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

IN THE MATTER OF:

[redacted]

Reg. No. 201213833
Issue No. 2009
Case No. [redacted]
Hearing Date: February 13, 2012
Macomb County 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 upon the claimant's request for a hearing. After due notice, a telephone hearing was held on February 13, 2012 from Detroit, Michigan. The claimant appeared and testified; [redacted] testified and 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 6/13/11, Claimant applied for MA benefits.

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

3. On 7/27/11, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 35-34).

4. On 8/9/11, DHS denied Claimant's application for MA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On 10/13/11, Claimant requested a hearing disputing the denial of MA benefits.

6. On 1/20/12, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual (see Exhibits 37-36), in part, by application of Medical-Vocational Rule 202.20.

7. As of the date of the administrative hearing, Claimant was a [redacted] year old male [redacted] with a height of 6'2'' and weight of 168 pounds.

8. Claimant smokes approximately 6-7 cigarettes per day and has no known relevant history of alcohol or drug abuse.

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

10. Claimant currently has no health insurance coverage, and has not had medical coverage since approximately 1/2008.

11. Claimant alleged that he is disabled based on impairments and issues including arthritis in his knees, lower back pain, Schamberg's disease, depression, paranoia and anxiety.

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).

The controlling DHS regulations are those that were in effect as of 6/2011, the month of the application which Claimant contends was wrongly denied. Current DHS manuals may be found online at the following URL: http://www.mfia.state.mi.us/olmweb/ex/html/.

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 current 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 the exhibits were numbered by DHS from back to front; thus, multiple page exhibits are cited from high number to low number.

A Social Summary (Exhibits 17-16) dated [redacted] was presented. A Social Summary is a standard DHS form to be completed by DHS specialists which notes alleged impairments and various other items of information. The presented form was unsigned. Impairments of depression, vasculitis and arthritis were provided. It was noted that Claimant reported paranoia concerning mail and the telephone due to a fear of receiving bad news. Claimant reported a lack of motivation and paranoia. It was also noted that Claimant reported being able to stand for an extended period of time.

A Medical Social Questionnaire (Exhibits 15-13) dated [redacted] was presented. The form is intended to be completed by clients for general information about their claimed impairments, treating physicians, previous hospitalizations, prescriptions, medical test history, education and work history. Claimant noted impairments of arthritis, vasculitis, back pain, anxiety, paranoia and depression. Claimant noted that he is unable to perform certain tasks due to his frame of mind; Claimant did not specify which tasks he could not perform. Claimant's only previous listed hospitalization was from 4/2009 due to depression.

A Medical Examination Report (Exhibits 12-11) dated [redacted] was completed by Claimant's treating physician. It was noted that the physician first treated Claimant in 2004 and last examined patient on 6/24/11. The following diagnoses were provided: degenerative disc disease (DDD), lumbago, back neuropathy/radiculopathy, major depression, paranoid thought disorder, Schamberg's disease and opiate dependence. It was noted that Claimant can meet his household needs. It was noted that Claimant's condition was deteriorating. It was noted that Claimant took the following medications: Oxycontin, Norco and Valium.

Claimant completed an Activities of Daily Living (Exhibits 5-1) dated [redacted]; this is a questionnaire designed for clients to provide information about their abilities to perform various day-to-day activities. Claimant noted having trouble sleeping at night due to a broken sleep. Claimant noted he takes one hour naps to get his mind off worries. Claimant noted he sometimes fixes his own meals. Claimant noted he daily performs work around the house such as laundry and lawn care. Claimant noted that he does this work in increments because his body does not allow him to work straight through. Claimant noted that he shops and helps his mom shop. Claimant noted he spends 1.5-2 hours shopping with sit down breaks. Claimant noted that he enjoys music. Claimant noted that he does not care about having enjoyment because he feels he does not deserve it. Claimant noted that he sees family members (other than his mother with whom he lives) once per week.

A Psychiatric/Psychological Examination Report (Exhibits 10-8) dated [redacted] was presented. The examination was from Claimant's treating psychiatrist. The examiner provided a diagnosis based on Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM4). Axis I represents the acute symptoms that need treatment. Axis II is to note personality disorders and developmental disorders. Axis III is intended to note medical or neurological conditions that may influence a psychiatric problem. Axis IV identifies recent psychosocial stressors such as a death of a loved one, divorce or losing a job. Axis V identifies the patient's level of function on a scale of 0-100 in what is called a Global Assessment of Functioning (GAF) Scale.

Axis I noted major depression, OCD (obsessive compulsive disorder) and GAD (Generalized Anxiety Disorder)/panic. Axis II noted paranoid traits. Axis III was deferred. Axis IV was "moderate". A GAF of 50 was provided. A GAF within the range of 41-50 is representative of a person with "serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g. no friends, unable to keep a job)."

A Mental Residual Functional Capacity Assessment (Exhibits 7-6) dated [redacted] was completed by Claimant's treating psychiatrist. This form lists 20 different work-related activities among four areas: understanding and memory, sustained concentration and persistence, social interaction and adaptation. A therapist or physician rates the patient's ability to perform each of the 20 abilities as either "not significantly limited", "moderately limited", "markedly limited" or "no evidence of limitation".

Claimant was markedly limited in 11 of 20 abilities including: understanding and remembering detailed instructions, carrying out detailed instructions, maintaining attention and concentration for extended periods, performing activities within a schedule while maintaining regular attendance and punctuality, completing a normal workday without interruption from psychological symptoms, interacting with the public, accepting

instructions and responding to criticism, responding to changes in the work setting, traveling to unfamiliar places and setting realistic goals. Claimant was moderately limited in 7 listed areas, leaving Claimant not significantly limited in only two listed abilities, the ability to carry out simple instructions and maintaining socially appropriate behavior while adhering to basic standards of cleanliness and neatness.

A DHS requested physical examination was performed on Claimant on [redacted]; the corresponding report (Exhibits 32-24) was presented. It was noted that Claimant reported pain in his lower back and feet. Claimant reported that lifting items over 25 pounds and activities such as shoveling snow aggravates Claimant's pain. It was noted that Claimant lives in a basement and is required to go up and down stairs at least 15 times per day.

Multiple views of Claimant's lumbosacral spine were taken. A 10% disc space narrowing at L5-S1 was noted. There was no evidence of fracture or dislocation.

Frontal and lateral views of the bilateral knees were taken. An impression was given that there were mild degenerative changes involving the medial femoral condyle. No fracture or dislocation was detected.

Claimant's straight leg raising test was negative. No spasm or tenderness was noted. Claimant was noted as having a stable gait. Claimant was able to walk on toes and heels. It was noted that Claimant had no difficulties in getting on and off the examination table. Claimant had a full range of motion in his back. Claimant also had a full range of motion in his knees and legs. Discoloration in Claimant's ankles with "superficial varicosities" was noted. It was noted that Claimant's legs lacked swelling, ulcers or atrophy. The examiner provided an overall impression of lower back pain, arthralgia of the knees and ankles and vasculitis.

A DHS requested mental status examination was performed on Claimant on [redacted]; the corresponding report (Exhibits 22-18) was presented. It was noted that Claimant reported struggling with depression for his life but became increasingly paranoid and anxious in the prior 3-4 years. It was noted that Claimant reported obstacles in his life including an employment lay-off, marital separation and the death of his father two weeks prior to the examination.

The examiner provided a DSM-IV diagnosis. Axis I noted major depressive disorder by history, generalized anxiety disorder and mood disorder. Axis II noted personality disorder with dependent features. Axis III noted vasculitis, arthritis, and chronic lower back pain. Axis IV noted restricted mobility, chronic pain, recent death of father, situational stressors. Claimant's GAF was 50.

The examiner provided a medical source statement concerning Claimant's psychological condition. It was noted that Claimant had symptoms of anxiety disorder with mild paranoid features and depression. It was noted that Claimant had social anxiety but did not show evidence of psychotic thoughts. It was noted that Claimant was independent with daily activities and was comfortably able to leave his home. The examiner indicated that Claimant could do work related activities at a sustained pace.

Claimant testified that he is capable of walking a long city block before needing a break. Claimant testified that he is capable of sitting for an hour before needing to get up. Claimant stated that his gripping and grasping ability were fine but that he has some lifting restrictions. Claimant does not require a walking aid for ambulation assistance. Claimant noted that he had difficulty in squatting because of difficulty bending his left leg. Claimant stated he can bend from the waist, but it is accompanied by a non-severe pain. Claimant is restricted in some exertional activities but it is not believed that he is significantly restricted in his overall performance of basic work activities.

The most direct evidence of Claimant's ability to perform basic work activities subject to psychological impairments was the MRFCA. As stated above, Claimant was markedly limited in 11 of 20 abilities. Most notably, Claimant was markedly limited in performing activities within a schedule while maintaining regular attendance and punctuality, completing a normal workday without interruption from psychological symptoms. This ability would affect every type of SGA. The limitations were generally supported by Claimant's testimony and other medical documentation. It is found that Claimant has psychological impairment which significantly affects his ability to perform basic work activities.

Medical records support finding that Claimant suffered psychological impairments for much of his life, but the symptoms worsened in the past few years. It is found that Claimant's impairments have lasted for more than 12 months. Accordingly, it is found that Claimant suffers a severe impairment and the analysis may proceed to step three.

Claimant's primary impairment involved anxiety and paranoia. Mental disorders are covered by Listing 12.00. Anxiety disorders are covered by SSA Listing 12.06 which reads:

> **12.06** ***Anxiety-related disorders***: In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders. 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 both A and C are satisfied.

A. Medically documented findings of at least one of the following:
1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:
a. Motor tension; or
b. Autonomic hyperactivity; or
c. Apprehensive expectation; or
d. Vigilance and scanning; or
2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or
3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or
4. Recurrent obsessions or compulsions which are a source of marked distress; or
5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;
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. Resulting in complete inability to function independently outside the area of one's home.

Starting with Part B of the listing, Claimant testified that he had some difficulties in performing daily activities. Claimant stated he was able to bathe and groom himself. Claimant cited physical problems in restricting his ability to clean, cook or do laundry. Claimant is also capable of driving. Based on the presented evidence, Claimant is not markedly restricted in performing daily activities.

SSA provides guidance on what is meant by “social functioning.” SSA regulations state:

> Social functioning includes the ability to get along with others, such as family members, friends, neighbors, grocery clerks, landlords, or bus drivers. You may demonstrate impaired social functioning by, for example, a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, or social isolation. You may exhibit strength in social functioning by such things as your ability to initiate social contacts with others, communicate clearly with others, or interact and actively participate in group activities. We also need to consider cooperative behaviors, consideration for others, awareness of others'

> feelings, and social maturity. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority (e.g., supervisors), or cooperative behaviors involving coworkers.

The evidence whether Claimant was restricted in social interactions was mixed. In the submitted psychological examination report, Claimant was considered friendly and cooperative (see Exhibit 21). This was consistent with Claimant's behavior during the hearing. Claimant's treating physician noted that Claimant was markedly restricted in interacting appropriately with the public and the ability to accept instructions and respond appropriately to criticism. The treating physician found Claimant moderately limited in asking simple question or requesting assistance and the ability to get along with coworkers. Claimant was found not significantly limited in maintaining socially acceptable behavior while maintaining basic standard of cleanliness and neatness. Claimant has no known history of altercations or other anti-social behavior. Though some social restrictions were established, it is found that Claimant is not markedly limited in his general social functioning.

There is a lack of evidence to find that Claimant suffers repeated episodes of decompensation. SSA noted that an example of decompensation would include psychiatric hospitalization. SSA also noted that it can be demonstrated by an exacerbation in symptoms or signs that would ordinarily require increased treatment. Claimant was voluntarily hospitalized in 4/2009 due to depression but has no record of any other hospitalizations. Claimant suffers from a chronic anxiety and testified that he suffers multiple panic attacks per week. Claimant described the attacks as uncontrollable coughing, shaking and gagging for periods of 5-20 minutes in duration. The attacks were not verified in any of Claimant's medical history but Claimant's testimony concerning the attacks was credible. However, the lack of evidence in an exacerbation of symptoms or an increased need for treatment justifies a finding that Claimant failed to meet this part of the above listing.

It is found that Claimant failed to establish suffering repeated episodes of decompensation. As Claimant failed to establish 3 of the 4 requirements for Part B, there is no need to consider whether Claimant is markedly limited in concentration, persistence or pace.

Looking at Part C of the listing for anxiety disorders, there is evidence to establish that Claimant is unable to function independently outside of the home. The testimony tended to establish that Claimant receives a lot of support from his mother. Claimant's mother was described as a very supportive and encouraging figure for Claimant. Claimant testified that she positively encouraged him to be more active and to get out of the house. Though Claimant shows some signs of dependence it cannot be stated that he has a complete inability to function independently outside of his home. Claimant's behaviors tend to be encouraging and supportive of finding that Claimant is quite

independent. Claimant can drive and shop independently. Claimant is slowly increasing his time spent outside of the house. It is found that Claimant's impairments have not resulted in a complete inability to function outside of his home. Based on other findings associate with the above listing, it is found that Claimant's impairments do not meet the SSA listing for anxiety disorders.

A listing for affective disorders (Listing 12.04) (i.e. depression) was also considered. Part B of the listing mirrors the listing for anxiety disorders and was rejected for identical reasons as cited in the anxiety disorder analysis. Part C of the listing notes an additional way to satisfy the listing, "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." The DHS assigned mental examiner noted that Claimant "should be able to do work related activities at a sustained pace" (see Exhibit 20). The examiner also noted that Claimant improved to a point of performing daily activities independently. Based on the presented evidence, Claimant's impairments do not meet the listing for affective disorders.

A listing for spinal disorders (Listing 1.04) was considered based on Claimant's back pain complaints. This listing was rejected due to a failure to establish motor loss or a positive straight leg raising test (Part A), spinal arachnoiditis (Part B) or an inability to ambulate effectively (Part C).

A listing for joint dysfunction (Listing 1.02) was considered based on complaints of knee pain and Schamberg's disease. This listing was rejected due to a failure to establish an inability to ambulate effectively (Part A) or an inability to perform fine and gross movements effectively (Part B).

It is found that Claimant failed to establish meeting an SSA listed impairment. 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 provided a list of his employment history (Exhibit 13). Claimant noted he has worked full-time for every month from 5/1990-1/2008. Claimant listed three different employers, each involving similar machine operator duties. Claimant testified that he was required to lift up to 70 pounds of weight in his employment duties. Claimant also testified that each job required substantial crouching, bending and squatting. Though no the record lacked explicit physical restrictions from a physician, there was evidence of back and knee pain and diagnoses of DDD, radiculopathy and mild degenerative changes in the lumbar spine. These diagnoses are sufficient to conclude that Claimant could not be reasonably expected to lift 70 pound items.

Based on the presented evidence, it is found that Claimant is incapable of performing past relevant employment. Accordingly, it is found that Claimant cannot perform his past relevant employment and the analysis moves to step five.

In the fifth and last 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).

Looking at exertional restrictions, Claimant established some. The treating physician diagnoses of DDD and radiculopathy supports some finding of restrictions. The diagnoses tended to be supported by the DHS assigned examiner who found LPB, arthralgia in the knees and vasculitis. Claimant testified to generally credible self-imposed restrictions such as not being able to lift heavier weights and being limited to walking a lengthy city block. Claimant conceded that he was less limited in sitting by

testifying that he could sit for an hour without having to stand. Claimant had a steady gait and required no walking assisted devices. Based on the presented evidence, Claimant is found capable of at least sedentary employment based on exertional restrictions.

Looking at Claimant's non-exertional restrictions, Claimant again established some. Claimant was markedly limited in several areas on the MRFCA, most notably in areas of adaptations and concentration. The DHS assigned examiner called Claimant's paranoia "mild". Claimant was free of psychotic thoughts, suicidal ideation and capable of performing daily activities independently. Claimant established taking several prescriptions (Valium, Paxil, Klonopin, Neurontinin and Zyprexa to treat his psychological symptoms. Claimant's chronic panic attacks and general anxiety also factor into the analysis.

Claimant's complaints of pain were also relevant. Despite Claimant's complaints, he has done well to overcome his pain. Claimant lives in a basement and goes up and down the stairs an estimated 15 times per day. Claimant established that he was prescribed medication (Norco and Oxycontin) for his pain. This evidence tends to support a finding that Claimant is not significantly restricted due to pain, at least as long as he has pain management medication.

Based on the combination of Claimant's exertional and non-exertional restrictions, it is found that Claimant would be so limited in employment opportunities that he is effectively disabled. Accordingly, it is found that DHS improperly denied Claimant's MA benefit application on the basis that Claimant was not a disabled individual.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that DHS improperly denied Claimant's application for MA benefits. It is ordered that DHS:

(1) reinstate Claimant's MA benefit application dated 6/13/11;
(2) upon reinstatement, evaluate Claimant's eligibility for MA benefits on the basis that Claimant is a disabled individual;
(3) supplement Claimant for any benefits not received as a result of the improper denial; and
(4) if Claimant is found eligible for future MA benefits, to schedule a review of benefits in one year from the date of this administrative decision.

The actions taken by DHS are REVERSED.

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

Date Signed: March 6, 2012

Date Mailed: March 6, 2012

NOTICE: Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative Hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the mailing of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt date of the rehearing decision.

CG/hw

cc: [redacted]