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

IN THE MATTER OF:

[redacted]

Reg. No.: 201235663
Issue No.: 2009
Case No.: [redacted]
Hearing Date: June 20, 2012
County: Macomb DHS (12)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 following Claimant's request for a hearing. After due notice, an in-person hearing was held on June 20, 2012 from Clinton Township, Michigan. Participants included the above named claimant; [redacted] appeared as Claimant's authorized hearing representative. On behalf of Department of Human Services (DHS), [redacted], Specialist, appeared and testified.

ISSUE

The issue is whether DHS properly denied Claimant's application for Medical Assistance (MA) on the basis that Claimant is not a disabled individual.

FINDINGS OF FACT

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

1. On 9/20/11, Claimant applied for MA benefits including retroactive MA benefits for 7/2011-8/2011.

2. Claimant's only basis for MA benefits was as a disabled individual.

3. On 10/19/11, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 47-46).

4. On 10/24/11, DHS denied Claimant's application for MA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On 1/17/12, Claimant requested a hearing disputing the denial of MA benefits.

6. On 4/10/12, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual (see Exhibits 63-62), in part, by application of Medical-Vocational Rule 201.21.

7. On 6/20/12, an administrative hearing was held.

8. Following the administrative hearing, Claimant presented new medical records (Exhibits A1-A18).

9. The additional medical records were submitted to SHRT for reconsideration of Claimant's disability.

10. On 6/30/12, SHRT determined that Claimant was not disabled, in part, by application of Medical-Vocational Rule 202.22.

11. As of the date of the administrative hearing, Claimant was a [redacted] year old male with a height of 5'10'' and weight of 270 pounds.

12. As of the date of the administrative hearing, Claimant stated that he stopped drinking alcohol in 2011 after he was hospitalized.

13. Claimant's highest education year completed was the 12th grade via obtainment of general equivalency degree.

14. As of the date of the administrative hearing, Claimant had no ongoing health coverage and last had medical overage in 3/2011.

15. Claimant alleged that he is disabled based on impairments and issues including: knee problems, liver and kidney problems, gout, anemia, high blood pressure, shortness of breath and high cholesterol.

CONCLUSIONS OF LAW

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). DHS (formerly known as the Family Independence Agency) 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 Reference Tables Manual (RFT).

MA provides medical assistance to individuals and families who meet financial and nonfinancial eligibility factors. The goal of the MA program is to ensure that essential

health care services are made available to those who otherwise would not have financial resources to purchase them.

The Medicaid program is comprised of several sub-programs which fall under one of two categories; one category is FIP-related and the second category is SSI-related. BEM 105 at 1. To receive MA under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled. *Id*. Families with dependent children, caretaker relatives of dependent children, persons under age 21 and pregnant, or recently pregnant, women receive MA under FIP-related categories. *Id*. AMP is an MA program available to persons not eligible for Medicaid through the SSI-related or FIP-related categories though DHS does always offer the program to applicants. It was not disputed that Claimant's only potential category for Medicaid eligibility would be as a disabled individual.

Disability for purposes of MA benefits is established if one of the following circumstances applies (see BEM 260 at 1-2):

- by death (for the month of death);
- the applicant receives Supplemental Security Income (SSI) benefits;
- SSI benefits were recently terminated due to financial factors;
- the applicant receives Retirement Survivors and Disability Insurance (RSDI) on the basis of being disabled; or
- RSDI eligibility is established following denial of the MA benefit application (under certain circumstances).

There was no evidence that any of the above circumstances apply to Claimant. Accordingly, Claimant may not be considered for Medicaid eligibility without undergoing a medical review process which determines whether Claimant is a disabled individual. *Id*. at 2.

Generally, state agencies such as DHS must use the same definition of SSI disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally defined as the inability to do any substantial gainful activity (SGA) 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 functionally identical definition of disability is found under DHS regulations. BEM 260 at 8.

Substantial gainful activity means a person does the following:

- Performs significant duties, and
- Does them for a reasonable length of time, and
- Does a job normally done for pay or profit. *Id*. at 9.

Significant duties are duties used to do a job or run a business. *Id*. They must also have a degree of economic value. *Id*. The ability to run a household or take care of oneself does not, on its own, constitute substantial gainful activity. *Id*.

The person claiming a physical or mental disability has the burden to establish a disability 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).

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled. 20 CFR 416.920. If there is no finding of disability or lack of disability at each step, the process moves to the next step. 20 CFR 416.920 (a)(4).

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person is statutorily blind or not. The 2011 monthly income limit considered SGA for non-blind individuals is $1,000.

In the present case, Claimant denied having any employment since the date of the MA application; no evidence was submitted to contradict Claimant's testimony. Without ongoing employment, it can only be concluded that Claimant is not performing SGA. It is found that Claimant is not performing SGA; accordingly, the disability analysis may proceed to step two.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the 12 month duration requirement. 20 CFR 416.920 (a)(4)(ii). The impairments may be combined to meet the severity requirement. If a severe impairment is not found, then a person is deemed not disabled. *Id*.

The impairments must significantly limit a person's basic work activities. 20 CFR 416.920 (a)(5)(c). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. *Id.* Examples of basic work activities include:

- physical functions (e.g. walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling)
- capacities for seeing, hearing, and speaking, understanding; carrying out, and remembering simple instructions
- use of judgment
- responding appropriately to supervision, co-workers and usual work situations; and/or
- dealing with changes in a routine work setting.

Generally, federal courts have imposed a de minimus standard upon claimants to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257,

1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v Bowen,* 880 F2d 860, 862 (6th Cir. 1988). Similarly, Social Security Ruling 85-28 has been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirement is intended "to do no more than screen out groundless claims." *McDonald v. Secretary of Health and Human Servs.*, 795 F.2d 1118, 1124 (1st Cir. 1986).

SSA specifically notes that age, education, and work experience are not considered at the second step of the disability analysis. 20 CFR 416.920 (5)(c). In determining whether Claimant's impairments amount to a severe impairment, all other relevant evidence may be considered. The analysis will begin with the submitted medical documentation. Some documents were admitted as exhibits but were not necessarily relevant to the disability analysis; thus, there may be gaps in exhibits numbers. It should be noted that DHS pre-numbered exhibits going from bottom-to-top; thus, exhibits are cited from high number to low number. Exhibits presented at or after the hearing are prefaced with an "A" to distinguish them from exhibits considered by DHS in the original disability determination.

A Social Summary (Exhibits 45-44) dated [redacted] was presented. Claimant's form was completed by a Medicaid advocate. It was noted that Claimant had impairments of generalized weakness, liver problems, muscle problems and stomach problems.

A Medical Social Questionnaire (Exhibits 43-41) dated [redacted] was presented. The form allows for reporting of claimed impairments, treating physicians, previous hospitalizations, prescriptions, medical test history, education and work history. It was noted that Claimant had two hospital encounters in 7/2011 due to respiratory failure and one in 8/2011 due to weakness and hyponatremia.

Hospital records (Exhibits 40-34, 30-25 and 14-9) were presented. It was noted that Clamant was admitted on [redacted] and discharged on [redacted]. It was noted that Claimant presented with complaints of leg and abdomen swelling. Claimant also reported shortness of breath. It was noted that Claimant had an extended history of drinking alcohol. The discharge diagnoses included: alcoholic liver disease, lower extremity edema, anemia, acute respiratory insufficiency and uncontrolled hypertension.

Hospital records (Exhibits 33-31, 24-15 and 8-3) were presented. It was noted that Clamant was admitted on [redacted] and discharged on [redacted]. It was noted that Claimant presented with complaints similar to the [redacted] admission. It was noted that Claimant was positive for alcohol and cannabis. It was noted that Claimant continued to drink alcohol after he left the hospital on [redacted]. A chest radiograph report

noted an impression of focal opacity. Exams of Claimant's knees revealed no acute osseous pathology.

Hospital records (Exhibits 54-48 and A1-A18) from 9/2011 were presented. It was noted that Claimant was hospitalized from [redacted]. It was noted that Claimant presented with complaints of weakness, particularly in the legs. Claimant also reported severe pain which prevents him from movement. The discharge diagnoses included: acute intractable weakness, hypertension, alcoholic liver disease, electrolyte imbalance, acute gout flare, anemia and others.

A Resident Discharge Information (Exhibit A1) form was presented. It was noted that Claimant was hospitalized from [redacted] though no supporting documents were presented.

A consultative physical examination report (Exhibits 61-55) dated [redacted] was presented. It was noted that Claimant hurt his knees approximately 5-6 years ago after falling off of a ladder and landing on his knees. It was noted that Claimant reported developing effusion in his knees after the fall. It was noted in Claimant's medical history that Claimant could not walk longer than 150 feet, nor stand for longer than 30 minutes. It was noted that Claimant's hypertension was under control. It was noted that Claimant reported shortness of breath after walking 100 feet due to an abdomen protuberance. It was noted that Claimant was jaundiced due to a history of alcohol abuse. Impressions were given of: cirrhosis, degenerative joint disease of the knees, history of alcohol abuse and alcoholic neuropathy of lower limbs. The physician suspected that Claimant was fatigued by liver failure and that ascites in the abdomen limit his respiration. Lab results (Exhibit 58) verified multiple out-of range levels concerning liver function. The examining physician restricted Claimant's bending (to 30 degrees), lifting (to 50-60 pounds) and stair climbing (no more than 6 steps). Claimant had normal ranges of motion in all tested areas other than knee and lumbar motion. It was noted that Claimant took the following medication: Prilosec, Metoprolol, Aldactone, Allopurinol, Gabapentin and Lasix.

Claimant testified that he was capable of walking 50 yards with crutches though his knees may buckle. Claimant conceded no problems with his gripping ability. Claimant stated that he can stand for extended period as long as he uses a knee brace and crutches. Claimant stated that bending makes him light-headed and that he can't tie his shoes. Claimant estimated that he can sit for one hour before he gets side and stomach pain. Claimant stated he bathes relying on handrails and is slow in dressing himself. Claimant stated he limits his cooking to microwave meals and that his family helps him clean and do laundry. Claimant does not drive due to non-physical related issues.

It was established that Claimant had walking restrictions. A consultative examiner noted that Claimant was restricted to 150 feet of walking and standing for 30 minutes. The medical evidence supported the physician restrictions. No evidence was submitted to contradict the restrictions. Standing and walking restrictions are sufficient to establish a significant impairment to the performance of basic work activities.

It was noted that Claimant had liver problems beginning 7/2011 and knee problems prior to that. The evidence tended to support a finding that Claimant's basic work activity restrictions have existed for 12 months or longer.

As it was found that Claimant established significant impairment to basic work activities for a period longer than 12 months, it is found that Claimant established having a severe impairment. Accordingly, the disability analysis may move to step three.

The third step of the sequential analysis requires a determination whether the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920 (a)(4)(iii). If Claimant's impairments are listed and deemed to meet the 12 month requirement, then the claimant is deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step.

Claimant's most established impairment involved liver dysfunction. SSA impairment policy states the following concerning how liver disease is evaluated:

> *General. Chronic liver disease* is characterized by liver cell necrosis, inflammation, or scarring (fibrosis or cirrhosis), due to any cause, that persists for more than 6 months. Chronic liver disease may result in portal hypertension, cholestasis (suppression of bile flow), extrahepatic manifestations, or liver cancer. (We evaluate liver cancer under 13.19.) Significant loss of liver function may be manifested by hemorrhage from varices or portal hypertensive gastropathy, ascites (accumulation of fluid in the abdominal cavity), hydrothorax (ascitic fluid in the chest cavity), or encephalopathy. There can also be progressive deterioration of laboratory findings that are indicative of liver dysfunction. Liver transplantation is the only definitive cure for end stage liver disease (ESLD).
>
> 2. *Examples of chronic liver disease* include, but are not limited to, chronic hepatitis, alcoholic liver disease, non-alcoholic steatohepatitis (NASH), primary biliary cirrhosis (PBC), primary sclerosing cholangitis (PSC), autoimmune hepatitis, hemochromatosis, drug-induced liver disease, Wilson's disease, and serum alpha-1 antitrypsin deficiency. Acute hepatic injury is frequently reversible, as in viral, drug-induced, toxin-induced, alcoholic, and ischemic hepatitis. In the absence of evidence of a chronic impairment, episodes of acute liver disease do not meet 5.05.

Listing 5.05 which covers chronic liver disease is the most applicable listing to Claimant's impairments. This listing would mandate a finding of disability based on liver disease if Claimant's condition meets the following:

> **A.** Hemorrhaging from esophageal, gastric, or ectopic varices or from portal hypertensive gastropathy, demonstrated by endoscopy, x-ray, or other appropriate medically acceptable imaging, resulting in hemodynamic instability

as defined in 5.00D5, and requiring hospitalization for transfusion of at least 2 units of blood. Consider under disability for 1 year following the last documented transfusion; thereafter, evaluate the residual impairment(s).

OR

B. Ascites or hydrothorax not attributable to other causes, despite continuing treatment as prescribed, present on at least 2 evaluations at least 60 days apart within a consecutive 6-month period. Each evaluation must be documented by:

1. Paracentesis or thoracentesis; or
2. Appropriate medically acceptable imaging or physical examination and one of the following:
    a. Serum albumin of 3.0 g/dL or less; or
    b. International Normalized Ratio (INR) of at least 1.5.

OR

C. Spontaneous bacterial peritonitis with peritoneal fluid containing an absolute neutrophil count of at least 250 cells/mm3

OR

D. Hepatorenal syndrome as described in 5.00D8, with on of the following:

1. Serum creatinine elevation of at least 2 mg/dL; or
2. Oliguria with 24-hour urine output less than 500 mL; or
3. Sodium retention with urine sodium less than 10 mEq per liter.

OR

E. Hepatopulmonary syndrome as described in 5.00D9, with:

1. Arterial oxygenation (PaO2) on room air of:
    a. 60 mm Hg or less, at test sites less than 3000 feet above sea level, or
    b. 55 mm Hg or less, at test sites from 3000 to 6000 feet, or
    c. 50 mm Hg or less, at test sites above 6000 feet; or

2. Documentation of intrapulmonary arteriovenous shunting by contrast-enhanced echocardiography or macroaggregated albumin lung perfusion scan.

OR

F. Hepatic encephalopathy as described in 5.00D10, with 1 and either 2 or 3:

1. Documentation of abnormal behavior, cognitive dysfunction, changes in mental status, or altered state of consciousness (for example, confusion, delirium, stupor, or coma), present on at least two evaluations at least 60 days apart within a consecutive 6-month period; and
2. History of transjugular intrahepatic portosystemic shunt (TIPS) or any surgical portosystemic shunt; or
3. One of the following occurring on at least two evaluations at least 60 days apart within the same consecutive 6-month period as in F1:
    a. Asterixis or other fluctuating physical neurological abnormalities; or
    b. Electroencephalogram (EEG) demonstrating triphasic slow wave activity; or
    c. Serum albumin of 3.0 g/dL or less; or
    d. International Normalized Ratio (INR) of 1.5 or greater.

OR

G. End stage liver disease with SSA CLD scores of 22 or greater calculated as described in 5.00D11. Consider under a disability from at least the date of the first score.

There was no medical evidence of: blood transfusions, bacterial peritonitis, hepatorenal syndrome, hepatopulmonary syndrome, Hepatic encephalopathy or end stage liver disease. Thus, the only part of SSA Listing 5.05 potentially applicable to Claimant is Part B.

Hospital records failed to note any abdomen protuberance (see Exhibits 50 and A5). The consultative examiner speculated that Claimant's shortness of breath was caused by a stomach protuberance caused by ascites. A single medical document suspecting ascites is insufficient to meet the listing for 5.05B. Accordingly, it is found that Claimant fails to meet the SSA listing for liver disease.

Claimant also provided substantial evidence of knee problems. Knee dysfunction would be covered by Listing 1.02 which reads:

> **1.02** ***Major dysfunction of a joint(s) (due to any cause)***: Characterized by gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankylosis, instability) and chronic joint pain and stiffness with signs of limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With:
> A. Involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in inability to ambulate effectively, as defined in 1.00B2b;
> OR
> B. Involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively, as defined in 1.00B2c.

The consultative examiner noted that Claimant was limited to 150 feet of walking and no more than 6 stairs of climbing. It was noted that Claimant could not perform heel and toe or tandem walking tests. These restrictions tend to support a finding that Claimant is unable to ambulate effectively.

The consultative examiner noted that Claimant does not require the use of a walking aid. It was noted that Claimant's gait was within normal limits. It was noted that Claimant was capable of carrying up to 50-60 pounds of weight. These conclusions tend to support a finding that Claimant is able to ambulate effectively.

Claimant's verified hospitalizations each concerned liver function, not knee problems. Though the hospitalizations began in part due to Claimant's general weakness which may have been impacted by Claimant's knee function, the bigger culprit was Claimant's liver function. The lack of medical treatment for Claimant's knee problems also tends to support a finding that Claimant is able to ambulate effectively. Based on the presented evidence, it is found that Claimant does not meet the listing for joint dysfunction.

Based on diagnoses for anemia, Listing 7.02 was considered. This listing was rejected due to a lack of evidence showing that hematocrit persisted at 30% or less.

It is found that Claimant failed to establish meeting a SSA listing. Accordingly, the disability analysis moves to step four.

The fourth step in analyzing a disability claim requires an assessment of the Claimant's residual functional capacity (RFC) and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if it is determined that a claimant can perform past relevant work. *Id*.

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 is 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.

Claimant's past relevant work involved extended employment as an electrician. Claimant described his duties as climbing and descending ladders, significant bending and standing and fair amounts of lifting.

Claimant also had employment involving excavation. Claimant stated that his duties including lifting 80 pound blocks, going in and out of holes and standing on scaffolds.

Claimant stated that he could not perform any of his past employment because his knees would prevent him from using ladders, heavy lifting and long periods of standing. Claimant's testimony was consistent with the medical records. It is found that Claimant is not capable of performing his past relevant employment and the disability analysis may proceed to step five.

In the fifth step in the process, the individual's RFC in conjunction with his or her age, education, and work experience, are considered to determine whether the individual can engage in any other substantial gainful work which exists in the national economy. SSR 83-10. 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).

To determine the physical demands (i.e. exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967. The definitions for each are listed below.

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 additionally 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 are considered nonexertional. 20 CFR 416.969a(a). Examples of non-exertional limitations 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 (i.e. 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.* In using the rules of Appendix 2, an individual's circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, is compared to the pertinent rule(s).

For purposes of this decision, it will only be considered whether Claimant was capable of performing sedentary employment. The consultative examiner restricted to Claimant to under 50-60 pounds of lifting, well above the maximum weights required for sedentary employment. There was some evidence that Claimant had back problems based on restricted lumbar ranges of motion but the consultative examining physician found no need to restrict Claimant's ability to sit. The only relevant consideration left in determining whether Claimant is capable of sedentary employment is Claimant's standing and walking ability.

Claimant is capable of 150 feet of walking per a consultative examining physician. Details of the restriction were not provided. For example, if Claimant could walk further following a short rest, the restriction is not as serious as a 150 foot per day walking limit. It was noted that Claimant gets short of breath after 100 feet of walking. Though such a restriction would be difficult to overcome, it is one that leaves Claimant capable of performing sedentary employment. It is found that Claimant is capable of performing sedentary employment.

Based on Claimant's exertional work level (sedentary), age (younger individual aged 45-49), education (high school), employment history (skilled- not transferrable), Medical-Vocational Rule 201.21 is found to apply. This rule dictates a finding that Claimant is not disabled. Accordingly, it is found that DHS properly found Claimant to be not disabled for purposes of MA benefits.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that DHS properly denied Claimant's MA benefit application dated 9/20/11, including retroactive MA benefits for 7/2011-8/2011, based on a determination that Claimant was not disabled. The actions taken by DHS are AFFIRMED.

Christian Gardocki
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: August 13, 2012

Date Mailed: August 13, 2012

NOTICE: Michigan Administrative Hearing System (MAHS) 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. MAHS 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. (60 days for FAP cases)

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.

Claimant may request a rehearing or reconsideration for the following reasons:

- A rehearing **MAY** be granted if there is newly discovered evidence that could affect the outcome of the original hearing decision.
- A reconsideration **MAY** be granted for any of the following reasons:
  - misapplication of manual policy or law in the hearing decision,
  - typographical errors, mathematical error, or other obvious errors in the hearing decision that effect the substantial rights of the claimant:
  - the failure of the ALJ to address other relevant issues in the hearing decision.

Request must be submitted through the local DHS office or directly to MAHS by mail at

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P. O. Box 30639
Lansing, Michigan 48909-07322

CG/hw

cc: [redacted]