[redacted]
MI [redacted]

Date Mailed: January 25, 2019
MAHS Docket No.: 18-006170
Agency No.: [redacted]
Petitioner: [redacted]

**ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris**

## 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 August 6, 2018, from Detroit, Michigan. The Petitioner was represented by herself. The Department of Health and Human Services (Department) was represented by Marlon Dorsey, Family Independence Manager, and Kimberly Stoddard, Eligibility Specialist.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. The requested documents were NOT received. The record closed on October 15, 2018; and the matter is now before the undersigned for a final determination based on the evidence presented.

## 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], 2017, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On May 30, 2018, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 6-12).

3. On May 30, 2018, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit A, pp. 4-5).

4. On June 12, 2018, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 2-3).

5. Petitioner alleged disabling impairment due to chronic pain and fatigue due to fibromyalgia, and hand and leg numbness. The Petitioner also alleged mental impairment due to depression.

6. On the date of the hearing, Petitioner was [redacted] years old with an [redacted], 1964, birth date; she is [redacted]' [redacted]" in height and weighs about [redacted] pounds.

7. Petitioner is a college graduate with a BA in Office Administration.

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

9. Petitioner has no employment history of work in the last 15 years except for approximately 6 months of employment as a [redacted] Rental customer service representative.

10. Petitioner has a pending 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 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 90 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 1**

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 2**

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. Social Security Ruling (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.

The medical evidence presented at the hearing, *and in response to the interim order,* was reviewed and is summarized below.

On August 23, 2018, the Petitioner was seen at [redacted] and received an epidural steroid injection (cervical) left.

The Petitioner was seen for an initial visit as a new patient at [redacted] for complaints of mid-back pain radiating to left shoulder. Pain at initial visit was rated as 5 on a scale of 0 to 10. Pain was described as aching, sharp, burning and stabbing and is worse in the morning. Pain is made worse by physical activity including lifting, pain is alleviated by heat, massage, stretching and medications. Petitioner reports headaches on left, and physical therapy did not help. Petitioner also reports low-back pain radiating to both legs with pain level of 7 and duration of three years. Right leg is reported weaker and has some numbness. Pain was affecting sleep, physical activity, relationships, dressing, appetite, emotions, concentration and getting out of bed or a chair, eating and bathing. The physical exam of thoracic spine noted kyphosis is decreased, facet signs are positive bilaterally, trigger point tenderness is present in bilateral parathoracic musculature. Exam of lumbar spine notes pain is worse with all planes of range of motion. Facet signs are positive bilaterally. Sacroiliac joints are provocative bilaterally. Trigger point tenderness is not palpable in the bilateral paralumbar musculature. Notes indicate osteopathic exam notes thoracic and pelvic somatic dysfunctions. Strength in all muscle groups is normal. Straight leg test is negative bilaterally. The Assessment was spondylosis without myelopathy or radiculopathy, cervical region. Segmental and somatic dysfunction of thoracic, sacral, rib cage, lumbar region and cervical region. Chronic pain syndrome diagnosis which

was a new diagnosis was made. Also noted as new was radiculopathy in cervical region. The MRI of cervical spine notes a 2mm retrolisthesis of C5 on C6, facet arthropathy at multiple levels, moderate to severe left and moderated right neural foraminal narrowing a C6-C7. Imaging of pelvis notes hardware, but also S1 joint degeneration bilaterally. Petitioner was referred to an osteopathic manipulative medicine physician to treat somatic dysfunctions before injections.

Petitioner was seen on June 28, 2018, and reported injection two weeks ago did not help. Received a facet injection in the thoracic spine left at T3/T4, T4/T5 and T5/T6. The Petitioner was also diagnosed with intercostal neuropathy.

On August 28, 2018, the Petitioner was seen for thoracic pain and had been following up with an osteopathic manipulative medicine physician that has been helping but has functionally limiting pain along left periscapular and thoracic region. At the visit, Petitioner received injections (nerve block) in the thoracic region on left side a T3/T4 and T4/T5 and T5/T6. Notes indicated that she has been compliant with physical therapy, chiropractic care and osteopathic manipulation without getting the results she needs.

The Petitioner's Psychiatrist completed a Psychiatric Examination Report on October 17, 2018. The Petitioner was first examined and evaluated on July 13, 2017. Notes indicate history of anxiety prominent; and even if she attempted to work, anxiety would be very inhibiting. Patient seen for psychotherapy monthly and for psych eval every six months.

The Psychiatrist found that although Petitioner is of average to above-average intelligence, cognitive functioning is limited. The notes indicate that patient is improving functionally as she is no longer homeless. She is attending church and making a more stable daily life. The Diagnosis was anxiety disorder with some features of PTSD, GAF score was 69 and had increased from 51 the prior year. A mental residual function capacity assessment was also performed: Understanding and Memory were all moderately limited. Sustained concentration was all moderately limited except the ability to carry out detailed instructions was markedly limited without any limitation to make simple work-related decisions. Social Interaction was moderately limited in all categories, except no limitation to ask simple questions or request assistance. Adaptation abilities were all moderately limited except the ability to travel in unfamiliar places are use public transportation was markedly limited.

The Petitioner was seen at the [redacted] on January 25, 2018; and x-rays of her bilateral hip and groin were taken due to complaints of pain. The findings were osseous structures with no acute fracture or dislocation. Deformity is seen with the postsurgical changes involving the left iliac and left ischium with intact orthopedic hardware. The joint alignments were maintained, minimal degenerative changes are seen involving the inferior SI joints. The soft tissues were intact, and no radiopaque foreign bodies identified. The impression was minimal degenerative changes involving the interior aspect of the SI joints. Posttraumatic/postsurgical changes involving the left iliac and left ischium.

On November 29, 2017, four x-rays were taken of the lumbar spine. The impression was 5 non-rib bearing lumbar vertebra. There may be partial articulation of the transverse process of L5 on the left with the sacrum. No displaced fracture. No destructive osseous lesion. While the lateral projection is somewhat oblique, no definitive spondylolisthesis is identified. Degenerative changes most pronounced at L5-S1 where they appear at least moderate. Partially imaged internal fixation hardware involving the left pelvis. Degenerative changes of the sacroiliac joints. Right upper quadrant surgical clips likely related to prior cholecystectomy. Atherosclerotic calcifications of the abdominal aorta.

On July 26, 2017, a bone density scan was completed. The findings concluded the patient has low bone density mass consistent with osteopenia. There is risk to increased risk of fractures. On June 12, 2017, the Petitioner was examined for left knee, and x-rays were taken. The findings were normal osseous structures of the left knee. Osseous structures are intact, and no osteochondral defects noted the joint spaces were well preserved. On June 12, 2018, x-rays were taken of the right knee with the same impression, normal osseous structures of the right knee.

On June 9, 2017, an MRI of the neck was performed, (cervical spine) and compared to a prior MRI taken in 2015. The findings were two-millimeter retrolisthesis at C5 on C6. There was no abnormal signal within the cervical cord or cervical medullary. Notes indicate multilevel degenerative changes, left facet arthropathy results in mild left neural foraminal stenosis. C3-C4 notes disc osteophyte complex and left facet arthropathy results in moderate left and mild right neural foraminal stenosis. C4-C5 notes small disc bulge and less facet arthropathy results in minimal left neural foraminal stenosis. C5-C6 notes disc osteophyte complex and mild facet arthropathy results in mild central canal stenosis with mild to moderate right and minimal left for neural foraminal narrowing. Findings are mildly progressed from prior. C6-C7 notes disc osteophyte complex and facet arthropathy results in moderate to severe left and moderate right neural foraminal stenosis. C7-T1 right facet arthropathy results in mild right neural foraminal stenosis. At T1-T2 notes indicate sagittal imaging only demonstrates mild left neural foraminal stenosis. The impression was mild multilevel degenerative changes, mildly progressed at C5-C6 but otherwise similar to prior exam.

On May 18, 2017, x-rays were taken of the cervical spine, impression was moderate and hand and leg numbness disease and spurring at C3-C4. Bony encroachment on several neural foramina. The neural foramina most narrowed is the left C6-C7 level caused at least in part by a 3mm anterolisthesis of C6 on C7. This may contribute to the patient's current symptoms.

An MRI of the brain was taken on April 26, 2017; the impression was a normal brain MRI for age; the findings indicated no abnormal enhancement, negative for restricted diffusion-acute ischemia. No mass effect. No evidence of acute intracranial hemorrhage. Ventricular size and configuration were normal. A few tiny foci of flair hypersensitivity in white matter nonspecific, but probably age-related small vessel disease. On March 23, 2017, x-rays of the thoracic spine were taken; the findings were no spondylolisthesis, no compression deformities, multilevel endplate osteophytes are

seen, and the paravertebral soft tissues were intact. The impression was mild degenerative changes of the cervical and thoracic spine.

On February 15, 2017, the Petitioner was admitted to the hospital for alcohol dependence for approximately one month. The chief complaint at the time of the admission was alcohol dependence relapse. Notes indicate that on December 21, 2016, the Petitioner drank three pints and was arrested for DUI. No further use of alcohol. The Petitioner was given Motrin and Gabapentin to address pain and neuropathy. Active problems were noted as osteopenia, alcohol dependence, nicotine dependence, low-back pain, anxiety disorder and hyperlipidemia. The Petitioner was examined by a psychology resident on June 12, 2017, after being placed in an out-patient level of care for alcohol use disorder with a diagnosis of severe alcohol dependence and PTSD. At the time of her treatment, notes indicate Petitioner had been sober for approximately six months. Notes further indicate Petitioner had been attending Alcoholics Anonymous meetings multiple times a week. At the time of the encounter, the Petitioner was recommended to engage in out-patient treatment with a focus on her substance use.

On June 13, 2017, the Petitioner was discharged after four months of treatment for alcohol dependence. The admission had been for residential rehabilitation. At the time of the discharge, the diagnosis was alcohol dependence, anxiety disorder, tobacco dependence, osteopenia, hyperlipidemia, headaches, cervical spondylosis and chronic sinus.

The discharge notes indicate the Petitioner was fully oriented with no psychosis evident, no thought disorder present with stable mood with no suicidal or homicidal ideation and the ability for patient to care for self at post discharge was rated as good. Notes indicate the Petitioner was seen at [redacted] for counseling with a psychologist on April 13, 2018; March 15, 2018; January 3, 2018; December 8, 2017; November 29, 2017; September 20, 2017; August 15, 2017; and July 13, 2017. Notes indicate also posttraumatic stress disorder (PTSD) and chronic pain syndrome and generalized anxiety disorder. The Petitioner also participated in group psychotherapy on June 6, 2017, regarding her chronic pain syndrome, PTSD and alcohol dependence.

A note dated February 5, 2018, indicates [redacted] was unable to treat patient for injections due to no specific diagnosis of area of the body that needed treatment suggested osteopathic manipulative medicine physician to treat Petitioner's somatic dysfunction's before treating with injections. Thereafter, on February 6, 2018, a referral was made to an osteopathic provider.

On February 1, 2018, the Petitioner was seen by a psychiatrist for medication review and reports of pain. The Notes in reference to the session indicate sleep varies from 4 to 8 hours depending on pain experience. At the exam, the mental status noted mood was euthymic, speech was clear and goal-directed, affect was constricted, suicidal thoughts were absent, perceptual disturbances were absent; the Petitioner was oriented times 3, attention was fair, memory was fair and level of intellectual functioning, judgment and insight were fair. The diagnosis was anxiety disorder. The Petitioner was seen by her therapist psychologist on January 3, 2018, and had a depression score of

15 noting severe; and notes indicate patient feels down and depressed, trouble falling or staying asleep, feeling tired or having little energy, with poor appetite half the days, trouble concentrating on things such as reading a newspaper or watching television, moving or speaking so slowly that other people could have noticed. None of the answers indicated that activities were very difficult. Notes indicate patient recognizes her moods are also driven by her physical pain and fatigue which make emotional problems worse. Petitioner mentions her extremities go numb at times, and she can't grip things; her knees give out; and her right calf and foot especially go numb. Notes indicate patient has been told she has osteoarthritis but believes there are other undiagnosed problems for which she wants to see a rheumatologist. The physical discomfort makes her not want to be around other people. The assessment was, patient's anxiety continues.

The Petitioner was also seen to receive medication for tobacco abuse on November 20, 2017.

On November 8, 2017, the Petitioner called the [redacted] and spoke to a nurse to report deep muscle pain all over and bilateral knee pain ongoing without swelling or redness. Notes indicate patient on Lyrica and helps a little. Patient requested an evaluation.

The Petitioner was seen on December 8, 2017, with complaints of chronic pain and fatigue with pain in bilateral lower extremities and knees, pain described as shooting and numbness. Pain was rated at 8 of 10 today.

On October 27, 2017, the Petitioner came in with complaints of cough and sharp back pain, 8/10 upon standing to come to the clinic. Notes indicate that a prescription for pain medication was given for back pain and that Petitioner was to seek emergency room assistance if the back pain becomes intractable.

The Petitioner was seen by her psychologist on September 20, 2017, notes indicate that she advised patient is taking Cymbalta and Lyrica now and that one or both of these meds are, "doing the trick" especially in controlling her pain. Notes also indicate that she finds her moods to be a bit brighter - she is more talkative, with less anxiety. She thinks she is clearer, less foggy in her thinking; a negative side effect is she is more hypervigilant on her new medication. Notes indicate patient sober for nine months, continues attending AA meetings, which also decreases her anxiety. Assessment notes by patients report, mood is better and anxiety is low; she isn't actively suicidal. In another note dated September 20, 2017, the score for anxiety was rated overall as low on a scale of 0 to 63 patient score was 21.

The Petitioner was seen by Psychiatrist Dr. [redacted] on September 18, 2017, for medication review. At the time of the visit, patient reported level of anxiety has increased substantially and that she is not sure why. As a sign, notes indicate she is chewing her lips. Patient is sleeping six hours at night; appetite is good; and she is also prescribed Lexapro for depression and anxiety. A prescription for Duloxetine was suggested for anxiety and fibromyalgia. At the time of the review of the mental status was, mood was anxious, speech was clear, coherent goal-directed with no loosening,

effect was anxious, psycho motor behavior had increased without any suicidal or homicidal thoughts or hallucinations. Attention, memory, level of intellectual functioning insight were fair; and judgment was rated between fair and poor. The prognosis was guarded.

On September 18, 2017, the psychiatrist, Dr. [redacted], also prescribed pain medication for radiculopathy from degenerative joint disease of the spine based on the suspicion for possible potential component of fibromyalgia pain and current use of Gabapentin.

On September 7, 2017, the Petitioner presented at the [redacted] for chronic pain visit. Notes indicate she completed chiropractic care during the week and did not help her pain. Since treatment, she has right groin pain. At the visit, patient noted that her legs are weak, arms "tender" and everything is painful. Patient also reported that her toes were numb. Knees were still throbbing as well. On presentation, the patient had no edema or effusion in bilateral knees, nontender medial and lateral joint lines of bilateral knees. Progress notes further indicate patellofemoral syndrome, continue the knee braces and physical therapy not helpful. Notes further indicate thoracic and cervical spine osteopathic arthritis and that patient symptoms suggest a fibromyalgia component.

On August 15, 2017, the Petitioner saw her therapist. Notes indicate anxiety score was severe. This was her second visit with her psychologist. The presenting problems were: patient self-reported being very busy with organizing her life, arranging or attending doctors' appointments and going to AA. She is volunteering at the community recovery center. Her anxiety is "out of this world". The patient continues to chew her lips. Patient reports symptoms of being anxious about change and things outside of her control. Patient describes herself as fretful and scared without always having clear provocation. Her heart races. Symptoms involving panic are reported to have begun after a car accident in 1999. The assessment noted that patient's anxiety remains strong as self-reported. On August 2, 2017, the Petitioner was advised that she had osteopenia, not osteoporosis, after a bone scan.

On July 27, 2017, the Petitioner was seen for a rehabilitation assessment consultation. The provisional diagnosis was patellofemoral disorders/syndrome, left knee. Notes indicate that pain has been present for 20+ years, on and off, alleviating factors include walking/activity. Veteran walks about one mile a day. Reports pain is worse with sitting, sleeping and carrying items. Functional mobility was also tested, and ability to sit and stand was within normal limits; a squat could be performed with mild pain; and all activities were performed without an assistive device. At the conclusion of the evaluation, notes indicate that patient presented with bilateral anterior knee pain without degenerative changes, consistent with patellofemoral pain syndrome. The patient PT evaluation revealed mild physical impairments. At the patient's request, self-management using home exercise plan and pain physiology education would be the course of treatment. The he notes concluded with the severity rated as worsening bilateral knees. The Petitioner was noted as a candidate for physical therapy with the prognosis for improvement rated as fair. No physical therapy was scheduled due to patient's inability to make regular visits.

The Petitioner was seen on July 13, 2017, for bilateral knee pain and left hip pain. At the visit, the Petitioner noted her knee pain is worse with squatting and requested a walker. Notes indicate she is walking a lot more which is giving her more knee pain. She is also experiencing left hip pain. The knee pain is worse with prolonged standing and sitting. The pain was reported at the last physical. Pain was a reported as a level 7/10. After the examination, the diagnosis and assessment was patellofemoral syndrome; and braces were recommended. The doctor's notes indicated that she does need a walker or wheelchair.

On July 14, 2017, the Petitioner was first seen for a mental status initial appointment based on a referral by her mental health care psychiatrist. During the appointment, the following notes were made: mood was anxious, thought processes organized, no evidence of formal thought disorder hallucination, delusions, mania or obsessive-compulsive features. She appears to be of average to above-average intelligence. No suicidal ideation denied. The patient self-reported anxiety out-of-the-roof, chewing her lips until raw, gets heart palpitations, muscle tension and time shortness of breath. The side of her face twitches or goes numb. Also reports racing thoughts. Patient reported chronic fatigue and pain. Reported history of turning to drinking to cope with the emotions and anxiety. At the conclusion, the assessment was anxiety disorder exacerbated by stress and chaotic personal history. PTSD was not clearly established.

A progress note was completed on June 28, 2017, indicating patient is having bilateral knee, back and neck pain; bilateral knee films are normal. Her spine films did show degenerative joint disease. Physical therapy made her pain worse. The pain is reported as everywhere and radiating up the neck and around over the top of the left shoulder. An MRI of the cervical spine in June 2017 showed multilevel degenerative joint disease was some neural foraminal stenosis. During the exam, the patient was advised to stop smoking; and patient reported no interest in quitting tobacco. At the conclusion of the exam, patient was offered PT evaluation and soft knee brace; but patient declined. Notes indicate no effusion or swelling.

On June 19, 2017, the Petitioner was given a psychiatric psychosocial assessment by her psychiatrist. At that time, her chief complaint was due to alcohol becoming problematic in 2004. At the initial assessment, the Petitioner self-reported being not depressed. At the time of the examination, attention, memory, level of intellectual functioning and insight were evaluated as fair; and judgment was rated as between fair and poor. The motivation for treatment noted, guarded prognosis. The diagnosis was alcohol dependence with alcohol induced mood disorder. The plan established was for outpatient substance abuse, group and individual therapy. Prescriptions were made for depression, insomnia and anxiety. At the time of the examination, the Petitioner was homeless.

The Petitioner participated in a psychology pain management group through the [redacted] ([redacted]) beginning June 14, 2017. The diagnosis for this group was noted as chronic pain syndrome. The Petitioner's MRI of her neck and spine were read by a physician's assistant at the [redacted] on June 13, 2017, noting recent MRI of neck and spine was read as being unchanged for mild degenerative arthritis changes from previously with mild progression of disease at only one specific disc space C5-C6.

There are more pinching and bone spurs on the left side which would explain problems in the left arm. The recommendation was further treatment for neck problems with a referral to a specialist rehabilitation physician. In addition, x-rays of the right and left knee were also reviewed suggestive of meniscus (shock absorber) cartilage problems were both normal; further MRI testing was needed.

On May 18, 2017, while in inpatient treatment, Petitioner was seen by the attending psychiatrist for upper back and neck pain. There was limited range of motion mostly in the direction toward left, lateral bending and rotation. There was some lower extremity sensory deficit reported and decreased grip strength. Subsequently, on May 16, 2017, a neurology consult was deemed necessary. The Petitioner was seen on May 11, 2017, while in inpatient treatment for alcoholism and reported pain in left side of body from pelvis up especially left side of neck, face temple, shoulder, shoulder blade and across chest. Throughout her inpatient stay the Petitioner was treated for severe-to-moderate left-sided pain which included facial and left arm numbness as well as pain in neck. Additional classes attended involved living with chronic pain and emotional coping skills mindfulness skills and various group therapy.

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 3**

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 1.04 Disorders of the Spine, and Mental Disorders 12.15 Trauma and stressor related disorders (PTSD) and 12.06 Anxiety and Obsessive-Compulsive 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, non-exertional, 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 non-exertional 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 non-exertional limitations due to her medical condition. Petitioner testified that she could stand for short periods 8-10 minutes and then must sit for 10 minutes; likewise, the Petitioner was unable to sit for long periods of time up to 10 minutes and then move. The Petitioner could walk a quarter mile, could not squat and could shower and dress herself, touch her toes and tie shoes. The Petitioner also testified that her hands go numb daily, and at times, she cannot pick up a coin and then her legs also go numb when sitting more on the left. She can carry her purse which she estimated weighed 2 pounds. The Petitioner also attends AA four days a week. The Petitioner can cook simple things and does not drive and has been sober for 19 months.

With respect to her mental impairments for anxiety and depression, the Petitioner testified that she has sleep disturbance with difficulty sleeping and uses a bite guard due to grinding her teeth and suffers from nightmares. She described her short-term memory as requiring her to struggle with putting things together, such as reading a book for an extended time, finding she cannot sit still or becomes overwhelmed with housekeeping. Petitioner described her anxiety attacks as making her hopeless, helpless and not leaving the house. When depressed, her self-care and hygiene suffers. The Petitioner also noted that she does not do well in noisy environments or enclosed spaces.

Given the Petitioner's chronic pain, objective findings of cervical positive MRI findings and ongoing treatment for chronic cervical, thoracic and lumbar pain with nerve block injections, it is determined that the Petitioner's residual functional physical capacity would allow her to perform sedentary work as defined by 20 CFR 416.967(a).

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has moderate limitations on her mental ability to perform basic work activities with marked limitations with respect to carrying out detailed instructions, and traveling in unfamiliar places. The evaluation made by her treating psychiatrist noted that she was improving, no longer homeless, and her GAF score was improved; however, her cognitive functioning despite average intelligence was limited further noting that even if she worked her anxiety would be a strong inhibiting factor.

Petitioner's RFC is considered at both Steps 4 and 5. 20 CFR 416.920(a)(4), (f) and (g).

**Step 4**

Step 4 in analyzing a disability claim requires an assessment of Petitioner's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed by Petitioner (as actually performed by Petitioner or as generally performed in the national economy) within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1) and (2). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner's work history in the 15 years prior to the application consists of work as a customer service job with [redacted] rental. This employment was not recalled during the hearing by Petitioner. There appears to be no other work history. Even though Petitioner has reported a BA in office administration, she has never been employed in any job fitting that description. Based upon the record presented, the Petitioner has no significant past relevant work. As such, 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 a person has a combination of exertional and non-exertional 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 53 years old at the time of application and 54 years old at the time of hearing, and thus, considered to be closely approaching advanced age (age 50-54) for purposes of Appendix 2. She is a high school graduate and a college graduate with no significant history of 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.

In this case, the Medical-Vocational Guidelines result in a disability finding based on Petitioner's exertional limitations based upon Rule 201.12.

In addition, due to the Petitioner's prior diagnosis of substance abuse and prior inpatient treatment for four months beginning in June 2017, the medical evidence demonstrated past alcohol abuse by Petitioner. At the time of the hearing, the Petitioner testified that she had been sober for 17 months and had not been drinking. The Petitioner also attend meetings at Alcoholics Anonymous (AA) four days per week on an ongoing basis. The medical records indicate that the alcoholism is tied to anxiety and PTSD as set forth in the Step 2 lengthy analysis of the medical evidence. Based upon the evidence presented, the issue as to whether the Petitioner's drug and alcohol abuse, referred to as DDA, is material must be examined.

The burden of proof to establish disability throughout the sequential evaluation process remains with the Petitioner. Alcohol abuse must be reviewed following the analysis found in SSR 13-2p to determine whether alcohol abuse or addiction is a contributing factor material to the determination of disability. See Social Security Act, Sections 223(d)(2)(C) and 1614(a)(3)(J) of the Social Security Act (Act). Also considered is whether considering all the Petitioner's medically determinable impairments, whether the Petitioner would continue to be disabled if he stopped using alcohol; that is, it must be determined whether alcohol abuse (DDA) is material. SSR 13 – 2p.

Five questions are posed to determine materiality.

1. Does the Petitioner have DDA?

   Based upon the medical documentation presented the answer is yes in that past hospitalizations and inpatient treatment are documented in the record. Medical records from his treating mental health provide indicate no alcohol use for over one year and that Petitioner is attending AA.

2. Is the Petitioner disabled considering all impairments including DDA?

   Yes. The Petitioner is determined to be disabled based upon her physical and mental impairments and is determined on the basis of finding of sedentary residual functional capacity, Petitioner is disabled based upon the Medical Vocational guidelines, rule 201.12.

3. Is DDA the only impairment?

   DDA is not the only impairment. Petitioner has both mental and physical impairments as detailed in the review of medical evidence contained in the Hearing Decision at Step 2.

4. Is the other impairment(s) disabling by itself while the Petitioner is dependent upon or abusing drugs or alcohol?

   Yes. The Petitioner's medical evidence clearly documents limitations both physical and mental based upon objective medical evidence presented and reviewed in this Hearing Decision at Step 2.

5. Does the DDA cause or affect the Petitioner's medically determinable impairment(s)

   The medical evidence does support DDA as being related to Petitioner ongoing anxiety and her PTSD however none of the evaluators and doctors gave an opinion that supported the conclusion that the Petitioner's anxiety, or PTSD is cause by her alcohol abuse although it may be exacerbated due to anxiety. Petitioner's medical records support that her other impairments would continue to be disabling given the Petitioner's most recent mental impairment evaluation as well as the physical limitations outlined that continue to persist despite prior alcohol abuse.

6. Would the other impairment(s) improve to the point of non-disability in the absence of DDA?

   No. The current several mental status evaluations and document physical evaluations and treatment sufficient medical evidence supports the Petitioner's continuing and ongoing disability after alcohol use ceased.

In conclusion, it is determined that based on the objective ongoing physical impairments and mental impairments documented in the record, no evidence was presented that would support that Petitioner's current conditions would improve if she no longer abused alcohol such that she would no longer be disabled.

Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner disabled for purposes of the SDA benefit program.

## DECISION AND ORDER

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

THE DEPARTMENT IS ORDERED TO 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. Reregister and process Petitioner's [redacted], 2017, SDA application to determine if all the other non-medical criteria are satisfied and notify Petitioner of its determination;

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

3. Review Petitioner's continued eligibility in January 2020.

LF/

**Lynn M. Ferris**
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**

Kimberly Kornoelje
MDHHS-Kent-Hearings

**Petitioner**

[redacted] MI [redacted]

BSC4
L Karadsheh
L M Ferris
MAHS