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GOVERNOR

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

MIKE ZIMMER
DIRECTOR

[redacted]

Date Mailed: May 12, 2016
MAHS Docket No.: 16-002606
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

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 April 18, 2016, from Detroit, Michigan. Petitioner appeared and represented herself. The Department of Health and Human Services (Department) was represented by [redacted] Medical Contact Worker.

ISSUE

Did the Department properly determine 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. On July 27, 2015, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On February 4, 2016, the Disability Determination Service (DDS)/ Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 2-9).

3. On February 10, 2016, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit A, pp. 491-492).

4. On March 4, 2016, the Department received Petitioner's timely written request for hearing (Exhibit A, p. 493).

5. Petitioner alleged disabling impairment due to multiple sclerosis (MS), Hashimoto's disease, blurry vision, bipolar disorder, and depression.

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

7. Petitioner is a high school graduate and has an associate's degree.

8. At the time of application, Petitioner was not employed.

9. Petitioner has an employment history of work as a registered nurse and hospice nurse.

10. Petitioner has a pending disability claim with the Social Security Administration (Exhibit B, Exhibit A, P. 58).

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 disabled person is eligible for SDA. BEM 261 (July 2015), 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).

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meets or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) 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 in this process, 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

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

Step Two

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that 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. 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, such as (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). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, 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.

In the present case, Petitioner alleges disabling impairment due to MS, Hashimoto's disease, blurry vision, bipolar disorder, and depression. The medical evidence presented at the hearing was reviewed and is summarized below.

In 2009, Petitioner was diagnosed with Hashimoto's thyroiditis, bipolar disorder, and hypothyroidism (Exhibit A, PP 111-117). In a September 22, 2015 office visit, it was noted that Petitioner's thyroid problems were mild (Exhibit A, pp. 122-126).

From May 19, 2014 to May 26, 2014, Petitioner was hospitalized at [redacted] after she attempted suicide by overdosing on Clozaril. (Exhibit A, pp. 248-249).

At a June 3, 2014 visit with her primary care physician, Petitioner complained of neurological problems, including loss of balance, speech change, movement disorder and dizziness, and mental health problems, including depression, disorganized speech, disorganized thought process, severe insomnia, and rapid thoughts. (Exhibit 1, P. 6.) Petitioner reported her recent admission to [redacted] after a severe episode of depression, suicidal thoughts, and unintentional overdose but stated that, since her discharge, she had quickly started to become what she stated was manic, sleeping a total of 5 to 9 hours in the last 5 days, and having speech changes, tense muscles, and movement difficulties diffusely over the last 3 days. The doctor concluded that Petitioner was experiencing some type of psychiatric crisis associated with bipolar illness on the manic side and concluded that the complexity of her symptoms required further evaluation. (Exhibit A, pp. 242-244).

Petitioner was hospitalized from June 3, 2014 to July 3, 2014 (Exhibit A, pp. 167-202). She had come to the hospital after a fall in the shower, complaining of worsening disturbed speech, gait instability, and overall difficulty functioning at home. She was seen by psychiatry and thought to be having on exacerbation of her bipolar disease due to medication overdose. During admission, Petitioner had a decline in mental status and was concurrently evaluated by neurology who ordered an MRI of her cervical spine and CTA of the head and neck. A spinal tap showed presence of inflammatory markers. Test results indicated a differential diagnosis including central demyelinating disease, vasculitic or autoimmune disorder, or subacute encephalitis; the abnormal results were suspicious for MS. However, Petitioner never described any typical MS attacks. A June 7, 2014 electroencephalogram (EEG) showed no evidence of epileptiform activity or cerebral dysfunction but was indicative of a mild encephalopathy.

During her hospitalization, Petitioner was intubated and developed deep vein thrombosis (DVT). (Exhibit A, pp. 161, 270-296, 214-215, 252-253, 271.)

Petitioner was hospitalized from November 29, 2014 to December 5, 2014 for blurred vision, fluctuating and worse at the end of the day (Exhibit A, pp. 162, 203).

In a January 19, 2015 office visit, the doctor noted that Petitioner reported that she had intermittent balance issues, increased urination frequency and urgency, difficulty finding words, and intermittent tremors in her hands. She denied any episode of unilateral loss of vision or double vision or any episode of unilateral or bilateral weakness or numbness in the past. The doctor advised Petitioner that her MRI findings and spinal fluid were related to a demyelinating disease of the central nervous system and it was possible she had MS but a definitive diagnosis could not be made because she did not have any typical attacks of MS (Exhibit A, pp. 222, 291-292.)

January 2015 test results showed that Petitioner did not have any current DVT in either leg (Exhibit A, PP 103-107). A January 28, 2015 MRI of the brain and cervical spine continue to be suggestive of demyelination but no acute lesion was noted (Exhibit A, pp. 204-207).

In a February 10, 2015 office visit with a physical therapist, Petitioner reported having problems with memory and concentration and loss of balance beginning November 2014, with three episodes of falling to the right. The therapist observed Petitioner was unable to tandem stand or single limb support and, while she ambulated without assistive device, she walked with a moderate wide base of support with deviation from a central line and tended to ambulate near a wall if able, occasionally dragging her right foot. The therapist concluded that Petitioner was at moderate risk for falls and recommended use of a straight cane. (Exhibit 1, p. 12-14; Exhibit A, pp. 223-225.) Petitioner participated in therapy between February 10, 2015 and March 24, 2015 (Exhibit A, pp. 232-240).

At the February 13, 2015 visit with her doctor, Petitioner denied any new symptoms since her last visit. She denied episodes of loss of vision or double vision but, because night bright lights bothered both eyes, she stopped driving. She denied any episode of weakness or numbness. She had chronic intermittent tremor in both hands, but the doctor noted that she was on Depakote which can cause intermittent tremors. She continued to have balance issues. The doctor noted that a repeat brain and cervical spine MRI was stable and showed no enhancing lesions or new T2 lesions. (Exhibit A, pp. 208-209, 227-228.)

An April 1, 2015 visual evoked potential test measured Petitioner's visual acuity of the left eye at 20/25 and of the right eye at 20/30. Exam results revealed a demyelinating lesion of the anterior optic pathway on the right side. The left visual evoked potential was in normal limits. (Exhibit 1, p. 11; Exhibit A, p. 219.)

In notes from a May 7, 2015 office visit, the doctor noted that Petitioner complained of blurry vision, mostly fluctuating and worse at the end of the day; intermittent numbness in the left lower extremity; and difficulties with memory. The doctor noted that Petitioner had signal changes in white matter of her brain and cervical spine suspicious for a demyelinating disease of the central nervous system but a definitive diagnosis of MS could not be made because she did not have a an attack typical for MS, her MRIs to date were stable without changes or active disease, and she was clinically stable. (Exhibit A, pp. 156-157, 160-161).

A May 22, 2015 MRI of the brain and C-spine was stable with no new hyper intense lesions and no new areas of enhancement. Visual evoked potentials were obtained, and P100 was prolonged on the right. Otherwise, Petitioner was able to ambulate without difficulty and her endurance for walking was not impaired.

On September 14, 2015, Petitioner went to her doctor complaining of elbow pain following a fall. She was diagnosed with an elbow fracture. (Exhibit A, PP 118-121.)

In notes from a November 2, 2015 office visit Petitioner's doctor noted that Petitioner had a high probability for developing definitive MS but a definitive diagnosis for MS could not be made because Petitioner did not describe clear typical attacks for MS. The doctor acknowledged that the symptoms may have been masked or gone unnoticed because of Petitioner's psychiatric history. Also, clinically she was stable. Given her high probability for developing MS, the doctor recommended Petitioner start Copaxone. The doctor noted that Petitioner's mood had been stable and she had been following up with a new psychiatrist who increased her Clozaril. (Exhibit A, pp. 64, 161-166, 171-173, 184-185; Exhibit 1, pp. 9-10)

A November 14, 2015 C-spine and brain MRI showed stable distribution and number of supra-and infratentorial T2 FLAIR hyperintensities, consistent with areas of demyelination and stable degree of patchy and ill-defined high T2 signal within the cervical cord, consistent with areas of demyelination (Exhibit A, pp. 210-213).

On August 15, 2015, Petitioner's family doctor completed a medical examination report, DHS-49, listing Petitioner's diagnoses as bipolar disorder, hypothyroid, and anemia. The doctor noted that Petitioner suffered from fatigue secondary to MS and had problems with focusing and memory due to her history of bipolar disorder. The doctor concluded that Petitioner's condition was stable and identified the following limitations: (i) she could frequently lift and carry 10 pounds, occasionally lift and carry 20 pounds, and never lift and carry 25 pounds or more; (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; and (iv) she could use both feet/legs to operate foot and leg controls. (Exhibit 1, pp. 2-4; Exhibit A, pp. 50-52.)

On August 19, 2015 Petitioner's psychiatrist completed a mental residual functional capacity assessment, DHS-49-E, regarding Petitioner's mental impairments and how

they affected her activities. The psychiatrist concluded that Petitioner had **no, or no significant,** limitations regarding her ability to remember locations and work-like procedures; understand and remember one or two-step instructions; carry out simple one or two step instructions; interact appropriately with the general public; ask simple questions or request assistance; and be aware of normal hazards and take appropriate precautions. The psychiatrist concluded that Petitioner had **moderate** limitations regarding her ability to understand and remember detailed instructions; carry out detailed instructions; perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; sustain an ordinary routine without supervision; make simple work-related decisions; accept instructions and respond appropriately to criticisms from supervisors; get along with coworkers or peers without distracting them or exhibiting behavioral extremes; maintain socially appropriate behavior and adhere to basic standards of neatness and cleanliness; respond appropriately to change in the work setting; travel in unfamiliar places or use public transportation; and set realistic goals or make plans independently of others. The psychiatrist concluded that Petitioner had **marked** limitations regarding her ability to maintain attention and concentration for extended periods; work in coordination with or proximity to others without being distracted by them; and 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. (Exhibit A, pp. 48-49.)

On August 31, 2015, Petitioner's psychiatrist completed a psychiatric evaluation diagnosing her with bipolar disorder. He indicated that Petitioner had been hospitalized 4 times the prior year for her condition. He noted that she was oriented to time, person, and place; had good memory; had acceptable abstract thinking; and had good logic. She was able to shop, keep appointments, do housework, and go to church. He assessed her global assessment of functioning (GAF) score at 45 and indicated she would be able to manage her own benefit funds. (Exhibit A, pp. 45-47.)

On January 19, 2016, Petitioner was examined by a licensed psychologist at the Department's request. The psychologist observed that Petitioner's grooming, hygiene and dress were appropriate; her speech was clear and communication was within normal limits; and she drove herself to the appointment and was on time. Petitioner reported performing most activities of daily living independently with additional time and rest periods needed due to pain, movement, and fatigue problems. She reported difficulty with standing, walking and balance issues. She could perform light housekeeping slowly, go shopping, and complete errands. The psychologist observed that Petitioner responded well to instructions and positive criticism and overall she was cooperative, motivated, and verbally responsive. He noted that her thoughts were logical, organized, simple and concrete, and goal oriented. He found that she had judgment, social skills, motivation, behavior, and attention/focus within normal limits and she had fair insight. Petitioner reported that her last manic episode was in May 2015 and her last depression episode was in November 2015, and the psychologist noted that she was not currently presenting with mania or depression. The psychologist

concluded that there was no difficulty in Petitioner's ability to comprehend and carry out simple directions, and perform repetitive, routine simple tasks or in her ability to comprehend complex tasks. Her prognosis was good. (Exhibit A, pp. 59-63.)

In a letter dated April 2016, a psychiatric mental health nurse practitioner at the mental health facility Petitioner frequented stated that Petitioner was being treated at the facility for depression and bipolar disorder; had shown increased signs of depression which resulted in prescriptions for Lamictal, clozapine, and Brintellix; and continued to struggle with MS for which she was recently prescribed Copaxone. (Exhibit 1, p. 1.)

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 Petitioner suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner 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.

Based on the medical evidence presented in this case, listings 2.02 (loss of central visual acuity), 2.03 (contraction of the visual fields in the better eye), 2.04 (loss of visual efficiency), 2.07 (disturbance of labyrinthine-vestibular function), 11.09 (multiple sclerosis), 12.04 (affective disorders), 12.06 (anxiety-related disorders, and 14.00 (immune system disorders) were considered.

Petitioner's medical packet does not include laboratory testing necessary to support a finding that her visual impairments meet or equal a listing under 2.02, 2.03, 2.04, or 2.07. Because the evidence showed that Petitioner's thyroid issues were controlled by her medication, her condition does not meet or equal any listing under 14.00.

A listing under 11.09 requires MS with (A) disorganization of motor function as described 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 and 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. The evidence presented indicated that Petitioner did not have typical MS attacks, significant and persistent disorganization of motor function in two extremities, or a loss of specific cognitive abilities or affective changes as described in 12.02 or a chronic organic mental

disorder of at least 2 years duration. Therefore, Petitioner's condition does not meet or equal a listing under 11.09.

A listing under 12.04 requires either (i) medically documented persistence of depressive, manic, or bipolar syndrome resulting in marked limitations in functioning or (ii) medically documented history of a chronic affective disorder of at least two years' duration that has caused more than a minimal limitation of ability to do basic work activities with either repeated episodes of decompensation, residual disease process, or one or more years' current inability to function outside a highly supportive living arrangement. A listing under 12.06 requires (i) marked limitations in functioning or repeated episodes of decompensation or (ii) complete inability to function independently outside the area of one's home. While the record clearly shows at least two hospitalizations involving psychiatric issues, both incidents were in 2014. Based on the evidence presented, Petitioner's mental condition at the time of her July 2015 application does not met or equal a listing under 12.04 or 12.06.

Because medical evidence presented does **not** show that Petitioner'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, Petitioner 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 Steps 4 and 5, 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 individual's impairments 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). The exertional requirements, or physical demands, of work in the national economy are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a). 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 and occasionally walking and standing. 20 CFR 416.967(a). 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 the light 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. 20 CFR 416.967(b). 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). 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). 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. 20 CFR 416.967(e).

In this case, Petitioner alleges both exertional and nonexertional limitations due to her medical condition. Petitioner testified that she could walk for 4 to 5 blocks, sit up to an hour before needing to stand, stand up to 45 minutes, and lift no more than 15 pounds. She suffered from balance issues that had resulted in several falls. She lived with her father. She could care for her personal hygiene and dress herself and do her own laundry and light chores as long as she could rest in between chores. She could shop slowly. She admitted that on her Copaxone, she was currently stable and not on active relapse.

Petitioner's cervical spine and brain MRIs indicate that she has a demyelinating disease of the central nervous system, very probably MS, but that, because she did not have any typical MS attacks, a definitive diagnosis was not possible. The record does support Petitioner's testimony that she has balance issues, with the physical therapist suggesting that she use a cane to assist her. In his August 15, 2015 DHS-49, Petitioner's family doctor acknowledged that Petitioner suffered from fatigue secondary to MS and had problems with focusing and memory due to her history of bipolar disorder but identified only the following limitations: (i) she could frequently lift and carry 10 pounds, occasionally lift and carry 20 pounds, and never lift and carry 25 pounds or more; and (ii) she could stand and/or walk less than 2 hours in an 8-hour workday. The doctor did not identify any sitting restrictions. With respect to Petitioner's exertional limitations, it is found based on a review of the entire record that Petitioner maintains the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a).

Petitioner also testified that that her vision problems and mental condition prevented her from engaging in basic work activities. 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). 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.

Petitioner testified that she had memory issues and could not concentrate and suffered from blurry vision that made her eyes sensitive to light and limited her ability to drive at night. She suffered from crying spells because of her health and finances. She was engaged in therapy since September 2015, meeting with a psychiatrist monthly and a counselor between one and four times monthly. She also met with the caseworker. She acknowledged that that some of her manic symptoms were controlled by medications, including Clozaril. She got together with friends and family and attended church.

Consistent with her testimony, diagnostic testing shows that Petitioner has a lesion on her right optical nerve, but her visual acuity was 20/30 in the right eye and 20/25 in the left eye. Petitioner testified that her vision problem was primarily affected by bright light. Therefore, she had mild limitations to her nonexertional RFC due to vision problems. In the DHS-49-E he completed, Petitioner's psychiatrist indicated that Petitioner had no significant limitations in remembering and carrying out simple one or two-step instructions; moderate limitations in performing in a scheduled work setting; and marked limitations in her ability to maintain attention and concentration for extended periods; work in coordination with or proximity to others without being distracted by them; and 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.

Based on the medical record presented, as well as Petitioner's testimony, Petitioner's nonexertional RFC results in mild limitations due to her vision problems; mild limitations on her activities of daily living; mild limitations to her social functioning; and moderate to

marked limitations to her concentration, persistence or pace. While there were episodes of decompensation, those seem to currently controlled by medication.

Petitioner'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 Petitioner'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).

Petitioner's work history in the 15 years prior to the application consists of work as a registered nurse and hospice nurse. Both jobs required standing most of the day. Because Petitioner's employment as a registered nurse required substantial lifting, up to 150 pounds, that job required very heavy exertion. Because Petitioner did not have to do any lifting but had to stand for her job as a hospice nurse, that job required light exertion.

Based on the RFC analysis above, maintains the exertional RFC to meet the physical demands to perform sedentary work activities. Because she is unable to perform her past relevant work due to her current exertional RFC, Petitioner 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 Petitioner'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 Petitioner to the Department to present proof that Petitioner 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, Petitioner was [redacted] years old at application and at the time of hearing, and, thus, considered to be a younger individual [redacted] for purposes of Appendix 2. She has an associate's degree and a history of semi-skilled work experience. Because her semi-skilled experience is tied to work requiring an exertional RFC greater than sedentary, Petitioner's skills are not transferable.

As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities. In this case, the Medical-Vocational Guidelines, 201.21, result in a finding that Petitioner is not disabled based on exertional limitations. Petitioner also has nonexertional limitations: her vision problems result in mild limitations in her ability to perform work related activities and she has mild limitations on her activities of daily living; mild limitations to her social functioning; and moderate to marked limitations to her concentration, persistence or pace. Petitioner's mental RFC and limitations due to her vision problems do not affect her ability to perform the non-exertional aspects of simple, one and two-step work-related activities, and, as such, she is able to adjust to other work. Accordingly, Petitioner is not disabled 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 **not disabled** for purposes of the SDA benefit program.

DECISION AND ORDER

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

ACE/tlf

Alice C. Elkin
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

[redacted]

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[redacted]