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

IN THE MATTER OF:

[redacted]

Reg. No.: 2013 42784
Issue No.: 2009, 4031
Case No.: [redacted]
Hearing Date: August 7, 2013
County: Wayne (18)

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

HEARING DECISION

Following Claimant's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, an in person hearing was held on August 7, 2013, from Taylor, Michigan. Participants on behalf of Claimant included the Claimant and [redacted] the Claimant's Authorized Hearing Representative. Participants on behalf of the Department of Human Services (Department) included [redacted] Medical Contact Worker.

ISSUE

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

FINDINGS OF FACT

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

1. On October 16, 2012, Claimant applied for MA-P and SDA.

2. On January 25, 2013 the Medical Review Team denied Claimant's request.

3. The Department sent the Claimant a Notice of Case Action dated January 30, 2013 denying the Claimant's MA-P and SDA application. Exhibit 1

4. On April 12, 2013 Claimant's Authorized Hearing Representative submitted to the Department a timely hearing request.

5. On July 3, 2013 the State Hearing Review Team (SHRT) found the Claimant not disabled and denied Claimant's request.

6. An Interim Order was issued on August 13, 2013 which transmitted new evidence accepted at the hearing to the State Hearing Review Team.

7. On October 2, 2013 the State Hearing Review Team found the Claimant not disabled and denied Claimant's request.

8. At the time of the hearing the Claimant was [redacted] years of age with a birth date of [redacted] The Claimant was 4'9" in height and weighed 138 lbs.

9. Claimant completed a high school education.

10. Claimant has employment experience as a bank teller and working at a meat market and deli counter, which work involved filling orders and stocking shelves. In that position the Claimant often picked up 40 to 50 pounds of weight and stood most of the day.

11. Claimant alleges physical disabling impairments due to chronic uncontrolled hypertension, coronary artery disease, chronic lower back pain radiating to left lower extremity, with also left arm pain. Claimant has a history of three CVI's with the diagnosis of cardiomyopathy with the last hospitalization in [redacted]. The Claimant has COPD, chronic anemia and vaginal bleeding.

12. The Claimant alleges mental disabling impairments due to anxiety and major depression.

13. Claimant's limitations have lasted for 12 months or more.

CONCLUSIONS OF LAW

MA-P is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department administers MA-P 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 Manual (RFT).

Pursuant to Federal Rule 42 CFR 435.540, the Department uses the Federal Supplemental Security Income (SSI) policy in determining eligibility for disability under MA-P. Under SSI, 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 set order is used to determine disability. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience are reviewed. If there is a finding that an individual is disabled or not disabled at any point in the review, there will be no further evaluation. 20 CFR 416.920.

Medical evidence may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of the impairment(s), including symptoms, diagnosis and prognosis, what an individual can do despite impairment(s), and the physical or mental restrictions. 20 CFR 416.927(a)(2).

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability. 20 CFR 416.927(e).

For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph (B) of the listings for mental disorders (descriptions of restrictions of activities of daily living, social functioning; concentration, persistence or pace; and ability to tolerate increased mental demands associated with competitive work). 20 CFR, Part 404, Subpart P, Appendix 1, 12.00(C).

The residual functional capacity is what an individual can do despite limitations. All impairments will be considered in addition to ability to meet certain demands of jobs in the national economy. Physical demands, mental demands, sensory requirements and other functions will be evaluated. 20 CFR 416.945(a).

To determine the physical demands (exertional requirements) of work in the national economy, we classify jobs as sedentary, light, medium and heavy. These terms have the same meaning as they have in the Dictionary of Occupational Titles, published by the Department of Labor. 20 CFR 416.967.

Pursuant to 20 CFR 416.920, a five-step sequential evaluation process is used to determine disability. An individual’s current work activity, the severity of the impairment, the residual functional capacity, past work, age, education and work experience are evaluated. If an individual is found disabled or not disabled at any point, no further review is made.

The first step is to determine if an individual is working and if that work is "substantial gainful activity" (SGA). If the work is SGA, an individual is not considered disabled regardless of medical condition, age or other vocational factors. 20 CFR 416.920(b).

Secondly, the individual must have a medically determinable impairment that is "severe" or a combination of impairments that is "severe." 20 CFR 404.1520(c). An impairment or combination of impairments is "severe" within the meaning of regulations if it significantly limits an individual's ability to perform basic work activities. An impairment or combination of impairments is "not severe" when medical and other evidence establish only a slight abnormality or a combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work. 20 CFR 404.1521; Social Security Rulings (SSRs) 85-28, 96-3p, and 96-4p. If the Claimant does not have a severe medically determinable impairment or combination of impairments, he/she is not disabled. If the Claimant has a severe impairment or combination of impairments, the analysis proceeds to the third step.

The third step in the process is to assess whether the impairment or combination of impairments meets a Social Security listing. If the impairment or combination of impairments meets or is the medically equivalent of a listed impairment as set forth in Appendix 1 and meets the durational requirements of 20 CFR 404.1509, the individual is considered disabled. If it does not, the analysis proceeds to the next step.

Before considering step four of the sequential evaluation process, the trier must determine the Claimant's residual functional capacity. 20 CFR 404.1520(e). An individual's residual functional capacity is his/her ability to do physical and mental work activities on a sustained basis despite limitations from his/her impairments. In making this finding, the trier must consider all of the Claimant's impairments, including impairments that are not severe. 20 CFR 404.1520(e) and 404.1545; SSR 96-8p.

The fourth step of the process is whether the Claimant has the residual functional capacity to perform the requirements of his/her past relevant work. 20 CFR 404.1520(f). The term past relevant work means work performed (either as the Claimant actually performed it or as is it generally performed in the national economy) within the last 15 years or 15 years prior to the date that disability must be established. If the Claimant has the residual functional capacity to do his/her past relevant work, then the Claimant is not disabled. If the Claimant is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth step.

In the fifth step, an individual's residual functional capacity is considered in determining whether disability exists. An individual's age, education, work experience and skills are used to evaluate whether an individual has the residual functional capacity to perform work despite limitations. 20 CFR 416.920(e).

The Claimant has alleged physical disabling impairments due to chronic uncontrolled hypertension, coronary artery disease, chronic lower back pain radiating to left lower extremity, with also left arm pain. Claimant has a history of three CVI's with the

diagnosis of cardiomyopathy with the last hospitalization in June 2012. The Claimant has COPD, chronic anemia and vaginal bleeding.

The Claimant alleges mental disabling impairments due to major depression and anxiety.

A summary of the medical evidence follows.

The Claimant was examined by a psychiatrist on [redacted] The evaluation was an initial evaluation by the Claimant's current mental health provider. The examiner found a diagnosis of major depressive disorder, single episode, mild (alcohol dependence) (active) cannabis abuse (active) with a deferred diagnosis. The GAF score assigned to the Claimant was 50. On the same date the Claimant had an Adult Health Assessment which found her condition physically to be rated as fair. The Claimant is currently using psychotropic and non-psychotropic prescribed medications to assist with her mental impairments. These medications were prescribed by her primary care physician. Claimant at that time also reported a history of cerebral vascular accident (X3) believed to be due to high blood pressure, as well as anemia, stiffness and pain in her back, and COPD.

The Claimant was admitted for a one day stay at the hospital on [redacted]13 due to abnormal uterine bleeding. The Claimant was prescribed ferrous sulfate. The Claimant was also seen at the emergency room on [redacted] and was given a battery of tests. No diagnosis was provided with the medical records nor were test results available.

The Claimant was admitted to the hospital on [redacted] due to chest pain and shortness of breath with coughing on movement and palpation. The Claimant's troponin level was positive. Due to her testing and chest discomfort as well as history, the patient was admitted to the hospital with a diagnosis of non-ST elevation myocardial infarction. The Claimant's blood pressure on admission was 236/127. At the time of her admission the Claimant had had at least three cardiac catheterizations, the impression was chest pain with stable left bundle branch block with history of multiple episodes of repeat chest discomfort. Long-standing hypertension status post-recent small ischemic infarct of unknown etiology. COPD due to long-standing smoking history. At the time Claimant was recommended to be on anti-ischemic and cardioprotective medications as per class 1 American Heart Association recommendations. An echocardiogram was completed and noted a left ventricular ejection fraction of 45% to 50%.

On [redacted] the Claimant was seen for a post-hospitalization follow-up. The Claimant had been discharged due to a sinus infection and chest pain. The notes indicate that the Claimant had the look of an individual with COPD and noted continues to smoke. Claimant was offered medications to assist in smoking cessation but Claimant could not afford them. The notes further indicate that the examining doctor found a need for a selective serotonin reuptake inhibitor such as Prozac. The Claimant was seen at that time due to her blood pressure condition.

The Claimant was seen on [redacted] for a follow-up and general checkup. The examiner noted that the patient appeared anxious with multiple co-morbidities due to failed treatment of an acute sinusitis infection. The Claimant at that time had failed two different courses of amoxicillin treatment. At that time the Claimant also reported lower back pain associated with shooting pains to bilateral anterior thighs. No lower extremity numbness, weakness or any shock-like sensations were reported. Claimant reported increasing social phobia and requested additional medications for her increasing anxiety although a slight improvement was noted due to the Prozac. The physical exam noted general tenderness to palpation of the entire back with increased tenderness in the thoracic and lumbosacral area. Bilateral anterior thigh tenderness greater on the left than right was noted. At that time the Claimant was prescribed tramadol to assist with her back pain, noted if not successful, x-rays should be obtained to determine structural abnormalities. Claimant also was prescribed Xanax and her Prozac was increased. The examining doctor noted a diagnosis of lumbago as regards Claimant's back condition and pain. The Claimant's blood pressure was assessed as the non-essential hypertension.

On [redacted] further follow-up was given to the Claimant in an outpatient office visit for acute sinusitis and worsening back pain. The Claimant, per the examiner's notes, appeared more anxious and depressed with bouts of crying. Further noted was generalize back pain affecting her daily activities. Also reported was bilateral radiating shoulder pain and occasional inability occasionally to hold onto objects. The Claimant has awakened four times with this dyspnea. Also noted was increased episodes of what appears to be a speech impediment secondary to the residual effects of her stroke. This impediment (or brain – speech disconnect) has increased her anxiety among friends and strangers and is becoming a reluctant recluse. The chronic problems were noted as localized related partial epilepsy, unspecified essential hypertension, congestive heart failure, lumbago, vitamin B12 deficiency anemia, chronic airway obstruction not elsewhere classified, history of tobacco use. The examiner noted on review of Claimant's systems increased back pain with straight leg raise no shooting pains or numbness elicited. The examiner's notes indicate patient's back is diffusely tender to the touch. More predominant on left. No evidence of external injury. Her neck, anterior chest wall and shoulders are also diffusely tender to palpation. The Claimant appeared depressed. The assessment and plan noted the following "Patient's debilitating back pain is due largely in part to her evolving psychiatric issues. Her complaints are very nonspecific and her muscular pains have now expanded from her back and neck to her entire body sparing only her abdomen. Patient prescribed Flexeril to be taken with tramadol. It is my hope that the muscle relaxant will be of some benefit. The key to her issues however in the psychiatric component and so for this reason she was referred to Dr. Marr of psychiatry." As regards Claimant's hypertension the notes indicate uncontrolled secondary to patient's chronic pain. Congestive heart failure was noted as stable. Chronic airway obstruction was noted to be influenced by patient stressors and patient directed to use inhalers. Patient will benefit from psychiatric intervention in terms of medication management and tools to deal with life challenges.

The Claimant was seen on [redacted] for an initial psychiatric evaluation on an outpatient basis at [redacted]. The reason for the visit was depression. The mental status exam noted problems with appetite, appropriate appearance, and orientation to person, place time and situation. Speech affect were both appropriate. Memory intact. Sensorium was clear, conscious. Patient's intellect was average. Patient displayed cooperative attitude and attention was maintained. Impulse control was good as was judgment. Thought content was unremarkable and processes were logical. The clinical assessment gave a diagnosis of depression, recurrent, the GAF score was 40. Valium was prescribed in addition to drugs prescribed for depression and anxiety.

On [redacted] the Claimant was clinically assessed and it was noted that her back pain could be a combination of degenerative spinal disease, muscle spasms, history of vertebral fracture and psychiatric component. Claimant was offered physical therapy and declined. Her blood pressure at the time was low secondary to taking Valium.

The Claimant was admitted for hospitalization on [redacted] after presenting to the emergency room with left arm pain with arm turning bluish purple. At that time an ultrasound was taken of her arteries and noted near complete occlusion of the left axillary artery with presence of collateral, partial occlusion of the proximal left brachial artery with low flow velocity of the radial and ulnar artery. Claimant was placed on breathing treatments as well, and was given heparin for her deep vein thrombosis. At the time of her admission the Claimant's diagnosis was non-ischemic cardiomyopathy, cerebrovascular accident, peripheral arterial disease, unstable angina, hyperlipidemia and hypertension. Claimant also was diagnosed with COPD, seizure disorder and chronic anemia.

During the admission, an arteriogram was performed and the embolus was removed and flow was reestablished. At that time the assessment was acute ischemia of left upper extremity, diffuse mild coronary cardiovascular disease, long-standing hypertension, well documented reversal of non-ischemic cardiomyopathy with known small caliber coronary arteries. History of transient ischemic attack with small cerebrovascular accident and peripheral arterial disease, hyperlipidemia, chronic stress anxiety and depression, previous alcohol abuse, chronic left bundle branch block, chronic COPD long-standing due to smoking, reported mildly impaired left ventricular ejection fraction on [redacted] no congestive heart failure on examination.

A transesophageal echocardiogram was also performed which noted in ejection fraction of 55 to 60% of the left ventricular systolic function and noted as normal. During the Claimant's stay her anemia worsened acutely. The Claimant was discharged on [redacted]

On [redacted] the Claimant was seen for a visit regarding Coumadin which she had previously been prescribed. The report notes that the patient was discharged from the hospital with artery clots on [redacted] and received 5 mg of Coumadin for two days, at which time her Coumadin dose was adjusted. This visit was a follow-up due to her

hospitalization due to a near complete occlusion of the left axillary artery with collateral occlusion of the left brachial artery. At the time of the visit post-procedure Claimant presented as healthy without any apparent distress reporting no deficits during the exam.

The Claimant was seen for follow-up on [redacted] due to atrial fibrillation and hyperlipidemia.

On [redacted] the Claimant was seen for medication refill and some lab testing. At that time her systems review was negative for fatigue, fever and night sweats. There was no note regarding any muscular skeletal complaints. At that time no unusual anxiety or evidence of depression was noted. The same evaluation occurred in a follow-up examination on [redacted] During this period the Claimant was primarily seen due to her prescribed Coumadin use which required monitoring.

The Claimant was seen on [redacted] due to severe abdominal bleeding and was admitted to the hospital. The diagnosis was weakness, dysfunctional uterine bleeding, and left sided paresthesias. An MRI of the brain noted cortical atrophy with chronic ischemic changes, no new infarction, hemorrhage or tumor.

The Claimant was admitted to the hospital on [redacted] for a three-day stay. On admission Claimant complained of dizziness, headaches and earlier nausea with increased slurred speech with tingling and numbness in the left arm to the fingertips. A CT of the head noted small stable areas of likely old infarcts noted in the left frontal and left parietal lobes. A new small area of infarction in the right frontal lobe new since [redacted] was also noted. At the time of admission imaging was negative for any thrombus in the venous system or any occlusions in the arterial system of the bilateral upper extremities. Blood pressure was uncontrolled. The Claimant was noted to be on Coumadin therapy due to deep vein thrombosis and gastro intestinal prophylaxis

On [redacted] the Claimant was seen due to bilateral bruising of her legs which occurred approximately one month prior and to monitor Coumadin use. The Claimant was seen in the hospital in May and was found after testing to have systems within normal limits. Claimant denied any trauma to legs or abuse. At that time Claimant was noted as positive for back pain and positive for easy bruising of lower extremities duration 2 to 4 weeks. The Claimant was on Norco for her chronic back pain.

On [redacted] Claimant was seen for follow up and presented with crying and sobbing and looking like a wreck with new bruising on her abdomen. She was transported by ambulance to the ER for anxiety and panic attack and suggesting that she was a risk to herself. It appears that the Claimant was hospitalized until [redacted] for depression and suicidal ideation.

On [redacted] Claimant was seen for follow-up visit due to dizziness which had persisted for two weeks. The Claimant also had complaints of loss of balance and unsteadiness on her feet. At that time Claimant's evaluator noted difficulty

concentrating, dizziness, gait disturbance, uncoordination, insomnia and other psychiatric symptoms. The assessment noted that disk equilibrium was likely multi-factorial medication effects/polypharmacy, B-12 deficiency and peripheral neuropathy.

On [redacted] the Claimant was again seen for follow-up visit, and at that time the assessment was noted that she would receive long-term use of anticoagulant.

On [redacted] the Claimant was seen for generalized fatigue, shortness of breath with mild – moderate activity. The symptoms have been associated with palpations after walking 4 to 5 blocks which are of an irregular pattern and lasting approximately one hour. Claimant presented with complaints of lightheadedness, blurring vision and feeling about to lose consciousness. Claimant also presented with complaints of back and shoulder pain with pain in the left elbow, tingling and numbness in her left hand, and is not responding to Norco, the prescribed pain medication. The Claimant's menses reported to be extremely heavy. As regards depression, Claimant reported loss of interest in any activities and energy due to extreme tiredness and wanting to sleep all the time. Appetite fluctuation also noted. Claimant also expressed suicidal ideation. Clinical notes patient is anxious, is fearful, is forgetful, feels hopeless, has poor attention span and concentration, and has suicidal ideation. In order to address the frequent menstruation and depression, further testing regarding the Coumadin as well as performing a thyroid panel with regard to the depression, noted if no positive findings Claimant will be referred to a psychiatrist. As regards back pain note indicated will continue with current dose of Norco; if no improvement or symptoms worsen, consider increasing the dose or adding another agent.

On [redacted] the Claimant was seen for a follow-up office visit. The notes indicate that the examining physician felt that the current treatment was merely holding pieces together. The examiner expressed that the Claimant was a very lovely person with very tough life circumstances, many dire medical conditions (vasculopathy), financial stressors and home life. Due to these stressors the Claimant expressed a need to see the clinic psychiatrists previously seen. The Claimant was tender to palpations all over her body.

On [redacted] the Claimant was reevaluated by the [redacted] The notes indicate minimal improvement to the various medications that she had been prescribed. Prozac was discontinued.

Claimant was seen in the clinic on [redacted] at which time the assessment was chronic pain associated with significant psychosocial conditions. Claimant went to the emergency room due to acute fracture of her eighth rib and her benign hypertension was not controlled. The clinic psychiatrist saw her on that date and noted Ms. [redacted] suffers from severe chronic pain as well as depression and anxiety. These conditions make her unable to work. She was hospitalized in [redacted] or depression and suicide ideology.

The Claimant was seen in the emergency room due to bleeding secondary to uterus fibroids, left arm numbness and tingling without acute cerebral process.

Claimant was seen at the emergency room on [redacted] due to chest pain, described as aching and constant pain level of 3 out of 10. Also noted was a positive procedure history for exercise treadmill test. The Claimant was discharged without admission in stable condition. An ECG was performed and was noted to be abnormal when compared to prior EKG of two weeks prior. Left bundle branch block is now present myoglobin values and troponin values were indicative of possible myocardial damage.

There were no other medical records submitted.

Here, Claimant has satisfied requirements as set forth in steps one and two, as the Claimant is not currently substantially gainfully employed and has demonstrated a serious impairment. After review of the Listings as required by Step 3 of the sequential evaluation, it is determined that Claimant's impairments do not meet a listing as set forth in Appendix 1, 20 CFR 416.926. Listing 1.04 Disorder of the Spine, 12.04 Affective Disorders (depression), 12.06 Anxiety related Disorders and 4.04 Ischemic Heart Disease were considered and were found not to be met. Therefore, vocational factors will be considered to determine Claimant's residual functional capacity to do relevant work.

In the present case, Claimant has been diagnosed with chronic uncontrolled hypertension, coronary artery disease, and chronic lower back pain with radiation to left lower extremity, with also left arm pain. Claimant has a history of three CVI's with the diagnosis of cardiomyopathy with the last hospitalization in [redacted]. The Claimant has COPD, chronic anemia and vaginal bleeding.

The Claimant also has mental impairments with a diagnosis of depression and anxiety

Claimant has a number of symptoms and limitations, as cited above, as a result of these conditions. Claimant credibly testified to the following symptoms and abilities: Claimant has pain in her back which radiates to her legs, with more radiation on the left, as well as left arm and shoulder pain. Claimant credibly testified that she can stand 30 minutes, can walk on a bad day 1 block, on a good day several blocks, due to blood pressure issues. Claimant cannot lift anything over 10 pounds but also cannot carry 10 pounds. Her ability to sleep is limited and is restless at night due to constant pain in Claimant's lower back. Claimant can sit 30 minutes, and the Claimant also becomes breathless climbing a few stairs making hard to breath and fatiguing. Lastly, Claimant is tired a lot and fatigued and stays home most of the time. The Claimant described her depression as affecting her concentration, friendships and does not want to do anything and prefers social isolation.

The fourth step of the analysis to be considered is whether the Claimant has the ability to perform work previously performed by the Claimant within the past 15 years. The

trier of fact must determine whether the impairment(s) presented prevent the Claimant from doing past relevant work. In the present case, Claimant has employment experience as a bank teller and working at a meat market and deli counter, which work involved filling orders and stocking shelves. In that position the Claimant often picked up 40 to 50 pounds of weight and stood most of the day.

Based upon the medical evidence positive straight leg raising and ongoing depression and anxiety as well as low back pain and shoulder pain and testimony of the Claimant, it is determined that the Claimant's past work required the ability to perform Medium work. This Administrative Law Judge finds, based on the medical evidence summarized above and objective, physical, and psychological findings, that Claimant is not capable of the physical activities required to perform any such position and cannot perform past relevant work, and thus a Step 5 analysis is required 20 CFR 416.920(e).

In the final step of the analysis, the trier of fact must determine if the Claimant's impairment(s) prevent the Claimant from doing other work. 20 CFR 416.920(f). This determination is based upon the Claimant's:

1. residual functional capacity defined simply as "what can you still do despite your limitations?" 20 CFR 416.945;
2. age, education, and work experience, 20 CFR 416.963-965; and
3. the kinds of work which exist in significant numbers in the national economy which the Claimant could perform despite her limitations. 20 CFR 416.966.

The residual functional capacity is what an individual can do despite limitations. All impairments will be considered in addition to ability to meet certain demands of jobs in the national economy. Physical demands, mental demands, sensory requirements and other functions will be evaluated. 20 CFR 416.945(a).

To determine the physical demands (exertional requirements) of work in the national economy, we classify jobs as sedentary, light, medium and heavy. These terms have the same meaning as they have in the Dictionary of Occupational Titles, published by the Department of Labor. 20 CFR 416.967.

> Sedentary work. Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 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. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. 20 CFR 416.967(a).
>
> Light work. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects

> weighing up to 10 pounds. Even though the 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. 20 CFR 416.967(b).
>
> Medium work. Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work. 20 CFR 416.967(c).
>
> Heavy work. Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work. 20 CFR 416.967(d).

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 44 years old and, thus, considered to be considered a younger individual. The Claimant has a high school 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 perform 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). Individuals approaching advanced age (age 50-54) may be significantly limited in vocational adaptability if they are restricted to sedentary work. 20 CFR 416.963(d).

After a review of the entire record, including the Claimant's testimony and medical evidence presented, it is determined that Claimant's impairments have a major effect on her ability to perform even basic work activities. The objective medical evidence provided by the Claimant's medical history and ongoing monthly treatment and medical evaluations by doctors who have previously treated or examined the Claimant place the Claimant at the less than sedentary activity level. The total impact caused by the physical impairments and mental impairments suffered by the Claimant must be considered. In doing so, it is found that the combination of the Claimant's physical

impairments and Claimant's mental impairment for ongoing depression and anxiety have a major impact on her ability to perform basic work activities. Accordingly, it is found that the Claimant is unable to perform the full range of activities for even sedentary work as defined in 20 CFR 416.967(a). After review of the entire record, and in consideration of the Claimant's age, education, work experience and residual functional capacity it is found that the Claimant is disabled for purposes of the MA-P program at Step 5.

The State Disability Assistance program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. Department policies are found in BAM, BEM, and RFT. A person is considered disabled for SDA purposes if the person has a physical or mental impairment 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.

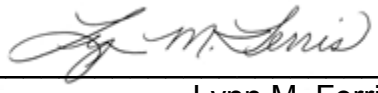
In this case, the Claimant is found disabled for purposes of the MA-P program; therefore, she is found disabled for purposes of SDA benefit program.

Accordingly, the Department's decision is hereby REVERSED

1. The Department is ORDERED to initiate a review of the application dated October 16, 2012 and State disability application of same date if not done previously, to determine Claimant's non-medical eligibility.

2. The Department shall initiate issuance of a supplement to the Claimant for SDA benefits, if any it determines that Claimant is otherwise entitled to receive, in accordance with Department Policy.

3. A review of this case shall be set for October 2014.



Lynn M. Ferris
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: October 31, 2013

Date Mailed: October 31, 2013

NOTICE OF APPEAL: 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 or Reconsideration was

made, within 30 days of the receipt date of the Decision and Order of Reconsideration or Rehearing Decision.

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).

A Request for Rehearing or Reconsideration may be granted when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion;
- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the client;
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The Department, AHR or the Claimant must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date the hearing decision is mailed.

The written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-07322

LMF/cl

cc: [redacted]