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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-009926
Issue No.: 4009
Case No.: [redacted]
Hearing Date: July 20, 2015
County: Gladwin

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, a telephone hearing was held on July 20, 2015, from Detroit, Michigan. Participants on behalf of Claimant included Claimant. Participants on behalf of the Department of Health and Human Services (Department) included [redacted], Assistance Payment Worker, and [redacted], Assistance Payment Worker.

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 February 18, 2015, Claimant submitted an application for public assistance seeking SDA benefits (Exhibit A, pp. 5-28).

2. On May 28, 2015, the Medical Review Team (MRT) found Claimant not disabled (Exhibit A, pp. 37-39).

3. On May 28, 2015, the Department sent Claimant a Notice of Case Action denying the application based on MRT's finding of no disability (Exhibit A, pp. 367-370).

4. On June 5, 2015, the Department received Claimant's timely written request for hearing (Exhibit A, pp. 2-4).

5. Claimant alleged disabling impairment due to severe allergies, asthma, migraines, herniated discs in the back, fibromyalgia, degenerative disc disease (DDD), bone spurs, neck pain, head pain, thoracic outlet syndrome, depression, anxiety, and post-traumatic stress disorder (PTSD).

6. 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.

7. Claimant obtained a [redacted].

8. Claimant has an employment history of work as a caregiver, document preparer/scanner, and data entry worker.

9. 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).

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 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. 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 severe allergies, asthma, migraines, herniated discs in the back, fibromyalgia, DDD, bone spurs, neck pain, head pain, thoracic outlet syndrome, depression, anxiety, and PTSD. The medical evidence presented at the hearing was reviewed and is summarized below.

Claimant's medical records from her primary care physician from to March 2015 reflected diagnoses of hyperlipidemia, C7 radiculopathy resulting in chronic left arm pain, fibromyalgia, asthma exacerbation from November 2014, memory changes, chronic tension headache, PTSD, DDD/back pain, and thoracic outlet syndrome, and multiple drug allergies. (Exhibit A, pp. 289-317, 336-340, 344-345, 361-362.) Claimant's doctor indicated that, as of February 13, 2015, she was unable to do physical labor due to her chronic illness (Exhibit A, p. 337). An October 2014 physical exam showed mild paraspinal tenderness in the upper back and muscle spasm particularly on the left side but no deficit in strength or range of motion (Exhibit A, pp. 301). Claimant's records included reports from her gynecological visits (Exhibit A, pp. 57-118).

A May 12, 2014, MRI of Claimant's cervical spine showed (i) postsurgical changes at the C4-C5 level, (ii) most pronounced degenerative changes at the C5-C6 level with particularly degenerative narrowing of the right C5-C6 neural foramen, and (iii) diffuse left-sided disk herniation at the C6-C7 disk level including extending into the left C6-C7 neural foramen. The MRI results indicated that correlation for left C7 radicular symptoms would be helpful. (Exhibit A, pp. 179-180, 354-355.)

A May 12, 2014, MRI of Claimant's thoracic spine showed (i) degenerative changes at the L4-L5 and L5-S1 disk levels with mild neural foraminal narrowing and only borderline narrowing of the spinal canal at the L4-5 level and (ii) diffusely bulging disk particularly at the L5-S1 level but without other focal disk protrusion or disk herniation or nerve root compression otherwise noted (Exhibit A, pp. 181-182, 356-357).

Claimant requested to discontinue physical therapy for her neck and shoulder pain in December 2014 complaining that her symptoms had worsened with respect to right upper extremity paresthesia and headaches (Exhibit A, pp. 185-186, 260-262).

Claimant's records for October 2014 to December 2014 from her pain management doctor indicate lower back pain radiating to bilateral legs with numbness or tingling, neck pain, bilateral shoulder pain. The doctor noted in the initial October 2014 exam that, with respect to her neck, Claimant had a 75% limitation to extension and 50% limitation to flexion, right and left side bending and right and left rotation and, with respect to her back, she had a 50% limitation to flexion, extension, right and left side bending, and right and left rotation. He also noted involuntary muscle spasms in the paravertebral muscles and posterior lumbar muscles, bilateral. Claimant reported that she had had C4-5 cervical fusion surgery and refused further neck surgery, she discontinued physical therapy because she did not believe it was helping, and she believed prior injections in 2011 had caused an adverse reaction. Prior to performing epidural injections, the doctor referred Claimant to an allergist to see if she had allergies to gadolinium, Omnipaque, Depo-Medrol, lidocaine, and betadine (Exhibit A, pp. 158-178). An October 22, 2014, electrodiagnostic nerve study showed bilateral lumbosacral radiculopathy involving at least the right S1 nerve root and denervation in the right gastroc muscle and the bilateral lumbar paraspinal muscles (Exhibit A, pp. 177-178, 359-360). A November 18, 2014, electrodiagnostic nerve study in response to Claimant's complaints of cervical pain radiating into bilateral shoulders with numbness and tingling in the arms and hands showed no evidence for peripheral neuropathy in the upper extremities and no evidence for a cervical radiculopathy (Exhibit A, pp. 183-184).

A September 2, 2014, mental health evaluation completed by a therapist noted that Claimant suffered from PTSD (Exhibit A, pp. 318-320).

A February 23, 2015 CT of Claimant's brain in response to complaints of slurred speech and memory alteration showed no acute or subacute intracranial abnormality (Exhibit A, pp. 349-350).

On March 9, 2015, Claimant's family medicine doctor completed a physical exam report, DHS-49, indicating that Claimant had C-7 radiculopathy and thoracic outlet syndrome and noted that she suffered from pain, migraines, decreased range of motion of the right shoulder and right arm pain secondary to radiculopathy. The doctor indicated that Claimant's condition was stable and identified the following limitations: (i) she could occasionally lift and carry 10 pounds; (ii) she could stand and/or walk less than 2 hours in an 8-hour workday; (iii) she could sit less than 6 hours in an 8-hour workday; (iv) she

could not use her right arm or hand to grasp, reach, or push/pull; and (v) she could use neither foot or leg to operate foot and leg controls (Exhibit A, pp. 364-366).

On March 17, 2015, Claimant visited an allergist for evaluation of multiple allergies to medications. Skin test results revealed positive reactions to cat dander, mold (aspergillus) and pollens (trees and weeds). She was advised to avoid contact with latex-containing material. She reported that she was sensitive to several antibiotics, including penicillin, Tetracycline, Quinolone, Clindamycin, Erythromycin, and sulfa group of antibiotics. The doctor noted that, because she is sensitive to numerous medications, there was an element of anxiety associated with any procedure or drug. It was noted that she did not have any history of adverse reactions after dental procedures (Exhibit A, pp. 121-126).

On April 1, 2015, Claimant's neurologist completed a DHS-49 indicating that Claimant had myalgia secondary to fibromyalgia, cervical radicular pain, and back pain with decreased range of motion, C-7 radiculopathy, PTSD, and anxiety. The doctor indicated that Claimant's condition was stable and identified the following limitations: (i) she could occasionally lift and carry 10 pounds but never more; (ii) she could stand and/or walk less than 2 hours in an 8-hour workday; (iii) she could sit less than 6 hours in an 8-hour workday; (iv) she could use neither arm or hand to reach, push/pull, or do fine manipulating; and (v) she could use neither foot or leg to operate foot and leg controls (Exhibit A, pp. 127-129).

On April 9, 2015, Claimant's pain management doctor completed a physical exam report, DHS-49, indicating that Claimant had reported low back pain that radiated down the bilateral lower extremities and neck pain that radiated down her bilateral upper extremities. The doctor noted that his physical exam of Claimant showed limitation in flexion and extension of Claimant's shoulders and wrists and well as neck and low back. The doctor refused to identify any weight or stand/walk/sit limitations because he had not seen Claimant since December 2014 (Exhibit A, pp. 51-53).

On April 23, 2015, Claimant was examined at the Department's request for a consultative mental status examination. In the report prepared in connection with the examination, the consulting psychologist indicated that Claimant reported a series of health issues following injuries in 1994 when scaffolding collapsed on her. Based on his examination, the doctor concluded that Claimant met the criteria for a diagnosis of dysthymic, or persistent depressive, disorder (mild but chronic depression), noting that she socially isolated and was generally withdrawn, and had traits for personality disorder with borderline feature, noting her instability in personal relationships including four marriages, suicide attempts, and chronic feelings of emptiness. The doctor concluded that Claimant would have difficulty sustaining consistent work based on her health and mental health prognosis and identified her prognosis as guarded, which could improve with adequate mental health and medical treatment (Exhibit A, pp. 46-50).

On May 13, 2105, Claimant submitted to a physical examination by a doctor at the Department's request. In the report prepared in connection with the examination, the consulting doctor noted tenderness over the trapezius muscle, more pronounced on the right than the left, and in the lower lumbar spine. Grip strength was decreased bilaterally, with jamar at 26 pounds in the right hand and 28 pounds in the left hand, but dexterity was unimpaired. The doctor noted that Claimant had mild difficulty getting on and off the examination table, heel and toe walking, squatting and standing 3 seconds on either foot. The straight leg raise was negative. Range of motion was normal in all joints except the cervical spine and dorso-lumbar spine, which were significantly limited. Claimant had non-dermatome sensory loss in the right leg and she walked with a guarded gait without the use of an assistive device. The doctor noted that some of her symptoms appeared to be due to deconditioning and that her PTSD and depression could result in the physical manifestations. He concluded that she was mostly sedentary due to her pain (Exhibit A, pp. 40-44).

On May 14, 2015, Claimant was examined for a neuropsychological evaluation following a referral by her neurologist due to subjective concerns about cognition. The neuropsychologist concluded that she was unable to comment on Claimant's cognitive or psychological ability to engage in gainful employment because "there were reasonable indications to not interpret data [at] face [value], given the borderline validity indicators on cognitive testing, the clear signs of embellishment on psychological testing, and the clinical presentation" (Exhibit 1).

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), 11.14 (peripheral neuropathy), 12.04 (affective disorders), 12.05 (intellectual disability), 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. Claimant testified that she had panic attacks once every two days that lasted all day, problems with her memory, and daily crying spells. She could not lift more than 8 pounds and experienced arm pain that shot to her head when she lifted her arm up; she could not sit more than 15 minutes without pain; she could stand no longer than 5 minutes before her legs would buckle from pain; she could walk a block unassisted; she had difficulty bending and squatting. She lived alone and could care for and dress herself but she testified that she struggled to wash her hair because of arm weakness and wore clothing without zippers or buttons. She admitted she did the chores in her home but testified that it took her a very long time and she simplified chores and cooking. She went shopping with a friend who would help lift groceries but limited her time in stores because she felt uncomfortable. She did not drive because of her anxiety.

The medical evidence presented supports exertional limitations. A May 12, 2014, MRI of Claimant's cervical spine showed diffuse left-sided disk herniation at the C6-C7 disk level extending into the left C6-C7 neural foramen. A November 18, 2014, nerve study showed no electrodiagnostic evidence for a peripheral neuropathy or cervical

radiculopathy in the upper extremities. A May 12, 2014, MRI of Claimant's thoracic spine showed (i) degenerative changes at the L4-L5 and L5-S1 disk levels with mild neural foraminal narrowing and only borderline narrowing of the spinal canal at the L4-5 level and (ii) diffusely bulging disk particularly at the L5-S1 level. An October 22, 2014, nerve study showed electrodiagnostic evidence of bilateral lumbosacral radiculopathy involving at least the S1 nerve right with denervation in the right gastroc muscle and the bilateral lumbar paraspinal muscles.

On April 1, 2015, Claimant's neurologist completed a DHS-49 identifying diagnoses of C-7 radiculopathy (despite the November 18, 2014 nerve study), myalgia secondary to fibromyalgia, cervical radicular pain, and back pain with decreased range of motion, PTSD, and anxiety. The doctor indicated that Claimant's condition was stable and identified the following limitations: (i) she could occasionally lift and carry 10 pounds but never more; (ii) she could stand and/or walk less than 2 hours in an 8-hour workday; (iii) she could sit less than 6 hours in an 8-hour workday; (iv) she could use neither arm or hand to reach, push/pull, or do fine manipulating; and (v) she could use neither foot or leg to operate foot and leg controls. Claimant's family medicine doctor completed a DHS-49 indicating that Claimant had C-7 radiculopathy and thoracic outlet syndrome and noted that she suffered from pain, migraines, decreased range of motion of the right shoulder and right arm pain secondary to radiculopathy. The doctor identified the same sitting, standing and foot/leg limitations as the neurologist and that Claimant could not use her right arm or hand to grasp, reach, or push/pull.

The findings by Claimant's treating doctors are consistent with those of the consulting doctor who examined Claimant on May 13, 2015, at the Department's request who noted that Claimant had tenderness over the trapezius muscle, more pronounced on the right than the left, and in the lower lumbar spine; decreased grip strength bilaterally but unimpaired dexterity; mild difficulty getting on and off the examination table, heel and toe walking, squatting and standing 3 seconds on either foot; normal range of motion in all joints except the cervical spine and dorso-lumbar spine, which were significantly limited. The doctor also noted Claimant had non-dermatome sensory loss in the right leg and she walked with a guarded gait without the use of an assistive device. While he indicated that some of her symptoms appeared to be due to deconditioning and that her PTSD and depression could result in the physical manifestations, he concluded that she was mostly sedentary due to her pain.

With respect to Claimant's exertional limitations, based on Claimant's testimony and the supporting medical evidence, it is found that Claimant maintains the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a).

Claimant has also alleged nonexertional limitations due to her depression and anxiety and to her memory loss. While the results of a May 14, 2015, neuropsychological evaluation for memory issues were inconclusive due concerns of embellishment, there was evidence in the medical evidence in the file support limitations due to mental conditions. 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). In this case, in an April 23, 2015, consultative mental status examination, the consulting psychologist concluded that Claimant met the criteria for a diagnosis of dysthymic, or persistent depressive, disorder, noting that she socially isolated and was generally withdrawn, and had traits for personality disorder with borderline feature, noting her instability in personal relationships including four marriages, suicide attempts, and chronic feelings of emptiness. The doctor concluded that Claimant would have difficulty sustaining consistent work based on her health and mental health prognosis and identified her prognosis as guarded, which could improve with adequate mental health and medical treatment. Based on the testimony and the consultative exam, Claimant's nonexertional RFC shows moderate limitations in her ability to engage in basic work activities.

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 no more than sedentary work activities and has moderate limitations in 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 caregiver (sedentary, unskilled), document preparer/scanner (sedentary, unskilled), and data entry worker (sedentary, unskilled). While Claimant maintains the exertional RFC to perform prior work, her nonexertional limitations would preclude her in being able to effectively engage in unskilled work activity on a sustained basis. Therefore, in light of her nonexertional limitations, 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.

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 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).

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 hearing and at application and, thus, considered to be a closely approaching advanced age (age [redacted] for purposes of Appendix 2. She has a [redacted] 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 and has moderate limitations on her mental ability to perform work activities. In this case, the Medical-Vocational Guidelines, 201.12, result in a disability finding based on Claimant's exertional limitations.

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.

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 February 18, 2015 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: **7/29/2015**

Date Mailed: **7/29/2015**

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]