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

IN THE MATTER OF:

[redacted]

Reg. No.: 201252084
Issue No.: 2009
Case No.: [redacted]
Hearing Date: December 19, 2012
County: Wayne DHS (31)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 following Claimant's request for a hearing. After due notice, an in-person hearing was held on December 19, 2012, from Detroit, Michigan. Participants included the above-named claimant. [redacted]s appeared as Claimant's authorized hearing representative. Participants on behalf of Department of Human Services (DHS) included [redacted], Specialist.

ISSUE

The issue is whether DHS properly denied Claimant's application for Medical Assistance (MA) on the basis that Claimant is not a disabled individual.

FINDINGS OF FACT

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

1. On 2/24/12, Claimant applied for MA benefits.

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

3. On 4/18/12, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 6-7).

4. On 4/23/12, DHS denied Claimant's application for MA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On 5/9/12, Claimant requested a hearing disputing the denial of MA benefits.

6. DHS did not forward any medical evidence to the State Hearing Review Team (SHRT) prior to the administrative hearing date.

7. On 12/19/12, an administrative hearing was held.

8. At, and following the hearing, Claimant presented new medical documents.

9. The new medical documents were forwarded to SHRT.

10. On 3/8/13, SHRT determined that Claimant was not a disabled individual (see Exhibits C1-C2), in part, by application of Medical-Vocational Rule 202.17.

11. As of the date of the administrative hearing, Claimant was a [redacted] year old female with a height of 5'5'' and weight of 196 pounds.

12. Claimant has no known relevant history of tobacco, alcohol or illegal substance abuse.

13. Claimant's highest education year completed was the 11th grade.

14. As of the date of the administrative hearing, Claimant had no medical coverage and last received medical coverage in 5/2012.

15. Claimant alleged impairments and issues including: migraine headaches, sleep apnea, sciatica, high blood pressure, anxiety and depression.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). DHS (formerly known as the Family Independence Agency) administers the MA program pursuant to MCL 400.10, et seq., and MCL 400.105. Department policies are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

MA provides medical assistance to individuals and families who meet financial and nonfinancial eligibility factors. The goal of the MA program is to ensure that essential health care services are made available to those who otherwise would not have financial resources to purchase them.

The Medicaid program is comprised of several sub-programs which fall under one of two categories; one category is FIP-related and the second category is SSI-related. BEM 105 at 1. To receive MA under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled. *Id*. Families with dependent children, caretaker relatives of dependent children, persons

under age 21 and pregnant, or recently pregnant, women receive MA under FIP-related categories. *Id*. AMP is an MA program available to persons not eligible for Medicaid through the SSI-related or FIP-related categories though DHS does always offer the program to applicants. It was not disputed that Claimant's only potential category for Medicaid eligibility would be as a disabled individual.

Disability for purposes of MA benefits is established if one of the following circumstances applies (see BEM 260 at 1-2):

- by death (for the month of death);
- the applicant receives Supplemental Security Income (SSI) benefits;
- SSI benefits were recently terminated due to financial factors;
- the applicant receives Retirement Survivors and Disability Insurance (RSDI) on the basis of being disabled; or
- RSDI eligibility is established following denial of the MA benefit application (under certain circumstances).

There was no evidence that any of the above circumstances apply to Claimant. Accordingly, Claimant may not be considered for Medicaid eligibility without undergoing a medical review process which determines whether Claimant is a disabled individual. *Id*. at 2.

Generally, state agencies such as DHS must use the same definition of SSI disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally defined as the inability to do any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905. A functionally identical definition of disability is found under DHS regulations. BEM 260 at 8.

Substantial gainful activity means a person does the following:

- Performs significant duties, and
- Does them for a reasonable length of time, and
- Does a job normally done for pay or profit. *Id*. at 9.

Significant duties are duties used to do a job or run a business. *Id*. They must also have a degree of economic value. *Id*. The ability to run a household or take care of oneself does not, on its own, constitute substantial gainful activity. *Id*.

The person claiming a physical or mental disability has the burden to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a).

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled. 20 CFR 416.920. If there is no finding of disability or lack of disability at each step, the process moves to the next step. 20 CFR 416.920 (a)(4).

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person is statutorily blind or not. The 2011 monthly income limit considered SGA for non-blind individuals is $1,000. The 2012 income limit is $1010/month.

In the present case, Claimant denied having any employment since the date of the MA application; no evidence was submitted to contradict Claimant's testimony. Without ongoing employment, it can only be concluded that Claimant is not performing SGA. It is found that Claimant is not performing SGA; accordingly, the disability analysis may proceed to step two.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the 12 month duration requirement. 20 CFR 416.920 (a)(4)(ii). The impairments may be combined to meet the severity requirement. If a severe impairment is not found, then a person is deemed not disabled. *Id*.

The impairments must significantly limit a person's basic work activities. 20 CFR 416.920 (a)(5)(c). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. *Id.* Examples of basic work activities include:

- physical functions (e.g. walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling)
- capacities for seeing, hearing, and speaking, understanding; carrying out, and remembering simple instructions
- use of judgment
- responding appropriately to supervision, co-workers and usual work situations; and/or
- dealing with changes in a routine work setting.

Generally, federal courts have imposed a de minimus standard upon claimants to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v Bowen,* 880 F2d 860, 862 (6th Cir. 1988). Similarly, Social Security Ruling 85-28 has been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirement is intended "to do no more than screen out groundless claims."

McDonald v. Secretary of Health and Human Servs., 795 F.2d 1118, 1124 (1st Cir. 1986).

SSA specifically notes that age, education, and work experience are not considered at the second step of the disability analysis. 20 CFR 416.920 (5)(c). In determining whether Claimant's impairments amount to a severe impairment, all other relevant evidence may be considered. The analysis will begin with the relevant submitted medical documentation.

A Final Report (Exhibit 32-34) of a hospital visit dated [redacted] was presented. It was noted that Claimant complained of back pain, depression and weakness related to heavy menses. It was noted that Claimant was prescribed Tylenol for back pain. It was noted that Claimant's HTN was controlled. Claimant was referred to an OB-GYN for the heavy menses.

Hospital documents (Exhibits 92-94; A110-A112) dated [redacted] were presented. It was noted that Claimant presented with complaints of increasing menorrhagia.

Hospital treatment documents (Exhibits 89-91) dated [redacted] were presented. It was noted that Claimant presented with complaints of increased anxiety and migraine headaches. It was noted that Claimant reported that she can only decrease her headache pain by lying in a dark room with her eyes closed. Claimant's anxiety was noted as related to an upcoming surgery (possibly hysterectomy surgery). Claimant received Imitrex to treat her headaches.

Hospital documents (Exhibits A113-A114) dated [redacted] were presented. It was noted that Claimant presented with complaints of frequent migraine headaches and increased menstrual bleeding.

A Final Report (Exhibits 67-69) of a hospital visit dated [redacted] was presented. It was noted that Claimant presented with right ear pain. It was noted that Claimant was given various prescriptions prior to discharge.

A Final Report (Exhibits 64-66) of a hospital visit dated [redacted] was presented. It was noted that Claimant presented with ankle pains after slipping in some water. An x-ray was noted as negative (see Exhibits 80-81). Claimant was given Norco for her pain.

A Final Report (Exhibits 60-63) of a hospital visit dated [redacted] was presented. It was noted that Claimant presented with chest and back pains. It was noted that an EKG was performed with no changes compared to a 2010 EKG. It was noted that Claimant was put on cardiac monitor and given pain medication prior to discharge.

A Psychiatric/Psychological Examination Report (Exhibits 18-19; A108-A109) dated [redacted] from Claimant's treating doctor was presented. It was noted that Claimant reported complaints of depression and anxiety. It was noted that Claimant has a 20 year history of panic attacks. It was noted that Claimant also reported difficulties with

sleeping and trouble concentration. It was noted that Claimant can care for herself but significant time was needed to complete daily tasks. The examiner provided a diagnosis based on Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV). Axis I diagnoses of panic disorder, generalized anxiety disorder and depression were noted. Claimant's GAF was 55-60.

Final Reports of hospital visits dated [redacted] (see Exhibits 47-49) and [redacted] (see Exhibits 39-43) were presented. It was noted that Claimant complained of chronic lower back pain.

A Final Report (Exhibits 56-59) of a hospital visit dated [redacted] was presented. It was noted that Claimant presented with complaints of fever and body aches. A diagnosis of viral syndrome was noted. A chest x-ray (see Exhibit 78) was performed and noted as negative.

A Final Report (Exhibits 53-55) of a hospital visit dated [redacted] was presented. It was noted that Claimant complained of right ear pain. It was noted that Claimant was given prescriptions for the pain.

A Final Report (Exhibits 50-52) of a hospital visit dated [redacted] was presented. It was noted that Claimant complained of migraine headaches. In response, it was noted that the physician gave Claimant sumatriptan.

A Final Report (Exhibits 39-43) of a hospital visit dated [redacted] was presented. It was noted that physical therapy has helped Claimant very much, presumably concerning back pain.

A Final Report (Exhibits 35-37) of a hospital visit dated [redacted] was presented. It was noted that Claimant had problems including: obesity, HTN, back pain and anxiety.

An MRI report (Exhibits 70-71) dated [redacted] of Claimant lumbar spine was presented. An impression was given of: no disc herniation, no spinal canal stenosis, no critical foraminal narrowing, mild foraminal narrowing at L5-S1 and facet joint arthropathy at L4-L5 and L5-S1.

An MRI report (Exhibit 10) of Claimant's abdomen and pelvis dated [redacted] was presented. An impression that a kidney stone was present was provided.

Hospital documents (Exhibits 86-99) dated [redacted] were presented. It was noted that Claimant presented with complaints of right ear pain and deafness. It was noted that Claimant was diagnosed with otis externa, otis media (ear infections) and vaginitis.

A Mental Residual Functional Capacity Assessment dated [redacted] was completed by Claimant's treating physician. It was noted that Claimant was markedly limited in 7 of 20 listed abilities including the ability to complete a normal workday without interruption

from symptoms. Claimant was not significantly limited in the abilities to understand and remember simple instructions.

A Medical Examination Report (Exhibit 8 and 16) dated [redacted] from Claimant's treating physician was presented. It was noted that the physician first treated Claimant on [redacted] and last examined Claimant on [redacted]. The physician provided diagnoses of back pain, hypertension, depression, migraine headaches and some unreadable diagnosis. It was noted that an MRI of Claimant's lumbar noted zero disc herniation or stenosis and foraminal canal narrowing. It was noted that mild narrowing was visible at L5-S1 and arthropathy was visible at L4-L5 and L5-S1. It was noted that Claimant had a normal range of motion.

Hospital documents (Exhibits A37-A85) were presented. It was noted that Claimant was admitted on [redacted]. It was noted that Claimant presented with non-radiating chest and back pain complaints. It was noted that a stress test was performed in the past and showed normal results. It was noted that a catheterization revealed normal: sinus rhythm, ejection fraction, left-sided pressure and right-sided pressure. It as noted that cardiac problems were not contributing to Claimant's chest pain. Claimant was discharged on [redacted] with diagnoses of: chest pain, back pain and depression. Claimant was given various medications upon discharge.

Hospital documents (Exhibits A1-A36) dated [redacted] were presented. It was noted that Claimant presented with complaints of chest pains over the past three days. It was also noted that Claimant complained of leg pain and swelling. It was noted that a chest x-ray was negative. Discharge diagnoses included: edema- pitting, anxiety and atypical chest pain. Documentation noted the chest pain was related to an anxiety attack. It was noted that no explanation was found for the edema. Claimant was discharged on her date of arrival.

Hospital documents (A100-A102) dated [redacted] were presented. It was noted that Claimant presented with complaints of chest pain, weakness and swelling. It was noted that a physical examination was performed and no abnormalities were noted.

Hospital documents (A100-A102) dated [redacted] were presented. It was noted that Claimant presented with complaints of body pain and swelling. It was noted that all lab results were negative. It was noted that Claimant asked for pain medication. It was noted that a physical examination was performed and no abnormalities were noted.

Hospital documents (Exhibits B113-B154) dated [redacted] were presented. It was noted that Claimant presented with complaints of abdomen, back and chest pain. It was noted that chest and abdomen x-rays revealed no evidence of abnormalities.

Hospital documents (Exhibits B9-B112) were presented. The documents verified a hospital admission on [redacted]. It was noted that Claimant presented with complaints of left-side tingling and chest pain. It was noted a chest x-ray was performed with an impression of a normal chest. It was noted that a CT brain was performed; an

impression was given of a normal unenhanced CT brain. It was noted that EKGs were normal. It was noted that Claimant was discharged on [redacted] with diagnoses of: atypical chest pain, HTN, anxiety, chronic back pain and anemia. It was noted that Claimant was prescribed Tylenol with codeine for pain.

A Psychiatric/Psychological Examination Report (Exhibits B5-B6) was presented, stemming from a [redacted] evaluation of Claimant. It was noted that Claimant had been attending the clinic since 3/2012. It was noted that Claimant receives ongoing psychotherapy and medications. It was noted that Claimant had: no apparent cognitive disturbances, average level of insight, memory lapses due to stress and orientation in all spheres. Axis I diagnoses of dysthymic disorder and manic disorder were noted. Claimant's GAF was 60. It was noted that Claimant could manage her own funds.

A Mental Residual Functional Capacity Assessment (Exhibits B7-B8) was presented, stemming from a [redacted] evaluation of Claimant. It was noted that Claimant was not markedly limited in any of the listed 20 abilities. It was noted that Claimant was not significantly limited in all listed abilities involving understanding and memory. Claimant was deemed moderately limited in the ability to complete a normal workday without interruption from symptoms. Overall, Claimant was moderately limited in 8 of 20 listed abilities.

A Medical Examination Report and other documents (Exhibits B1-B4) dated [redacted] completed by Claimant's treating physician were presented. It was noted that the physician first treated Claimant on [redacted] and last examined Claimant on [redacted]. The physician provided diagnoses of: controlled HTN, chest pain and morbid obesity. An impression was given that Claimant's condition was stable. It was noted that Claimant was capable of occasionally lifting less than 10 pounds but never 10 pounds or more. It was noted that Claimant was capable of standing or walking about 6 hours of an 8 hour workday. It was noted that Claimant had no repetitive arm or leg restrictions. Mental limitations were noted based on Claimant's complaints. It was noted that Claimant can meet household needs. It was noted that a negative work-up occurred for a recent hospital trip for chest pain.

It was established that Claimant received ongoing medical treatment for depression. There was also documented history that Claimant suffered from panic attacks and anxiety. In 10/2011, Claimant's GAF was established to be 55-60. Claimant's GAF was found to be a comparable 60 in 12/2012. A GAF within the range of 51-60 is representative of someone with moderate symptoms or any moderate difficulty in social, occupational, or school functioning. Claimant's moderate difficulties were consistent with moderate restrictions in Claimant's abilities of concentration noted on the presented MRFCA forms. This evidence is sufficient to meet the de minimus requirement for establishing basic work restrictions. Based on the provided dates, Claimant also established meeting the 12 month durational requirement for a severe impairment.

As it was found that Claimant established significant impairment to basic work activities for a period longer than 12 months, it is found that Claimant established having a severe impairment. Accordingly, the disability analysis may move to step three.

The third step of the sequential analysis requires a determination whether the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920 (a)(4)(iii). If Claimant's impairments are listed and deemed to meet the 12 month requirement, then the claimant is deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step.

Claimant presented substantial evidence of anxiety-related problems. Listing 12.06 covers anxiety-related disorders and reads:

> **12.06** ***Anxiety-related disorders***: In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders.
>
> The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in both A and C are satisfied.
>
> A. Medically documented findings of at least one of the following:
> 1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:
> a. Motor tension; or
> b. Autonomic hyperactivity; or
> c. Apprehensive expectation; or
> d. Vigilance and scanning; or
> 2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or
> 3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or
> 4. Recurrent obsessions or compulsions which are a source of marked distress; or
> 5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;
> AND
> B. Resulting in at least two of the following:
> 1. Marked restriction of activities of daily living; or
> 2. Marked difficulties in maintaining social functioning; or
> 3. Marked difficulties in maintaining concentration, persistence, or pace; or
> 4. Repeated episodes of decompensation, each of extended duration.

> OR
> C. Resulting in complete inability to function independently outside the area of one's home.

The analysis will begin with Part B of the above listing. The most recent psychological evaluation from Claimant (from 12/2012) noted no marked restrictions to any of Claimant's abilities. Based on the presented MRFCA, at most, it can be stated that Claimant has moderate social and concentration restrictions. There is zero evidence of psychological hospitalizations to support a finding of repeated episodes of decompensation. Based on the presented evidence, it is found that Claimant does not meet Part B of the above listing.

There is little evidence to imply that Claimant is incapable of functioning independently. For example, Claimant was found capable of managing her funds in 12/2012. It is found that Claimant does not meet Part C of the above listing.

As Claimant does not meet Parts B and C, Claimant can not meet the above listing for anxiety-related disorders. Claimant also complained of chronic back pain. Back pain is related to spinal disorders (Listing 1.04) which reads:

> **1.04** ***Disorders of the spine*** (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the cauda equina) or the spinal cord. With:
>
> A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine);
> OR
> B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours;
> OR
> C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b.

A plethora of medical documents were presented. Few involved a primary complaint of back pain. An MRI of Claimant's lumbar confirmed no disc herniation, no spinal canal stenosis and no critical foraminal narrowing. This is exceptionally persuasive evidence that Claimant does not meet the listing for spinal disorders. Though the MRI verified mild foraminal narrowing at L5-S1 and facet joint arthropathy at L4-L5 and L5-S1, this is

insufficient evidence to meet the above listing. It is found that Claimant does not meet the listing for spinal disorders.

It is found that Claimant failed to establish meeting a SSA listing. Accordingly, the analysis moves to step four.

The fourth step in analyzing a disability claim requires an assessment of the Claimant's residual functional capacity (RFC) and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if it is determined that a claimant can perform past relevant work. *Id*.

Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

Claimant has past full-time employment including: babysitting, clerking and patient care. Claimant testified that each of her previous jobs required regular lifting of at least 30 pounds, which she can no longer perform. Claimant's testimony is consistent with the medical records. It is found that Claimant can not perform her past employment and the analysis may proceed to step five.

In the fifth step in the process, the individual's RFC in conjunction with his or her age, education, and work experience, are considered to determine whether the individual can engage in any other substantial gainful work which exists in the national economy. SSR 83-10. While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

To determine the physical demands (i.e. exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967. The definitions for each are listed below.

Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are

sedentary if walking and standing are required occasionally and other sedentary criteria are met.

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

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.*

Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.*

Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands are considered nonexertional. 20 CFR 416.969a(a). Examples of non-exertional limitations include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e. can’t tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i)-(vi) If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2)

The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.* In using the rules of Appendix 2, an individual's circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, is compared to the pertinent rule(s).

Claimant's treating physician noted that Claimant was restricted from lifting 10 pounds. Such a restriction is consistent with an inability to perform sedentary employment. Treating source opinions cannot be discounted unless the Administrative Law Judge provides good reasons for discounting the opinion. *Rogers v. Commissioner,* 486 F. 3d 234 (6th Cir. 2007)*; Bowen v Commissioner.*

Claimant's treating physician also determined that Claimant had no repetitive arm or leg restrictions. The treating physician also found that Claimant had no ambulation restrictions. Generally, this evidence is not consistent with a person incapable of performing sedentary employment.

Presumably, the only basis to restrict Claimant's lifting would be based on Claimant's back problems. Back pain was not even listed as a diagnosis by the physician restriction Claimant from lifting 10 pounds. Claimant's back problems verified by MRI would not reasonably lead to a restriction from ever lifting 10 pounds.

The medical records were littered with regular complaints of chest pain by Claimant. The records also verified no particularly concerning abnormalities. It cannot be reasonably contended that the physicians did not take Claimant's complaints seriously because there was ample evidence of radiology and heart monitoring to support the impressions of no abnormalities.

Claimant complained of migraine headaches. At the hearing, Claimant's AHR contended that Claimant's weekly headaches should justify a finding of disability. The medical evidence is unsupportive of such a finding. A CT of Claimant's brain showed no abnormalities and there is no medical basis to conclude that Claimant should be disabled simply based of weekly migraine headaches.

Though Claimant was deemed to have psychological work restrictions in step two, step three concluded that the restrictions were not severe enough to preclude Claimant from performing employment. It was established that Claimant has moderate restrictions, nut none that would justify a finding of disability. Based on the presented evidence, it is found that Claimant is capable of performing at least a sedentary exertional level of employment.

Based on Claimant's exertional work level (sedentary), age (younger individual), education (literate and able to communicate in English), employment history (unskilled), Medical-Vocational Rule 201.23 is found to apply. This rule dictates a finding that Claimant is not disabled. Accordingly, it is found that DHS properly found Claimant to be not disabled for purposes of MA benefits.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that DHS properly denied Claimant's MA benefit application dated 2/24/12 based on a determination that Claimant is not disabled. The actions taken by DHS are AFFIRMED.

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

Date Signed: 3/21/2013

Date Mailed: 3/21/2013

NOTICE: Michigan Administrative Hearing System (MAHS) may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. MAHS will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request. (60 days for FAP cases)

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

Claimant may request a rehearing or reconsideration for the following reasons:

- A rehearing **MAY** be granted if there is newly discovered evidence that could affect the outcome of the original hearing decision.
- A reconsideration **MAY** be granted for any of the following reasons:
  - misapplication of manual policy or law in the hearing decision,
  - typographical errors, mathematical error, or other obvious errors in the hearing decision that effect the substantial rights of the claimant:
  - the failure of the ALJ to address other relevant issues in the hearing decision.

Request must be submitted through the local DHS office or directly to MAHS by mail at
Michigan Administrative Hearings
Reconsideration/Rehearing Request
P. O. Box 30639
Lansing, Michigan 48909-07322

CG/hw

cc: [redacted]