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

IN THE MATTER OF:

[redacted]

Reg. No.: 14-004027
Issue No.: 4009
Case No.: [redacted]
Hearing Date: September 18, 2014
County: Wayne (18-Taylor)

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

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, a telephone hearing was held on September 18,2014, from Detroit, Michigan. Participants on behalf of Claimant included Claimant. Participants on behalf of the Department of Human Services (Department) included [redacted]

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional records. Claimant was ordered to obtain a DHS-49, Medical Examination Report, from his treating physician, [redacted] and a DHS-49D, Psychiatric/Psychological Examination Report, and DHS-49E, Mental Residual Functional Capacity Assessment, from his treating psychiatrist, [redacted] The record was extended to October 17, 2014, to allow Claimant to deliver the requested documents. The documents were received, and the record was closed on October 17, 2014. The matter is now before the undersigned for a final determination based on the medical documents presented.

ISSUE

Whether the Department properly determined that Claimant was not disabled for purposes of the State Disability Assistance (SDA) 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. On February 21, 2014, Claimant submitted an application for public assistance seeking SDA benefits.

2. On May 11, 2014, the Medical Review Team (MRT) found Claimant not disabled.

3. On May 17, 2014, the Department sent Claimant a Notice of Case Action denying the application based on MRT's finding of no disability.

4. On May 18, 2014, the Department received Claimant's timely written request for hearing.

5. Claimant alleged physical disabling impairment due to spinal stenosis, lower back and neck pain, and chronic obstructive pulmonary disease (COPD).

6. Claimant alleged mental disabling impairment due to depression.

7. On the date of the hearing, Claimant was 51 years old with an [redacted] birth date; he is 5'11" in height and weighs about 180 pounds.

8. Claimant has an 11th grade education and received state certification to remove asbestos.

9. Claimant has an employment history of work as an asbestos remover and supervisor.

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

CONCLUSIONS OF LAW

Department policies are contained in the Department of Human Services Bridges Administrative Manual (BAM), Department of Human Services Bridges Eligibility Manual (BEM), and Department of Human Services Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180.

A disabled person is eligible for SDA. BEM 261 (July 2014), p. 1. A person is considered disabled for SDA purposes if the person has a physical or mental impairment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. BEM 261, p. 1. To be disabled for SSI purposes, Claimant must be disabled as defined in Title XVI of the Social Security Act (SSA). 20 CFR 416.901. A disability is 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). A person who

meets this standard for at least ninety days is eligible for SDA. BEM 261, p. 2. Receipt of SSI benefits based on disability or blindness, or the receipt of Medical Assistance (MA) benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program. BEM 261, p. 2.

To determine whether an individual is disabled for SSI purposes, federal regulations require application of a five-step sequential evaluation process that requires the trier of fact to consider the following:

> (1) whether the individual is engaged in substantial gainful activity (SGA);
> (2) whether the individual's impairment is severe;
> (3) whether the impairment and its duration meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404;
> (4) whether the individual has the residual functional capacity to perform past relevant work; and
> (5) whether the individual has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work.
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> 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In general, the individual has the responsibility 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, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 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, are insufficient to establish disability. 20 CFR 416.927(d).

Step One

The first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered as not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Claimant has not engaged in SGA activity during the period for which assistance might be available. Therefore, Claimant is not ineligible under Step 1 and the analysis continues to Step 2.

Step Two

Under Step 2, the severity of an individual's alleged impairment(s) is considered. If the individual does not have a severe medically determinable physical or mental impairment that meets the duration requirement, or a combination of impairments that is severe and meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for MA-P means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 12 months. 20 CFR 416.922. For SDA, the duration requirement is 90 days. BEM 261, p. 2.

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). 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); see also *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921(b). Examples include (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b).

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. A disability claim obviously lacking in medical merit may be dismissed. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may 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). However, under the *de minimus* standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs* at 862.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). In the present case, Claimant alleges physical disability due to spinal stenosis, back and neck pain, COPD and a mental disability due to depression. The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

[redacted] an MRI of Claimant's brain showed no evidence of pathologic enhancement or evidence to suggest stroke, no evidence of mesial temporal sclerosis, and a grossly normal MRI appearance in both the contrast and non-contrast imaging.

[redacted] x-rays of Claimant's cervical spine showed multilevel degenerative changes, particularly in the mid and lower cervical spine, but without any obvious subluxation dislocation on flexion-extension view.

[redacted] an MRI of Claimant's cervical spine showed (i) large left paracentral disc osteophyte complex at C3-C4 mildly deforming the ventral cervical cord and causing severe left neural foraminal and lateral recess stenosis, with the exiting left C4 and traversing left C5 nerve roots likely compressed; (ii) central left paracentral disc osteophyte complex at C6-C7 with interval increased ventral cord flattening, with increasing bony spondylotic changes also causing severe left neural foraminal stenosis compressing the exiting left C7 and traversing left C8 nerve roots; and (iii) additional multilevel uncovertebral joint and degenerative disc disease which is largely unchanged from an [redacted] MRI and results in indentation of the ventral cervical cord at multiple levels though no cord signal abnormality is identified.

[redacted] Claimant was seen by the hospital emergency department for a dog bite of the lower leg. An x-ray of the left tibia and fibula showed soft-tissue injury with no evidence of radiopaque foreign body or acute osseous. He was treated with stitches and discharged.

[redacted] Claimant returned to the hospital complaining of worsening pain in the left leg and lower back pain. An x-ray of the lumbar spine showed severe disc space narrowing at L5-S1, moderate disc space narrowing at L4-L5, minimal anterior and plate osteophyte formation at L3-L4; and no evidence of a fracture. The conclusion was spondylotic change of the lower lumbosacral spine. A CT-scan of the thorax with contrast showed coronary artery disease but no aortic intrathoracic process. A chest CTA showed no evidence of pulmonary embolus, and a chest x-ray showed normal chest appearance. Duplex sonography and color-flow analysis of the deep venous system of the left lower extremity showed normal left lower extremity venous duplex examination with no evidence of deep venous thrombosis. Claimant was diagnosed with cellulitis of the left lower leg, elevated troponin, and dog bite of the lower leg. He was discharged [redacted]

[redacted] Claimant was hospitalized after he informed the emergency department that he had pain all over and he planned to jump into the river by his home. He admitted having used cocaine, marijuana and alcohol. Past medical history showed musculoskeletal disorder and chronic back pain. A psychiatric exam at the hospital found that Claimant was oriented to person, place and time and his recent memory and concentration were normal, but his judgment and insight were poor. Suicidal ideations were present. Claimant's primary diagnosis at discharge was depressive disorder with polysubstance dependency. His global assessment

functioning (GAF) score was 20 on admission, 50 on discharge. On discharge, he was in stable condition, not suicidal. He was prescribed neurotin for anxiety and mood swings, celexa for depression and trazodone for sleep. His prognosis was poor.

During his hospitalization, Claimant was examined for foot pain and edema. The consulting doctor noted bilateral ankle pain, right worse than left; significant pitting edema bilateral lower extremity with sharp aching burning pain with manipulation of the right posterior knee, right posterior leg muscles extending to the ankle joint, with the pain extending to the digits bilaterally, right worse than left; non-diabetic neuropathy, likely secondary to chronic back pain, suspected proximal nerve compression syndrome; onychomycosis with underlying poor pedal hygiene; and hammertoes.

[redacted] Claimant was referred to a consultation for possible pneumonia. The doctor found that Claimant's chest x-ray showed definite left lower lobe infiltrate, but unclear concerning the right side. The doctor noted acute pneumonia, COPD and a history of asbestos exposure and recommended follow-up testing if the infiltrates failed to resolve in one month.

[redacted] Claimant had a psychiatric evaluation with [redacted] who found that (i) Claimant's appearance was pleasant but he appeared stiff, as if he had pain in his back, (ii) his mood was slightly sad and his affect restricted; (iii) his thinking was scattered but without psychosis; (iv) he was oriented to person but did not know the day of the month; (v) he had limited immediate, recent and remote memory; (vi) his concentration, insight, and judgment was limited; (vii) he did not have suicidal or homicidal thoughts. His GAF score was 50. His prognosis was guarded. His diagnosis was major depressive disorder, single episode, moderate, and included polysubstance dependence. The evaluation noted that Claimant wanted continued valium prescriptions and the doctor agreed to provide one month's prescription and advised him of the need to take an antidepressant.

[redacted] Claimant's psychiatrist completed a DHS-49, Medical Examination Report, identifying Claimant's diagnosis as major depressive disorder, single episode, moderate and pain. The doctor found that Claimant's mental condition was calm and alert but that his judgment, concentration and insight were limited. His condition was identified as deteriorating. The doctor identified limitations in Claimant's ability to carry any weight, his ability to stand, walk or sit, and his use of either arm or hand to push or pull.

[redacted] Claimant had a CT of his head without contrast in response to dizziness and giddiness; the results showed no acute intracranial process. .

[redacted] Claimant went to follow-up visits with [redacted] that showed normal range of motion for the neck and musculoskeletal and negative for psychiatric/behavior issues.

[redacted] Claimant was hospitalized for in-inpatient psychiatric treatment after police found him during a suicide attempt and brought him to the hospital. Claimant was diagnosed with major depressive disorder, recurrent, severe, without psychosis, anxiety disorder, chronic pain issues and bronchitis. Claimant received medication and was discharged with no suicidal or homicidal thought or perpetual disturbances but a notation in the discharge document indicated that his judgment and insight were marginal. Attention, concentration and memory were marginal at admission, adequate at discharge.

[redacted] Claimant's treating physician completed a DHS-49, medical exam report, identifying Claimant's condition as knee pain, back pain, and bipolar disorder. The doctor stated that Claimant had physical impairments that (i) kept him from lifting any weight; (ii) required him to use a cane to ambulate; (iii) made him unable to use his hands or arms to reach or push/pull. No limitations were identified concerning Claimant's ability to stand, walk or sit or concerning his ability to grasp and manipulate and to operate foot or leg controls. Although the doctor marked that Claimant's limitations were not expected to last more than 90 days, he also indicated that Claimant's condition was deteriorating. The doctor also noted that Claimant had mental limitations concerning comprehension, sustained concentration, reading/writing, and memory.

[redacted] a psychiatrist at [redacted] Claimant's mental health provider, completed a mental residual functional capacity assessment for Claimant. The doctor found that Claimant was not significantly limited with respect to his understanding and memory but he was moderately limited with respect to his ability to (i) carry out detailed instructions; (ii) sustain an ordinary routine without supervision; (iii) work in coordination with or proximity to others without being distracted by them; (iv) make simple work-related decisions; (v) interact appropriately with the general public; (vi) ask simple questions or request assistance; (vii) respond appropriately to change in the work setting; and (viii) be aware of normal hazards and take appropriate precautions. Claimant was found to be markedly limited with respect to his ability to (i) perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; (ii) complete a normal workday and worksheet without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods; (iii) accept instructions and respond appropriately to criticism from supervisors; (iv) get along with co-workers or peers without distracting them or exhibiting behavioral extremes; (v) maintain socially appropriate behavior and adhere to basic standards of neatness and cleanliness; (vi) travel in unfamiliar places or use public transportation; and (vii) set realistic goals or make plans independently of others.

In consideration of the *de minimus* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Claimant suffers from severe impairments that have lasted or are expected to last for a

continuous period of not less than 12 months. Therefore, Claimant has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step Three

Step 3 of the sequential analysis of a disability claim requires a determination of whether the individual'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 an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

The evidence shows diagnosis of, and treatment for, depression and back and neck pain, and lower left leg pain. Based on the objective medical evidence concerning Claimant's mental condition, listings 12.04 (affective disorders) and 12.09 (substance addiction disorders) were considered. However, Claimant's medical file does not establish the required medically-documented persistence of characteristics or the medically-documented two years' duration necessary to meet or equal the requirements of the listings.

With respect to Claimant's diagnosis, and treatment for, back and neck pain, listing 1.04 (disorders of the spine) was reviewed. With respect to his lower left leg pain from the 2013 dog bite and from evidence in the medical record concerning neuropathy, listings 1.08 (soft tissue injury) and 11.14 (peripheral neuropathies) were reviewed. The medical evidence fails to establish continuing surgical management or a significant and persistent disorganization of motor function in two extremities (listing 11.04B) necessary to support meeting either listing.

Therefore, Claimant's impairments do not meet, or equal, the required level of severity of a listing to be considered as disabling without further consideration. The disability analysis, therefore, proceeds to Step 4.

Residual Functional Capacity

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Step 4, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. Impairments, and any related symptoms, may cause physical and mental limitations that affect what a person can do in a work setting. 20 CFR 416.945(a)(1). RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s) and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4). The total limiting effects of all impairments, including those that are not severe, are considered. 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s)

provided by the individual or other persons. 20 CFR 416.945(a)(3). This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If the limitations and restrictions imposed by the individual's impairment(s) and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b). To determine the exertional requirements, or physical demands, of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a).

> 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.
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> 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. 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. If someone can do light work, … he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.
>
> 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, … he or she

> can also do sedentary and light work.
>
> 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, … he or she can also do medium, light, and sedentary work.
>
> Very heavy work.
> Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If someone can do very heavy work, … he or she can also do heavy, medium, light, and sedentary work.
>
> 20 CFR 416.967.

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands (i.e., sitting, standing, walking, lifting, carrying, pushing, or pulling), the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (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, Claimant alleged both exertional limitations due to his back and neck pain and lower left leg pain and nonexertional limitations due to his depression. When a person has a combination of exertional and nonexertional limitations or restrictions, the rules in Appendix 2 provide a framework to guide a decision but do not directly apply unless there is a rule that directs a conclusion that the client is disabled. 20 CFR 416.969a(d).

Claimant testified that, because of his pain, he could only walk 50 feet before he would need to rest, that he could only sit 10 to 15 minutes at a time, that he could only take stairs if he moved slowly, that he could only stand for 10 minutes at a time. He

complained that his back hurt when he tried to lift a gallon of milk and that his hand shook when he tried to write.

Claimant explained that he lived with a friend. He could bathe himself but it took a long time; his shower was equipped with a handicap bar to assist him. Claimant stated he could dress himself but it would take up to an hour and he modified his attire to wear slip-on shoes with no ties and to wear clothing with zippers rather than buttons. His daughter did the cooking, cleaning, and laundry; he explained that his pain prevents him from doing these things himself.

Claimant's medical record supports his testimony concerning his neck and back pain as well as neuropathy. [redacted] MRI of Claimant's cervical spine showed (i) large left paracentral disc osteophyte complex at C3-C4 mildly deforming the ventral cervical cord and causing severe left neural foraminal and lateral recess stenosis, with the exiting left C4 and traversing left C5 nerve roots likely compressed; (ii) central left paracentral disc osteophyte complex at C6-C7 with interval increased ventral cord flattening, with increasing bony spondylotic changes also causing severe left neural foraminal stenosis compressing the exiting left C7 and traversing left C8 nerve roots; and (iii) additional multilevel uncovertebral joint and degenerative disc disease which is largely unchanged from an [redacted] MRI and results in indentation of the ventral cervical cord at multiple levels though no cord signal abnormality is identified. An x-ray of Claimant's lumbar spine on [redacted] showed severe disc space narrowing at L5-S1, moderate disc space narrowing at L4-L5, minimal anterior and plate osteophyte formation at L3-L4; and no evidence of a fracture. The conclusion was spondylotic change of the lower lumbosacral spine. Following a foot exam during Claimant's [redacted] hospitalization, the doctor noted non-diabetic neuropathy, likely secondary to chronic back pain.

While Claimant's treating physician indicated in a cursory comment [redacted] notes concerning an office visit that Claimant had normal range of motion of the neck and musculoskeletal system, it is noted that this was Claimant's first office visit with the doctor after his [redacted] hospitalization. In the [redacted] DHS-49, medical exam report he completed, the same doctor indicated that Claimant had limitations with respect to lifting any weight and using either hand to reach or push/pull, and his condition was deteriorating. Although the doctor identified the limitations as not expected to last more than 90 days, this appears to be an error in light of his indication that Claimant's condition is deteriorating. In light of the doctor's extensive responses in the DHS-49, his cursory comment in his [redacted] notes is given limited weight.

Ultimately, after review of the entire record to include Claimant's testimony, it is found based on Claimant's physical conditions that Claimant maintains the physical capacity to perform, at best, sedentary work as defined by 20 CFR 416.967(a).

Claimant also has additional limitations resulting from his mental condition. For mental disorders, 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 are considered. 20 CFR 416.920a(c)(1).

At the hearing, Claimant explained that he was depressed and his depression had led to several suicide attempts, resulting in three hospitalizations. His medication helped with his anxiety attacks and his crying spells. He testified that he did not get together on a regular basis with any family other than the daughter who helped care for him but admitted that sometimes his friends took him out.

Claimant's medical record supports two hospitalizations based on suicidal episodes: [redacted] Claimant was hospitalized after he informed the emergency department that he had pain all over and he planned to jump into the river by his home, and [redacted] he was hospitalized for inpatient psychiatric treatment after police found him during a suicide attempt and brought him to the hospital. He is diagnosed with major depressive disorder, recurrent, severe, without psychosis. At the [redacted] hospitalization, his global assessment functioning (GAF) score was 20 on admission, 50 on discharge, and while his condition at discharge was stable, not suicidal, his prognosis was poor. After the [redacted] incident, he was medicated and discharged with no suicidal or homicidal thoughts or perpetual disturbances but the discharge document indicates that Claimant's attention, concentration and memory were marginal at admission, adequate at discharge, and his judgment and insight were marginal.

[redacted] Claimant had a psychiatric evaluation with [redacted] who found that Claimant's thinking was scattered but without psychosis; he had limited immediate, recent and remote memory; and his concentration, insight, and judgment were limited. His GAF score was 50, and his prognosis was guarded. The doctor noted that Claimant wanted continued valium prescriptions and the doctor agreed to provide one month's prescription and advised him of the need to take an antidepressant. Claimant's psychiatrist completed a DHS-49, Medical Examination Report, [redacted] identifying Claimant's diagnosis as major depressive disorder, single episode, moderate, and pain and indicating that Claimant's mental condition was calm and alert but that his judgment, concentration and insight were limited. His condition was identified as deteriorating.

[redacted] a psychiatrist at [redacted], Claimant's mental health provider, completed a mental residual functional capacity assessment for Claimant finding that Claimant was moderately or markedly limited in abilities pertaining to sustained concentration and persistence, social interaction, and adaptation.

In assessing Claimant's mental RFC, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered with the degree of limitation for the first three

functional areas rated by a five-point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(3) and (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.* Based on the medical record and Claimant's testimony, Claimant has moderate to marked limitations on his mental ability to perform basic work activities.

Claimant's RFC is considered at both Steps 4 and 5. 20 CFR 416.920(a)(4), (f) and (g).

Step Four

The fourth step in analyzing a disability claim requires an assessment of Claimant's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

As determined in the RFC analysis above, Claimant is limited to no more than sedentary work activities and has moderate to marked limitations on his mental ability to perform basic work activities. Claimant's work history in the 15 years prior to the application consists of work as an asbestos remover (skilled, medium). In light of the entire record and Claimant's RFC, it is found that Claimant is unable to perform past relevant work. Accordingly, Claimant cannot be found disabled, or not disabled, at Step 4 and the assessment continues to step 5.

Step 5

In Step 5, an assessment of Claimant's RFC 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 this point in the analysis, the burden shifts from Claimant to the Department to present proof that Claimant has the RFC to obtain and maintain SGA. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). The age for younger individuals (under 50) generally will not seriously affect the ability to adjust to other work. 20 CFR 416.963(c). If the individual can adjust

to other work, then there is no disability. Disability is found if an individual is unable to adjust to other work. *Id.*

In this case, at the time of hearing, Claimant was 51 years old and, thus, considered to be a closely-approaching-advanced-age individual for MA-P purposes. Claimant has an 11th grade education and did not complete high school. While Claimant maintains the physical RFC for work activities on a regular and continuing basis to meet the physical demands required to perform sedentary work as defined in 20 CFR 416.967(a), he has moderate to marked limitations in his mental abilities to engage in work activities on a regular and continuing basis. Accordingly, after review of the entire record and in consideration of Claimant's age, education, work experience, RFC, and using the Medical-Vocational Guidelines (20 CFR 404, Subpart P, Appendix II) as a guide, specifically Rule 201.10, Claimant is found disabled at Step 5.

It is noted that, although at the hearing Claimant denied alcohol or illegal drug use, his medical record includes references to such use, with the psychiatric diagnosis including polysubstance abuse. However, there is no evidence that Claimant's drug and alcohol use is material to his physical and mental impairments.

DECISION AND ORDER

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

Accordingly, the Department's determination is REVERSED.

THE DEPARTMENT IS ORDERED TO BEGIN DOING THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE OF MAILING OF THIS DECISION AND ORDER:

1. Process Claimant's February 21, 2014, SDA application to determine if all the other non-disability criteria are satisfied and notify Claimant of its determination;

2. Supplement Claimant for lost benefits, if any, that Claimant was entitled to receive if otherwise eligible and qualified, from February 1, 2014 onging;

3. Review Claimant's continued eligibility in November 2015.

Alice Elkin
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: **10/23/2014**

Date Mailed: **10/23/2014**

ACE / pf

NOTICE OF APPEAL: A party may appeal this Hearing Decision in the circuit court in the county in which he/she resides, or the circuit court in Ingham County, within 30 days of the receipt date.

A party may request a rehearing or reconsideration of this Hearing Decision from the Michigan Administrative Hearing System (MAHS) within 30 days of the mailing date of this Hearing Decision, or MAHS may order a rehearing or reconsideration on its own motion.

MAHS may grant a party's Request for Rehearing or Reconsideration 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 party requesting a rehearing or reconsideration 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 this Hearing Decision is mailed.

A written request may be faxed or mailed to MAHS. If submitted by fax, 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

cc: [redacted]