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

IN THE MATTER OF:

[redacted]

Reg. No.: 14-013886
Issue No.: 4009
Case No.: [redacted]
Hearing Date: December 03, 2014
County: WAYNE-DISTRICT 15 (GREYDALE)

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

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, telephone hearing was held on December 3, 2014, from Detroit, Michigan. Participants on behalf of Claimant included the Claimant. Participants on behalf of the Department of Human Services (Department) included [redacted], Medical Contact Worker, Eligibility Specialist.

ISSUE

Whether the Department properly determined that Claimant was not disabled for purposes of the Medical Assistance (MA) and/or State Disability Assistance (SDA) benefit programs?

FINDINGS OF FACT

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

1. On August 12, 2014, the Claimant submitted an application for public assistance seeking State Disability Assistance (SDA)

2. On September 26, 2014, the Medical Review Team ("MRT") found the Claimant not disabled.

3. The Department notified the Claimant of the MRT determination on September 29, 2014.

4. On October 15, 2014, the Department received the Claimant's timely written request for hearing.

5. An Interim Order was issued December 3, 2014. New evidence was received by the undersigned and reviewed.

6. The Claimant has alleged mental disabling impairments including anxiety and bipolar disorder.

7. The Claimant alleges physical disabling impairments due to pseudo seizure disorder and seizures, Charcot-Marie-Tooth disease and chronic body pain and bilateral peripheral neuropathy in hands, legs and feet, and diabetes. The Claimant is also obese with a BMI of 35.5.

8. At the time of hearing, the Claimant was [redacted] years old with a [redacted] birth date. Claimant is 5'6" tall in height; and weighed 220 pounds.

9. The Claimant completed 9th grade. The Claimant can read and write as well as do basic math. The Claimant also attended special education classes in elementary and middle school

10. The Claimant's work experience included performing cashiering work for both a fast food restaurant and retail sales outlet. She also stocked shelves, and was also a home health aide taking patients to doctors, running errands, medication reminder and lifting and transporting patients.

11. The Claimant's impairments have lasted or are expected to last 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.

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code,

Rules 400.3151 – 400.3180. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a). The person claiming a physical or mental disability has the burden to establish it 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). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant 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).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (e.g., age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a) (4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need 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). If impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3 to Step 4. 20 CFR 416.920(a)(4); 20 CFR

416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). 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). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

As outlined above, the first step looks at the individual's current work activity. In the record presented, the Claimant is not involved in substantial gainful activity and was not employed at the time of the hearing and, therefore, is not ineligible for disability benefits under Step 1.

The severity of the Claimant's alleged impairment(s) is considered under Step 2. The Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b). 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 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b). Examples include:

1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

5. Responding appropriately to supervision, co-workers and usual work situations; and dealing with changes in a routine work setting.

Id.

The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still 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). An impairment qualifies as non-severe only if, regardless of a Claimant's age, education, or work experience, the impairment would not affect the Claimant's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985).

The Claimant has alleged mental disabling impairments including anxiety and bipolar disorder.

The Claimant alleges physical disabling impairments due to pseudo seizure disorder and seizures, Charcot-Marie-Tooth disease and chronic body pain and bilateral peripheral neuropathy in hands, legs and feet, and diabetes. The Claimant is also obese with a BMI of 35.5.

A summary of the medical evidence presented at the hearing and received pursuant to the Interim Order follows.

A letter dated [redacted] from a neurologist who had treated the Claimant as a patient at the [redacted] advised that she was diagnosed with psychogenic non-epileptic spells in [redacted]. It notes that Claimant continues to have syncopal episodes and is under care of a cardiologist for diagnosis of these events. The letter also notes that Claimant has recently been diagnosed with Charcot-Marie-Tooth Disease which will cause weakness, numbness and muscle cramping and severe pain. The doctor notes that because the Claimant has episodes with loss of awareness which are mostly unpredictable, she cannot drive or operate heavy machinery until she is seizure free for 6 months per the DMV code. The doctor suggests caution should be used in regards to swimming or having a bath unsupervised, or climbing tall heights/ladders, cooking with oil or grease due to possibility of severe injuries.

The Claimant's employer provided a letter dated [redacted] indicating that the Claimant can no longer work in her job as her job requires operating heavy machinery and operating a motor vehicle which is an essential part of her job.

One of the Claimant's neurologists who has seen her completed a Medical Examination report dated [redacted]. The diagnosis was psychogenic non-epileptic spells. The report notes back pain extending down the leg with complaints of numbness. The doctor rated the Claimant as capable of using her hands and arms for repetitive motions. The notes indicate under Mental Limitations that Claimant expresses frustration related to medical condition. The doctor imposed a mental limitation regarding memory indicating patient experiences loss of awareness. Regarding

assistance needed, the doctor's notes indicate that because Claimant's conditions are unpredictable, patient should be supervised while cooking, bathing, etc.

A Mental Residual Functional Capacity Assessment was completed by the Claimant's treating psychiatrist on [redacted]. The Claimant was markedly limited in almost all of the categories regarding Understanding and Memory, Sustained Concentration and Persistence, Social Interaction and Adaptation. The numerous Marked Limitations clearly would cause difficulty for the Claimant in maintaining employment both cognitively and socially. The notes also indicate that Claimant is experiencing confusion, worry and a sense of being overwhelmed most of the time. Several psychiatric evaluations for medication review were noted and diagnosed bipolar disorder. A psychiatric examination evaluation was completed by the Claimant's treating psychiatrist on [redacted] by the Claimant's treating psychiatrist who diagnosed the Claimant with bipolar disorder with a GAF score of 45. During the exam the Claimant's affect was blunted, mood expansive, fund of knowledge was inadequate, insight was fair and judgment was compromised, the Claimant's speech was pressured with daily crying spells noted.

Another psychiatric exam for medications completed on [redacted] notes that the claimant is improving. Her judgment and insight was rated as fair and the remainder of the evaluation of Claimant was within normal limits including concentration and attention and her mood was noted as expansive. A medical review was completed also in [redacted] which noted mood to be anxious and depressed and was again noted as improving.

The Claimant's Cardiologist with a specialty in Electrophysiology as well as cardiology has treated the Claimant since [redacted]. He completed a Medical Exam Report on [redacted]. The current diagnosis was syncope, unexplained tachycardia. The doctor notes that an implanted loop recorder demonstrated recurrent narrow complex tachycardia with heart rate greater than 180 beats per minute. The doctor indicated that the Claimant was deteriorating and indicated that the Claimant's limitation was expected to last more than 90 days. No limitation boxes were checked. The support for the diagnosis was the documented rapid heart rate that corresponds to the Claimant's reported symptoms.

A Medical Exam Report dated [redacted] was prepared Claimant's neurologist who saw her in [redacted] The diagnosis given was Charcot-Marie-Tooth Disease. The neurological evaluation noted paresthesias tingling and numbness, twitches, jerks and spasm bilateral hands. The Claimant was rated stable and limitations were imposed which were to last 90 days or more. The Claimant could frequently lift 10 pounds for 2/3 of an 8 hour day and had full use of both hands for all repetitive actions including simple grasping, reaching pushing/pulling and fine manipulating. While no restrictions for walking/standing or sitting were checked, the report section requesting medical findings supporting the physical limitations note patient has spasms, pains and jerkiness and difficulty walking secondary to her diagnosis of Charcot-Marie-Tooth Disease.

An Electromyography was conducted on [redacted] to complete a nerve conduction study. The conclusion was that there is electrodiagnostic evidence of a pronounced bilateral, sensorimotor diffusely even, primarily demyelinating peripheral polyneuropathy affecting the upper and lower extremities. The neuropathy is more severe in the lower extremities and the distal muscles of the legs and feet. Mild to moderate primarily demyelinating medial mononeuropathy of the bilateral wrists, (Carpal Tunnel). The clinical correlation section of the report results and their interpretation noted that the abnormal findings are consistent with the patient's clinical complaints of numbness, pain and difficulty walking on a peripheral nerve or muscle basis. The report concluded that given the diffuse and relatively uniformly abnormal demyelinating findings, and strong family history, the insidious onset of symptoms in the patient, this likely reflects an inherited demyelination polyneuropathy such as seen in Charcot Marie Tooth Disease.

On [redacted] the Claimant was treated for tachycardia, pain and anxiety with a triage code level of 2. The Claimant's heart rate was 156 and eventually came down. Claimant arrived via EMS and was very anxious and no history could be obtained. She also reported no medications. The Claimant had tachycardia with a heart rate of 150 and was complaining of pain all over with history of Charot-Marie-Tooth. The Claimant was out of klonopin for last 4 days. The Claimant was admitted in fair condition and for observation. Mild elevation of CPK sickle cell trait was of concern. The assessment and plan noted that Claimant has demyelinating peripheral neuropathy on EMG nerve conduction study and physical exam consistent with peripheral neuropathy, decreased reflexes at the ankles bilaterally. The Claimant had been prescribed Neurontin and has not taken it. Seizure precautions were imposed; no driving for 6 months. Discharge diagnosis included pseudo seizure, hypokalemia, demyelinating peripheral neuropathy.

On [redacted] the Claimant was seen in ER for seizure witnessed by her boyfriend with all four limbs shaking and frothing at the mouth, urination on herself and difficulty breathing with vomiting. The seizure lasted 5 minutes. While in the ER trauma bay she had another seizure with curling of hands and toes and was tachycardic in the 150's. Claimant also reported bad muscle spasms and pain all over her body. On examination neurologically she had abnormal balance, numbness and tingling. Claimant also exhibited anxiety. On this admission the impression was seizure versus pseudo seizure, notes indicate that Claimant had two events what were captured at EMU at Harper on video EEG with no EEG finding. After the Claimant was diagnosed with pseudo seizure a Keppra anti-seizure med was slowly tapered by her treating doctor. After the seizure in ER Claimant was administered Keppra and Phenytoin. Claimant was placed on seizure precautions and admitted. The Claimant also had a seizure while hospitalized and seen by night nurse, tonic-clonic movement of arms and legs with frothing from the mouth.

The Claimant was seen in the ER on [redacted] with complaint of right-sided muscle pain and seizure. Notes indicate that the Claimant had stopped taking her anti-epileptic medications and had not had any seizures. The neurological exam showed no

focal neurologic deficits. Due to concern as to whether the seizure was a seizure versus psychogenic non-epileptic seizure, the Claimant was going to be admitted for re-evaluation and re-start of anti-epileptic medications, but the Claimant did not want to be placed back on anti-seizure meds and left the hospital against medical advice.

On [redacted] the Claimant was in the ER for seizure with complaints of right arm and leg numbness and tingling and she was shaking on right side. Family members had heard sound like she was having a seizure. The Claimant lost urinary control during the seizure. The Claimant advised that she was compliant with her medication. Due to med compliance the doctor indicated that the seizure was a break through seizure. The Claimant was admitted for work up for break through seizures. The Claimant was also admitted on [redacted] for seizure disorder.

Claimant was also seen at the hospital on [redacted] with complaints of seizures. The history noted that the Claimant had bitten her tongue with tonic-clonic movements. After the first seizure at home, the Claimant's mother was summoned and witnessed a second seizure, and then en route EMS noted another seizure. The Claimant was wearing an electrode helmet for electrode mapping of her brain for seizure treatment which was placed the prior day. The Claimant was compliant with her anti-seizure medication. The Claimant was admitted for observation and her condition was serious and seizure precautions were assigned. The Claimant had acute breakthrough seizures with therapeutic Depakote level and mild asthma exacerbation. An MRI of the brain was done with the impression of mild asymmetric volume loss and T2 prolongation affecting the right hippocampus when compared to the left.

In [redacted] the Claimant presented to the emergency room with complaints of twitching and muscle spasms over the last 4 days. She had seen her doctor 3 days prior and was prescribed muscle relaxers which had only been taken twice over the course of three days. The Claimant was prescribed Depakote in [redacted] and had never taken it. The Claimant also had a headache and right-sided numbness. On examination the Claimant was positive for muscle twitching. No tobacco or drug use was reported. The Claimant was noted as appearing to have right-sided weakness. EKG was normal. The final impression was acute possible cerebrovascular accident and notes serious condition. While receiving a CT scan the admitting doctor was alerted that the Claimant was having a seizure which the doctor did not witness; however, the sporadic twitching continued. The attending doctor noted that the patient's physical symptoms related to emotional upset and noted a psychiatric possibility of a conversion disorder. Claimant was treated for deep venous thrombosis and gastrointestinal prophylaxis with Heparin. The Claimant was discharged [redacted]

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the Claimant has presented objective medical evidence establishing that she

does have some physical limitations on her ability to perform basic work activities. Accordingly, the Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, the Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The Claimant has alleged mental disabling impairments including anxiety and bipolar disorder.

The Claimant alleges physical disabling impairments due to pseudo seizure disorder and seizures, Charcot-Marie-Tooth disease and chronic body pain and bilateral peripheral neuropathy in hands, legs and feet, and diabetes. The Claimant is also obese with a BMI of 35.5.

In light of both physical and mental disabling impairments which are presented several listings were reviewed. Listing 14.00 regarding immune system disorders was consulted based on the Claimant's diagnosis for Charcot-Marie-Tooth disease but the evidence presented did not satisfy the listing or its medical equivalent. Likewise the Claimant's bipolar and anxiety mental issues were also examined in light of Listing 12.04 B. (Bipolar), which was examined. The Claimant did present evidence of problems with judgment and insight as well as an initially low GAF score of 45 with a significantly markedly limited evaluation in many categories of the recent Mental Residual Functional Capacity Assessment referenced above. However the two most recent psychiatric evaluations note the Claimant is improving. Thus, based upon the entire record presented it is determined that the Listing 12.04 is not met. Likewise 12.06, Anxiety Related Disorders, was also examined in light of the documented hospital admissions for anxiety related to seizure and tachycardia; however, the Claimant's treating psychiatrist made no notes relative to anxiety, and therefore the medical evidence did not demonstrate that the Listing was met. Lastly Listing 13.02 Epilepsy – Convulsive and Listing 13.03 Epilepsy – Non Convulsive were examined in light of the Claimant's numerous hospitalizations for seizure-related symptoms; however, in light of the Claimant's diagnosis of pseudo seizure and the lack of required measurements of blood serum levels, it must be determined that the listing or its medical equivalent is not met. The Listing for Neurologic Disorders and the required medical evidence for 13.02 and 13.03 are found in 11.00 A, and provide:

> Under 11.02 and 11.03, the criteria can be applied only if the impairment persists despite the fact that the individual is following prescribed antiepileptic treatment. Adherence to prescribed antiepileptic therapy can ordinarily be determined from objective clinical findings in the report of the physician currently providing treatment for epilepsy. Determination of blood levels of phenytoin sodium or other antiepileptic drugs

> may serve to indicate whether the prescribed medication is being taken. When seizures are occurring at the frequency stated in 11.02 or 11.03, evaluation of the severity of the impairment must include consideration of the serum drug levels.

Ultimately, it is found that the Claimant suffers from some medical conditions; however, the Claimant's impairments do not meet the intent and severity requirement of Listings reviewed above based upon the available medical evidence.

Therefore, the Claimant cannot be found disabled, or not disabled, at Step 3. Accordingly, the Claimant's eligibility is considered under Step 4. 20 CFR 416.905(a).

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 he/she can perform past relevant work. *Id*.; 20 CFR 416.960(b)(3). 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 are 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.

To determine the physical demands (exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967.

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 additional 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 (exertional requirements, e.g., sitting, standing, walking, lifting, carrying, pushing, or pulling) are considered nonexertional. 20 CFR 416.969a(a). In considering whether an individual can perform past relevant work, a comparison of the individual's residual functional capacity to the demands of past relevant work must be made. *Id.* If an individual can no longer do past relevant work, the same residual functional capacity assessment along with an individual's age, education, and work experience is considered to determine whether an individual can adjust to other work which exists in the national economy. *Id.* Examples of non-exertional limitations or restrictions include difficulty function 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 (e.g., 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.*

The Claimant's prior work history consists of employment performing cashiering for a fast food restaurant and retail outlets which required standing all day and use of both hands. The Claimant also was a home health care aide which required driving of patients assigned to Claimant to the doctor, running errands such as shopping, as well as other duties including lifting and transferring clients when necessary. Based upon the above documented limitations on the Claimant's driving due to seizure acitvity and by her neurologist indicating she has difficulty walking and is otherwise rated as deteriorating by her cardiologist, it is therefore demonstrated that the Claimant's current restrictions imposed by her doctors would no longer allow the Claimant to perform this prior work. In light of the Claimant's testimony and records, and in consideration of the Occupational Code, the Claimant's prior work is classified as unskilled light work.

In addition, the Claimant credibly testified to the following restrictions and limitations. The Claimant could stand less than an hour and could sit about 10 minutes due to body pain requiring her to move. The Claimant requires some assistance buttoning her clothes and can shower, but at times needs help with dressing and combing her hair due to pain and cramping in her hands. The Claimant, due to her seizures, also is required to be supervised when bathing and cooking with oil as well as being restricted in climbing ladders and the like based on her doctor's noted precautions.

If the impairment or combination of impairments does not limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. 20 CFR 416.920. In consideration of the Claimant's testimony, medical records, and current limitations, it is found that the Claimant is not able to return to past relevant work; due in large part the driving requirements, inability to operate heavy equipment due to seizures, lifting requirements and prolonged standing/sitting and her medically noted difficulty with walking by her neurologist. Thus, the fifth step in the sequential analysis is required.

In Step 5, an assessment of the individual's residual functional capacity 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). The Claimant is [redacted] years old and, thus, is considered to be an individual of younger age for MA purposes. The Claimant also completed the 9th grade. Disability is found if an individual is unable to adjust to other work. *Id.* At this point in the analysis, the burden shifts from the Claimant to the Department to present proof that the Claimant has the residual capacity to substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). The Department did not present any vocational evidence.

Based upon the foregoing objective medical evidence including the functional limitations with walking, her non-exertional limitations based on her psychiatric treatment and evaluations finding her improving, but markedly limited in most categories evaluated on the Mental Residual Functional Capacity Assessment, Claimant's numerous hospitalizations for seizures and pseudo seizures and her diagnosis of Charot-Marie-Tooth Disease which clinically supports her pain and peripheral demyelinating neuropathy based on an EMG test as well as those limitations imposed by her neurologist and cardiologist regarding walking, these limitations in combination do not support a finding that Claimant is capable of performing sedentary work. Sedentary work requires lifting 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.

This Administrative Law Judge does take into account Claimant's complaints of pain and finds that such complaints are supported by the Charot-Marie-Tooth Disease diagnosis which can be reasonably expected to produce Claimant's pain and numbness in her feet and difficulty walking. In addition, the pain complaints are further supported by the medical limitations imposed by her doctors and the EMG testing provided. Subjective complaints of pain where there are objectively established medical conditions that can reasonably be expected to produce the pain must be taken into account in determining a Claimant's limitations. *Duncan v Secretary of HHS*, 801 F2d 847, 853 (CA6, 1986); 20 CFR 404.1529-416.929.

The Claimant's treating doctor notes serious restrictions due to Claimant's physical impairment related to her difficulty walking and her cardiologist's finding she is deteriorating, were considered when making this determination. The evaluations and medical opinions of a "treating" physician is "controlling" if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record. 20 CFR§ 404.1527(d)(2), Deference was given by the undersigned to objective medical testing including EMG testing and clinical observations of the Claimant's treating neurologist who place the Claimant at less than sedentary. The numerous hospitalizations were also considered and would make it unlikely that the Claimant could sustain continuing employment. The total impact caused by the physical impairment and mental impairment suffered by the Claimant and their attendant limitations in combination must be considered. In doing so, it is found that the Claimant's physical and mental impairments have a major impact on her ability to perform even basic work activities. In consideration of the foregoing and in light of the medically objective physical limitations and pain, and the fact that the Department did not present any vocational evidence to support whether any jobs exist in the national economy that the Claimant could perform given her limitations, accordingly, it is found that the Claimant is unable to perform the full range of activities for even sedentary work as defined in 20 CFR 416.967(a).

After review of the entire record, and in consideration of the Claimant's age, education, work experience and residual functional capacity it is found that the Claimant is disabled for purposes of the SDA program at Step 5.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Claimant disabled for purposes of the SDA benefit program.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, finds Claimant disabled for purposes of the SDA benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is REVERSED.

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE OF MAILING OF THIS DECISION AND ORDER:

1. The Department shall process the Claimant's August 12, 2014 SDA application and determine if all non-medical eligibility requirements are met.

2. The Department shall issue a supplement to the Claimant for SDA benefits the Claimant is otherwise eligible to receive in accordance with Department policy.

3. A review of this case shall be completed in March 2016.

Lynn M. Ferris
Administrative Law Judge
for Nick Lyon, Interim Director
Department of Human Services

Date Signed: **3/6/2015**

Date Mailed: **3/6/2015**

LMF / cl

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]