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

IN THE MATTER OF:

Reg. No.:	14-000597
Issue No.:	2009
Case No.:	
Hearing Date:	October 13, 2014
County:	Wayne-District 18

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 3-way telephone hearing was held on October 13, 2014, from Detroit, Michigan. Participants on behalf of Claimant included the Claimant; , Claimant's partner; and ., hearing representative with , Claimant's authorized hearing representative (AHR). Participants on behalf of the Department of Human Services (Department) included , Medical Contact Worker.

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 Department was ordered to obtain medical records and a verification of employment and the AHR was ordered to obtain August 2014 hospitalization records. The Department and AHR submitted the requested documents, and the record closed on December 10, 2014. The matter is now before the undersigned for a final determination.

ISSUE

Whether the Department properly determined that Claimant was not disabled for purposes of the Medical Assistance (MA-P) benefit program.

FINDINGS OF FACT

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

1. On September 26, 2013, Claimant submitted an application for public assistance seeking MA-P benefits, with a retroactive coverage to June 2013.

2. On December 19, 2013, the Medical Review Team (MRT) found Claimant not disabled.

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

4. On March 31, 2014, the Department received Claimant's timely written request for hearing.

5. On April 18, 2014, the State Hearing Review Team (SHRT) found Claimant not disabled.

6. In her application, Claimant alleged physical disabling impairment due to abdominal pain, morbid obesity, high blood pressure, asthma and cellulitis.

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

8. On the date of the hearing, Claimant was years old with an , birth date; she was in height and weighed about pounds.

9. Claimant did not graduate from high school; she has an grade education and is able to read and write.

10. Claimant has an employment history of work as a stocker at a grocery store and a line worker at a fast-food establishment.

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

CONCLUSIONS OF LAW

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

The 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.

MA-P benefits are available to disabled individuals. BEM 105 (January 2014), p. 1; BEM 260 (July 260); BEM 261 (July 2013), p. 1. Disability for MA-P purposes is defined as the inability to do any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a). To meet this standard, a client must satisfy the requirements for eligibility for Supplemental Security Income (SSI) receipt under Title XVI of the Social Security Act. 20 CFR 416.901.

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

(1) whether the individual is engaged in 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)(1) and (4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need 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, there was evidence at the hearing that Claimant returned to work in October 2013 but stopped working in March 2014. A verification of employment from Claimant's employer fails to establish that Claimant engaged in SGA while employed during this time. Because Claimant has not engaged in SGA activity during the period for which assistance might be available, 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, including (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.

In the present case, Claimant alleges physical disabling impairment due to abdominal pain, morbid obesity, high blood pressure, asthma and cellulitis and mental disabling impairment due to depression and anxiety. The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

A September 12, 2011, lumbar spine x-ray showed minimal early degenerative hypertrophic range at L3-L4 anteriorly and was otherwise negative (Exhibit 1, p. 43). A June 12, 2012 preliminary report from radiology in connection with a CT scan of Claimant's head in response to headache pain in the top right side of the head concluded that there was no CT evidence of mass effect, intercranial hemorrhage or skull fracture and that ventricular volume and visualized paranasal sinus and mastoid air cells were clear (Exhibit 1, p. 44).

On June 17, 2013, Claimant was admitted to [redacted] for a hernia and abdominal pain. She was examined and discharged the next day in stable condition. (Exhibit 1, pp. 45, 58-60, 92-96, 110-111; Exhibit A, pp. 71-72, 83-84). She returned on June 24, 2013, then again on June 27, 2013, complaining of abdominal pain, with nausea and vomiting. Although she was scheduled for outpatient surgery, the pain persisted and she was admitted for further evaluation by her surgeon. However, she was subsequently discharged and told to return for out-patient surgery. (Exhibit 1, pp. 61-65 70-72, 76-81, 87-91, 97-102, 109, 112; Exhibit A, pp. 58-64).

On July 9, 2013, she had surgery to repair her ventral hernia. Because she is morbidly obese, she was notified that there was a risk of recurrence. Hospital records reference that Claimant had hernia surgery two years prior (Exhibit 1, pp. 66-69, 73-74, 103). She returned to the emergency room two days later with a fever and an ultrasound revealed a possible subcutaneous tissue abscess, in the anterior abdominal wall at the surgical site. X-rays of the abdomen and chest showed (i) nonspecific appearing abdomen without evidence of obstruction or free air (ii) degenerative changes of the spine and (iii) stable chest (limited exam) with no acute process. (Exhibit 1, pp. 47-60, 83-86, 103-108, 109; Exhibit A, pp. 53-57, 73-82)

On September 23, 2013, Claimant visited her treating physician, [redacted], for a post-surgery checkup and it was noted that her adhesions were healing (Exhibit 1, pp. 41-42).

On November 20, 2013, Claimant submitted to a physical examination at the request of the Social Security Administration (SSA). In his physical examination, the doctor noted that Claimant ambulated with normal gait, which was not unsteady, lurching or unpredictable and did not require use of a handheld assistive device; the lung fields were clear on auscultation without wheezes or rhonchi and there was no accessory muscle recruitment noted or chest tenderness to palpitation; the abdomen had a soft bulging hernia in the midline, below the umbilicus that was quite large and very tender to palpitation; her grip strength was normal and graded 5/5 bilaterally; there was decreased range of motion in the hips and knees bilaterally, with the left lower extremity

swollen to 3+ of pitting edema and the right lower extremity having a 1+/2+ pitting edema; there was decreased range of motion in the hips bilaterally; and Claimant could not walk on the heels or toes, squat or bend.

The consulting doctor's impressions were morbid obesity; chronic venous insufficient and recurrent cellulitis of the lower left leg; status post, hernia repair of the lower abdomen x 2; asthma with shortness of breath with moderate exertion; chronic depression/anxiety (on medication and seeing a therapist); well-controlled hypertension; and history of multiple abdominal hernia repairs with chronic abdominal hernia remaining. The doctor concluded that (i) Claimant's upper extremities were stiff and painful with range of motion but with effort she could achieve range of motion; (ii) her lower extremities had significant limitations due to her morbid obesity and her chronic problems with cellulitis of the left leg but she seemed capable of non-strenuous type tasks performed in a strictly sedentary type environment; and (iii) her ability to perform work-related activities such as bending, stooping, lifting walking, crawling, squatting, carrying and traveling as well as pushing and pulling heavy objects is moderately impaired due to the findings described. The doctor indicated that Claimant could stand up to 10 minutes, could not bend or squat, and could climb stairs with difficulty. (Exhibit 1, pp. 20-29.)

On November 21, 2013, Claimant submitted to a mental status examination at the request of SSA. Claimant reported being diagnosed with major depression and anxiety in 2009 by Team Mental Health. She took Ativan, 2 mg two times daily, and Celexa, 20 mg two times daily. She reported difficulty walking but performing activities of daily living herself. The evaluator concluded as follows:

> Overall the patient is verbal and pleasant. She responds to humor and smiles appropriately. There is no apparent mood disorder.
>
> The patient's problems are also physical.
>
> There is no difficulty in the patient's ability to comprehend and carry out simple directions, and perform repetitive, routine simple tasks.
>
> There is no difficulty in the patient's ability to comprehend complex tasks.
>
> The patient is able to carry out complex tasks with physical limits.

The doctor identified Claimant's judgment and insight as fair and her motivation, social skills, behavior and attention/focus as within normal limits. He diagnosed her with depression and with panic disorder with agoraphobia; per patient. (Exhibit 1, pp. 15-19).

Included in the medical file were Claimant's progress notes and medication review notes from Team Mental Health for May 28, 2013; June 28, 2013; July 3, 2013; August 13, 2013 (Exhibit 1, pp. 7, 30-40).

From March 26, to April 11, 2014, Claimant was hospitalized at ████ after complaints of abdominal pain and swelling. She was diagnosed with a seroma following post-draining of an abscess of the abdominal wall and acute sinusitis. The site was drained, and because her pain continued to get worse, she returned to the operating room for another incision and drainage. Claimant did not have an infection, and an x-ray showed no bowel obstruction. Her medical history showed diagnoses for obesity, anxiety, chronic back pain, stable hypertension, ulcer disease (10 years prior), gastroesophageal reflux disease, diabetes mellitus, asthma, lumbar pain, bilateral arthritis of the knees, and depression. She was released with a wound VAC for follow-up on an out-patient basis. (Exhibit A, pp. 1-27; Exhibit B, pp. 1-13, 73-86; Exhibit C, pp. 248-279.)

On April 13, 2014, Claimant returned to the hospital complaining of abdominal pain. The attending physician noted that Claimant's abdominal wound was open but healing with granulation tissue and no signs of infection. A candida rash in the groin was noted. An abdominal x-ray showed no bowel obstruction. Claimant was discharged in stable condition after she indicated she felt better. (Exhibit B, pp. 87-91).

On April 20, 2014, Claimant returned to the emergency room complaining of pain in the wound that was intentionally left open after post-operative complications. She told the attending physician that she was supposed to get a wound vacuum but could not get it because of lack of insurance. The wound was found to not be infected. Claimant was discharged with instructions to follow-up for a wound vacuum (Exhibit B, pp. 92-95).

On April 22, 2014, Claimant returned to the hospital complaining of intractable pain at the site of her abdominal wound and diarrhea and was admitted. Her cultures were positive for MSSA (methicillin-sensitive staphylococcus aureus). On April 29, 2014, her abdominal wall seroma was drained. She was discharged in fair condition on May 1, 2014 to continue wound care. (Exhibit B, pp. 91-101, 167; Exhibit C, pp. 224-247.)

On May 4, 2014, Claimant returned to the hospital with complaints of abdominal pain and a greenish discharge from her wound. The discharge summary noted that, because Claimant's insurance did not cover for a wound vacuum, she had previously been discharged with the abdominal wall packing. An abdominal wall ultrasound showed an abscess. Cultures were positive for diphtheroids. Another incision and drainage of the abscess was performed. She was placed on the wound vacuum and, once in stable condition, discharged on May 9, 2014. (Exhibit B, pp. 128-152; Exhibit C, pp. 193-222.)

Claimant returned to the hospital on May 25, 2014 and was admitted. She was treated with Vancomycin and Zosyn. A debridement of the wound site showed no infection of

the hernia mesh. The wound was surgically closed. Another abdominal wall ultrasound was taken in response to Claimant's complaints of right lower quadrant abdominal pain but was negative for any new abscess site. Claimant's white count was normal. She was discharged on June 3, 2014. (Exhibit B, pp. 153-193; Exhibit C, pp. 160-191.)

On June 12, 2014, Claimant was seen at [redacted] after complaining of back pain and hand numbness. The physical exam noted equal strength and sensation in the bilateral upper extremities and some neck pain when pushing on the neck and some left pain in the area of the trapezius. An x-ray of the cervical spine showed minimal arthritis at C6-C7, without acute fracture or subluxation. (Exhibit B, p. 90-92.)

On June 20, 2014 Claimant was admitted for abdominal and chest pain. Claimant was on long-term IV antibiotics at home, and her PICC line became loose. When the visiting nurse tried to push it in, Claimant experienced chest pain. She also experienced sharp abdominal pains under the incision from the flap closure of her abdominal wound. Claimant was seen by infectious disease and by surgery. The consult concluded that there was a very good chance that Claimant's mesh was infected and the infection would not clear up unless the entire mesh was removed. Another possibility was that Claimant may have irritation or localized allergic reaction to the mesh. An ultrasound showed the redevelopment of another seroma/abdominal wall abscess. A drainage catheter was placed at the site. She was discharged in stable condition on June 30, 2014, and referred to U of M for outpatient treatment. (Exhibit B, pp. 194-225; Exhibit C, pp. 121-158). A July 14, 2014 chest x-ray showed no acute pulmonary process. A July 14, 2014 duplex venous ultrasound of Claimant's right arm was negative for venous thrombosis. (Exhibit B, p. 195).

On July 2, 2014, Claimant returned complaining of abdominal pain, diarrhea, and vomiting. Lab results were abnormal for platelet count, potassium and magnesium levels. The catheter was noted to be continuing to properly drain. She was treated and released. (Exhibit B, pp. 226-242; Exhibit C, pp. 111-120.)

On July 14, 2014 Claimant returned to [redacted] and was treated for chest pain and abdominal pain. A chest x-ray showed no acute cardiopulmonary process. A duplex venous assessment of the right upper extremity was negative for venous thrombosis. A lung ventilation perfusion was negative for pulmonary embolism. There were no changes in the abdominal wall peri-umbilical fluid collection from the prior ultrasound. (Exhibit B, pp. 244-261; Exhibit C, pp. 102-109.)

On July 18, 2014, Claimant came to [redacted] because her abdominal drainage catheter was leaking. The catheter was readjusted. She returned July 21, 2014 with severe abdominal pain and while she was in the ER, she stepped on the cord and her drain came out. A CT of the abdomen showed a redemonstration of inflammatory changes in the anterior soft tissues of the pelvic wall with a more focal fluid collection and several foci of gas concerning for residual/recurrent abscess with associated cellulitis and otherwise no acute process within the abdomen or pelvis. The drain was

replaced. Claimant was discharged on July 24, 2014, and returned the next day with abdominal pain and nausea. (Exhibit B, pp. 262-304; Exhibit C, pp. 66-100).

From August 5, 2014, to August 8, 2014, Claimant was hospitalized for ongoing abdominal pain. A CT scan showed significant decrease in the fluid collection along the anterior pelvic wall since the prior study with only tiny ill-defined fluid collection remaining, bilateral enlarged common femoral lymph nodes, possibly due to an inflammatory or infection process. Hospital records show that Claimant had low pain threshold and required heavy doses of pain medication and was advised concerning pain management and wound care (Exhibit C, pp. 41-64).

Claimant was seen at the emergency department on August 14, 2014 after her drain became clogged. A collection of seroma was noted. (Exhibit C, pp. 1-41.)

Claimant's records included medical notes from her visits with [redacted], her treating doctor, on February 5, 2013 (which noted that Claimant had lost 100 pounds); April 29, 2013; September 23, 2013; November 15, 2013 (which noted that her asthma was under good control); and February 14, 2014 (Exhibit A, pp. 28-52; Exhibit B, pp. 14-38). Claimant's medical file also included summaries of Claimant's hospital visits directed to [redacted] (Exhibit A, pp. 53-86; Exhibit B, pp. 39-72).

On November 10, 2014, Claimant's surgeon completed a physical examination report, DHS-49, identifying Claimant's diagnosis as infected mesh and her impairment and chief complaint as a recurrent abdominal abscess, non-healing abdominal surgical wound that required frequent hospitalization and outpatient procedures. The doctor noted that Claimant also suffered from fatigue, shortness of breath and depression. The doctor identified Claimant's condition as stable but identified the following limitations: (i) Claimant is unable to lift any weight; (ii) for the standing/walking and sitting limitations, he wrote "unable to work;" (iii) Claimant is unable to use either foot or leg to operate controls. The doctor did not identify any limitations with respect to Claimant's use of her hands or arms or her mental condition. Claimant was on daily Daptomycin 4/mg/Kg daily IV therapy (antibiotic for serious bacterial infections) and Dilaudid, 2 mg four times daily (narcotic pain reliever for moderate to severe pain).

On October 10, 2014, Claimant's primary care doctor, [redacted], completed a DHS-49 identifying Claimant's impairments as recurrent abdominal abscesses; morbid obesity; depression; chronic pain; chronic leg edema; asthma; and high blood pressure. In his physical exam, he noted fatigue, shortness of breath, soft mild tenderness in the abdomen, and depression. The doctor identified the same limitations as that identified by the surgeon in the surgeon's DHS-49 but indicated that she could occasionally lift up to 10 pounds. [redacted] completed another DHS-49 on November 11, 2014 with the same limitations except with respect to the standing/walking and sitting restrictions, he indicated that Claimant could stand less than 2 hours in an 8-hour workday and she could sit less than 6 hours in an 8-hour workday.

In consideration of the de minimus standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Claimant suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 12 months. Therefore, Claimant has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step Three

Step 3 of the sequential analysis of a disability claim requires a determination as to whether the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920(a)(4)(iii). If an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

The evidence shows diagnosis of, and treatment for, abdominal pain, morbid obesity, high blood pressure, asthma, arthritis and cellulitis. In light of those diagnoses, Listings 1.00 (musculoskeletal), particularly 1.02 (major dysfunction of a joint) and 1.04 (disorders of the spine); 3.00 (respiratory system), particularly 3.03 (asthma); 4.00 (cardiovascular); 5.00 (digestive system); 8.00 (skin), particularly 8.04 (chronic infections of the skin or mucous membranes) were considered. Because the record also references depression and anxiety, Listing 12.00 (mental disorders), particularly 12.04 (affective disorders) and 12.06 (anxiety-related disorders), were considered. The medical record is insufficient to establish that Claimant's impairments meet, or equal, the level of severity to establish any of the referenced listings.

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

> Sedentary work.
> Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.
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> Light work.
> Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, [an individual] must have the ability to do substantially all of these activities. If someone can do light work, … he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.
>
> Medium work.
> Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, … he or she can also do sedentary and light work.

> Heavy work.
> Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, … he or she can also do medium, light, and sedentary work.
>
> Very heavy work.
> Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If someone can do very heavy work, … he or she can also do heavy, medium, light, and sedentary work.
>
> 20 CFR 416.967.

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of nonexertional 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).

In this case, Claimant alleges both exertional and nonexertional limitations due to her impairments. Although the record references anxiety and although Claimant testified that suffers from three to four anxiety attacks monthly and frequent crying spells and she sees a therapist weekly, there are no medical records establishing limitations to Claimant's ability to perform basic work activities as a consequence of any mental impairments. In fact, in the November 21, 2013 consultative exam ordered by SSA, the consulting doctor confirmed a diagnosis of depression and panic disorder but noted that there was no difficulty in Claimant's ability to comprehend and carry out simple directions and perform repetitive, routine tasks or in her ability to comprehend complex tasks and to carry out complex tasks with physical limits. Under the evidence presented, Claimant has, at most, mild nonexertional limitations to her ability to perform basic work activities due to any mental impairment.

With respect to her exertional limitations, Claimant testified that her ability to walk was limited such that she could not take more than five steps without getting weaker and often had to stop; she used a cane to walk; she had no problems sitting; she could not stand for more than a few minutes without feeling week; she gets dizzy when she bends or squats, she can take stairs one at a time; she can grip and grasp but has numbness; her ability to lift is limited because of the numbness in her hand and her neck problems.

She testified that she lived with her partner; she could not do any household chores unless she was sitting down; she did not drive because of her anxiety; she can dress and bathe herself although she uses a chair to shower and her partner sometimes has to help her out of the shower; and she can shop if she uses a scooter.

Claimant's physical limitations are supported by the record. In the November 20, 2013, physical consultative exam ordered by SSA, the consulting doctor confirmed diagnoses of morbid obesity; chronic venous insufficient and recurrent cellulitis of the lower left leg; status post, hernia repair of the lower abdomen x 2; asthma with shortness of breath with moderate exertion; chronic depression/anxiety (on medication and seeing a therapist); well-controlled hypertension; and history of multiple abdominal hernia repairs with chronic abdominal hernia remaining. He concluded that (i) Claimant's upper extremities were stiff and painful with range of motion but with effort she could achieve range of motion; (ii) her lower extremities had significant limitations due to her morbid obesity and her chronic problems with cellulitis of the left leg but she seemed capable of non-strenuous type tasks performed in a strictly sedentary type environment; and (iii) her ability to perform work-related activities such as bending, stooping, lifting walking, crawling, squatting, carrying and traveling as well as pushing and pulling heavy objects is moderately impaired due to the findings described. The doctor indicated that Claimant could stand up to 10 minutes, could not bend or squat and could climb stairs with difficulty. (Exhibit 1, pp. 20-29.)

While the consulting doctor indicates that Claimant could perform non-strenuous type tasks in a strictly sedentary type setting, in the most recent DHS-49 completed on November 11, 2014, Claimant's treating doctor indicated that Claimant could lift less than 10 pounds occasionally (1/3 of an 8 hour day) and never more and she could stand or walk less than 2 hours in an 8-hour day and sit less than 6 hours in an 8-hour day. There were no restrictions identified with respect to Claimant's use of her hand/arms or her feet/legs. Claimant's abdominal surgeon, who had treated Claimant since 2010, also completed a DHS-49 on November 10, 2014 and indicated that Claimant could never lift any weight or use either foot/leg to operate foot controls. Where asked to identify any standing and sitting restrictions, the doctor stated "unable to work." Both treating doctors also noted that Claimant's recurrent abdominal wall abscesses require frequent hospitalization and outpatient procedures, a conclusion supported by the medical record. These frequent hospitalizations impose additional limitations on Claimant's ability to engage in work activities and must be considered in accessing RFC. See 20 CFR 416.945(d). Also, Claimant, who is ███" and weighs ███ pounds, has a body mass index (BMI) over 60, and it would be expected that the combined effects of Claimant's obesity with other impairments would be greater than might be expected without obesity. See Program Operations Manual System (POMS) DI 24570.001.

Based on the limitations identified by Claimant's doctors, which are supported by the medical evidence presented, and Claimant's testimony, it is found, that Claimant has maintains the physical capacity to perform less than sedentary work as defined by 20 CFR 416.967(a).

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

Step Four

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

As determined in the RFC analysis above, Claimant is limited to less than sedentary work activities and has, at most, mild limitations in her mental capacity to perform basic work activities. Claimant's work history in the 15 years prior to the application consists of work as a stocker at a grocery store (heavy, unskilled) and a line worker at a fast-food establishment (medium, unskilled). In light of the entire record and Claimant's RFC limiting her exertional capacity to less than sedentary work, it is found that Claimant is unable to perform past relevant work. Accordingly, Claimant cannot be found disabled, or not disabled, at Step 4 and the assessment continues to Step 5.

Step 5

In Step 5, an assessment of Claimant's RFC and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v). 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.*

At this point in the analysis, the burden shifts from Claimant to the Department to present proof that Claimant has the RFC to obtain and maintain SGA. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978).

When the impairment(s) and related symptoms, such as pain, only affect the ability to perform the exertional aspects of work-related activities, Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix 2, 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). However, when a person has a combination of exertional and nonexertional 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, at the time of hearing, Claimant was ███ years old and, thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. She has an ██ grade education but is able to read and write. In light of her unskilled work history, she does not have transferable skills. 20 CFR 416.968(a), (d).

As discussed above, Claimant maintains the RFC for work activities on a regular and continuing basis to meet the physical demands to perform less than sedentary work activities and has mild limitations on her mental ability to perform work activities. In consideration of her age, education and non-transferrable skills, Claimant is disabled under the Medical-Vocational Guidelines based on her exertional limitations. Therefore, Claimant is found disabled at Step 5 for purposes of MA-P benefit program.

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

DECISION AND ORDER

Accordingly, the Department's MA-P 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 September 26, 2013, MA application, with request for retroactive coverage to June 2013, 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 January 2016.

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

Date Signed: **12/30/2014**

Date Mailed: **12/30/2014**

ACE / tlf

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

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

MAHS may grant a party's Request for Rehearing or Reconsideration when one of the following exists:

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

The party requesting a rehearing or reconsideration must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date this Hearing Decision is mailed.

A written request may be faxed or mailed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

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

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

cc: