STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]
MI [redacted]

Date Mailed: March 27, 2017
MAHS Docket No.: 17-001115
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, a telephone hearing was held on March 1, 2017, from Detroit, Michigan. The Petitioner was present for the hearing and her sister/witness, [redacted] was also present for the hearing. The Department of Health and Human Services (Department) was represented by Gwen Steward, Hearings Facilitator.

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit programs?

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 [redacted] 2016, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On October 19, 2016, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program. Exhibit A, pp. 12-18.

3. On October 25, 2016, the Department sent Petitioner a Notice of Case Action denying the application effective July 1, 2016, based on DDS/MRT's finding of no disability. Exhibit A, pp. 4-7.

4. On January 20, 2017, the Department received Petitioner's timely written request for hearing. Exhibit A, p. 2.

5. Petitioner alleged disabling impairments due multiple sclerosis (MS), hand pain, feet and lower leg numbness, pancreatitis, anxiety and depression.

6. On the date of the hearing, Petitioner was 49 years old with a date of birth of [redacted] 1967; she was 5'7" in height and weighed 180 pounds.

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

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

9. Petitioner has an employment history of work as a licensed optician.

10. Petitioner has a pending appeal for a disability claim with the Social Security Administration.

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.

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the de minimis standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs v Bowen*, 880 F2d 860, 862-863 (CA 6, 1988), citing *Farris v Sec of Health and Human Services*, 773 F2d 85, 90 n.1 (CA 6, 1985). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. SSR 85-28. If such a finding is not clearly established by medical evidence or if the effect of an impairment or combination of impairments on the individual's ability to do basic work activities cannot be clearly determined, adjudication must continue through the sequential evaluation process. *Id.;* SSR 96-3p.

In the present case, Petitioner alleges disabling impairments due to MS, hand pain, feet and lower leg numbness, pancreatitis, anxiety and depression. The medical evidence presented at the hearing was reviewed and is summarized below.

In an internal medical examination of Petitioner dated [redacted] 2015, the doctor diagnosed Petitioner with paresthesias, possible small fiber neuropathy, electromyogram (EMG) normal; suspected peripheral vertigo, prior magnetic resonance imaging (MRI) with no central etiology; and tremor and myoclonus, improved, likely related to elevated liver function tests (LFTs). Exhibit A, pp. 222-224.

On [redacted] 2015, Petitioner was admitted to the hospital for abdominal pain, nausea, and vomiting. Exhibit A, pp. 87 and 100. A magnetic resonance cholangiopancreatography (MRCP) was performed on Petitioner, which resulted in no filling defect in the biliary ductal system to suggest choledocholithiasis, the biliary tree measures 7 mm which is borderline prominent for age group, the pancreatic duct is normal in caliber, there is prominent diffuse fatty infiltration throughout the liver. Exhibit A, p. 158. There was an ultrasound of her gallbladder as well, which found mild layering, nonmobile sludge again noted at the gallbladder fundus, there may be a few tiny echogenic gallstones, no gallbladder wall thickening or distention, no dilated biliary ducts are noted; and steatosis of the liver without focal liver mass or enlargement.

Exhibit A, pp. 96-97. Petitioner was discharged on [redacted], 2015 and diagnosed with acute abdominal pain, alcohol-induced acute pancreatitis, and elevated LFTs. Exhibit A, p. 106.

Petitioner completed a detoxification and residential treatment from [redacted], 2015 to [redacted] 2016. Exhibit A, p. 209. There was a Master Treatment Plan dated on or about [redacted] 2015 of the Petitioner, in which the doctor preliminary diagnosed Petitioner with alcohol use disorder, severe; sedative use disorder, severe; tobacco use disorder, severe; depressive disorder; acid reflux, MS pancreatitis, fatty liver; and a Global Assessment of Functioning (GAF) score of 45. Exhibit A, p. 212. On [redacted] 2016, the Licensed Professional Counselor (LPC) completed a Summary of Services indicating her mental health issues were identified during the course of treatment as mild/moderate, diagnosed with alcohol disorder, severe; sedative use disorder severe; tobacco use disorder, severe; depressive disorder; anxiety disorder; acid reflux, MS, pancreatitis, fatty liver; and she was admitted to the mental health services with a GAF score of 45, but at the time of her discharge, had a GAF of 52 and her prognosis was good. Exhibit A, p. 210. Also, a History and Physical was completed by the doctor on or about [redacted] 2016, in which it was indicated past medical/surgical history of MA and depression; her mental health status is improving, but she has mood swings, and her neurological is unsteady, and her abdomen described as tender hepatomegaly. Exhibit A, p. 211.

On [redacted] 2016, Petitioner was admitted into a 21-day residential treatment stay with [redacted] and discharged from treatment on [redacted] 2016. Exhibit A, p. 160. The records also included a physical exam of Petitioner by a doctor on [redacted] 2016. Exhibit A, p. 188.

In an intake assessment form dated [redacted] 2016, the therapist diagnosed her with alcohol use disorder and pancreatitis. Exhibit A, pp. 53-55.

In progress notes dated from [redacted] 2016 to [redacted] 2016, Petitioner's LPC indicated she had major depressive disorder, recurrent, severe without psychotic features; moderate episode of recurrent major depressive disorder; generalized anxiety disorder; alcohol dependence in early full remission; MS; occupation problems, current GAF of 35 to 40; and highest GAF in the last 12 months of 50 to 60. Exhibit A, pp. 74-75.

On [redacted] 2016, Petitioner had a consultative psychiatric evaluation diagnosing her with bipolar disorder, mixed type; alcohol dependence in early full recovery; and borderline personality disorder. Exhibit A, pp. 46-49. The doctor wrote that Petitioner shows no signs to act out in self-destructive behaviors or isolating and socially withdrawing, she shows no signs of thought disorder or psychosis, but has longstanding problems with affect modulation. Exhibit A, p. 48. The doctor noted with treatment and medications there is no psychological reason she cannot work, but, sobriety and treatment compliance are the key factors to her being able to function and work. Exhibit A, p. 48.

In a progress note dated [redacted] 2017, Petitioner's Certified Nurse Practitioner (CNP) indicated Petitioner has severe episode of recurrent major depressive disorder with psychotic features, generalized anxiety disorder, alcohol use disorder, rule/out (r/o) bipolar affective disorder (BPAD) secondary to MS, MS, history of gastric bypass, other psychosocial or environmental problems, current GAF of 50, and highest in the last 12 months was 60. Exhibit 1, pp. 1-5.

On February 27, 2017, Petitioner's CNP wrote a letter indicating Petitioner has severe episode of recurrent major depressive disorder with psychotic features and indicated she is unable to work due to her current symptoms. Exhibit 1, p. 1.

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step Three

Step 3 of the sequential analysis of a disability claim requires a determination if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920(a)(4)(iii). If an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

Based on the medical evidence presented in this case, listings 1.02 (major dysfunction of a joint(s) (due to any cause)), 1.04 (disorders of the spine), 11.09 (multiple sclerosis), 12.04 (affective disorders), and 12.06 (anxiety-related 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 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 alleges disabling impairments due to MS, hand pain, feet and lower leg numbness, pancreatitis, anxiety and depression. She testified she can lift a gallon of milk. She can stand for 15 to 20 minutes before her legs get numb. She can sit unlimited periods of time. She can walk for about 25 to 30 minutes. She is limited in using her hands. She is able to dress/undress herself, bathe/shower, but needs assistance in preparing meals. She indicated that she suffers from depression and anxiety. She can't concentrate or work with others and she is only able to complete tasks or follow instructions if they are written down by her sister. She cries all of the time and she has difficulty in making decisions. She is always blocked and that is the best way she can describe it. She testified that she was admitted to rehabilitation facility due to her alcohol abuse in [redacted] of 2016 and has been sober since then. The sister testified that she needs help to take care of Petitioner.

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] 2015, Petitioner was admitted to the hospital for abdominal pain, nausea, and vomiting. Exhibit A, pp. 87 and 100. Petitioner was discharged on [redacted] 2015 and diagnosed with acute abdominal pain, alcohol-induced acute pancreatitis, and elevated LFTs. Exhibit A, p. 106. In a medical examination of Petitioner dated [redacted] 2015, the doctor diagnosed Petitioner with paresthesias, possible small fiber neuropathy, EMG normal; suspected peripheral vertigo, prior MRI with no central etiology; and tremor and myoclonus, improved, likely related to elevated LFTs. Exhibit A, pp. 222-224. Also, in a Master Treatment Plan dated [redacted] 2015, the doctor's preliminary assessment diagnosed Petitioner with MS, pancreatitis, fatty liver, and another doctor acknowledged she has a history of MS. Exhibit A, pp.

211-212. This evidence was sufficient to support Petitioner's allegation of pancreatitis, MS, and hand, feet, and leg numbness/pain.

In the Master Treatment Plan dated on or about [redacted] 2015, the doctor also preliminary diagnosed Petitioner with alcohol use disorder, severe; sedative use disorder, severe; tobacco use disorder, severe; depressive disorder; and a GAF score of 45. Exhibit A, p. 212. In progress notes dated [redacted] 2016 to [redacted] 2016, Petitioner's LPC indicated she had major depressive disorder, recurrent, severe without psychotic features; moderate episode of recurrent major depressive disorder; generalized anxiety disorder; alcohol dependence in early full remission; MS; occupation problems, current GAF of 35 to 40; and highest GAF in the last 12 months of 50 to 60. Exhibit A, pp. 74-75. On [redacted] 2016, Petitioner had a psychiatric evaluation diagnosing her with bipolar disorder, mixed type; alcohol dependence in early full recovery; and borderline disorder. Exhibit A, pp. 46-49. Therefore, Petitioner also has a medical diagnosis supporting her symptoms of depression and anxiety.

With respect to the intensity, persistence and limiting effects of her symptoms, the medical evidence included Petitioner's hospitalization record in which she was diagnosed with acute abdominal pain, alcohol-induced acute pancreatitis, and elevated LFTs. Exhibit A, p. 106. Furthermore, Petitioner had a medical examination report dated [redacted] 2015, in which he diagnosed Petitioner with paresthesias. Exhibit A, pp. 222-224. The doctor noted that she was doing better and would continue on the medication. Exhibit A, p. 223. And finally, on February 27, 2017, Petitioner's CNP wrote a letter indicating Petitioner has severe episode of recurrent major depressive disorder with psychotic features and indicated she is unable to work due to her current symptoms. Exhibit 1, p. 1. Petitioner stated she can't stand for a long time, yet she said she can walk for about 25 to 30 minutes a time. She stated she can't use her hands because they get numb, which is the reason why she left her prior employment. Petitioner testified that she could only lift up to 1 pound as a licensed optician because of her MS. There was medical evidence presented showing her doctor preliminary diagnosing her with MS an [redacted] 2015 and a medical report confirming that she has paresthesian, which supports her argument of hand pain, feet and lower leg numbness. Exhibit A, p. 223. Finally, Petitioner testified that her current hobby is crocheting and does it for 2 hours a day.

Accordingly, the undersigned Administrative Law Judge (ALJ) finds that based on a review of the entire record, including Petitioner's testimony and the fact that she is able to walk 25-30 minutes at a time and that she uses her hands for 2 hours a day to crochet, the evidence was sufficient to establish that Petitioner maintains the physical capacity to sedentary work as defined by 20 CFR 416.967(a).

With respect to Petitioner's nonexertional limitations, Petitioner was preliminary diagnosed by a doctor in [redacted] of 2015 with depressive disorder and a GAF score of 45. Exhibit A, p. 212. In progress notes dated [redacted] 2016 to [redacted] 2016, Petitioner's LPC indicated she had major depressive disorder, recurrent, severe without

psychotic features; moderate episode of recurrent major depressive disorder; generalized anxiety disorder; alcohol dependence in early full remission; MS; occupation problems, current GAF of 35 to 40; highest GAF in the last 12 months of 50 to 60, she is unable to work; and her prognosis is good. Exhibit A, pp. 74-75. Of note, Petitioner's GAF score of 35 occurred right after she completed her rehabilitation program in [redacted] of 2016. The medical records from Petitioner's LPN show that she was only treated by him for less than 2 months. Petitioner also provided medical records from her CNP dated as of [redacted] 2017. Exhibit 1, pp. 1-5. Although on February 27, 2017, Petitioner's CNP wrote a letter indicating Petitioner has severe episode of recurrent major depressive disorder with psychotic features and indicated she is unable to work due to her current symptoms, in her explanation, the CNP noted that Petitioner had a GAF score of 50 and Petitioner's psychiatric and physical exam resulted in normal vital signs. Exhibit 1, pp. 1 and 3. Moreover, on [redacted] 2016, Petitioner had a psychiatric evaluation in which the doctor noted with treatment and medications there is no psychological reason she cannot work. Exhibit A, p. 48. The doctor diagnosed her with bipolar disorder, mixed type; alcohol dependence in early full recovery; and borderline disorder. Exhibit A, pp. 46-49. Petitioner, though, questioned the mental health report pointing out his description of her was inaccurate. However, the undersigned ALJ reviewed the report and despite Petitioner's questioning of the report, the doctor accurately described her work history of illness/chief complaints and therefore, the undersigned ALJ finds the report credible. Exhibit A, p. 46.

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild to moderate limitations to her activities of daily living; mild to moderate limitations to her social functioning; and mild to moderate limitations to her concentration, persistence or pace. The undersigned ALJ concluded Petitoiner's mild to moderate limitations based on the "medical source" and "other source" opinions provided for the evidence record (i.e, nurse practitioners and counselors), Petitioner's most recent GAF score of 50, Petitioner's CNP psychiatric exam of her showing normal results as to her thought process, judgment, fund of knowledge, and the psychiatric evaluation in which the doctor noted with treatment and medications there is no psychological reason she cannot work. Exhibit A, p. 48. See SSR 06-03p. Furthermore, Petitioner did not present medical evidence showing that she has been treated for her mental limitations for an extended period time. Petitioner's CNP medical documentation showed that her encounter date was as of [redacted] 2017, and her progress notes with her LPC lasted from only [redacted] 2016 to [redacted] 2016. There were other medical records presented for the record, but nothing showing further restrictions to her nonexertional limitations. Accordingly, the undersigned ALJ finds mild to moderate limitations in Petitioner's mental capacity.

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 licensed optician. Petitioner had different employers as a licensed optician, thus, her exertional requirements varied. Some of Petitioner's work required standing 4 hours a day and sitting 4 hours a day. Other employment required sitting 8 hours a day or standing all day. Based on Petitioner's work history as a licensed optician, the undersigned ALJ finds that her work history result in light 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 49 years old at the time of hearing, and, thus, considered to be a younger individual (age 45-49) for purposes of Appendix 2. Petitioner is a high school graduate with an associate degree and a history of semi-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, 201.21 (not transferable) and/or 201.22 (transferrable), 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's medical record also shows nonexertional limitations resulting in mild to moderate limitations to her activities of daily living; mild to moderate limitations to her social functioning; and mild to moderate limitations to her concentration, persistence or pace. It is found that those limitations would not preclude her from engaging in simple, unskilled work activities on a sustained basis. Therefore, Petitioner is able to adjust to other work and is not disabled at Step 5

Accordingly, 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 SDA benefit 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 SDA benefit program.

Accordingly, the Department's 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

Vivian Worden
41227 Mound Rd.
Sterling Heights, MI
48314

Petitioner

[redacted] MI

cc: SDA: L. Karadsheh
Macomb County AP Specialist