RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

Date Mailed: May 12, 2017
MAHS Docket No.: 17-003348
Agency No.:
Petitioner:

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on April 13, 2017, from Detroit, Michigan. Petitioner appeared and represented herself. Petitioner's support person, testified on Petitioner's behalf. The Department of Health and Human Services (Department) was represented by Veronica Bracey, Eligibility Specialist.

ISSUE

Did the Department properly determine that Petitioner was not disabled for purposes of continued State Disability Assistance (SDA) benefit program eligibility?

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 , 2015, Petitioner applied for SDA and disability-based Medicaid (MA-P).

2. In a June 25, 2015 medical social eligibility certification, the Disability Determination Service (DDS)/Medical Review Team (MRT) reviewed Petitioner's medical evidence and concluded that Petitioner was disabled beginning December 2014 because she was incapable of performing other work under Medical/Vocational Grid Rule 201.00(h). DDS/MRT set a June 2016 review date. (Exhibit A, pp. 272-276.) Petitioner was approved for SDA.

3. In connection with the June 2016 review, DDS/MRT assessed Petitioner's allegations of chronic obstructive pulmonary disease (COPD), post-traumatic stress disorder (PTSD), anxiety, and depression. DDS/MRT concluded that Petitioner was capable of light work and had moderate limitations in understanding, remembering or applying information; moderate limitations in interacting with others; moderate limitations in concentrating, persisting or maintaining pace; and mild limitations in adapting or managing herself (Exhibit A, pp. 10-36). DDS/MRT determined on January 20, 2017 that Petitioner was capable of performing other work under Medical Vocational Grid Rule 202.11 and, as a result, concluded that Petitioner was no longer disabled. (Exhibit A, pp. 3-9).

4. On February 16, 2017, the Department sent Petitioner a Notice of Case Action notifying her that her SDA case would close effective March 1, 2017 because, in relevant part, she was not disabled (Exhibit B).

5. On ██████ 2017, the Department received Petitioner's timely written request for hearing concerning the closure of her SDA case (Exhibit A, pp. 1-2).

6. Petitioner alleged disabling impairment due to COPD, back pain, depression, anxiety, and PTSD.

7. At the time of hearing, Petitioner was 53 years old with a █████████ 1952 birth date; she is 5'6" in height and weighs about 205 pounds.

8. Petitioner completed the 8th grade.

9. Petitioner has an employment history of work as a health care aide.

10. Petitioner has a pending disability claim with the Social Security Administration (Exhibit C).

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Health and Human Services Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180.

A disabled person is eligible for SDA. BEM 261 (July 2014), 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 lasting, or expected to last, 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).

Once an individual has been found disabled, continued entitlement to benefits based on a disability is periodically reviewed in accordance with the medical improvement review standard in order to make a current determination or decision as to whether disability remains. 20 CFR 416.993(a); 20 CFR 416.994(a). If the individual is not engaged in substantial gainful activity (SGA), the trier of fact must apply an eight-step sequential evaluation in evaluating whether an individual's disability continues. 20 CFR 416.994. The review may cease and benefits may be continued at any point if there is sufficient evidence to find that the individual is still unable to engage in SGA. 20 CFR 416.994(b)(5). In this case, Petitioner has not engaged in SGA at any time since she became eligible for SDA. Therefore, her disability must be assessed to determine whether it continues.

An eight-step evaluation is applied to determine whether an individual has a continuing disability:

> **Step 1.** If the individual has an impairment or combination of impairments which meets or equals the severity of an impairment listed in 20 CFR Appendix 1 of subpart P of part 404, the disability will be found to continue. 20 CFR 416.994(b)(5)(i).
>
> **Step 2.** If a listing is not met or equaled, it must be determined whether there has been medical improvement as defined in paragraph (b)(1)(i) of 20 CFR 416.994 and shown by a decrease in medical severity. If there has been a decrease in medical severity, Step 3 is considered. If there has been no decrease in medical severity, there has been no medical improvement unless an exception in Step 4 applies. 20 CFR 416.994(b)(5)(ii).
>
> **Step 3.** If there has been medical improvement, it must be determined whether this improvement is related to the individual's ability to do work in accordance with 20 CFR 416.994(b)(1)(i) through (b)(1)(iv); *i.e.*, there was an increase in the individual's residual functional capacity (RFC) based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to the individual's ability to do work, the analysis proceeds to Step 4. If medical improvement *is* related to the individual's ability to do work, the analysis proceeds to Step 5. 20 CFR 416.994(b)(5)(iii).

Step 4. If it was found at Step 2 that there was no medical improvement or at Step 3 that the medical improvement is not related to the individual's ability to work, the exceptions in 20 CFR 416.994(b)(3) and (b)(4) are considered. If none of them apply, the disability will be found to continue. If an exception from the first group of exceptions to medical improvement applies, the analysis proceeds to Step 5. If an exception from the second group of exceptions to medical improvement applies, the disability is found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process. 20 CFR 416.994(b)(5)(iv).

Step 5. If medical improvement is shown to be related to an individual's ability to do work or if one of the first group of exceptions to medical improvement applies, **all** the individual's current impairments in combination are considered to determine whether they are severe in light of 20 CFR 416.921. This determination considers all the individual's current impairments and the impact of the combination of these impairments on the individual's ability to function. If the RFC assessment in Step 3 shows significant limitation of the individual's ability to do basic work activities, the analysis proceeds to Step 6. When the evidence shows that all the individual's current impairments in combination do not significantly limit the individual's physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature and the individual will no longer be considered to be disabled. 20 CFR 416.994(b)(5)(v).

Step 6. If the individual's impairment(s) is severe, the individual's current ability to do substantial gainful activity is assessed in accordance with 20 CFR 416.960; i.e., the individual's RFC based on all current impairments is assessed to determine whether the individual can still do work done in the past. If so, disability will be found to have ended. 20 CFR 416.994(b)(5)(vi).

Step 7. If the individual is not able to do work done in the past, the individual's ability to do other work given the RFC assessment made under Step 6 and the individual's age, education, and past work experience is assessed (unless an exception in 20 CFR 416.994(b)(5)(viii) applies). If the individual can, the disability has ended. If the individual cannot, the disability continues. 20 CFR 416.994(b)(5)(vii).

Step 8. Step 8 may apply if the evidence in the individual's file is insufficient to make a finding under Step 6 about whether the individual can perform past relevant work. If the individual can adjust to other work based solely on age, education, and RFC, the individual is no longer disabled, and no finding about the individual's capacity to do past relevant work under Step 6 is required. If the individual may be unable to adjust to other work or if 20 CFR 416.962 may apply, the individual's claim is

assessed under Step 6 to determine whether the individual can perform past relevant work. 20 CFR 416.994(b)(5)(viii).

Step One

Step 1 in determining whether an individual's disability has ended requires the trier of fact to consider the severity of the impairment(s) and whether it meets or equals a listed impairment in Appendix 1 of subpart P of part 404 of Chapter 20. 20 CFR 416.994(b)(5)(i). If a listing is met, an individual's disability is found to continue with no further analysis required.

The medical record presented was reviewed and is briefly summarized below.

An [redacted] 2015 lumbar spine x-ray showed moderate degenerative disc disease in the lumbar spine from L2-L3 to L5-S1 levels (Exhibit A, p. 170).

A [redacted], 2015 letter to Petitioner from her insurer advised her that her doctor's request for her lower back spine MRI (magnetic resonance imaging) was denied because exam findings did not show unequal reflexes or weakness on one side. (Exhibit A, pp. 161-162.)

On [redacted] 2015, Petitioner's mental health doctor completed a verification of disability for the [redacted] indicating that Petitioner had a physical, emotional or mental impairment that was expected to be of long-continued or indefinite duration, substantially impeded her ability to live independently, and her ability to live independently could be improved by more suitable housing conditions. (Exhibit A, pp. 158-159.)

On [redacted] 2016, Petitioner was assessed with mild leukocytosis and mild erythrocytosis (Exhibit A, pp. 154-156). At an [redacted] 2016 follow-up, it was found that Petitioner's WBC (white blood count) was normal, Petitioner was asymptomatic, and no intervention was needed. Petitioner was advised to stop smoking. (Exhibit A, p. 163).

On [redacted] 2016, Petitioner was referred to [redacted] [redacted] for a diabetic eye evaluation. Petitioner was found to have age-related cataracts of the right and left eyes but no diabetes-based retinopathy. She was advised to quit smoking and tightly control her blood glucose levels. (Exhibit A, pp. 164-165.)

A [redacted], 2016 bilateral lower extremities arterial Doppler US (ultrasound) showed no hemodynamically significant stenosis. (Exhibit A, pp. 174-175.) [redacted] 2016 bone density test results were normal (Exhibit A, pp. 176-177).

Petitioner's records include notes from visits to her primary care physician between [redacted] 2015 and [redacted] 2016 (Exhibit A, pp. 211-271, 291-320, 328). At a [redacted] 2016 visit, Petitioner requested a refill for medication bilateral ankle pain that had increased in severity but her request was denied. It was noted that her hypertension was stable on medication; her diabetes was slightly elevated and she was advised to improve her

eating habits, increase exercise and take medication daily; and she was advised to stop all smoking in response to her COPD. (Exhibit A, pp. 223-226, 291-357.) At a [redacted] 2016 visit she reported increased leg pain for the last 1 to 2 months. Petitioner was prescribed a lumbar back brace to treat her degenerative disc disease. (Exhibit A, pp. 217-222.)

Petitioner's records include ongoing medication reviews with her doctor at the mental health facility she frequented beginning [redacted] 2015 showing ongoing issues with anxiety, including frequent panic attacks and trouble sleeping. Petitioner reported that her depression was controlled with medication. (Exhibit A, pp. 106-153.) In a [redacted] 2016 psychiatric evaluation, Petitioner reported long history of depression, anxiety and PTSD and being on her current medication regimen for 8 years. She was diagnosed with anxiety disorder, depressive disorder, and PTSD and assigned a global assessment of functioning (GAF) score of 47. (Exhibit A, pp. 146-149.) In notes from an [redacted] 2016 office visit with her mental health provider, Petitioner reported increased anxiety with daily panic attacks making it hard for her to leave the house. She reported tossing all of her Ativan, which she had been taking for 20 years, because it was no longer working. The doctor noted that Petitioner's mood was anxious, her thinking was not homicidal or suicidal, her insight and judgment were good, and her gait was normal. (Exhibit A, pp. 106-108.)

On [redacted], 2016, Petitioner was evaluated by a limited licensed psychologist at the request of DDS. Petitioner was highly jumpy, fearful to leave her home, untrusting, hypervigilant, and ruminated daily about childhood abuse. She reported hearing voices from "Lisa" and having daily panic attacks lasting from 60 minutes to hours with symptoms including pressure in her chest, shortness of breath, racing heart, weakness in her limbs, shaking, sweating, and dizziness. She reported laying on the couch throughout the day but being able to lightly cook and clean with several breaks. The psychologist noted that Petitioner's gait and gross physical movements were slow and she walked with a limp and her breathing was audible. The psychologist concluded that no symptoms of psychosis were evident and Petitioner appeared to be in good contact with reality but with low self-esteem. She presented with even-pace and reasonable clarity stream of mental activity, no evidence of thought disorder, and anxious affect. Based on her evaluation, the psychologist concluded that Petitioner's functional abilities were highly impaired, finding that symptoms of her severe anxiety had increased with her COPD onset. She was diagnosed with panic disorder without agoraphobia, PTSD, and unspecified depressive disorder with a guarded prognosis. (Exhibit A, pp. 38-43.)

On [redacted] 2016, Petitioner was examined by a doctor at the Department's request. Petitioner reported being short of breath when walking distances of 200 feet and having to stop and rest for five minutes before she could go the same distance again. She could care for herself. She used two different inhalers daily which helped with her condition. She complained of lower back pain and a burning sensation and pain in her right leg. She wore a back brace but did not use a cane or walker. The doctor observed that Petitioner was ambulatory without any walking aid; had no tendency for lurching, swaying or falling; was able to touch her toes and squat

completely; had no edema of the feet; had a negative straight-leg raise test bilaterally; and had 42-pound hand grip on the right and 40-pound hand grip on the left. The doctor found that Petitioner could open a jar, button clothing, write legibly, pick up a coin, and tie shoelaces with either hand. The doctor performed a pulmonary function test that showed moderate obstructive airway disease, with the FVC (forced vital capacity) at 2.98, FEV1 (forced expiratory volume-one second) at 1.89 and FEV1/FVC ratio at 63.4 pre-bronchodilation and the FVC at 3.13, FEV1 at 1.85 and FEV1/FVC ratio at 59.4 post-bronchodilation. The doctor concluded that Petitioner was diagnosed with COPD and was symptomatic and had degenerative arthritis of the lumbar spine radiating to the right leg but her lumbar spine range of motion was normal. Her other medical problems, including hypertension, diabetes, and hyperlipidemia, appeared stable with medication. (Exhibit A, pp. 45-55, 57-67.)

In light of the medical evidence presented, listings 1.04 (disorders of the spine), 3.02 (chronic respiratory disorders), 12.04 (affective disorders), 12.06 (anxiety-related disorders), and 12.15 (trauma and stressor-related disorders) were considered. There was no evidence of compromise of a nerve root or spinal cord to support a listing under 1.04. Petitioner's pulmonary function test results do not support a listing under 3.02. Petitioner's medical record does not reflect marked limitation of the ability to understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; or adapt or manage herself or establish that her mental disorder is "serious and persistent," as defined in 12.04C, 12.07C, and 12.15C. Therefore, Petitioner's condition does not meet a listing under 12.04, 12.06, or 12.15.

Because 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, a disability is not continuing under Step 1 of the analysis, and the analysis proceeds to Step 2.

Step Two

If the impairment(s) does not meet or equal a Listing under Step 1, then Step 2 requires a determination of whether there has been medical improvement as defined in 20 CFR 416.994(b)(1). 20 CFR 416.994(b)(5)(ii). Medical improvement is defined as any decrease in the medical severity of the impairment(s) which was present at the time of the most favorable medical decision that the individual was disabled or continues to be disabled. 20 CFR 416.994(b)(1)(i). For purposes of determining whether medical improvement has occurred, the current medical severity of the impairment(s) present at the time of the most recent favorable medical decision that found the individual disabled, or continued to be disabled, is compared to the medical severity of that impairment(s) at the time of the favorable decision. 20 CFR 416.994(b)(1)(vii). If there is medical improvement, the analysis proceeds to Step 3, and if there is no medical improvement, the analysis proceeds to Step 4. 20 CFR 416.994(b)(5)(ii).

The most recent favorable decision finding Petitioner disabled was the ████████, 2015 medical-social eligibility certification finding that Petitioner was incapable of adjusting to other work (Exhibit A, pp. 272-276). In connection with her application, Petitioner

alleged breathing problems due to COPD and a broken arm (Exhibit A, p. 484). In connection with the application, the Department requested that Petitioner be evaluated by an independent consultative doctor and that she undergo a pulmonary function test. The medical evidence relied at the point DDS/MRT made its June 26, 2015 decision included the following evidence:

- ████████ 2015 bilateral ankle x-rays showed no acute fracture or erosive change and well-corticated ossific densities near the medial malleolus bilaterally likely due to remote avulsion injury (Exhibit A, p. 401).
- On ████████ 2015, Petitioner was discharged from the emergency department with a simple elbow fracture, with x-rays showing nondisplaced radial neck fracture (Exhibit A, pp. 396, 459-471, 521-531).
- At a ██████ 2015 follow-up, Petitioner reported significant left elbow and wrist pain and wore a removable brace on the wrist. The doctor noted diffuse severe tenderness to light touch over the volar forearm, out of proportion with exam, with the doctor noting that Petitioner was reluctant to allow passive elbow or wrist range of motion and did spontaneously demonstrate functional elbow and nearly full arc of wrist range of motion. The doctor also noted that left radial neck fracture healing was incomplete, complicated by continued tobacco use. She was advised not to lift, pull, or push 5 or more pounds with the left upper extremity. (Exhibit A, pp. 513-515.)
- Notes from Petitioner's ██████, 2015 office visit with her primary care physician showed unlabored respiratory effort; clear auscultation with no rales, rhonchi, or wheezes; normal range of motion and strength of all extremities; normal alignment and mobility of head and neck and spine, ribs, and pelvis; and normal gait and station (Exhibit A, pp. 416-422).
- On █████, 2015, Petitioner went to the emergency department with lower abdominal pain and bilateral flank pain, with hypokalemia at 3.1 (Exhibit A, pp. 490-491).
- On █████, 2015, Petitioner was examined by an independent medical examiner. She reported back problems that kept her from standing or walking any distance; ankle pain; and COPD on rescue inhaler with no nebulizer or other medication and continuing to smoke. Her Jamar grip strength test was 40 pounds bilaterally. She had full range of motion of the cervical spine. There was no restriction of shoulder range of motion; negative leg raising signs both sitting and supine; no pain radiating into the legs; no edema of the lower extremities; normal patellar reflexes; and normal ambulation. The doctor observed that Petitioner was able to sit, stand, bend, stoop, carry, push and pull; had normal reflexes; could not walk on heels and toes but had a stable gait within normal limits; and had no limitations in her joint range of motion. The doctor found that Petitioner evidenced COPD, using only a rescue inhaler several times daily. He concluded that her shortness of breath caused more of a limitation to walk any distance because there did not appear to be a disc problem in the lower back. (Exhibit A, pp. 492-494, 498-501.)
- A █████ 2015 pulmonary function test showed moderate obstructive airway disease without any reversibility after bronchodilation with the FVC at 2.86, FEV1

> at 1.86 and FEV1/FVC ratio at 65 pre-bronchodilation and the FVC at 3.34, FEV1 at 1.88 and FEV1/FVC ratio at 67 post-bronchodilation. (Exhibit A, pp. 495-497.)

The evidence shows that DDS/MRT considered Petitioner's fracture and COPD at the time of her ■■■■■ 2015 application. Although Petitioner suffered from a simple elbow fracture in 2015, with x-rays showing nondisplaced radial neck fracture, the evidence presented in connection with the ■■■■ 2016 review does not show any continuing issues with respect to her neck or wrist. Therefore, there has been medical improvement concerning the neck fracture and resulting wrist pain. The results of Petitioner's ■■■■■■■■■■■ 2016 pulmonary function test compared to the results of her June 3, 2015 pulmonary function test show a very small decrease in her FEV1, FVC and FEV1/FVX ratio. Therefore, there was no medical improvement in her COPD.

Because there was a medical improvement in one of the impairments present at the time of ■■■■■■■ 2015 medical-social eligibility certification, the most recent favorable decision finding Petitioner disabled, the analysis proceeds to Step 3.

Step Three

If there has been medical improvement, it must be determined whether there is an increase in the individual's residual functional capacity (RFC) based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to the individual's ability to do work, the analysis proceeds to Step 4. If medical improvement *is* related to the individual's ability to do work, the analysis proceeds to Step 5. 20 CFR 416.994(b)(5)(iii).

In this case, Petitioner had been advised by her doctor not to lift, pull, or push 5 or more pounds with the left upper extremity due to her neck fracture and left wrist and elbow pain. Because there was no evidence of any continuing medical impairment concerning Petitioner's neck and wrist, Petitioner's medical improvement is related to her ability to do work. Accordingly, the analysis proceeds to Step 5.

Step 5

Where medical improvement is shown to be related to an individual's ability to do work, **all** the individual's current impairments in combination are considered to determine whether they are severe in light of 20 CFR 416.921. An individual's impairments are not severe only if, when considered in combination, they 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 this case, the medical record shows that Petitioner was diagnosed with panic disorder without agoraphobia, PTSD, and depressive disorder with a guarded prognosis. She had COPD, with a pulmonary function test showing moderate obstructive airway disease. The evidence presented was sufficient to establish that Petitioner's impairments have more than a minimal effect on her ability to perform basic work activities. Therefore, the impairments are severe, and the analysis proceeds to Step 6.

Step 6
Under Step 6, the individual's RFC based on all current impairments is assessed to determine whether the individual can still do work done in the past. If so, disability will be found to have ended. 20 CFR 416.994(b)(5)(vi).

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 (involving 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), light (involving lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds, or a good deal of walking or standing, or sitting most of the time with some pushing and pulling of arm or leg controls), medium (involving lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds), heavy (involving lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds), and very heavy (involving 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; 20 CFR 416.969a(a).

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).

In this case, Petitioner complained of poor breathing due to COPD, a lack of strength, back problems, and cataracts. She testified that she could not walk more than 50 feet, sit more than 15 minutes, lift more than 10 pounds, or stand more than 10 minutes. She wore a back brace and found that physical therapy was too painful and did not help. She had cataracts on both eyes that affected her vision and required surgery. She had problems gripping and grasping because her fingers locked up. She lived alone and could bathe and dress herself but sometimes needed her daughter because she got overwhelmed. She could cook and clean but she often needed to sit and use her inhaler. Her daughter took her shopping but she had difficulty staying focused. She did not drive. Petitioner also complained that she suffered from anxiety and PTSD that

resulted in daily anxiety attacks that made it difficult for her to even get her mail. She had issues with concentration and suffered from crying spells. She heard voices others did not. She did not get together with her family for family functions. She had tried to go to church but had only managed to go once in two months.

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.

An [redacted], 2015 lumbar spine x-ray showed moderate degenerative disc disease in the lumbar spine from L2-L3 to L5-S1 levels. A [redacted] 2016 pulmonary function test showed moderate obstructive airway disease. She has been diagnosed by a psychologist with anxiety disorder, depressive disorder, and PTSD. She was diagnosed with age-related cataracts of both eyes on [redacted], 2016. This medical evidence supports Petitioner's complaints of back pain, breathing problems, vision problems, and mental health problems.

The record was reviewed to establish the intensity, persistence and limiting effects of Petitioner's symptoms. The consultative doctor who examined Petitioner at the Department's request observed that Petitioner was ambulatory without any walking aid; had no tendency for lurching, swaying or falling; was able to touch her toes and squat completely; had no edema of the feet; and had a negative straight-leg raise test bilaterally. The doctor concluded that Petitioner had degenerative arthritis of the lumbar spine radiating to the right leg but her lumbar spine range of motion was normal. However, the evidence also shows that Petitioner's treating physician prescribed the back brace to treat her degenerative disc disease. The limited licensed psychologist who evaluated Petitioner the day before the consultative doctor examined her had observed that Petitioner's gait and gross physical movements were slow, she walked with a limp, and her breathing was audible. Based on the results of the pulmonary function test, the consultative doctor concluded that Petitioner was diagnosed with COPD and was symptomatic.

With respect to her mental health condition, records from Petitioner's mental health provider show ongoing issues with anxiety, including daily panic attacks making it difficult for her to leave the house. Based on her evaluation, the consultative psychologist concluded that Petitioner's functional abilities were highly impaired, finding that symptoms of her severe anxiety had increased with her COPD onset. The Department representative observed at the hearing that Petitioner wore a brace, was very fidgety, and rocked back and forth.

Based on the evidence on the record, including Petitioner's testimony, it is found that Petitioner has an exertional RFC to perform sedentary work and a nonexertional RFC that results in mild limitations in her ability to understand, remember, or apply

information; mild to moderate limitations in her ability to adapt or manage herself; marked limitations in her ability to interact with others, and moderate to marked limitations in her ability to concentrate, persist, or maintain pace and some visual limitations.

Petitioner reported past employment as a home health aide. This employment, which required substantial standing and lifting up to 50 pounds, required medium physical exertion. Based on her current exertional RFC, Petitioner is unable to do work done in the past. Accordingly, Petitioner is incapable of performing past relevant work, and the analysis proceeds to Step 7.

Step 7

In Step 7, an assessment of an individual's RFC and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.994(5)(B)(vii). If the individual can adjust to other work, then the disability has ended. *Id.* If the individual cannot adjust to other work, then the disability continues. *Id.*

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 54 years old at the time of the decision at review and at the time of hearing, placing her age within closely approaching advanced age (age 50-54) category for purposes of Appendix 2. She completed the 8th grade and stated she has problems with spelling and reading. The skills from her past employment, which was tied to medium physical exertion, are not transferable. As discussed above, Petitioner maintains the RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities. In light of these factors, the Medical-Vocational Guidelines, 201.10, results in a disability finding based on Petitioner's exertional RFC. Accordingly, Petitioner's disability is found to continue at Step 7.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Petitioner has continuing disability for purposes of the SDA benefit program. Therefore, Petitioner's SDA eligibility continues and the Department did not act in accordance with Department policy when it closed her SDA case.

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

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE THE ORDER WAS ISSUED:

1. Reinstate Petitioner's SDA case effective March 1, 2017;

2. Issue supplements to Petitioner for any lost SDA benefits that she was entitled to receive from March 1, 2017 ongoing if otherwise eligible and qualified in accordance with Department policy;

3. Notify Petitioner of its decision in writing; and

4. Review Petitioner's continued SDA eligibility in November 2017 in accordance with Department policy.

ACE/tlf

Alice C. Elkin
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

Via Email: MDHHS-Saginaw-Hearings@michigan.gov
BSC4 Hearing Decisions
B. Cabanaw
D. Shaw
MAHS

Petitioner –
Via First-Class Mail: