STATE OF MICHIGAN

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

IN THE MATTER OF:

[redacted]

Reg No.: 2012-71279
Issue No.: 2009
Case [redacted]
Hearing Date: December 19, 2012
Oakland County DHS (03)

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 telephone hearing was conducted from Detroit, Michigan on Wednesday, December 19, 2012. The Claimant appeared, along with [redacted]. Participating on behalf of the Department of Human Services ("Department") was [redacted]

During the hearing, the Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional medical evidence. The records were received, reviewed, and forwarded to the State Hearing Review Team ("SHRT") for consideration. On March 6, 2013, this office received the SHRT determination which found the Claimant not disabled. This matter is now before the undersigned for a final decision.

ISSUE

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

FINDINGS OF FACT

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

1. The Claimant submitted an application for public assistance seeking MA-P benefits, retroactive to June 2012, on July 16, 2012.

2. On August 1, 2012, the Medical Review Team ("MRT") found the Claimant not disabled. (Exhibit 1, pp. 9, 10)

3. On August 7, 2012, the Department notified the Claimant of the MRT determination. (Exhibit 1, pp. 7, 8)

4. On August 14, 2012, the Department received the Claimant's timely written request for hearing.

5. On October 4, 2012 and February 25, 2012, the State Hearing Review Team ("SHRT") found the Claimant not disabled. (Exhibit 2)

6. The Claimant alleged physical disabling impairments due to neck pain, back pain, shoulder pain, arthritis, bilateral knee pain, bleeding gastric ulcers, high blood pressure, stomach ulcers, and a history of ulcerative colitis.

7. The Claimant alleged mental disabling impairments due to depression and anxiety.

8. At the time of hearing, the Claimant was 54 years old with a [redacted], birth date; was 5'8" in height; and weighed 200 pounds.

9. The Claimant has an Associate's Degree with vocational training as a respiratory therapist and an employment history as a greeter, fast food cook, and at a staffing company.

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-relate 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 applicants 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 and, 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 neck pain, back pain, shoulder pain, arthritis, bilateral knee pain, bleeding gastric ulcers, high blood pressure, stomach ulcers, history of ulcerative colitis, depression, and anxiety.

In support of her claim, some older records from 2010 were submitted which document treatment/diagnoses of left foot pain, cellulitis of left and right lower extremities, left knee pain, osteomyelitis of left foot, severe edema, degenerative joint disease of the left knee, cardiac a-fibrillation, chronic obstructive pulmonary disease ("COPD"), depression, hypertension, lumbar disc disease, coronary artery disease, and deep vein thrombosis.

On January 21, 2011, an echocardiogram/Doppler study revealed dilated left atrium; mild mitral valve insufficiency; and mild to moderate tricuspid valve insufficiency. The tests were suggestive of mild pulmonary hypertension. The ejection fraction was estimated to be greater than 55 percent. Ultimately, the results were within normal limits.

On January 26, 2011, Claimant was treated/diagnosed, in part, osteopenia, COPD, hypertension, and disc disease.

On February 11, 2011, a repeat mammogram was negative.

On February 21, 2011, Claimant was evaluated for questionable flare-up of her ulcerative colitis. As a result, a colonoscopy was scheduled.

On February 23, 2011, Claimant was treated for/diagnosed with COPD, osteoarthritis, and hypertension.

On March 7, 2011, Claimant sought treatment for hemoglobin of 7.5 with rectal bleeding and black stools. Imaging studies revealed degenerative changes of the lower thoracic/upper lumbar region and degenerative changes of the lumbar facets. An esophagogastroduodenoscopy and a colonoscopy were performed which confirmed gastroesophageal reflux disease. There was no evidence of ulcerative colitis. The discharge the following day with the diagnoses was antral ulcer, gastrointestinal bleed, and anemia.

On March 9th and March 21, 2011, Claimant was treated/diagnosed with COPD, osteoarthritis, hypertension, and duodenitis bleed.

On April 11, 2011, Claimant was treated/diagnosed with anemia.

On May 2, 2011, Claimant was treated/diagnosed with COPD, osteoarthritis, hypertension duodenitis bleed, anemia, and lumbar disc pain.

On May 24, 2011, Claimant was treated/diagnosed with chronic obstructive pulmonary disease ("COPD"), osteoarthritis, hypertension, and anemia.

On June 14, 2011, Claimant was treated for anemia, hypertension, and dislocated right shoulder.

On June 15, 2011, Claimant sought treatment after falling and injuring her right shoulder. The physical examination confirmed reduced strength with positive O'Brien's test. The diagnoses were right shoulder instability and internal derangement of right shoulder. A MRI was prescribed.

On July 11th, Claimant was treated for hypertension and anemia.

On August 1, 2011, Claimant sought treatment for chronic back pain.

On October 12th, October 26th, and November 9, 2011, Claimant attended follow-up appointments for her left wrist.

On October 12th and 26th, 2011, Claimant sought treatment for a wrist injury. X-rays showed distal radius fracture. A cast was applied.

On November 23, 2011, Claimant attended a follow-up appointment for her left wrist. Claimant's range of motion was decreased due to pain. The wrist was healing as expected and Claimant was to return to light work.

On December 14, 2011, Claimant sought treatment for left wrist pain status post fixation and right shoulder pain. X-rays confirmed healed distal radius. The diagnosis was left distal radius fracture.

On March 7, 2012, Claimant was admitted to the hospital with rectal bleeding and hemoglobin of 7.5. Claimant was treated and discharged the following day with the diagnosis of antral ulcer, gastrointestinal bleed, and anemia.

On March 20, 2012, Claimant attended her yearly physical. A spirometry was normal.

On March 28, 2012, Claimant underwent an endoscopy. Biopsies of the antrum revealed an ulcer with inflammatory granulation tissue and acute inflammation. The post-operative diagnoses were pyloric channel ulcer, mild duodenitis, status post biopsy for H pylori.

On April 6, 2012, Claimant attended a follow-up appointment regarding severe epigastic pain. Claimant had two ulcers but no stigmata, and was anemic. Further blood work was ordered.

On June 13, 2012, chest x-rays were unremarkable. An electrocardiogram was abnormal showing sinus bradycardia with sinus arrhythmia.

On July 10, 2012, a psychiatric evaluation was performed. The diagnoses were mood disorder, major depressive disorder, and anxiety (not otherwise specified). The Global Assessment Functioning ("GAF") was 55.

On July 12, 2012, Claimant sought treatment for left knee pain. The physical examination was positive for left knee pain. The assessment was knee pain, hypertension (stable), and dyslipidemia.

On July 15, 2012, x-rays revealed tri-compartmental degenerative changes with narrowing and spurring involving the medial, lateral, and patellofemoral joint spaces. There was no evidence of fracture or dislocation. X-rays of the lumbar spine revealed

degenerative changes with endplate spurring and narrowing at L5-S1 with associated facet hypertrophy as well as degenerative changes at L1-2 and L2-3. There was no evidence of fracture of subluxation.

On July 19, 2012, Claimant sought treatment for bilateral knee pain and back pain. The physical examination revealed bilateral leg swelling and bilateral knee tenderness. The diagnoses were bilateral knee pain and hypertension.

On August 7, 2012, a Medication Review was completed. The diagnoses were mood disorder, major depressive disorder, anxiety disorder (not otherwise specified). The GAF was 55.

On August 12, 2012, Claimant attended a follow-up appointment where joint injection/aspiration of the right and left knee was performed without complications. The diagnoses were joint pain involving lower leg, acute arthritis of the knees, and benign hypertension.

On October 8, 2012, a Medication Review was completed. The mental status examination was unremarkable. The diagnoses were mood disorder, major depressive disorder, and anxiety (not otherwise specified). The GAF was 55.

On November 26, 2012, a Medication Review was completed. The mental status examination was unremarkable. The diagnoses were mood disorder, major depressive disorder, and anxiety disorder (not otherwise specified). The GAF was 70.

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the Claimant has presented some medical evidence establishing that she does have some physical and mental limitations on her ability to perform basic work activities. The degree of functional limitation on the Claimant's activities, social function, concentration, persistence, or pace is mild to moderate. The degree of functional limitation in the fourth area (episodes of decompensation) is a 1. 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 hypertension, osteopenia, COPD, ulcerative colitis, osteoarthritis, GERD, antral ulcer, gastrointestinal bleed, anemia, duodenitis bleed, lumbar pain, right shoulder instability, distal radius fracture (right and left), sinus bradycardia with sinus arrhythmia, mood disorder, major depressive disorder, anxiety, knee pain, dyslipidemia, degenerative changes with end plate spurring and narrowing, bilateral knee pain, and joint pain.

Listing 1.00 (musculoskeletal system), Listing 3.00 (respiratory system), Listing 4.00 (cardiovascular system), Listing 5.00 (digestive disorders), Listing 7.00 (hematological disorders), and Listing 12.00 (mental disorders) were considered in light of the objective evidence. There was no evidence of major dysfunction of joints, non-healing fracture, or nerve root impingement resulting in ineffective ambulation; major dysfunction of two or more joints in the upper extremities resulting in the inability to perform fine and/or gross motor skills; or ongoing treatment for shortness of breath or COPD. The evidence does not meet the intent or severity requirement of cardiac impairment, despite prescribed treatment, noting an ejection fraction of 55 percent. There was no evidence of organ damage due to Claimant's hypertension, or any other severe impairment as a result of Claimant's, GERD, ulcer, ulcerative colitis, or gastrointestinal bleed. The Claimant has not had blood transfusions as a result of her anemia. Mentally, there is no evidence of marked limitations in any functional area with a recent GAF of 70. Ultimately, the objective medical records establish physical and mental impairments; however, 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.

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 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 hypertension, osteopenia, COPD, ulcerative colitis, osteoarthritis, GERD, antral ulcer, gastrointestinal bleed, anemia, duodenitis bleed, lumbar pain, right shoulder instability, distal radius fracture (right and left), sinus bradycardia with sinus arrhythmia, mood disorder, major

depressive disorder, anxiety, knee pain, dyslipidemia, degenerative changes with end plate spurring and narrowing, bilateral knee pain, and joint pain. The Claimant testified that she is able to walk short distances; grip/grasp without issue; sit for less than 2 hours; lift/carry 10 pounds; stand less than 2 hours; and is able to bend but is unable to squat. The objective medical evidence does not contain and significant physical and/or mental restrictions. Regarding, social functioning, there was no objective findings of markedly limitations and as such, the degree of limitation is mild. In the area of concentration, persistence, or pace, the evidence does not demonstrate marked limitations such that the degree of limitation is mild. And finally, there is no evidence or repeated episodes of decompensation. Applying the four point scale, the Claimant's degree of limitation in the fourth functional area is at most a 1. After review of the entire record to include the Claimant's testimony, it is found that the Claimant maintains the residual functional capacity to perform at least limited, sedentary work as defined by 20 CFR 416.967(a). Limitations being the alternation between sitting and standing at will.

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

The Claimant's prior work history consists of work as a greeter, fast food cook, and at a staffing company. In consideration of the Claimant testimony and the Occupational Code, the Claimant's prior work as a greeter and fast food cook is classified as unskilled light work, while the staffing position is considered semi-skilled, 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. Claimant testified that the staffing position required her to sit for extended periods, which, without sit/stand accommodation would not be feasible. Ultimately, 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.

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, the Claimant was 54 years old thus considered to be closely approaching advanced age for MA-P purposes. The Claimant has an Associate's Degree with vocational training. 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 hypertension, osteopenia, COPD, ulcerative colitis, osteoarthritis, GERD, antral ulcer, gastrointestinal bleed, anemia, duodenitis bleed, lumbar pain, right shoulder instability, distal radius fracture (right and left), sinus bradycardia with sinus arrhythmia, mood disorder, major depressive disorder, anxiety, knee pain, dyslipidemia, degenerative changes with end plate spurring and narrowing, bilateral knee pain, and joint pain. The evidence further establishes Claimant's condition is stable with prescribed treatment. After review of the entire record, and in consideration of the Claimant's age, education, work experience, and RFC, finding no contradiction with Claimant's non-exertional impairments, and using the Medical-Vocational Guidelines [20 CFR 404, Subpart P, Appendix II] as a guide, specifically Rule 201.15, it is found that the Claimant is not disabled for purposes of the MA-P program.

DECISION AND ORDER

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

Accordingly, It is ORDERED:

The Department's determination is AFFIRMED.

Colleen M. Mamelka

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

Date Signed: June 19, 2013

2012-71279/CMM

Date Mailed: June 19, 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: [redacted]