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

IN THE MATTER OF:

[redacted]

Reg No.: 2012-37449
Issue No.: 2009
Case No.: [redacted]
Hearing Date: August 13, 2012
Huron County DHS

ADMINISTRATIVE LAW JUDGE: Colleen M. Mamelka

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Claimant's request for a hearing. After due notice, a hearing was held in Bad Axe, Michigan on Monday, August 13, 2012. The Claimant appeared and testified. The Claimant was represented by [redacted] of [redacted]. Participating on behalf of the Department of Human Services ("Department") was [redacted]. Observing the proceedings from the Department were [redacted], [redacted]

During the hearing, the Claimant waived the time period for the issuance of this decision, in order to allow for the submission of additional medical evidence. The records were received, reviewed, and forwarded to the State Hearing Review Team ('SHRT") for consideration. On October 16, 2012, this office received the SHRT determination which found the Claimant not disabled. This matter is now before the undersigned for a final decision.

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of the Medical Assistance ("MA-P") benefit program?

FINDINGS OF FACT

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

1. The Claimant submitted an application for public assistance seeking MA-P benefits on December 28, 2011.

2. On February 14, 2012, the Medical Review Team ("MRT") found the Claimant not disabled. (Exhibit 2, pp. 1, 2)

3. On February 22, 2012, the Department notified the Claimant of the MRT determination.

4. On March 2, 2012, the Department received the Claimant's written request for hearing.

5. On April 20th and October 4, 2012, the SHRT found the Claimant not disabled. (Exhibit 2)

6. The Claimant alleged physical disabling impairments due to right knee pain, and swelling, scoliosis, asthma, high blood pressure, and acid reflux.

7. The Claimant alleged mental disabling impairments due to severe depression, panic disorder, personality disorder, agoraphobia, anxiety, and post traumatic stress disorder ("PTSD").

8. At the time of hearing, the Claimant was 37 years old with an [redacted] birth date; was 5'8" in height; and weighed 242 pounds.

9. The Claimant has the equivalent of a high school education with an employment history in a factory, as a cashier, and in shelf stocking.

CONCLUSIONS OF LAW

The Medical Assistance program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department of Human Services, formerly known as the Family Independence Agency, 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 Bridges Reference Tables ("RFT").

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 CFR 416.913. 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 (i.e. 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 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 three to step four. 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 416.945(a)(1). An individual's residual functional capacity assessment is evaluated at both steps four and five. 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).

In addition to the above, when evaluating mental impairments, a special technique is utilized. 20 CFR 416.920a(a). First, an individual's pertinent symptoms, signs, and laboratory findings are evaluated to determine whether a medically determinable mental impairment exists. 20 CFR 416.920a(b)(1). When a medically determinable mental impairment is established, the symptoms, signs and laboratory findings that substantiate the impairment are documented to include the individual's significant history, laboratory findings, and functional limitations. 20 CFR 416.920a(e)(2). Functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. *Id.;* 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality is considered. 20 CFR 416.920a(c)(1). In addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of functional limitation. 20 CFR 416.920a(c)(3). The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. *Id.* The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. *Id.*

After the degree of functional limitation is determined, the severity of the mental impairment is determined. 20 CFR 416.920a(d). If severe, a determination of whether the impairment meets or is the equivalent of a listed mental disorder is made. 20 CFR 416.920a(d)(2). If the severe mental impairment does not meet (or equal) a listed impairment, an individual's residual functional capacity is assessed. 20 CFR 416.920a(d)(3).

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 therefore is not ineligible for disability benefits under Step 1.

The severity of the Claimant's alleged impairment(s) is considered under Step 2. The Claimant 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 416.920(a)(4)(ii); 20 CFR 416.920(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 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921(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, the Claimant alleges disability due to right knee pain, and swelling, scoliosis, asthma, high blood pressure, acid reflux, severe depression, panic disorder, personality disorder, agoraphobia, anxiety, and PTSD.

On October 15, 2010, an initial psychiatric evaluation was performed. The diagnoses were bipolar disorder, PTSD, and panic disorder. The Global Assessment Functioning ("GAF") was 50.

On November 24, 2010, the Claimant sought treatment for knee pain. The diagnoses were knee pain, anxiety, and depression.

On December 2, 2010, the Claimant's annual gynecological examination was unremarkable.

On January 7, 2011, the Claimant sought treatment for runny nose, sinus pressure, and left knuckle pain. The diagnoses were bronchitis, sinusitis, and tendinitis.

On April 8, 2011, the Claimant sought treatment for right knee pain and sinus drainage at night. The diagnoses were sinusitis, knee pain, and post-nasal discharge.

On June 28, 2011, the Claimant sought treatment for productive cough and shortness of breath. Chest x-rays found no evidence of acute cardiopulmonary disease. A Pulmonary Function Test ("PFT") showed a Forced Expiratory Volume at 1 second ("FEV_1") of 2.45, 2.57, and 2.68 before bronchodilator and a Forced Vital Capacity ("FVC") of 2.84, 3.18, and 3.18. After the bronchodilator the FEV_1 was 2.33 and the FVC 3.14. The Claimant's lung age was 72. The diagnoses were bronchitis, bronchospasm, post-nasal discharge, sinusitis, depression, and hypertension.

On July 7, 2011, the Claimant was treated for shortness of breath. The Claimant did not have any evidence of upper respiratory infection. The diagnoses were neuropathy, sleep disorder, depression, dyslipidemia, and anxiety.

On September 13, 2011, the Claimant attended a follow-up appointment. X-ray of the right knee (September 7, 2011) was unremarkable. The Claimant was diagnosed with neuropathy, sleep disorder, depression, vitamin D deficiency, hypertension, and knee pain. The Claimant was in stable condition.

On September 14, 2011, the Claimant was diagnosed with chronic right knee pain, chronic low back pain without radicular symptoms, and a history of scoliosis.

On October 12, 2011, the Claimant attended a follow-up appointment for her low back pain. An MRI of the right knee showed mild osteoarthritis and small joint effusion. Straight leg raising was negative bilaterally. The diagnosis was right knee pain, chronic, secondary to osteoarthritis.

On October 14, 2011, the Claimant was brought to the emergency room after her daughter called the police because of a text received by the Claimant the she "wished she could die." The Claimant was found stable and was discharged.

On November 1, 2011, the Claimant was diagnosed with neuropathy, sleep disorder, depression, anxiety, dyslipidemia, and urinary incontinence.

On December 14, 2011, the Claimant was treated/diagnosed with major depressive disorder and PTSD.

On January 4, 2012, the Claimant sought treatment for sinus pain/pressure with productive cough.

On January 11, 2012, the Claimant sought treatment for sinus pain and cough. The physical examination revealed some scoliosis and tenderness upon palpitation in the

lumbar area. Straight leg raising was negative bilaterally. The Claimant's depression and anxiety were stable. The diagnosis was right knee pain, chronic, secondary to osteoarthritis.

On January 16, 2012, the Claimant sought treatment for coughing and congestion. A PFT showed a FEV_1 of 1.40, 1.40, and 2.58 before bronchodilator and a FVC of 2.67, 2.65, and 3.07. After the bronchodilator the FEV_1 was 3.17, 2.64, and 2.62 and the FVC 3.63, 3.14, and 3.10. The Claimant's lung age was 69. The diagnoses were neuropathy, sleep disorder, depression, dyslipidemia, bronchospasm, and hypertension.

On January 24, 2012, the Claimant attended a follow-up appointment where here congestion had improved. The Claimant's depression appeared stable with prescribed treatment.

On January 28, 2011, a medication review was completed resulting in the diagnoses of bipolar disorder (depressed type), PTSD, and panic disorder with agoraphobia. The Claimant's medications remained the same.

On March 3, 2011, a medication review was completed resulting in the diagnoses of bipolar disorder (depressed type), PTSD, and panic disorder with agoraphobia. The Claimant's medications were decreased.

On April 21st and July 7, 2011, a medication review was completed resulting in the diagnoses of bipolar disorder (depressed type), PTSD, and panic disorder with agoraphobia. The Claimant's medications were unchanged.

On September 26, 2011, a medication review was completed resulting in a change in prescribed treatment. The diagnoses were bipolar disorder (depressed type), PTSD, and panic disorder with agoraphobia.

On December 19, 2011, a medication review was completed resulting in a change in prescribed treatment. The diagnoses were bipolar disorder (depressed type), PTSD, and panic disorder with agoraphobia.

On January 12, 2012, a Mental Residual Functional Capacity Assessment was completed on behalf of the Claimant. The Claimant was markedly limited in 4 factors (ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; sustain an ordinary routine without supervision; accept instruction and respond appropriately to criticism from supervisors; and set realistic goals and make plans independently of others). The Claimant was moderately limited in 7 of the 20 factors. There was no evidence that the Claimant was unable to remember locations and work-like procedures; understand/remember one or two-step

instructions; carry out simple, one of tow-step instructions; make simple work-related decisions; and ask simple questions or request assistance.

On January 16, 2012, a Medical Examination Report was completed on behalf of the Claimant. The current diagnosis was bipolar disorder and panic disorder with agoraphobia. The physical examination revealed fatigue, depressed mood, mild bronchial spasm, anxiety, and difficulty focusing. The Claimant's condition was deteriorating recommending psychiatric care.

On March 16, 2012, a psychiatric evaluation was performed. The diagnoses were PTSD, major depressive disorder (recurrent, moderate), and panic disorder with agoraphobia. Problems with concentration, feelings of hopelessness, and nightmares were also noted. The GAF was 50.

On May 10, 2012, the Claimant presented to a crisis center with suicidal ideations despite compliance with medication. The Claimant was treated and discharged with the diagnoses of major depression (recurrent) and PTSD.

On May 21, 2012, the Claimant attended a follow-up appointment where she was diagnosed with major depressive disorder (recurrent, moderate), PTSD, panic disorder with agoraphobia, and borderline personality disorder.

On June 18, 2012, the Claimant attended a follow-up appointment where she was diagnosed with major depressive disorder (recurrent, moderate), PTSD, panic disorder with agoraphobia, and borderline personality disorder.

On July 3, 2012, the Claimant was brought to the emergency room by the police after cutting herself while intoxicated. The Claimant was treated and discharged with the diagnosis of major depression.

On July 12, 2012, the Claimant attended a follow-up appointment where she was diagnosed with major depressive disorder (recurrent, moderate), PTSD, panic disorder with agoraphobia, and borderline personality disorder.

On August 15, 2012, the Claimant attended a consultative evaluation. The diagnoses were knee and foot pain, and asthma.

As previously noted, the 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 medical evidence establishing that she does have some physical and mental limitations on her ability to perform basic work activities. The degree of functional limitation on the Claimant's activities, social function, concentration, persistence, or pace is mild to moderate. The degree of functional

limitation in the fourth area (episodes of decompensation) is at most a 2. The medical evidence has established that the 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, the 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 Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The evidence confirms treatment/diagnoses of bipolar disorder, PTSD, panic disorder with agoraphobia, anxiety, bronchitis, sinusitis, tendinitis, right knee pain, depression, hypertension, neuropathy, sleep disorder, back pain, osteoarthritis, dyslipidemia, urinary incontinence, asthma, foot pain, and borderline personality disorder.

Listing 1.00 (musculoskeletal system), Listing 3.00 (respiratory system), Listing 4.00 (cardiovascular system), and Listing 12.00 (mental disorders) were considered in light of the objective medical evidence. There were no objective findings of major joint dysfunction, fracture, or nerve root impingement; ongoing treatment for shortness of breath requiring hospitalization; or persistent, recurrent, and/or uncontrolled (while on prescribed treatment) cardiovascular impairment or end organ damage resulting from the Claimant's hypertension. Finally, the evidence does not show that the Claimant symptoms persist despite prescribed treatment or that the Claimant has very serious limitations in her ability to independently initiate, sustain, or complete activities of daily living. Mentally, the Claimant was found capable of remembering locations, work-like procedures, understanding/remembering/carrying-out simple, one of two-step procedures, make simple work-related decisions, and ask simple questions or request assistance. The evidence reveals improvement with prescribed treatment. There was no evidence of marked limitations in the areas of daily living and/or social functioning. In the area of sustained concentration and persistence, the Claimant was markedly limited in 2 of the 8 factors with no evidence of any limitation in her ability to make simple work-related decision. Although the objective medical records establish some physical and mental impairments, these records do not meet the intent and severity requirements of a listing, or its equivalent. Accordingly, the Claimant can not be found disabled, or not disabled at Step 3; therefore, the Claimant's eligibility is considered under Step 4. 20 CFR 416.905(a).

Before considering the fourth step in the sequential analysis, a determination of the individual's residual functional capacity ("RFC") is made. 20 CFR 416.945. An individual's RFC is the most he/she can still do on a sustained basis despite the limitations from the impairment(s). *Id.* The total limiting effects of all the impairments, to include those that are not severe, are considered. 20 CFR 416.945(e).

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 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 (exertional requirements, i.e. 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 with the demands of past relevant work. *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 to function 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 this case, the evidence confirms treatment/diagnoses of bipolar disorder, PTSD, panic disorder with agoraphobia, anxiety, bronchitis, sinusitis, tendinitis, right knee pain, depression, hypertension, neuropathy, sleep disorder, back pain, osteoarthritis, dyslipidemia, urinary incontinence, asthma, foot pain, and borderline personality disorder. The Claimant testified that she is able to walk ¼ mile with a knee brace; grip/grasp with some difficulties; sit for less than 2 hours; lift/carry approximately 15 pounds with her left hand and 5 pounds with her right; stand less than 2 hours; and has difficulties bending and/or squatting. The objective medical evidence does not contain any physical limitations. As detailed above, the evidence reveals some mental limitations; however, these limitations, considered collectively, are not severe. After review of the entire record and considering the Claimant's testimony, it is found, at this point, that the Claimant maintains the residual functional capacity to perform at least unskilled, limited, sedentary work as defined by 20 CFR 416.967(a). Limitations being the alternation between sitting and standing at will.

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 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 is not considered. 20 CFR 416.960(b)(3).

The Claimant's prior employment was consisted of work in stocking shelves, at a factory, and as a cashier. Each position required a good deal of standing and/or walking. In consideration of the Claimant's testimony and Occupational Code, the prior employment is classified as unskilled, light work. If the impairment or combination of impairments does not limit 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. As noted above, the objective evidence does not contain any physical that would preclude employment. Mentally, the Claimant's limitations were mild to moderate. In light of the entire record and the Claimant's RFC (see above), it is found that the Claimant is unable to perform past relevant work. Accordingly, the Claimant cannot be found disabled, or not disabled, at Step 4.

In Step 5, an assessment of the Claimant'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 37 years old and, thus, considered to be a younger individual for MA-P purposes. The Claimant has the equivalent of a high school education. 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).

In this case, the evidence confirms treatment/diagnoses of bipolar disorder, PTSD, panic disorder with agoraphobia, anxiety, bronchitis, sinusitis, tendinitis, right knee pain, depression, hypertension, neuropathy, sleep disorder, back pain, osteroarthritis, dyslipidemia, urinary incontinence, asthma, foot pain, and borderline personality disorder. The Claimant testified that she was able to perform physical activity comparable to less than sedentary activity. Conversely, the evidence does not contain any physical limitations. Mentally, there was no evidence that the Claimant was unable to remember locations and work-like procedures; understand/remember one or two-step instructions; carry out simple, one of two-step instructions; make simple work-related decisions; and ask simple questions or request assistance. In light of the foregoing, it is found that the Claimant maintains the residual functional capacity for work activities on a regular and continuing basis 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, finding no contradiction with the Claimant's non-exertional limitations, and in consideration of the Claimant's age, education, work experience, RFC, and using the Medical-Vocational Guidelines [20 CFR 404, Subpart P, Appendix II] as a guide, specifically Rule 201.27, the Claimant is found not disabled 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 benefit program.

Accordingly, it is ORDERED:

The Department's determination is **AFFIRMED**.

Colleen M. Mamelka
Administrative Law Judge
For Maura Corrigan, Director
Department of Human Services

Date Signed: October 30, 2012

Date Mailed: October 30, 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

CMM/tm

cc: [redacted]