RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

[redacted] Mailed: February 10, 2017
MAHS Docket No.: 16-018294
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Eric J. Feldman

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 January 12, 2017, from Detroit, Michigan. Petitioner was represented by her Authorized Hearing Representative (AHR)/spouse, [redacted]; Petitioner was also present at the proceeding and provided testimony. The Department of Health and Human Services (Department) was represented by [redacted] Hearings Facilitator.

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the Medical Assistance (MA-P) 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. Petitioner was an ongoing recipient of the Healthy Michigan Plan (HMP) benefits.

2. During the period in which Petitioner received HMP coverage, she also submitted an application for State Disability Assistance (SDA) coverage on December 7, 2015. Exhibit C, p. 1.

3. On or about December 8, 2015, the Department sent the medical packet to the Disability Determination Service (DDS)/Medical Review Team (MRT) for not only a disability determination of SDA benefits, but also for a MA-P determination, while she was receiving HMP coverage. Exhibit A, p. 27.

4. On September 6, 2016, DDS/MRT found Petitioner not disabled for purposes of MA-P and SDA. Exhibit A, pp. 32-33.

5. On December 2, 2016, the Department sent Petitioner a Health Care Coverage Determination Notice indicating that she was not eligible for HMP coverage due to excess income and that she was not disabled effective January 1, 2017. Exhibit A, pp. 6-7.

6. On December 12, 2016, the AHR filed a timely hearing request, disputing the determination that she was not disabled for purposes of MA-P. Exhibit A, pp. 2-5.

7. Petitioner alleged disabling impairment due to migraines, high blood pressure, chest pain with moderate risk for cardiac etiology, anxiety disorder, elevated white blood cell count, low blood potassium, heart attack, acute chest pain, high cholesterol or triglycerides, heart disease due to blocked artery, cigarette smoker, family history of coronary artery disease, adverse drug reaction, heart problem, Raynaud's disease, spinning disease, inoperable cyst on the brain, nerve damage, panic attacks, and arthritis in the knees.

8. At the time of hearing, Petitioner was 48 years old with a date of birth of [redacted]; she was 5'8" in height and weighed 130 pounds.

9. Petitioner is a high school graduate and also had one year of vocational training as a certified administrative specialist from a business school.

10. At the time of the MA-P disability determination, Petitioner was not employed.

11. Petitioner has an employment history of work as a machine operator, quality clerk, and retail manager.

12. Per the credible testimony of the AHR, Petitioner has a pending request for a Supplemental Security Income (SSI) Appeals Council review with the Social Security Administration (SSA).

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 Medical Assistance (MA-P) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the

Department of Human Services) administers the MA-P program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

Preliminary matter

On September 6, 2016, DDS/MRT found Petitioner not disabled for purposes of SDA benefits as well. Exhibit A, pp. 32-33. On September 13, 2016, the Department sent Petitioner a Notice of Case Action denying Petitioner's SDA application based on DDS/MRT's finding of no disability effective January 1, 2017. Exhibit A, pp. 612-615. The AHR/Petitioner only requested a hearing to dispute the MA-P denial and not the SDA denial. Exhibit A, pp. 2-5. Further, the undersigned Administrative Law Judge (ALJ) lacks the jurisdiction to address the denial of SDA benefits. See BAM 600 (October 2016), pp. 1-6. As such, the undersigned ALJ will only address whether the Department properly determined if Petitioner was not disabled for purposes of the MA-P program.

MA-P program

MA-P benefits are available to disabled individuals. BEM 105 (October 2016), p. 1; and BEM 260 (July 2015), pp. 1-4. Disability for MA-P purposes is defined as the inability to do any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a). To meet this standard, a client must satisfy the requirements for eligibility for Supplemental Security Income (SSI) receipt under Title XVI of the Social Security Act. 20 CFR 416.901.

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

As outlined above, the first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

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

Step Two

Under Step 2, the severity of an individual's alleged impairment(s) is considered. If the individual does not have a severe medically determinable physical or mental impairment that meets the duration requirement, or a combination of impairments that is severe and meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for MA-P 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 12 months. 20 CFR 416.922.

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 migraines, high blood pressure, chest pain with moderate risk for cardiac etiology, anxiety disorder, elevated white blood cell count, low blood potassium, heart attack, acute chest pain,

high cholesterol or triglycerides, heart disease due to blocked artery, cigarette smoker, family history of coronary artery disease, adverse drug reaction, heart problem, Raynaud's disease, spinning disease, inoperable cyst on the brain, nerve damage, panic attacks, and arthritis in the knees. The medical evidence presented at the hearing was reviewed and is summarized below.

Progress Notes by Petitioner's Physician Assistant (PA) from [redacted] to [redacted], and [redacted], assessed her with migraine headache (HA), anxiety, hypertension, laryngitis, back pain, tension HA, chest pain/abnormal Electrocardiogram (EKG or ECG), ST elevation myocardial infarction (STEMI), and headaches. Exhibit A, pp. 471-475 and 482-483.

Provider Notes dated [redacted], which the doctor concluded STEMI and unspecified artery (HCC). Exhibit A, pp. 475-477.

On [redacted], Petitioner had a cardiovascular catheterization procedure. Exhibit A, pp. 504-505.

On [redacted], Petitioner had an ECG 12 performed, which showed that following results: (i) normal sinus rhythm; (ii) ST elevation, consider inferior or acute infarct – acute myocardial infarction (MI) / STEMI; and (iii) an abnormal ECG. Exhibit A, pp. 508-510.

On [redacted], Petitioner had an echocardiogram (Echo), which showed (i) ejection fraction is estimated to be 60% in the range of 55-60%, normal left ventricular (LV) ejection fraction; (ii) LV cavity size is normal, LV wall thickness is moderately increased; (iii) normal LV filling pressures; (iv) spectral doppler shows normal pattern of LV diastolic filling; (v) normal right ventricular size and normal global right ventricular (RV) systolic function; and (vi) there is no evidence of pericardial effusion. Exhibit A, pp. 510-511.

On [redacted], Petitioner was discharged from the hospital, but also had a cardiovascular catheterization procedure that took place with the following results: (i) LV angiography: left ventricular ejection fraction (LVEF) 50-55%, mild hypokinesis of the inferior wall, global left ventricular systolic function was mildly reduced; (ii) coronary angiography: insignificant, non-obstructive coronary artery disease; and (iii) there was mild haziness near origin of second OM, no significant coronary lesion or small side branch. Exhibit A, pp. 477-482 and 529-532.

From [redacted] to [redacted], there were provider notes from Petitioner's doctors, which showed that she was diagnosed with other chest pain, check/back pain, and that a Ccath revealed no significant coronary artery disease (CAD) with normal LVF, no evidence of myocardial ischemia, hypertension (HTN) - blood pressure (BP) is adequately controlled on current meds, and gastroesophageal reflux disease (GERD) - continue zantac bid. Exhibit A, pp. 483-487.

On [redacted], Petitioner was admitted to the hospital and discharged on [redacted]. Exhibit A, pp. 488. The doctor's diagnosed Petitioner with hypertension, headache, dysthymia, anxiety. Exhibit A, p. 490.

On [redacted], Petitioner had chest x-ray, which showed minimal left basilar atelectasis, lungs and pleural spaces are clear, heart is not enlarged, intact bones, and the doctor's impression was no acute process. Exhibit A, pp. 514-515.

On [redacted], Petitioner had an echocardiogram, which reported: (i) ejection fraction is estimated to be 60% in the range of 60 – 65%, normal LV ejection fraction: (ii) normal right ventricular size and normal global RV systolic function; (iii) mild redundancy of the anterior greater than posterior mitral leaflet; (iv) mild aortic valve sclerosis; and (v) no evidence of pericardial effusion. Exhibit A, pp. 516-517.

On [redacted], Petitioner had a x-ray, which showed mild atherosclerotic changes of the infrarenal aorta and iliac arteries, no aneurysm, stenosis, dissection or pulmonary interval is some, mild stigmata and chronic obstructive pulmonary disease (COPD). Exhibit A, pp. 518-520.

Progress notes by Petitioner's PA/doctors from [redacted] to [redacted], to show Petitioner was assessed her with chest pain, musculoskeletal, resolved, ingrown toenail, left great toe, contraceptive counseling, hyperlipidemia, urinary tract infection (UTI), influenza prophylaxis, body mass index (BMI) 21.0-21.9 adult, midline thoracic back pain, midline low back pain without sciatica, coronary arteriosclerosis in native artery, essential hypertension, eczema, unspecified eczema, ankle right injury, persistent ankle pain, and leg weakness. Exhibit A, pp. 496-503.

On [redacted], Petitioner had a screening mammography bilateral, which showed benign findings. Exhibit A, pp. 520-522.

On [redacted], Petitioner had an office visit for an initial cardiovascular consultation. Exhibit A, p. 570. The doctor's impression and plan for Petitioner as a result of the visit was as follows: (i) coronary artery disease involving native coronary artery of native heart with unstable angina pectoris; (ii) non-ST segment elevation myocardial infarction (NSTEMI), secondary to OM; (iii) prinzmetal's angina; (iv) Raynaud's disease; (v) medication side effect, initial encounter; (vi) hyperlipidemia; (vii) cigarette smoke; and (viii) family history of premature CAD. Exhibit A, p. 572.

On [redacted], Petitioner had a myocardial perfusion imaging completed, which the doctor indicated the following impressions: (i) resting ECG; (ii) normal hemodynamic response to lexiscan infusion; (iii) no significant arrhythmia; (iv) a large fixed inferolateral defect with small reversible component at the periphery, and (v) inferior wall thinning and akinesis with an estimated ejection fraction of 50%. Exhibit A, pp. 583-586.

On [redacted], Petitioner had a thoracic spine x-ray, which showed stable mild degenerative changes involving the lower thoracic spine. Exhibit A, pp. 523-524.

On [redacted], Petitioner had two ECGs, which showed normal ECGs. Exhibit A, pp. 542-543 and 597-604.

On [redacted], Petitioner was admitted to the hospital for a left heart catheterization, coronary angiography, and percutaneous transluminal coronary angioplasty (PTCA) and stent placement of the third obtuse marginal vessel. Exhibit A, p. 556. On [redacted], Petitioner was discharged and the impressions of Petitioner's procedures was acute Class III anginal symptoms with good medical regiment and a stent placed in the third obtuse marginal vessel. Exhibit A, p. 558. It appears there was a follow-up with a doctor for a cardiology progress note on [redacted], which recommended continued treatments. Exhibit A, pp. 567-569.

Progress notes by Petitioner's PA from [redacted] to [redacted], which assessed Petitioner with persistent ankle pain, leg weakness, and lower back pain (LBP) with radiculopathy. Exhibit A, pp. 456-457.

On [redacted], a doctor completed a letter indicating Petitioner is under the doctor's care for cardiovascular concerns. Exhibit A, p. 380. The doctor noted Petitioner has a history of coronary artery disease, she underwent successful coronary stenting on [redacted] of her third obtuse marginal vessel, and she has residual disease of 40% stenosis in her proximal left anterior descending artery as well as 30% in her proximal right coronary artery. Exhibit A, p. 380.

On [redacted], Petitioner had a magnetic resonance imaging (MRI) lumber spine w/wo contract and the doctor's impression was (i) mild sacral dural ectasia, this may relate to patient's presentation; (ii) minimal facet arthropathy; and (iii) no disc protrusion or spinal stenosis. Exhibit A, pp. 459-460.

In a progress note dated [redacted], the doctor notified Petitioner that her MRI shows some changes in the spine and need to see an orthopedic doctor for further evaluation. Exhibit A, p. 458.

In a progress note by Petitioner's PA dated [redacted], the PA assessed Petitioner with ankle pain, right, and migraine HA. Exhibit A, p. 458.

On [redacted], Petitioner had an exam of the ankle right 2 view and the doctor's impression was no acute osseous abnormality. Exhibit A, p. 461.

On [redacted], Petitioner had a psychiatric evaluation at the Department's request and diagnosing her with (i) persistent depressive disorder (dysthymia); (ii) rule out

depressive disorder due to medical conditions (migraine cluster headaches and myocardial infraction); and (iii) her prognosis was fair to guarded. Exhibit A, p. 467. The doctor noted Petitioner (i) presents negative past psychiatric illnesses and interview; (ii) the patient seemed anxious and worried; (iii) patient seemed to be concerned/worried in regard to other aspects of her medical conditions, such as severity of migraine; (iv) the patient appeared preoccupied with cognitive impairment, difficulty remaining focused, and concentrate; and (v) she did not seem to perform her assignments with perseverance. Exhibit A, pp. 464-467.

On [redacted], Petitioner had an office visit with her PA complaining of back pain and the PA diagnosed her visit with former smoker - primary, body mass index (BMI) 19 or less, adult, and positive depression screening. Exhibit 2, p. 4.

On [redacted], Petitioner was examined by a doctor at the Department's request for an internal medicine examination (consultative examination (CE)). Exhibit A, p. 368. The doctor noted that Petitioner reported a disability due to heart disease, migraine, cyst on the brain, musculoskeletal (MSK), and Raynaud's disease. Exhibit A, p. 368. The doctor concluded that Petitioner had (i) hypertension; (ii) coronary artery disease; (iii) migraine headache; (iv) low back pain; and (v) Raynaud's disease. Exhibit A, p. 370. The doctor noted the following: (i) Petitioner's blood pressure is within normal limits; (ii) chest pain is atypical in character and comes only when she has severe anxiety or panic attack; (iii) no signs of congestive heart failure; (iv) no neck vein distension, heart murmur, gallop, pulmonary rales, visceromegaly or leg edema; (v) she has no orthopnea or paroxysmal nocturnal dyspnea; (vi) cranial nerves II-XII are within normal limits; (vii) deep tendon reflexes are symmetrical; (viii) she has photophobia and phonophobia; (ix) the strength in all four extremities is 5/5; (x) back has no paraspinal spasm or tenderness; (xi) straight leg raising was negative on both sides; (xii) she carries a cane, but she can walk without it; and (xiii) while standing she was able to bend down with flexion of 0-80 degrees, extension of 0-25, and lateral flexion on both sides of 0-25 degrees. Exhibit A, pp. 370-375.

On [redacted], Petitioner's PA completed a letter indicating that Petitioner has an extensive medical history of cardiac disease, including hypertension, NSTEMI, Prinzmetal angina and coronary artery disease, history of chronic back pain, migraine headache, Reynaud's disease, anxiety, and hyperlipidemia. Exhibit 1, p. 4. The PA stated Petitioner is unable to work because of these conditions and that she is on multiple medications to control these illnesses. Exhibit 1, p. 4. The PA includes a list Petitioner's medication as of [redacted]. Exhibit 1, pp. 6-11.

On [redacted], Petitioner had an office visit with her PA complaining of back pain and the PA diagnoses her visit with back pain - primary, blood pressure check, former smoker, body mass index between 19-24 (adult), coronary artery disease involving heart, angina presence unspecified, unspecified vessel or lesion type, high blood pressure, anxiety problem, and high cholesterol or triglycerides. Exhibit 1, p. 2.

On [redacted], Petitioner's PA completed a letter indicating that Petitioner is taking medication that abruptly stopping could lead to nausea, vomiting, seizure, and increased risk for heart attack. Exhibit 1, p. 1.

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 12 months. 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 of whether 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 1.04 (disorders of the spine), 3.09 (chronic pulmonary hypertension due to any cause), 4.04 (ischemic heart disease), 12.04 (affective disorders), 12.06 (anxiety-related disorders), and 14.04 (systemic sclerosis) (scleroderma)) 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 addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of mental functional limitation. 20 CFR 416.920a(c)(3). The degree

of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. *Id.* The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. *Id.*

In this case, Petitioner alleges both exertional and nonexertional limitations due to her medical condition. Petitioner indicated that she has extensive medical history of cardiac disease. She also claimed a history of back pain, and Raynaud's disease. She can't stand, sit, or lay down for a long time. She needs assistance getting out of bed and doing chores. She testified she can lift a maximum of 10 pounds, she can stand 15 to 20 minutes, and she can sit for 15 to 20 minutes. She is able to dress/undress herself, bathe/shower, but needs assistance in preparing meals or grocery shopping. She can walk up to 300 yards/less than a block and can lift no more than a gallon of milk. She indicated that she suffers from migraine headaches, anxiety attacks, and depression. She can't concentrate, she is overwhelmed, and can't work with others due to anxiety.

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.

On [redacted], Petitioner's PA completed a letter indicating that Petitioner has an extensive medical history of cardiac disease, including hypertension, NSTEMI, Prinzmetal angina and coronary artery disease, history of chronic back pain, Reynaud's disease, and hyperlipidemia. Exhibit 1, p. 4. In an independent consultative internal medicine examination, she was diagnosed with hypertension, coronary artery disease, migraine headache, low back pain, and Raynaud's disease. Exhibit A, p. 370. An MRI of her lumbar spine showed sacral dural ectasia, this may relate to patient's presentation, but minimal facet arthropathy and no disc protrusion or spinal stenosis. Exhibit A, p. 460. This evidence was sufficient to support Petitioner's allegations of cardiac disease and back and hand pain.

On [redacted], Petitioner's PA also indicated that she suffers from anxiety and migraine headache. In an independent consultative mental status examination, she was diagnosed with persistent depressive disorder (dysthymia). Exhibit A, p. 467. Moreover, the independent consultative internal medicine examination also stated she was diagnosed migraine headache. Exhibit A, p. 370. Therefore, Petitioner also has a medical diagnosis supporting her symptoms of depression and migraine headache.

With respect to the intensity, persistence and limiting effects of her symptoms, the medical evidence included consultative independent physical and mental status examinations, as well as reports from Petitioner's visits with her doctors/PA. The doctor

who performed the consultative internal medical examination requested by the Department found, based on his examination, that Petitioner had no signs of congestive heart failure and her blood pressure is within normal limits and she had a full range of motions (strength in all four extremities is 5/5) and while standing she was able to bend down with flexion of 0-80 degrees, extension of 0-25, and lateral flexion on both sides of 0-25 degrees. Exhibit A, pp. 370-375. But, Petitioner's PA and doctors indicates a history of cardiac disease, chronic back pain, migraine headache, and Reynaud's disease. Exhibit 2, p. 1 and Exhibit A, p. 572. On December 16, 2015, Petitioner was discharged from the hospital after having a stent placed in the third obtuse marginal vessel and being diagnosed with an acute Class III anginal symptoms with good medical regiment. Exhibit A, p. 558. Another doctor confirmed that Petitioner has a history of coronary artery disease and she was under his care after the successful coronary stenting. Exhibit A, p. 380. On May 19, 2015, a cardiovascular catheterization took place and she was found to have (i) LV angiography: LVEF 50-55%, mild hypokinesis of the inferior wall, global left ventricular systolic function was mildly reduced; (ii) coronary angiography: insignificant, non-obstructive coronary artery disease; and (iii) there was mild haziness near origin of second OM, no significant coronary lesion or small side branch. Exhibit A, pp. 477-482 and 529-532. Petitioner also has an extensive history of visits with her doctors/PA diagnosing her with ankle pain, leg weakness, and lower back pain. Exhibit A, pp. 456-458 and 471-539.

Based on foregoing information, the undersigned ALJ finds that the medical records are consistent with Petitioner's allegations of coronary artery disease and back and hand pain. The opinion by Petitioner's PA, is not medical evidence, but supports Petitioner's allegation that she has a history of cardiac disease and hand and back pain and that she unable to work due to these conditions. See Exhibit 2, p. 1. Moreover, Petitioner's extensive visits with her doctor(s)/PA also show that she has limitations based on her history of coronary artery disease and back and hand pain. Exhibit A, pp. 456-458 and 471-539. This evidence, including Petitioner's testimony, was sufficient to establish that Petitioner's coronary artery disease and back and hand pain limited her to sedentary work as defined by 20 CFR 416.967(a).

The independent psychiatrist who evaluated Petitioner on [redacted] diagnosed her with persistent disorder (dysthymia) and ruled out depressive disorder due to medical conditions (migraine cluster headaches and myocardial infraction). Exhibit A, p. 467. The doctor noted Petitioner presents negative past psychiatric illnesses and interview, the patient seemed anxious and worries, she seemed to be concerned/worried in regard to other aspects of her medical conditions, such as severity of migraine, she appeared preoccupied with cognitive impairment, difficulty remaining focused and concentrating, and she did not seem to perform her assignments with perseverance. Exhibit A, pp. 464-467. Moreover, the evidence record established that Petitioner has a history of migraines as diagnosed by the independent consultative independent physical examination, the opinion of her PA, and her extensive doctor/PA visits. Exhibit A, p. 370, 456-458, and 471-539.

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild limitations to her activities of daily living; mild limitations to her social functioning; and mild to moderate limitations to her concentration, persistence or pace.

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 by Petitioner (as actually performed by Petitioner or as generally performed in the national economy) 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) and (2). 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 machine operator, quality clerk, and store manager. Petitioner's work as a machine operator and quality clerk, which required standing substantially all day and lifting up to 50 pounds regularly, required medium physical exertion. Her work as a store manager, as described by Petitioner, required standing substantially all day and lifting up to 40 pounds regularly, which again, required medium physical exertion.

Based on the RFC analysis above, Petitioner is limited to no more than sedentary work activities and has mild to moderate limitations in her mental capacity to perform basic work activities. In light of the entire record and Petitioner's RFC, including her mental limitations, it is found that Petitioner is unable to perform past relevant work. Accordingly, Petitioner cannot be found disabled, or not disabled, at Step 4 and the assessment continues to Step 5.

Step 5

If an individual is incapable of performing past relevant work, Step 5 requires an assessment of the individual's RFC and age, education, and work experience to determine whether an adjustment to other work can be made. 20 CFR 416.920(a)(4)(v); 20 CFR 416.920(c). If the individual can adjust to other work, then there is no disability; if the individual cannot adjust to other work, then there is a disability. 20 CFR 416.920(a)(4)(v).

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(c)(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 48 years old at the time of hearing, and, thus, considered to be a younger individual (age 45-49) for purposes of Appendix 2. She is a high school graduate with one-year of vocational training and a history of skilled 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 on Petitioner's age, education, work experience, and exertional RFC, the Medical-Vocational Guidelines result in a finding that Petitioner is not disabled based on her exertional limitations.

While the Medical-Vocational Guidelines do not result in a disability finding based on Petitioner's exertional limitations, Petitioner medical record also shows nonexertional limitations resulting in mild limitations to her activities of daily living; mild limitations to her social functioning; and mild to moderate limitations to her concentration, persistence or pace. It is found that these nonexertional limitations would not preclude Petitioner from being able to adjust to other work. After review of the entire record, including Petitioner's testimony, and in consideration of Petitioner's age, education, work experience, physical as well as mental RFC, Petitioner is found not disabled at Step 5 for purposes of the MA-P benefit program.

Accordingly, Petitioner is found not disabled for purposes of the MA-P program.

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 MA-P program.

Accordingly, the Department's MA-P determination is **AFFIRMED**.

EF/tm

Eric J. Feldman
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

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cc: [redacted]