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

IN THE MATTER OF:

[redacted]

Reg. No.: 20147973
Issue No.: 2009, 4009
Case No.: [redacted]
Hearing Date: March 5, 2014
County: Wayne (82)

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 March 5, 2014 from Detroit, Michigan. Participants on behalf of Claimant included Claimant. Participants on behalf of the Department of Human Services (Department) included [redacted], Eligibility Specialist.

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 June 11, 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 September 4, 2013, Claimant submitted an application for public assistance seeking MA-P and SDA benefits.

2. On October 8, 2013, the Medical Review Team (MRT) found Claimant not disabled.

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

4. On October 17, 2013, the Department received Claimant's timely written request for hearing.

5. On January 15, 2014 and June 5, 2014, SHRT found Claimant not disabled.

6. Claimant alleged physical disabling impairment due to back and joint pain and fatigue.

7. Claimant alleged mental disabling impairments due to depression and post-traumatic stress syndrome.

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

9. Claimant is a high school graduate, with some college, and has an employment history of work as travel agent, cashier, ticket agent and temporary agency employee.

10. 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. 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.

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 joint pain and fatigue and mental disability due to depression and post-traumatic stress syndrome.

On May 28, 2013, Claimant was seen at the hospital emergency room following his friend's suicide and was diagnosed with depression. During the physical exam, the doctor noted normal range of motion and normal motor strength and tone. The doctor noted normal respiratory effort and breath sounds. Because Claimant complained of chest pain, a chest x-ray was obtained. The x-ray showed no acute process of the chest and possible mild lingular atelectasis. Claimant was prescribed Xanax, advised to participate in outpatient therapy, and discharged in satisfactory condition.

On June 28, 2013, Claimant went to an office visit at the Community Health and Social Service Center with complaints of back pain with radiculopathy since a 2005 work injury lifting boxes, insomnia resulting from the back pain, bilateral knee pain, and grief due to the loss of his friend to suicide as well as financial strain. The general examination showed that, with respect to the respiratory system, there were no crackles, rhonchi, or wheezes, and, with respect to musculoskeletal system, Claimant's spine was acutely tender to palpitation throughout, with Claimant having difficulty going from sitting to standing. The doctor noted a full range of motion but knee pain on flexion. The doctor suggested weight loss to relieve Claimant's joint pain. Progress notes by Claimant's doctor show that Claimant attended office visits on July 19, 2013 and August 12, 2013. At the August 12, 2013 office visit, the doctor noted in the physical exam that Claimant had no difficulty going from sitting to standing and had full range of motion, no more knee pain on flexion.

In a July 24, 2013 psychiatric evaluation, Claimant disclosed that he felt guilty and depressed because his close friend had committed suicide with a gun in his home two months prior. He indicated that he had suffered from depression but never been treated. He indicated that his mental health also suffered because of his back pain. The doctor noted that Claimant was oriented to place, time and situation and had intact memory, alert awareness, normal concentration, fair judgment, unremarkable content of thought, and unremarkable thought processes. No remarkable characteristics of speech or presentation presented. Claimant's emotional state and reaction was appropriate. Claimant was diagnosed with major depressive disorder, severe with psychosis. His current global assessment functioning (GAF) score was identified as 50.

A mental residual functional capacity assessment was completed on August 26, 2013. Claimant was identified moderately or markedly limited in his understanding and memory; sustained concentration and persistence; social interaction; and adaption. The form was signed by an individual with "Community Care Svc."

On September 27, 2013, an x-ray of Claimant's lumbar spine showed no fracture or subluxation, minimal degenerative osteoarthritic changes of the lumbar spine, and minimal narrowing and sclerotic changes of the intervertebral dis space at L5-S1.

On January 24, 2014, Claimant's treating physician, who saw Claimant monthly since June 28, 2013, completed a multiple impairment questionnaire. He listed Claimant's diagnosis as thoracic/lumbosacral radiculitis; depression; pain in joints, multiple sites; pre-diabetes; cough; vitamin D deficiency; adjustment disorder with depressed mood. The doctor noted that Claimant's spinal column was tender to palpitation from T7 to L5; his straight leg raise test was positive with radiculitis; and his knees had pain on flexion bilaterally. He noted that Claimant walked with a cane. He could sit for one hour but then had to walk hourly. However, he could not stand or walk for more than one hour. He could occasionally lift 5 to 10 pounds and carry up to 5 pounds. He could not lift repeatedly due to chronic back pain. He had moderate limitations on his ability to reach. The doctor also noted that Claimant's depression affected his level of concentration making it difficult to perform sustained activities and his adjustment disorder occasionally makes it difficult to carry out self-care or activities of daily living.

A psychiatric/psychological impairment questionnaire addressed to Claimant's psychiatrist showed that Claimant had had a psychiatric evaluation on January 16, 2014, that he was diagnosed with major depressive disorder, single, severe with psychotic features, and that he was treated biweekly. The questionnaire showed several marked or moderate limitations with respect to Claimant's understanding and memory, sustained concentration and persistence, social interactions, and adaptation. However, the questionnaire was not signed and it is not clear who completed the document.

On March 22, 2014, Claimant's treating physician also completed a medical examination report, DHS-49, in which he listed Claimant's chief complaints as polyarticular joint pain (back, shoulders, knees); depression; cough/wheezing; fatigue and obesity. The doctor indicated Claimant had labored, but steady, gait, difficulty going from standing to sitting, and was using a cane to walk at multiple visits. He had decreased range of motion, with 45 degree bilateral knee flexion, 15 degree inversion shoulder bilaterally; 15 degrees hip flexion and abduction bilaterally; and 10 degree waist forward and lateral bend; unable to flex backward at waist; and 90 degree bilateral shoulder flexion/abduction; and positive bilateral straight leg raise. The doctor noted tenderness on palpitation of the spine at C8-S1. The doctor described Claimant as having a sad mood, suffering from depression with suicidal ideation and noted that this limited his sustained concentration.

The doctor limited Claimant to occasionally lifting less than 10 pounds; standing and/or walking less than 2 hours in an 8-hour work day; sitting less than 6 hours in an 8-hour

day (noting in writing that he would need to walk hourly to help manage his pain); never using either hand or arm for reaching or pushing/pulling; and never using feet or legs to operate foot/leg controls. The doctor noted that Claimant used a cane to walk to help manage the pain radiating from the back to posterior legs.

The medical needs form completed on March 27, 2014 by Claimant's nurse practitioner opined that Claimant did not need assistance in the home and he could work provided he did not have to sit for more than an hour or stand for more than one hour.

On April 11, 2014, Claimant had a CT scan of the abdomen and lumbar and thoracic spine that revealed that (i) thoracic and lumbar vertebral body heights and alignment were maintained; (ii) no acute fracture or traumatic subluxation was noted; (iii) no bony lytic or blastic lesions were identified; and (iv) visualized soft tissues appeared unremarkable. The doctor concluded that there was no acute fracture or traumatic subluxation.

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 as a result of joint and back pain and depression 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, depression and joint and back pain.

Based on the objective medical evidence of joint and back pain, Listing 1.00 (musculoskeletal), particularly 1.02 (major dysfunction of a joint) and 1.04 (disorders of the spine) were considered. A listing under 1.02 requires findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). A listing under 1.04 requires a compromise of a nerve root. In this case, there was no medical evidence to show that Claimant's condition satisfies the requirements under either listing.

Based on the objective medical evidence of depression, Listing 12.00 (mental disorders), particularly 12.04 (affective disorders), was considered. To meet the severity of a listing under 12.04, the evidence must establish at least two of the following: (i) marked restriction of activities of daily living; (ii) marked difficulties in maintaining social functioning; (iii) marked difficulties in maintaining concentration, persistence, or pace; or (iv) repeated episodes of decompensation, each of extended duration. 12.04(B). Although there was a psychiatric/psychological impairment questionnaire addressed to Claimant's psychiatrist that included mental residual functional capacity assessment showing several limitations concerning Claimant's mental ability to perform basic work activities, the document was not signed and it is not clear who prepared it. The medical file also includes a mental residual functional assessment, DHS 49E, that was signed by someone who did not identify herself as a doctor or psychologist. Accordingly, both documents have limited, if any, weight in the assessment of whether Claimant's mental condition meets the severity required to satisfy a listing under 12.04. It is noted that even if the assessments are considered, they fail to establish the degree of marked restrictions or limitations necessary to establish the degree of severity necessary to satisfy a listing under 12.04.

Because Claimant's physical and mental conditions are insufficient to meet, or to equal, the severity of a listing, Claimant is not disabled under step 3 and the analysis continues 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 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.*

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). In addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of mental functional limitation. 20 CFR 416.920a(c)(3). The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(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.

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 alleged both exertional and non-exertional limitations. With respect to his exertional limitations, he testified that he experienced a continuous sharp pain extending from his lower back down his left leg, usually to the knee but sometimes to his foot. He did not have any accompanying bladder or bowel issues although he sometimes had difficulties with bowel movements when he was in pain. As a result of his pain, it hurt when he walked and he could walk a block and a-half before he would need to sit down. He had been prescribed a cane but did not have one. He testified that he could sit for 30 minutes without a problem but then needed to stand. He could stand for thirty minutes at a time. He avoided bending or squatting. While he could lift with both hands, he noted he had problems with gripping and grasping with his right hand because of carpal tunnel.

Claimant testified that he lived alone and took care of most of his own daily activities: he cleaned and dressed himself, and he cooked and usually cleaned for himself. He did not do his own laundry because he had difficulty using the stairs to get to the facilities. He did not have a driver's license and did not drive because of the pain caused by the sitting and driving motions.

The diagnostic tests performed on Claimant did not show any significant impairment to Claimant's spine. The September 27, 2013 x-ray of his lumbar spine revealed no fracture or subluxation; minimal degenerative osteoarthritic changes of the lumbar spine; minimal narrowing and sclerotic changes of the intervertebral dis space at L5-S1. Based on the April 11, 2014, CT scan of Claimant's abdomen and lumbar and thoracic spine, that revealed that (i) thoracic and lumbar vertebral body heights and alignment were maintained; (ii) no acute fracture or traumatic subluxation was noted; (iii) no bony lytic or blastic lesions were identified; and (iv) visualized soft tissues appeared unremarkable, the doctor concluded that there was no acute fracture or traumatic subluxation.

Nevertheless, in a March 22, 2014, medical examination report, Claimant's treating physician limited Claimant to occasionally lifting less than 10 pounds; standing and/or walking less than 2 hours in an 8-hour work day; sitting less than 6 hours in an 8-hour day (noting in writing that he would need to walk hourly to help manage his pain); never using either hand or arm for reaching or pushing/pulling; and never using feet or legs to operate foot/leg controls. The doctor observed that Claimant had labored, but steady, gait, difficulty going from standing to sitting, and was using a cane to walk at multiple visits. He had decreased range of motion, with 45 degree bilateral knee flexion, 15 degree inversion shoulder bilaterally; 15 degrees hip flexion and abduction bilaterally; and 10 degree waist forward and lateral bend; unable to flex backward at waist; and 90 degree bilateral shoulder flexion/abduction; and positive bilateral straight leg raise. The doctor noted tenderness on palpitation of the spine at C8-S1.

Based on the treating physician's limitations and Claimant's testimony, Claimant maintains the physical capacity to perform, at a minimum, sedentary work as defined by 20 CFR 416.967(a).

Claimant also alleged that he suffered from depression. He testified that he had ongoing depression and anxiety because he continued to live in the home where his friend committed suicide. He said he had anxiety attacks about 2 to 3 times a month, lasting up to the whole day. He had difficulty with his concentration and was forgetful. He testified that he sometimes heard the voice of his father who died in 2004. He also had thoughts of suicide 3 to 4 times a month. He stated that he did not get together with friends because he was depressed. However, his testimony showed that he relied

on his sister for assistance and admitted that his five sisters came to visit him about once a week.

In a July 24, 2013 psychiatric evaluation, Claimant was diagnosed with major depressive disorder, single, severe with psychosis. The doctor noted that Claimant was oriented to place, time and situation and had intact memory, alert awareness, normal concentration, fair judgment, unremarkable content of thought, and unremarkable thought processes. No remarkable characteristics of speech or presentation presented. Claimant's emotion state and reaction was appropriate. His GAF score at that time was identified as 50. Although Claimant's record includes a mental residual functional capacity assessment completed on August 26, 2013 in which Claimant was identified moderately or markedly limited in his understanding and memory; sustained concentration and persistence; social interaction; and adaption, the form was signed by an individual with "Community Care Svc" who was not Claimant's treating psychiatrist. Another psychiatric/psychological impairment questionnaire addressed to Claimant's psychiatrist that showed marked and moderate limitations was unsigned. Therefore, there was no medical evidence from Claimant's treating psychiatrist imposing any non-exertional limitations. Claimant's treating physician did note, however, that Claimant suffered from depression with suicidal ideation and noted that this condition limited his sustained concentration.

The record concerning Claimant's non-exertional limitations, taking into consideration Claimant's testimony, the degree of functional limitation(s) concerning his activities of daily living, social functioning, concentration, and persistence or pace shows that he had, at most, mild to moderate limitations on his mental ability to function independently, appropriately, effectively, and on a sustained basis.

Claimant's RFC is considered at both steps four and five. 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 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 sedentary work activities and has mild to moderate limitations on his mental ability to function

independently, appropriately, effectively, and on a sustained basis. Claimant's prior work history in the 15 years prior to the application consists of work as a cashier (unskilled, light/medium), ticket agent (semi-skilled/medium) and temporary employee acting as an on-site company representative, a job requiring lots of standing (unskilled, light). In light of the entire record and Claimant's physical RFC, it is found that Claimant is unable to perform this past relevant work. Claimant also worked as a travel agent, a job that required no standing or lifting but significant interaction with the public. Based on Claimant's mental RFC, it is found that Claimant is unable to perform this 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 has mild to moderate limitations on his ability to mentally engage in basic work activities. At the time of hearing, the Claimant was 45 years old and, thus, considered to be a younger individual for MA-P purposes. The Claimant is a high school graduate with some college. His education renders his skills transferable. Accordingly, after review of the entire record and in consideration of Claimant's age, education, work experience, RFC, Claimant is found not disabled at Step 5.

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. 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 **not** disabled for purposes of the MA-P program and, therefore, **not** 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 **not** disabled for purposes of the MA-P and SDA benefit programs.

Accordingly, It is ORDERED that the Department's determination is AFFIRMED.

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

Date Signed: July 2, 2014

Date Mailed: July 2, 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

cc: [redacted]