STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

[redacted]

Reg. No.: 2012-48749
Issue No.: 2009; 4031
Case No.: [redacted]
Hearing Date: November 16, 2011
County: Chippewa

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

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 November 16, 2011. Claimant personally appeared and testified.

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional medical evidence. The new evidence was forwarded to the State Hearing Review Team ("SHRT") for consideration. On March 21, 2012, the SHRT found Claimant was not disabled. This matter is now before the undersigned for a final decision.

ISSUE

Whether the Department of Human Services (the department) properly denied Claimant's application for Medical Assistance (MA-P), Retro-MA 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 April 28, 2011, Claimant filed an application for MA, Retro-MA and SDA benefits alleging disability.

(2) On July 7, 2011, the Medical Review Team (MRT) denied Claimant's application for MA-P and Retro-MA indicating that Claimant was capable of performing other unskilled work, based on Medical Vocational Grid Rule 202.21. MRT denied Claimant's application for SDA for lack of duration.

(3) On July 11, 2011, the department sent out notice to Claimant that his application for Medicaid had been denied.

(4) On August 15, 2011, Claimant's representative filed a request for a hearing to contest the department's negative action.

(5) On October 3, 2011, the State Hearing Review Team (SHRT) upheld the denial of MA-P and Retro-MA benefits indicating Claimant had a severe impairment but, using Medical Vocational Grid Rule 202.18 as a guide, Claimant retained the capacity to perform light exertional work and would likewise need a sit/stand option. The SHRT denied SDA because the nature and severity of Claimant's impairments would not preclude work activity at the above stated level for 90 days. (Department Exhibit B, pp 1-2).

(6) On March 21, 2012, the SHRT upheld the denial of MA and Retro-MA indicating that Claimant retains the capacity to perform a narrow range of simple unskilled light exertional work with standing limited to 6 hours and the need of a sit/stand option as afforded by normal breaks and lunch, based on Medical Vocational Grid Rule 202.19. SHRT denied SDA because the nature and severity of Claimant's impairments would not preclude work activity at the above stated level for 90 days. (Department Exhibit C, pp 1-2).

(7) Claimant has a history of back problems with a fractured L3, hairline fracture of L4 and mild disc narrowing at L5-S1 and annular bulge with mild subarticular and foraminal stenosis, high blood pressure, arthritis, diabetes, depression, gout, and Hepatitis-C.

(8) Claimant is a [redacted] man whose birthday is [redacted]. Claimant is 6'0" tall and weighs 250 lbs. Claimant completed the tenth grade. Claimant last worked in 2008 as a dealer in a casino for 14 years.

(9) Claimant was appealing the denial of Social Security disability benefits at the time of the hearing.

CONCLUSIONS OF LAW

The Medical Assistance ("MA") program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department, (DHS or department), 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 Reference Tables Manual ("RFT").

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. DHS administers the SDA program

pursuant to MCL 400.10, *et seq.*, and Mich Admin Code, Rules 400.3151-400.3180. Department policies are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

Current legislative amendments to the Act delineate eligibility criteria as implemented by department policy set forth in program manuals. 2004 PA 344, Sec. 604, establishes the State Disability Assistance program. It reads in part:

> Sec. 604 (1) The department shall operate a state disability assistance program. Except as provided in subsection (3), persons eligible for this program shall include needy citizens of the United States or aliens exempt from the Supplemental Security Income citizenship requirement who are at least 18 years of age or emancipated minors meeting one or more of the following requirements:
>
> (b) A person with a physical or mental impairment which meets federal SSI disability standards, except that the minimum duration of the disability shall be 90 days. Substance abuse alone is not defined as a basis for eligibility.

Specifically, this Act provides minimal cash assistance to individuals with some type of severe, temporary disability which prevents him or her from engaging in substantial gainful work activity for at least ninety (90) days.

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a). The person claiming a physical or mental disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and, (4) the effect of the applicant's pain on his or her ability to

do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

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

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4). If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3 to Step 4. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

As outlined above, the first step looks at the individual's current work activity. In the record presented, the Claimant is not involved in substantial gainful activity and testified that he has not worked since February 2008. Therefore, he is not disqualified from receiving disability benefits under Step 1.

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

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

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

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

6. Dealing with changes in a routine work setting. *Id.*

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

In the present case, Claimant alleges disability due to back problems with a fractured L3, hairline fracture of L4 and mild disc narrowing at L5-S1 and annular bulge with mild subarticular and foraminal stenosis, high blood pressure, arthritis, diabetes, depression, and hepatitis-C.

On May 30, 2010, Claimant was admitted to the hospital after jumping off a bridge from approximately 15 feet off the ground. After he sobered up, Claimant developed pain in the area of L-3. Claimant was seen by the orthopedic surgeon who arranged for an appropriate lumbar orthosis. He had a high-profile LLSO brace fitted and will follow-up in two weeks. The CAT scan of Claimant's lumbar spine showed a one-third canal space narrowing compromised due to retropulsion of burst fragment L3, disruption of the anterior vertebral body both cephalad and caudad through both endplates into both adjacent discs, and there was a small undisplaced or minimally displaced laminar fracture also. Also a nondisplaced hairline fracture right L4 lamina and mild disc narrowing at L5-S1 and annular bulge with mild subarticular and foraminal stenoses. Thus it appears that to some degree at least 2 of the 3 columns of the lumbar spine are disrupted and possibly somewhat the third column. Impression: Serious L-3 burst fracture with substantial narrowing of the spinal canal space and laminar fracture but no current neurologic symptoms; history of chronic orthopedic pain involving the right ankle; and history of alcoholism or episodic alcohol misuse. On May 31, 2010, Claimant

was examined and found to have had no problems overnight except for left calf discomfort. A CAT scan of Claimant's lumbar spine showed a stable L3 burst fracture with a mild interval increase in right perinephric fluid. Lovenox was started and incentive spirometry. An MRI was scheduled for anatomical detail on discs to help make surgical decision making. On June 1, 2010, an MRI of Claimant's lumbar spine showed an acute L3 burst fracture with mild bony retropulsion, and L5-S1 small broad based left parecentral/foraminal disc herniation. The x-ray of Claimant's thoracic spine revealed that T12 raises suspicion for possible compression minimally and there is shifting of the trachea to the left at the level of T1. The lateral film raised suspicion for prevertebral soft tissue swelling. On June 3, 2010, the x-ray of Claimant's lumbar spine showed the fractured L3 vertebral body which appeared to have progressed since the previous examination of 5/30/10. The interval progression of narrowing of the central portion of the L3 vertebral body is now at or greater than 50%. There is also ventral shifting of the anterior aspect of the vertebral body. Claimant was discharged on June 3, 2010, and prescribed Colace, Lisinopril, Lopressor, Slo-K and Percocet and instructed to wear the back brace when out of bed.

On July 8, 2010, Claimant underwent a psychological evaluation at the department's request. Diagnosis: Axis 1: Depressive Disorder, NOS; Alcohol Dependence (Sustained Full Remission); Axis V: 58.

On July 19, 2010, Claimant underwent a medical examination on behalf of the department. The physician's conclusion was that Claimant continues to undergo post traumatic care with a hard brace. There were no active radicular symptoms during the exam. He did have some difficulty doing orthopedic maneuvers mostly due to pain. He walked with a guarded wide based gait. In the short-term, he continues to require the use of his brace. He will require prolonged physical therapy. At this point in the short-term, he is not able to work, however, in the next twelve months this may change.

On August 24, 2010, Claimant went to the health center requesting a referral for a CAT scan of his lower back. Claimant also requested refill of Ultram, because he does not want narcotics for pain. A musculoskeletal exam revealed pain and tenderness at the lumbar spine area with very limited range of motion and muscle spasm present.

On August 27, 2010, the CAT scan of Claimant's lumbar spine revealed a known L3 fracture where the vertebral body fragments appeared sclerotic when compared to the CAT scan dated 5/31/10. There had been progressive narrowing of the mid portion of the fractured vertebral body and the ventral fragment appears to have been displaced ventrally slightly. There was persistent stenosis seen at the level of L3 and broad based disc bulging was seen at L2-L3 and L3-L4, and there was also narrowing of the left neural foramen at L3-L4.

On October 7, 2010, Claimant was seen at the health center requesting a referral to see the orthopedic surgeon. Claimant stated that he had no numbness or tingling down he legs, and the pain was not worse, just not getting any better. Claimant stated the pain was a 4/10. He is taking Ultram and Norco for pain control. Claimant stated that he is

supposed to be taking Lisinopril for hypertension but he does not take the medication because it makes him lightheaded. A musculoskeletal exam revealed pain and tenderness at the lumbar area. He had limited range of motion and muscle spasm. Claimant was given a referral to the orthopedic surgeon. His blood pressure was high, 160/110 and Tenormin was prescribed for his blood pressure.

On October 14, 2010, Claimant saw his orthopedic surgeon for follow-up of his burst fracture with continuing severe lower back pain and some left leg pain. A new lateral x-ray was obtained showing significant abnormality without evidence for healing. Nonunion L3. Spot lateral view is most notable for coronal separation of the anterior and posterior vertebral bodies with prominence of the posterior portion cephalad of the L3 vertebral body. Standard lateral view shows kyphosis of approximately 10 degrees across the L3 vertebral body and lateral tilt of approximately 8 degrees with greater collapse on the right than the left side of the vertebral body. On the lumbar CAT scan, again the known L3 fracture is seen. The vertebral body fragments now appear sclerotic. There has been progressive narrowing of the mid portion of the fractured vertebral body and the ventral fragment appears to have been displaced ventrally slightly. There is persistent stenosis seen at the level of L-3. Broad-based disc bulging is seen at L2-L3 and L3-L4 and there is narrowing of the left neural foramen at L3-L4. Spine tenderness on palpation over the lower lumbar spine without visible external deformity or scarring. Sitting straight leg raise bilaterally provides back discomfort with quad muscle testing. Gait slow, short stride, changes position and ambulates cautiously. Describes intermittent dysesthesia lower extremities, left greater than right. Diagnosed with (1) Closed fracture of lumbar vertebra without spinal injury; (2) Arrest of bone development or growth; (3) Low back pain. Nonoperative care does not seem to be providing significant resolution of symptoms. Claimant probably merits evaluation for possible anterior/posterior reconstruction or posterior stabilization. The magnitude of potential surgical intervention is sufficient to consider referral to tertiary center and/or obtaining a second opinion with another orthopedic colleague.

On October 31, 2010, Claimant went to the emergency room complaining of back pain. Claimant was diagnosed with chronic low back pain and administered Dilaudid and instructed to follow-up with his primary care physician after discharge.

On November 8, 2010, Claimant went to the emergency room stating he needed pain medication for his back pain. Claimant was administered Dilaudid by IV and prescribed Vistaril and discharged.

On December 17, 2010, Claimant went to the emergency room complaining of back pain. Claimant was out of pain medication and was prescribed Lortab and Norco and discharged.

Beginning in the year 2011, Claimant was seen in either the emergency room, clinic or health center complaining of only back pain five times in January, 2011, twice in April, 2011, two times in May, 2011, once in June, 2011, twice in July, 2011, once in August,

2011, twice in September, 2011, once in October, 2011, five times in November, 2011, and twice in December, 2011.

On February 17, 2011, Claimant went to the emergency room complaining of chest pain and shortness of breath. Claimant's chest x-rays were unremarkable and revealed no acute pulmonary disease. Claimant was diagnosed with asthmatic bronchitis and an IV was started. He was prescribed Zithomiacine, Prednixone and Albuterol and discharged in stable condition.

On April 8, 2011, Claimant was seen at the health center complaining of chronic back pain. Claimant requested a letter stating that he cannot work so he can receive assistance to see a specialist and for physical therapy. A musculoskeletal exam of Claimant revealed no bruising or abrasions, full range of motion in flexion, extension and side to side bending, no spinous process tenderness; no paraspinal tenderness/muscle spasm. Negative straight leg raise bilaterally. Claimant was able to move around pretty well, so the physician did not know if Claimant was disabled from working at the casino dealing cards, and no heavy work. The physician referred Claimant for a disability determination and help if needed. Claimant did have dermatophytosis of the nail, fungus on his nails, especially the left hand. He asked for a topical fungoid liquid application, which were ordered. Claimant was not a good candidate for Lamisil as he has Hepatitis C.

On May 4, 2011, Claimant went to the clinic requesting his doctor write a letter that he was disabled. Claimant's medical records at the clinic were reviewed and did not support Claimant's claim of disability or medical documentation supporting Claimant's inability to work. Claimant was referred to behavioral services. Claimant volunteered that he has "on occasion" used alcohol to cope with pain that he had concerns about using alcohol again. Claimant stated he remains homeless and resides with family or friends. Vocational rehabilitation was also discussed as one recommendation. Claimant stated that he would not be able to work in any capacity, stating that he cannot stand, bend, walk or sit for any period of time without having to change position and has constant pain.

On October 24, 2011, Claimant went to the Tribal Health Center to establish care. Claimant has had a loss of controlled substance privileges and typically has used marijuana and alcohol to treat some of his symptoms. He does not sleep well. He has this specific low back pain from a fracture. Most recent CAT scan showed spinal stenosis at L3 due to the worsening fracture fragments, causing stenosis into the spinal cord. He also takes a blood pressure pill. He is currently taking Tramadol four pills a day and it helps some. Diagnoses: (1) Chronic pain, will increase Tramadol to six pills a day; (2) Back pain, for now he could be a surgical candidate; (3) Hypertension; continue current medication.

During Claimant's five visits to the emergency room in November 2011, the first visit on 11/3/11, Claimant stated he had been assaulted. Alcohol was noted and he was given Toradol and Ultram for his back pain. On 11/13/11, Claimant stated he had fallen, and

decreased range of motion and muscle spasm was noted. Claimant was prescribed Valium, Toradol, Morphine, and Ultram. On 11/21/11, alcohol intoxication was noted. Claimant was offered a shot of Toradol. Claimant declined and asked for Demerol and Visteril. Claimant claimed he had not had a drink in 14 hours. After Claimant's blood alcohol level was determined to be 0.83, Claimant was denied Demerol and Visteril and he asked for the shot of Toradol.

On November 28, 2011, Claimant went to the emergency room with a swollen and painful left hand. Claimant has a history of known poorly controlled hypertension and was previously hospitalized for it as well as ankle pain and swelling. He was felt to have gout. Claimant was discharged from the hospital on 10/11/1 and had not arranged any follow-up. Claimant stated he had been taking his blood pressure medications as directed. Initial blood pressure was 213/146. There was minimal erythema and swelling diffusely around the left wrist. There was no specific point of tenderness. BMP reveals a creatinine of 1.13, uric acid 9.8. X-ray of wrist revealed nonspecific soft tissue swelling. Ultrasound revealed no evidence of DVT. Claimant initially received 20 mg of hydralazine. Repeat blood pressure was coming down 192/118. He was given another 50 mg of hydralazine and discharged home to continue his usual medications. He was also treated with indomethacin which improved his pain as well as a splint. He was diagnosed with hypertension with poor control and elevated uric acid and left wrist swelling, probably gouty flare.

On December 7, 2011, Claimant followed up with his doctor after having been in the emergency room on November 28, 2011, for hypertension. Claimant was in the hospital in October 2011 for four days, diagnosed with gout and hypertension. Claimant had mild swelling of his left wrist, which was mildly tender. His left foot was also swollen, inflamed and tender, especially his great toe.

On December 14, 2011, Claimant saw his doctor for a recheck of his hypertension and gout. Claimant's left hand is better, but his left foot remains swollen, but it was better than last week. His left great toe was still inflamed and very tender. Claimant had to walk an hour to get to the appointment. The plan is to continue hypertensive medications until Claimant sees the internist who may be able to change medications and start alopurinal if acute gout is improved in his left foot.

On December 26, 2011, Claimant saw his doctor for a recheck of his hypertension. Claimant was feeling well with no chest pain or headache, and no history of heard disease. Blood pressure was 160/120. His chest was clear, heart regular with no murmurs, rate 72. No lower extremity edema. He had left wrist swelling, since at least late November 2011, and denies injury. Left wrist swelling may or may not be very hard to evaluate hypertension in light of binge drinking yesterday, but lowering his blood pressure is the first priority.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the Claimant has presented some limited medical evidence establishing that he does

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

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. Claimant has alleged physical disabling impairments due to back problems with a fractured L3, hairline fracture of L4 and mild disc narrowing at L5-S1 and annular bulge with mild subarticular and foraminal stenosis, high blood pressure, arthritis, diabetes, depression, gout, and hepatitis-C.

Listing 1.00 (musculoskeletal system), Listing 4.00 (cardiovascular system), Listing 5.00 (digestive system), Listing 9.00 (endocrine disorders), Listing 11.00 (neurological) and Listing 12.00 (mental disorders) were considered in light of the objective evidence. Based on the foregoing, it is found that Claimant's impairment(s) does not meet the intent and severity requirement of a listed impairment; therefore, Claimant cannot be found disabled, or not disabled, at Step 3. Accordingly, Claimant's eligibility is considered under Step 4. 20 CFR 416.905(a).

The fourth step in analyzing a disability claim requires an assessment of the individual's residual functional capacity ("RFC") and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if he/she can perform past relevant work. *Id*.; 20 CFR 416.960(b)(3). Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s) and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

To determine the physical demands (exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967. Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). 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. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b). Even though 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. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially

all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.* Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.* Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.* Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

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

Claimant's prior work history consists of work as a dealer in a casino. In light of Claimant's testimony, and in consideration of the Occupational Code, Claimant's prior work is classified as skilled, light work, and Claimant is unable to return to his past relevant work and his past work skills do not transfer to other work found within their functional limitations.

Claimant testified that he is able to walk short distances and can lift/carry approximately 10 pounds. The SHRT found Claimant retains the capacity to perform a narrow range of simple unskilled light exertional work with standing limited to less than 6 hours and the need of a sit/stand option as afforded by normal breaks and lunch. It is unclear where the SHRT found these limitations listed as a review of the medical file did not

indicate limitations. If the impairment or combination of impairments does not limit an individual's physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. 20 CFR 416.920. In consideration of the Claimant's testimony, medical records, and current limitations, Claimant cannot be found able to return to past relevant work. Accordingly, Step 5 of the sequential analysis is required.

In Step 5, an assessment of the individual's residual functional capacity and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v) At the time of hearing, the Claimant was 50 years old and was, thus, considered to be an individual approaching advanced age for MA-P purposes. Claimant has a high school degree and was trained in robotic welding. Disability is found if an individual is unable to adjust to other work. *Id.* At this point in the analysis, the burden shifts from the Claimant to the Department to present proof that the Claimant has the residual capacity to substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). The age for younger individuals (under 50) generally will not seriously affect the ability to adjust to other work. 20 CFR 416.963(c). Where an individual has an impairment or combination of impairments that results in both strength limitations and non-exertional limitations, the rules in Subpart P are considered in determining whether a finding of disabled may be possible based on the strength limitations alone, and if not, the rule(s) reflecting the individual's maximum residual strength capabilities, age, education, and work experience, provide the framework for consideration of how much an individual's work capability is further diminished in terms of any type of jobs that would contradict the non-limitations. Full consideration must be given to all relevant facts of a case in accordance with the definitions of each factor to provide adjudicative weight for each factor.

In this case, the evidence reveals that Claimant suffers back problems with a fractured L3, hairline fracture of L4 and mild disc narrowing at L5-S1 and annular bulge with mild subarticular and foraminal stenosis, high blood pressure, arthritis, diabetes, depression, gout, and hepatitis-C. The SHRT found Claimant retains the capacity to perform a narrow range of simple unskilled light exertional work with standing limited to less than 6 hours and the need of a sit/stand option as afforded by normal breaks and lunch. In light of the foregoing, it is found that Claimant maintains the residual functional capacity for work activities on a regular and continuing basis which includes the ability to meet the physical and mental demands required to perform at least sedentary work as defined in 20 CFR 416.967(a). After review of the entire record using the Medical-Vocational Guidelines [20 CFR 404, Subpart P, Appendix II] as a guide, specifically

Rule 201.24**,** it is found that Claimant is not disabled for purposes of the MA-P program at Step 5.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Claimant not disabled for purposes of the MA-P, Retro-MA and SDA benefit programs.

Accordingly, it is ORDERED:

The Department's determination is AFFIRMED.

/s/_____
Vicki L. Armstrong
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: 4/24/12

Date Mailed: 4/24/12

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.

VLA/ds

[redacted]