GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

[redacted]
[redacted]
[redacted] MI [redacted]

Date Mailed: March 22, 2019
MAHS Docket No.: 19-000460
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Vicki Armstrong

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250. After due notice, a telephone hearing was held on February 20, 2019, from Lansing, Michigan. Petitioner personally appeared and testified. Petitioner submitted 31 exhibits which were admitted into evidence.

The Department of Health and Human Services (Department) was represented by Assistance Payment Worker, Karen Brown-Shelton. Ms. Brown-Shelton testified on behalf of the Department. The Department submitted 358 exhibits which were admitted into evidence. The record was closed at the conclusion of the hearing.

ISSUE

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

FINDINGS OF FACT

The Administrative Law Judge, based on competent, material, and substantial evidence on the whole record, finds as material fact:

1. Petitioner applied for SDA on [redacted] 2018. [Hearing Summary].

2. On January 25, 2019, Petitioner submitted a Request for Hearing contesting her SDA denial. [Dept. Ex. 2-3].

3. Petitioner applied for disability based on osteoarthritis, a paralyzed left hand, left-sided weakness and strokes.

4. Petitioner was diagnosed with a cardiovascular accident (CVA), stroke, transient ischemic attack (TIA), hemiplegia, hemiparesis, hypertension, sleep apnea, arthritis, osteoarthritis, low back pain, mild degenerative disc disease, right MCA ischemic stroke in 2009, status post right ICA stent placement in 2011, benign bowel villous mucosa and mild chronic gastritis, antral and oxyntic mucosa, obstructive sleep apnea (OSA) and being overweight.

5. On [redacted] 2017, Petitioner returned to [redacted] for a recheck of her obstructive sleep apnea. She was diagnosed with sleep apnea four years ago. She was complaining of positive snoring, daytime sleepiness and witnessed apneas. She reported she moved to a new apartment last month and lost her CPAP. Petitioner was assessed with dyspnea on exertion most likely deconditioning, frequent nocturnal awakening, a cerebral vascular accident with residual left upper extremity weakness, fatigue secondary to untreated obstructive sleep apnea syndrome, and snoring with frequent nocturnal arousals. It was recommended that Petition obtain a mandatory split-night sleep study, begin an exercise program and avoid over sedation. [Dept. Ex. 71-73].

6. On [redacted] 2017, Petitioner presented for a recheck of her obstructive sleep apnea. The physician noted that Petitioner had mild sleep apnea. He discussed the sleep study results with her in detail. Petitioner was placed on a CPAP. She was instructed to continue using the CPAP and exercise. The physician noted that she was still laid off from work and was attending physical therapy. [Dept. Ex. 74-75].

7. On [redacted] 2018, Petitioner was referred to a physician specializing in physical rehabilitation for spastic left hemiparesis and a history of two cerebral vascular accidents. Petitioner presented with shoulder pain. She had chronic left spastic hemiparesis. She had a stroke in 2008 and one in 2009. She had a history of carotid stenosis when she had a carotid stent placed. She was on baby aspirin once a day. She had been going to physical therapy since the beginning of January 2018. The physical therapist was concerned about some retraction of the shoulders and tightness in the trapezoid as well as the hands. Petitioner had tried baclofen in the remote past which she reported helped somewhat, but it did make her tired. She had been seen in the office over five years ago and had received Botox injections. She denied any headaches, dizziness, seizure, shortness of breath, chest pain, spasms, or tightness in the left leg except on occasion when she was lying down. She had no right arm or leg weakness, numbness, tingling or tightness. She denied dysphagia, dysarthria, or dizziness. Petitioner stated she was trying to do better with home stretches. She walked without an assistive device. She reported tightness in her hand where it goes up to an 8/10 in pain. On examination, Petitioner appeared well-developed and well-nourished. She was alert, oriented to conversational speech. Her mood and affect appeared to be appropriate and she was cooperative with the exam. She was able to stand and ambulate independently with a normal gait pattern and no antalgia. She had a normal spine alignment with no visible deformity. She had some mild decreased

balancing when she bent over. There was no obvious instability. Her motor strength, bulk and tone were without obvious abnormalities. Her left leg had full functional range of motion with no obvious instability. The cervical spine was functionally active with a passive range of motion in all directions. Her left arm had no visible deformities or tenderness to palpation or impingement. The strength in her left arm was at a Brunnstrom Stage 5, weakest in the hand where there was less movement but more isolated proximally. There was increased tone in her finger flexors, thumb abductors and mildly in the pronator teres muscle. She had no obvious instability in the left arm. Her coordination was difficult to test because she was dysmetric due to the weakness. The treating physician assessed her for cerebral ischemia, and spastic hemiplegia affecting her left non-dominant side, cramp and spasm. She was started on Baclofen and Botox was scheduled for the left arm. [Dept. Exh. 92-114].

8. On February 1, 2018, Petitioner returned for a recheck of her obstructive sleep apnea. Petitioner reported she was still experiencing daytime sleepiness and shortness of breath on exertion. She reported she was compliant with medications and the CPAP. She was assessed with fatigue, dyspnea on exertion more than likely deconditioning, frequent nocturnal awakenings improved with CPAP use, snoring resolved with CPAP use, and controlled hypertension with medications. Petitioner was highly encouraged to use CPAP as she was benefitting from therapy and to continue with weight loss and exercise programs. [Dept. Ex. 76-78].

9. On [redacted] 2018, Petitioner underwent an endoscopy for epigastric abdominal pain. The results showed her esophagus was normal. There was erythematous mucosa in the stomach and a normal duodenal bulb in second part of the duodenum. Both were biopsied. There was also a non-bleeding duodenal diverticulum observed. Final diagnosis was benign bowel villous mucosa and mild chronic gastritis, antral and oxyntic mucosa. [Dept. Ex. 198-230].

10. On [redacted] 2018, Petitioner went to the emergency department complaining of dizziness. She stated that she had been feeling dizzy like she would pass out and her left hand was “not acting right.” On examination, Petitioner appeared alert and oriented. She had chronic 4/5 muscle strength of the left upper extremity, and 5/5 in the right upper and lower extremities as well as in the left lower extremity. An EKG showed normal sinus rhythm, no ST elevation or depression. The T waves appeared normal. On further questioning by the examining physician, her symptoms sounded more like lightheadedness and syncope. She had no other complaints. She was given IV fluids and was resting comfortably. It was recommended that she obtain an outpatient echocardiogram and a possible Holter monitor for further evaluation of her near-syncope. She was discharged in stable condition. [Dept. Ex. 183-196].

11. On [redacted] 2018, Petitioner presented for a recheck of her obstructive sleep apnea. The physician indicated that her PAP compliance was more than 83.3% with an average use of 5 hours with auto PAP. She was still experiencing

excessive daytime sleepiness with an Epworth Sleeping Scale of 12/24. No significant weight change, chest or abdominal pain. Questionable shortness of breath with exertion. She was assessed with OSA on CPAP, hypersomnia, and narcolepsy. [Dept. Ex. 79-81].

12. On [redacted] 2018, Petitioner presented to a clinic for an evaluation of her carotid stent. The examining physician noted that Petitioner had a stroke and TIA of the right side of the brain leaving her left hemiparetic. She had consented to a carotid stent being placed. On exam, the physician found Petitioner was alert and oriented x3. Cranial nerves II through XII were grossly intact. Muscle strength in the right upper and right lower extremity was 5/5. Muscle strength in the left upper extremity was 1/5 and 4/5 in the left lower extremity. She was assessed with an old CVA and hemiparesis, a carotid artery stent placement and the presence of other vascular implants and grafts. [Dept. Ex. 61-63].

13. On [redacted] 2018, Petitioner underwent an abdominal/pelvic ultrasound which showed a fatty infiltration of the liver. [Dept. Ex. 152-153; Petitioner Ex. 15].

14. On [redacted] 2018, Petitioner saw a physician for neck pain. She presented with no significant past medical history. The examining physician noted that Petitioner was also requesting evaluation of her right-side MC stroke and right ICA stent placement. In 2009, Petitioner reported that she had a right MCA ischemic stroke. She believed the etiology of the stroke was secondary to right ICA dissection. She underwent right ICA stent placement in 2011 and was last seen in 2014. Since 2014, she had not seen a vascular neurologist for follow-up. Petitioner denied any new complaints, new focal weakness or numbness. On examination Petitioner had generalized weakness, neck stiffness and a gait disturbance. The motor examination revealed left upper extremity 4/5, increased tone, left lower extremity 5/5; right upper and lower extremity 5/5. It was noted that Petitioner walked without assistance. Petitioner was assessed with an old occlusion of the right carotid artery and CVA, and hemiparesis. [Dept. Ex. 64-67].

15. On [redacted] 2018, Petitioner was evaluated by Physical Therapy and diagnosed with unilateral primary osteoarthritis in both hips, contracture in the left hand and arm, and hemiplegia and hemiparesis. [Dept. Ex. 248, 308]

16. On [redacted] 2018, Petitioner returned to the clinic for a follow-up regarding her right ICA stent placement. Petitioner's carotid Doppler results showed that the right ICA stent was patent. No other abnormal findings were noted. She denied any new complaints of tingling, numbness, weakness, neck pain, blurred or double vision. [Dept. Ex. 68-70].

17. On [redacted] 2018, Petitioner was evaluated by an orthopedist for bilateral hip pain. X-rays of Petitioner's hips revealed arthritic changes, worse on the left than the right, with narrowing of the joint line and some spur formation. Petitioner reported arthralgias, joint pain and back pain. She denied fever, night sweats, significant weight gain or loss, exercise intolerance, chest pain, arm pain on

exertion, shortness of breath when walking, wheezing, abdominal pain, vomiting, diarrhea or coughing up blood. [Petitioner's Ex. 9-11].

18. On [redacted] 2018, the x-ray of Petitioner's lumbosacral spine showed mild degenerative changes since the [redacted] 2018 exam, at the L5-S1. [Dept. Ex. 115].

19. On [redacted] 2018, Petitioner was discharged from physical therapy for hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, and contracture in the left shoulder and hand. She was discharged to a home exercise program with a plan of care to return following the next round of Botox injections. [Dept. Ex. 248-358].

20. On [redacted] 2018, a functional analysis was completed regarding Petitioner's physical therapy progress. Since starting physical therapy on [redacted] 2018, her functional status remained the same or had decreased in some areas. There were no changes in her pain levels. She was being put on hold. She verbalized and demonstrated good understanding of the home exercise program. [Dept. Ex. 303].

21. On [redacted] 2018, Petitioner met with the physician specializing in physical rehabilitation she had been following with since [redacted] 2018. Petitioner complained of hip pain, spastic left hemiparesis, lumbar pain and an unsteady gait. Botox was ordered as it had been four months since her last injections in the left upper extremity. She was also complaining of more back pain. The physician reviewed Petitioner's x-ray from a week ago which only showed some degenerative changes at L5-S1. Petitioner indicated the pain was going to her right buttock and she was feeling increased tightness in her left upper extremity. She was taking Baclofen and Tramadol, which was not as helpful. She stated that she was going to physical therapy but that they were not doing much for her back and the pain could get up to a 9/10. The physician added back treatment to her physical therapy regimen. An MRI was ordered and dependent on the results, an epidural injection could be appropriate. During the physical examination, the physician noted Petitioner's lumbar spine had normal alignment, with tenderness on palpation over her paraspinals historically. She had forward flexion and extension lag about 10 degrees with increased pain. The straight leg raise was negative. Her left leg had essentially normal strength. Her left arm had full functional range of motion. She was at a Brunnstrom stage 5 to 6, with increased tone in her finger and thumb muscles, and mildly in her biceps and pronator. [Dept. Ex. 92-112].

22. On [redacted] 2018, the MRI of Petitioner's lumbar spine revealed minimal overall degenerative disc disease without high-grade spinal canal stenosis. [Dept. Ex. 146-147].

23. On December 11, 2018, the Medical Review Team denied Petitioner's SDA application. [Dept. Ex. 6-12].

24. On January 15, 2019, the Department issued Petitioner a Notice of Case Action informing her that her application for SDA had been denied. [Dept. Ex. 1].

25. Petitioner submitted a Return to Work/Disability Form, dated [redacted] 2019. Because the document is dated after the denial of SDA was made on [redacted] 2018, it cannot be considered. [Petitioner Ex. 14, 19].

26. Petitioner is a [redacted]year-old woman born on [redacted] She is [redacted] and weighs [redacted] pounds. She is a high school graduate and last worked in [redacted] of 2016.

27. Petitioner testified during the hearing in the above-captioned matter that she can walk a block and a half, stand for five minutes, is unable to sit for long and can carry two pounds. [Testimony of [redacted] 2/20/2019].

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

29. Petitioner's impairments have lasted, or are expected to last, continuously for a period of 90 days or longer.

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) 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 program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

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

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

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

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months [90 days for SDA]. 20 CFR 416.905(a). The person claiming a physical or mental disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and, (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (e.g., age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4). If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3 to Step 4. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

As outlined above, the first step looks at the individual's current work activity. In the record presented, Petitioner is not involved in substantial gainful activity and credibly testified that she has not worked since December of 2016. Therefore, she is not disqualified from receiving disability benefits under Step 1.

The severity of the individual's alleged impairment(s) is considered under Step 2. The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b). An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b). Examples include:

1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

5. Responding appropriately to supervision, co-workers and usual work situations; and

6. Dealing with changes in a routine work setting. *Id.*

The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). An impairment qualifies as non-severe only if, regardless of a claimant's age, education, or work experience, the impairment would not affect the claimant's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985).

In the present case, Petitioner is diagnosed with a cardiovascular accident (CVA), stroke, transient ischemic attack (TIA), hemiplegia, hemiparesis, hypertension, sleep apnea, arthritis, osteoarthritis, low back pain, mild degenerative disc disease, right MCA ischemic stroke in 2009, status post right ICA stent placement in 2011, benign bowel villous mucosa and mild chronic gastritis, antral and oxyntic mucosa, obstructive sleep apnea (OSA) and being overweight.

As previously noted, Petitioner bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, Petitioner has presented medical evidence establishing that she does have some physical limitations on her ability to perform basic work activities. The medical evidence has established that Petitioner has an impairment, or combination thereof, that has more than a *de minimis* effect on Petitioner's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, Petitioner is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404.

A review of the listings of impairments under the Social Security Disability Evaluation were considered in light of the objective evidence. Based on the foregoing, it is found that Petitioner's impairments do not meet the intent and severity requirement of a listed

impairment; therefore, Petitioner cannot be found disabled at Step 3. Accordingly, Petitioner's eligibility is considered under Step 4. 20 CFR 416.905(a).

The fourth step in analyzing a disability claim requires an assessment of the individual's residual functional capacity ("RFC") and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if he/she can perform past relevant work. *Id*.; 20 CFR 416.960(b)(3). Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). 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). RFC is assessed based on impairment(s) and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

To determine the physical demands (exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967. Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b). Even though weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.* 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). An individual capable of performing medium work is also capable of light and sedentary work. *Id.* 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). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.* Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands (exertional requirements, e.g., sitting, standing, walking, lifting, carrying, pushing, or pulling) are considered nonexertional. 20 CFR 416.969a(a). In considering whether an individual can perform past relevant work, a comparison of the individual's residual functional capacity to the demands of past relevant work must be

made. *Id.* If an individual can no longer do past relevant work, the same residual functional capacity assessment along with an individual's age, education, and work experience is considered to determine whether an individual can adjust to other work which exists in the national economy. *Id.* 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 (e.g., can't 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). 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). The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.*

Petitioner's prior work history consists of working as a senior accountant. In light of Petitioner's testimony, and in consideration of the Occupational Code, Petitioner's prior work is classified as skilled, sedentary work.

Petitioner testified that she is able to walk approximately a block and a half and can lift/carry approximately 2 pounds. The objective medical evidence indicates conflicting evidence of difficulties with shortness of breath on exertion. If the impairment, or combination of impairments, does not limit an individual's physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. 20 CFR 416.920. In consideration of Petitioner's testimony, medical records, and current limitations, Petitioner can be found able to return to past relevant work. Accordingly, Step 5 of the sequential analysis is required.

The fifth and final step of the analysis applies the biographical data of the applicant to the Medical Vocational Grids to determine the residual functional capacity of the applicant to do other work. 20 CFR 416.920(g). See *Felton v DSS* 161 Mich. App 690, 696 (1987). Once Petitioner reaches Step 5 in the sequential review process, Petitioner has already established a *prima facie* case of disability. *Richardson v Secretary of Health and Human Services,* 735 F2d 962 (6th Cir, 1984). At that point, the burden of proof is on the state to prove by substantial evidence that Petitioner has the residual functional capacity for substantial gainful activity.

The medical information indicates that Petitioner suffers from a cardiovascular accident (CVA), stroke, transient ischemic attack (TIA), hemiplegia, hemiparesis, hypertension, sleep apnea, arthritis, osteoarthritis, low back pain, mild degenerative disc disease, right MCA ischemic stroke in 2009, status post right ICA stent placement in 2011, benign bowel villous mucosa and mild chronic gastritis, antral and oxyntic mucosa, obstructive sleep apnea (OSA) and being overweight.

Petitioner is [redacted] years old, with a high school education. Petitioner's medical records are in conflict with her testimony that she is unable to engage in even a full range of sedentary work on a regular and continuing basis. 20 CFR 404, Subpart P. Appendix 11, Section 201.00(h). See Social Security Ruling 83-10; *Wilson v Heckler*, 743 F2d 216 (1986).

In light of the foregoing, it is found that Petitioner maintains the residual functional capacity for work activities on a regular and continuing basis which includes the ability to meet the physical and mental demands required to perform at least sedentary work as defined in 20 CFR 416.967(a). After a review of the entire record using the Medical-Vocational Guidelines [20 CFR 404, Subpart P, Appendix II] as a guide, specifically Rule 201.14**,** it is found that Petitioner is not disabled for purposes of the MA-P program 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 is not disabled for purposes of the SDA benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is AFFIRMED.

It is SO ORDERED.

VLA/dh

Vicki Armstrong
Administrative Law Judge
for Robert Gordon, 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) 763-0155; 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

Denise McCoggle
27260 Plymouth Rd
Redford, MI 48239

Wayne County (District 15), DHHS

BSC4 via electronic mail

L. Karadsheh via electronic mail

B. Cabanaw via electronic mail

Petitioner

[redacted]
[redacted]
[redacted] MI [redacted]