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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-009145
Issue No.: 4009
Case No.: [redacted]
Hearing Date: July 06, 2015
County: Macomb-District 20

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

HEARING DECISION

Following Claimant's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, an in-person hearing was held on July 6, 2015, from Warren, Michigan. Participants on behalf of Claimant included Claimant. Participants on behalf of the Department of Health and Human Services (Department) included [redacted], Hearing Facilitator, and [redacted], Eligibility Specialist.

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional records. The requested documents were received. The record closed on August 5, 2015, and the matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

Did the Department properly determine that Claimant was not disabled for purposes of the State Disability Assistance (SDA) benefit program?

FINDINGS OF FACT

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

1. On July 10, 2013, the Department sent Claimant a Notice of Case Action approving her application for SDA benefits for August 1, 2013, ongoing (Exhibit 2).

2. Claimant received SDA benefits from August 1, 2013, to July 31, 2014, and from August 16, 2014, to September 30, 2014 (Exhibit D).

3. Claimant received cash assistance under the Family Independence Program (FIP) from February 1, 2014, to September 30, 2014 (Exhibit D).

4. On July 29, 2014, Claimant submitted an application for public assistance seeking cash assistance (Exhibit B).

5. On October 3, 2014, Claimant submitted a medical packet to the Department (Exhibit H).

6. On March 3, 2015, the Medical Review Team (MRT) found Claimant not disabled (Exhibit A).

7. On March 9, 2015, the Department sent Claimant a Benefit Notice denying an August 1, 2014, application based on MRT's finding of no disability (Exhibit C).

8. On May 14, 2015, the Department received Claimant's timely written request for hearing (Exhibit F).

9. Claimant alleged disabling impairment due to asthma, high blood pressure, diabetes, high cholesterol, obesity, arthritis, back pain, heart murmur, depression, and anxiety.

10. On the date of the hearing, Claimant was [redacted] years old with a [redacted], birth date; she is [redacted]" in height and weighs about [redacted] pounds.

11. Claimant obtained a GED.

12. Claimant has an employment history of work as a certified nursing assistant and sandwich maker.

13. Claimant's impairments have lasted, or are expected to last, continuously for a period of 90 days or longer.

CONCLUSIONS OF LAW

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

As a preliminary matter, it is noted that Claimant's case involves an unusual set of circumstances. Claimant received cash assistance under both the FIP and SDA programs from February 2014 through September 2014 (Exhibit D). Claimant explained that she believed she received FIP for her two children and SDA for herself based on her disability. The eligibility summary shows that, consistent with her understanding, Claimant received FIP for a group size of two, presumably the two children, and SDA for one person, Claimant (Exhibit D). The Department explained that Claimant's FIP case

closed because Claimant exceeded the 60-month limit on receipt of benefits (Exhibit E), and her SDA case closed because MRT concluded that she was not disabled.

Although Claimant contended that she had been previously found disabled by the Department and that her SDA case closed following a review, the Department responded that MRT had never previously assessed Claimant for a disability and that the SDA benefits were issued to her in error. When it realized the error, it stopped issuing SDA benefits to Claimant, requested medical documentation from her, and forwarded the documents to MRT. It appears from the record presented that the Department treated a July 29, 2014, application for cash assistance Claimant submitted after she was advised that her cash assistance case was closing due to a child support sanction (which was subsequently rectified) as a new application. When MRT concluded that Claimant was not disabled, the Department sent her the March 9, 2015, Benefit Notice notifying her that ther SDA application, which it identifies as submitted on August 1, 2014, was denied. The issue addresssed at the hearing and in this Hearing Decision is limited to whether the Department properly concluded that Claimant was not disabled and closed her SDA case.

The 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 disabled person is eligible for SDA. BEM 261 (July 2014), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

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

> (1) whether the individual is engaged in substantial gainful activity (SGA);
> (2) whether the individual's impairment is severe;
> (3) whether the impairment and its duration meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404;
> (4) whether the individual has the residual functional capacity to perform past relevant work; and
> (5) whether the individual has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If

a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4).

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

Step One

As outlined above, the first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Claimant has not engaged in SGA activity during the period for which assistance might be available. Therefore, Claimant is not ineligible under Step 1 and the analysis continues to Step 2.

Step Two

Under Step 2, the severity of an individual's alleged impairment(s) is considered. If the individual does not have a severe medically determinable physical or mental impairment that meets the duration requirement, or a combination of impairments that is severe and meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for SDA 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 90 days. 20 CFR 416.922; BEM 261, p. 2.

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). Basic work activities mean the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921(b). Examples include (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. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, 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 v Bowen,* 880 F2d 860, 862-863 (CA 6, 1988), citing *Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985).

In the present case, Claimant alleges disabling impairment due to asthma, high blood pressure, diabetes, high cholesterol, obesity, arthritis, back pain, heart murmur, depression, and anxiety. According to the medical file presented by the Department, MRT considered only a consultative physical examination in determining that Claimant was not disabled. At the hearing, Claimant presented considerably more medical documents, including records pertaining to her psychological treatment. The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

On August 7, 2012, Claimant went to the emergency department complaining of abdominal pain, headaches, nausea, vomiting; glucose greater than 1000. She was admitted for hyperglycemia, which might be reflective of early diabetic ketoacidosis (DKA). She was again hospitalized from October 23, 2012 to October 25, 2012, and diagnosed with uncontrolled type I diabetes without ketoacidosis due to missed dosage of Lantus on day of presentation, migraine headaches, nausea and abdominal pain secondary to diabetic gastroparesis. It was noted that her hypertension, asthma, low back pain, and depression were stable. Claimant's medical record shows ongoing emergency department visits, including admissions, related to her insulin resistant diabetes and resulting blood sugar levels over 400 and up to the 600s including diagnoses for diabetic ketoacidosis on January 7, 2013; January 11, 2013; April 29, 2013; June 24, 2013; July 25, 2013; October 11, 2013; November 20, 2013; December 28, 2013; and January 1, 2014.

A June 11, 2013, MRI showed low-grade degenerative disc disease at L4-L5 and L5-S1 with mild bilateral foraminal stenosis and mild-to-moderate facet arthropathy. A September 2013 EMG showed right S1 radiculopathy with the medial gastroc displaying complex repetitive discharges which indicated a chronic nature to the condition. Progress notes from Claimant's office visits to her neurologist for September 2013, October 2013, November 2013 and December 2013 show treatment for low back pain, including Norco and injections, with a diagnosis including lumbar degenerative disc disease and lumbar spondylosis.

On January 22, 2014, Claimant's psychiatrist completed a mental residual functional capacity questionnaire that identified Claimant's diagnosis as bipolar I disorder and depression with a guarded prognosis and indicated that her highest global assessment of functioning (GAF) score for the past year was 55. The doctor indicated that Claimant was unable to meet competitive standards in a regular work setting to sustain an ordinary routine without special supervision or to complete a normal workday and workweek without interruptions from psychologically based symptoms. Claimant's psychiatric records included medication review notes from April 11, 2014, showing that she had returned to treatment after a nine-month hiatus during which time she had learned she was pregnant and discharged all medications as advised. During the time she was off medication, she had increased anxiety and, after her miscarriage, also increased depression. The file also included a May 2012 psychiatric evaluation, medical reviews to December 3, 2012, and progress notes to January 2014.

On January 28, 2015, Claimant was examined by a doctor at the Department's request. Claimant reported that she suffered from asthma, high blood pressure, diabetes, high cholesterol, obesity, depression, arthritis, back pain, heart murmur, headaches, and depression. Claimant reported a history of asthma, had never been admitted or seen and treated in the emergency department, and was taking her medication as prescribed. She also had a history of hypertension from 2001 but was never admitted. She had had a heart murmur since 1996, took medication for her high blood pressure, and is usually seen by her cardiologist at least once a year. She reported she was diagnosed with diabetes in 1994, was on insulin, had a current A1C of 12.5, had paresthesia of her hands and feet, had proteinuria with a kidney consultation scheduled, and had multiple admissions. She also reported a history of chronic depression since 2006, with ongoing mental health treatment and medication, and a history of chronic pain in her back and left knee aggravated by stooping, squatting, walking, and lifting. The doctor noted that Claimant did not use a cane or walking aid; was able to get on and off the examination table slowly; could slowly tandem walk, heel walk and toe walk; and could squat to 70% of the distance and recover and bend to 70% of the distance and recover. Straight leg raise was 0 to 50 degrees while lying and 0 to 90 degrees while sitting. She also noted limitations in Claimant's flexion of her lumbar spine to 70 degrees (normal is 0 to 90 degrees), her forward flexion of both hips to 50 degrees (normal is 0 to 100 degrees). Claimant's Jamar grip strength was 35 pounds on the right and 0 on the left. The doctor did not identify any limitations on Claimant's abilities or reflexes (Exhibit A.)

On July 13, 2015, Claimant's primary care physician completed a medical examination report, DHS-49, listing Claimant's diagnoses as diabetes mellitus, uncontrolled; degenerative disc disease; lower back pain; and spinal stenosis. The doctor noted that Claimant's right side was weaker than the left and she had problems with movement, writing, and clothing herself and that she had numbness in her legs and left side. However, she did not need an assistive device. The doctor concluded that Claimant's condition was deteriorating and identified the following limitations: (i) she could not lift any weight; (ii) she could use her left arm or hand to grasp, reach, push/pull, or manipulate; and (iii) she could not use her left foot or leg to operate foot and leg

controls. The doctor did not identify any sitting restrictions and did not clearly identify any standing/walking restrictions. The doctor also noted that Claimant's mental condition resulted in limitations in her sustained concentration, memory, and social interactions, and that she needed assistance with household chores, cooking, and driving (Exhibit 3.)

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

The medical evidence presented does **not** show that Claimant's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Listings 1.02 (major dysfunction of a joint), 1.04 (disorders of the spine), 3.03 (asthma), 4.00 (cardiovascular system) particularly 4.05 (recurrent arrhythmias), 9.00 (endocrine disorders), 11.14 (peripheral neuropathies), 12.04 (affective disorders), and 12.06 (anxiety-related disorders) were considered. Because Claimant's impairments 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 RFC takes into consideration the total limiting effects of all impairments, including those that are not severe. 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s)

provided by the individual or other persons. 20 CFR 416.945(a)(3). This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicants takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

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

> Sedentary work.
> Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.
>
> Light work.
> Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, [an individual] must have the ability to do substantially all of these activities. If someone can do light work, … he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.
>
> Medium work.
> Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, … he or she can also do sedentary and light work.
>
> Heavy work.
> Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, … he or she can also do medium, light, and sedentary work.

> Very heavy work.
> Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If someone can do very heavy work, … he or she can also do heavy, medium, light, and sedentary work.
>
> 20 CFR 416.967.

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional 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., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi).

In this case, Claimant alleges both exertional and nonexertional limitations due to her medical condition. She testified that she suffered from twice daily panic attacks, each lasting 30 minutes; decreased memory; crying spells; and appetite changes resulting in gaining and losing over 30 pounds over a 6 month period. She further testified that she could not walk more than 70 to 80 feet without pain, had no strength in her left hand, could lift up to a gallon of milk with her right hand but not more than 6 pounds, could stand no more than 30 minutes, and could sit no more than 30 minutes before experiencing lower back pain. She lived with her minor children but relied on a daily caregiver paid by the State to assist her with laundry, household chores, making meals, and shopping. She stated that she could bathe and dress herself but used a shower chair and grab bars in the bathroom and dressed in large-sized clothing with no buttons to make dressing easier. She tended not to socialize.

While the medical documents support Claimant's testimony that she has asthma, hypertension, a heart murmur, and high blood pressure, she admitted in the physical consultative examination that those conditions were being controlled by medication. There was no medical evidence presented showing that any of these conditions resulted in any limitations in Claimant's exertional RFC to perform work activities.

Claimant testified that she took insulin four times daily but continued to experience high blood sugar levels resulting in repeated hospital visits. The record showed that Claimant had many hospital visits and admissions for nausea, abdominal pain, and migraine headaches from August 2012 to January 2014 due to uncontrolled diabetes, with blood sugar levels up to the 600s and a diagnosis of ketoacidosis. While there was no medical documentation to support any further admissions after January 2014, Claimant's doctor confirmed in the July 15, 2015, DHS-49 that she completed that Claimant continued to suffer from uncontrolled Type I diabetes.

The medical record included a June 2013 MRI showing low-grade degenerative disc disease at L4-L5 and L5-S1 with mild bilateral foraminal stenosis and mild-to-moderate facet arthropathy and a September 2013 EMG that showed right S1 radiculopathy that supported limitations concerning Claimant's ability to sit, stand, and lift. The consulting physician from the January 28, 2015, examination concluded that Claimant had no grip strength in her left hand, consistent with Claimant's testimony and her doctor's finding that she was precluded from using her left hand for grasping, reaching, pushing/pulling, and fine manipulating. Both the consulting physician and Claimant's doctor indicated that no assistive device was needed for Claimant to ambulate although the consulting physician acknowledged that Claimant moved slowly. Although Claimant's doctor indicates that Claimant cannot lift any weight, Claimant acknowledged at the hearing that she could lift a maximum of 6 pounds but using only her right hand.

Claimant's medical conditions are further complicated by her obesity. At [redacted] and [redacted] pounds, Claimant has a body mass index (BMI) of 37.3, placing her in the obese category. It would be expected that the combined effects of Claimant's obesity with other impairments would be greater than might be expected without obesity. See Program Operations Manual System (POMS) DI 24570.001.

With respect to Claimant's exertional limitations, it is found based on a review of the entire record that Claimant maintains the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a).

Claimant also alleged nonexertional limitations due to her mental condition. For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1).

In this case, there is evidence that Claimant was diagnosed with bipolar I disorder and depression. A mental residual functional capacity questionnaire completed by Claimant's psychiatrist in January 22, 2014, indicated that Claimant was unable to meet competitive standards in a regular work setting to sustain an ordinary routine without special supervision or to complete a normal workday and work week without interruptions from psychologically based symptoms. The last medical record pertaining to Claimant's mental health treatment was an April 11, 2014, medication review note that indicated that Claimant had experienced a period of increased anxiety and depression while she was off medication due to a pregnancy. Claimant's primary care physician indicated in the July 2015 DHS-49 that Claimant has limitations to her sustained concentration, memory and social interaction due to her mental condition. Based on the record presented and Claimant's testimony concerning her mental condition, it is found that Claimant has moderate limitations in social functioning and moderate to marked limitations in her concentration, persistence or pace.

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

Step Four

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

As determined in the RFC analysis above, Claimant is limited to sedentary work activities and has moderate limitations in social interactions and moderate to marked limitations in her persistence, concentration and pace to her mental capacity to perform basic work activities. Claimant's work history in the 15 years prior to the application consists of work as a certified nursing assistant (light, unskilled) and sandwich maker (sedentary, unskilled). Claimant is not precluded by her exertional RFC, which limits her to sedentary work, from performing her former activities as a sandwich maker, which she described as a job involving no standing or lifting. However, based on her mental condition, Claimant lacks the nonexertional RFC to perform her prior work activities as a sandwich maker. In light of the entire record and Claimant's mental RFC, it is found that Claimant is unable to perform past relevant work. Accordingly, Claimant cannot be found disabled, or not disabled, at Step 4 and the assessment continues to Step 5.

Step 5

In Step 5, an assessment of Claimant's RFC and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v). If the individual can adjust to other work, then there is no disability. Disability is found if an individual is unable to adjust to other work. *Id.*

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

When the impairment(s) and related symptoms, such as pain, only affect the ability to perform the exertional aspects of work-related activities, Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix 2, may be used to satisfy the burden of proving

that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). However, 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). When a person has a combination of exertional and nonexertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination **unless** there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969a(d).

In this case, Claimant was [redacted] years old at the time of application and [redacted] years old at the time of hearing, and, thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. She has a high school equivalency degree and a history of unskilled work experience. As discussed above, Claimant maintains the RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities. The Medical-Vocational Guidelines, 2201.27, do not result in a disability finding based on Claimant's exertional limitations. However, Claimant's nonexertional limitations result in moderate to marked restrictions in her ability to perform basic work activities. After review of the entire record, including Claimant's testimony, and in consideration of Claimant's age, education, work experience, and physical as well as mental RFC, Claimant is found disabled at Step 5 for purposes of 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 BEGIN DOING THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE OF MAILING OF THIS DECISION AND ORDER:

1. Reregister and process Claimant's July 29, 2014 SDA application to determine if all the other non-medical criteria are satisfied and notify Claimant of its determination;

2. Supplement Claimant for lost benefits, if any, that Claimant was entitled to receive if otherwise eligible and qualified;

3. Review Claimant's continued eligibility in January 2016.

Alice C. Elkin
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Signed: **8/12/2015**

Date Mailed: **8/12/2015**
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]