insurance.

\* \* \*

The psychiatrist provided the following mental status exam:

\* \* \*

Claimant appeared her stated age, was appropriately dress and groomed, cooperative and maintained good eye contact. Kinetics showed no abnormal movements. Speech was normal, not pressured. Mood was reported as depressed, affect was mood congruent, tearful. Thought process was goal directed and logical. No FOI, no LOA, no mania, or hypomania. Eye contact was negative for SI/Hi and tone was flat. Perceptions were negative for psychotic symptoms as she did not seem to be responding to internal stimuli during the interview.

The psychiatrist provided the following assessment:

Axis I—major depressive disorder, recurrent; generalized anxiety disorder; rule out panic disorder.

\* \* \*

Axis V/GAF—45.

(9) The claimant alleges a mental impairment: depression and anxiety disorder. The psychiatric report in the record provides the following diagnoses: major depressive disorder; generalized anxiety disorder; rule out panic disorder. The psychiatrist who submitted the report opined that the claimant is totally unable to work. Furthermore, claimant did not provide a DHS-49D or 49E to establish a mental residual functional capacity.

(10) The probative medical evidence does not establish an acute (exertional) physical impairment, or combination of impairments expected to prevent claimant from performing all customary work functions for the required period of time. The medical reports establish that claimant has rheumatoid lung, diabetes, fibromyalgia, and rheumatoid arthritis. These impairments prevent claimant from lifting large amounts on a continuous basis. They also prevent claimant from performing work that requires a great deal of stamina and lung capacity.

(11) The family physician reports that claimant is totally unable to do any work. Therefore, the medical record contains contradictory evidence. Based on the medical records, there is no consensus on claimant's physical limitations based on her rheumatoid arthritis, rheumatoid lung and fibromyalgia. The record does indicate that claimant was unable to lift heavy weights, and unable to stand continuously for a long period. At this time, however, there was no reliable medical evidence to establish a severe disabling condition which prevents claimant from performing all work activities.

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

CONCLUSIONS OF LAW

**CLAIMANT'S POSITION**

Claimant thinks she is entitled to MA-P/SDA because of her combination of medical impairments.

**DEPARTMENT'S POSITION**

The department states that claimant can perform unskilled light work. The department denied when she told them of her impairments using the SSI Listings of 20 CFR 404, Subpart P, Appendix.

Claimant's vocational profile is [a younger individual, with a high school and a two-year Associates degree, and work experience as a self-employed dog groomer and as a secretary.] The department denied the disability benefits based on Med-Voc 202.30, as a guide.

**LEGAL BASIS**

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).

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).

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).

To determine to what degree claimant's alleged mental impairments limit her ability to work, the following recommendations can be considered:

(a) **Activities of daily living.**

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

(b) **Social Functioning.**

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

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

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

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

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

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

**STEP #1**

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

SGA is defined as the performance of significant duties over a reasonable period of time for pay. Claimants who are working, or otherwise performing substantial gainful activity (SGA), are not disabled regardless of mental condition, age, education or work experience. 20 CFR 416.920(b). The vocational evidence of record shows that claimant is not currently performing SGA.

Therefore, claimant meets the Step 1 disability test.

**STEP #2**

The issue at Step 2 is whether claimant has impairments which meet the SSI definition of severity/duration. Claimant must establish an impairment which is expected to result in death, has existed for at least 12 months, and totally prevents all basic work activities. 20 CFR 416.909.

Also, to qualify for MA-P/SDA, claimant must satisfy both the gainful work and the duration criteria. 20 CFR 416.920(a).

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

**STEP #3**

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

**STEP #4**

The issue at Step 4 is whether claimant is able to do her previous work. Claimant previously worked as a secretary for her local church. This was sedentary work.

The medical evidence of record establishes that claimant does have diabetes, rheumatoid arthritis, rheumatoid lung and fibromyalgia. However, claimant is currently being successfully treated for these conditions.

There is no evidence in this record that claimant is totally unable to return to her previous sedentary work as a secretary.

Therefore, the claimant does not meet the Step #4 disability test.

**STEP #5**

**Claimant has the burden of proof** to show by a preponderance of the medical/psychiatric evidence in the record that her combined impairments meet the department's definition of disability for MA-P/SDA purposes.

First, claimant alleges a mental impairment: anxiety disorder and depression. The psychiatric reports in the record show that the claimant's mental condition is not a severe impairment. The consulting psychologist reports the following diagnoses: major depressive disorder, recurrent; generalized anxiety disorder; rule out panic disorder. The psychiatrist did not report that claimant is totally unable to work. Also, claimant did not provide a DHS-49D or DHS-49E to establish a mental residual functional capacity to establish her residual mental functional capacity.

Second, claimant alleges disability based on diabetes, rheumatoid lung, rheumatoid arthritis and fibromyalgia. Claimant's lung impairments prevent her from doing work which requires a high level of physical exertion. These impairments also prevent her from working at positions which require constant lifting and walking. Although claimant is precluded from heavy lifting and excessive walking, the medical evidence of record does not show that claimant is totally unable to perform any work.

Third, claimant testified that a major impairment to her return to work was for pain arising out of her fibromyalgia and breathing dysfunction. Unfortunately, evidence of pain, alone, is insufficient to establish disability for MA-P/SDA purposes.

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

In short, the Administrative Law Judge is not persuaded that claimant is totally unable to work based on her combination of impairments. Claimant performs a significant number of activities of daily living, has an active social life with her husband, attends church on a regular basis, is able to drive several times a month and is computer literate. Considering the entire medical record, in combination with claimant's testimony, the Administrative Law Judge concludes that claimant is able to perform simple, unskilled sedentary work (SGA). In this capacity, she is able to work as a ticket taker for the theater, as a parking lot attendant, as a greeter for [REDACTED] and as a church secretary.

Based on this analysis, the department correctly denied claimant's MA-P/SDA application based on the following sequential analysis, as decided above.

DECISION AND ORDER

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

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

SO ORDERED.

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

Date Signed: May 18, 2009

Date Mailed: May 19, 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 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.

JWS/tg

cc:

