[redacted]

Date Mailed: October 31, 2018
MAHS Docket No.: 18-008061
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 September 6, 2018, from Detroit, Michigan. The Petitioner was represented by herself. The Department of Health and Human Services (Department) was represented by Kendra Hall, Medical Contact Worker.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Medical records were received from [redacted] and marked into evidence as Exhibit B; The Interim Order dated September 6, 2018 also requested records from [redacted] and from [redacted]. **The requested documents were NOT received.** The record closed on October 8, 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 11, 2018, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 13-19).

3. On July 26, 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. 3-12).

4. On [redacted], 2018, the Department received Petitioner's timely written request for hearing (Exhibit A, p. 2).

5. Petitioner alleged disabling impairment due to osteoarthritis in both knees with a total knee replacement of Left knee with ongoing pain. Bilateral carpal tunnel with injections and ongoing pain in right hand post release. The Petitioner is also obese with a BMI of 38.

6. On the date of the hearing, Petitioner was 51 years old with a [redacted], 1966 birth date; she is 5"5" in height and weighs about 230 pounds.

7. Petitioner is *a* high school graduate.

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

9. Petitioner has an employment history of work as Nurse's Aide.

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 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 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.

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (July 2015), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security

Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If an individual is found disabled, or not disabled, at any step in this process, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In general, the individual has the responsibility to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

Step One

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

In this case, Petitioner was not working during the period for which assistance might be available. Because Petitioner was not engaged in SGA, s/he is not ineligible under Step 1, and the analysis continues to Step 2.

Step Two

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or

mental impairment (or a combination of impairments) that meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for SDA means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the de minimis standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. Higgs v Bowen, 880 F2d 860, 862-863 (CA 6, 1988), citing Farris v Sec of Health and Human Services, 773 F2d 85, 90 n.1 (CA 6, 1985). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. 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 [redacted] 2018 the Petitioner was seen by her primary care physician for pain. At the time of the appointment the assessments noted chronic pain, primary generalized osteoarthritis, pain in left hand, pain in joints of right hand, pain in left knee, pain in right knee and presence of left artificial knee joint. During the appointment the doctor reviewed x-rays of patients right and left hands. The notes indicate mild degenerative changes no severe abnormalities. Notes indicate the doctor's treatment is limited due to the fact that patient has had surgery for carpal tunnel, injections in the interphalangeal joints and has had therapy. None of this has helped her with her pain. With regard to

her knee pain suggested follow-up with surgeon who did the knee replacement surgery to confirm no abnormalities. Pain medications were continued to attempt to give some relief with follow-up for testing and urine screens which she has been compliant with.

The Petitioner was seen by [redacted] on [redacted], 2018 for follow-up regarding bilateral hand pain and also knee pain. Notes indicate since last visit nothing had changed. Notes indicate pain exists still in both hands mainly in the thumb which is worse with gripping. She is also having sharp pain in her left knee with no new trauma, pain is worse with standing and walking. She is getting some minimal relief with medications. The examination noted morbid obesity, patient able to ambulate independently with slight antalgic on the left. Range of motion noted crepitus with movements of the knee and some mild pain but otherwise functional. Some medial and lateral instability at the knee was noticed, otherwise within normal limits. Left leg inspection noted there is some generalized obesity of the legs and mild tenderness at the knee. Some discomfort ranging the knee but no other abnormalities with some medial and lateral instability at the knee, otherwise within normal limits. Both arms were inspected with mild areas of tenderness with no significant swelling with range of motion noted as overall functional in all interphalangeal joints with strength overall 5/5 although some weakness with pinching.

The Petitioner was seen by [redacted] on [redacted], 2018 regarding unilateral primary arthritis of the first carpal metacarpal joint of the right hand. The right hand was injected at the first CMC joint space.

The Petitioner was seen by her primary care physician on [redacted], 2018 regarding chronic pain. Notes indicate that x-rays of the left hand were ordered. Noted degenerative changes in the right hand with likely same on the left. Injections into the first MCP joints bilaterally under ultrasound guidance was prescribed. Pain medications were renewed and notes indicate patient has been compliant with medications. Doctor notes patient must work on continued exercise, weight loss and smoking cessation.

The Petitioner was seen again at the [redacted] for follow-up after injections in [redacted] 2018. Patient was seen with complaints of mainly hand pain that is still severe on the right and getting worse on the left. She points around the thumbs as the main area of pain. She has difficulty with grip and holding onto objects, apparently she has seen a rheumatologist. Patient is also having ongoing knee pain. An injection was given by her orthopedic doctor recently in the right knee which has helped. Pain is worse overall with standing and walking. She is getting some relief with medications with no reported side effects. Examination of the range of motion in the hand on the right noted some difficulty with flexion of the thumb otherwise functional strength 5/5 overall with some weakness with pinching. Left arm/hand noted some difficulty with flexion of thumb otherwise functional strength five of five overall some arthritic changes were noted in both hands with no swelling.

The Petitioner was seen on [redacted] 2018 by the [redacted] for a review of chronic pain and medications. Notes indicate she needs to work on exercise

and weight loss which was discussed during the appointment pain medications were continued.

A diagnostic imaging report taken [redacted] 2018 of the left hand noted three views and a negative study with no acute abnormality noted negative ulner variance.
The Petitioner had a total knee arthroplasty (TKA) on [redacted] 2017. The surgery was successful and the Petitioner was discharged home with a walker after a one day stay
The Petitioner has been diagnosed with an anxiety disorder with by her primary care physician and was directed to take Xanax if she is feeling anxious. The Petitioner has had no treatment for anxiety or depression.

On [redacted], 2017 the Petitioner was seen by [redacted] At that time notes indicate some arthritic changes in her hands noted as mild. Apparently, another physician told her she had carpal tunnel and she had an EMG previously. Therefore, she is going to proceed with this carpal tunnel surgery. The carpal tunnel surgery was for the right hand. Knee pain is worse with standing and walking. A physical exam noted no significant swelling of the left knee or right knee. Some discomfort with knee range of motion but otherwise functional throughout with regard to her right hand she is very tender at the first MCP joint and slightly positive for Tinels.

The Petitioner had an eye examination on [redacted] 2017 and stable glaucoma was noted.

The Petitioner was seen at the [redacted] on [redacted], 2017. The Petitioner was noted as negative for anxiety, depression and feeling down. A physical exam was conducted noting minimal tenderness of the IP joint of the thumbs question of minimal swelling of the second MCP joint. Gait was normal, cervical spine was normal, thoracic spine was normal as well as lumbar spine. Shoulders right and left hands, hips right and left and knees noted normal. Her neurological testing noted all systems were normal. The diagnosis was pain in both hands the impression is rule out osteoarthritis versus inflammatory arthritis a basic metabolic panel testing for rheumatoid factor and other markers were to be performed and x-rays were ordered of the hands bilaterally.

The Petitioner was seen by her orthopedic doctor on [redacted] 2017 regarding a check of her left knee following left knee joint replacement surgery. The exam was four weeks after the replacement surgery. The patient presented using a cane and is doing well. Patient was still in physical therapy and doing well. On examination the Petitioner's weight was assessed and based on her BMI was given BMI management. Activity and exercise education was also given. Postoperatively, the range of motion of the left knee is satisfactory ambulation with a standard cane and strength is improving with physical therapy. The Petitioner was seen on [redacted] 2017 by her orthopedic doctor at which time she was seen for follow-up post left total knee arthroplasty, replacement. Notes indicate that she is doing well Notes further indicate patient states there are no complaints she is in very little pain. At that time range of motion was excellent with strength improving.

The Petitioner was seen at a sports medicine clinic at the [redacted] office. On [redacted] 2017 regarding follow-up for right hand carpal tunnel syndrome. At the time of the exam Petitioner reported having three injections which had minimal effect on her symptoms. Notes indicate pain in her right hand and right arm specified. Patient has been wearing of thumb spec splint. An EMG was obtained on [redacted] 2017 which revealed suggestive findings of median nerve mono neuropathy in right wrist. Physical exam of the right hand was made in noted positive Phalen's test on the right wrist, positive Durkin's test on right wrist and negative Tinel's test. At the conclusion of the examination the assessment was right carpal tunnel syndrome. Notes indicate that given patients continued symptoms despite three steroid injections patient is requesting a surgical intervention invention.

The Petitioner was seen for a return visit on [redacted], 2017 for a review of osteoarthritis of both knees and right hand with bi lateral carpal tunnel syndrome. The doctor ordered lab studies for rheumatoid factor and CCP with additional workup for connective tissue diseases such as lupus. Doctor notes she has arthritis of her hands and carpal tunnel and trigger fingers which are more orthopedic in nature than rheumatological. Physical exam noted prominent base of the thumb on IP joint prominence, negative trigger thumb on right and had some joint bony prominences with crepitation and rotation of both knees. In conclusion, the doctor ordered further testing to evaluate wait for inflammatory arthritis as well as rheumatoid and lupus. Doctor indicated she needs to follow-up with orthopedic surgery and will need an EMG. The doctor noted that the sedimentation rate was elevated requiring evaluation for inflammatory poly arthritis. This exam was conducted at the [redacted].

The Petitioner was seen at an [redacted] in [redacted] 2017 at which time popping clicking and locking was noted in the right thumb with decreased grip strength, mild tenderness over the volar aspect with hand swelling at the MP joint bilaterally Tinel's carpal positive right, negative left. At the conclusion of the exam, the doctor noted electrodiagnostic evidence suggestive, but not diagnostic of very mild sensory, primarily demyelinating, median mono neuropathy at the right wrist. There was no electrodiagnostic evidence of a generalized peripheral polyneuropathy or necrotizing myopathy affecting the bilateral upper extremities. Clinical correlation is very mildly abnormal, findings may or may not be consistent with patient's complaints of numbness and tingling which do not adequately account for the patient's complaints outside of the nerve distribution test; on the right, the impression was right trigger thumb, third cortisone injection done [redacted] 2017 very mild right carpal tunnel syndrome per EMG status. The plan was to continue cortisone injections, continue with bilateral thumb spec splints, to defer rheumatoid arthritis after rheumatologist follow-up next week. Surgery was to be considered if no improvement.

The Petitioner was seen at the [redacted] on [redacted] 2018 and discharged the same day. The Petitioner presented with left knee pain, exam showed some generalize pain and swelling. Patient was referred to orthopedic surgery as well as her normal pain specialists. Patient was discharged home in stable condition. Diagnosis was chronic left knee pain.

The Petitioner was seen at [redacted] in [redacted] 2017 for decisions regarding back, knee and hand pain at that time a medication review was conducted and medications were reviewed and patient was compliant. Petitioner was given the name a psychologist to discuss her anxiety. On physical exam both hands demonstrated arthritic changes at the interphalangeal joints with no significant swelling.

On [redacted], 2017 the Petitioner was seen for a joint injection to the right hand. The Petitioner had a consultation with rheumatology on [redacted] 2017 the primary diagnosis was osteoarthritis of the right hand, x-rays were reviewed showing mild ostracized at the bases of the first thumb, this is minimal, patient referred to hand surgeon. Referral was also made for evaluation in injection to the trigger finger of the right hand. Notes indicate bilateral carpal tunnel syndrome positive, prescribed carpal tunnel splints to wear in the evening. Osteoarthritis of the bilateral knees was diagnosed based on her x-ray which showed severe medial joint space compartment with bone on bone follow-up with her pain management doctor for injections.

On [redacted] 2017 the Petitioner was seen for left knee pain by [redacted] at which time Petitioner was scheduled for steroid injections into both knees and the first MCP of the right hand. A referral to a rheumatologist was made due to patients concern about further progression. On [redacted] 2016 the Petitioner was seen at the [redacted] practice at which time pain medication, Norco was prescribed after review of Petitioner x-rays of both knees and right hand with scheduled injections for both knees and right hand at the first M CP. Physical therapy program started for both knees. The Petitioner received x-rays of both the right and left hand on [redacted] 2016 due to pain in joints the impression noted some degenerative changes without evidence of acute osseous abnormality. X-rays of the right hand noted bone mineralization unremarkable, no evidence of acute fracture, no major bone or joint abnormality seen. Mild degenerative changes more prominent involving the radial carpal and first carpal metacarpal joint consistent with osteoarthritis. The x-rays of the knees taken on [redacted] 2016 also noted moderate bilateral osteoarthritis.

On [redacted] 2018 an independent medical examination was conducted. During the exam the Petitioner reported complaints of knee replacement with pain, Crohn's disease and right hand surgery. Notes indicate that Petitioner reported pain in her knees when she walks more than a block at a time. Pain is 10 of 10. During the examination, records were presented by several of her doctors. With regard to the activities of daily living, Petitioner reported she's able to get in and out of bed, dress and bathe herself and is able to drive, but not cook and clean for herself. With respect to cooking and cleaning her daughters assist with those chores. Notes indicate that no assistive device was brought or used during the examination. With respect to her knees normal range of motion was noted with no discomfort within these ranges. Finger thumb joint indicates ranges of motion (without indicating right or left) with no discernible discomfort within normal ranges noted, nodules noted over MCPs bilaterally, swelling also noted over MCPs.

At the conclusion of the exam the diagnosis was [redacted] status post left total knee surgery with chronic right knee pain and meniscal tear, status post right carpal tunnel and right first digit trigger finger surgeries, bilateral osteoarthritis in the hands and obesity. With regard to the examiner's functional assessment notes indicate no recommended limitation regarding the number of hours Petitioner should be able to sit during a normal eight hour workday, standing no recommended limitations regarding hours able to stand during a normal workday, walking there are no recommended limitations regarding the number of hours for walking during the normal eight hour workday, weight-bearing no recommended limitations regarding the amount of weight she should be able to lift or carry during a normal eight hour workday. Postural recommendations no limitations associated with bending, stooping squatting crouching or crawling. With respect to manipulative recommendations osteoarthritis in the hands is noted as well as noting that manipulative activities such as reaching pushing, pulling, handling, grasping, fingering, and/or feeling should be feasible continuously. No assistive devices were recommended.

On [redacted] 2017 the Petitioner had a surgery for a right carpal tunnel release and a right trigger thumb release.

The Petitioner was seen by the [redacted] on [redacted] 2017 after examination the diagnosis was pain in both hands rule out osteoarthritis versus inflammatory arthritis. Testing was ordered.

On [redacted], 2017 the Petitioner was seen and received an x-ray of her left knee postoperatively with very little pain noted excellent range of motion reported strength improving and neurovascular status in tact ambulating with a standard cane.

The Petitioner had in electromyogram on [redacted], 2017 the exam notes that there is electrodiagnostic evidence suggestive but not diagnostic of very mild only borderline on more sensitive palmar studies of demyelinating median mono neuropathy at right wrist. Carpal tunnel syndrome only if considered symptomatic with no evidence of prior denervation or reinterpretation. Clinical correlation noted these are mildly abnormal findings which may or may not be consistent with complaints the testing did not meet the electrodiagnostic evidence criteria for carpal tunnel syndrome.

The Petitioner attended physical therapy post left knee surgery and was discharged on [redacted] 2017 with notations that ability to negotiate stairs/curbs partially met and ability to prepare meals, partially met, ability to stand for a prolonged time (30 minutes) partially met and ability to walk up to 1 mile not met. This result was after 25 physical therapy sessions.

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner suffers from severe impairments that have lasted or are expected to last for a

continuous period of not less than 90 days. Therefore, Petitioner has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step Three

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

Based on the medical evidence presented in this case, listings 1.02 Major Dysfunction of a Joint(s) due to any cause and Listing 1.03, Reconstructive Surgery or surgical arthrodesis of a major weight bearing joint were considered. The medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Steps 4 and 5, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s), including those that are not severe, and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4); 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). *This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3).* The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b).

The exertional requirements, or physical demands, of work in the national economy are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a). Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools and occasionally walking and standing. 20 CFR 416.967(a). Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds; even though the weight lifted may be very little, a job is in the light category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. 20 CFR 416.967(b). Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. 20 CFR 416.967(e).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi).

In this case, Petitioner alleges exertional limitations due to her medical condition. Petitioner testified that she could stand thirty minutes, sit an hour or more, walk one block, could not squat, she could shower and dress herself, and has significant pain of 6 or more out of 10 even with pain medications, she is right hand dominant and has pain in her right hand at the thumb causing pain with writing, and difficulty lifting more than a pound. She receives assistance from her daughter who cooks for her, and assists Petitioner with her household chores because Petitioner cannot vacuum, sweep, scrub or do laundry. The Petitioner can prepare a bowl of cereal or microwave food for herself. In addition, the Department caseworker present at the hearing testified that she observed very visible arthritic swelling of Petitioner's hand joints in the wrists and knuckles and the Petitioner could not flatten her hand. In addition, the Petitioner is obese with a BMI of 38. It should also be noted that the Independent Medical Exam can only be useful to some extent and is given less weight due to the findings which are non-specific with regard to functional assessments made. Instead of specifying any specific assessment the examiner imposed no limitations whatsoever. By was of example, the examiner finds no recommended limitations regarding the number of hours Petitioner should be able to walk, lift and carry or stand. While assessing manipulative recommendations regarding reaching, pushing, pulling, handling, grasping, fingering and/or feeling the notes indicate should be feasible continuously, with the

notes acknowledging bilateral continuously, “osteoarthritis in the hands” – right. It is further unclear what if any testing was performed to determine the functional capacity. The IME examiner found no discernable discomfort with flexion of wrist and finger/thumb joint. Other medical examiners, including her ongoing treating doctor’s repeatedly note pain with range of motion in the hand and wrists. Thus, the findings of the IME are weighted accordingly, and are given little if any weight in light of the rest of Petitioner’s history. In addition, Petitioner suffers from pain due to her osteoarthritis in her left knee and hands and continues to receive significant pain medications based upon her doctor’s assessment of the necessity for pain medications. The Petitioner’s medical records also verify her total compliance with pain medication usage.

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.

With respect to Petitioner’s exertional limitations, it is found based on a review of the entire record that Petitioner maintains the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a) with some limitation regarding the use of the right hand.

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

Step Four

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

Petitioner’s work history in the 15 years prior to the application consists of work as a nurse’s aide. Petitioner’s work as a nurse’s aide, which required standing 7 hours and lifting up to 120 pounds regularly when transferring patients, pushing loaded meal carts, and wheel chairs, and feeding patients, which required medium to heavy physical exertion by Petitioner.

Based on the RFC analysis above, Petitioner’s exertional RFC limits her to no more than sedentary work activities. As such, Petitioner is incapable of performing past

relevant work. Because Petitioner is unable to perform past relevant work, Petitioner cannot be found disabled, or not disabled, at Step 4, and the assessment continues to Step 5.

Step 5

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

At this point in the analysis, the burden shifts from Petitioner to the Department to present proof that Petitioner has the RFC to obtain and maintain substantial gainful employment. 20 CFR 416.960(c)(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services, 587 F2d 321, 323 (CA 6, 1978).*

When the impairment(s) and related symptoms, such as pain, only affect the ability to perform the exertional aspects of work-related activities, Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix 2, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

In this case, Petitioner was 51 years old at the time of application and 51 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 with a history of work experience as a Nurse's Aide, an unskilled work occupation with no direct entry or transferability. 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 rule 201.12 results in a disability finding based on Petitioner's exertional limitations.

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 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. Re-register 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 October 2019.

LF/cg

Lynn M. Ferris
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) 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

Via Email:

MDHHS-Wayne-31-Hearings
L. Karadsheh
B. Sanborn
B. Cabanaw
BSC4- Hearing Decisions
MAHS

Petitioner – Via First-Class Mail:

[redacted]