

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: 2010-6120
Issue No: 2009; 4031
Case No: [REDACTED]
Load No: [REDACTED]
Hearing Date:
December 17, 2009
Jackson 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 December 17, 2009, in Jackson. Claimant personally appeared and testified under oath. Claimant was accompanied by [REDACTED].

The department was represented by Amy Connell (FIM).

The Administrative Law Judge appeared by telephone from Lansing.

ISSUES

- (1) Did claimant establish a severe mental impairment expected to preclude her from substantial gainful work, **continuously**, for one year (MA-P) or 90 days (SDA)?
- (2) Did claimant establish a severe physical impairment expected to preclude her from substantial gainful work, **continuously**, for one year (MA-P) or 90 days (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) Claimant is an MA-P/retro/SDA applicant (January 29, 2009) who was denied by SHRT (November 13, 2009) based on claimant's ability to perform unskilled light work. SHRT relied on Med-Voc Rule 202.17 as a guide. Claimant requests retro MA for October, November and December 2008. The disputed eligibility period is November 13, 2009 to December 17, 2009.

(2) Claimant's vocational factors are: age--45; education--9th; post high school education--none; work experience--meat slicer and [REDACTED] restaurant, cashier at [REDACTED] restaurant.

(3) Claimant has not performed Substantial Gainful Activity (SGA) since 2007 when she worked as a meat slicer at [REDACTED] restaurant.

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

- (a) Back trouble;
- (b) Leg pain;
- (c) Completed the 8th grade;
- (d) Unable to stand for long periods;
- (e) Unable to work;
- (f) Unstable mental status; and
- (g) Status post panic attack.

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

OBJECTIVE MEDICAL EVIDENCE (November 13, 2009)

Claimant was admitted in 3/09 due to feeling overwhelmed and having suicidal ideations. The claimant had been noncompliant with medication. She has a history of drug abuse but reported being clean for about a year (page 25). Speech was normal and thought process was goal directed. Thought content was devoid of any delusions but the claimant was quite preoccupied about her

situation (homeless and depressed without financial means). Diagnoses included major depressive disorder and history of polysubstance use. (Page 27).

A physical examination dated 3/009 showed the claimant was 5/6" and 310 pounds. Blood pressure was 163/74 (page 30). Lung sounds were clear. She had full strength and no redness or effusion of the joints. There were no focal neurological abnormalities (page 31).

In 1/09 the claimant's examination was normal except for asthma, lumbago [pain in the lumbosacral pain] and depression (page 20). She is able to ambulate without assistance (page 21).

ANALYSIS

The claimant has a history of substance abuse. She has depression but no evidence of a formal thought disorder and her thought processes was goal directed, she is obese and was over 300 pounds. However, there was no evidence of neurological abnormalities. Lungs were clear. She can walk without assistance.

The claimant's treating physician has given less than sedentary work restrictions based on the claimant's physical impairments. However, this medical source opinion (MSO) is inconsistent with the great weight of the objective medical evidence in the record and per 20 CFR 416.927c and 20 CFR 416.927d. This evidence will not be given controlling weight. The collective objective medical evidence shows claimant is capable of performing simple, unskilled, light work.

* * *

(6) Claimant lives her 20-year-old son and performs the following Activities of Daily Living (ADLs): dressing, bathing, cooking (sometimes), light cleaning, and grocery shopping (needs help). Claimant does not use a cane, walker, wheelchair, or shower stool. Claimant does not wear braces. Claimant received inpatient hospital care in 2008 at a psychiatric ward. Claimant did not receive inpatient hospital care in 2009.

(7) Claimant does not have a valid driver's license and does not drive an automobile. Claimant is not computer literate.

(8) The following medical records are persuasive:

- (a) An [REDACTED] psychiatric discharge summary was reviewed. The reporting psychiatrist provided the following history:

REASON FOR ADMISSION:

Claimant was admitted by her daughter; felt overwhelmed, depressed and had nowhere to go. Claimant felt suicidal.

ADMITTING DIAGNOSIS:

- (1) Axis I--major depressive disorder, recurrent, without psychotic features with vague suicidal ideations.
- (2) History of polysubstance abuse.
- (3) Axis IV/GAF--25.

The psychiatrist reports the following assessment:

- (1) Major depressive disorder, treatment per psychiatrist;
- (2) Hypertension, current control is unclear;
- (3) Osteoarthritis;
- (4) Morbid obesity;
- (5) Nicotine abuse;
- (6) Gastroesophageal reflux disease;
- (7) Chronic microcytic anemia, with dysfunctional uterine bleeding.

The treating psychiatrist provided the following discharge diagnosis:

- (1) Axis I--major depressive disorder, recurrent, without psychotic features, without suicidal ideation;

(2) History of polysubstance abuse.

(b) A [REDACTED] medical consultation was reviewed.

The physician provided the following history:

Claimant is a single 44-year-old African-American female, who has been living with her daughter, but was kicked out last night for reasons the patient won't further specify. She felt overwhelmed. She states that she was worried that she was going to be homeless, and started contemplating suicide as a fix for her problems. She didn't actually want to go through with this plan and thought she was definitely at risk, and so she presents to the emergency room for further evaluation and treatment.

She was continuing to verbalize suicidal ideation and the determination was made that she cannot be released into the community. She was brought in to the inpatient psychiatric setting for further evaluation and treatment. She was accepted by the psychiatric team here for further evaluation and treatment.

Claimant states that prior to this recent event, she had been feeling well. She thought that things were working out well in her life.

She has a history of depression, and has taken Celexa in the past, but it should be noted that she has not been compliant with this medication.

She does have a history of polysubstance abuse in the past. She denies any recent substance abuse.

The physician provides the following medical history:

- (1) Depression;
- (2) Hypertension;
- (3) Osteoarthritis;
- (4) Morbid obesity;
- (5) History of polysubstance abuse (currently only nicotine abuse);
- (6) Gastroesophageal reflux disease;
- (7) Chronic microcytic anemia;
- (8) Chronic lumbago.

The physician provided the following assessment and plan:

- (1) Major depressive disorder, with suicidal ideation. Patient has been admitted by and followed by inpatient psychiatry who will manage the majority of the inpatient stay.
- (2) Hypertension: Current control is unclear. She has had a few episodes of an accelerated hypertension here, but also many episodes of normotension.
- (3) Osteoarthritis: Will start claimant on Naprosyn, as she states she does have some knee discomfort that has not been controlled with Ultram.
- (4) Morbid obesity.
- (5) Nicotine abuse: Again, she is being followed by inpatient psychiatry, who will manage the majority of the inpatient stay.
- (6) Gastroesophageal reflux disease: Protonix has been started.
- (7) Chronic microcytic anemia, with dysfunctional uterine bleeding.

* * *

- (c) A January 21, 2009 Medical Examination Report (DHS-49D) was reviewed. The physician provided the following history: Hypertension, lumbago, GERD, endometriosis, depression, asthma, iron deficiency anemia, and cocaine dependence.

The physician reported the following physical limitations:

Claimant is able to lift 20 pounds occasionally. She is able to stand and/or walk less than two hours in an eight-hour day. She is able to use her hands/arms for simple grasping and fine manipulating; unable to use them for reaching or pushing-pulling.

Under mental limitations, the physician states 'depression--controlled with medications.

* * *

(9) The probative psychiatric evidence does not establish an acute (non-exertional) mental impairment expected to prevent claimant from performing all customary work functions for the required period of time. Claimant reports that she has an unstable mental state and panic attacks. However, the [REDACTED] psychiatric discharge summary reports: (a) major depressive disorder, recurrent, without psychotic features and without suicidal ideation; (b) history of polysubstance abuse. The most recent Axis V/GAF score is 40. The treating psychiatrist did not state that claimant is totally unable to work due to her mental impairments. Claimant did not provide a DHS-49D or DHS-49E to establish her mental residual functional capacity.

(10) The probative medical evidence does not establish an acute (exertional) physical impairment expected to prevent claimant from performing all customary work functions for the required period of time. Claimant testified that she has back trouble, light pains, inability to stand for long periods, an inability to work. The treating physician from Allegiance Health states that claimant has the following diagnoses: depression; hypertension; osteoarthritis; morbid obesity; history of polysubstance abuse; gastroesophageal reflux disease; chronic microcytic and chronic lumbago. The consulting internist did not state that claimant is totally unable to work due to her combined physical impairments.

(11) Claimant recently applied for federal disability benefits (SSI) with the Social Security Administration. Social Security denied her application. Claimant filed a timely appeal.

(12) Claimant's eligibility for disability benefits was recently reviewed by ALJ Magyar (March 10, 2009) in a decision dated March 20, 2009, ALJ Magyar denied claimant's request for MA-P and SDA due to chronic drug abuse.

CONCLUSIONS OF LAW

CLAIMANT'S POSITION

Claimant thinks she is entitled to MA-P/SDA based depression, morbid obesity; muscle spasms and swelling in legs and feet, shortness of breathe upon exertion, chronic back pain, learning disabilities and arthritis.

DEPARTMENT'S POSITION

The department thinks that claimant has the residual functional capacity to perform w wide range of unskilled light work.

The department thinks that claimant has a history of depression, but no evidence of former thought disorder and her thought process was goal-directed. The department considered claimant's physician's report stating that claimant is unable to work. However, this medical source opinion (MSO) is inconsistent with the great weight of the objective medical evidence and will not be given controlling weight for that reason.

LEGAL BASE

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 does 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 limits her ability to work, the following regulations must 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 or 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).

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 earning substantial income, she is not disabled for MA-P/SDA purposes.

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 medical 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 current work activities. 20 CFR 416.909.

Also, to qualify for MA-P, the 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 the 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 was last employed as a meat cutter for [REDACTED] restaurant. This work was light work. However, it required claimant to stand constantly for her eight-hour shift.

The medical evidence of record establishes that claimant has difficulty standing for long periods. Therefore, claimant is not able to return to her previous work as a meat cutter for [REDACTED].

Since claimant is no longer able to work at [REDACTED], she meets the Step 4 disability test.

STEP #5

The issue at Step 5 is whether claimant has the Residual Functional Capacity (RFC) to do other work.

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

First, claimant alleges disability based on depression, anxiety and a learning disability.

The psychiatric reports in the record show that claimant's mental condition is not a severe impairment.

The consulting psychiatrist reported that claimant's depressive disorder, recurrent, is without psychotic features and without suicidal ideation. Furthermore, SHRT determined that there is no evidence of a formal thought disorder and claimant demonstrated a thought process which was goal directed.

Second, claimant alleges disability based on a combination of physical impairments. Claimant's arthritis prevents her from standing constantly for eight hours. However, claimant's combination of physical impairments does not preclude sedentary work.

In short, the Administrative Law Judge is not persuaded that claimant is totally unable to work based on her combined impairments. Claimant performs a significant number of activities of daily living, has an active social life with her son and daughter. Claimant was able to represent herself competently at the hearing.

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 a theater, as a parking lot

attendant, and as a greeter for [REDACTED]. Work of this type would afford claimant a sit-stand option.

Based on this analysis, the department correctly denied claimant's MA-P/SDA application, based on Step 5 of the sequential analysis, as presented above.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that 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, 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 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.

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cc:

