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: 2010-08515
Issue No: 2009; 4031
Case No: [redacted]
Load No:
Hearing Date:
January 20, 2010
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 January 20, 2010. 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 May 8, 2009, claimant filed an application for Medical Assistance and State Disability Assistance benefits alleging disability.

(2) On September 3, 2009, the Medical Review Team denied claimant's application stating that claimant could perform other work.

(3) On September 10, 2009, the department caseworker sent claimant notice that her application was denied.

(4) On September 24, 2009, claimant filed a request for a hearing to contest the department's negative action.

(5) On December 7, 2009, the State Hearing Review Team again denied claimant's application stating that it had insufficient evidence and requested a complete physical examination and a psychiatric evaluation.

(6) The hearing was held on January 20, 2010. 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 January 21, 2010.

(8) On January 26, 2010, the State Hearing Review Team again denied claimant's application stating that claimant is capable of performing other work in the form of light work per 20 CFR 416.967(b), unskilled work per 20 CFR 416.968(a) pursuant to Medical Vocational Rule 202.18.

(9) Claimant is a 46-year-old woman whose birth date is [redacted]. Claimant is 5' 1" tall and weighs111 pounds. Claimant attended the 9th grade and does not have a GED. Claimant did receive a certificate for certified nursing assistant.

(10) Claimant is able to read and write and does have basic math skills, but stated that it is hard because of a head injury and she needs to use a paper and pencil.

(11) Claimant last worked in 2005 as a [redacted]. Claimant has also worked as a cashier at a [redacted] and a [redacted].

(12) Claimant alleges as disabling impairments: hypertension, herniated disc, dizziness, arthritis, closed head injury, ringing in her ears, knee problems, anxiety, poor memory and an inability to focus.

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 Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) 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 Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) 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 –
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> (1) Medical history.
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> (2) Clinical findings (such as the results of physical or mental status examinations);
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> (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 2005. Claimant is not disqualified from receiving disability at Step 1.

The objective medical evidence on the record indicates that a psychological evaluation of January 6, 2010 indicates that patient presented as being in apparent adequate overt contact with reality with no evidence of an overt thought disorder. She appeared to be an accurate historian, although she was extremely angry and also self-pitying to some extent understandable so in light

of the history of abuse and mistreatment as she reported, although she certainly appears to have significant characterological components to her difficulties. Her thoughts were frequently circumstantial and tangential and she kept perseverating on her anger about the mix up about the appointment times. She reported hearing ringing and said she has only 40% hearing in her right ear. She does not feel others are against her except "the guys who beat me." She denies suicidal thoughts, feelings or attempts or beliefs that she has magical or unusual powers. She denied believing that she receives secret messages from a radio or TV either. The patient says she is sad and depressed most of the time and teared up again. She said her mother died in 2000 and she was divorced in 2002. She said the State took her kid in 2004 for his behavioral problems at age 14. She spelled her first and last names correctly and knew today's date. She did not know the name of the office. She repeated three digits forward and three digits backward and was able to repeat three out of three objects immediately after they were stated to her. She recalled two of three objects after a delay of 3 minutes, remembering pencil and quarter, but forgetting key. In the past presidents, in reverse order she said "Obama" and she didn't know Clinton. She knew her birth date and her age. (Page 3, New Information)

A physical examination report, dated January 6, 2010, indicates that claimant was well-developed, well-nourished, and cooperative, in no acute distress. She was awake, alert and oriented x3. She was dressed appropriately and answered questions fairly well. She was 4' 11" tall and weighed 111 pounds. Her pulse was 88. Her respiratory rate was 14, her blood pressure was 170/96, 150/90 and 166/94. Her visual acuity without glasses was 20/40 on the right and 20/40 on the left. HEENT: Normal, and atraumatic. Eyes and lids were normal. There was no exophthalmos, conjunctiva, erythema, or exudates noted. TERRLA: extraoccular movements intact. Ears, 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. In the mouth, the teeth are in fair repair. The neck was subtle. No JVD noted. No tracheal deviation. No lymphadenopathy. Thyroid is not visible or palpable. ENT, external, especially the ears and nose reveal no evidence of acute abnormality. The chest is symmetrical and equal to expansion. The lung fields are clear to auscultation and percussion bilaterally. There are no rales, rhonchi or wheezes noted. No accessory muscle use is noted. No cyanosis noted. There was no cough. In the cardiovascular area there was normal sinus rhythm S1 and S2, no rubs, murmur or gallop. The gastrointestinal area was soft and non-distended, non-tender with no guarding, rebound, palpable masses. Bowel sounds were present. Liver and spleen were not palpable. In the scan there was no significant skin rashes or ulcers. In the extremities there were no obvious spinal deformities, swelling or muscle spasm noted. Pedal pulses were 2+ bilaterally. There was no calf tenderness, clubbing, erythema, varicose veins, brawny erythema, stasis dermatitis, chronic leg ulcers and muscle atrophy or joint deformity or enlargement noted. There was mild tenderness to palpation in the lower lumbar area noted. She was wearing an elastic back brace. She did not use a cane or aid for walking. She was able to get on and off the table without difficulty. Her gait was slow and stance was normal. Tandem walk, heel walk and toe walk are done slowly. She was able to squat to 60% of the distance and recover and bend 50% of the distance and recover. Grip strength, see JMAR. The examinee is right-handed. Gross and fine dexterity appear bilaterally intact. Abduction of the shoulders is 0-150. Flexion of the knees 0-150. Straight leg raising while lying is 0-50, and while sitting 0-90. In her neurological areas she was alert, awake and oriented to person, place and time. Cranial nerve II, the vision was as stated in the vital signs. III, IV and 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 whispering voice. IX and X, swallowing intact, and gag reflex intact. Uvula, mid-line. XI, head and shoulder movement against resistance were equal.

XII, no sign of tongue atrophy. No deviation with protrusion of tongue. Sensory functions intact to sharp and dull gross testing. Motor examination revealed fair muscle tone without specificity or paralysis. The impression is hypertension. She is currently on medication. Her blood pressure was still elevated on the exam in both systolic and diastolic. She had pain in her hands, back, knees, ribs and does take pain medication for her problems. She had chronic headache secondary to domestic problems and she had a history of memory problems secondary to head injuries and domestic violence. (Page 7-11)

On claimant's mental status examination, she named some big cities as Detroit, New York City and Atlanta. Current events were "killings like always." When asked for specific events, she said the "plane crash. I don't know where." Her calculations for serial 7's from 100, 94, done with her fingers; 4 plus 7 equals 11, 16 minus 9 equals 7, 4 times 6 equals 24, and 42 divided by 7 equals "I don't' know." Her abstract thinking, the grass is greener on the other side of the fence, she stated "the grass is prettier on the other side, or something," and don't cry over spilled milk, "probably 'cause you spill your milk, don't cry." Similarities and differences , how a bush and tree are alike, "they are trees," and how they are different, "one is shorter." On judgment, when she was asked what you would do if you found a stamped, addressed envelope, she stated, "put it in the mailbox." If she saw a fire in a theatre, she would "scream." As to plans for the future, she "didn't really have any." She reported herself as stressed, sad and depressed. Her GAF was 47. Her prognosis was guarded and she was diagnosed with post-traumatic stress disorder, bi-polar affective disorder, and alcohol abuse. The doctor stated that in light of her history of alcohol abuse and report of not managing money well, she is not felt to be capable of managing her own benefit funds. (Page 4)

A medical examination report, dated June 4, 2009, indicates a clinical impression that claimant is stable. She can frequently lift less than 10 pounds, but never lift 10 pounds or more.

She can stand or walk less than 2 hours in an 8-hour day, but sit less than 6 hours in an 8-hour day. She could do simple grasping, reaching, pushing and pulling and fine manipulating with both upper extremities. She could operate foot and leg controls with both lower extremities, although that was limited. She had limited memory. (Page 8)

An MRI of the brain, with or without contrast, dated May 1, 2008, indicates that claimant had unremarkable MRI without contrast. The sulci and gyri about the convexities were normal. The ventricular system was normal. There were no hypo- or hyper-intensities within the brain or brain parenchyma to suggest acute masses, infarcts or bleed. There was no evidence for old subdural hematomas. The visualized portion of the paranasal sinuses, mastoid air cells and orbits are normal. (Page 12)

A December 26, 2007 clinical examination indicates that a thoracic contrast CT indicated fracture of the 11th and 12th right ribs posteriorly. There was no pneumothorax or mediastinal shift. The lungs and plural spaces were clear. No abnormal mediastinal fluid collects were seen. The pulmonary arteries and thorax aorta were grossly unremarkable. No hilar or mediastinal lymphadenopathy was present. (Page 13)

A March 25, 2008 MRI of the lumbar spine indicates that T11-T12, L1-L2, L2-L3, and L3-L4 at these disc levels, there is normal disc height and disc hydration. There is no evidence for disc bulge or herniation. There is no central canal stenosis or neuroforaminal narrowing. The posterior elements including facets were normal. The surrounding soft tissue structures were normal. L4-L5, at this disc level there was moderate disc space narrowing and disc desiccation. Once again, there is posterior central disc herniation of the protrusion type, minimally effacing the anterior thecal sac. The circumferential disc bulge, however, is slightly more pronounced at this examination when compared to prior study and is extending into the bilateral existing neuroforaminal slightly asymmetric on the left. There is effacement of the left L4 nerve root and

narrowing of the left existing neural canal. Minimal narrowing of the right existing neural canal is seen without nerve root impingement. The findings are contributing to borderline AP dimensional stenosis. These findings are worse when compared to the prior study. The remainder is normal. L5-S1 at this disc level, there is mild disc desiccation. There is mild circumferential disc bulge slightly asymmetric and towards the right. There is effacing of the right L5 nerve root in the existing neural canal. The left L5 nerve root is normal. The sacral nerves are normal. The surrounding soft tissue structures are normal. An MRI, pelvis, coccyx: Multi-plane and multi-echo MRI of the sacrum, and coccyx was performed, long and short axis, fat and waterway imaging. The bony pelvis throughout was included. The sacrum, coccyx, and sacroiliac joints are unremarkable. There was no sacral mass. There are no pelvic masses. The surrounding soft tissue structures are normal. The osseous structures were normal. (Page 14) The impression is that claimant has mild central canal stenosis and moderate left neuroforaminal stenosis and narrowing of the right exiting neural canal in L5-S1. (Page 16)

A CT of the head without contrast, dated February 12, 2006, indicates that a continuous axial section of the head was obtained without the prior admission of intravenous contrast. The ventricles were normal in size and position. No focal areas of hemorrhage or mass identified. There were no extra axial fluid collections seen. The impression was normal unenhanced CT examination of the head. (Page 17)

Claimant testified on the record that she can stand for 5 to 10 minutes, and sit for 20 minutes at a time. She can walk one block. She can squat with pain and bend at the waist with pain in her lower back. Claimant testified that she can shower and dress herself and tie her shoes. She lifts her foot, but can't touch her toes. Claimant testified that her level of pain on a scale from 1 to 10 without medication was a 10, and with medication is a 7. Claimant testified that she has arthritis in her right hand and that she has two bad knees and shooting pains and torn

ligaments and tendons. Claimant testified that the heaviest weight that she can carry is 5 pounds, and that she smokes six cigarettes per day. Her doctor has told her to quit, but she's not in a cessation program. Claimant testified she watches television all day because she can't concentrate.

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 a 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. This Administrative Law Judge cannot give weight to the treating physician's DHS-49 as it is inconsistent with the entirety of the objective medical information contained in the file. Clinical impressions indicate claimant is stable. There is no finding that claimant has any muscle atrophy or trauma, abnormality or injury that indicates a deteriorating condition. In short, the DHS-49 has restricted claimant from tasks associated with occupational functioning based upon claimant's reports of pain (symptoms) rather than medical findings. Reported symptoms are an insufficient basis upon which a finding 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.

There is insufficient objective medical/psychiatric evidence in the record indicating that claimant suffers severe mental limitations resulting from a reportedly depressed or anxious state. The psychiatric report in the file indicates that claimant was oriented to time, person and place. Claimant was able to answer all the questions at the hearing. Claimant was responsive to the questions. Claimant does not have any hallucinations, psychosis, or delusions. For these reasons,

this Administrative Law Judge finds that the evidentiary record is insufficient to find that claimant suffers a severely restrictive mental impairment.

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

There is insufficient objective medical/psychiatric evidence contained in the file of depression or a cognitive dysfunction that is so severe that it would prevent claimant from working at any job. In addition, based upon the medical reports, it is documented that claimant had use of alcohol, which would have contributed to her physical and alleged mental problems.

For these reasons, this Administrative Law Judge finds that claimant has failed to meet her burden of proof at Step 2. Claimant must be denied benefits at this step based upon her failure to meet the evidentiary burden.

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

If claimant had not already been denied at Step 2, this Administrative Law Judge would have to deny her again at Step 4 based upon her ability to perform her past relevant work. Claimant's past relevant work was light work. 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's activities of daily living do not appear to be very limited and she should be able to perform light or sedentary work even with her impairments. Claimant has failed to provide the necessary objective medical evidence to establish that she has a severe impairment or combination of impairments which prevent her from performing any level of work for a period of 12 months. The claimant's testimony as to her limitations indicates that she should be able to perform light or sedentary work.

Claimant's complaints of pain, while profound and credible, are out of proportion to the objective medical evidence contained in the file as it relates to claimant's ability to perform work. Therefore, this Administrative Law Judge finds that the objective medical evidence on the record does not establish that claimant has no residual functional capacity. Claimant is disqualified from receiving disability at Step 5 based upon the fact that she has not established by objective medical evidence that she cannot perform light or sedentary work even with her impairments.

Under the Medical-Vocational guidelines, a younger individual (age 46), with a less than high school education and an unskilled work history who is limited to light work is not considered disabled.

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.

Landis Y. Lain__/s/_____
Admnistrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: _May 17, 2010_____

Date Mailed: _May 18, 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/cv

cc: