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

IN THE MATTER OF:

[redacted]

Reg. No.: 14-013238
Issue No.: 2009
Case No.: [redacted]
Hearing Date: December 01, 2014
County: Macomb-District 20

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, an in-person hearing was held on December 1, 2014, from Warren, Michigan. Participants on behalf of Claimant included Claimant; Steven Hosmer, appeals department manager at [redacted] Claimant's [redacted], Claimant's husband. Participants on behalf of the Department of Human Services (Department) included Lynda Brown, Hearing Facilitator.

ISSUE

Did the Department properly determine 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 May 14, 2014, Claimant submitted an application for public assistance seeking MA-P benefits, with request for retroactive coverage to February 2014.

2. On July 10, 2014, the Medical Review Team (MRT) found Claimant not disabled.

3. On July 23, 2014, the Department sent Claimant a Notice of Case Action denying the application based on MRT's finding of no disability.

4. On October 7, 2014, the Department received Claimant's AHR's timely written request for hearing.

5. Claimant alleged physical disabling impairment due to endometriosis of several organs, chronic abdominal pain, nausea and vomiting, asthma, and paralytic ileus.

6. Claimant alleged mental disabling impairments due to mild depression.

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

8. Claimant is a high school graduate**,** with some college classes.

9. Claimant has an employment history of work as telemarketing/customer service agent and store manager.

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.

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 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 the trier-of-fact to 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 to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In general, the individual has the responsibility to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

Step One

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 SGA, then the individual must be considered 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, 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 chronic abdominal pain, nausea and vomiting, endometriosis of several organs, asthma, and paralytic ileus and mental disabling impairment due to depression. The medical evidence presented at the hearing was reviewed and is summarized below.

On April 12, 2014, Claimant was seen at the [redacted] emergency room complaining of right-sided abdominal pain, nausea, vomiting and hematuria and reported that she had adhesions and believed she had adhesions on her kidneys causing blood in her urine (Exhibit A, p. 15). Labs results were normal and the abdominal chest x-rays were normal, showing no evidence of obstruction but showing considerable stool. Claimant was treated with Dilaudid and discharged with findings of chronic intermittent right flank pain and abdominal pain, etiology unclear, and nausea and vomiting. (Exhibit A, pp. 15-19).

On April 30, 2014, Claimant was seen at the [redacted] emergency room complaining of abdominal pain, nausea, vomiting and bloody diarrhea and was admitted. The doctor's notes from the physical examination state that "when [patient] distracted no reproducible

pain, when I am asking where her pain is she states diffuse. No rebound or guarding" (Exhibit A, p. 4). The attending doctor also noted that there was no stool in the rectal vault, no blood and negative guaiac (Exhibit A, p. 4). Claimant was admitted for acute on chronic abdominal pain "unknown reason vs. IBS" with a notation of her history of endometriosis. (Exhibit A, pp. 8-11). A chest x-ray on May 1, 2014 showed moderate amount of retained stool, nonspecific intestinal gas pattern, no free air, no active pulmonary disease (Exhibit A, p. 6). Lab results for April 30, 2014 were normal (Exhibit A, pp. 5-6). Claimant admitted using marijuana (Exhibit A, p. 9). She advised doctors that she was to follow up with [redacted] for adhesions surgery but was awaiting Medicaid reinstatement (Exhibit A, p. 9). On May 1, 2014, Claimant was seen by a gastroenterologist who concluded with the following impressions: (i) nausea, vomiting, abdominal pain, diarrhea, hematochezia, but negative stool per rectal exam, (ii) history of endometriosis, (iii) multiple abdominal surgeries and adhesion; (iv) chronic pain syndrome (for which she is on medication); (v) asthma (Exhibit A, pp. 12-14).

On May 21, 2014, Claimant was seen at the [redacted] emergency room complaining of abdominal pain, nausea, vomiting and diarrhea. The attending doctor noted that Claimant was ambulating without difficulty when he walked into the room but then sat in the bed and started complaining of abdominal pain. A CAT scan of the abdomen and pelvis was unremarkable for any acute process. Claimant notified the doctor that she was prescribed Vicodin for pain and the doctor reviewed the Michigan Automated Prescription System showing that she was given a prescription for 30 tablets of hydrocodone which she filed on April 11, 2014, refilled on April 14, 2014 for 15 tables; refilled again on April 17, 2014 for 15 tablets, on April 20, 2014 for 30 tablets and on April 24, 2014 for 20 tablets. The doctor assessed acute on chronic abdominal pain, possibly related to her endometriosis and prior adhesions and noted that drug-seeking behavior needed to be ruled out. (Exhibit 2, pp. 14-15.)

On June 10, 2014, Claimant's primary care physician completed a medical examination report, DHS-49, identifying Claimant's diagnoses as chronic abdominal pain due to endometriosis, recurrent nausea and recurrent vomiting. The doctor did not identify any abnormalities in his examination of Claimant's vision, respiratory, cardiovascular, musculoskeletal, or neuro systems. He did note some mild anxiety but found no mental limitations. He also found that Claimant was tender in all abdominal quadrants. He identified her condition as deteriorating and identified the following limitations due to her chronic pain: (i) Claimant could occasionally (1/3 of an 8 hour day) lift less than 10 pounds daily; (ii) she could never lift 10 pounds or more; (iii) she could stand and/or walk less than 2 hours in an 8-hour workday; (iv) she could not use either arm or hand for pushing/pulling. The doctor indicated that Claimant would need assistance with cleaning and cooking. (Exhibit 2, pp. 10-13.)

On July 9, 2014, Claimant went to [redacted] hospital complaining of dyspnea and a rash (Exhibit B, pp. 1-8).

On July 25, 2014, Claimant returned to [redacted] hospital emergency complaining of abdominal pain. The doctor's notes show "past medical history significant for chronic abdominal pain, endometriosis, hysterectomy and narcotic dependence" (Exhibit A, p. 20). The physical examination showed the abdomen was tender, soft with normal appearance and bowel sounds; no rigidity, rebound or guarding (Exhibit A, p. 22). An abdominal x-ray showed nonspecific bowel gas pattern with no radiographic evidence of intestinal obstruction, no evidence of free intraperitoneal air, and moderate stool burden throughout the colon (Exhibit A, pp. 22-23). Lab and radiology studies were normal (Exhibit A, pp. 22-24). The doctor's notes show that Claimant was advised of the negative results but repeatedly requested pain medication and was given an additional dose of dilaudid (Exhibit A, p. 24). A CAT scan had been ordered but Claimant did not want to drink the oral contrast and she left the emergency department (Exhibit A, p. 25).

On August 4, 2014, Claimant went to [redacted] emergency complaining of abdominal pain, acute with nausea and vomiting. A CT of the abdomen and pelvis showed no bowel obstruction, (ii) mild wall thickening in the transverse colon and left colon, suspicious for mild colitis; (iii) no free air, (iv) no gross inflammatory changes in the mesentery; (v) although the appendix is not seen, no significant right lower quadrant inflammatory process; (vi) no evidence of pancreatitis; (vii) no hydro; (viii) no calcified gallstones and no gross gallbladder wall thickening, pericholecystic fluid or inflammatory changes; the bladder is contracted (Exhibit B, pp. 9-25).

She returned to [redacted] on August 11, 2014 with continuing complaints of diarrhea, nausea and vomiting and was admitted. An esophagogastroduodenoscopy performed on August 13, 2014 showed normal entire esophagus, an ulcer in the body of the stomach and antrum, portal hypertensive gastropathy in the cardia and fundus, and normal 2nd portion of the duodenum and duodenal bulb (Exhibit B, p. 36). Claimant was discharged on August 15, 2014. (Exhibit B, pp. 26-48.)

On August 22, 2014, returned with abdominal pain. Abdominal x-rays showed no acute process. (Appendix B, pp. 56-61). On August 24, 2014, Claimant returned to [redacted] with abdominal pain, and she was referred to GI. (Appendix B, pp. 49-55.)

On September 5, 2014, Claimant returned to [redacted], again with abdominal pain but she left the same day against medical advice (Appendix B, pp. 62-71).

On November 5, 2014, Claimant returned to the [redacted] department complaining of abdominal pain and back pain. She advised the attending physician that she occasionally took Vicodin for her pain but she vomited when she tried to take it that day to control her symptoms (Exhibit A, p. 26). Radiology and lab results were found normal (Exhibit A, pp. 27-29). The doctor noted that he reviewed the Michigan Automated Prescription System which showed that Claimant received 88 narcotic

prescriptions in the past 14 months, including 7 prescriptions from separate providers filled in the past calendar month at 5 separate pharmacies (Exhibit A, p. 30). The doctor also noted that, despite her complaints of a 70 pound weight loss in the preceding few months and inability to keep anything down, studies showed normal white blood count and hemoglobin and an unremarkable metabolic panel. The doctor found no focal abdominal tenderness and concluded that, in light of the multiple abdominal CTs revealing no evident pathological process, another CT was not warranted. (Exhibit A, p. 30.)

The record showed, in addition to the above-referenced CT scans, additional CT scans of Claimant's abdomen and pelvis, with kidney stone protocol, taken in response to Claimant's complaints of flank pain. An October 30, 2013, CT showed no acute abdominal or pelvic findings with focus on the urinary tract kidneys ureters and bladder. (Exhibit 2, p. 18). A February 26, 2014 CT showed a single loop of prominent small bowel within the mid-abdomen but no other findings within the bowel concerning for obstruction (noting that this could represent a focal ileus versus a normal peristaltic wave), and no renal/ureteral calculi or hydronephrosis (Exhibit 2, pp. 21-22). A March 26, 2014 CT showed no evidence of nephrolithiasis on either side, no perinephric fluid, no hydronephrosis, no ureteral calculi or bladder calculi, no distended bowl, and no free fluid or free air (Exhibit 2, pp. 19-20). Also, lab results from November 4, 2013 did not show any abnormal findings (Exhibit 2, pp. 23-32).

Because Claimant's medical records concerning abdominal pain span from October 2013 to November 2014, Claimant has established that she has a medical impairment that has lasted, or is expected to last, for a continuous period of at least 12 months. Under the de minimus standard necessary to establish a severe impairment under Step 2, the medical record presented is sufficient to establish that Claimant suffers from severe impairments. 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, chronic abdominal pain with nausea and vomiting, endometriosis, and asthma. Based on the objective medical evidence presented, Listing 5.00, particularly 5.06 (inflammatory bowel disease) and 5.08 (weight loss due to any digestive disorder); Listing 6.00 (genitourinary disorders); and 3.00 (respiratory system), particularly 3.03 (asthma), were reviewed. However, Claimant's impairments are not of a severity to meet or equal any of these listings.

Because Claimant also alleged mild depression, Listing 12.00, particularly 12.04 (affective disorders) was reviewed. However, the medical record does not support a finding that Claimant's mental condition presents a severe impairment that meets, or equals, 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, 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.
>
> 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 exertional and nonexertional limitations. However, there are no nonexertional limitations identified in Claimant's record. Claimant's doctor indicated that Claimant was mildly anxious but identified no nonexertional limitations due to her mental condition in the DHS-49 he completed. Claimant admitted at the hearing that she was more frustrated than depressed. In light of the medical evidence and Claimant's testimony, it is found that Claimant has no nonexertional limitations on her ability to perform basic work activities.

With respect to her physical limitations, Claimant's doctor indicated in the DHS-49 he completed on June 10, 2014, that Claimant's chronic pain caused severe limitations and identified the following limitations: Claimant could stand and/or walk less than 2 hours in an 8-hour workday; she could occasionally lift less than 10 pounds but never lift 10 or more pounds; and she could not use either hand or arm for repetitive pushing and pulling. However, at the hearing, Claimant testified that her condition does not does not pose limitations with respect to her ability to lift or stand. Rather her concerns are related to the fact that her chronic abdominal pain resulted in diarrhea and vomiting that prevented her from being able to maintain employment.

Limitations and restrictions due to medically determinable impairment (such as seizures, impairment of vision, hearing or other senses) which may reduce an individual's ability to do past work and other work must also be assessed in deciding the individual's RFC. 20 CFR 416.945(d). Claimant testified that she suffers from severe abdominal pain and that she has unexpected episodes of vomiting and diarrhea. She complained that her condition resulted in significant weight loss, 70 pounds in the 6 months preceding the hearing. However, the medical record and her testimony show that her weight ranged from 175 pounds in April 2014 to 168 pounds at the December 1, 2014 hearing. In response to Claimant's complaints of significant weight loss and inability to keep "things down," the emergency room attending physician at the November 5, 2014 hospital visit noted that lab studies showed normal white blood count and hemoglobin and an unremarkable metabolic panel (Exhibit A, p. 30).

Claimant testified that she took Vicodin for pain, at most once a day. However, there were concerns expressed in the May 21, 2014 and November 6, 2014 hospital records regarding the significant number of prescriptions for narcotics prescribed to Claimant by different providers and filled by different pharmacies; in October 2014 Claimant had 7 prescriptions for Vicodin filled at 5 different pharmacies (Exhibit 2, pp. 14-16; Exhibit A, pp. 26-30). Numerous CT abdominal exams from October 13, 2013 to August 4, 2014 showed no acute process, although the August 4, 2014 CT showed mild wall thickening in the transverse colon and left colon, suspicious for mild colitis. An

esophagogastroduodenoscopy performed on August 13, 2014 showed normal entire esophagus; an ulcer in the body of the stomach and antrum; portal hypertensive gastropathy in the cardia and fundus; and normal 2nd portion of the duodenum and duodenal bulb (Exhibit B, p. 36).

The medical evidence presented does establish that Claimant has some basis for her abdominal pain but does not support the severity of pain alleged by Claimant. Ultimately, after review of the entire record to include Claimant's testimony, it is found, based on Claimant's mental and physical conditions, that Claimant maintains the physical and mental capacity to perform, at a minimum, sedentary work as defined by 20 CFR 416.967(a). She has no mental limitations on her ability to perform basic work activities and she has mild restrictions due to her abdominal pain.

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 sedentary work activities. She has no limitations in her mental capacity to perform basic work activities and mild limitations in her ability to participate in basic work activities due to abdominal pain. Claimant's work history in the 15 years prior to the application consists of work as a telemarketer (sedentary, unskilled), and store manager (medium, unskilled). The objective medical documentation does **not** show that Claimant has any restrictions that would prevent returning to previous work, specifically that in telemarketing. Therefore, Claimant retains the RFC to meet the physical and mental demands of past work and cannot be considered as disabled. Accordingly, Claimant is found **not** disabled at Step 4, and no further analysis is required.

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 benefit program.

DECISION AND ORDER

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: **12/23/2014**

Date Mailed: **12/26/2014**

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 48909-8139

cc: [redacted]