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

IN THE MATTER OF:

Reg. No.: 2015-24
Old Reg No: 2014-22378
Issue No.: 2009
Case No.:
Hearing Date: May 14, 2014
County: Jackson

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

HEARING DECISION

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to the Claimant's Authorized Hearing Representative's (AHR) timely Request for Rehearing/Reconsideration of the Hearing Decision generated by the assigned Administrative Law Judge (ALJ) at the conclusion of the hearing conducted on May 14, 2014, and mailed on June 27, 2014, in the above-captioned matter.

The Rehearing and Reconsideration process is governed by the Michigan Administrative Code, Rule 400.919, *et seq.*, and applicable policy provisions articulated in the Bridges Administrative Manual (BAM), specifically BAM 600, which provide that a rehearing or reconsideration must be filed in a timely manner consistent with the statutory requirements of the particular program or programs that is the basis for the claimant's benefits application, and **may** be granted so long as the reasons for which the request is made comply with the policy and statutory requirements.

This matter having been reviewed, an Order Granting Reconsideration was mailed on November 10, 2014.

ISSUE

Whether the Department properly determined that Claimant was not disabled for purposes of the Medical Assistance (MA) benefit 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. Findings of Fact No. 1 through 6 under Registration Number 2014-22378 are incorporated by reference.

2. On May 14, 2014, a hearing was held resulting in a Hearing Decision mailed on June 27, 2014, which found Claimant was not disabled.

3. On July 25, 2014, Claimant's authorized representative requested reconsideration/rehearing.

4. The Request for Rehearing/Reconsideration was GRANTED.

CONCLUSIONS OF LAW

In the instant case, Claimant requested rehearing/reconsideration asserting misapplication of policy that would impact the outcome of the original hearing decision.

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a). The person claiming a physical or mental disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 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). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

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

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

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need 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). If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3

to Step 4. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

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).

As outlined above, the first step looks at the individual's current work activity. To be eligible for disability benefits, a person must be unable to engage in **substantial gainful activity** (**SGA**). A non-blind person who is earning more than $ SGA in 2014, is ordinarily considered to be engaging in SGA. In the record presented, Claimant testified that she was working and had been working, 20-25 hours a week at $ an hour since 2011, earning approximately $ a month. Therefore, Claimant is not involved in substantial gainful activity and is not disqualified from receiving disability benefits under Step 1.

The severity of the individual's alleged impairment(s) is considered under Step 2. The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b). An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b). Examples include:

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

2. Capacities for seeing, hearing, and speaking;

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

4. Use of judgment;

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

6. Dealing with changes in a routine work setting. *Id.*

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

In the present case, Claimant alleges disability due to cervical spinal stenosis, lower back pain, degenerative disc disease, osteoarthritis bilateral knees, hepatitis C, asthma, spinal spondylosis, gastroesophageal reflux disease, arthritis, learning disorder, collapsed and bulging discs at C5, C6, and C7, lumbago, sciatica, neuropathy, irritable bowel syndrome and rotator cuff tear in the left shoulder, depression and posttraumatic stress disorder.

In support of her claim, Claimant submitted the following medical records.

On [redacted], Claimant presented to the emergency department complaining of local pain over the left shoulder. The affected joint was painful with movement. Claimant had mild to moderate joint pain with movement of the left clavicle and AC joint. It was extremely tender to palpation over the left clavicle and AC joint. Examination over the left clavicle and AC joint demonstrated a mild to moderate amount of swelling. The rest of the shoulder exam was normal. Claimant was discharged in stable condition.

On [redacted], an MRI of the cervical spine showed mild to moderate degenerative disc disease at C5-C6 and C6-C7 levels and minimal disc degeneration at C4-C5. At C5-C6, there is a small asymmetric disc bulge or protrusion along left posterior disc and additional disc bulge and disc osteophyte complex along the posterior lateral disc. These appear to be mainly chronic findings at C5-C6, are associated with mild spinal stenosis and moderate narrowing of the left C5-C6 neuroforamen. At C6-C7, there is a small to moderate-sized disc herniation along the left posterior disc. This results in asymmetric effacement of the left lateral recess and to a mild degree of the left anterior cord contour. This also encroaches on the medial left C6-C7 neural foramen causing moderate neuroforaminal narrowing. This disc herniation at C6-C7 has developed since the prior exam of [redacted]. The MRI of the left shoulder revealed evidence of mild impingement of the rotator cuff and mild rotator cuff tendinopathy involving supraspinatus and infraspinatus tendons. The MRI also showed a low-grade partial tear along the undersurface of the mid to distal supraspinatus tendon, over a diameter of approximately 7 x 9mm.

On [redacted], Claimant was evaluated for physical therapy of her left arm. During the evaluation, Claimant became nauseas and vomited. Claimant's primary physician was notified, and physical therapy was canceled and she was referred to another physician.

On [redacted], Claimant was seen for low back pain down the center of the spine which radiated to both legs. X-rays showed degenerative disc disease of L3-L4 and L4-L5 which represented progression since the prior examination on [redacted].

On [redacted] Claimant had x-rays for bilateral knee pain which had gotten progressively worse. The x-rays revealed minimal narrowing of right lateral patellofemoral joint space and right medial knee joint space. There was minimal to moderate narrowing of left lateral patellofemoral joint space and mild progressive bilateral medial knee joint space narrowing with weight bearing.

On [redacted], Claimant presented to the emergency room complaining of chest pain. There was no change with DuoNeb and nitroglycerin. She was admitted for observation. Her EKG was checked, showing questionable anteroseptal infarct and bradycardia with borderline right axis deviation. There was a QS pattern V1 through V3 and several of the EKGs with inverted T waves. She was ruled out with serial troponins. A head CT scan showed some minimal chronic left ethmoid sinusitis and was otherwise negative. The exercise stress echocardiogram on [redacted] was normal, with normal left ventricular size and systolic function and exercise capacity. It was negative for ischemia. The left ventricular ejection fraction was 60%.

Claimant's treating physician completed a Medical Examination Report dated [redacted]. Claimant was diagnosed with hepatitis C, allergic rhinitis, asthma, irritable bowel syndrome, cervical spondylosis, shortness of breath and sore throat. During the examination, Claimant was irritable and complained of night sweats, vertigo, blood in stool, constipation, diarrhea, hemorrhoids, and nausea. Claimant had moderate dyspnea, with wheezing. She was having palpitations. She also complained of back pain, headache, and syncope. She was anxious. The physician opined Claimant's condition was deteriorating. Claimant is limited to lifting/carrying less than 10 pounds, standing/walking less than 2 hours in an 8-hour workday, unable to sit about 6 hours in an 8 hour workday and no simple grasping, reaching, pushing or pulling.

On [redacted], an ultrasound of Claimant's liver was performed for hepatitis C. The ultrasound was unremarkable of the liver and right upper quadrant.

On [redacted], Claimant presented to her primary care physician with musculoskeletal pain. The pain is constant and worsening in her right shoulder due to an injury. The pain is aggravated by lifting, movement, pushing, sitting and standing. Associated symptoms include decreased mobility, difficulty initiating sleep, nocturnal awakening, nocturnal pain, numbness and weakness. She also has right sided back pain with sciatica to the entire right leg. The physician opined that other joint pain may be related to untreated hepatitis C.

On [redacted], Claimant attended an office visit with her primary care physician for medication refills, weight gain and back pain. Claimant is still gaining weight in the context of current medications, decreased mobility, decreased physical activity, depression and stress. Her back pain severity level is moderate to severe. Location of the pain is middle back, lower back and neck. The pain radiates to the right foot. Symptoms are aggravated by daily activities.

On [redacted], Claimant presented to the [redacted] with cervical spine pain. Claimant described the pain as constant and located in the bilateral lateral and posterior neck. The pain radiates to the left shoulder and left arm to index and ring fingers.

She described the pain as aching, burning, sharp, stabbing, tingling, numbness, cracking, snapping and popping. She had numbness and tingling in her right arm. The examination revealed the biceps deep tendon reflex was absent on the right and left, the brachloradialis deep tendon reflex was absent on the right and left, and the triceps deep tendon deep tendon reflex was absent on the right and left. Claimant was assessed with cervical spinal stenosis and radiculitis of left cervical region. She was scheduled for a cervical epidural steroid injection.

On [redacted], Claimant presented to the emergency department after being assaulted by her husband. Claimant had a loss of consciousness and said he hit her in the jaw. She denied her jaw hurting but said her head hurt. She also reported right ankle pain. The skin over the right medial malleolus was intact without visible abrasion or laceration. There was pain noted over the right medial malleolus. A deformity was noted over the right medial malleolus. Claimant was unable to bear weight to walk. She was diagnosed with a minor head injury, strain of neck muscle, contusion of elbow and sprain of ankle. A CT of the head showed a hypodensity within the left external capsule is nonspecific. If she has local neurological deficit, an acute infarct is difficult to exclude. Right ankle x-rays showed medial soft tissue swelling without evidence of fracture or dislocation. Claimant was discharged in stable condition with an ankle splint and crutches.

On [redacted], Claimant followed up with her primary care physician after the assault. Claimant was assessed with menopausal and perimenopausal disorder, abnormal brain MRI, asthma and ankle enthesopathy. Claimant was counseled regarding menopause and started on a trial of Premarin. She was referred to [redacted] to evaluate the abnormal MRI. The physician counseled Claimant on controlling exposure to allergens and prescribed a nebulizer and inhaler. She was also instructed on keeping the ankle elevated, applying ice 20 minutes three times a day and to wear an air cast when out of the house.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). Based on the medical evidence, Claimant has presented medical evidence establishing that she does have some physical and mental limitations on her ability to perform basic work activities. The medical evidence has established that Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, Claimant is not disqualified from receipt of MA-P benefits under Step 2 and the ALJ erred in finding otherwise.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The evidence confirms treatment/diagnoses of cervical spinal stenosis, lower back pain, degenerative disc disease, osteoarthritis bilateral knees, hepatitis C, asthma, spinal spondylosis, gastroesophageal reflux disease, arthritis, learning disorder, collapsed and bulging discs at C5, C6, and C7, lumbago, sciatica, neuropathy, irritable bowel syndrome and rotator cuff tear in the left shoulder, depression and posttraumatic stress disorder.

Listing 1.00 (musculoskeletal system), Listing 3.00 (respiratory system), Listing 5.00 (digestive system) and Listing 12.00 (mental disorders) were considered in light of the objective evidence. Based on the foregoing, it is found that Claimant's impairment(s) do not meet the intent and severity requirement of a listed impairment; therefore, Claimant cannot be found disabled at Step 3. Accordingly, the Claimant's eligibility is considered under Step 4. 20 CFR 416.905(a).

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

This step examines the physical and mental demands of the work done by Claimant in the past. 20 CFR 416.920(f). Claimant's past work history is that of a janitor/housekeeper and as such, Claimant would be unable to perform the duties associated with her past work. Likewise, Claimant's past work skills will not transfer to other occupations. Accordingly, Step 5 of the sequential analysis is required.

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, Claimant had a high school education, was 47 years old and was, thus, considered to be a younger individual for MA-P purposes. Disability is found if an individual is unable to adjust to other work. *Id.*

At this point in the analysis, the burden shifts from the Claimant to the Department to present proof that the Claimant has the residual capacity to substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

The Department failed to provide vocational evidence which establishes that Claimant has the residual functional capacity for substantial gainful activity and that given Claimant's age, education, and work experience, there are significant numbers of jobs in the national economy which Claimant could perform despite Claimant's limitations.

In addition, Claimant's treating physician has opined that Claimant's condition is deteriorating and her restrictions are for less than sedentary work. Because Claimant's treating physician's opinion is well supported by medically acceptable clinical and laboratory diagnostic techniques, it has controlling weight. 20 CFR 404.1527(d)(2). Accordingly, this Administrative Law Judge concludes Claimant is disabled for purposes of the MA program.

As a result, the ALJ's determination which found Claimant not disabled at Step 2 (non-severe impairment) is VACATED and the Department's determination which found Claimant is not disabled is

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, it is determined that Administrative Law Judge erred in affirming the Department's determination which found Claimant not disabled.

Accordingly, it is ORDERED:

1. The ALJ's Hearing Decision mailed on June 27, 2014, under registration Number 2014-22378 which found Claimant not disabled is VACATED.

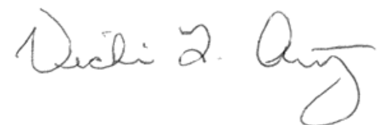
2. The Department's determination which found Claimant not disabled is **REVERSED**.

3. The Department shall initiate processing of the August 20, 2013, application to include any applicable requested retroactive months, to determine if all other non-medical criteria are met and inform Claimant of the determination in accordance with Department policy.

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

5. The Department shall review Claimant's continued eligibility in December, 2015, in accordance with Department policy.

IT IS SO ORDERED.



Vicki L. Armstrong
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: December 4, 2014

Date Mailed: December 4, 2014

NOTICE OF APPEAL: The law provides that within 30 days of receipt of this decision, the Claimant may appeal this decision to the circuit court for the county in which he/she lives.

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