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

IN THE MATTER OF:

[redacted]

Reg. No.: 14-013279
Issue No.: 2009
Case No.: [redacted]
Hearing Date: November 17, 2014
County: Oakland-District 4

ADMINISTRATIVE LAW JUDGE: Alice 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 November 17, 2014, from Pontiac, Michigan. Participants on behalf of Claimant included the Claimant and [redacted], Claimant's ex-wife. Claimant was represented by [redacted]; Claimant's authorized hearing representative (AHR) from Independent Medical Network. [redacted], Assistance Payment Supervisor, represented the Department of Human Services (Department).

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional records, specifically a consultative physical examination report and medical records from July 2011 to May 2013 from his primary care physician. The documents were received, and on January 17, 2014 the record closed. This matter is now before the undersigned for a final determination.

ISSUE

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

1. On October 9, 2013, Claimant submitted an application for public assistance seeking MA-P benefits, with retroactive coverage to July 2013.

2. On February 6, 2014, the Medical Review Team (MRT) found Claimant not disabled.

3. On August 12, 2014, the Department sent Claimant a Benefit Notice denying the application based on MRT's finding of no disability.

4. On September 3, 2014, the Department received Claimant's timely written request for hearing.

5. Claimant alleged physical disabling impairment due to compressed disc, lower back pain, fractured ribs, and punctured lung.

6. Claimant alleged mental disabling impairments due to a closed head injury.

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

8. Claimant completed the [redacted]. He had problems with writing and reading and took special education classes in high school.

9. Claimant completed vocational training in mechanics.

10. Claimant has no employment history.

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.

In its hearing summary, the Department contended that Claimant's hearing request was not timely submitted. At the hearing, the AHR established that the Department first notified Claimant and the AHR of the denial of Claimant's October 9, 2013 MA-P application, with request for retroactive coverage to July 2013, in a Benefit Notice sent August 12, 2014 (Claimant's Exhibit A). Therefore, the AHR's September 3, 2014 request for hearing disputing the denial was timely filed. See BAM 600 (July 2014), p. 6. The hearing proceeded to address the merits of the Department's decision denying Claimant's MA-P application.

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.
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> 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 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, 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 compressed disc, lower back pain, fractured ribs, and punctured lung and mental disabling impairments due to a closed head injury. The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

An October 2011 MRI of Claimant's cervical spine showed (i) no MR evidence for focal disc protrusion to suggest disc herniation; (ii) multilevel disc desiccation and diffuse disc bulge and/or disc osteophyte complex formations contributing to multilevel encroachment of the respective epidural spaces at C3-C4, C4-C5, C5-C6 and C6-C7

without high grade central canal stenosis; and (iii) multilevel neural foraminal narrowing from disc osteophyte and facet change particularly at C4-C5, C5-C6 and C6-C7. (Exhibit 4, pp. 1-2.) A December 23, 2011 MRI of Claimant's lumbar spine showed mild multilevel disc desiccation and diffuse disc bulge which, along with facet change, contributed to multilevel mild bilateral neural foraminal narrowings, findings greatest at L4-L5, and superimposed moderate central disc herniation at L4-L5 (Exhibit 4, pp. 3-4).

On July 31, 2013, Claimant went to the emergency department after falling from a roof or porch onto his left ribcage. He reported lower back and rib pain. He advised the attending doctors that he normally took Vicodin and Xanax for back pain. He was able to walk without difficultly. Chest x-rays showed minimally displaced rib fracture at the lateral left seventh rib, no pneumonia. An x-ray of the lumbar spine showed that lumbar vertebral body height, alignment, and disc spaces were preserved; no fracture or spondylolisthesis; intact pedicles and sacroiliac joints; and no significant degenerative changes. An x-ray of the left scapula showed no acute fracture or dislocation and no evidence of soft tissue swelling. Claimant was given a prescription for pain medication and released. (Exhibit 1, pp. 54-60.)

In August 1, 2013 to August 9, 2013, Claimant was hospitalized after he returned to the hospital complaining of pain that was worsening and difficulty breathing. A chest x-ray revealed left-sided pneumothorax and his diagnosis was changed to broken ribs and left-sided hemopneumothorax. In the physical exam, it was noted that Claimant's left mid-back, left shoulder, left hip and right knee were tender to palpitation. Claimant reported taking Vicodin and Xanax for his back pain. An August 1, 2013 CT of the head showed no intracranial hemorrhage, mass effect or midline shift. An August 1, 2013 CT scan of Claimant's chest, abdomen, and pelvis showed (i) small complex left plural fluid collection with associated airspace disease which likely represented blood/hemothorax with overlying atelectasis, lung contusion and/or pneumonia, (ii) right lower lung airspace disease, likely secondary atelectasis, (iii) nodular appearance of the left adrenal gland, and (iv) minimally displaced left seventh lateral rib fracture and non-displaced fracture of the left lateral eight rib. An x-ray of the right tibia and fibula showed no acute fracture or dislocation, no significant joint effusion, intact ankle mortise, mild narrowing of the medial femoral tibial joint space, no significant soft tissue swelling. Two chest tubes were inserted into Claimant's lungs and drained over a liter of blood. The tubes were removed, Claimant was placed on oral medications and was able to ambulate, and he was discharged in improved condition (Exhibit 1, pp. 16-53, 72-83).

On December 1, 2013, Claimant went to the emergency department stating he was in pain and out of his pain medication. He indicated that it hurt to move and to breathe. The physical exam showed no swelling in the upper and lower extremities bilaterally, equal pulses in all extremities, left chest wall tenderness to palpitation; motor strength 5/5 in all extremities; sensation to light touch to all extremities intact. A chest x-ray

showed bibasilar atelectasis but no pneumothorax or pleural effusion. He was discharged with prescriptions for Norco and Neurontin and advised to follow-up with the doctor who performed his surgery. (Exhibit B, pp. 4-12.)

On January 23, 2014, Claimant returned to the emergency department because he ran out of his prescriptions for Neurontin, Norco and Xanax. In the physical examination of Claimant, the attending doctor noted that, with respect to Claimant's musculoskeletal system, he had normal range of motion, motor strength and tone, and with respect to his neurological system, Claimant's examination was normal, with strength 5 out of 5, and no evidence of radial ulnar or medical nerve palsy. The doctor noted that Claimant ambulated without difficulty or assistance. Claimant was given a prescription for his chronic pain but advised to follow-up with a primary care physician. (Exhibit B, pp. 1-3.)

On December 15, 2014, a physical exam report was completed at the Department's request. The examining doctor noted that Claimant reported that he injured his upper and lower back in 2011 when a tow truck fell on him and in 2013 when he fell from a roof almost two to three stories high and was hospitalized for one and a-half months. He complained of neck and back pain that got worse when he moved and stated that he used a cane outside the home to avoid falling. He also complained of tingling and numbness in both hands, the right side being worse. The doctor noted in Claimant's physical examination as follows:

> MUSCULOSKELETAL: Examination of the neck revealed the patient has some spasm in the cervical area. Range of motion is adequate. Examination of the back lumbar spasm is noted. [Claimant's] SLR is up to 20 degrees on the right side and 30 degrees on the left side. Examination of both shoulders revealed spasms in the shoulders area. He does not have full range of shoulder movements. Examination of both elbows and the wrist are normal. The grip in his right hand is weaker than the left hand. Examination of both hip joints also reveals spasms and painful movements. Examination of both knees is normal. Examination of both ankles are normal.
>
> NEUROLOGICAL: The patient is awake, alert and oriented x3. Cranial nerves II through XII are intact. Sensory system is intact. The motor system reveals weakness, motor system shows the power in the right upper extremity is 4/5 and left upper extremity is 5/5 and both lower extremities have power 5/5. The grip in the right hand is weaker than the left. The patient's gait is abnormal. The patient is using a cane.

The doctor concluded that Claimant had neck pain, bilateral shoulder pain, back pain, cervical radiculopathy, and tobacco-ism and "definitely has chronic pain problems and neuropathy" and needed further imaging studies like and MRI or EMG. (Exhibit 3.)

Claimant's medical record included physical therapy records showing that Claimant engaged in ongoing physical therapy, two to three times weekly, from July 26, 2011 to

April 5, 2013. The physical therapy was intended to decrease Claimant's neck and shoulder pain and increase his mobility, flexibility, and range of motion (Exhibit 4, pp. 5-469).

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.

In this case, Claimant alleged physical disabling impairments due to compressed disc, lower back pain, fractured ribs, and punctured lung. Based on the objective medical evidence concerning these impairments, Listings 1.00 (musculoskeletal system), particularly 1.04 (disorders of the spine), and Listing 3.00 (respiratory system), particularly 3.02 (chronic pulmonary insufficiency) were considered. Because there is no evidence of nerve root or spinal cord compromise, Claimant's impairments do not meet, or equal, the severity of a listing under 1.04. In the absence of any pulmonary function test results, there is insufficient evidence to support a finding that Claimant's impairments meet or equal a listing under 3.00.

Although Claimant also alleged mental disabling impairments due to a closed head injury following a 2011 accident, there was no evidence in the medical record of any mental impairment or any limitations due to mental impairments. Because the record does not include any evidence of diagnosis or treatment for mental impairment, Claimant's allegations concerning mental impairments are not considered at Step 3 or thereafter.

Because Claimant's physical 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, the medical record supports diagnosis and treatment for punctured lungs; fractured ribs; and neck, back and shoulder pain. At the hearing, Claimant testified that he suffered from ongoing, aching pain from his head to his lower back, and he used drugs (cocaine, heroin, marijuana and alcohol) daily to control his pain because he had been unable to obtain his prescription medication. He explained that, because of his pain, he could not pick up anything over 40 pounds; he could not hold onto items too long; he could only walk a half block; he could stand for only five to ten minutes; he could bend but not squat; he was able to sit because he wore a back brace prescribed by his primary care physician; and his hands went numb, making it difficult for him to hold items or to use his hands to button. He lives with his ex-wife. He sometimes needs assistance getting out of the bathtub or tying his shoes. His ex-wife handles the cooking, cleaning and laundry because he has difficulty holding things to cook and clean and difficulty with the stairs to get to the laundry facilities.

The medical records show that Claimant was hospitalized for a week in August 2013 for broken ribs and left-sided hemopneumothorax, but he was treated and discharged in

improved condition (Exhibit 1, pp. 16-53, 72-83). A December 2013 chest x-ray showed bibasilar atelectasis but no pneumothorax or pleural effusion (Exhibit B, pp 4-12).

The October 2011 MRI of Claimant's cervical spine showed that Claimant had multilevel disc desiccation and diffuse disc bulge and or disc osteophyte complex formations contributing to multilevel encroachment of the respective epidural spaces at C3-C4, C4-C5, C5-C6 and C6-C7 without high grade central canal stenosis and multilevel neural foraminal narrowing from disc osteophyte and facet change particularly at C4-C5, C5-C6 and C6-C7 (Exhibit 4, pp. 1-2). A December 23, 2011 MRI of the lumbar spine showed mild multilevel disc desiccation and diffuse disc bulge that, along with facet changes, contributed to multilevel mild bilateral neural foraminal narrowings greatest at L4-L5 and superimposed moderate central disc herniation at L4-L5 (Exhibit 4, pp. 3-4). Claimant's medical records show that he participated in physical therapy sessions twice or three times weekly from July 2011 to April 2013 in order to reduce pain in his neck and shoulders and increase his flexibility, mobility and range of motion (Exhibit 4, pp. 5-469).

The physical examinations during Claimant's hospital visits in December 2013 and January 2014 show strength 5 out of 5 in all extremities. The attending doctor at the January 23, 2014, visit noted normal range of motion in his exam of Claimant's musculoskeletal system. (Exhibit B, pp. 1-12.) However, in a December 15, 2014 physical exam report requested by the Department, the consulting doctor examined Claimant and noted that he had spasms in the cervical and shoulder area. The doctor found that Claimant had adequate range of motion in the neck but not the shoulders. The doctor indicated that Claimant's straight leg raise was up to 20 degrees on the right side and 30 degrees on the left side. His right hand grip was weaker than the left hand. The doctor concluded that Claimant "definitely has chronic pain problems and neuropathy" and assessed him with neck, bilateral shoulder, and back pain and cervical radiculopathy.

The medical evidence presented was sufficient to support Claimant's testimony of ongoing pain and limitations, particularly with respect to his neck, shoulder, and back. However, while Claimant has some pain and limitations, based on the medical evidence and Claimant's testimony, it is found that Claimant maintains the physical capacity to perform light work as defined by 20 CFR 416.967(b).

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 no more than light work activities. Claimant's identified no work history in the 15 years prior to the application. 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).

In this case, at the time of hearing, Claimant was [redacted] years old and, thus, considered to be a closely approaching advanced age (age 50-54) for purposes of Appendix 2. He has a [redacted] [redacted] education and testified that he had issues reading and writing and was in special education classes in high school. He has no work experience for the 15 years preceding the application.

As discussed above, Claimant maintains the RFC for work activities on a regular and continuing basis to meet the physical demands to perform light work activities. A review of the Medical-Vocational Guidelines shows that, based on his age, education, work skills, and RFC, Claimant is **not** disabled under 202.10 of Appendix 2.

Although Claimant testified at the hearing that he used drugs, including heroin, cocaine, marijuana and alcohol, to treat his pain when he was no longer able to obtain his

prescribed medication, an assessment of whether Claimant's drug addiction or alcoholism (DAA) is a contributing factor material to the determination of disability is not necessary in light of the finding that he is not disabled.

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, the Department's determination is AFFIRMED.

Alice Elkin
Administrative Law Judge
for Nick Lyon, Interim Director
Department of Human Services

Date Signed: **2/6/2015**

Date Mailed: **2/6/2015**

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]