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

IN THE MATTER OF:

MAHS Reg. No.: 15-014733
Issue No.: 2009
Agency Case No.:
Hearing Date: October 05, 2015
County: Wayne-District 17

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 October 5, 2015, from Detroit, Michigan. Participants on behalf of Claimant included Claimant; , Claimant's daughter; and , representative with , Claimant's authorized hearing representative (AHR). Participants on behalf of the Department of Health and Human Services (Department) included , Medical Contact Worker.

ISSUE

Whether the Department properly determined that Claimant was not disabled for purposes of the disability-based Medical Assistance (MA-P) 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 October 12, 2013, Claimant submitted an application for public assistance seeking MA-P benefits, with request for retroactive MA-P benefits to August 2013.

2. On June 12, 2015, the Medical Review Team (MRT) found Claimant not disabled (Exhibit A, pp. 14-19).

3. On June 19, 2015, the Department sent Claimant a Notice of Case Action denying the application based on MRT's finding of no disability.

4. On June 22, 2015, the Department notified the AHR, Claimant's authorized representative, of the denial.

5. On August 18, 2015, the Department received the AHR's timely written request for hearing (Exhibit A, pp. 2-13).

6. Claimant alleged disabling impairment due to arthritis, seizures, heart palpitations, neoplasm of the adrenal gland and depression.

7. At the time of hearing, Claimant was [redacted] years old with a [redacted], birth date; she was 5'7" in height and weighed 156 pounds.

8. Claimant is a high school graduate with some college.

9. Claimant has an employment history of work as a home health care provider, certified nursing assistant, and clinical post/pre-op technician.

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 Health and 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 Department of Human Services) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

MA-P benefits are available to disabled individuals. BEM 105 (January 2014), p. 1; BEM 260 (July 2014), pp. 1-4. Disability for MA-P purposes is defined as the inability to do any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a). To meet this standard, a client must satisfy the requirements for eligibility for Supplemental Security Income (SSI) receipt under Title XVI of the Social Security Act. 20 CFR 416.901.

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

(1) whether the individual is engaged in SGA;
(2) whether the individual's impairment is severe;
(3) whether the impairment and its duration meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404;

(4) whether the individual has the residual functional capacity to perform past relevant work; and
(5) whether the individual has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work.

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 MA-P means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 12 months. 20 CFR 416.922.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). An impairment, or combination of impairments, is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a); see also *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985). Basic work activities means the abilities and aptitudes necessary to do most jobs, including (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b).

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. 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). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28. If such a finding is not clearly established by medical evidence or if the effect of an impairment or combination of impairments on the individual's ability to do basic work activities cannot be clearly determined, adjudication must continue through the sequential evaluation process. *Id.*; SSR 96-3p.

In the present case, Claimant alleges disabling impairment due to arthritis, seizures, heart palpitations, neoplasm of the adrenal gland and depression. The medical evidence presented at the hearing was reviewed and is summarized below.

On [redacted], Claimant sought treatment for her depression through [redacted] [redacted] On [redacted], she was diagnosed by an LLPC at [redacted] with major depressive disorder, recurrent, severe without psychotic features and assigned a current GAF score of 43 (serious symptoms or impairments). The goals of treatment were to significantly lessen her depression and to terminate her smoking and gambling. (Exhibit A, pp. 61-104, 358-360). On [redacted], the GAF score was 49, assigned by a doctor. On [redacted], Claimant's psychiatrist noted that the severity of Claimant's presenting illness was mild to moderate. In a mental status examination, the doctor noted guarded attitude, poor eye contact and limited disclosure, mood swing moderate impact of socialization on overall functioning, slowed movement, moderate impact of energy level on functioning, monotone speech, constricted affect, dysphoric mood, moderate impact of mood on overall functioning, no hallucinations, decreased appetite and weight, difficulty falling asleep with reversal of day/night cycle,

adequate concentration and mild impact of concentration on functioning, difficulty recalling, superior intellectual functioning, adequate judgment, mild impact of judgment on functioning. (Exhibit A, pp. 106-110, 236-247, 382-386.) Claimant's progress notes showing therapy attendance from October 2013 to July 2014 were included in the medical file, with notations of missed appointments in August 2014 and September 2014 (Exhibit A, pp. 112-158, 308-339).

On [redacted], Claimant went to [redacted] complaining of a seizure. She was having a seizure when she arrived and had another seizure six hours later where tremors were noted to all extremities. She suffered a third seizure while awaiting admission. Notes indicated Claimant had not taken medication as prescribed. An [redacted] brain CT scan showed no acute intracranial process (Exhibit A, pp.233, 260-287).

On [redacted] Claimant's therapist completed a psychiatric/psychological examination report, DHS-49D, indicating that Claimant was having major depressive symptoms, apathy, lack of motivation, flat affect, and difficulty concentrating and completing tasks. (Exhibit A, pp. 235-236.)

On [redacted], Claimant was seen by her neurologist, [redacted], regarding her spells, which were considered a combination of partial complex seizures and pseudo seizures. The doctor noted that spells had decreased in frequency to approximately three per month. The doctor reviewed two episodes taped by Claimant's daughter and concluded that the longer episode lasting 4 minutes showed autistic-like behavior but was difficult to discern if it was a pseudo-event or partial seizure and the second clip was quite nonspecific. (Exhibit A, pp. 247-248). In notes from a [redacted], visit, Claimant's neurologist indicated that Claimant was unable to work because of the persistence of her spells which have resulted in episodes where she falls to the ground and becomes unconscious and unresponsive. (Exhibit A, pp. 249-250.) Letters show the neurologist's ongoing assessment of Claimant between [redacted]2 and [redacted] and indicate that Claimant was examined for episodes of alteration in consciousness, responsiveness, with body shaking, and had extensive workup that provided no evidence that the events were epileptic. The doctor concluded that, most likely, Claimant had underlying pseudo seizures with an off-chance, but highly unlikely, possibility that she may have superimposed partial seizures. It was noted that episodes increased with stress. (Exhibit A, pp. 251-258).

On [redacted], Claimant's neurologist, who had treated her since 2011, completed a signed and dated DHS-49, listing Claimant's diagnoses as seizures/spells. The doctor concluded that Claimant had the following physical limitations: (i) she could frequently lift and carry up to 10 pounds, occasionally lift and carry 10 pounds, and never lift and carry more, and (ii) she could stand and/or walk less than 2 hours in an 8-hour workday. The doctor indicated Claimant had no restrictions in her ability to use her hands/arms or feet/legs for repetitive motions. No sitting restrictions were identified. The doctor indicted Claimant experienced loss of consciousness during her spells. He also noted limitations in Claimant's sustained concentration. He indicated Claimant could meet her needs in the home. (Exhibit A, pp. 227-228.) Progress notes completed by Claimant's

neurologist from [redacted], to [redacted], for spells show that she was not to drive and was to avoid unsupervised/unprotected exposure to heights, large bodies of water, or operating heaving machinery. She was prescribed Klonopin, 2 mg, 2 ½ tablets daily and Lamictal, 300 mg daily. (Exhibit A, pp. 159-166.)

On [redacted], Claimant's internal medicine doctor since 2001 completed a medical examination report, DHS-49, listing Claimant's diagnoses as seizures, marked grand mal seizure, referencing an EEG. The doctor noted that Claimant appeared fatigued with a slowed mental status. The doctor concluded that Claimant's condition was stable and indicated she could occasionally lift and carry up to 10 pounds but never more. The doctor indicated Claimant had no restrictions in her ability to use her hands/arms or feet/legs for repetitive motions. No standing/walking or sitting restrictions were identified. The doctor also noted limitations in Claimant's comprehension and memory. (Exhibit A, pp. 225-226.) Claimant's records include notes from her primary care physician for [redacted], to [redacted]. The notes show treatment for seizures through [redacted], osteoarthrosis, right shoulder pain and depressive disorder. Her problem list/past medical includes benign neoplasm of the adrenal gland, ankle and foot joint pain, anemia/iron deficiency, and cardiac dysrhythmia. (Exhibit A, pp. 288-307.)

On [redacted], Claimant went to [redacted] following a seizure. It was noted at that time that Claimant did not have a documented actual seizure disorder. (Exhibit A, pp. 167-177.)

On [redacted], Claimant went to [redacted] in an altered mental status after taking an unknown amount of her medication and concerns of a possible overdose. She was argumentative on arrival and trying to bite at her clothing and monitor wires. Claimant denied a suicide attempt. During her admission, she was noted to be having a seizure-like activity, with stiffness, moving right arm in rhythmic motion, and snorting respirations. A [redacted], brain CT scan showed no acute intracranial process. Inpatient psychiatric treatment was recommended but refused. Claimant was released [redacted]. (Exhibit A, pp. 178-200.)

On [redacted], Claimant went to [redacted] with her daughter who stated that Claimant had had three seizures that day. Claimant was actively seizing in the emergency room. Four mg of Ativan was administered and resolved the seizure. The admission notes indicated Claimant's family was a poor historian. It was not known whether Claimant was compliant with her antiepileptic drugs. A chest x-ray showed no acute abnormality. She was discharged in stable condition and referred to her neurologist for follow-up. (Exhibit A, pp. 201-208.)

From [redacted], to [redacted], Claimant completed epilepsy monitoring with video monitoring for a second opinion about her seizures. Claimant reported a family history of seizures, having her first seizure in 2011 while at work, being diagnosed at that time with complex partial seizure from her left temporal region following epilepsy monitoring at [redacted], and having had twice monthly seizures since then. She was taking Lamictal, 300 mg daily, treatment. During the

evaluation, two incidents were observed with no clear alteration of EEG rhythms except EMG and movements seen during the two events. There was no post-event slowing of EEG rhythms. The evaluator concluded that the clinical semiology and electrographic findings were suggestive of psychogenic non-epileptic episodes. (Exhibit A, pp. 47-60.)

On [redacted], Claimant went to the emergency department following a two-minute seizure at her home witnessed by a family member. She was treated with valproate sodium and ondansetron (Zofran) and was released after her condition improved. (Exhibit A, pp. 33-39, 211-214).

On [redacted], Claimant participated in a mental status examination at the Department's request. The psychologist concluded that Claimant suffered from depression and assigned her a global assessment of functioning (GAF) score of 51. He indicated that Claimant's prognosis was fair to good and that she could manage her own benefit funds. (Exhibit A, pp. 29-32.)

On [redacted], Claimant was examined by a doctor at the Department's request. In a physical examination report, the doctor reported that Claimant alleged disability due to depression, arthritis, headaches, seizures, palpitations, and neoplasm. In her physical examination of Claimant, the doctor noted that she did not use a cane or walking aid, was able to get on and off the examination table slowly, could squat to 70 percent of the distance and recover and bend to 80 percent of the distance, her straight leg raise was 0 to 50 while lying and 0 to 90 while sitting. Her lumbar spine flexion was 80 degrees (normal is 0 to 90). Her bilateral hip forward flexion was 50 degrees (normal is 0 to 100). All other range of motion readings were normal and no limitations to current abilities were cited. Claimant's JAMAR grip strength was 80 pounds on the right, 40 pounds on the left. The doctor concluded based on Claimant's reported history that (1) Claimant had a history of mental illness, including a previous suicide attempts, and was being followed by a mental health specialist and was on medication; (2) she has a history of arthritis of her left hip and has chronic pain there; (3) she has a history of syncopal episodes, past surgery for cardiac tamponade, and ongoing palpitations; and (4) history of neoplasm of her adrenal gland. (Exhibit A, pp. 20-28).

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Claimant suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 12 months. Therefore, Claimant has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

<u>Step Three</u>

Step 3 of the sequential analysis of a disability claim requires a determination of whether the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920(a)(4)(iii). If an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

The medical evidence presented does **not** show that Claimant's impairments meet or equal the required level of severity of any of the above-referenced listings to be considered as disabling without further consideration. Listings 1.02 (major dysfunction of a joint), 1.04 (disorders of the spine), 4.05 (recurrent arrhythmias), 9.00 (endocrine disorders), 11.02 (epilepsy, convulsive), 11.03 (epilepsy, nonconvulsive), 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. RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s), including those that are not severe, 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); 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 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).

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 nonexertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi).

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 addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of mental functional limitation. 20 CFR 416.920a(c)(3). The degree of limitation for the first three functional areas is rated by a five-point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). A four-point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. Id. The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. Id.

In this case, Claimant has also been diagnosed with an impairment that impacts the work environment. Some medically determinable impairment(s), such as seizures, impairment of vision, hearing or other senses, impose environmental restrictions which may cause limitations and restrictions which affect other work-related abilities. 20 CFR 416.945(d). Therefore, any resulting limitations and restrictions due to Claimant's seizures which may reduce her ability to do past work and other work must be assessed in deciding the RFC.

In this case, Claimant testified that she had arthritis in her right leg and left hip that did not affect her ability to stand but limited her walking and limited her ability to sit to 20 minutes before she would become agitated and need to stand. She further testified that she could not lift more than 10 pounds. She lived with her husband and adult son and daughter. She used a shower chair but cared for her own hygiene and dressed herself. She did limited chores in the home, went grocery shopping with her daughter but then needed to rest the remainder of the day, and did not drive because of her seizure history. She experienced two seizures per month, each lasting up to ten minutes, but the seizures had become less severe; they were induced by stress and depression and affected her concentration and memory. She also experienced episodes of dizziness due to her abnormal heart rhythm. She testified that her insomnia had improved.

In the [redacted] physical consultative examination, the doctor noted that Claimant did not use a cane or walking aid and was able to slowly get on and off the examination table but had some limitations on her ability to squat and bend, her bilateral hip forward flexion, and her lumbar spine flexion and had a positive straight leg raise while lying. In the [redacted], DHS-49, Claimant's primary care doctor since 2001 concluded that Claimant's condition was stable and she could lift and carry up to 10 pounds but never more; the doctor did not identify any standing/walking or sitting restrictions. Claimant's neurologist also completed a DHS-49 indicating that Claimant could frequently lift and carry up to 10 pounds, occasionally lift and carry 10 pounds, and never lift and carry more and that she could stand and/or walk less than 2 hours in an 8-hour work day. No sitting restrictions were identified.

Although the medical evidence presented supports Claimant's testimony that she has exertional limitations resulting from her impairments, it does not support the level of severity alleged by Claimant. Based on the medical evidence presented, particularly

those of her treating physicians, it is found that Claimant maintains the exertional RFC to perform sedentary work as defined by 20 CFR 416.967(a).

Claimant also alleged nonexertional limitations due to both her mental condition and her seizure disorder. In the [redacted], mental examination consultative exam, the examining doctor concluded that Claimant suffered from depression and had a GAF score of 51. Claimant had participated in treatment for her depression since [redacted] and had been diagnosed with depressive disorder (recurrent, severe, without psychotic features) in [redacted]. On [redacted], she was brought to the hospital following a drug overdose, with concerns of a suicide attempt. During her hospitalization, she was witnessed having seizure-like activity. Similar seizures resulted in hospital visits on [redacted]; [redacted]; [redacted]; and [redacted]. In [redacted], Claimant underwent epilepsy monitoring and was diagnosed with psychogenic non-epileptic episodes. The medical record supports Claimant's testimony that the episodes are triggered by stress. Both Claimant's primary physician and her neurologist noted Claimant's mental limitations: the primary care physician to Claimant's comprehension and memory and the neurologist to her sustained concentration.

Based on Claimant's testimony and the medical records, Claimant has mild limitations to her activities of daily living; mild limitations to her social functioning; and moderate to marked limitations on her concentration, persistence or pace due to her mental condition. She also has limitations due to her seizure disorder, which is triggered by stress and prevents her from driving and limits her from unsupervised exposure to heights and operating heavy machinery.

Claimant's RFC is considered at both Steps 4 and 5. 20 CFR 416.920(a)(4), (f) and (g).

Step Four

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

Claimant's work history in the 15 years prior to the application consists of work as a home health care provider, certified nursing assistant, and clinical post/pre-op technician, positions that involved medium to very heavy work. As determined in the RFC analysis above, Claimant is limited to sedentary work activities. Therefore, Claimant would be unable to perform any of the exertional aspects of prior employment. 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, at the time of hearing, 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 [redacted]) for purposes of Appendix 2. She is a high school graduate with some college with a history of semi-skilled work experience involving nontransferable skills. 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, 201.21, do not result in a disability finding based on Claimant's exertional limitations. However, Claimant's limitations on her RFC to perform nonexertional aspects of basic work activities must also be considered. As discussed above, Claimant has mild limitations to her activities of daily living; mild limitations to her social functioning; and moderate to marked limitations on her concentration, persistence or pace due to her mental condition. She also has limitations due to her seizure disorder, which prevents her from driving and limits her from unsupervised exposure to heights and operating heavy machinery. The seizures are triggered by stress and result in a loss of consciousness. After review of the entire record, including Claimant's testimony, and in consideration of Claimant's age, education, work experience, it is found that Claimant's nonexertional limitations would

significantly limit in her ability to engage in basic work activities at the sedentary level. Therefore, Claimant is found disabled at Step 5 for purposes of MA-P benefit program.

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Claimant disabled for purposes of the MA-P benefit programs.

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. Process Claimant's October 12, 2013, MA-P application, with request for retroactive coverage to August 2013, 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 September 2016.

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

Date Mailed: **10/23/2015**

ACE/jaf

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: