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

IN THE MATTER OF:

[redacted]

Reg. No.: 14-019650
Issue No.: 2009
Case No.: [redacted]
Hearing Date: May 20, 2015
County: Wayne (19)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

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; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10. After due notice, a telephone hearing was held on May 20, 2015, from Detroit, Michigan. Participants included the above-named Claimant. [redacted] testified and appeared as Claimant's authorized hearing representative (AHR). Participants on behalf of the Department of Health and Human Services (DHHS) included [redacted], medical contact worker.

ISSUE

The issue is whether DHHS properly denied Claimant's Medical Assistance (MA) eligibility for the reason that Claimant is not a disabled individual.

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 [redacted] Claimant applied for MA benefits, including retroactive MA benefits from December 2013.

2. Claimant's only basis for MA benefits was as a disabled individual.

3. On [redacted] the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 5-6).

4. On [redacted], DHHS denied Claimant's application for MA benefits and mailed a Health Care Coverage Determination Notice (Exhibits 105-107) informing Claimant of the denial.

5. On [redacted], Claimant's AHR requested a hearing disputing the denial of MA benefits (see Exhibit 2).

6. As of the date of the administrative hearing, Claimant was a 26 year old male.

7. Claimant has not earned substantial gainful activity since before the first month of benefits sought.

8. Claimant alleged disability based on restrictions related to left eye blindness, learning disabilities, carpal-tunnel syndrome (CTS), left arm pain, back pain, and foot pain.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by the Title XIX of the Social Security Act, 42 USC 1396-1396w-5, and is implemented by 42 CFR 400.200 to 1008.59. The Department of Human Services (formerly known as the Family Independence Agency) administers the MA program pursuant to MCL 400.10 and MCL 400.105. Department policies are contained in the Department of Human Services Bridges Administrative Manual (BAM) and Department of Human Services Bridges Eligibility Manual (BEM) and Department of Human Services Reference Tables Manual (RFT).

Prior to a substantive analysis of Claimant's hearing request, it should be noted that Claimant's AHR noted special arrangements in order to participate in the hearing; specifically, a 3-way telephone hearing was requested. Claimant's AHR's request was granted and the hearing was conducted accordingly.

The Medicaid program is comprised of several sub-programs which fall under one of two categories; one category is FIP-related and the second category is SSI-related. BEM 105 (October 2010), p. 1. To receive MA under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled. *Id*. Families with dependent children, caretaker relatives of dependent children, persons under age 21 and pregnant, or recently pregnant, women receive MA under FIP-related categories. *Id*. It was not disputed that Claimant's only potential category for Medicaid eligibility would be as a disabled individual.

Disability for purposes of MA benefits is established if one of the following circumstances applies:
- by death (for the month of death);
- the applicant receives Supplemental Security Income (SSI) benefits;
- SSI benefits were recently terminated due to financial factors;

- the applicant receives Retirement Survivors and Disability Insurance (RSDI) on the basis of being disabled; or
- RSDI eligibility is established following denial of the MA benefit application (under certain circumstances).
  BEM 260 (July 2012) pp. 1-2

There was no evidence that any of the above circumstances apply to Claimant. Accordingly, Claimant may not be considered for Medicaid eligibility without undergoing a medical review process which determines whether Claimant is a disabled individual. *Id*., p. 2.

Generally, state agencies such as DHHS must use the same definition of SSI disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally 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 functionally identical definition of disability is found under DHHS regulations. BEM 260 (July 2012), p. 8.

SGA means a person does the following: performs significant duties, does them for a reasonable length of time, and does a job normally done for pay or profit. *Id*., p. 9. Significant duties are duties used to do a job or run a business. *Id*. They must also have a degree of economic value. *Id*. The ability to run a household or take care of oneself does not, on its own, constitute SGA. *Id*.

The person claiming a physical or mental disability has the burden 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 ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913. 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).

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled. 20 CFR 416.920. If there is no finding of disability or lack of disability at each step, the process moves to the next step. 20 CFR 416.920 (a)(4).

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person is statutorily blind or not. "Current" work activity is interpreted to include all time since the date of application. The 2014 monthly income limit considered SGA for non-blind individuals is $1,070.

Claimant credibly denied performing any employment since the date of the MA application; no evidence was submitted to contradict Claimant's testimony. Based on the presented evidence, it is found that Claimant is not performing SGA and has not performed SGA since the date of MA application. Accordingly, the disability analysis may proceed to step two.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the 12 month duration requirement. 20 CFR 416.920 (a)(4)(ii). The impairments may be combined to meet the severity requirement. If a severe impairment is not found, then a person is deemed not disabled. *Id*.

The impairments must significantly limit a person's basic work activities. 20 CFR 416.920 (a)(5)(c). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. *Id.* Examples of basic work activities include:

- physical functions (e.g. walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling)
- capacities for seeing, hearing, and speaking, understanding; carrying out, and remembering simple instructions
- use of judgment
- responding appropriately to supervision, co-workers and usual work situations; and/or
- dealing with changes in a routine work setting.

Generally, federal courts have imposed a de minimus standard upon claimants to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v Bowen,* 880 F2d 860, 862 (6th Cir. 1988). Similarly, Social Security Ruling 85-28 has been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirement is intended "to do no more than screen out groundless claims." *McDonald v. Secretary of Health and Human Servs.*, 795 F.2d 1118, 1124 (1st Cir. 1986).

SSA specifically notes that age, education, and work experience are not considered at the second step of the disability analysis. 20 CFR 416.920 (5)(c). In determining whether Claimant's impairments amount to a severe impairment, all other relevant evidence may be considered. The analysis will begin with a summary of presented medical documentation.

An Individual Educational Planning Team Report (Exhibits 95-104) from 2007 was presented. It was noted that Claimant was in the 11th grade at the time of report. Claimant's reading and comprehension level was noted to be at a 7th grade level. Claimant's written expression was tested at a 6th grade level.

Eye institute documents (Exhibits 46-49) dated [redacted] were presented. It was noted that Claimant reported left eye blindness. Claimant testified that he had cataracts at birth and that he underwent an unsuccessful correction surgery as a baby. Claimant's right eye vision was noted to be 20/20. An impression that Claimant was essentially monocular was noted.

Chiropractor detailed examination notes (Exhibits 52-57) dated [redacted] were presented. It was noted that Claimant presented and appeared to be extremely uncomfortable and "in a great deal of distress." Claimant reported that he was in an auto accident on [redacted]. Claimant testified that he was a passenger in a vehicle when the vehicle in which he was riding crashed into a wall. Claimant reported that the impact caused jarring neck movements. It was noted that Claimant reported breaking several ribs. Reported complaints included occasional mid-back pain, shooting shoulder pain, constant chest pain, and severe lower back pain which shoots to his hips and right foot. Claimant reported that pain pills improve pain. Claimant reported that standing, sitting, walking, coughing, and repetitive movements increase his pain. Claimant also reported regular headaches. Several decreased ranges of motion were noted in Claimant's cervical, thoracic, and lumbar spine. A right leg assessment of 3+/5 was noted following manual muscle testing. Moderate fixation of spinal joints at C2, C5, C6, T1, T3, T6, T9, T11, T12, L2, L5, and the left ilium-sacrum was noted as elicited. It was noted that medium levels of pain were noted at 12 spinal locations. It was noted that moderate muscle hypertonicity was found throughout the spinal muscles. Long-term plans included the following: hot or cold pack therapy, extraspinal certified massage therapy including manual extremity manipulation, massage and trigger point therapy, tens unit, back brace for lumbar, and a home traction device. A plan to have Claimant return three times per week was noted. Claimant was noted to be disabled through [redacted].

Chiropractor office visit notes (Exhibits 58-59) dated [redacted] were presented. Claimant reported slight improvements in his mid-back and chest pain. Claimant reported significant improvement in his right hip pain. Ongoing lumbar pain was noted. A spinal evaluation was noted to reveal moderate fixation at 12 spinal discs.

Chiropractor office visit notes (Exhibits 60-61) dated [redacted] were presented. It was noted that Claimant reported increased pain in his neck, left shoulder, and mid-back. Increased headache pain was also noted. Claimant reported that his left hip pain was "much better" and that there was "much improvement" in his right hip pain. Right foot pain and chest pain were reported by Claimant as "substantially better" (pain level 4/10).

Chiropractor detailed examination notes (Exhibits 62-67) dated [redacted] were presented. It was noted that moderate spinal joint fixation was elicited at C2, C5, C6, T1, T3, T6, T9, T11, T12, L2, L5, and the left ilium-sacrum. Moderate muscle hypertonicity was noted throughout the spine. It was noted that Claimant was referred for physical therapy by his primary care physician. A plan of three times per week chiropractor visits was noted. Claimant was deemed to be disabled through [redacted].

Various chiropractor office visit notes (Exhibits 68-77) from August 2013 and September 2013 were presented. Ongoing pain complaints were reported by Claimant.

Chiropractor detailed examination notes (Exhibits 78-83) dated [redacted] were presented. Moderate fixation was elicited at C6, T3, T6, T11, T12, L2, L5, and the left ilium-sacrum. Digital palpation examination demonstrated moderate pain at the left side of C2, C7, T5, T8, L1, and L4. Right sided pain was demonstrated at C3, C5, T1, T4, and T9 while bilateral pain was found at C6, T3, T11, T12, L2, L5, and the ilium-sacrum. Moderate muscle hypertonicity was noted throughout Claimant's spine.

Chiropractor office visit notes (Exhibits 50-51; 84-85) dated [redacted] were presented. It was noted that Claimant reported ongoing neck pain, and increases in shoulder and thoracic pain. A slight improvement in headaches and lumbar pain was noted. Claimant's chiropractor deemed Claimant to be disabled through October 2013.

Chiropractor office visit notes (Exhibits 86-87) dated [redacted] were presented. It was noted that Claimant reported significant improvement in his mid-back. Slight improvement in Claimant's lumbar and hip pain was noted. Claimant reported the following pain levels: 6/10 for headaches, 6/10 at mid-back, 9/10 for lumbar, 9/10 for left hip pain, 7/10 in right hip pain,7/10 right foot numbness, and 4/10 chest pain.

Chiropractor office visit notes (Exhibits 88-89) dated [redacted] were presented. It was noted that Claimant reported the following pain levels: headaches (7/10), neck pain (8/10), shoulder (7/10), mid-back (6/10), lower back (10/10), Left hip (4/10), right hip (4/10), right foot numbness (4/10), and chest (4/10).

Hospital documents (Exhibits 29-31) from an encounter dated [redacted] were presented. It was noted that Claimant presented with his caretaker with complaints of a shooting and non-radiating back pain. Claimant reported that Norco and muscle relaxers provide little pain relief. A normal range of motion was noted. Claimant was noted as capable of ambulating. A follow-up with a neurologist was noted.

An MRI report of Claimant's lumbar (Exhibit A14-A15) dated [redacted] was presented. Normal height, normal disc contour, normal central canal, and no abnormality were noted at every single disc space. An impression of a normal cervical spine MRI was noted.

An MRI report of Claimant's lumbar (Exhibit A12-A13) dated [redacted] was presented. Normal height, normal disc contour, normal central canal, and no abnormality were noted at every single disc space. An impression of a normal lumbar spine MRI was noted.

Hospital documents (Exhibits 15-28; 32-33) from an admission dated [redacted], [redacted] were presented. It was noted that Claimant presented with two knife wounds, one in Claimant's right anterior chest wall, below his clavicle. A right-sided hemothorax was treated by placing a chest tube and draining. Claimant also had a left arm wound. It was noted that Claimant reported left grip strength weakness and burning sensation along the median nerve. Muscle strength loss in first and second left fingers and joints was noted. It was noted that Claimant underwent laceration repairs for both wounds. A post-surgery MRI noted possible median nerve laceration. Noted discharge diagnoses included traumatic hemothorax and open forearm (with complication). A follow-up with neurosurgery for left hand treatment was noted. A discharge date of [redacted] was noted.

Handwritten medical clinic office notes dated [redacted] (Exhibit A18) were presented. Claimant reported ongoing lower back pain. A plan to prescribe Norco was noted.

A mental status examination report (Exhibits 90-94) dated [redacted] was presented. The report was unsigned but is presumed to have been completed by a consultative psychologist. Claimant reported ongoing depression, a learning disability, and a diagnosis of ADD. Claimant's gait was noted to be normal and motor activity was noted to be slow. Noted observations of Claimant made by the consultative examiner included the following: adequate contact with reality, diminished self-esteem, talkative, feelings of worthlessness, emotionally distant, and adequate insight. Claimant was unable to repeat 3 numbers backwards. Claimant answered that 9-5 = 3. Diagnoses of adjustment disorder with a history of ADD and a learning disorder were noted. Claimant's social interaction ability was noted to be moderately impaired. Claimant's ability to understand, remember, and carry out directions was found to be moderately impaired. It was noted that Claimant could perform simple repetitive tasks as well as more complex tasks. Moderate difficulty in performing multiple step tasks was noted.

An internal medicine examination report (Exhibits 41-45) dated [redacted] was presented. The report was noted as completed by a consultative physician. Claimant reported problems of lifelong left-eye blindness, HTN, shortness of breath, and back pain since a motor vehicle accident in June 2013. Claimant's blood pressure was noted to be 184/100. Claimant reported being unable to carry weight with left hand. Claimant's right eye vision was noted to be 20/50. Straight-leg-raising test was noted as negative. Limited thumb, pointer finger, and middle finger flexion was noted on Claimant's left hand; sub-normal dexterity was noted. It was noted that Claimant had "much difficulty" performing toe walking and heel walking with his cane. Reduced strength (4/5) was noted in Claimant's left arm. Claimant reported that he does not do housework,

shopping, or yard work. It was noted that Claimant has not had eye treatment since 2010; a referral to an eye institute was noted (see Exhibits 44-45).

Handwritten medical clinic office notes dated [redacted] (Exhibit A17) were presented. Claimant reported vision black-outs 2-3 times per month and ongoing lower back pain.

Physician office notes dated [redacted] (Exhibit A28) were presented. It was noted that Claimant's visit was his first. A complaint of nerve pain was noted. Impressions of shoulder and wrist pain were noted. A referral to a pain management physician was noted.

Hospital documents (Exhibits A43-A49) from an encounter dated [redacted] were presented. It was noted that Claimant presented with complaints of left hand pain. It was noted that Claimant was discharged after receiving Norco for pain.

Handwritten medical clinic office notes dated [redacted] (Exhibit A9) were presented. Prescriptions for Tylenol #4, Flexeril, and prednisone were noted.

Handwritten medical clinic office notes dated [redacted] (Exhibit A5) were presented. It was noted that Claimant had a history of CTS. Prescriptions for Neurontin and Claritin were noted.

Handwritten medical clinic office notes dated [redacted] (Exhibit A5) were presented. It was noted that Claimant had a history of ADHD. Prescriptions for Klonopin and Xanax were noted.

Handwritten medical clinic office notes dated [redacted] (Exhibit A4) were presented. It was noted that Claimant reported needing HTN medication because he had a near stroke 2 weeks earlier. Prescriptions for Ultram and Ambien were noted.

Handwritten medical clinic office notes dated [redacted] (Exhibit A3) were presented. It was noted that Claimant requested a higher dose of pain medication. Paresthesia of Claimant's left hand was noted.

Handwritten medical clinic office notes dated [redacted] (Exhibit A1) were presented. It was noted that Claimant reported anxiety and lower back pain. Prescriptions for Tylenol #4 and Xanax were noted.

Claimant received treatment for black-outs in April 2014. Claimant did not testify to ongoing problems with black-outs. The treatment appears to be a one-time complaint which does not meet the durational requirements of a severe impairment.

Claimant testified that he was stabbed in his left arm rendering him with ongoing left arm pain. Claimant testified that a tendon and his left median nerve were injured in the

attack. Claimant testified that he cannot snap his fingers or make a fist with his left hand and that that his left hand is essentially useless. Claimant's testimony was consistent with presented records.

Claimant testified that his ongoing pain exacerbated his blood pressure. Claimant's testimony was consistent with presented records which verified high blood pressure readings and ongoing blood pressure medication.

Claimant testified that he ongoing foot, neck, and back pain related to a car accident. Claimant testified that the pain restricts his ability to walk, stand, and sit. Claimant's testimony was consistent with treatment documents.

Claimant testified that he sometimes experiences audio hallucinations. Claimant testified that he sometimes feels paranoid. It was noted that Claimant denied hallucinations (see Exhibit 93). Presented records did not otherwise reference a compliant of hallucinations. Claimant failed to verify restrictions related to hallucinations.

Claimant testified that he recently had his ear sliced when he tried to break up a fight and was hit with a glass bottle. No records of related medical treatment were presented. Claimant did not establish a severe impairment related to a severed ear.

Claimant testified that he is blind in his left eye. Claimant also testified that he is concerned about decreasing right eye vision. Claimant's testimony was supported by medical records.

Presented records sufficiently verified restrictions related to back pain, neck pain, left arm debility, high blood pressure, and left eye vision loss, each for a period of longer 12 months. Accordingly, it is found that Claimant established having a severe impairment and the disability analysis may proceed to Step 3.

The third step of the sequential analysis requires a determination whether the Claimant'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 Claimant's impairments are listed and deemed to meet the 12 month requirement, then the claimant is deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step.

A listing for joint dysfunction (Listing 1.02) was considered based on Claimant's complaints of hip pain. The listing was rejected due to a failure to establish that Claimant is unable to ambulate effectively.

A listing for spinal disorders (Listing 1.04) was considered based on Claimant's cervical, throacic, and lumbar complaints. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root.

A listing for visual acuity (Listing 2.02) was considered based on left eye blindness. This listing was rejected due to a failure to establish a corrected eyesight of worse than 20/200 in Claimant's best eye.

A listing for chronic skin infections (Listing 8.04) was considered based on Claimant's treatment for cellulitis. The listing was rejected due to a failure to establish extensive fungating or extensive ulcerating skin lesions that persist for at least 3 months despite continuing prescribed treatment.

A listing for anxiety-related disorders (Listing 12.06) was considered based on a diagnosis of anxiety disorder. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Claimant had a complete inability to function outside of the home.

It is found that Claimant failed to establish meeting a SSA listing. Accordingly, the analysis moves to step four.

The fourth step in analyzing a disability claim requires an assessment of the Claimant's residual functional capacity (RFC) and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if it is determined that a claimant can perform past relevant work. *Id*.

Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

Claimant states that he worked in August 2014. He states that he cleaned and did inventory for a disaster clean-up company. Claimant says he was fired because he was a liability and could not carry anything.

Claimant states that he performed various jobs from 2004-2011. Claimant testified that some of his jobs included mowing lawns, roofing, and shoveling snow.

Claimant testified that he worked for a carnival for one week in 2011. Medical records noted that Claimant ran a game booth. Medical records also noted that Claimant was fired for mixing up the prizes. Presumably, Claimant's one week of employment did not amount to SGA.

Claimant testified that he is unable to perform the lifting and carrying of his previous employment that amounted to SGA income levels. Claimant's testimony was consistent with presented medical records. It is found that Claimant may not return to past employment and the analysis may proceed to the final step.

In the fifth step in the process, the individual's RFC in conjunction with his or her age, education, and work experience, are considered to determine whether the individual can engage in any other substantial gainful work which exists in the national economy. SSR 83-10. While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

To determine the physical demands (i.e. exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967. The definitions for each are listed below.

Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). 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. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b) Even though 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. *Id.* 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. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additionally limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.*

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.*

Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.*

Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands are considered nonexertional. 20 CFR 416.969a(a). Examples of non-exertional limitations include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i)-(vi) If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2)

The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.* In using the rules of Appendix 2, an individual's circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, is compared to the pertinent rule(s).

Given Claimant's age, education and employment history a determination of disability is dependent on Claimant's ability to perform sedentary employment. For sedentary employment, periods of standing or walking should generally total no more than about 2 hours of an 8-hour workday. Social Security Rule 83-10.

Physician statements of Claimant restrictions were not presented. Restrictions can be inferred based on presented documents.

Claimant testified that he can bathe himself, but that he has some difficulty washing his right side because of left arm dysfunction. Claimant testified that he cannot tie his shoes, wash dishes, or cook because of left hand dysfunction. Claimant testified that he is capable of light cleaning (e.g. wipe off tables and vacuum). Claimant testified that he does his own shopping. Claimant's testimony was consistent with presented records which verified that a stab wound renders Claimant's left arm to be minimally useful.

Claimant's left arm dysfunction would reasonably restrict Claimant to sedentary forms of employment which require a minimum of lifting/carrying. Claimant would also reasonably have difficulty with jobs that require bilateral arm or hand dexterity (e.g. typist or assembly).

Claimant verified vision loss in his left eye. A deterioration in Claimant's right eye was verified, however, the deterioration is not severe. Claimant's right eye vision was most recently tested to be 20/50. Claimant did not verify any optical treatment since 2010, thus, it is reasonable to presume that some improvement in right eye vision would occur with proper medical treatment. The evidence sufficiently established that Claimant's vision restricts him from performing employment reliant on binocular or strong vision (e.g. pilot or inspector).

At the second step of the analysis, it was found that medical records sufficiently verified that Claimant has spinal pain which impedes Claimant's ability to sit, stand, and walk. Claimant testified that he is restricted to 1/8th of a mile of walking due to spinal pain. Claimant estimated he needs 30-40 minutes of rest before walking another 1/8th of a mile. Claimant testified that back pain restricts his sitting to 35 minutes, at most.

Medical records verified that Claimant received chiropractor treatments and pain medications. Claimant testified that he attended physical therapy for 4 months after his car accident (though records were not presented). Claimant testified his physical therapy was cut short because he could not afford further treatment. During the hearing, Claimant was asked why he did not restart therapy now that he has health insurance. Clamant testified that he is too busy with GED classes to now attend therapy.

In lieu of specific physician restrictions, the best evidence to determine sitting and walking restrictions is radiology. Claimant's cervical and lumbar MRI reports found no abnormalities. A normal MRI report is not necessarily representative of Claimant's back problems. Medical records verified that Claimant attended chiropractor treatments for four months in 2013, received strong narcotic pain medication from his personal physician throughout 2014, and was found by a consultative examiner to have difficulty with walking. Based on Claimant's overall treatment history, it is probable that Claimant's spinal problems preclude the performance of any employment greater than sedentary. Without supporting radiology, a finding that Claimant is unable to perform even sedentary employment is inappropriate.

Presented psychological documentation was minimal. Education records and a consultative examination established that Claimant has learning restrictions. A restriction from performing complex employment is a reasonable inference. Further mental restriction would be unsubstantiated.

Claimant established that he is restricted to mostly sitting employment, requiring non-binocular vision, and one arm and hand dexterity. It was further verified that Claimant is restricted to performing non-complex employment. It is possible that sufficient employment opportunities exist for Claimant. Claimant's restrictions are so restrictive that it cannot be presumed that sufficient job opportunities exist without vocational expertise; DHHS presented no such vocational expertise.

Based on the presented evidence, it is found that Claimant is disabled. Accordingly, it is found that DHHS improperly denied Claimant's MA application by finding that Claimant was not disabled.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that DHHS improperly denied Claimant's application for MA benefits. It is ordered that DHHS:

(1) reinstate Claimant's MA benefit application dated [redacted], including retroactive MA benefits from December 2013;
(2) evaluate Claimant's eligibility for benefits subject to the finding that Claimant is a disabled individual;
(3) initiate a supplement for any benefits not issued as a result of the improper application denial; and
(4) schedule a review of benefits in one year from the date of this administrative decision, if Claimant is found eligible for future benefits.

The actions taken by DHHS are **REVERSED**.

Christian Gardocki
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Signed: **6/4/2015**

Date Mailed: **6/4/2015**

CG / hw

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]