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: 2010-25639
Issue No: 2009; 4031
Case No: [redacted]
Load No:
Hearing Date:
April 8, 2010
Calhoun 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 April 8, 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 January 4, 2010, claimant filed an application for Medical Assistance, State Disability Assistance and Retroactive Medical Assistance benefits alleging disability.

(2) On February 23, 2010, the Medical Review Team denied claimant's application stating that claimant could perform other work pursuant to Medical Vocational Rule 203.29.

(3) On February 26, 2010, the department caseworker sent claimant notice that his application was denied.

(4) On March 3, 2010, claimant filed a request for a hearing to contest the department's negative action.

(5) On March 23, 2010, the State Hearing Review Team again denied claimant's application stating that claimant had a non-severe impairment work condition per 20 CFR 416.920(c).

(6) Claimant is a 37-year-old man whose birth date is [redacted] Claimant is 5' 10 ½" tall and weighs 175 pounds. Claimant is a GED and is able to read and write and does have basic math skills.

(7) Claimant last worked approximately 5 years before the hearing hanging drywall. Claimant has also worked as roofer and doing factory jobs.

(8) Claimant alleges as disabling impairments: shoulder and leg arthritis, mood disorder, bi-polar disorder and gastroesophageal reflux disease.

CONCLUSIONS OF LAW

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

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the MA program pursuant to MCL 400.10,

et seq., and MCL 400.105. Department policies are found in the Program Administrative Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM).

Pursuant to Federal Rule 42 CFR 435.540, the Department of Human Services uses the federal Supplemental Security Income (SSI) policy in determining eligibility for disability under the Medical Assistance program. Under SSI, disability is defined as:

> ...the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.... 20 CFR 416.905

A set order is used to determine disability. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience is reviewed. If there is a finding that an individual is disabled or not disabled at any point in the review, there will be no further evaluation. 20 CFR 416.920.

If an individual is working and the work is substantial gainful activity, the individual is not disabled regardless of the medical condition, education and work experience. 20 CFR 416.920(c).

If the impairment or combination of impairments do not significantly limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. Age, education and work experience will not be considered. 20 CFR 416.920.

Statements about pain or other symptoms do not alone establish disability. There must be medical signs and laboratory findings which demonstrate a medical impairment.... 20 CFR 416.929(a).

> ...Medical reports should include –

(1) Medical history.

(2) Clinical findings (such as the results of physical or mental status examinations);

(3) Laboratory findings (such as blood pressure, X-rays);

(4) Diagnosis (statement of disease or injury based on its signs and symptoms).... 20 CFR 416.913(b).

In determining disability under the law, the ability to work is measured. An individual's functional capacity for doing basic work activities is evaluated. If an individual has the ability to perform basic work activities without significant limitations, he or she is not considered disabled. 20 CFR 416.994(b)(1)(iv).

Basic work activities are the abilities and aptitudes necessary to do most jobs. Examples of these include --

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting. 20 CFR 416.921(b).

Medical findings must allow a determination of (1) the nature and limiting effects of your impairment(s) for any period in question; (2) the probable duration of the impairment; and (3) the residual functional capacity to do work-related physical and mental activities. 20 CFR 416.913(d).

Medical evidence may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of the impairment(s), including your symptoms, diagnosis and prognosis, what an individual can do despite impairment(s), and the physical or mental restrictions. 20 CFR 416.927(a)(2).

All of the evidence relevant to the claim, including medical opinions, is reviewed and findings are made. 20 CFR 416.927(c).

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability.... 20 CFR 416.927(e).

A statement by a medical source finding that an individual is "disabled" or "unable to work" does not mean that disability exists for the purposes of the program. 20 CFR 416.927(e).

When determining disability, the federal regulations require that several considerations be analyzed in sequential order. If disability can be ruled out at any step, analysis of the next step is not required. These steps are:

1. Does the client perform Substantial Gainful Activity (SGA)? If yes, the client is ineligible for MA. If no, the analysis continues to Step 2. 20 CFR 416.920(b).

2. Does the client have a severe impairment that has lasted or is expected to last 12 months or more or result in death? If no, the client is ineligible for MA. If yes, the analysis continues to Step 3. 20 CFR 416.920(c).

3. Does the impairment appear on a special listing of impairments or are the client's symptoms, signs, and laboratory findings at least equivalent in severity to the set of medical findings specified for the listed impairment? If no, the analysis continues to Step 4. If yes, MA is approved. 20 CFR 416.290(d).

4. Can the client do the form er 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 th e guidelines set forth at 20 CFR 404, Subpart P, Appendix 2, Sections 200.00-204.00? If yes, the analysis ends and the clien t is ine ligible f or 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 approximately 2005. Claimant is not disqualified from receiving disability at Step 1.

The objective medical evidence on the record indicates that on page 16 of the Medical Report that the claimant presented on January 6, 2010 for a blood pressure check. He denied chest pains. He reported trying to quit smoking, stating that a pack lasts 2 days and he was smoking a ppd. Claimant was praised for this and encouraged to continue on his way to cessation. His pulse was 96, his blood pressure was 138/90 and his respiration was 16. (p16) A December 7, 2009, Medical Examination Report indicates that the claimant's temperature was 98.2, his pulse was 104, his blood pressure was 162/103, his respiration was 16, and he was 5'9" tall and weighed 170 pounds and BMI 24.56. He was a smoker and he had some knee symptoms and had a rash that began a few months ago on his feet. (p17) He had normal activity and energy level and no change in appetite. No major weight gain or loss. No fatigue, general feeling of being ill, the laze, chills, fever or diaphoresis. He denied any problems with his vision, visual fields, ptosis, pain, discharge, itching, dryness, watering, redness, scratchiness or swelling. He denied hearing difficulties, loss, and sensitivity to loud noises, pain, tinnitus, or vertigo. He denied any hoarseness or swallowing difficulties. No nasal or sinus bleeding or blockage, conjestion or discharge. No sores, pain or lesions of the mouth, throat or mucus membranes. In his respiratory system, he had no shortness of breath, cough, hemoptysis or wheezing. In the

cardiac, he had no chest pain, pressure, discomfort, palpatations, tachyarrhythmias, orthopnea, dyspnea, cyanosis, coldness of extremities or edema. He had frequent heart burn. He had joint pain in the musculoskeletal area but in neurological he had no difficulties in motor strength, gait, sensation, level of patchesness, memory, concentration, mood, affect or general thought processes. He was well-developed, well-nourished and a well-hydrated individual in no acute distress. His conjunctivae appeared normal. His pupils were equal and normally reactive and accommodation. Iris's appeared normal bilaterally. Retinal background was uniformly pink in appearance. The optic discs were sharp. There was no AV nicking, hemorrhages or exudates and the ratio of AV is approximately 4-5. Overall normal appearance of the external ears and nose with no scars, lesions, or masses. In the ears the tympanic membranes were shiny without retractions. Canals were unremarkable. In the nose, no abnormality of the nasal mucosa, septum or terbinates. The oral mucosa was unremarkable with non-inflamed posterior pharynx. No scars, lesions or masses. His neck and thyroid was supple with no thyroid enlargement, tenderness, mass, or lymphadenopathy. There is normal respiratory effort and it was clear to auscultation. In the cardiovascular area, there was regular rate and rhythm with no murmurs, gallops, rubs, or abnormal heart sounds. He had no edema or varicosities of the extremities. In the gastrointestinal area, the abdomen was soft and non-tender, without masses, hernia's or bruits. Bowel sounds were accurate in all four quadrants. The libel is smooth, firm and non-tender. Kidneys were non-palpable and without CDA tenderness. No splenomegaly or tenderness. He had no hernias present. His genital urinary area was normal in appearance with no hydrocele, spermatocele, tenderness of cord, or testicular mass. He had no lesions on glands and the shaft was normal. Lymphatics, there was no lymphadenopathy in the neck, axillaee, or groin. His gait was intact. He station and posture were normal. His head and neck were normal

to inspection and palpation. Full, painless range of motion of the neck. Normal stability. Normal strength and tone. The spine, ribs and pelvis, there was no kyphosis, lordosis or tenderness. Full range of motion. Normal rotation. Stable. Normal strength and tone in the spine, ribs, and pelvis. In the extremities there was no misalignment or tenderness. Full range of motion. Normal stability. Psychiatric, claimant had appropriate judgment and insight. He was oriented to time person and place and had normal, recent and remote memory. (p. 19)

A [redacted] customer assessment of June 4, 2008, indicates that claimant had slurred speech, withdrawal symptoms and frequent job and school absence, as well as related social problems. (p. 36) He was diagnosed with alcohol abuse, anxiety disorder, depressive disorder, mood disorder, axis 3 high, blood alcohol at the time of his hospitalization, he had 30% liver damage, with a GAF of 45 (p. 41) The clinical summary indicates that several years ago claimant had a crack habit and self medicates with alcohol (p. 42). A [redacted] assessment update on February 26, 2009, indicates that claimant was in jail from [redacted] and went to the hospital from [redacted] when he was detoxed because he had a .35 blood alcohol level. He was still drinking at that point (p. 44) An October 22, 2009, [redacted] discharge summary from [redacted] indicates that claimant was admitted October 22, 2009, discharged on October 30, 2009. He was experiencing suicidal ideation and his urine drug screen was negative for any drugs, blood alcohol level on admission was .46 a repeat blood alcohol level of .32 was gained before he was transferred to Fieldstone Center. His CVC revealed an increase of MCV of 101.5. Platelets were slightly low at 113. Urinalysis was unremarkable. He experienced a psychotic episode, which was believed to be related to withdrawal from alcohol. His condition stabilizes in 24 hours (p. B1). He had a global assessment of functioning at discharge of 60 (p. b2). On a physical examination, his vital signs

were; temperature 98, heart rate 84, respiration 16, 95% on room air and blood pressure 153/86. His height was 72" and his weight was 182 pounds. His BMI was 22. General information was a Caucasian male, awake, alert, oriented, cooperative and in no acute distress. HEENT: a swollen face and puffy eyes. Pupils were equal, round, and reactive to light in accommodation. His extraocular movements were intact. Not anemic or icteric. JVD was negative. Mucosa was wet. Heart sounds; S1 and S2. No S3 or S4. Lungs were clear and quiet. No rales or wheezes. Abdomen was soft and non-tender. No organomegaly. No rebound or guarding. Extremities were warm. Calves were soft. Pulses were palpable. CNS was non-focal and intact. Skin was dry and warm. His assessment was cardioobstructive pulmonary disease, tobacco abuse, substance abuse by history, alcohol abuse, alcohol intoxication. (pp. B3-B4)

At Step 2, claimant has the burden of proof of establishing that he has a severely restrictive physical or mental impairment that has lasted or is expected to last for the duration of at least 12 months. There is insufficient objective clinical medical evidence in the record that claimant suffers a severely restrictive physical or mental impairment. Claimant has reports of pain in multiple areas of his body; however, there are no corresponding clinical findings that support the reports of symptoms and limitations made by the claimant. The clinical impression that claimant is stable. There is no medical finding that claimant has any muscle atrophy or trauma, abnormality or injury that is consistent with a deteriorating condition. In short, the claimant has restricted himself from tasks associated with occupational functioning based upon his reports of pain (symptoms) rather than medical findings. Reported symptoms are an insufficient basis upon which a finding that claimant has met the evidentiary burden of proof can be made. This Administrative Law Judge finds that the medical record is insufficient to establish that claimant has a severely restrictive physical impairment.

Claimant alleges the following disabling mental impairments: bipolar disorder, and anxiety.

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

There is insufficient objective medical/psychiatric evidence in the record indicating claimant suffers mental limitations resulting from his reportedly depressed state. There is no Mental Residual Functional Capacity Assessment in the record. The evidentiary record is insufficient to find that claimant suffers a severely restrictive mental impairment. For these reasons, this Administrative Law Judge finds that claimant has failed to meet his burden of proof at Step 2. Claimant must be denied benefits at this step based upon his 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 he 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 him again at Step 4 based upon his ability to perform past relevant work. There is insufficient objective medical evidence upon which this Administrative Law Judge could base a finding that claimant is unable to perform work which he has engaged in, in the past. Therefore, if claimant had not already been denied at Step 2, he would again be denied 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 his 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).

Medium work. Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work. 20 CFR 416.967(c).

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

There is insufficient objective medical/psychiatric evidence contained in the file of depression or a cognitive dysfunction that is so severe that it would prevent claimant from working at any job. Claimant was able to answer all the questions at the hearing and was responsive to the questions. Claimant was oriented to time, person and place during the hearing. Claimant's complaints of pain, while profound and credible, are out of proportion to the objective medical evidence contained in the file as it relates to claimant's ability to perform work. Claimant did testify that he does receive relief from his pain medication. 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 he has not established by objective medical evidence that he cannot perform light or sedentary work even with his impairments. Under the

Medical-Vocational guidelines, a younger individual (age 37), with a high school education and an unskilled work history who is limited to light work is not considered disabled.

The Federal Regulations at 20 CFR 404.1535 speak to the determination of whether Drug Addiction and Alcoholism (DAA) is material to a person's disability and when benefits will or will not be approved. The regulations require the disability analysis be completed prior to a determination of whether a person's drug and alcohol use is material. It is only when a person meets the disability criterion, as set forth in the regulations, that the issue of materiality becomes relevant. In such cases, the regulations require a sixth step to determine the materiality of DAA to a person's disability.

When the record contains evidence of DAA, a determination must be made whether or not the person would continue to be disabled if the individual stopped using drugs or alcohol. The trier of fact must determine what, if any, of the physical or mental limitations would remain if the person were to stop the use of the drugs or alcohol and whether any of these remaining limitations would be disabling.

Claimant's testimony and the information indicate that claimant has a history of tobacco, drug, and alcohol abuse. Applicable hearing is the Drug Abuse and Alcohol (DA&A) Legislation, Public Law 104-121, Section 105(b)(1), 110 STAT. 853, 42 USC 423(d)(2)(C), 1382(c)(a)(3)(J) Supplement Five 1999. The law indicates that individuals are not eligible and/or are not disabled where drug addiction or alcoholism is a contributing factor material to the determination of disability. After a careful review of the credible and substantial evidence on the whole record, this Administrative Law Judge finds that claimant does not meet the statutory disability definition under the authority of the DA&A Legislation because her substance abuse is material to her alleged impairment and alleged disability.

It should be noted that claimant continues to smoke despite the fact that his doctor has told him to quit. Claimant is not in compliance with her treatment program. It should also be noted that claimant continues to drink alcohol in addition to his smoking and therefore, is also is not in compliance with his treatment program for the continued use of alcohol.

If an individual fails to follow prescribed treatment which would be expected to restore their ability to engage in substantial gainful activity without good cause, there will not be a finding of disability.... 20 CFR 416.994(b)(4)(iv).

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.

The Department has established by the necessary competent, material and substantial evidence on the record that it was acting in compliance with department policy when it determined that claimant was not eligible to receive Medical Assistance and/or State Disability Assistance.

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 his impairments.

The department has established its case by a preponderance of the evidence.

Accordingly, the department's decision is AFFIRMED.

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

Date Signed: July 1, 2010

Date Mailed: July 1, 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/alc

cc: [redacted]