RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: September 13, 2016
MAHS Docket No.: 16-007771
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 July 21, 2016, from Detroit, Michigan. Petitioner appeared and represented herself. The Department of Health and Human Services (Department) was represented by [redacted] Eligibility Specialist.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. A DHS-49, medical examination report, completed and signed by Petitioner's orthopedic specialist was received and marked into evidence as Exhibit 2. The requested DHS-49 completed and signed by Petitioner's neurologist and the DHS-49D, psychiatric/psychological evaluation, and DHS-49E, mental residual functional capacity assessment, completed and signed by Petitioner's therapist were NOT received. The record closed on August 19, 2016, and the matter is now before the undersigned for a final determination based on the evidence presented.

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 October 19, 2015, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On June 9, 2016, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 25-31, 32-61).

3. On June 13, 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. 8-9).

4. On June 13, 2016, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 10-11).

5. Petitioner alleged disabling impairment due to multiple sclerosis (MS), fibromyalgia, blurred vision, loss of balance, knee problems, chronic migraines, irritable bowel syndrome (IBS) with constipation, neuropathy, chronic fatigue, depression, anxiety, and poor memory and concentration.

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.

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

9. Petitioner has an employment history of work as deli counter worker; health care aide at a nursing home; and certified nursing assistant.

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

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.

Petitioner applied for cash assistance alleging a disability. 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 meet 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 was not working during the period for which assistance might be available. Because Petitioner was not engaged in SGA, she 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, fibromyalgia, blurred vision, loss of balance, knee problems, chronic migraines, IBS with constipation, neuropathy, chronic fatigue, depression, anxiety, and poor memory and concentration. The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

On [redacted], Petitioner went to the emergency department complaining of left-sided headache, and left facial, tongue, throat and arm numbness. She received intravenous fluids, her symptoms remarkably improved, and she was discharged in no distress with a diagnosis of atypical migraine headache. (Exhibit A, pp. 233-240.)

On [redacted], Petitioner went to the emergency department complaining of substernal pressure with sharp pains and mild shortness of breath. She was transferred to another hospital for admission for a cardiology workup. (Exhibit A, pp. 241-252.)

A [redacted] stress echocardiography report indicated overall normal/negative results with a low probability of ischemia (Exhibit A, pp. 296-297).

An [redacted] cervical spine x-ray showed very minimal disc space narrowing at C4-C5 and otherwise within normal limits (Exhibit A, pp. 156-157, 258-259).

On [redacted], Petitioner saw a surgical specialist concerning difficulty eating, bloating, abdominal pain, and severe reflux disease. (Exhibit A, pp. 253-257.)

On [redacted], Petitioner went to the emergency department complaining of abdominal pain (Exhibit A, pp. 260-267).

On [redacted], Petitioner was referred for an esophagogastroduodenoscopy in response to complaints of bloating, nausea, and occasional vomiting (Exhibit A, pp. 268-271). She was diagnosed with erosive gastritis (Exhibit A, pp. 272-274).

A [redacted] pulmonary function test showed no evidence of obstructive airway disease or volume restriction. The report indicated Petitioner had some improvement in FEV1 and airway resistance post-bronchodilator therapy. (Exhibit A, pp. 147-148, 277-283.)

A [redacted] brain MRI showed nonspecific hyperintensity within the right frontal lobe (Exhibit A, pp. 139-140, 228-229).

On [redacted], Petitioner went to the emergency department complaining of pain and numbness in the bilateral upper extremities and lower extremities for the past month. She was diagnosed with acute paresthesias with unclear etiology and discharged with a referral to neurology. (Exhibit A, pp. 202-227.)

[redacted] and [redacted] neurology consults in response to tingling in both hands and feet, stiffness in the left hand, and balance issues led to a referrals for EEG (electroencephalogram) for evaluation of her memory loss and EMG (electromyogram) for evaluation of sensory neuropathy, and an LP (lumbar puncture) to rule out demyelinating disease (Exhibit A, pp. 311-316).

A [redacted] EEG was normal and did not reveal any focal, lateralized, or epileptiform abnormalities (Exhibit A, pp. 306).

A [redacted] EMG showed electrodiagnostic evidence of mild left median nerve compressive mononeuropathy at the wrist, i.e. carpal tunnel syndrome. It did not reveal any electrodiagnostic evidence of any radiculopathy in the upper extremities. (Exhibit A, pp. 307-308).

A [redacted] EMG showed electrodiagnostic evidence of an early sensory neuropathy in the lower extremities and no electrodiagnostic evidence of a radiculopathy in the lower extremities (Exhibit A, pp. 309-310).

An [redacted] visual evoked response test showed dysfunction in the visual pathways bilaterally (Exhibit A, pp. 121-122, 380).

An [redacted] cardiology transtelephonic monitoring report showed normal sinus rhythm and sinus tachycardia (Exhibit A, pp. 303-304).

A [redacted] cervical spine MRI was normal (Exhibit A, pp. 87-88, 106, 365.)

A [redacted] thoracic spine x-ray showed no acute fractures or dislocations and mild degenerative joint disease changes (Exhibit A, pp. 125-126).

A [redacted] thoracic spine MRI showed no central canal stenosis, neural foraminal narrowing, focal protrusions, or displaced fractures and maintained vertebral body heights. (Exhibit A, pp. 124, 201)

A [redacted] lumbar spine MRI showed small central disc protrusion at L5-S1, without significant central canal stenosis; facet degenerative changes at this level; and mild stenosis of the left neural foramen (Exhibit A, pp.199-200).

A [redacted] left shoulder MRI following a labral repair with orthopedic anchors at the anterosuperior glenoid was negative for labral tear/re-tear. A left shoulder arthrography showed no suggestion of a full-thickness rotator cuff tear. (Exhibit 2, pp. 4-7).

[redacted] notes from Petitioner's orthopedic doctor show that Petitioner was diagnosed with multiple sclerosis after her shoulder surgery in 2014 and she was treating herself with injections. (Exhibit A, pp. 19-21).

The medical file includes office notes from Petitioner's visits to her primary care doctor between [redacted] and [redacted], showing ongoing complaints of weakness and blurred vision (Exhibit A, pp. 127-196, 391-434). At the [redacted] visit, she complained that when her fibromyalgia flared up her pain was 10/10 and she had to take her Norco twice daily but other days her symptoms were well-controlled and she would take one or none (Exhibit A, pp. 183-187). At the [redacted] visit, she complained of fatigue, rapid heartbeat, blurred vision, and dizziness, noting that she had been recently hospitalized for these condition with no resolution (Exhibit A, pp. 177-182). At the [redacted] and [redacted] office visits, she complained of migraines and nausea, vomiting and bloating that the doctor concluded was related to her GERD. She was also treated for sinusitis. (Exhibit A, pp. 158-163, 417-422). At the [redacted] office visit, Petitioner complained of swelling of the small joints of the hands and feet, extreme fatigue, blurred vision, weakness, and some loss of coordination (Exhibit A, pp. 404-409). At the [redacted] office visit she reported an increase in discomfort from her fibromyalgia with increased activity level but tolerable with medication (Exhibit A, pp. 149-155). At the [redacted] office visit she complained of joint pain in her hands, fatigue with blurred vision, weakness and some loss of coordination. The doctor noted that MRI showed some small foci and hyperintensity in the white matter of the cerebral hemispheres, nonspecific but progressive from the previous study. (Exhibit A, pp. 141-146.) At the [redacted] office visit she complained of joint pain in her hands; the doctor noted that she was recently diagnosed with mild carpal tunnel syndrome and was wearing a wrist brace. She also complained of depression, and the doctor referred her for a psychiatric evaluation, noting that her symptoms appeared to be psychosomatic. (Exhibit A, pp. 133-138, 398-403.) At the [redacted] office visit she complained of ongoing back pain in her mid-thoracic area, a cold lasting over a month, and itching in her ear. The doctor noted tenderness on palpitation of the mid-thoracic area and lumbar-sacral area and positive straight leg raises bilaterally and noted a known history of

degenerative changes of the disc at L4-L5 and L5-S1. She was diagnosed with midline thoracic back pain, maxillary sinusitis and degeneration of lumbar or lumbosacral intervertebral disc and referred for updated lumbar and thoracic spine MRIs. (Exhibit A, pp. 127-132, 391-397.)

The medical records include office notes from Petitioner's office visits with her neurologist at [redacted] between [redacted] and [redacted] (Exhibit A, pp. 87-105, 351-362). When Petitioner went to her first visit on [redacted], she reported fatigue, numbness, tingling, memory issues, slurred speech, blurred vision, and balance problems for the preceding three months. The doctor concluded that Petitioner had myelopathic quadriparesis and clinically isolated syndrome and ordered a brain and cervical spine MRI for a diagnosis. (Exhibit A, pp. 360-362). A [redacted] brain MRI supported dissemination in space criteria for multiple sclerosis. (Exhibit A, pp. 85-86, 363-364). Petitioner's diagnosis was clinically isolated syndrome, with a finding that she met the space criteria for an MS diagnosis, but not time, with a current extended Kurtzke score of 6.5, score of 3 in the pyramidal axis, 2 in the brainstem, bowel and bladder axes, 1 in the visual axis, 0 in the cerebellar and sensory axes. On [redacted], she agreed to begin treatment with Betaseron. (Exhibit A, pp. 353-354). On [redacted], Petitioner reported a little bit of slight imbalance and no associated fatigue. The doctor noted that her Kurtzke score was 1 in the bowel and bladder axes and 0 in other axes if she could walk 500 meters. He noted rapid reversal of quadriparesis that had been going on for at least two months, probably months to years, with only a quarter dose of Betaseron once weekly and only four shots. The doctor indicated that this reflected a good prognosis for the future with the condition "most likely stopped . . . in its tracks and she will not have any other attacks." (Exhibit A, pp. 91-105, 351-352).

A discharge plan form [redacted] dated [redacted] showed that Petitioner was voluntarily discharged from the program. The discharge plan showed a diagnosis of adjustment disorder/depressed mood and a GAF (global assessment of functioning) score of 65 at admission and at discharge. (Exhibit A, pp. 76-78.)

On [redacted], Petitioner was evaluated by a psychiatrist at the Department's request, and a psychiatric report was prepared. Petitioner reported numerous physical problems, including fibromyalgia diagnosed in 2001; migraines; DDD in the neck, mid and low back with pinched nerve and bulging disc; irritable bowel syndrome; vision problems; tachycardia; high blood pressure; high cholesterol level; gastroesophageal reflux disease; hiatal hernia; diverticulosis; recently-diagnosed multiple sclerosis; hypoglycemia; asthma; Epstein-Barr syndrome; arthritis; and history of total hysterectomy. She also complained of a torn ligament in the left shoulder which had been surgically repaired in 2014 and pain in both knees, with the right knee being surgically replaced. Emotionally, she complained of depression, lack of support system, isolation, problems sleeping, poor appetite, crying spells, irritability, and having suicidal thoughts. The psychiatrist noted that Petitioner used a walker. The psychiatrist

diagnosed Petitioner with major depressive disorder with anxious distress and nicotine use disorder. He observed that Petitioner did not display any depression or anxiety during the evaluation but noted that she was on antidepressant and anti-anxiety medication. He indicated that her prognosis was guarded and she would benefit from therapeutic intervention and support services. He opined that, based on a combination of her physical and emotional problems, she would have difficulty functioning in a work situation. (Exhibit A, pp. 69a-73a).

The medical record included office notes from Petitioner's office visits with her orthopedic doctor between [redacted] and [redacted] (Exhibit A, pp. 10-18). On [redacted], Petitioner went to her orthopedic doctor, who had lasted treated her in [redacted], complaining of left shoulder pain. X-rays of the left shoulder showed joint arthritis but no other abnormalities or fractures. A spinal exam and lower extremity exam were within normal limits (Exhibit 2, pp. 10-11). Two left shoulder injections were given on [redacted] (Exhibit A, pp. 12, 19-21). On [redacted], Petitioner returned to the orthopedic doctor complaining of right knee pain and swelling beginning Saturday morning. The doctor noted right knee arthroplasty in [redacted]. The doctor observed some swelling and fluid surrounding the knee, no warmth or erythema, good knee movement, and some crepitation with flexion/extension. An x-ray showed no acute bony deformity and good placement of the prosthesis (Exhibit 2, pp. 12-16). Notes from the [redacted] office visit to the orthopedic doctor noted good resolution of the shoulder pain but ongoing complaint of right knee pain. The doctor noted that x-rays showed bony fragment of inferior patella compatible with a fracture and ligamentous laxity at the joint. The doctor recommended an arthrotomy, excision of the non-union fractured inferior pole of the patella, along with patellar tendon repair and suggested addressing additional problems found, if any, with subsequent surgeries. (Exhibit A, pp. 17-18.)

On [redacted], Petitioner's orthopedic surgeon completed a medical examination report, DHS-49, listing Petitioner's diagnoses as non-union fx (fracture) inferior patella of the right knee, instability, and laxity of ligaments. The doctor noted that Petitioner had right knee pain and swelling and used a cane for ambulation. The doctor concluded that Petitioner's condition was deteriorating. Although he did not know if Petitioner's limitations were expected to last more than 90 days, he identified the following limitations: (i) she could occasionally lift and carry 10 pounds and never lift and carry 20 pounds or more; (ii) she could sit about 6 hours in an 8-hour workday; (iii) she could use either arm or hand to grasp, reach, push/pull, fine manipulate but use only the right foot or leg to operate foot and leg controls. She needed to use a cane to ambulate but could meet her needs in the home. (Exhibit 2, pp. 1-3.)

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.

In this case, listings 1.02 (major dysfunction of a joint), 1.04 (disorders of the spine), 2.02 (loss of central visual acuity), 2.03 (contraction of the visual fields in the better eye), 2.04 (loss of visual efficiency), 5.06 (inflammatory bowel disease (IBD)), 11.14 (peripheral neuropathies), 11.09 (multiple sclerosis), 12.04 (affective disorders), and 12.06 (anxiety-related disorders) were considered.

There was no clear evidence of ongoing inability to ambulate effectively, as defined in 1.00B2b, to support a listing under 1.02. Because Petitioner's vision in the better eye even without correction is better than 20/200, Petitioner's condition does not support a listing under 2.02. There was no diagnostic testing to support a listing under 2.03 or 2.04. There is no disorganization of motor function as described in 11.04B to support a listing under 11.14.

Because there was no medical evidence of obstruction of stenotic areas in the small intestine or colon requiring hospitalization or surgery and occurring on at least two occasions at least 60 days apart within a consecutive 6-month period as described in 5.06A or lab results, physical examination, perineal disease, involuntary weight loss exceeding 10%, or a need for supplemental nutrition via a gastrostomy or a central venous catheter as described in 5.06B, Petitioner's condition does not meet either of the two listing options under 5.06.

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. In this case, Petitioner's diagnosis was clinically isolated syndrome, with a finding that she met the space criteria for an MS diagnosis, but not the time criteria. Further, the evidence presented indicated that Petitioner did not have 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. Petitioner's medical file does not support a listing under 12.04 or 12.06.

Because the 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).

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 this case, Petitioner alleges both exertional and nonexertional limitations due to her medical condition. Petitioner testified that her ability to walk, sit and stand changed depending on the day, with some days better than others. She walked using a cane, walker or wheelchair, depending on her condition that day. She could not lift more than 10 pounds. She lived alone in a second floor apartment. She was generally able to care for her personal hygiene and dress herself but made some modifications to simplify her routine. She prepared only microwave meals and relied on others to assist her with chores. She was chronically fatigued and slept up to 18 hours daily. She could sometimes drive, depending on the day.

A two-step process is applied in evaluating an individual's symptoms: (1) whether the individual has a medically determinable impairment that could reasonably be expected to produce the individual's alleged symptoms and (2) whether the individual's statement about the intensity, persistence and limiting effects of symptoms are consistent with the objective medical evidence and other evidence on the record from the individual, medical sources and nonmedical sources. SSR 16-3p.

Based on a brain MRI and visual evoked response test, Petitioner's neurologist concluded that Petitioner had clinically isolated syndrome and she filled the space

criteria for an MS diagnosis but not the time criteria. This evidence was sufficient to show that Petitioner had a medically determinable impairment that could reasonably be expected to produce her alleged symptoms of fatigue, numbness, tingling, memory issues, slurred speech, blurred vision, and balance problems. An esophagogastroduodenoscopy confirmed a diagnosis of erosive gastritis, supporting complaints of nausea. The [redacted] lumbar spine MRI showing small central disc protrusion and facet degenerative changes at L5-S1 and mild stenosis of the left neural foramen, as well as tenderness on palpitation of the mid-thoracic area and lumbar-sacral area and positive straight leg raises bilaterally noted at a [redacted] office visit, support complaints of back pain. The orthopedic doctor's diagnoses based on right knee x-ray of non-union fracture of the inferior patella of the right knee with laxity of ligaments supported Petitioner's complaints of knee pain.

The medical evidence on the record showed that Petitioner was treated with Betaseron injections beginning on [redacted]; at the [redacted] office visit, Petitioner's neurology noted a rapid reversal of quadriparesis that had been going on at least two months and indicated that this reflected a good prognosis of her future condition. Petitioner's orthopedic doctor concluded that Petitioner's knee condition was deteriorating, with a recommendation of an arthrotomy and patellar tendon repair, but could not assert that the condition would last more than 90 days. He found that she needed to use a cane to ambulate but could meet her needs in the home. While Petitioner used a cane when she went to the [redacted], [redacted] appointment with her orthopedic surgeon, the psychiatrist who evaluated Petitioner on [redacted] noted that she used a walker, supporting Petitioner's testimony that the intensity and persistence of her symptoms varied. However, overall, Petitioner's testimony, viewed in light of the medical evidence presented, supports a finding that Petitioner maintains the exertional RFC to perform sedentary work as defined by 20 CFR 416.967(a).

Petitioner also alleged nonexertional limitations due to her mental condition and blurry vision. She testified that she suffered from depression and anxiety due to her inability to do anything and isolated from others. She stated that she had participated in therapy beginning [redacted] but was looking for a new therapist. She testified that her vision was intermittently blurry, sometimes for a week at a time.

Documentation from Advantage Counseling and Educational Services showed an intake on [redacted] and voluntary discharged on [redacted]. The discharge plan showed a diagnosis of adjustment disorder/depressed mood and a GAF score of 65 at admission and at discharge. The psychiatrist who evaluated Petitioner on [redacted] at the Department's request diagnosed her with major depressive disorder with anxious distress and nicotine use disorder. This evidence shows that Petitioner has a medically determinable impairment supporting her complaints of depression and anxiety.

While the psychiatrist opined that Petitioner would have difficulty functioning in a work setting due to her combination of physical and emotion problems, the doctor observed

that, on her antidepressant and anti-anxiety medication, she did not display any depression or anxiety during the evaluation. He indicated that Petitioner would benefit from therapeutic intervention and support services. The record does not reflect that Petitioner had pursued any significant treatment for her mental condition. Based on the record presented, it is found that Petitioner has mild limitations on her mental ability to perform basic work activities.

With respect to her vision, office notes from Petitioner's visits to her doctors show that Petitioner complained of blurry vision. However, Petitioner's notes from her visits with her neurologist show that, from [redacted] to [redacted], her vision was no worse than 25/20 bilaterally. The neurologist identified a Kurtzke score of 0 or 1 in the visual axes. The Kurtzke Expanded Disability Status Scale measures the disability status of people with MS. A score of 1.0 evidence minimal signs in the functional system. http://www.nationalmssociety.org/For-Professionals/Researchers/Resources-for-Researchers/Clinical-Study-Measures/Functional-Systems-Scores-(FSS)-and-Expanded-Disab. Based on the evidence presented, Petitioner has mild limitations on her ability to perform basic work activities due to her vision issues.

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 deli counter worker; health care aide at a nursing home, and certified nursing assistant. All these jobs required standing almost all of the day. Work as a deli counter worker, which required lifting 20 pounds regularly and up to 50 pounds, required medium physical exertion. Her work as a health care aide and certified nursing assistant, which required lifting up to 40 pound regularly up to 100 pounds, required heavy physical exertion.

Based on the RFC analysis above, Petitioner's exertional RFC limits her sedentary work activities. As such, Petitioner is incapable of performing past relevant work based on her current exertional RFC. Because Petitioner is unable to perform past relevant work, she 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 the time of application and [redacted] years old at the time of hearing, and, thus, considered to be a younger individual (age [redacted]) for purposes of Appendix 2. She is a high school graduate with a history of unskilled work experience. 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. Based solely on her exertional RFC, the Medical-Vocational Guidelines result in a finding that Petitioner is not disabled. Petitioner also has a nonexertional RFC that results in mild limitations in her ability to perform basic work activities due to her mental condition and due to vision issues. It is found that those limitations would not preclude her from engaging in simple, unskilled work activities on a sustained basis. Therefore, based on her RFC and age, education, and work experience, Petitioner can adjust to other work. Therefore, 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

DHHS

[redacted]

Petitioner

[redacted]

Via Email:

[redacted]