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

IN THE MATTER OF:

8

Reg No.: 2012-65462
Issue No.: 2009, 4031
Case No.:
Hearing Date: October 31, 2012
Wayne County DHS (19)

ADMINISTRATIVE LAW JUDGE: Colleen M. Mamelka

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Claimant's request for a hearing. After due notice, a hearing was held in Inkster, Michigan on Wednesday, October 31, 2012. The Claimant appeared and testified. The Claimant was represented by . Participating on behalf of the Department of Human Services ("Department") was .

During the hearing, the Claimant waived the time period for the issuance of this decision, in order to allow for the submission of additional medical evidence. The records were received, reviewed, and forwarded to the State Hearing Review Team ('SHRT") for consideration. On December 11, 2012, this office received the SHRT determination which found the Claimant not disabled. This matter is now before the undersigned for a final decision.

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of the Medical Assistance ("MA-P") and State Disability Assistance ("SDA") benefit programs?

FINDINGS OF FACT

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

1. The Claimant submitted an application for public assistance seeking MA-P retroactive to August 2011, and SDA benefits on November 15, 2011.

2. On April 10, 2012, the Medical Review Team ("MRT") found the Claimant not disabled. (Exhibit 1, pp. 12, 13)

3. On April 13, 2012, the Department notified the Claimant of the MRT determination. (Exhibit 1, pp. 9 – 11)

4. On April 20, 2012, the Department received the Claimant's written request for hearing. (Exhibit 1, p. 2)

5. On September 7th and December 7, 2012, the SHRT found the Claimant not disabled. (Exhibit 3)

6. The Claimant alleged physical disabling impairments due to bursitis, arthritis, carpal tunnel syndrome ("CTS"), back pain, restless leg syndrome, asthma, abdominal pain, irritable bowel syndrome ("IBS"), kidney stones, migraines, fibromyalgia, and residual complications from two strokes.

7. The Claimant alleged mental disabling impairments due to anxiety, learning disorder, attention deficit hyperactivity disorder ("ADHD"), and depression.

8. At the time of hearing, the Claimant was 46 years old with a [redacted] birth date; was 5'7" in height; and weighed 220 pounds.

9. The Claimant has a limited education with an employment history as a janitor, customer service representative, and as a waitress.

10. The Claimant's impairments have lasted, or are expected to last, continuously for a period of 12 months or longer.

CONCLUSIONS OF LAW

The Medical Assistance program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department of Human Services, formerly known as the Family Independence Agency, pursuant to MCL 400.10 *et seq.* and MCL 400.105. Department policies are found in the Bridges Administrative Manual ("BAM"), the Bridges Eligibility Manual ("BEM"), and the Bridges Reference Tables ("RFT").

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a). The person claiming a physical or mental disability has the burden to establish it through the use of competent medical evidence

from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

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

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

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

basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

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

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

As outlined above, the first step looks at the individual's current work activity. In the record presented, the Claimant is not involved in substantial gainful activity therefore is not ineligible for disability benefits under Step 1.

The severity of the Claimant's alleged impairment(s) is considered under Step 2. The Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(b). An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c).

Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921(b). Examples include:

1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

5. Responding appropriately to supervision, co-workers and usual work situations; and

6. Dealing with changes in a routine work setting.

Id.

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

In the present case, the Claimant alleges disability due to bursitis, arthritis, CTS, back pain, restless leg syndrome, asthma, abdominal pain, IBS, kidney stones, migraines, fibromyalgia, residual complications from two strokes, anxiety, ADHD, learning disorder, and depression.

In support of her claim, some older records from as early as 2008 were submitted which document treatment/diagnoses of fibromyalgia, shoulder pain, osteoarthritis, chronic fatigue, acute chest pain, acute urinary tract infection, sinus tachycardia, TIAs (July 2009), memory loss, acute bronchitis, chronic low back pain, GERD, asthma, chronic abdominal pain, chest pain, and CTS.

On January 26, 2011, the Claimant attended a follow-up appointment with a history of fibromyalgia, clinical depression, two TIAs, GERD, and high cholesterol. The Claimant was placed on a new medication for her fibromyalgia.

On this same date, January 26th, imaging studies of the lumbar sacral spine and cervical spine revealed mild degenerative changes in the cervical spine and mild spondylosis of the lower lumbar spine.

On January 27, 2011, the Claimant was sought treatment for her fibromyalgia.

On February 18, 2011, the Claimant sought treatment for right flank pain noting a history of kidney stones.

On February 18, 2011, a CT of the pelvis revealed non-obstructing bilateral renal calculi.

On March 2, 2011, the Claimant attended a follow-up appointment where she was treated for joint pain.

On March 22, 2011, a colonoscopy revealed a small rectal polyp which was resected. The examination was otherwise unremarkable.

On March 28, 2011, the Claimant sought treatment for cough, loss of voice, sore throat, and right ear pain.

On May 31, 2011, the Claimant sought treatment for severe cough, depression, and anxiety. The diagnoses were bronchitis (acute), fibromyalgia, and depression.

On June 21, 2011, the Claimant presented to the emergency room with depression and thoughts of suicide. The Claimant was discharged the following day with the diagnosis of depression.

On June 29, 2011, a mental status assessment was performed noting symptoms of depression, anxiety, suicidal ideation, and paranoia. The Claimant's insight was fair and her judgment was poor. The diagnosis was dysthymic disorder with a Global Assessment Functioning ("GAF") of 50.

On July 13, 2011, an assessment was completed. The diagnoses were depression with psychotic features, ADHD, and generalized anxiety disorder. The GAF was 45 to 50.

On August 9, 2011, a psychiatric evaluation revealed delusional thoughts; however, her insight and judgment were fair. The diagnoses were depression with psychotic features, ADHD, and generalized anxiety disorder. The GAF was 45 to 50. Bipolar disorder was not ruled out. The Claimant's medications were increased.

On August 21, 2011, the Claimant was treated for a vaginal area abscess. The abscess was drained without complication. The Claimant was discharged the same day.

On September 9, 2011, a Medication Review revealed diagnoses of ADD and anxiety. The medication regime was not changed.

On October 11, 2011, a Medication Review was completed. The diagnosis was generalized anxiety disorder. Bipolar disorder and ADD were not ruled out. The medication regime was changed.

On November 29, 2011, a Psychiatric/Psychological Examination Report was completed on behalf of the Claimant. The diagnosis was dysthymic disorder with a GAF of 50.

On December 3, 2011, the Claimant sought treatment for pain on the left side of her neck. The Claimant was treated and discharged the same day.

On December 5, 2011, the Claimant was admitted to the hospital with complaints of a spider bite on her neck. Surgical drainage and debridement of the abscess was performed without complication. The Claimant was discharged on December 8th with the diagnosis of abscess/cellulitis on the left side of neck.

On December 13, 2011, the Claimant presented to the hospital for treatment of her surgical wound from the spider bite. The Claimant was treated and discharged.

On December 29, 2011, the Claimant presented to the emergency room with complaints of joint muscle pain and kidney pain along with nausea and facial flushing. The Claimant was treated and discharged with the diagnoses of arthralgia (shoulder) and back pain.

On January 13, 2012, a Medication Review was completed. The diagnosis was generalized anxiety. Bipolar disorder and major depressive disorder recurrent with psychosis was not ruled out. The Claimant medication regime remained the same.

On January 20, 2012, a consultative evaluation was performed. The Claimant has 4 trigger points in her back due to her fibromyalgia noting that she is not taking any medication or doing physical therapy. Arthritis in the back and legs was documented noting positive straight leg raising on the left. Overall, the Internist opined mild physical limitations. The diagnoses were TIA, fibromyalgia, arthritis in neck/back, CTS, bursitis in the right shoulder, migraines, kidney stones, and depression.

On this same date, a consultative mental status evaluation was performed. The diagnoses were major depressive disorder, recurrent and cognitive disorder (not

otherwise specified). The GAF was 50. The Claimant's ability to understand, retain, and follow simple instructions, and perform basic, routine, and tangible tasks were moderately impaired. The Claimant's ability to interact with others outside the home, supervisors, and the public was adequate. The Claimant was found able to manage benefit funds independently.

On February 20, 2012, the Claimant presented to the emergency room with complaints of sudden onset of severe right flank pain with nausea and vomiting. The Claimant was treated and discharged the following day with the diagnoses of ureterolithiasis.

On February 14, 2012, the Claimant attended a follow-up appointment where she was diagnosed with compression arthralgia of the head/neck/trunk, backache, and intercostal myositis.

On February 21, 2012, the local DHS office received a completed Mental Residual Functional Capacity Assessment completed on behalf of the Claimant. The Claimant was markedly limited in 13 of the 20 factors and moderately limited in the remaining 7.

On April 2, 2012, an assessment resulted in the diagnosis of dysthymic disorder with a GAF of 50.

On April 5, 2012, the Claimant sought treatment for joint pain. The physical examination was unremarkable with the exception of limited range of motion in all joints tested in the upper and lower extremities. The diagnoses were fibromyalgia, open fracture of the medial malleolus, obesity, and gait difficulty.

On April 18, 2012, a Medication Review was completed resulting in the diagnoses of major depressive disorder, recurrent with psychosis (not otherwise specified) and generalized anxiety disorder. The medication regime remained unchanged.

On May 2, 2012, a Medical Examination Report was completed on behalf of the Claimant. The current diagnoses were fibromyalgia and intractable pain. The physical examination confirmed the need for a cane for ambulation. The Claimant's condition was deteriorating.

On June 19, 2012, the Claimant attended a follow-up appointment where she was diagnosed with fibromyalgia flare-up, intermittent dizziness, depression, and fine tremor.

On July 18, 2012, the Claimant sought treatment for back pain. The diagnosis was fibromyalgia.

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized

above, the Claimant has presented medical evidence establishing that she does have physical and mental limitations on her ability to perform basic work activities. The degree of functional limitation on the Claimant's activities, social function, concentration, persistence, or pace is moderate to marked. The degree of functional limitation in the fourth area (episodes of decompensation) is a 2. The medical evidence has established that the Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, the Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The evidence confirms treatment/diagnoses of fibromyalgia, depression with psychotic features, history of TIAs, GERD, high cholesterol, degenerative changes in the cervical spine, mild spondylosis of the lumbar spine, kidney stones, depression, anxiety, asthma, bronchitis, dysthymic disorder, vaginal abscess, ADD, neck abscess, joint pain, shoulder pain, migraines, intractable pain, and fine tremors.

Listing 1.00 (musculoskeletal system), Listing 3.00 (respiratory system), Listing 4.00 (cardiovascular system), Listing 6.00 (genitourinary system), Listing 8.00 (skin disorders), Listing 11.00 (neurological disorders), and Listing 12.00 (mental disorders) were considered in light of the objective medical evidence. There were no objective findings of major joint dysfunction or nerve root impingement; ongoing treatment for shortness of breath; or persistent, recurrent, and/or uncontrolled (while on prescribed treatment) cardiovascular impairment. The evidence shows a history of asthma; however, the Claimant has not required any ongoing treatment for these conditions. There was no evidence to meet the intent and severity requirement necessary to meet a digestive system impairment, genitourinary impairment, or a skin disorder. There was no evidence to show any serious neurological deficits. Mentally, the evidence shows several marked limitations; however other evidence shows that the Claimant is able to meet her activities of daily living and capable of interacting with others outside the home, with supervisors, and the public. The evidence does not show repeated episodes of decompensation each of extended duration. Although the objective medical records establish physical and mental impairments, these records do not meet the intent and severity requirements of a listing, or its equivalent. Accordingly, the Claimant can not be found disabled, or not disabled at Step 3; therefore, the Claimant's eligibility is considered under Step 4. 20 CFR 416.905(a).

Before considering the fourth step in the sequential analysis, a determination of the individual's residual functional capacity ("RFC") is made. 20 CFR 416.945. An individual's RFC is the most he/she can still do on a sustained basis despite the

limitations from the impairment(s). *Id.* The total limiting effects of all the impairments, to include those that are not severe, are considered. 20 CFR 416.945(e).

To determine the physical demands (exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967. Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b). Even though weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additionally limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.* Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.* Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.* Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id.*

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands (exertional requirements, i.e. sitting, standing, walking, lifting, carrying, pushing, or pulling) are considered nonexertional. 20 CFR 416.969a(a). In considering whether an individual can perform past relevant work, a comparison of the individual's residual functional capacity with the demands of past relevant work. *Id.* If an individual can no longer do past relevant work the same residual functional capacity assessment along with an individual's age, education, and work experience is considered to determine whether an individual can adjust to other work which exists in the national economy. *Id.* Examples of non-exertional limitations or restrictions include difficulty to function due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping,

climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2). The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.*

In this case, the evidence confirms treatment/diagnoses of fibromyalgia, depression with psychotic features, history of TIAs, GERD, high cholesterol, degenerative changes in the cervical spine, mild spondylosis of the lumbar spine, kidney stones, depression, anxiety, asthma, bronchitis, dysthymic disorder, vaginal abscess, ADD, neck abscess, joint pain, shoulder pain, migraines, intractable pain, and fine tremors. The Claimant testified that she is able to walk short distances; grip/grasp without issue; sit for less than 2 hours; lift/carry approximately 10 pounds; stand for less than 2 hours; and has difficulties bending and/or squatting. The objective medical evidence shows that the Claimant's condition is deteriorating requiring a cane for ambulation noting limited range of motion in joints in the upper and lower extremities. Mentally, the Claimant has several marked limitations. After review of the entire record and considering the Claimant's testimony, it is found that the combination of the Claimant's physical and mental impairments and accompanying limitations render the Claimant incapable of performing even sedentary work as defined by 20 CFR 416.967(a).

The fourth step in analyzing a disability claim requires an assessment of the Claimant's residual functional capacity ("RFC") and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if he/she can perform past relevant work. *Id.*; 20 CFR 416.960(b)(3). Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3).

The Claimant's prior employment was that of a janitor, customer service representative, and as a waitress. In consideration of the Claimant's testimony and Occupational Code, the prior employment as a janitor and waitress is classified as unskilled, light work while the customer service position is considered unskilled sedentary. If the impairment or combination of impairments does not limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. 20 CFR 416.920. As noted above, the objective evidence contains limitations that would preclude employment. In light of the entire record and the Claimant's RFC (see above), it is found that the Claimant is unable to perform past relevant work. Accordingly, the Claimant cannot be found disabled, or not disabled, at Step 4.

In Step 5, an assessment of the Claimant's residual functional capacity and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v). At the time of hearing, the Claimant was 46 years old and, thus, considered to be a younger individual for MA-P purposes. The Claimant has a limited education. Disability is found if an individual is unable to adjust to other work. *Id.* At this point in the analysis, the burden shifts from the Claimant to the Department to present proof that the Claimant has the residual capacity to substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

In this case, the evidence confirms treatment/diagnoses of fibromyalgia, depression with psychotic features, history of TIAs, GERD, high cholesterol, degenerative changes in the cervical spine, mild spondylosis of the lumbar spine, kidney stones, depression, anxiety, asthma, bronchitis, dysthymic disorder, vaginal abscess, ADD, neck abscess, joint pain, shoulder pain, migraines, intractable pain, and fine tremors. Physically, the evidence shows that the Claimant's condition is deteriorating. Mentally, the Claimant was markedly limited in 13 factors with moderate limitations in the remaining 7. In light of the foregoing, it is found that the combination of the Claimant's physical and mental impairments render her incapable of meeting the physical and mental demands required to perform sedentary work as defined in 20 CFR 416.967(a). Accordingly, the Claimant is found disabled at Step 5 with no further analysis required.

The State Disability Assistance program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program purusant to MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. Department policies are found in BAM, BEM, and RFT. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal SSI disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness automatically qualifies an individual as disabled for purposes of the SDA program.

In this case, the Claimant is found disabled for purposes of the MA-P program; therefore, she is found disabled for purposes of SDA benefit program.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law finds the Claimant disabled for purposes of the MA-P and SDA benefit programs.

Accordingly, it is ORDERED:

1. The Department's determination is **REVERSED**.

2. The Department shall initiate processing of the November 15, 2011 application, to include any applicable requested retroactive months, to determine if all other non-medical criteria are met and inform the Claimant, and her Authorized Hearing Representative, of the determination in accordance with department policy.

3. The Department shall supplement for any lost benefits (if any) that the Claimant was entitled to receive if otherwise eligible and qualified in accordance with department policy.

4. The Department shall review the Claimant's continued eligibility in February 2014 in accordance with department policy.

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

Date Signed: January 2, 2013
Date Mailed: January 3, 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

CMM/tm

cc: