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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-011696
Issue No.: 4009; 1000; 2000
Case No.: [redacted]
Hearing Date: August 31, 2015
County: Berrien (District 22)

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 August 31, 2015, from Detroit, Michigan. Claimant was represented by attorney Maureen Gottlieb. Claimant and [redacted], Claimant's daughter, appeared on Claimant's behalf. The Department of Health and Human Services (Department) was represented by Assistant Attorney General [redacted]. Joanne Sepic, Assistance Payment Supervisor, and [redacted], Assistance Payment Worker, appeared on behalf of the Department.

During the hearing, Claimant's counsel waived the time period for the issuance of this decision in order to allow for the submission of additional records. A medical examination report, DHS-49, completed by Claimant's doctor, and a psychiatric/psychological examination report, DSH-49D, and mental residual functional capacity assessment, DHS-49E, completed by the nurse practitioner at the mental health practice Claimant attended were timely received and admitted into evidence. The record closed on September 30, 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 April 15, 2015, Claimant submitted an application for public assistance seeking SDA benefits (Exhibit A, pp. 2-13).

2. On June 6, 2015, Disability Determination Services (DDS) found Claimant not disabled (Exhibit A, pp. 20-22).

3. On June 6, 2015, the Department sent Claimant a Notice of Case Action denying the application based on DDS's finding of no disability (Exhibit A, pp. 14-17).

4. On July 1, 2015, the Department received Claimant's timely written request for hearing concerning SDA, Family Independence Program (FIP), and Medical Assistance (MA) benefits.

5. Claimant alleged disabling impairment due to depression, lower back pain and arthritis.

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 graduated from high school and obtained nursing aide certification.

8. Claimant has an employment history of work as scheduler and trainer at a home health provider.

9. Claimant is appealing an unfavorable decision from the Social Security Administration.

10. 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 requested a hearing concerning SDA, Medical Assistance (MA), and Family Independence Program (FIP). Claimant's counsel confirmed at the hearing that Claimant wished to dismiss her hearing request concerning FIP and MA and proceed with a hearing only with respect to the Department's denial of her SDA application. See Exhibit A, p. 80.

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. 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 minimis* 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 depression, lower back pain and arthritis. The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

Claimant was referred to the [redacted] on July 9, 2014 to obtain psychiatric clearance in order to have back surgery after epidurals, nerve blocks, cortisone shots and other procedures failed to provide any relief. The licensed professional counselor who interviewed her at the time listed Claimant's diagnosis as post-traumatic stress disorder. (Exhibit A, pp. 43-52.)

MD Notes from Claimant's meetings with a nurse practitioner at [redacted] from January 13, 2015; March 10, 2015; and April 10, 2015 were included in the medical file (Exhibit A, pp. 53-58). Documents completed by a nurse practitioner cannot be used to establish the existence of a medically determinable impairment, but may provide insight into the severity of the impairment(s) and how it affects the individual's ability to function. Social Security Ruling (SSR) 06-03p.

The January 13, 2015 MD Note signed by the nurse practitioner showed a diagnosis of depressive disorder and a global assessment of functioning (GAF) score of 61. The notes indicated that Claimant reported back pain 10 out of 10 but did not appear to be in acute distress. Claimant had a normal gait, and no abnormal movements were noted. Her speech was spontaneous and her thought process was logical and goal-oriented. The notes further indicated that Claimant was alert and oriented to person, place, and date, but her insight and judgment appeared to be limited (Exhibit A, pp. 57-58).

The March 10, 2015 MD Note signed by the nurse practitioner showed a diagnosis of depressive disorder and a GAF score of 54. Claimant reported pain that was 10 out of 10, where 10 was the worst. Her affect was tearful at times, secondary to a recent upset in her relationship. She had a normal gait, and no abnormal movements were noted. Her speech was spontaneous and her thought process was logical and goal oriented. She was alert and oriented to person, place, and date, but her insight and judgment appeared to be limited (Exhibit A, pp. 55-56).

The April 10, 2015 MD Note signed by the nurse practitioner showed a diagnosis of depressive disorder and a global assessment of functioning score of 54. Claimant was noted to have a slowed gait with limping but did not appear to be in any acute distress. Her speech was spontaneous and her thought process was logical and goal directed. Insight and judgment appeared to be limited (Exhibit A, pp. 53-54).

A May 8, 2015 diagnostic information form completed by a nurse practitioner showed a GAF score of 52. The nurse practitioner indicated that, at a May 8, 2015 meeting, Claimant was pleasant and cooperative, with good eye contact. She became tearful when she spoke about her pain. She had a slow gait with limping. Her speech was spontaneous. Her thought process was logical and sequential. She denied suicidal or homicidal ideations. She denied symptoms of psychosis and none were noted. She was alert and oriented to person, place and date. Her insight and judgment appeared to be limited (Exhibit A, pp. 40-42).

The DHS-49D psychiatric/psychological examination report is not signed or dated and therefore is not acceptable medical evidence. The DHS 49E mental residual functional capacity assessment regarding Claimant's mental impairments and how they affected her activities was completed by a nurse practitioner but is not dated. In this case, the nurse practitioner concluded that Claimant had no, or no significant, limitations regarding her ability to understand and remember one or two-step instructions and carry out simple one or two step instructions. The nurse practitioner concluded that Claimant

had moderate limitations regarding her ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; complete a normal workday and worksheet without interruptions from psychologically based symptoms and perform at a consistent pace without an unreasonable number and length of rest periods; interact appropriately with the general public; ask simple questions or request assistance; and maintain socially appropriate behavior and adhere to basic standards of neatness and cleanliness. The nurse practitioner concluded that Claimant had marked limitations regarding her ability to remember locations and work-like procedures; understand and remember detailed instructions; carry out detailed instructions; maintain attention and concentration for extended periods; sustain an ordinary routine without supervision; work in coordination with or proximity of others without being distracted by them; accept instructions and respond appropriately to criticisms from supervisors; get along with co-workers or peers without distracting them or exhibiting behavioral extremes; respond appropriately to change in the work setting; be aware of normal hazards and take appropriate precautions; travel in unfamiliar places or use public transportation; and set realistic goals or make plans independently of others.

On August 21, 2013, Claimant went for an initial consultation with [redacted]. Claimant reported being in good health until involved in a motor vehicle accident on April 19, 2013. She complained of back pain with rare numbness and tingling in her bilateral legs and feet. The pain is described as a dull, aching pain which can be sharp, burning, throbbing, and cramping, and the pain is constant but varies with activity. The doctor noted that an August 5, 2013 MRI was fairly normal-looking with the L4-5 completely black and a very clear high intensity zone indicative of an annular tear, which he described as “absolutely remarkable in its clarity.” He also noted some relatively mild facet joint hypertrophy in the lower lumbar region. In examining Claimant, the doctor noted that she was not in apparent distress; could sit comfortably; could transfer from sit to stand and ambulate slowly; demonstrated some pain behaviors in ambulation but was able to get up on her toes and her heels for at least short distances; could demonstrate about 80 degrees of forward flexion though with lots of verbal complaints and pain behaviors, 10 to 15 degrees of extension of the lumbar spine, again with the “show,” 35 degrees of lateral bending to each side, and full range of motion with her hips, knees and ankles; has little to no pain with straight-leg raise while seated; has complaints of pain while palpating the spinous processes in the thoracic and lumbar spine though there was no particularly palpable lesion. The doctor recommended diagnostic medical branch blocks for the lumbar spine (Exhibit A, pp. 76-78).

Notes from Claimant’s doctor at [redacted] for August 28, 2013; September 5, 2013 September 16, 2013; December 9, 2013 showed ongoing treatment for back pain. In a December 11, 2013 procedure note, Claimant’s [redacted] doctor noted that Claimant had had problems since a motor vehicle accident on April 19, 2013. An August 5, 2013 MRI showed relatively normal looking with a black disk at L4-5 and a very clear high intensity zone and some facet joint hypertrophy. She had had epidural

injections with short terms relief and was having her third epidural injection on December 11, 2013. (Exhibit A, pp. 68-70, 71-75.)

Notes from Claimant's office visits at [redacted] completed by a family nurse practitioner from March 5, 2014; May 28, 2014; June 25, 2014; July 28, 2014; August 25, 2014, October 20, 2015; January 12, 2015; February 9, 2015; March 11, 2015 showed ongoing complaints of lower back pain with bilateral tingling and numbness in both legs and feet. The forms were marked "no acute distress." Neck and knee pain were also noted in the February 2015 and March 2015 notes (Exhibit A, pp. 59-74). No assistive device was noted as being used since July 8, 2014 (Exhibit A, pp. 59-64).

On September 17, 2015, Claimant's primary care physician completed a medical examination report, DHS-49, listing Claimant's diagnoses as osteoarthritis of the right knee, lumbago and obesity. The doctor noted that Claimant was obese, appeared to be in pain when she moved her spine, and had bilateral straight leg raise. The doctor concluded that Claimant's condition was stable and identified the following limitations: (i) she could frequently lift and carry 20 pounds; (ii) she could stand and/or walk less than 2 hours in an 8-hour workday; (iii) she could use both arms/hands to grasp, reach, push/pull, fine manipulate. The doctor noted that Claimant's daughter and sister assisted her in the home (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), 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. Claimant testified that she was very emotional and had difficulty coping. She had problems sleeping and went without sleep for up to three days. She had difficulty walking due to her chronic back pain. Although she had a cane, she tried to avoid using it. She testified she could not sit or stand more than 20 minutes. She could lift up to 10 pounds but claimed she dropped things because of pain in her hands. She lived with her sister who assisted her with bathing and with most of the chores. She could drive and shop, although she limited the length of time she spent at the store because of her walking difficulties. She went to church but had problems sitting if service was too long.

Claimant, at [redacted] and [redacted], has a body mass index of 42.7, which places her at level III, or extreme, obesity. See Social Security Ruling (SSR) 02-1p. The medical records reference Claimant's obesity among her diagnoses. Claimant's obesity is a medically determinable impairment often associated with disturbances of the musculoskeletal system and the cumulative effects of obesity must be considered in assessing the individual's RFC. 1.00(Q).

The On September 17, 2015, Claimant's primary care physician completed a medical examination report that showed that Claimant's condition was stable, she could frequently lift and carry 20 pounds, could stand and/or walk less than 2 hours in an 8-hour workday, and had no restrictions in the use of her hands/arms for repetitive motions. In August 2013, Claimant's pain doctor at [redacted] noted that Claimant's August 5, 2013 MRI was fairly normal-looking with the L4-5 completely black and a very clear high intensity zone indicative of an annular tear with some relatively mild facet joint hypertrophy in the lower lumbar region. Notes show that Claimant had ongoing visits to [redacted] complaining of back pain and, at times, neck pain.

While the medical evidence supports Claimant's testimony concerning exertional limitations due to back pain, it does not support the severity claimed by Claimant. Based on a review of the entire record and taking into consideration Claimant's obesity, it is 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 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).

In this case, the medical record shows that Claimant was diagnosed with depressive disorder. Although the nurse practitioner that Claimant met with monthly between January 2015 and May 2015 completed a DHS-49E showing many marked limitations in Claimant's ability to perform detailed instructions, it also shows that she had no or no significant limitations in her ability to perform simple tasks. It is further noted that the notes completed by the nurse practitioner in connection with the monthly meetings do not support the level of marked limitations identified on the DHS-49E. The notes show that Claimant had limited insight and judgment, but her thought process was logical and sequential and her speech was spontaneous. The notes also show that Claimant's GAF score during this period ranged from the low 50s to low 60s. Based on the medical record presented, as well as Claimant's testimony, Claimant has mild to moderate limitations on her mental ability to perform 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).

Claimant's work history in the 15 years prior to the application consists of work as a scheduler and trainer at a home health care provider, a position that required her to stand 70% of the day and to lift more than 100 pounds. As determined in the RFC analysis above, Claimant is limited to sedentary work activities and has mild to moderate limitations in her mental capacity to perform basic work activities. Because Claimant's prior employment involved heavy work, 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 application and 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 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 mild to moderate limitations on her mental ability to perform work activities. In this case, the Medical-Vocational Guidelines result in a finding that Claimant is not disabled based on exertional limitations. Claimant's mental RFC does not affect her ability to perform the non-exertional aspects of simple, unskilled work-related activities.

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 **not disabled** for purposes of the SDA benefit program.

DECISION AND ORDER

Claimant's July 1, 2015 hearing request concerning the FIP and MA issues is DISMISSED.

The Department's SDA determination is **AFFIRMED.**

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

Date Signed: **10/16/2015**

Date Mailed: **10/16/2015**

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]