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

IN THE MATTER OF:

[redacted]

Reg. No.: 201271247
Issue No.: 2009
Case No.: [redacted]
Hearing Date: November 28, 2012
County: Wayne DHS (19)

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 November 28, 2012, from Inkster, Michigan. Participants included the above-named claimant. [redacted] appeared as Claimant's authorized hearing representative. Participants on behalf of Department of Human Services (DHS) included [redacted], Specialist.

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 8/25/11, Claimant applied for MA benefits, including retroactive MA benefits from 6/2011-7/2011.

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

3. On 10/5/11, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 5-6).

4. On 1/3/12, DHS denied Claimant's application for MA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On 3/23/12, Claimant requested a hearing disputing the denial of MA benefits.

6. On 10/11/12, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual (see Exhibits 199-200), in part, by application of Medical-Vocational Rule 201.21.

7. On 11/28/12, an administrative hearing was held.

8. At the hearing, Claimant presented new medical documents (Exhibits 201-221).

9. The new medical packet was forwarded to SHRT for review.

10. On 1/30/13, SHRT determined that Claimant was not a disabled individual (see Exhibits 222-223), in part, by application of Medical-Vocational Rule 201.22.

11. As of the date of the administrative hearing, Claimant was a [redacted] year old female with a height of 5'3'' and weight of 282 pounds.

12. Claimant is a smoker and former cocaine abuser with no known current relevant use of alcohol or illegal drugs.

13. Claimant's highest education year completed was the 12th grade.

14. As of the date of the administrative hearing, Claimant received Adult Medical Program (AMP) benefits which covered prescription and doctor visit costs.

15. Claimant alleged that she is disabled based on impairments and issues including: left leg sciatica, left knee pain, sleep apnea, chronic obstructive pulmonary disorder, vertigo, bipolar disorder, left ear hearing loss and circulation restrictions.

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. The 2012 income limit is $1010/month.

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 relevant submitted medical documentation.

A physician letter (Exhibit 201) dated [redacted] was presented. It was noted that Claimant had multiple medical problems including: asthma, avascular necrosis in the hips and chronic dizziness. The physician considered Claimant to be disabled.

A Medical- Social Questionnaire (Exhibits 9-11) dated [redacted] was presented. The form was completed by a patient rep. Three previous Claimant hospital encounters were noted: in 6/2011 due to cellulitis, in 6/2011 due to diarrhea and in 2/2011 due to ACL surgery.

Progress notes (Exhibits 19) from Claimant's treating psychiatrist were presented. The notes were dated [redacted]. It was noted that Claimant demonstrated good grooming, timeliness, orientation times four, good eye contact, normal speech, intact judgment, good insight, no delusional thought, no obsessive or compulsive thoughts, coherent and logical thought process and calm behavior. It was noted that Claimant was diagnosed with bipolar disorder and cocaine dependence. Claimant's GAF was 54.

A physician letter (Exhibit 14) dated [redacted] was presented. It was noted that Claimant complained of left knee pain and numbness. It was noted that Claimant also complained of right knee pain and occasional knee buckling. It was noted that x-rays revealed degenerative changes in both of Claimant's knees, though joint spacing was noted as reasonably well preserved. It was noted that x-rays also revealed periarticular spurring on both knees. An impression of osteoarthritis related to Claimant's previous knee surgery was noted. A plan of injections for Claimant to deal with the pain was noted.

Progress notes (Exhibits 16-18) from Claimant's treating psychiatrist were presented. The notes were dated [redacted]. It was noted that Claimant presented with complaints of: mood swings, sadness, racing thoughts, low energy, decreased appetite, forgetfulness and dyspnea. Claimant's GAF was 52.

Hospital documents (Exhibits 20-71; 121-124) were presented. The documents noted a hospital admission on [redacted] and discharge date of [redacted] It was noted that Claimant presented with complaints of swelling and pain in the left shoulder area. It was noted

that Claimant was admitted secondary to acute left upper cellulitis. It was noted that Claimant's symptoms gradually decreased following administration of antibiotics, fluids, steroids and pain medications.

Hospital documents (Exhibits 70-120; 125) were presented. It was noted that Claimant presented with complaints of diarrhea over the past week and abdominal pain. It was noted that Claimant was admitted on [redacted] and discharged on [redacted]. It was noted that Claimant smoked a pack of cigarettes per day and was morbidly obese. Radiology was taken of Claimant's abdomen and chest which showed no remarkable findings.

A letter (Exhibit 152) dated [redacted] from Claimant's treating physician was presented. It was noted that Claimant complained of pain in both knees. It was noted that an exam revealed some medial joint tenderness. An impression of bilateral knee osteoarthritis was noted. It was noted that the osteoarthritis was unresponsive to conservative treatment. A plan of injections was recommended.

Progress notes (Exhibits 15) from Claimant's treating psychiatrist were presented. The notes were dated [redacted]. It was noted that Claimant demonstrated good grooming, timeliness, orientation times four, good eye contact, normal speech, intact judgment, good insight, no delusional thought, no obsessive or compulsive thoughts, coherent and logical thought process and calm behavior. It was noted that Claimant was diagnosed with bipolar disorder and cocaine dependence. Claimant's GAF was 50.

Claimant completed an Activities of Daily Living (Exhibits 126-129) dated [redacted]. Claimant noted that she can't sleep at night and does not take naps during the day. Claimant noted that she does not fix her own meals due to hip pain- her daughter cooks and Claimant warms them. Claimant noted that she does not clean. Claimant noted she is not able to stand for long periods. Claimant noted that she does not get up some days due to depression. Claimant testified that she drives. Claimant also testified that her daughter assists her with several daily activities including getting into the shower, cooking, shopping and cleaning.

A Medical Examination Report (Exhibits 12-13) dated [redacted] was completed by Claimant's treating physician. It was noted that the physician first treated Claimant on 4/4/08 and last examined Claimant on [redacted]. The physician provided diagnoses of bursitis of right hip, bipolar disorder, dizziness and an issue with the left knee. An impression was given that Claimant's condition was improving. It was noted that Claimant can meet household needs.

Medical documents (Exhibits 132-151) from Claimant's treating physician were presented. The documents ranged in date from [redacted]. It was noted that Claimant presented with complaints of right hip pain and left knee pain. It was noted on [redacted]1 that Claimant walked with a cane, but wanted to use a walker. On [redacted] it was noted that Claimant lost 20 pounds and stopped using a walking assistance device though her complained pain was getting worse. The document dated [redacted] noted an

impression of avascular necrosis of the right hip, morbid obesity and probable degenerative disease with sciatica.

Psychological treatment records (Exhibits 175-176) dated [redacted] were presented. It was noted that Claimant was asymptomatic (see Exhibit 175). Claimant reported past symptoms including: sadness, racing thoughts, mood swings, anger control, agitation, low energy and anxiety. It was noted that medications were beneficial and Claimant is doing well. No side effects were reported. An examination revealed Claimant displayed: good grooming, timeliness, orientation x4, normal speech, no psychosis, logical thought, calm behavior and intact judgment. A diagnosis of bipolar disorder and cocaine dependence was given. Claimant's GAF was 50. Continuation of psychotherapy and medications was recommended.

Various psychological treatment documents (Exhibits 157-174) were presented. The documents ranged in date from 9[redacted]. It was repeatedly noted that Claimant was asymptomatic. The diagnoses of bipolar disorder and cocaine dependence remained constant. Claimant's GAF remained constant at 55.

A Medical Progress Note (Exhibit 156) dated [redacted] was presented. The document appeared similar to previous documents but it was noted that Claimant complained of crying spells, racing thoughts, mood swings, anger control problems, low energy and anxiety. An examination revealed Claimant displayed: good grooming, timeliness, orientation x4, normal speech, no psychosis, logical thought, calm behavior and intact judgment. A diagnosis of bipolar disorder and cocaine dependence was given. Claimant's GAF was 55.

A Mental Residual Functional Capacity Assessment (Exhibits 154-155) dated [redacted] was completed by Claimant's treating physician. It was noted that Claimant was markedly limited in: 3 of 3 listed understanding and memory abilities, 5 of 7 listed concentration abilities and 4 of 4 listed adaptation abilities.

Claimant's psychological treatment records (Exhibits 218-221) from 5/2012 and 6/2012 were presented. It was noted that Claimant was currently asymptomatic though she had many symptoms in the past. A GAF of 48 was provided.

A Medical Examination Report (Exhibits 216-217) dated [redacted] was completed by Claimant's treating cardiologist. It was noted that the physician first treated Claimant on [redacted] and last examined Claimant on [redacted]. The physician provided diagnoses of COPD, asthma and mild mitral regurgitiation. An impression was given that Claimant's condition was stable. It was noted that Claimant can meet household needs.

A Medical Examination Report (Exhibits 214-215) dated [redacted] was completed by Claimant's treating psychological physician. It was noted that the physician first treated Claimant on [redacted] and last examined Claimant on [redacted] The physician provided a diagnosis of bipolar disorder. An impression was given that Claimant's condition was deteriorating. It was noted that Claimant can not perform daily activities.

A Medical Examination Report (Exhibits 212-213) dated [redacted] was completed by Claimant's treating physician. It was noted that the physician first treated Claimant in 4/2008 and last examined Claimant on [redacted]. The physician provided diagnoses of COPD, avascular necrosis, degenerative joint disorder and vertigo. It was noted that Claimant had an unspecified restriction in her hip range of motion. An impression was given that Claimant's condition was deteriorating. It was noted that Claimant can not meet household needs of yard work and house work.

Cardiology treatment records (Exhibits 203-207) dated [redacted] were presented. It was noted that Claimant was a daily smoker over the past 26 years. An EKG and physical examination were performed. Claimant's ejection fraction was 50%-55%. It was noted that the EKG was atypical and a diagnosis of atypical chest pain was noted. A left heart catheterization was recommended to rule put ischemic heart disease. It was noted that Claimant complained of edema but no evidence of dep vein thrombosis was found. It was noted that Claimant complained of palpitations but a recent 24 hour Holter monitor was normal. Lifestyle modification was recommended.

A physician letter (Exhibit 202) dated [redacted] was presented. It was noted that Claimant had avascular necrosis in the hips. The physician considered Claimant to be permanently disabled.

Hospital documents (Exhibits 208-211) dated [redacted] were presented. It was noted that Claimant presented with complaints of chest pain. A diagnosis of COPD was noted. Claimant was prescribed various medications. Discharge instructions included avoiding over-tiring physical activity.

Claimant testified that she can barely walk and requires the use of crutches. Claimant testified that she can only stand 2-5 minutes and sit for 15 minutes due to pain. Based on Claimant's testimony, her most serious ailment appears to be hip, back and/or knee pain.

The medical evidence established that Claimant was diagnosed with multiple problems including avascular necrosis, knee pain, bipolar disorder, COPD and heart problems. COPD and avascular necrosis would reasonably restrict Claimant's physical movements to some extent. The bipolar disorder and relatively low GAF are persuasive evidence of further restrictions in Claimant's work abilities. It is found that Claimant established a significant impairment to performing basic work activities.

The evidence established that Claimant received treatment for several years for bipolar disorder and knee pain. It is found that Claimant meets the durational requirement for a severe impairment.

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.

A significant amount of medical records addressed Claimant's treatment for knee and hip pain. The listing for joint dysfunction is covered by Listing 1.04 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.

Claimant testified that she requires two crutches to walk, which is consistent with an inability to ambulate effectively. However, no medical evidence supports the need for crutches. Claimant's physician found Claimant to be disabled and unable to perform daily activities. The physician's last treatment documentation was from 3/2012 and noted that Claimant stopped using a walking assistance device, though Claimant still complained of pain. For an unspecified reason, no treating records for avascular necrosis after 4/2012 were presented. Claimant's knee pain was not referenced after 7/2011. Though Claimant's physician considered Claimant to be disabled, a restriction in range of motion and complaints of pain is insufficient evidence of disability. It is found that Claimant does not meet the listing for joint dysfunction

Substantial medical documentation was presented concerning a bipolar disorder diagnosis. The listing for bipolar disorder is covered by affective disorders and reads:

> **12.04** ***Affective disorders***: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation. The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:

a. Anhedonia or pervasive loss of interest in almost all activities; or
b. Appetite disturbance with change in weight; or
c. Sleep disturbance; or
d. Psychomotor agitation or retardation; or
e. Decreased energy; or
f. Feelings of guilt or worthlessness; or
g. Difficulty concentrating or thinking; or
h. Thoughts of suicide; or
I. Hallucinations, delusions, or paranoid thinking

OR

2. Manic syndrome characterized by at least three of the following:

a. Hyperactivity; or
b. Pressure of speech; or
c. Flight of ideas; or
d. Inflated self-esteem; or
e. Decreased need for sleep; or
f. Easy distractibility; or
g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
h. Hallucinations, delusions or paranoid thinking

OR

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration

OR

C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or

> 3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

Starting with Part B of the listing, it was noted by Claimant's treating psychological physician that Claimant was markedly limited in several work abilities including: memory and understanding, social functioning and adaptability. The marked limitations are suggestive of a highly symptomatic patient with a GAF no higher than 50. Throughout Claimant's treatment, her GAF was 55 and she was considered asymptomatic. The medical records do not support that Claimant is markedly limited in the areas of concentration, social function and adaptability. It was established that Claimant deals with bipolar disorder. It was also established that Claimant receives ongoing psychological treatment and medications for the disorders. Claimant has never been psychologically hospitalized.

Turning to part C, there is insufficient evidence that the stress of employment would cause Claimant to decompensate or that she requires a highly supportive living arrangement. As noted above, there are no past incidents of decompensation episodes (i.e. hospitalizations).

It is found that Claimant does not meet Parts B or C of the listing for affective disorder. Thus, Claimant does not meet the listing for affective disorders.

A listing for chronic pulmonary insufficiency (Listing 3.02) and asthma (Listing 3.03) was considered based on diagnoses of COPS and asthma. These listing were rejected due to a failure to verify respiratory testing or hospitalizations due to COPD.

It is found that Claimant failed to establish meeting a SSA listing. Accordingly, the 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 testified that she last worked full-time in 1998 as a drug store clerk. It cannot be known for certain whether the employment was within the last 15 years- that would

depend on the month that Claimant last worked. For purposes of this decision, it will be presumed that Claimant's last date of employment was within the last 15 years.

Claimant's clerk duties included stocking shelves and working the cash registers. Claimant stated that her employment required her to stand for most of her shift. Claimant testified that she is unable to perform the standing necessary to perform her past employment. Claimant's testimony is consistent with a diagnosis of avascular necrosis. It is found that Claimant is unable to perform her past employment as a clerk. Accordingly, the 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, only an analysis of sedentary employment will be undertaken. All of Claimant's reported medical problems will be considered in the analysis.

Claimant complained of left hearing loss. There is no medical evidence to verify the loss. There is also no evidence to suggest that the hearing loss, if verified, would significantly restrict Claimant's performance of sedentary employment.

It was established that Claimant deals with bipolar disorder. Claimant receives psychological treatment and medication for the disorder. Claimant was consistently asymptomatic during her treatment. There is no evidence of hospitalization. In 4/2012, Claimant was considered markedly limited in several areas of function and documentation did not indicate that Claimant was asymptomatic. It is possible that Claimant's psychological function regressed; however, due to the lack of treatment records following 4/2012, such a conclusion is based only on speculation. Claimant's GAF of 55 is consistent with moderate functioning difficulties. The presented evidence is consistent with a conclusion that Claimant is capable of completing simple tasks.

Claimant complained of vertigo. The complaint was documented, though very few medical records addressed the complaint in detail. Accepting Claimant's complaint would reasonably restrict Claimant from performing employment involving heavy machinery and heights.

It was verified that Claimant suffered from COPD (yet continued to smoke). There was a general absence of evidence concerning the degree to which Claimant is affected by COPD. It is known that Claimant's physician restricted Claimant from performing housework and yard work. This restriction would not preclude Claimant's performance of sedentary employment.

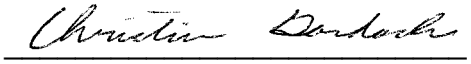
It was established that Claimant was treated for heart problems. Claimant's ejection fraction level (55%) and normal Holter Monitor results both are consistent with a person capable of performing sedentary employment.

It was established that Claimant has joint dysfunction in her hips. Claimant's multiple physicians found Claimant to be disabled but the medical records failed to specify any restrictions. For sedentary employment, sitting six hours a day, two hours of standing or walking and lifting up to 10 pounds would be expected. The mere diagnosis and treatment for avascular necrosis does not necessarily prevent Claimant from performing the required standing, walking and listing required of sedentary employment. Based on the presented evidence, it is found that Claimant can perform sedentary employment.

Based on Claimant's exertional work level (sedentary), age (younger individual aged 45-49), education (literate and able to communicate in English), employment history (unskilled), Medical-Vocational Rule 201.18 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 8/25/11 based on a determination that Claimant is not disabled. The actions taken by DHS are AFFIRMED.



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

Date Signed: March 1, 2013

Date Mailed: March 1, 2013

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]