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

IN THE MATTER OF:

[redacted]

Reg. No.: 2012-54221
Issue No.: 2009; 4031
Case No.: [redacted]
Hearing Date: October 3, 2012
County: Clinton

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

HEARING DECISION

This matter is before the undersigned Administrative Law Judge upon Claimant's request for a hearing made pursuant to Michigan Compiled Laws 400.9 and 400.37, which govern the administrative hearing and appeal process. After due notice, a telephone hearing was commenced on October 3, 2012, from Lansing, Michigan. Claimant personally appeared and testified. Participants on behalf of the Department of Human Services (Department) included Eligibility Specialist [redacted].

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional medical evidence. The new evidence was forwarded to the State Hearing Review Team ("SHRT") for consideration. On January 25, 2013, the SHRT found Claimant was not disabled. This matter is now before the undersigned for a final decision.

ISSUE

Whether the Department of Human Services (the department) properly denied Claimant's application for Medical Assistance (MA-P), Retro-MA and State Disability Assistance (SDA) benefit programs?

FINDINGS OF FACT

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

(1) On March 5, 2012, Claimant filed an application for MA/Retro-MA and SDA benefits alleging disability.

(2) On May 8, 2012, the Medical Review Team (MRT) denied Claimant's application for MA-P indicating that she was capable of other work

pursuant to 20 CFR 416.920(f). SDA was denied due to lack of duration. (Dept Ex. A, pp 19-20).

(3) On May 18, 2012, the department caseworker sent Claimant notice that her application was denied.

(4) On May 23, 2012, Claimant filed a request for a hearing to contest the department's negative action.

(5) On June 20, 2012, the State Hearing Review Team (SHRT) found Claimant was not disabled and retained the capacity to perform a wide range of sedentary work. SDA was denied because the nature and severity of Claimant's impairments would not preclude work activity at the sedentary level for 90 days. (Dept Ex. B).

(6) Claimant has a history of osteoarthritis, rheumatoid arthritis, migraines, chronic anemia, severe pica, hypertension, fibromyalgia, chronic pain syndrome, hyperthyroidism, anxiety, borderline personality, major depression, and suicidal ideation.

(7) At the time of the hearing, Claimant was 41 years old with a [redacted] birth date; was 5'0" in height and weighed 185 pounds.

(8) Claimant has an Associate of Arts Degree. Her work history includes processing payroll and automatic data processing.

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

CONCLUSIONS OF LAW

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. The Department of Human Services (DHS or department) administers the SDA program pursuant to MCL 400.10, *et seq.*, and Mich Admin Code, Rules 400.3151-400.3180. Department policies are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

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

> Sec. 604 (1). The department shall operate a state disability assistance program. Except as provided in subsection (3), persons eligible for this program shall include needy citizens

> of the United States or aliens exempt from the Supplemental Security Income citizenship requirement who are at least 18 years of age or emancipated minors meeting one or more of the following requirements:
>
> (b) A person with a physical or mental impairment which meets federal SSI disability standards, except that the minimum duration of the disability shall be 90 days. Substance abuse alone is not defined as a basis for eligibility.

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

The Medical Assistance (MA) program is established by the Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (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).

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

When determining disability, the federal regulations require several factors to be considered, including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitations in light of the objective medical evidence presented. 20 CFR 416.929(c)(94).

In determining whether you are disabled, we will consider all of your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with objective medical evidence, and other evidence. 20 CFR 416.929(a). Pain or other symptoms may cause a limitation of function beyond that which can be determined on the basis of the anatomical, physiological or psychological abnormalities considered alone. 20 CFR 416.945(e).

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

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

As outlined above, the first step looks at the individual's current work activity. In the record presented, Claimant is not involved in substantial gainful activity and testified that she has not worked since February, 2010 or 2011. Therefore, she is not disqualified from receiving disability benefits under Step 1.

The severity of the individual's alleged impairment(s) is considered under Step 2. The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b). An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of

age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b). Examples include:

> 1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;
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> 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
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> *6.* Dealing with changes in a routine work setting. *Id.*

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

In the present case, Claimant alleges disability due to osteoarthritis, rheumatoid arthritis, migraines, chronic anemia, severe pica, hypertension, fibromyalgia, chronic pain syndrome, hyperthyroidism, anxiety, borderline personality, major depression, and suicidal ideation.

On March 16, 2011, Claimant saw an orthopedist to evaluate her right knee. She reported sustaining injury to her right knee when she slipped on a parking ramp and hit her knee and head. She has pain with flexion and her range of motion was limited secondary to pain. Diagnosis was a torn lateral meniscus of the right knee and osteoarthritis of the right knee. Arthroscopic surgery of her right knee was recommended and she wished to proceed.

On March 23, 2011, Claimant went to her appointment at the cancer center for her Venofer treatment. Claimant underwent gastric surgery and has had trouble ever since absorbing iron. She recently had a colonoscopy and was told that her "duodenum was missing." She does have intermittent severe iron deficiency anemia with ferritins as low as 4. Her most recent low ferritin was 1/24/11 when it was 8. She does get intermittent

Venofer and her most recent ferritin level was 99 on 3/1/11. Due to her iron deficiency anemia, Claimant was placed on a regular schedule of Venofer to maintain her ferritin level within the normal range and attempt to increase her hemoglobin to the normal range as well.

On April 15, 2011, Claimant underwent arthroscopic surgery on her right knee for a torn lateral meniscus and chondromalacia. There was grade 2 chondromalacia of the patellofemoral joint, most severely affected with the median ridge of the patella. Chondroplasty of the patellofemoral articulation was performed to stabilize the articular cartilage. There was also grade 2 chondromalacia of the medial femoral condyle. Chondroplasty was performed of the medial femoral condyle to restore stability to the articular cartilage. The lateral compartment was entered and the shredded tear of the anterior horn of the lateral meniscus was present. The meniscus was repaired and stability was confirmed of the lateral meniscus.

On May 31, 2011, Claimant entered the emergency department complaining of hearing loss. An MRI showed no evidence of either a cochlear or a vestibular schwannoma.

On July 9, 2011, Claimant went to the emergency department complaining of urinary retention. A non contrast CT of her abdomen and pelvis revealed a negative unenhanced CT exam of the abdomen and pelvis. There was a filter device within the inferior vena cava. She was diagnosed with low back pain and prescribed Norco.

On July 22, 2011, Claimant's multiplanar multisequence MR imaging lumbar spine revealed minor facet arthropathy at L3-L4, L4-L5 and L5-S1. There was no significant central canal stenosis or neural foraminal compromise at any level. There was a degenerative cyst associated with the right superior L4 facet.

On August 1, 2011, Claimant followed up with her rheumatologist to review the MRI's from 7/22/11. The MRI revealed some mild degenerative disc disease at L3-L4, L4-L5, and L5-S1. No significant central stenosis or spinal nerve root impingement was noted. There were some facet cysts noted consistent with degenerative facet disease. She had significant tenderness throughout the lumbosacral spine. Range of motion was also painful in the lower extremities. She appeared to have lost weight. She had tenderness throughout the right knee, but the straight leg raise was only positive for low back pain. Diagnoses: Chronic low back pain with lumbar spondylosis and facet syndrome; chronic right peroneal neuritis; status-post right hip and knee contusion stable; history of bilateral sacroilitis and chronic myofascial pain; history of chronic right elbow lateral epicondylitis; history of chronic multi-extreme osteoarthritis; history of "iron malabsorptioin syndrome," being followed by hematology and internal medicine, and a history of depression, anxiety, and opiate dependence disorder.

On August 10, 2011, Claimant was evaluated by physical therapy for a lumbar spine intake. Onset was 16-17 years ago and she stated that the symptoms had worsened since her fall downstairs on 7/17/11. Her current treatment included a TENS unit. She stated she is having difficulty with activities of daily living, sleep, walking, sitting and

driving. Past evaluation included an MRI prior to her fall and pain medication evaluation.

On August 16, 2011, the ultrasound examination of Claimant's liver and thyroid were both normal.

On August 17, 2011, Claimant followed up with her orthopedist following her arthroscopic surgery. She stated she had had 2 falls since the surgery. One on 7/14/11, when she said she lost her balance and her leg gave way. The second fall occurred on 7/17/11 when she fell down some stairs. An MRI was performed which suggested a new tear of the medial meniscus and some tearing of the anterior horn of the lateral meniscus. There also appeared to be a sprain of her anterior cruciate ligament. The orthopedist suggested repeat arthroscopic surgery.

On October 4, 2011, Claimant was prepped for surgery of her right knee due to a partial tear anterior cruciate ligament, and a possible torn lateral meniscus. During the surgery, a synovial cyst was found and removed. There was no evidence of a tear of the anterior cruciate ligament. There was evidence of a previous partial lateral meniscectomy present and extensive degenerative disease.

On October 17, 2011, Claimant followed up with her rheumatologist complaining of significant back pain that was affecting her functionally. She was having fatigue throughout the day. She was diagnosed with chronic pain syndrome, chronic low back pain, sacroilitis, possible facet syndrome, history of right knee status-post arthroscopic knee surgery, meniscal repair, chronic/depression/anxiety, opiate dependence syndrome and a history of questionable malabsorption syndrome. She also saw her orthopedist who found she was actually doing better. She had some crepitation, but overall was making good progress. Her knee was minimally swollen. The puncture site looked good. She said she did have some bleeding for a few days, but overall had made good progress. No evidence of DVT. She had full range of motion of her knee and was instructed to increase her activities to tolerance.

On October 18, 2011, Claimant went to the department of surgery for her preoperative history and physical, prior to undergoing abdominal panniculectomy. She complained of anemia, loss of appetite, weight loss, and fatigue. Her physical examination showed she was well developed, well nourished, obese, and in no acute distress. She was alert and cooperative, normal mood and affect, normal attention span and concentration. Based on the exam, preoperative medical management included monitoring hypertension, chronic pain, chronic anemia, and difficulty with anesthesia including waking up early.

On October 25, 2011, Claimant was admitted to the hospital for abdominal panniculectomy. She had chronic pain secondary to fibromyalgia, compression fractures, and sacroiliac joint fracture, for which she was taking the fentanyl patch, Nucynta, and Tramadol with reasonable control. She was having 7-8/10 sharp abdominal pain from the surgery, requiring frequent IV narcotic medications. She was

discharged on October 27, 2011, status post-abdominal panniculectomy, chronic pain syndrome, status post-ventral herniorrhaphy, on long-term narcotics, low back pain/osteoarthritis/fibromyalgia, depression/anxiety, and abdominal pain secondary to status post-abdominal panniculectomy.

On November 1, 2011, Claimant followed up with her surgeon, one week status post-abdominal panniculectomy. She was out of oxycodone, tearful and emotional. She was healing well with no evidence of infection or wound breakdown.

On November 5, 2011, Claimant presented to the hospital emergency room complaining of redness and erythema in her midline excision. She was status post panniculectomy on 10/28/11. She was admitted to the hospital and a CAT-scan was performed that showed a fluid collection versus hematoma at the umbilical site. There was some erythema and induration around the umbilical site, approximately 5 cm in diameter. She was admitted for IV antibiotic therapy and further evaluation of the wound. She improved over the next 48 hours. She was discharged on November 9, 2011, with a diagnosis of postoperative cellulitis.

On November 11, 2011, Claimant went to the hospital because of right leg pain and swelling. A physical examination revealed a mild edema and range of motion of the right knee appeared to be fair. She also complained of double vision, even if she closed one eye, she was still seeing double. Claimant saw neurology who recommended a lumbar puncture. The lumbar puncture was performed, which revealed unremarkable findings. Claimant has chronic anemia for which she sees a hematologist and receives monthly IV iron injections. The etiology of the anemia is unclear. She does have a history of DVT in the past and has had IVC filter placement, repeated venous Doppler of this hospital stay revealed no evidence of DVT. CT scan of her right knee showed no evidence of an acute fracture. MRI of the brain was performed which revealed multiple T2 signal hyperdensities within cerebral bilaterally. Findings could be secondary to the chronic microvascular changes, or her hypertension. However, other etiology could also be possible, such as a post traumatic event, or possible demyelinating conditions. Follow-up in 6 months was recommended if clinically warranted. There were no other acute changes. Per neurology, Claimant did not need any further work up. She was given some Lasix and was feeling better regarding the swelling. She was able to ambulate without difficulty. Due to her chronic pain condition, the hospital pain service was also consulted and she was given additional Oxycodone. Claimant had had a recent panniculectomy. She had a wound infection. Surgery saw her and recommended continue antibiotic and wound care. There was no evidence of abscesses. The treating physician believed Claimant's pain was likely due to an exacerbation of chronic pain syndrome, and fibromyalgia. Her Duragesic patch was increased from 75 to 100 mcg. Claimant was discharged on November 17, 2011, with a diagnosis of exacerbation of chronic pain syndrome and post lumbar puncture headache.

On November 25, 2011, Claimant was brought to the hospital by the visiting nurse for altered mental status. Claimant stated she had been taking her pain medications every

4 hours instead of every 6 hours, and took too many pills. She stated that she took too long to open the door for the nurse and the nurse called 911. She was then brought into the emergency department where she was mildly confused. She was found to have a potassium level of 5.9. The initial CAT scan was negative. There was mild elevation of creatinine for which she was rehydrated and creatinine came back to normal. For the potassium, some of the medications that were causing high potassium were stopped. With regards to an EKG that was done for the high potassium, there were some changes noted, namely a left bundle branch block for which cardiology was consulted and who then ordered 3 sets of cardiac enzymes which were all negative and it was dismissed that the changes were most likely due to metabolic problems, namely the hyperkalemia. She was discharged on November 27, 2011, in stable condition with a diagnoses of acute encephalopathy, resolved, secondary to pain medication; medication induced tremors and focal deficits, resolved; prerenal azotemia, secondary to dehydration, resolved; hyperkalemia, secondary to prerenal azotemia, resolved; new left bundle branch block on EKG, stable; nausea and vomiting secondary to narcotics, resolved. Chest x-ray on 11/25/11 revealed an unremarkable cardiomediastinal silhouette with no infiltrates. The CAT scan of the head and brain on 11/26/11 showed no evidence of mass or hemorrhage.

On January 17, 2012, Claimant followed up with her surgeon, 3 months status post panniculectomy. Her balance and core strength had improved. Her sacroiliac joint and knee pain had also both improved. The abdominal contour was actually improved by strengthening the rectus muscles.

On January 20, 2012, Claimant was seen in the emergency room for chest pain and a migraine. Her ECG was normal. X-rays showed no evidence of an acute cardiopulmonary process. She was diagnosed with chest wall pain and migraines. She was discharged with prescriptions for Toradol and Xanax.

On March 4, 2012, Claimant went to the emergency department with multiple medical problems. She was nauseated and tired. She was diagnosed with malaise and weakness.

On March 30, 2012, Claimant saw her primary care physician. While speaking to him she stated she just wanted to end it all. He diagnosed her with suicidal ideation, borderline personality disorder, and major depression. Claimant was then transported to the emergency department by ambulance with suicidal ideations. She was fighting with her family. She was anxious, depressed, and sad. She was transferred to community mental health.

On April 6, 2012, Claimant underwent a medical examination by her treating physician. Claimant was diagnosed with post traumatic stress disorder, major depression, migraines, and chronic pain. She had a flat affect and lacked eye contact. Her physician indicated her condition was deteriorating.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, Claimant has presented some limited medical evidence establishing that she does have some physical limitations on her ability to perform basic work activities. The medical evidence has established that Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. Claimant has alleged physical and mental disabling impairments due to osteoarthritis, rheumatoid arthritis, migraines, chronic anemia, severe pica, hypertension, fibromyalgia, chronic pain syndrome, hyperthyroidism, anxiety, borderline personality, major depression, and suicidal ideation.

Listing 1.00 (musculoskeletal system), Listing 2.00 (special senses and speech), Listing 3.00 (respiratory system), Listing 4.00 (cardiovascular system), Listing 5.00 (digestive system), Listing 7.00 (hematological disorders), Listing 8.00 (skin disorders), Listing 9.00 (endocrine disorders), Listing 11.00 (neurological), Listing 12.00 (mental disorders) and Listing 14.00 (immune system disorders), were considered in light of the objective evidence. Based on the foregoing, it is found that Claimant's impairment(s) does not meet the intent and severity requirement of a listed impairment; therefore, Claimant cannot be found disabled at Step 3. Accordingly, Claimant's eligibility is considered under Step 4. 20 CFR 416.905(a).

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

To determine the physical demands (exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967. Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary

criteria are met. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b). Even though weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.* Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.* Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.* Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

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

Claimant's prior work history consists of work as processing payroll clerk and automatic data processing. In light of Claimant's testimony, and in consideration of the Occupational Code, Claimant's prior work is classified as semi-skilled, light work.

Claimant testified that she is able to walk very short distances and can lift/carry approximately 4 to 5 pounds. The objective medical evidence notes no limitations. However, her treating physician did indicate Claimant's condition was deteriorating. If the impairment or combination of impairments does not limit an individual's physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. 20 CFR 416.920. In consideration of Claimant's testimony, medical records, and no current limitations, Claimant cannot be found able to return to past relevant work. Accordingly, Step 5 of the sequential analysis is required.

In Step 5, an assessment of the individual's residual functional capacity and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v). At the time of hearing, Claimant was 41 years old and was, thus, considered to be a younger individual for MA-P purposes. Claimant has a Associate's degree. Disability is found if an individual is unable to adjust to other work. *Id.* At this point in the analysis, the burden shifts from Claimant to the Department to present proof that 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 reveals that Claimant suffers from osteoarthritis, rheumatoid arthritis, migraines, chronic anemia, severe pica, hypertension, fibromyalgia, chronic pain syndrome, hyperthyroidism, anxiety, borderline personality, major depression, and suicidal ideation. The objective medical evidence notes no limitations. Furthermore, the MRI's and ultrasounds of her brain, chest, pelvis, and abdomen were for the most part, normal. While Claimant does have some health issues, treatment was always centered on the administration of pain medications, and her reliance upon them. Furthermore, while Claimant testified to a list of impairments, the medical evidence did not support a diagnosis of stroke, rheumatoid arthritis, or macular degeneration. In light of the foregoing, it is found that Claimant maintains the residual functional capacity for work activities on a regular and continuing basis which includes the ability to meet the physical and mental demands required to perform at least sedentary work as defined in 20 CFR 416.967(a). After review of the entire record using the Medical- Vocational Guidelines [20 CFR 404, Subpart P, Appendix II] as a guide, specifically Rule 201.28, it is found that Claimant is not disabled for purposes of the MA-P program at Step 5.

The department's Bridges Eligibility Manual contains the following policy statements and instructions for caseworkers regarding the State Disability Assistance program: to receive State Disability Assistance, a person must be disabled, caring for a disabled

person or age 65 or older. BEM, Item 261, p 1. Because Claimant does not meet the definition of disabled under the MA-P program and because the evidence of record does not establish that Claimant is unable to work for a period exceeding 90 days, Claimant does not meet the disability criteria for State Disability Assistance benefits.

DECISION AND ORDER

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

Accordingly, it is ORDERED:

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

/s/

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

Date Signed: February 19, 2013

Date Mailed: February 20, 2013

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.

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

VLA/las

cc: [redacted]