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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: May 3, 2016
MAHS Docket No.: 15-024720
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

HEARING DECISION

Following Petitioner'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 March 9, 2016, from Detroit, Michigan. The Petitioner was represented by herself. The Department of Health and Human Services (Department) was represented by [redacted], Hearing Facilitator.

ISSUE

Whether the Department properly determined that Petitioner 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. The Petitioner applied for SDA on September 29, 2015.

2. The Medical Review Team (MRT) denied Petitioner's request on December 7, 2015.

3. The Department sent the Petitioner a Notice of Case Action on December 7, 2015.

4. The Petitioner requested a timely hearing on December 28, 2015.

5. An Interim Order was issued on March 9, 2016, requesting the Petitioner and the Department obtain additional medical records. Some of the medical evidence was provided.

6. The Petitioner has alleged physical disabling impairments including multiple sclerosis resulting in optical neuritis and vision loss, memory impairment short-term and migraine headaches and left-sided weakness and dysfunction of use of the left hand. The Petitioner, at the time of the hearing, was [redacted] years of age with a birth date of [redacted]. The Petitioner was 5'7" in height and weighed [redacted] pounds. The Petitioner completed a high school education and one year of college.

7. The Petitioner's past relevant work included working at a call center requiring her to utilize three headsets and use of the keyboard. Prior to that job, she worked at [redacted] for four years as a cashier. The Petitioner also worked for [redacted] preparing mortgages for closing. The Petitioner last worked in 2015.

8. The Petitioner's impairments have lasted or are expected to last 90 days or more.

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 State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a). The person claiming a physical or mental disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health

professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and, (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

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

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4). If impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before

moving from Step 3 to Step 4. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

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

The severity of the Petitioner's alleged impairment(s) is considered under Step 2. The Petitioner bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b). An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b). Examples include:

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

2. Capacities for seeing, hearing, and speaking;

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

4. Use of judgment;

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

Id.

The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). An impairment qualifies as non-severe only if, regardless of a Petitioner's age, education, or work experience, the impairment would not affect the Petitioner's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985).

The Petitioner has alleged physical disabling impairments including multiple sclerosis resulting in optical neuritis and vision loss, memory impairment short-term and cervical spine problems and

migraine headaches and left sided weakness and dysfunction of the use of the left hand. A summary of the medical evidence follows.

A Medical Examination Report was completed by the Petitioner's treating neurologist on [redacted]. The current diagnosis was relapsing remitting multiple sclerosis. The exam noted that the Petitioner experiences migraine headaches, speech was clear and fluent. The doctor noted laboratory and x-ray findings, which included MRIs and ophthalmology notes. The Petitioner was assessed by her Doctor based upon his clinical impression that she was deteriorating. The neurologist imposed limitations, which were expected to last more than 90 days. The limitations included lifting full restrictions indicating Petitioner was not capable of lifting or carrying weight. The Petitioner could stand or walk less than two hours in an eight-hour day and sit about six hours in an eight-hour workday. The Petitioner could use her hands/arms for reaching, pushing/pulling with both hands; however, simple grasping and fine manipulating was only accomplished with the right hand. The Petitioner was also evaluated as capable of operating foot/leg controls. The neurologist also indicated that the Petitioner had limitations with reading and writing due to her vision impairment. In addition, the Doctor found that the Petitioner needed assistance meeting her needs in the home due to her impaired vision.

Attached with the Medical Examination Report of the treating neurologist's evaluation was an MRI of the cervical spine. The report notes that small posterior osteophytes protrude into the spinal canal with minimal effacement of the ventral cord at C6 – C7; however, assessment of the cord signal was not possible. Shoddy nonspecific lymph nodes were present in the neck bilaterally. Demonstrated presence of multiple lesions in the brainstem are consistent with the known demyelinating disease. A central lesion with enhancement in the mid pons likely related to capillary telangiectasia as described in the MRI of the brain. The

notes also indicate that the exam was degraded by motion artifact an assessment of the cord signal was not possible. A small central posterior disc protrusion at C6 – C7 with minimal effacement of the ventral cord. Multiple lesions in the pons with a central point tiny capillary as described. A prior MRI in [redacted] was also attached, which noted numerous discrete lesions in the cerebral white matter, brainstem and cerebellum consistent with demyelinating plaques of multiple sclerosis.

Also attached to the neurologist's Medical Examination Report evaluation was a [redacted] report dated [redacted], [redacted] indicating optic neuritis ongoing as of [redacted] The report noted that the Petitioner was seen for blurry vision in right eye and left eye; report further notes hospitalization two weeks ago for optic neuritis requiring IV steroids for 3 to 4 days. The report notes decrease in vision and that Petitioner's glasses no longer work due to changes in her vision. Visual acuity examination was conducted in the Petitioner had 20/20 vision in her right eye and 20/60 vision in her left eye. The external examination noted constriction in the left eye visual field. Also horizontal and vertical CD ratios were lessened in the left eye. The diagnosis was optic neuritis retro bulbar (acute), left. The left eye vision had decreased from 20/20 to 20/60. The exam also noted a decrease in color discrimination in the left eye. A final diagnosis was nuclear sclerosis bilateral.

The Petitioner was seen by her neurologist on [redacted] for an office visit. On the day of the examination the Petitioner had reported due to an urgent need to be seen as she was having blurred vision which began two days prior to her visit. The blurred vision was in her left eye. At the time of the examination the visual acuity was 20/25 in the right eye and 20/40 in the left side. Extraocular movements were full. There was no edema or pallor after funduscopic exam. Facial sensation and strength were normal bilaterally. Cranial nerves appear intact. The Petitioner

was given new medication for high blurriness due to a possible multiple sclerosis flare-up. The Petitioner takes Copaxone shots every day.

The Petitioner was thereafter hospitalized from [redacted], due to chronic migraine, depression and multiple sclerosis.

The Petitioner was seen on [redacted], for a modified barium swallow. Scout image demonstrated loss of cervical lordosis. Anterior osteophytes are noted at C4 and C5 vertebral bodies. The results were a normal modified barium swallow study.

The Petitioner was seen by her neurologist for follow-up on [redacted]. At that time, the neurological assessment noted speech is clear, fluent and appropriate. Rate and latency of behavior are okay. Extraocular movements are full without nystasgmus. Visual fields are full. Visual acuity is 20/25 on right and 20/30 and left. The assessment and plan noted relapsing – remitting multiple sclerosis currently in remission.

The Petitioner was seen by her neurologist on [redacted], for follow-up. The notes indicate Petitioner was diagnosed with multiple sclerosis in [redacted] with unilateral loss of vision in the left eye. An MRI of the brain showed multiple plaques, some of which were enhancing. She was treated successfully with intravenous methylprednisolone.

The Petitioner presented with Orbital pain worse with moving the left eye with decreased vision. The report notes she has been diagnosed with recurrent left optic neuritis by the [redacted] At the time of the exam, visual acuity is 20/25 on right and 20/50 on left. The plan noted a relapse consisting of the left optic neuropathy, and the Petitioner was given intravenous methylprednisolone. The Petitioner was admitted for the intravenous

infusion due to the requirement that it be done in a monitored setting. Petitioner was to be evaluated for difficulty with swallowing as well. At the time, the Petitioner was placed in the hospital.

While hospitalized on [redacted], the Petitioner was given the following assessment: recurrent optic neuritis of left eye with chronic optic neuropathy; and exaggeration of multiple sclerosis, pain on global movement, acuity decline in central visual scotoma, subtle T2 optic nerve changes on MRI. Currently on IV. The patient was monitored for bradycardia due to the IV solution. On [redacted], improvement in vision was reported by the patient. Able to read words on the board on the wall clearly. At that time, significant improvement was noted in the scotoma. Visual fields were full in all directions. Decreased color perception and left eye especially the red color persisted. On [redacted], the Petitioner was discharged from the hospital. The MRI of the brain and cervical spine revealed possible subtle nonenhancing T2 changes of the optic nerve without any new enhancing lesions elsewhere. The Petitioner was discharged in improved condition after a two-day hospital stay.

An MRI of the brain stem was conducted on [redacted], and was compared with a previous study in [redacted] the findings noted innumerable discrete white matter lesions that appear bright on the T2 flare sequences in the deep cerebral and periventricular white matter bilaterally with several lesions in the corpus callosum and brainstem. A single lesion was noted in the right cerebellum white matter. The conclusion was: numerous discrete lesions in the cerebral white matter, brain stem and cerebellum consistent with demyelinating plaques of multiple sclerosis. No enhancing lesion is seen on the current exam. A single lesion in the central ponds shows gradient susceptibility and central pattern of enhancement is more consistent with capillary telangiectasia rather than demyelinating plaque.

The Petitioner was seen at the [redacted] on [redacted] At the examination, the Petitioner reported some decreased vision and large central scotoma with an onset of one week prior. Petitioner described occasional floaters and flashes one to two times a week and also reported feeling of her left eye drifting out temporarily one time weekly. Visual acuity for the right eye was 20/20; and due to dilation, there was no visual acuity left eye. The assessment was optic neuritis left eye. Patient was sent to the emergency room after the examination due to evidence of nerve inflammation, white light perception reduced to 5% and red light perception reduced to 5% in left eye. The optical Coherence Tomography Report noted retinal nerve fiber layer analysis abnormal nerve fiber layer detected in the right eye and was outside normal limits, disc edema was also noted in the left eye.

The Petitioner was seen again at the [redacted] on [redacted], with essentially no changes reported at the time her left eye near vision was 20/25 and distance vision was 20/40.

The patient was also seen for an office visit at the [redacted] on [redacted]. At that time, the left eye vision was 20/50 and the Petitioner was prescribed eyeglasses. Report noted that patient was improving clinically also has MRI findings of plaque of brain and C-spine. Visual acuity continues to improve and follow-up with neurology today.

The Petitioner was also seen at the [redacted] on [redacted], at which time her visual acuity in her left eye was 20/60 distance and 20/15 near. At the conclusion of the exam, the notes indicated there was some suggestion of progression the visual loss on the left eye. Petitioner had pain on abduction the left eye and movements are normal. Had some visual vertigo-like symptoms with glasses so new glasses were given. The impression was evidence of progression of optic neuritis as has loss of GC L OU at 67, 53 from 66, 82 previously.

An MRI of the cervical spine was performed on [redacted]. The exam demonstrated presence of multiple lesions in the brainstem consistent with the known demyelinating disease. A central lesion with enhancement in the mid-of the ponds is likely related to something other than demyelinating disease. A small central posterior disc protrusion at C6 – C7 with minimal effacement of the ventral cord was noted.

The Petitioner's treating neurologist completed a Multiple Sclerosis Residual Functional Capacity Questionnaire on [redacted]. The examination noted that the Petitioner has been seen since [redacted], every 2 to 3 months. The diagnosis was made based on an MRI, history and neurological examination. The prognosis was fair; and the symptoms were identified as follows: fatigue, balance problems weakness on the left side, increase muscle tension, bladder problems, sensitive to heat and cold, pain, difficulty remembering, depression, emotional lability, difficulty solving problems, double obscured vision/partial or complete blindness, speech/communication difficulties (Stuttering), migraines three per week were also noted. The patient was noted as not being a malingerer. The patient did not have significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movement. The patient did have significant reproducible fatigue of motor function with substantial muscle weakness on repetitive activity demonstrated on a physical examination resulting from neurological dysfunction in areas of the central nervous system known to be pathologically involved by the multiple sclerosis process. An example of this weakness was repetitive actions caused left-hand weakness and spasm. The remainder of the form noted that the patient's physical impairments were reasonably consistent with the symptoms and functional limitations that were described in the evaluation.

The neurologist in his evaluation also noted that Petitioner's experience of pain, fatigue and other symptoms were severe enough to interfere with attention and concentration on a constant basis. When asked to what degree the patient could tolerate work stress, the doctor noted patient was incapable of even low stress job. Finally, the impairments were evaluated as lasting or expected to last at least 12 months and that the earliest date that the description of symptoms and limitations in the questionnaire applied was [redacted]. The Petitioner could walk two blocks. Could sit 20 minutes at one time; she could stand for 10 minutes. The Petitioner could sit less than two hours in a total eight-hour working day with normal breaks. The Petitioner was evaluated as needing shifting positions from sitting to standing and walking. The doctor further noted that the patient would need to take unscheduled breaks during an eight-hour day; the functional limitations did not include the patient's legs being elevated; and an assistive device was not deemed necessary.

The neurologist's evaluation noted the patient could occasionally carry less than 10 pounds, rarely carry 10 pounds and never 20/50 pounds. Regarding various activities the Petitioner could not stoop, crouch, climb ladders or stairs and could rarely twist. The Petitioner also had significant limitations in doing repetitive reaching handling or fingering. When the use of hands/fingers/arms were evaluated, the left-hand was noted as significantly limited and could be used for 5% of an eight-hour day to twist objects or reach and never fine manipulation. The doctor also evaluated environmental restrictions including cold, heat, wetness and humidity, noise, fumes, odors etc. and hazards with machinery and heights. The Petitioner's impairments were likely to produce both good and bad days. And it was estimated that the Petitioner would be absent from work as a result of the impairments more than four days per month.

The Petitioner was seen and admitted to the hospital on [redacted], complaining inability to see out of the left eye.

The assessment noted central scotoma in the left eye with CT findings worrisome for multiple sclerosis was noted in the assessment. At the time of the assessment, the patient had been started on IV steroids. The Petitioner was given a multiple sclerosis work up an MRI of the brain, and orbits were pending. The patient had been referred from the [redacted] who had diagnosed left optic neuritis. Over a week, the central scotoma had enlarged in Petitioner's left eye from the center going out into the periphery of the eye with painful live movement. At the time of the examination, on the left there was a large central blind spot or scotoma; but fingers were counted in the periphery of the eye. The remainder the physical examination was normal. CT of the head showed several subcentimeter foci of hypo attenuation within the cerebral white matter in both sides concerning for demyelinating process. A CCT performed by ophthalmology showed optic nerve edema on the left with generalized depression of the left visual field. On [redacted], [redacted] a cardiology consultation was requested and performed. The complaint was bradycardia. While receiving an IV of Solumedrol for the diagnosed optic neuritis, she experienced heart palpitations, light-headedness, dizziness, heaviness in her chest and generalized fatigue. While hospitalized, the Petitioner's heart rate dropped to the 40s when it had previously been 70 to 90. In this case, it was determined that this sinus bradycardia was due to steroid induced tachycardia. The Petitioner was discharged on [redacted], in an improved condition.

A CT of the head performed at that time noted relatively well circumscribed subcentimeter foci of hypo attenuation scattered in the deep white matter bilaterally these are highly concerning for demyelinating lesions of multiple sclerosis.

An MRI of the brain was also performed on [redacted]. The impression was numerous T2 hyper intense lesions in the supratentorial white matter, corpus callosum, brainstem, and cerebellar white matter, the appearance and distribution of which are typical for demyelinating lesions of multiple sclerosis. For lesions, three in white matter of bilateral frontal lobes and one in the central ponds, enhance upon the gadolinium suggesting the acute nature of the demyelinating process no brain atrophy was noted. Many of the cerebral white matter lesions are in the region of bilateral optic radiations.

An MRI of the cervical spine was performed [redacted]. The impression was two small very faint intramedullary lesions in the cervical spinal cord in several brainstem lesions consistent with demyelinating lesions of multiple sclerosis. Mild spondylotic changes at most cervical levels as described above no cord compression, spinal canal or neural for mental stenosis.

An MRI of the cervical spine was performed on [redacted]; the conclusion was no abnormal enhancement seen. Small central posterior disc protrusion at C6 – C7 with minimal effacement of the ventral cord. Multiple lesion in the pons with a central point tiny capillary telangiectasia. Multiple lesions in the brainstem consistent with known demyelinating disease were present.

A Final Report was completed in [redacted] by the Petitioner's neurologist after the hospital stay. Her MRI of the brain showed extensive lesions lesion load both supra-and in front 10 Torino in distribution typical in distribution and appearance for multiple sclerosis had three discrete post contrast enhancing lesions shown in bilateral cerebral hemisphere. The assessment and plan was that an MRI of the cervical spine to look for any MS plaque in the cord and an OCT test for the patient.

As previously noted, the Petitioner bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the Petitioner has presented objective medical evidence establishing that she does have some physical limitations on her ability to perform basic work activities. Accordingly, the Petitioner has an impairment, or combination thereof, that has more than a *de minimis* effect on the Petitioner's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, the Petitioner is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Petitioner's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The Petitioner has alleged physical disabling impairments including Multiple Sclerosis and optical neuritis with vision loss, memory impairment short-term, migraine headaches and left sided weakness and dysfunction of the left hand with repetitive use. As regards these impairments, Listing 11.09 and 2.00 were examined.

11.09 *Multiple sclerosis.* With:
A. Disorganization of motor function as described in 11.04B; or

B. Visual or mental impairment as described under the criteria in 2.02, 2.03, 2.04, or 12.02; or

C. Significant, reproducible fatigue of motor function with substantial muscle weakness on repetitive activity, demonstrated on physical examination, resulting from neurological dysfunction in areas of the central nervous system known to be pathologically involved by the multiple sclerosis process.

11.04 B provides: Significant and persistent disorganization of motor function in two extremities, resulting in sustained

disturbance of gross and dexterous movements, or gait and station (see 11.00C).

This listing is not met as two extremeties are not involved as regards 11.04B and reproducible fatigue of motor function.

Also reviewed in conjunction with 11.09 B were Listings found in 2.00 Special Senses and Speech – Adult regarding visual acuity.

The Act also provides that an eye that has a visual field limitation such that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered as having a central visual acuity of 20/200 or less. (For visual field testing requirements, see 2.00A6.)

2.02 Loss of Central Visual Acuity. Remaining vision in the better eye after best correction is 20/200 or less.

2.03 Contraction of the visual field in the better eye, **with:**

A. The widest diameter subtending an angle around the point of fixation no greater than 20 degrees;

OR

B. An MD of 22 decibels or greater, determined by automated static threshold perimetry that measures the central 30 degrees of the visual field (see 2.00A6d).

OR

C. A visual field efficiency of 20 percent or less, determined by kinetic perimetry (see 2.00A7c).

2.04 *Loss of visual efficiency, or visual impairment, in the better eye:*

A. A visual efficiency percentage of 20 or less after best correction (see 2.00A7d).

OR

B. A visual impairment value of 1.00 or greater after best correction (see 2.00A8d).

The above Listings found in 2.00, (2.02, 2.03 and 2.04) were reviewed and are not met as the Petitioner's condition is intermittent and the documented test results documenting demonstration of visual acuity requirements are not met.

As the Petitioner has not been found disabled or not disabled at Step 3, the analysis will proceed to Step 4.

The fourth step in analyzing a disability claim requires an assessment of the Petitioner's residual functional capacity ("RFC") and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if he/she can perform past relevant work. *Id*.; 20 CFR 416.960(b)(3). Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s) and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

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

Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a

sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b). Even though weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.*

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.*

Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.* Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands (exertional requirements, e.g., sitting, standing, walking, lifting, carrying,

pushing, or pulling) are considered nonexertional. 20 CFR 416.969a(a). In considering whether an individual can perform past relevant work, a comparison of the individual's residual functional capacity to the demands of past relevant work must be made. *Id.* If an individual can no longer do past relevant work, the same residual functional capacity assessment along with an individual's age, education, and work experience is considered to determine whether an individual can adjust to other work which exists in the national economy. *Id.* Examples of non-exertional limitations or restrictions include difficulty function due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (e.g., can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2). The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.*

The Petitioner's prior work history includes working performing at a call center requiring her to utilize three headsets and use of the keyboard. Prior to that job she worked at [redacted] for four years as a cashier. The Petitioner also worked for [redacted] preparing mortgages for closing. The Petitioner last worked in 2015 at a call center, which required use of three headsets, computer keyboard and screen. The Petitioner had difficulty with taking credit card information, seeing the numbers and difficulty with migraine headaches due to the job requirements requiring

extreme multitasking. The Petitioner also was a loan preparer for [redacted] requiring verifying numbers and requiring vision accuracy for financial details. The Petitioner testified that she could not do the [redacted] job cashiering because she cannot stand for long periods of time due to fatigue and also due to vision blurriness. The Petitioner completed high school and one year of college. In light of the Petitioner's testimony and records, and in consideration of the Occupational Code, the Petitioner's prior work is classified as semi-skilled light. It is determined that the Petitioner can no longer do such work as the Petitioner's ability to see, use her left hand for repetitive motion and limitations on lifting and walking and standing for prolonged periods as well as optic neuritis which is causing vision deterioration would preclude the level of activity required for these jobs.

If the impairment or combination of impairments does not limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. 20 CFR 416.920. Because Petitioner's past work involved light exertion, Petitioner does not maintain the RFC to perform past relevant work. In consideration of the Petitioner's testimony, medical records, and current limitations, it is found that the Petitioner is not able to return to past relevant work. Thus, the fifth step in the sequential analysis is required.

In Step 5, an assessment of the individual's residual functional capacity and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v). The Petitioner is [redacted] years old and, thus, is considered to be a younger individual for MA purposes. The Petitioner has a high school education with one year of college. Disability is found if an individual is unable to adjust to other work. *Id.* At this point in the analysis, the burden shifts from the Petitioner to the Department to present proof that the Petitioner has the residual capacity to substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human*

Services, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

In this case, the evidence reveals that the Petitioner has medical impairments due to multiple sclerosis resulting in optical neuritis and vision loss, memory impairment short-term, migraine headaches and left-sided weakness and dysfunction particularly in the left hand with repeated use.

Based upon the foregoing objective medical evidence particularly the limitations imposed by the Petitioner's treating neurologist which include: Petitioner could occasionally carry less than 10 pounds, rarely carry 10 pounds and never 20/50 pounds. Regarding various activities the Petitioner could not stoop, crouch, climb ladders or stairs and could rarely twist. The Petitioner also had significant limitations in doing repetitive reaching handling or fingering. When the use of hands/fingers/arms were evaluated the left-hand was noted as significantly limited and could be used for 5% of an eight-hour work day to twist objects or reach and never fine manipulation. The doctor also evaluated environmental restrictions including cold, heat, wetness and humidity, noise, fumes, odors etc. and hazards with machinery and heights. The Petitioner's impairments were likely to produce both good and bad days. And it was estimated that the Petitioner would be absent from work as a result of the impairments more than four days per month. These limitations do not support a finding that Petitioner is

capable of performing sedentary work. Sedentary work requires lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

This Administrative Law Judge does also take into account Petitioner's treating neurologist's opinions imposing serious restrictions due to Petitioner's physical impairment and non exertional limitations including her vision and those work place related conditions, which she cannot be exposed to, which are noted in the preceding paragraph related to her diagnosis of multiple sclerosis. The treater also evaluated Petitioner as deteriorating and requires assistance with activities of daily living. The evaluations and medical opinions of a "treating "physician is "controlling" if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record. 20 CFR§ 404.1527(d)(2), Deference was given by the undersigned to objective medical testing including the MRI and clinical observations of the Petitioner's treating physician that completed the DHS-49 and the residual functional capacity assessment and who places the Petitioner at less than sedentary. The total impact caused by the physical impairment suffered by the Petitioner must be considered. In doing so, it is found that the Petitioner's physical impairments have a major impact on her ability to perform even basic work activities. In consideration of the foregoing and in light of the medically objective physical limitations and pain, and the fact that the Department did not present any vocational evidence to support whether any jobs exist in the national economy that the Petitioner could perform given her limitations, accordingly, it is found that the Petitioner is unable

to perform the full range of activities for even sedentary work as defined in 20 CFR 416.967(a).

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

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

DECISION AND ORDER

Accordingly, the Department's determination is **REVERSED**.

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

1. The Department shall process the Petitioner's September 29, 2015, application and determine if all non-medical eligibility requirements are met.

2. A review of this case shall be completed in May 2017.

LMF/jaf

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

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; 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

DHHS

[redacted]

Petitioner

[redacted]

cc: [redacted]