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: December 22, 2016
MAHS Docket No.: 16-016607
[redacted]

ADMINISTRATIVE LAW JUDGE: Vicki Armstrong

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 - 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on December 7, 2016, from Lansing, Michigan. Petitioner personally appeared and testified. Petitioner submitted Exhibit A (1-32 pages) and Exhibit B (1-49 pages). Exhibits A and B were admitted into evidence.

The Department of Health and Human Services (Department) was represented by Assistance Payment Supervisor [redacted] and Assistance Payment Worker [redacted] and [redacted] testified on behalf of the Department. The Department submitted [redacted] exhibits which were admitted into evidence. The record was closed at the conclusion of the hearing.

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) On September 16, 2016, Petitioner filed an application for SDA benefits alleging disability.

(2) On October 12, 2016, the Medical Review Team (MRT) denied Petitioner's application for SDA. [Dept. Exh. 10-16].

(3) On October 17, 2016, the Department sent Petitioner notice that her SDA application was denied. [Dept. Exh. 5-].

(4) On November 1, 2016, Petitioner submitted a Request for Hearing to contest the Department's negative action.

(5) Petitioner alleges disability based on high cholesterol, status post two heart attacks, fibromyalgia, methicillin-resistant staphylococcus aureus (MRSA), chronic pain and a compromised immune system.

(6) On [redacted], Petitioner underwent an uneventful esophagogastroduodenoscopy. She was found to have an antral ulcer. A biopsy was performed and Petitioner was discharged home. The biopsy tested negative for H. Pylori. [Dept. Exh. 532-534].

(7) On [redacted], Petitioner's bilateral renal ultrasound revealed a right renal cyst, non-obstructing calculi seen on the CT study but not evidenced on the ultrasound. No evidence of hydronephrosis was observed. [Dept. Exh. 339].

(8) On [redacted], Petitioner was diagnosed with non-familial hypogammaglobulinemia. [Dept. Exh. 230].

(9) On [redacted], Petitioner was evaluated by an urologist concerning her hematuria. The urologist reassured Petitioner that her bladder was normal. That the low-grade microscopic hematuria could be related to her 2mm non-obstructive left renal calculus or from a small amount of blood that passes through her glomeruli. The urologist concluded that no further evaluation was necessary because Petitioner stated it had been present for at least [redacted] years. [Dept. Exh. 220-223].

(10) On [redacted], Petitioner presented to her cardiologist and was diagnosed with coronary artery disease status post percutaneous coronary angioplasty and an abnormal coronary angiogram. [Dept. Exh. 233-238].

(11) On [redacted], Petitioner underwent a CT of the thorax without contrast. No significant acute or chronic lung disease was found. Coronary artery calcification was redemonstrated. Some multilevel spurring in the spine was seen. [Dept. Exh. 337].

(12) On [redacted], Petitioner underwent a transthoracic echocardiogram. The study found the left ventricle was normal with an estimated ejection fraction of 55%. The right ventricle was also normal. The mitral valve was structurally normal with trivial regurgitation. The aortic valve was normal with no significant regurgitation. The tricuspid valve revealed mild regurgitation. Petitioner also underwent a nuclear stress and rest myocardial scan. The left ventricular ejection fraction was normal at 73%. There was a small fixed defect at the anteroseptal wall which was probably due to scarring from an old myocardial infarction. Petitioner had average exercise tolerance. There was a positive EKG part of the exercise stress test and positive symptoms with chest pain. [Dept. Exh. 334-335; 475-479].

(13) On [redacted], Petitioner underwent a nasal endoscopy. The endoscopy found no erythema or purulent discharge bilaterally. There was moderate diffuse edema throughout the nose. [Dept. Exh. 243-247].

(14) On [redacted], Petitioner was evaluated by an ear, nose and throat specialist. The specialist opined that Petitioner had a complicated medical history with overlapping medical problems, each of which could be responsible for many of the symptoms she complained about. Petitioner's issues included headaches with atypical facial pain, temporomandibular joint disorder (TMJ) dysfunction, allergic rhinitis and recurrent upper and lower respiratory tract infections, and nasopharyngitis vs. sinusitis. The physician reviewed recent lab reports in addition to recent CT scans of the paranasal sinuses. The sinus CT scan performed on May 29, 2015, was within normal limits. There was very mild mucosal thickening in the left maxillary sinus on January 16, 2015. The physician opined that Petitioner most likely suffered from intermittent infections and the majority of her symptoms were likely attributable to migraine variant headaches with atypical facial pain. Exacerbating factors included rhinitis, stress and TMJ issues. There was no evidence of infection at the time of the consultation. [Dept. Exh. 238-242].

(15) On [redacted], Petitioner saw her cardiologist for follow-up. Petitioner was post percutaneous transluminal coronary angioplasty (PTCA) and stent. Petitioner told her cardiologist that she was doing better and her pain had improved. She had no chest discomfort suggestive of ischemia. She had not had palpitations, syncope or near syncope. She denied claudication. There was no discoloration or ulceration of the lower extremities. She had no transient ischemic attack (TIA) or stroke-like symptoms. Petitioner was diagnosed with atherosclerotic heart disease of the native coronary artery without angina pectoris and multivessel coronary artery disease. The cardiologist opined that Petitioner would be on chronic medical therapy. [Dept. Exh. 254-255].

(16) On [redacted], Petitioner had a rheumatology consult. The rheumatologist noted Petitioner was healthy appearing and in no acute distress. She was ambulating normally. The rheumatologist opined that Petitioner had generalized symptoms suggestive of fibromyalgia and he would be running a complete connective tissue disease panel. [Dept. Exh. 248-253].

(17) On [redacted], Petitioner followed up with her rheumatologist. The rheumatologist reviewed the lab results with Petitioner and reassured her that he had found no evidence of rheumatoid arthritis. From the standpoint of the rheumatologist, Petitioner did not have any obvious autoimmune disease. [Dept. Exh. 256-271].

(18) On [redacted], Petitioner underwent a nuclear medicine bone scan. There was increased activity in the trochanteric region of both hips that could reflect bursitis. [Dept. Exh. 333].

(19) On [redacted], Petitioner was evaluated for recurrent pneumonia. She was diagnosed with recurrent pneumonia possibly contributed by non-familial hypogammaglobulinemia, chronic persistent asthma, coronary artery disease, dyslipidemia and hypertension. [Dept. Exh. 272-274].

(20) On [redacted], Petitioner's chest x-ray was revealed the heart, lungs and osseous thorax to be normal with no significant change from 2015. [Dept. Exh. 326].

(21) On [redacted], Petitioner saw her primary care physician complaining of chronic shortness of breath, wheezing, and a cough with mild wheezing. Petitioner's primary medical history listed hematuria syndrome, kidney cyst, generalized anxiety disorder, obesity, chronic obstructive pulmonary disease (COPD), osteoarthritis, immunodeficiencies disorder, rheumatoid arthritis, rhinitis, hypogammaglobulinemia, hypercholesterolemia, essential hypertension, headache, myalgia, myositis, peptic ulcer of stomach, coronary artery disease, old myocardial infarction, dysthymia and pure hyperglyceridemia. Petitioner was diagnosed with exacerbation of COPD, MRSA purulent tracheobronchitis vs colonization, persistent mild asthma controlled well with nebulizers, history of recurrent pneumonias, mild non-familial-IgG hypogammaglobinemia not approved for monthly IgG therapy, coronary artery disease with a history of stents, myocardial infarction, and hypertension. [Petitioner Exh. A, pp 13-14].

(22) On [redacted], Petitioner followed up with her allergy and asthma specialist. Petitioner had a sinus culture completed which was ordered by her primary care physician and was positive for heavy growth of MRSA. She was diagnosed with moderate persistent asthma, perennial allergic rhinitis, non-familial hypogammaglobulinemia and chronic sinusitis. [Dept. Exh. 310-315].

(23) On [redacted], Petitioner saw her cardiologist complaining of chronic fatigue and infection. Petitioner stated that over the past two months she has remained largely in bed due to her severe fatigue. She had been placed on multiple courses of oral antibiotics and steroids for presumptive sinusitis without interval improvement. Petitioner provided the cardiologist volumes of laboratory and imaging studies. There was a consistent mild depression of IgG subclass 1 with a significant response to vaccine challenge. Petitioner had been followed by immunology and had been told that IVIG was not indicated. The cardiologist noted that Petitioner had a myriad of complaints including fatigue, an inability to perform her daily activities of living due to profound weakness, and complaints of recurrent sinus infections with refractory to prolonged courses of oral antibiotic therapy. The cardiologist opined that her symptoms were unlikely related to an infectious process or IgG deficiency. The cardiologist suggested that Petitioner may benefit from an evaluation at University of Michigan Medical Center for chronic fatigue. [Dept. Exh. 318-320].

(24) On [redacted], Petitioner's thyroid ultrasound revealed right and left lobe thyroid nodules. [Petitioner's Exh. 26].

(25) On [redacted], Petitioner saw her primary care physician complaining of recent worsening shortness of breath, wheezing and cough. The physician indicated that Petitioner was in no distress. Congestion was noted with mild wheezing and increased expiration time. No rales, rhonchi or crackles. Petitioner was diagnosed with exacerbation of COPD and acute asthma. [Petitioner Exh. 15-17].

(26) On [redacted], Petitioner underwent fine needle aspiration cytology of the lateral left lobe of the thyroid gland. It was a non-diagnostic study because there were too few follicular cells for proper cytologic evaluation. [Petitioner Exh. 24].

(27) Petitioner is a [redacted]-year-old woman born on [redacted]. She is [redacted]" tall and weighs [redacted] lbs. She completed high school and last worked in [redacted] as a secretary.

(28) Petitioner was appealing the denial of Social Security disability benefits at the time of the hearing.

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.

Current legislative amendments to the Act delineate eligibility criteria as implemented by department policy set forth in program manuals. 2004 PA 344, Sec. 604, establishes the State Disability Assistance program. It reads in part:

> Sec. 604 (1). The department shall operate a state disability assistance program. Except as provided in subsection (3), persons eligible for this program shall include needy citizens of the United States or aliens exempt from the Supplemental Security Income citizenship requirement who are at least 18 years of age or emancipated minors meeting one or more of the following requirements:
>
> (b) A person with a physical or mental impairment which meets federal SSI disability standards, except that the minimum duration of the disability shall be 90 days. Substance abuse alone is not defined as a basis for eligibility.

Specifically, this Act provides minimal cash assistance to individuals with some type of severe, temporary disability which prevents him or her from engaging in substantial gainful work activity for at least ninety (90) days.

A person is disabled for SDA purposes if he or she:

- Receives other specified disability-related benefits or services, see Other Benefits or Services below, or
- Resides in a qualified Special Living Arrangement facility, or

- Is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability.

- Is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS), see Medical Certification of Disability. BEM 261, pp 1-2 (7/1/2014).

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 (90 days for SDA). 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 an 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).

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability. 20 CFR 416.927(e).

As outlined above, the first step looks at the individual's current work activity. In the record presented, Petitioner is not involved in substantial gainful activity and testified that she has not worked in six years. Therefore, she is not disqualified from receiving disability benefits under Step 1.

The severity of the individual's alleged impairment(s) is considered under Step 2. The individual 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

6. 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).

In the present case, Petitioner alleges disability due to high cholesterol, status post two heart attacks, fibromyalgia, MRSA, chronic pain and a compromised immune system.

As previously noted, Petitioner bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, Petitioner has presented some medical evidence establishing that she does have some physical limitations on her ability to perform basic work activities, based on her asthma diagnosis. The medical evidence has established that Petitioner has an impairment, or combination thereof, that has more than a *de minimis* effect on Petitioner's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, 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 individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. Petitioner has alleged high cholesterol, status post two heart attacks, fibromyalgia, MRSA, chronic pain and a compromised immune system.

Petitioner has the burden of establishing her disability. The record evidence was insufficient to meet a listing. While there was evidence of asthma, MRSA and non-familial hypogammaglobulinemia, there was no evidence that her asthma was severe enough to meet a listing. Therefore, the analysis continues to Step 4.

Before considering step four of the sequential evaluation process, the Administrative Law Judge must first determine the petitioner's residual functional capacity. (20 CFR 404.1520(e) and 416.920(e)). An individual's residual functional capacity is his/her ability to do physical and mental work activities on a sustained basis despite limitations from his/her impairments. In making this finding, all of the petitioner's impairments, including impairments that are not severe, must be considered. (20 CFR 404.1520(e), 404.1545, 416.920(e), and 416.945; SSR 96-8p).

Based on the record evidence, Petitioner has the residual functional capacity to perform sedentary work as defined in 20 CFR 404.1567(a). In making this finding, the Administrative Law Judge considered all Petitioner's symptoms and the extent to which

these symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence.

Petitioner testified that she had high cholesterol, status post two heart attacks, fibromyalgia, MRSA, chronic pain and a compromised immune system. She said she had been in bed for the past six years. Petitioner also stated that due to her chronic pain, compromised immune system and her diagnosis of non-familial-IgG hypogammaglobinemia for which her insurance company would not pay to have treated, it was attacking her body and bones.

The record evidence indicated that Petitioner had an uneventful esophagogastroduodenoscopy in July, 2015, and the biopsy tested negative for H. Pylori. She had a bilateral renal ultrasound in September, 2015, which showed a non-obstructing calculi, although it could not be seen on the ultrasound. There was no evidence of hydronephrosis. She was evaluated in November, 2015 for hematuria. She was assured her bladder was normal and that the low-grade microscopic hematuria could be related to her 2mm non-obstructive left renal calculus or from a small amount of blood that passes through her glomeruli, but no further evaluation was necessary because it had been present for over [redacted] years.

In December, 2015, Petitioner had a CT of the thorax that showed no significant acute or chronic lung disease. She also underwent a transthoracic echocardiogram that showed the left and right ventricles were normal. It also revealed trivial regurgitation in the mitral valve which was structurally normal and mild regurgitation in the tricuspid valve. The nuclear stress test and myocardial scan revealed the left ventricular ejection fraction was normal. There was a small fixed defect at the anteroseptal wall which was probably due to scarring from an old myocardial infarction.

In January, 2016, Petitioner underwent a nasal endoscopy that showed no erythema or purulent discharge bilaterally. She did have moderate diffuse swelling throughout the nose.

In February, 2016, the ear, nose, and throat specialist opined that Petitioner had a complicated medical history with overlapping medical problems, each of which could be responsible for many of the symptoms she complained about. Petitioner's issues included headaches with atypical facial pain, TMJ dysfunction, allergic rhinitis and recurrent upper and lower respiratory tract infections, nasopharyngitis vs. sinusitis. The physician opined that Petitioner most likely suffers from intermittent infections, the majority of her symptoms were likely attributable to migraine variant headaches with atypical facial pain. Exacerbating factors included rhinitis, stress and TMJ issues. She also saw her cardiologist where she reported that she was doing better and her pain had improved. She had no chest discomfort suggestive of ischemia. Petitioner was diagnosed with atherosclerotic heart disease of the native coronary artery without angina pectoris and multivessel coronary artery disease. The cardiologist opined that Petitioner would be on chronic medical therapy. She saw her Rheumatologist who

noted that Petitioner was healthy appearing and in no acute distress. She was ambulating normally and had generalized symptoms suggestive of fibromyalgia.

In March, 2016, Petitioner followed up with her Rheumatologist who assured her that she did not have rheumatoid arthritis or any other obvious autoimmune diseases. A bone scan revealed increased activity in the trochanteric region of both hips that could reflect bursitis.

In July, 2016, Petitioner's chest x-ray was revealed the heart, lungs and osseous thorax to be normal with no significant change from 2015. She also saw her primary care physician complaining of chronic shortness of breath, wheezing, a cough and mild wheezing. Her physician found that her persistent mild asthma was well controlled with nebulizers. On July 20, 2016, she was diagnosed with MRSA.

In August, 2016, Petitioner saw her cardiologist complaining of chronic fatigue and infection causing her to remain largely bedridden for the past two months. The cardiologist noted that Petitioner has a myriad of complaints including fatigue, inability to perform her daily activities of living due to profound weakness, and complaints of recurrent sinus infections refractory to prolonged courses of oral antibiotic therapy. The cardiologist opined that her symptoms were unlikely related to an infectious process or non-familial-IgG hypogammaglobinemia deficiency. The cardiologist suggested that Petitioner may benefit from an evaluation at University of Michigan Medical Center for chronic fatigue.

In September, 2016, Petitioner's thyroid ultrasound revealed right and left lobe thyroid nodules. In November, 2016, Petitioner underwent fine needle aspiration cytology of the lateral left lobe of the thyroid gland. It was a non-diagnostic study because there were too few follicular cells for proper cytologic evaluation.

After considering the evidence of record, the Administrative Law Judge finds that Petitioner's medically determinable impairments could reasonably be expected to produce the alleged symptoms, and that the Petitioner's statements concerning the intensity, persistence and limiting effects of these symptoms are partially credible.

Next, the Administrative Law Judge must determine at step four whether the petitioner has the residual functional capacity to perform the requirements of her past relevant work. (20 CFR 404.1520(f) and 416.920(f)). The term past relevant work means work performed (either as the petitioner actually performed it or as it is generally performed in the national economy) within the last [redacted] years or [redacted] years prior to the date that disability must be established. In addition, the work must have lasted long enough for the petitioner to learn to do the job and have been substantial gainful activity (SGA). (20 CFR 404.1560(b), 404.1565, 416.960(b), and 416.965). If the petitioner has the residual functional capacity to do her past relevant work, the petitioner is not disabled. If the petitioner is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth and last step.

Petitioner's past relevant employment was as a secretary. The demands of the Petitioner's past relevant work do not exceed the residual functional capacity. As a result, Petitioner is not disabled. If Petitioner had not been found disabled at this step, the analysis would have continued to Step 5.

At the last step of the sequential evaluation process (20 CFR 404.1520(g) and 416.920(g)), the Administrative Law Judge must determine whether the Petitioner is able to do any other work considering his/her residual functional capacity, age, education, and work experience. If the Petitioner is able to do other work, he/she is not disabled. If the Petitioner is not able to do other work and meets the duration requirements, he/she is disabled.

To determine the physical demands (exertional requirements) of work in the national economy, we classify jobs as sedentary, light, medium and heavy. These terms have the same meaning as they have in the *Dictionary of Occupational Titles*, published by the Department of Labor. 20 CFR 416.967. Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. 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 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. 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. If someone can do medium work, we determine that he or she can also do sedentary and light work. 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. If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work. 20 CFR 416.967(d).

At Step 5, the burden of proof shifts to the Department to establish that Petitioner does have residual function capacity. The residual functional capacity is what an individual can do despite limitations. All impairments will be considered in addition to ability to meet certain demands of jobs in the national economy. Physical demands, mental demands, sensory requirements and other functions will be evaluated. See discussion at Step 2 above.

In this case, Petitioner alleged high cholesterol, status post two heart attacks, fibromyalgia, MRSA, chronic pain and a compromised immune system.

Since July, 2015, Petitioner has been to her cardiologist, rheumatologist, and an ear, nose and throat specialist. The cardiologist opined that her symptoms were unlikely related to an infectious process or non-familial-IgG hypogammaglobinemia deficiency. Her Rheumatologist who assured her that she did not have rheumatoid arthritis or any

other obvious autoimmune diseases. The ear, nose and throat specialist opined that Petitioner most likely suffered from intermittent infections and the majority of her symptoms were likely attributable to migraine variant headaches with atypical facial pain.

Further, Petitioner told her cardiologist that she was doing better and her pain had improved. She had no chest discomfort suggestive of ischemia. Her rheumatologist noted that Petitioner was healthy appearing and in no acute distress and she was ambulating normally. Her primary care physician indicated that Petitioner's persistent mild asthma was well-controlled with nebulizers.

Petitioner underwent multiple tests of the bladder, heart, lungs, osseous thorax, left and right ventricles, aortic valve, mitral valve, left ventricular ejection fraction, and sinuses and all were normal. The CT of the thorax showed no significant acute or chronic lung disease. An esophagogastroduodenoscopy tested negative for H. Pylori. A bilateral renal ultrasound showed no evidence of hydronephrosis and lab test found no evidence of rheumatoid arthritis.

The multiple tests did reveal an antral ulcer, a right renal cyst, non-familial hypogammaglobulinemia, a 2mm non-obstructive left renal calculus, coronary artery disease status post percutaneous coronary angioplasty and an abnormal coronary angiogram, some multilevel spurring in the spine, trivial regurgitation in the mitral valve, mild regurgitation in the tricuspid valve, a small fixed defect at the anteroseptal wall probably due to scarring from an old myocardial infarction, generalized symptoms suggestive of fibromyalgia, possible bursitis, exacerbation of COPD, and MRSA.

As indicated above, no doctor supported Petitioner's testimony regarding her symptoms or indicated that Petitioner was unable to work.

Petitioner credibly testified that she could walk a block or two, stand for 15 minutes, carry 10-20 pounds and sit for an hour before being in pain.

Therefore, this Administrative Law Judge finds that the objective medical evidence on the record does establish that Petitioner has the residual functional capacity to perform other work. Petitioner is disqualified from receiving disability at Step 5 based upon the fact that she has not established by objective medical evidence that she cannot perform sedentary work. Under the Medical-Vocational guidelines, an individual aged 45 – 49 (Petitioner is 48 years of age), with a high school education and an unskilled or limited work history who can perform even only sedentary work is not considered disabled pursuant to Medical-Vocational Rule 201.23.

Petitioner has not presented the required competent, material, and substantial evidence which would support a finding that Petitioner has an impairment or combination of impairments which would significantly limit the physical or mental ability to do basic work activities. 20 CFR 416.920(c). Although Petitioner has cited medical problems, the clinical documentation submitted by Petitioner is not sufficient to establish a finding that Petitioner is disabled. There is no objective medical evidence to substantiate

Petitioner's claim that the alleged impairment(s) are severe enough to reach the criteria and definition of disabled.

The Department's Bridges Eligibility Manual contains the following policy statements and instructions for caseworkers regarding the State Disability Assistance program: to receive State Disability Assistance, a person must be disabled, caring for a disabled person or age 65 or older. BEM, Item 261, p. 1. Because Petitioner does not meet the definition of disabled and because the evidence of record does not establish that Petitioner is unable to work for a period exceeding 90 days, the Petitioner does not meet the disability criteria for State Disability Assistance benefits.

The Department has established by the necessary competent, material and substantial evidence on the record that it was acting in compliance with department policy when it determined that Petitioner was not eligible to receive State Disability Assistance.

DECISION AND ORDER

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.

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

[redacted]

Vicki Armstrong
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]

[redacted]