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

IN THE MATTER OF:

Reg. No.:	201366125
Issue No.:	2009; 4009
Case No.:	
Hearing Date:	January 29, 2014
County:	Wayne (49)

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 January 29, 2014 from Detroit, Michigan. Participants on behalf of Claimant included Claimant. Participants on behalf of the Department of Human Services (Department) included , Family Independence Manager.

During the hearing, Claimant waived the time period for the issuance of this decision, in order to allow for the submission of additional records. The records were received, reviewed, and forwarded to the State Hearing Review Team (SHRT) for consideration. On May 6, 2014, this office received the SHRT determination which found Claimant not disabled. This matter is now before the undersigned for a final determination.

ISSUE

Did the Department properly determine that Claimant was not disabled for purposes of the Medical Assistance (MA-P) and State Disability Assistance (SDA) benefit programs?

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 March 21, 2013, Claimant submitted an application for public assistance seeking MA-P and SDA benefits.

2. On August 14, 2013, the Medical Review Team (MRT) found Claimant not disabled.

3. On August 15, 2013, the Department sent Claimant a Notice of Case Action denying the application based on MRT's finding of no disability.

4. On August 26, 2013, the Department received Claimant's timely written request for hearing.

5. On October 14, 2013 and April 25, 2014, SHRT found Claimant not disabled.

6. Claimant alleged physical disabling impairment due to multiple sclerosis and fibromyalgia.

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

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

9. Claimant did not complete high school.

10. Claimant has an employment history of work as press operator, labeler, and dispatcher.

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

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Family Independence Agency) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

The State Disability Assistance (SDA) program is established by the Social Welfare Act, MCL 400.1-.119b. The Department of Human Services (formerly known as the Family Independence Agency) administers the SDA program pursuant to 42 CFR 435, MCL 400.10 and Mich Admin Code, R 400.3151-.3180.

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

MA-P and SDA benefits are available to disabled individuals. BEM 105 (January 2014), p. 1; BEM 260 (July 260); BEM 261 (July 2013), p. 1. In order to receive MA benefits based upon disability, Claimant must be disabled as defined in Title XVI of the Social Security Act. 20 CFR 416.901. Disability for MA purposes 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).

In order to determine whether or not an individual is disabled, federal regulations require application of a five-step sequential evaluation process. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider (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. 20 CFR 416.920(a)(4); 20 CFR 416.945.

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

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

As outlined above, 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 substantial gainful activity (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. She testified that she had attempted to apply for dispatcher positions and believed she could do the work but was denied employment because of her medical history. Because Claimant has not engaged in SGA during the relevant period, she 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 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.

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 multiple sclerosis (MS) and fibromyalgia.

Claimant was diagnosed with MS in 2010. On May 8, 2010, she was hospitalized, complaining of increased right-sided tingling and numbness from her foot to her face. She added that her skin on her right side was sensitive to touch and her arm felt increasingly heavy. A CT of Claimant's head showed no acute intracranial process. An MRI of Claimant's brain and stem showed more than 20 T2hyperintense lesions in the supratentorial white matter with involvement of the medulla and upper cervical spinal cord. The doctor concluded that the appearance and distribution of the lesions was consistent with a demyelinating process such as multiple sclerosis.

On June 29, 2010, Claimant was seen at the emergency department for right arm pain. Claimant stated she had intermittent numbness and tingling in her right arm and her Lyrica was not helping. Her gait was normal, and she denied any dizziness, blurry vision, or difficulty walking. Claimant was able to move all extremities equally and symmetrically with good tone and strength. Claimant's pain was treated although the attending doctor did not believe that the pain was associated with her MS.

On September 20, 2010, Claimant was seen at the emergency department for joint pain and a rash on her face. The doctor concluded that Claimant's pain was possibly due to MS exacerbation. Claimant informed the doctor that the facial rash also was related to her MS. Claimant was given Toradol and Solu-Medrol and discharged in fair condition.

On January 2, 2011, Claimant was seen at the emergency department for pain in her right extremities located in her joints that she described as so intolerable that her Vicodin prescription did not ameliorate her symptoms. She described the pain in her joints as diffuse and not related to any movement or tender to palpation. She also complained of shaking in the right lower extremity, which she stated was new, and a rash on her face that she attributed to the Copaxone that she administers to 7 different sites on her body. The doctor noted that Claimant was able to ambulate without difficulty and muscle strength was 5/5 on the left extremities and on the right upper extremity and 4/5 on the right lower extremity. Claimant's symptoms were deemed exacerbation of her MS. Claimant was administered Toradol, prednisone and morphine and discharged in fair condition.

On January 25, 2011, Claimant was seen at the emergency department for pain in her bilateral lower extremities and face consistent with pain experienced with her MS. Claimant stated that she often came to the emergency department for treatment for her pain. Claimant's examination was essentially unremarkable. Claimant moved all extremities spontaneously and no motor deficits or facial asymmetry was noted.

Claimant was administered Dilaudid subcutaneously and discharged with a prescription for Vicodin.

On February 25, 2011, Claimant was seen at the emergency department for chronic aching pain on the right side of her body. She had no weakness or neurological deficits. The doctor noted normal gait, equal motor strength in all extremities, normal sensation, and no visual complaints. Claimant was given a prescription for tramadol and discharged in improved condition. Claimant was administered Dilaudid and prescribed Vicodin at discharge.

On March 17, 2011, Claimant was admitted into the hospital after complaining of headaches and suspected MS exacerbation. Chronic right-sided weakness of about 4/5, unchanged from her baseline, was noted. Because of a questionable finding in the midbrain on the CT scan, she was admitted and an MRI was performed that showed no evidence of anything other than typical MS changes and did not confirm any lesion in the midbrain. However, after the MRI, Claimant experienced chest pain that partially responded to nitroglycerin. A subsequent cardiac workup showed normal EKG and normal troponins and a consulting cardiologist concluded her pain was atypical and no further workup was necessary. Claimant had a somewhat elevated blood pressure. She was discharged on March 20, 2011.

On April 17, 2011, Claimant was seen at the emergency department for acute generalized pruritus. The doctor concluded that she had no airway symptoms and was not in need of prednisone. Claimant was prescribed Benedryl and discharged home in good condition.

On May 18, 2011, Claimant was seen at the emergency department for chronic leg pain that she stated was associated with an MS flare up. She did not complain of any weakness, and no difficulty with balance or gait was observed. Claimant was given a dose of Vicodin and discharged in good condition.

On June 20, 2011, Claimant was seen at the emergency department for chronic leg pain that she stated was associated with an MS flare up. Claimant admitted taking Lyrica, the medication prescribed to her by her neurologist but was unsatisfied with how the drug treated her pain. The treating doctor noted that Claimant was walking without difficulty and laboratory tests, mainly electrolytes, were normal. She had no focal motor deficits in her extremities. She had palpable dorsalis pedis pulse in feet. She had paresthesia on palpation of toes on both feet with intact sensation. Claimant was given pain medication but advised that the emergency department would not adjust medication prescribed to her by her neurologist to treat her MS. She was discharged in good condition.

On August 17, 2011, Claimant was seen at the emergency department for intermittent slurred speech, likely due to exacerbation of her MS. She was treated with prednisone after indicating that she did not wish to be admitted for steroids therapy and was discharged in stable condition.

A February 28, 2012 MRA of Claimant's head and MRI of her brain. The MRI revealed nonspecific foci of abnormal signal involving the deep white matter which could be seen with a small vessel ischemic disease and, more probably, demyelinating process such as MS. The MRA was unremarkable.

On July 9, 2012, Claimant was seen at the hospital emergency department at the request of her primary care physician after she complained of intermittent tingling in both legs that she believed was a new MS symptom. In consultation with Claimant's family doctor, the emergency department doctor, who noted Claimants' extensive medications prescribed by her neurologist, gave Claimant a Solu-medrol IV and sent her home with a Medrol Dosepak.

On July 18, 2012, Claimant went to the hospital complaining of weakness in the muscles in her lower extremities that made it difficult to walk, and she was admitted for an exacerbation of her MS and for intravenous steroid. An MRI of Claimant's thoracic spine on July 19, 2012 showed preserved spine alignment, unremarkable intervertebral disc spaces and vertebral body heights, no disc herniation or spinal canal stenosis, and no abnormal marrow signal. It also showed numerous patchy foci of increased T2 signal within the thoracic spine primarily located above the T8 level with none demonstrating post-gadolinium enhancement. The radiologist concluded that the patchy increased T2 signal was consistent with Claimant's MS diagnosis. However, no enhancing lesions were identified, and there was no comparison imaging to evaluate for new lesions. Claimant was discharged on July 19, 2012 in improved condition.

On September 18, 2012, Claimant was admitted to the hospital complaining of shortness of breath. The doctor concluded that the symptoms were suggestive for possible congestive heart failure. A 2-D echo revealed normal ejection fraction of 55% to 60%. A chest x-ray showed clear lung fields and cardiac size within normal limits. A CT of the thorax ruled out a pulmonary embolism. Cardiology did not believe that Claimant had any active cardiac disease or cardiac basis for her symptoms. However, given Claimant's history, diastolic heart failure was considered a possibility and an outpatient pulmonary function test was ordered. Claimant's MS was deemed stable at the time of her discharge.

On October 11, 2012, Claimant was admitted to the hospital complaining of double vision and loss of balance for the preceding 6 to 7 days. She had a primary diagnosis of an acute exacerbation of relapsing and unremitting type of MS and a secondary diagnoses of hypertension, fibromyalgia, gastroesophageal reflux disease, anxiety,

depression, herniated lumbar disk disease and hyperglycemia. Claimant complained of worsening blurry vision and chronic weakness on her right side and chronic tingling in both hands and lower extremities, although she did not have acute weakness or numbness at admission. An exam revealed no acute abnormalities concerning range of motion, stability and tone of upper and lower extremities; motor strength was 5/5 in all extremities and sensation was grossly intact. Claimant was discharged on October 13, 2012 with symptoms improving, but not completely. She was advised to use a cane as needed.

On November 20, 2012, Claimant visited her neurologist for a follow-up exam and prescription refill. The doctor noted that that Claimant was mildly unstable but ambulatory without support. There were no new concerns at the time.

On November 28, 2012, Claimant came to the emergency department complaining of generalized fatigue, paresthesias, and weakness and difficulty with urination, believing she was having an MS exacerbation. A chest x-ray showed both lung fields were clear and the heart was normal in size. The attending physician concluded that Claimant had an acute MS exacerbation and acute urinary retention with possible neurogenic. Claimant was discharged in good condition.

On January 2, 2013, Claimant was admitted to the hospital complaining of numbness in her lower extremities with intermittent urine incontinence in the preceding two weeks and more blurry vision. Her principal diagnosis was a mild MS flare up with secondary diagnoses of depression, hypertension, and fibromyalgia. A chest x-ray showed clear lungs with no pleural effusion or pulmonary congestion and the heart, hila and mediastinum having a normal appearance. The attending physician concluded that the flare up was secondary to a flu infection and recommended an MRI on an out-patient basis. Medication was continued for depression and hypertension and pain management was continued for fibromyalgia. Claimant was discharged on January 3, 2013 in stable condition.

On February 20, 2013, an MRI of Claimant's thoracic spine was administered. The MRI showed no disc herniation, spinal canal stenosis, or significant foraminal narrowing. However, there were patchy abnormal foci of increased intramedullary T2 signal scattered throughout the thoracic spinal cord (at T2 posteriorly, T3 centrally, T4 on the left, T4-5 centrally and anteriorly on the right, T5-6 in the central right cord, T6-7 centrally to the left, T7-8 posteriorly, T9 posteriorly, T10-11 posterolaterally on the right and T11-12 posteriorly). The doctor compared the MRI to one performed on July 20, 2012 MRI and found that while no definite new lesions were identified, some lesions appreciated on the prior MRI were less well delineated on the current study. No abnormal intradural enhancement was identified.

On March 14, 2013, Claimant visited her neurologist for a follow-up exam and MRI test results. The doctor noted that Claimant had no evidence of language or cognitive dysfunction but her memory was deteriorating. She also noted that Claimant's transverse myelitis and neurogenic bladder issues had been resolved. She reported that Claimant was ambulatory but had an unstable gait.

On April 13, 2013, Claimant went to the emergency department complaining of leg pain that she had been experiencing intermittently over the past 2 months. She also complained of loss of libido. The attending physician found no tenderness, swelling, induration or erythema to the bilateral lower extremities or calf asymmetry. He noted that Claimant was able to ambulate without difficulty. A chest x-ray showed no acute cardiopulmonary processes. Claimant was administered pain medication and discharged.

On April 26, 2013, Claimant visited her neurologist, and the neurologist discussed MS issues with her.

On May 11, 2013, Claimant was admitted to the hospital due to a syncopal episode, with a working diagnosis of exacerbation of MS. Claimant's history showed Claimant's MS was relapsing and remitting and she had had 9 hospitalizations during MS exacerbations, 2 to 3 times in the last 1 to 2 years. Claimant's laboratory results were unremarkable. Claimant's condition improved during her stay. The doctor found "no elements of any acute cardiac or neurological ischemia __ consistent with exacerbation of multiple sclerosis" and Claimant was discharged on May 14, 2013.

On May 24, 2013, Claimant had an ECG performed to evaluate syncope in light of her history of hypertension; she tested negative for orthostatic hypotension, vasoinhibitory response. A bone mineral density test of the lumbar spine and femur performed the same day was in the normal range.

On May 30, 2013, Claimant visited her neurologist. The neurologist reported that Claimant's fluency, tested with both language and clock symbol fluency, was in the high functioning range, and her executive function testing based on ability to organize, respond quickly, and inhibit incorrect responses, was in the normal range. However, the doctor found that her memory function based on acquisition and short-term retention was in the moderately impaired range and her overall cognitive function score was in the moderately impaired range for her educational level. She also found that on the depression scale, Claimant answered 9 out of 10 questions in the symptomatic direction. The doctor added memory loss to Claimant's diagnoses.

On May 31, 2013, an MRI of Claimant's lumbar spine showed preserved lumbar spine alignment, unremarkable intervertebral disc spaces into the body heights, and no abnormal marrow signals. The doctor noted conus medullaris located at L1-L2 with the

distal visualized spinal cord normal in size and signal characteristics with unremarkable intrathecal nerve roots. The L4-L5 showed shallow left paracentral/foraminal disc protrusion without spinal canal or foraminal narrowing, and the L5-S1 showed shallow central disc protrusion that contacted the left S1 nerve root but did not displace it and patent exit foramen.

On June 13, 2013, Claimant visited the emergency department complaining of dizziness, which she believed was due to her blood pressure being low (90/60) and may have been due to a reduction in her Norvasc dosage. Claimant admitted she felt no weakness, blurred vision, double vision, numbness, tingling or other concerns and did not feel that the dizziness was a flare of her MS. The attending physician reviewed the EKG performed on Claimant and noted no signs of ischemia or injury; the results were consistent with a prior EKG found to be stable. Claimant did not have low blood pressure while at the emergency department. She was discharged in stable condition.

On June 20, 2013, Claimant's family doctor, who had started seeing Claimant on May 16, 2013, completed a 49-D, medical examination report, and listed Claimant's diagnoses as hypertension, fibromyalgia, multiple sclerosis, and depression. The doctor noted that Claimant suffered from wheezing, fatigue, weakness in her lower left extremities. He listed her condition as stable. He indicated she could frequently lift less than 10 pounds, occasionally lift 10 pounds, and could never lift greater weight. No standing, walking or sitting restrictions were indicated. The only limitations concerning her extremities were for repetitive actions for pushing/pulling involving either upper extremity. The doctor also noted comprehension and memory limitations due to depression.

On August 2, 2013, Claimant was seen at the emergency department complaining of pain in the bilateral lower extremity distal to the patella, describing the pain as pins and needles and painful. She also reports the pain in both hands and an unusual vaginal discharge. The doctor diagnosed Claimant with acute MS exacerbation and acute bacterial vaginitis. She also diagnosed acute renal insufficient based on the mildly elevated creatinine levels. The doctor noted that strength was 5/5 in the upper and lower extremities, with no tenderness to palpation. There were no abnormal neurological findings. Claimant was treated for the MS exacerbation with dexamethasone and Dilaudid and for the bacterial vaginitis. She was released in stable condition.

On August 24, 2013, Claimant was seen at the emergency department complaining of dizziness and intermittent double vision over the last 2 days. After receiving fluids and a valium, Claimant stated she was feeling better and was sent home in stable condition.

On September 18, 2013, Claimant met with a neurologist at the hospital's neurology clinic for the first time since December 7, 2011. In addition to MS, Claimant had a

history of central pain syndrome affecting the right side of her body. Claimant complained of continuing right body pain, aching and throbbing in nature, sometimes with numbness. She described the pain as a burning sensation from the shoulders to the posterior thighs bilaterally with intermittent tingling of the feet, with the sensation worse on the right. She was prescribed Lyrica, Norvasc, hydralazine, Cymbalta, Abilify, Xanax, Copaxone, Baclofen, Meloxicam. The doctor noted that Claimant's visual acuity of 20/40 in the left eye and 20/80 in the right eye. Her muscle tone and bulk were normal with 5/5 strength in the lower left and bilateral upper extremities and 5-/5 in the right lower extremity. Reflexes were 3+ in all extremities. Sensation was intact to pinprick in the trunk and all extremities, decreased to vibration in the toes. Gait was normal, but slow, and tandem gait was mildly unsteady. Claimant's Lyrica prescription was increased and she was advised that her neuropathic pain/central pain syndrome was best treated with medications other than the Vicodin she requested.

On October 11, 2013, Claimant was seen at the emergency department complaining of boils in her bilateral axilla and throat swelling. The axilla lesions were consistent with folliculitis and she was treated with antibiotics. The doctor concluded that there was minimal, if any, appreciable throat swelling or any tongue or facial swelling. The doctor noted that Claimant's airway was completely intact and she was breathing comfortably. However, because Claimant was taking Lisinopril for her blood pressure, the doctor was unable to rule out angioedema and treated Claimant for possible angioedema. Claimant was discharged in fair condition.

On October 15, 2013, an MRI of Claimant's brain was performed and the results were compared to a March 19, 2011 MRI. The doctor who interpreted the MRI concluded that there were multiple T2 hyperintense foci in the cerebral white mater, cerebellum, and corpus callosum, consistent with demyelinating disease, some of which were new since the prior MRI. The doctor also noted 4 x 7 mm T2 hyperintense lesion in the right orbit, which appeared continuous with the superior orbital vein and might represent a varix and was unchanged from the prior MRI.

On October 28, 2013, Claimant again met with the neurologist at the hospital's neurology clinic. Claimant reported that she has right body pain, aching and throbbing in nature and occasional numbness. Claimant advised the doctor that, although her Lyrica prescription was increased from 75 mg twice daily to 100 mg twice daily, she was taking 150 mg twice daily and reported that her pain had improved somewhat. She also reported taking Vicodin, which she purchased without a prescription. She took Copaxone, but only 6 days per week. In his physical examination, the doctor noted that Claimant had normal muscle tone and bulk and 5-/5 strength in the right lower extremity and 5/5 in all remaining extremities. Her visual acuity was 20/50 OS and 20/40 OD for near vision. Her reflexes were 2+ in all extremities. Her sensation was intact to light touch in all extremities, decreased to vibration in the toes. Her gait was normal, tandem gait mildly unsteady. The doctor noted that Claimant's right-sided pain, which was

burning in nature, had been diagnosed as central pain syndrome. The doctor increased Claimant's Lyrica dosage to 200 mg twice daily and her Copaxone therapy to 7 days per week.

Claimant also alleges mental disability due to depression and anxiety.

On March 27, 2012, Claimant participated in a psychiatric evaluation due to worsening depression. Claimant informed the psychiatrist that her depression began in 2007 after the death of her great grandmother who had raised her. Claimant alleged a history of physical and sexual abuse and stated that she had attempted suicide when she was 7 and after her MS diagnosis in May 2010. In the mental status exam, the doctor noted that Claimant was oriented, had good grooming and hygiene, and had visual hallucinations of her deceased brothers coming to her to tell her that her deceased daughter was going to be okay. The doctor noted a depressed mood, pre-occupied thought content, cooperative behavior, constricted affect, and fair concentration. Claimant's speech was goal-oriented, well-organized, normal tone and volume and productive. The doctor diagnosed Claimant with major depressive disorder, recurring, severe without psychosis. Her global assessment functioning (GAF) score at the time of assessment was 50 and her prognosis was guarded.

On May 8, 2013, Claimant's psychiatrist completed another psychiatric evaluation. In the mental status evaluation, the doctor found Claimant oriented, with fair grooming and hygiene, having no hallucinations. The doctor noted a depressed mood, organized and coherent thought content, cooperative behavior, anxious affect when experiencing MS symptoms, and fair concentration. Claimant's speech was goal-oriented with normal tone and volume. Claimant's diagnosis of major depressive disorder, recurring, severe without psychosis was continued. Her GAF score at the time of assessment was again 50 and her prognosis was conditional pending compliance with medication and circumstances.

As summarized above, Claimant has presented medical evidence establishing that she does have some physical and mental limitations on her ability to perform basic work activities. In consideration of the de minimis 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 if 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, MS, fibromyalgia, depression, and anxiety.

Based on the objective medical evidence of MS and fibromyalgia, Listing 11.00 (neurological), particularly 11.09 (multiple sclerosis) and 11.17 (degenerative disease not listed elsewhere) were considered. To meet a listing under 11.09, the medical evidence must establish (A) disorganization of motor function as described in 11.04B; (B) visual or mental impairment as described under the criteria in 2.202, 2.03, 2.04, or 12.02; or (C) significant, reproducible fatigue of motor function with substantial muscle weakness on repetitive activity, demonstrated on physical examination, resulting from neurological dysfunction in areas of the central nervous system known to be pathologically involved by the multiple sclerosis process. Loss of motor function as described in 11.04B is "significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station." Claimant's medical record does not establish the degree of disorganization of motor function, visual or mental impairment or substantial muscle weakness to meet the criteria under 11.09.

Meeting a listing under 11.17 requires disorganization of motor function as described in 11.04B or (b) chronic brain syndrome as evaluated under 12.02. The medical evidence presented does not meet this criteria.

With respect to the medical diagnosis and treatment of depression and anxiety, Listing 12.00 (mental disorders), particularly 12.04 (affective disorders) and 12.06 (anxiety-related disorders) were considered. The medical evidence presented does not establish either at least two of the following: marked restriction of activities of daily living, or marked difficulties in maintaining social function; marked difficulties in maintaining concentration, persistence, or pace; or repeated episodes of decompensation of extended duration. Listing 11.04(B); Listing 11.06(B). It also fails to establish medically documented history of the disorder of at least 2 years' duration that caused more than a minimal limitation of ability to do basic work activities (Listing 11.04(C)) or complete inability to function independently outside the area of one's home (Listing 11.06(C)). Accordingly, Claimant's depression and anxiety do not meet or equal any of the applicable listings under mental disorders.

Because Claimant's medical record also includes an MRI of Claimant's lumbar spine showing some shallow disc protrusion and contact with the nerve root, Listing 1.04 (disorders of the spine) was also reviewed. However, because there was no nerve root compression, spinal arachnoditis, or spinal stenosis, Claimant's spinal condition did not meet or equal a listing under 1.04.

Because the evidence does **not** show that Claimant's impairments meet or are equal to the required level of severity of a listing to be considered as disabling, Claimant is not disabled at step 3 and the analysis continues.

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 applicants takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, non-exertional, 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.
>
> 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 non-exertional 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.*

When a person has a combination of exertional and non-exertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination unless there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969a(d).

In this case, Claimant suffers from MS, fibromyalgia, depression and anxiety resulting in both exertional and non-exertional limitations.

Claimant testified at the hearing that her primary concern was the pain she experienced, primarily from her lower back down her legs that felt like a burning or tingling sensation. She admitted that her medication sometimes helped control the pain, and at the time of the hearing she was feeling “okay.” She also complained of double vision and added that the aching sensations and double vision were worse during her MS flare ups, which she testified occurred every two weeks. She also had some incontinence issues. She testified that she had numerous visits to the hospital for her flare ups where she would be treated with prednisone and sent home. She testified that she had no problems sitting for about a ½ hour and could stand for about an hour without needing to sit before her back would start to hurt. She testified that she usually had no problems gripping or grasping items although her hands sometimes shook because of her MS. She admitted she could lift a gallon of milk but tried to limit the amount of weight she carried.

Claimant lives with her sister. She testified that she can wash herself and get in and out of the shower but used a chair in the shower. She can cook and clean and do laundry but her back hurts if she has to bend down. She shops with her sister but limits her time at the store. She does not drive because she once passed out while taking a shower and her doctor advised her not to drive. Claimant also testified that she suffered from depression as a result of her daughter’s death and the death of other family members. Her illness sometimes affected her memory and concentration and she did not like to deal with other people.

The February 20, 2013 MRI showed that Claimant had patchy abnormal foci of increased intramedullary T2 signal scattered throughout the thoracic spinal cord (at T2 posteriorly, T3 centrally, T4 on the left, T4-5 centrally and anteriorly on the right, T5-6 in the central right cord, T6-7 centrally to the left, T7-8 posteriorly, T9 posteriorly, T10-11 posterolaterally on the right and T11-12 posteriorly). The doctor compared the MRI to one performed on July 20, 2012 MRI and found that while no definite new lesions were identified, some lesions appreciated on the prior MRE were less well delineated on the current study. Another MRI of Claimant’s brain on October 15, 2013, showed that there were multiple T2 hyperintense foci in the cerebral white mater, cerebellum, and corpus callosum, consistent with demyelinating disease, some of which were new since a March 19, 2011 brain MRT. The doctor also noted 4 x 7 mm T2 hyperintense lesion in the right orbit, which appeared continuous with the superior orbital vein and might represent a varix and was unchanged from the prior MRI. The MRIs show that there appeared to be some progression of Claimant’s MS.

Claimant met with a neurologist at the hospital’s clinic on September 18, 2013 and October 28, 2013, and, consistent with her testimony at the hearing, she reported body pain, aching and throbbing in nature, sometimes with numbness and described the pain as a burning sensation from her shoulders to the posterior thighs bilaterally with

intermittent tingling of the feet, with the sensation worse on the right. Claimant's Lyrica prescription was increased at both visits and her Copaxone therapy was increased to daily. The neurologist found normal muscle tone and bulk and 5-/5 strength in the right lower extremity and 5/5 in all remaining extremities. He categorized Claimant's pain as central pain syndrome.

Claimant's doctor indicated in the June 20, 2013 DHS 49-D that Claimant was in stable condition and she had no limitations in her ability to stand or sit and only had limitations concerning repetitive actions for pushing/pulling involving either upper extremity. He indicated she could lift up to 10 pounds frequently, lift 10 pounds occasionally, and could never lift greater weight. However, the doctor was a family doctor who had first seen Claimant a month prior. As such, his statements are afforded limited weight in the assessment of Claimant's physical limitations.

Claimant's medical record is littered with emergency department visits, averaging about once a month, to address her MS exacerbations. She is treated and released, often in good or fair condition. There were three hospitalizations from 2012 to the hearing: (i) October 11, 2012 to October 13, 2012; (ii) January 2, 2013 to January 3, 2013; and (iii) May 11, 2013 to May 14, 2013. In October 2012 she was admitted complaining of right side weakness, double vision and loss of balance, all attributable to a MS exacerbation. In January 2013 she was admitted due to numbness in her lower extremities and blurry vision in the preceding two weeks, which was deemed a flare up due to the flu. In May 2013, she was admitted for a syncope episode in connection with her MS.

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

The medical evidence also supported Claimant's allegations of limitations due to mental conditions. For mental conditions, 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).

Claimant was also diagnosed with major depressive disorder, recurring, severe, without psychosis. Her GAF score was 50 on her March 27, 2012 and May 8, 2013 psychiatric evaluations. In the most recent psychiatric evaluation, the doctor noted depressed mood, organized and coherent thought content, cooperative behavior, anxious affect when experiencing MS symptoms, and fair concentration. Claimant's speech was goal-oriented with normal tone and volume. Claimant's psychiatrist did not identify any limitations in her basic work activities due to her mental condition. However, following a

May 30, 2013 visit, Claimant's neurologist noted that her memory function based on acquisition and short-term retention was in the moderately impaired range and her overall cognitive function score is in the moderately impaired range for her educational level. She also found that on the depression scale, Claimant answered 9 out of 10 questions in the symptomatic direction. The doctor added memory loss to Claimant's diagnoses. Furthermore, Claimant's multiple hospital visits would impose at least moderate restrictions in her ability to engage in social function and ongoing basic work activity. Overall, the medical evidence establishes that Claimant's mental condition imposes, at a minimum, moderate limitations on her ability to engage in basic work activities independently, appropriately, effectively, and on a sustained basis.

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 a substantial gainful activity 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 moderate restrictions on her metal ability to engage in basic work activities. Claimant's prior work history in the 15 years prior to the application consists of work as a dispatcher (semi-skilled, light), press operator (skilled, light) and a labeler (semi-skilled, light). In light of the entire record and Claimant's RFC, it is found that Claimant is unable to perform past relevant work. Accordingly, the 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 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 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, Claimant maintains the 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), but also has moderate limitations in her mental ability to perform basic work activities. At the time of hearing, Claimant was 44 years old and, thus, considered to be a younger individual for MA-P purposes. Claimant did not complete high school. After review of the entire record and in consideration of Claimant's age, education, work experience, and RFC, Claimant is found disabled at Step 5.

A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (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. BEM 261 (July 2013), p. 2.

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

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 MA-P and SDA benefit programs.

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 March 31, 2013, MA-P and SDA application to determine if all the other non-medical 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;

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

Alice C. Elkin
Administrative Law Judge
For Maura Corrigan, Director
Department of Human Services

Date Signed: May 28, 2014

Date Mailed: May 28, 2014

NOTICE OF APPEAL: A party may appeal this Hearing Decision in the circuit court in the county in which he/she resides or has its principal place of business in the State, 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

ACE/tlf

2014-66125/ACE

cc: