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: June 10, 2016
MAHS Docket No.: 16-004519
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, an in-person hearing was held on May 19, 2016, from Mt. Clemens, Michigan. Petitioner appeared and represented herself. [redacted], her friend and neighbor, testified on her behalf. The Department of Health and Human Services (Department) was represented by [redacted], Hearing Facilitator.

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 September 14, 2015, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On February 26, 2016, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 2-8).

3. On March 3, 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. 133-136).

4. On April 11, 2016, the Department received Petitioner's timely written request for hearing.

5. Petitioner alleged disabling impairment due to cervical whiplash, herniated disc, sciatic nerve injury, neuropathy, radiculopathy, dizziness, migraines, chronic pain, shortness of breath, traumatic brain injury, Post-Traumatic Stress Disorder (PTSD), and anxiety. .

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 completed the [redacted] grade and has some difficulties with reading, writing, and basic math.

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

9. Petitioner has an employment history of work as a housecleaner and a clerical worker at a mortgage company.

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 cervical whiplash, herniated disc, sciatic nerve injury, neuropathy, radiculopathy, Meniere's disease, dizziness, migraines, chronic pain, shortness of breath, traumatic brain injury, PTSD, and anxiety. The medical evidence presented at the hearing was reviewed and is summarized below.

On April 17, 2011, Petitioner was involved in a motor vehicle accident. After the accident, she reported short term memory loss, dizziness, blurred vision, cervical whiplash, and low back pain with radiculopathy on the left. A June 7, 2011 x ray of the cervical spine was normal and of the lumbosacral spine showed dextroscoliosis and degenerative disc disease (Exhibit 1, p. 208). The doctor noted that the MRI of the cervical spine showed two tiny disc herniation without significant pressure on the spinal cord or nerve root, the MRI of the lumbar spine showed disc herniation at L5-S1 with no spinal stenosis but with mild impingement upon the neural foramen bilaterally, and the EMG nerve studies were abnormal for left L5-S1 radiculopathy. (Exhibit 1, pp. 145-146, 148-150, 152-153, 154-155.) A June 6, 2011 MRI of the brain following Petitioner's complaints of headaches showed no evidence of intracranial hemorrhage, mass lesion or apparent acute infarct but did show three very small focal lesions in the juxta-cortical deep white matter near the vertex at the right parietal lobe of uncertain significance but appeared to account for left body numbness (Exhibit 1, pp. 147, 150). A July 20, 2011 electroencephalogram was normal, and it was noted that several dizzy spells noted in a diary were without EEG or EKG accompaniments (Exhibit 1, pp. 206-207). A September 19, 2011 video-nystagmography (video ENG) showed no significant central vestibular dysfunction but showed significant central vestibular dysfunction with recommendation of balance rehabilitation targeting the abnormality (Exhibit 1, pp. 161-171).

On August 15, 2011, Petitioner participated in a neuropsychological evaluation by [redacted], a licensed psychologist, at the request of Petitioner's neurologist, [redacted]. Petitioner was referred to [redacted] with a diagnosis of a postconcussive syndrome sustained in the April 2011 motor vehicle accident and the evaluation was ordered to assess Petitioner's cognitive and emotional status as related to that injury. Petitioner complained of burning, numbness and tingling in her entire left

side, decreased range of motion with the left upper extremity with pain extending to the shoulder and neck, decreased use of the dominant left hand, dizziness, blurred vision, frequent headaches, forgetfulness, anxiety, and depression. [redacted] concluded that Petitioner's history surrounding the accident was clearly suggestive of traumatic brain injury. The doctor noted that, while Petitioner did not appear to clearly attempt to exaggerate or feign deficits, her suboptimal performance on measures of motivation and cooperation suggested that the severity of her cognitive impairment in the current evaluation should be interpreted cautiously. The doctor believed that Petitioner's extreme emotional and physical pain resulting from the motor vehicle accident may have interfered with her ability to reliably engage in testing and likely adversely affected her ability to function in her everyday living and exacerbated her experience of cognitive function and physical discomfort in her everyday living. [redacted] diagnosed Petitioner with postconcussive syndrome, adjustment disorder with anxiety, and pain disorder associated with psychological features and general medical condition. (Exhibit 1, pp. 211-219.)

On October 6, 2011, Petitioner participated in a neuropsychological evaluation by a [redacted], a licensed psychologist, which was requested by a third party in connection with the accident. In a report prepared on October 17, 2011, the psychologist concluded that [redacted] evaluation did not support a finding that Petitioner had suffered a traumatic brain injury as a result of the April 2011 car accident. Instead, he diagnosed her with a primary diagnosis of borderline intellectual functioning and a secondary diagnosis of mathematics disorder and undifferentiated somatoform disorder. He also noted that her recent memory was normal. (Exhibit A, pp. 172-182.) [redacted] completed a supplemental neuropsychological report after reviewing Petitioner's June 6, 2011 brain MRI and indicating that the MRI results did not change his opinion other than to conclude that the significance of the brain MRI lesions was overstated by [redacted] (Exhibit A, p. 185).

In April 12, 2012 office visit notes, [redacted] responded to [redacted] evaluation, noting that he had not diagnosed or treated traumatic brain injury patients in the last [redacted] years and that Petitioner's neurological signs and right perinatal lobe finding was consistent with her left sided weakness, left-sided hyperreflexia, and sensory symptoms on the left side as well as her weakened left hand grip. (Exhibit 1, p. 194.)

An August 13, 2014 lumbar spine MRI showed moderate diffuse disc bulge at L4-L5 with mild to moderate facet hypertrophy resulting in mild to moderate bilateral neural foramina stenosis; moderate disc height loss and desiccation; and moderate degenerative endplate spurring and endplate degenerative marrow changes (Exhibit 1, pp. 119-120). An August 21, 2014 EMG nerve study confirmed right L5 radiculopathy and noted that previous testing had shown similar findings on the left side, both appearing to be related to the post-motor vehicle accident changes at L4-5 (Exhibit 1, pp. 121-126).

Beginning July 10, 2014, Petitioner participated in physical therapy. Her medical records show ongoing participation in physical therapy from January 2015 through May 2015. She reinitiated treatment on July 10, 2015, when it was noted that her cervical, bilateral hip, and bilateral knee ranges of motion were within functional limits in all planes but her lumbar range of motion was limited: flexion to 40° with complaints of significant tightness, extension to 5°, bilateral rotation to 20°, and bilateral side bending to 10°, all with significant complaints of lumbar pain. She reported no significant changes in her symptoms as of September 14, 2015 after completing eight sessions. (Exhibit A, pp. 31-96, 107-113.)

A November 2, 2015 quantitative electroencephalogram (QEEG) was performed by a psychologist/psychotherapist after Petitioner complained of additional medical and psychological difficulties including dramatic mood swings, depression and anxiety, migraines, memory loss, attention deficit disorder (ADD), and difficulty with reading comprehension. In the report prepared in connection with the QEEG, the psychologist stated that the results supported Petitioner's lack of focus; difficulty with executive functions; instability; dysregulation; aphasia; memory loss; and difficulty with motor control and sleep. Diagnostic impressions included lack of coordination; major depressive disorder, single episode, unspecified; apraxia; attention-deficit hyperactivity disorder, unspecified type; insomnia; headache; mood disorder; narcolepsy with cataplexy. (Exhibit 1, pp. 127-144; Exhibit 2, pp. 3-36.)

On December 18, 2015, Petitioner was examined by an independent medical examiner at the Department's request. The doctor noted that Petitioner reported traumatic brain injury and low back pain and left leg pain following an April 2011 motor vehicle accident. She complained of dizziness, head injury, blurred vision, problems with balance and falling, shortness of breath, chest pain, nausea, tremors and weakness, and hearing loss. The doctor found that Petitioner was positive for Meniere's disease. Her JAMAR grip strength was 53 pounds on the right and 17 pounds on the left. Her right sensory and vibration perception was decreased in the upper and lower limbs. The doctor observed that Petitioner's cervical spine range of motion was within normal limits with complaints of pain and lumbar spine range of motion was as follows: flexion was 0 to 30° (normal is 0 to 90°), extension was 0 to 5° (normal is 0 to 25°), right lateral flexion was 0 to 10° (normal is 0 to 25°), and left lateral flexion was 0 to 5° (normal is 0 to 25°). Her range of motion of the right shoulder, and both elbows, wrists, and hands was within normal limits; her range of motion of the left shoulder was limited with pain as follows: abduction was 0 to 70° (normal is 0 to 150°), internal rotation was 0 to 45° (normal is 0 to 80°), external rotation was 0 to 45° (normal is 0 to 90°), and forward elevation was 0 to 80° (normal is 0 to 150°). The doctor observed that Petitioner was able to bear weight with pain, ambulate without a cane but with a slow gait and antalgic on the left. The doctor concluded that Petitioner had complex chronic upper and lower back pain syndrome and weakness more on the left upper and lower limbs with left upper limb strength at 4/5 and left lower limb strength at 3/5, with a history of April 2011 motor vehicle accident; bilateral shoulder pains with left rotator cuff impingement syndrome; upper and lower limb joints pains without deformity; Phalen's positive on the

left; and right sensory and vibration perception decreased in the upper and lower limbs with no right foot sensory but discordant left sensory and vibration perception from head to toes equivocal; and eye tracking causing dizzy response. The doctor concluded that Petitioner's limitations were mild-moderate to moderate, especially with standing and bending mobility. (Exhibit A, pp. 116-123.)

In an April 25, 2016 letter, Petitioner's neurologist stated that Petitioner was being treated for the following conditions: costochondritis, delayed sleep phase syndrome, insomnia, pseudobulbar affect, headaches, traumatic brain injury, dyspraxia, apraxia, adult attention deficit disorder (ADD), neuralgia, lumbago, intervertebral disc disorder with myelopathy, and depression. The doctor opined that Petitioner's conditions were lifetime and incurable and rendered her permanently disabled. (Exhibit 1, p. 1.)

In May 3, 2016 letter, Petitioner's psychologist/psychotherapist stated he had treated Petitioner since November 2, 2015 and that, due to her medical complications following the motor vehicle accident, she was totally disabled for life and unable to work. Among the diagnoses listed were insomnia, pseudobulbar affect, major depressive disorder single episode, attention deficit hyperactivity disorder, lack of coordination, traumatic brain injury, right knee pain, neuralgia, lumbago, benign paroxysmal positional vertigo, and intervertebral disc disorder with myelopathy. (Exhibit 2, pp. 1-2.)

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 1.02 (major dysfunction of a joint), 1.04 (disorders of the spine), 2.07 (disturbance of labyrinthine-vestibular function), 11.18 (cerebral trauma), 12.06 (anxiety-related disorders), and 12.07 (somatoform disorders) were considered. 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. Therefore, 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 she could walk no more than one block and needed to wear a back brace, sit no more than 20 minutes, and stand no more than 20 minutes. She could lift with her right hand, but not with her left. She lived alone in a second-floor apartment. She could bathe and dress herself but had some difficulties because of her left sided weakness. She was able to cook and do some housekeeping with assistance from her neighbor and some family and could do light shopping. She could drive, but only when necessary. Petitioner testified that she also had difficulty with comprehension, concentration and memory, and she suffered from crying spells, anger issues, mood swings, and anxiety attacks. She testified that her pain medication and psychiatric medications helped her condition. Her neighbor and friend observed that Petitioner's pain was worse some days than others and she had periods where she was distant.

The medical evidence showed that, after her April 2011 motor vehicle accident, Petitioner had a lumbar spine MRI that showed disc herniation at L5-S1 with mild impingement upon the neural foreman bilaterally and abnormal EMG nerve studies for left L5-S1 radiculopathy. A June 2011 brain MRI showed 3 very small focal lesions of uncertain significance. A September 2011 video ENG showed significant central vestibular dysfunction. Although there was a medical dispute concerning whether Petitioner suffered a traumatic brain injury as a consequence of the 2011 accident, Petitioner's medical record shows ongoing physical complaints. An August 13, 2014 lumbar spine MRI showed moderate diffuse disc bulge at L4-L5 with mild to moderate facet hypertrophy resulting in mild to moderate bilateral neural foramina stenosis; moderate disc height loss and desiccation; and moderate degenerative endplate spurring and endplate degenerative marrow changes. An August 21, 2014 EMG nerve study confirmed right L5 radiculopathy. A November 2, 2015 QEEG supported diagnoses of lack of coordination; major depressive disorder, single episode, unspecified; apraxia; attention-deficit hyperactivity disorder, unspecified type; insomnia; headache; mood disorder; narcolepsy with cataplexy.

In his December 18, 2015 examination, the independent medical examiner observed significant limitations in Petitioner's lumbar spine range of motion and her left shoulder.

He also noted that her JAMAR grip strength was 53 pounds on the right and 17 pounds on the left. Her right sensory and vibration perception was decreased in the upper and lower limbs. The doctor found no evidence of cerebellar ataxia but concluded that Petitioner, who complained of hearing problems, was positive for Meniere's disease; had complex chronic upper and lower back pain syndrome and weakness more on the left upper and lower limbs with left upper limb strength at 4/5 and left lower limb strength at 3/5; had bilateral shoulder pains with left rotator cuff impingement syndrome; had upper and lower limb joints pains; had Phalen's positive on the left; had a dizzy response to tracking; and had right sensory and vibration perception decreased in the upper and lower limbs with no right foot sensory.

Although the independent medical examiner doctor concluded that Petitioner's limitations were mild-moderate to moderate, especially with standing and bending mobility, her treating neurologist since 2011 opined that Petitioner's conditions were lifetime and incurable and rendered her permanently disabled. While the treating physician's opinion of disability is not dispositive, as Petitioner's treating physician for 5 years and in light of his specialty in neurology, his opinion is afforded considerable weight. SSR 96-6p; SSR 6-03p.

With respect to Petitioner's exertional limitations, it is found based on a review of the entire record that Petitioner, with her significant limitations in her lumbar spine and left shoulder range of motion, weakened strength in her upper and lower limbs, her decreased grip strength in her left hand, her decreased right-side sensory and vibration perception in the upper and lower limbs, and her dizziness, maintains the physical capacity to perform less than sedentary work as defined by 20 CFR 416.967(a).

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 housecleaner and a clerical worker at a mortgage company. Petitioner's past relevant work as a cleaner, which required standing all day and lifting up to 20 pounds regularly, involved light work. Her past relevant work as a clerical worker, which required limited standing and weightlifting, involved sedentary work.

Based on the RFC analysis above, Petitioner's exertional RFC limits her to less than sedentary work activities. Accordingly, Petitioner is unable to do any of her past relevant work. 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 [redacted]) for purposes of Appendix 2. Petitioner's education is limited to completing the [redacted] grade. Her employment history involves unskilled work. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform less than sedentary work. In this case, the Medical-Vocational Guidelines, Appendix 2 do not support a finding that Petitioner is not disabled based on his exertional limitations. The Department has failed to counter with evidence of significant numbers of jobs in the national economy which Petitioner could perform despite her limitations. Therefore, the Department has failed to establish that, based on her RFC and age, education, and work experience, Petitioner can adjust to other work. Therefore, Petitioner is 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 **disabled** for purposes of the SDA benefit program.

DECISION AND ORDER

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

THE DEPARTMENT IS ORDERED TO BEGIN DOING THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE OF MAILING OF THIS DECISION AND ORDER:

1. Reregister and process Petitioner's September 14, 2015 SDA application to determine if all the other non-medical criteria are satisfied and notify Petitioner of its determination;

2. Supplement Petitioner for lost benefits, if any, that Petitioner was entitled to receive if otherwise eligible and qualified;

3. Review Petitioner's continued eligibility in December 2016.

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]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]