[redacted]
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Date Mailed: January 29, 2019
MAHS Docket No.: 18-010121
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 October 31, 2018, from Detroit, Michigan. The Petitioner was represented by herself. Edward Forrest appeared as a witness for Petitioner. The Department of Health and Human Services (Department) was represented by Cheryl Watkins, Assistance Payments Supervisor, and Sharan Lamar, Assistance Payments 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. The Interim Order requested records from Dr. [redacted], Dr. [redacted], Dr. [redacted] and Dr. [redacted]. There were documents already in the hearing packet for Dr. Brennen, which were reviewed. The requested documents were not received. The record closed on December 3, 2018. 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], 2018, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On August 30, 2018, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 5-11).

3. On August 30, 2018, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit F, pp. 51-54).

4. On September 24, 2018, the Department received Petitioner's timely written request for hearing (Exhibit A 1, pp. 2-3).

5. Petitioner alleged disabling impairment due to dysautonomia pots syndrome, posterior orthostatic tachycardia syndrome which cause her blood pressure to drop when she stands or sits too long, seizures, knee injury with chronic pain, and vascular necrosis and chronic pain syndrome.

6. On the date of the hearing, Petitioner was [redacted] years old with a [redacted], 1986, birth date; she is [redacted]' [redacted]" in height and weighs about [redacted] pounds.

7. Petitioner is a high school graduate and has a certificate as a certified nurse's assistant.

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

9. Petitioner has an employment history of work as a patient admissions clerk at a physical therapy clinic as well as a receptionist, and assisted the physical therapists with regard to setting up equipment and setting up charts.

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 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 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, was reviewed and is summarized below.

The Petitioner was seen at the ER on April 2, 2018, due to an elevated heart rate and near syncope with report of increasing episodes in the last month. Original episodes were on urinating or standing, the current episode happened while resting. The Petitioner stayed overnight to see a cardiologist in the morning. An MRI of the brain

due to complaints of syncope and history of brain tumor was normal with no evidence of recurrent intracranial brain tumor.

On August 9, 2018, Petitioner was seen for right knee pain described as sharp pain and chronic. Patient was using cane for ambulation. Injury of the knee was due to direct trauma. Note pertinent findings decreased range of motion, instability, limping, pain with movement swelling and weakness. An EEG was done with neurology, which was negative. At the time of the exam, patient denied abdominal pain, nausea and vomiting and dizziness. The BMI was 40. The diagnosis included chronic pain due to trauma.

A nurse practitioner completed a Medical Needs Form dated June 15, 2018, noting chronic illness due to syncope and collapse, possibly seizures. The Petitioner was found able to perform personal-care activities without assistance, and was found unable to work at any job, until resolution of the symptoms, and medical process still ongoing to determined cause of illness/condition. No testing or other medical data was referenced.

On February 14, 2018, the Petitioner was seen at the Core Institute for her knee pain; and after an exam, the doctor noted that she does show some mild degenerative changes and a Baker's cyst, which was present prior to her fall. The doctor could not find a good reason for her inability to bear weight. The MRI showed degenerative changes of the patella. Functionally she was very limited. The doctor notes loss of articular cartilage made her susceptible to chronic pain. The Doctor's notes indicate that he did not like the idea of performing an arthroscopy of her knee because he thought patient would be difficult to manage. The examining doctor made a referral to surgery for lateral release due to lateral tracking.

The Petitioner was seen at the [redacted] on March 11, 2018, with complaints of abdominal pain, nausea and vomiting. The pain has persisted for roughly 1½ weeks, and current level of pain is for out of 10. The pain is described as dull crampy-type pain. Patient also noted bilateral back pain. History of kidney stones noted. Petitioner was seen earlier in the week with bloodwork and exams with same complaints. The urinalysis was negative UTI. After a thorough examination, the diagnosis was abdominal pain, nausea and vomiting; suspect likely due to marijuana use. Suggested she stop marijuana use and return to the emergency department if symptoms persist. Also noted that all consults, labs and imaging were reviewed and were unremarkable.

The doctor noted that she may be showing signs of cannabinoid hyperemesis syndrome and was told she should try to stop all her marijuana use to see if that was the cause of her nausea and vomiting. A CT of the abdomen and pelvis found no bowel obstruction, no enlarged lymph nodes, no bowel wall thickening; and other organs were unremarkable with a negative abdominal x-ray series as well.

On May 24, 2018, the Petitioner presented at her family practice with knee pain, reported as moderate. Patient also reported with seizure, more frequent recently with

extreme fatigue, no associated factors were triggers. Awaiting tilt table test, patient is concerned that she has POTS. Patient also reported necrosis of femur. The exam of the right knee noted swelling, small effusion and tender joint line, with pain with flexion and extension, stability was normal; and gait and station overall was normal. Also noted was necrosis of right femur, and a referral for MRI was made. The Petitioner reported to the doctor's office several times in May presenting on May 13, 2018, with vomiting and low back pain, and abdominal pain with two visits to the ER with no UTI found. The Petitioner's anxiety was treated with Lexapro. On May 10, 2018, Petitioner was seen by [redacted] for follow-up for right knee pain. Prescribed brace causes her foot and toes to go numb; exam notes walks with limp; patient is deconditioned and overweight, and cannot bear weight on her heels. She is unable to step up with her right leg. There is no swelling, erythema or ecchymosis. The knee cap was tender to palpation, with patellar crepitus, with lateral patellar tilt. Stability was good. Lymphedema distally. The Petitioner received steroid injection and prescribed Neurontin for burning pain.

On July 17, 2018, the Petitioner was seen for right knee pain due to smashing her femur with a severe contusion in the proximal tibia. Physical therapy was tried but was limited due to pain. Patient reports she cannot bear full weight through her right heel due to pain; therapists have noted abnormal patellar tracking. Petitioner was seen by several doctors, including an orthopedic surgeon noted tibial bruising, and arthritis. Another doctor gave her a series of injections of hyaluronic acid was caused severe pain and swelling; cortisone injections were also tried, causing pain. Another orthopedic surgeon prescribed patellar repositioning of the tendon. This procedure was not agreed to. Finally, a doctor attempted cortisone injections, which resulted in the swelling, and determined patient had osteonecrosis in the distal right femur. Petitioner noted she did not tolerate Lyrica which caused her to pass out. Her companion at the exam noted that she had a seizure. A physical examination was conducted, and the exam was restricted due to right lower knee and was limited due to pain. Range of motion in the right knee was fine except for pain with the right knee flexion. Also reviewed were MRI from October 2017 and January 2018 showing tibial bone edema with stable stage for chondromalacia, no evidence of osteomyelitis or osteonecrosis. The assessment noted after falling into a metal gate, the superimposed patellar front of Baker's cyst occurred. She had a tibial contusion, which is now resolved; she also has burning right foot pain due to plantar fasciitis and Morton neuroma with over pronation and provocation on exam. The doctor revised the medications continuing Gabapentin, adding a Lidocaine patch, Tylenol 1000 mg and suggested PCP be consulted about use of Lexapro versus Cymbalta; and physical therapy at Med Rehab and pain psychology was suggested. No injections were recommended and no repeat imaging. Follow-up was to be 4 to 6 weeks follow up.

The Petitioner was seen at [redacted] on March 26, 2018, by Dr. Schueller. Date of knee injury is noted as August 26, 2017. The Petitioner reported pain with stairs and walking. The Petitioner reported she had been receiving aspirations due to a Bakers cyst every several weeks. At the time of the examination, she was

using a cane. A history of brain tumor in 2011 is also reported. History of kidney disease and acute kidney failure reported in 2017. The patient's BMI was 39.7. Exam notes indicate patient is deconditioned and overweight, neutral alignment with no hind foot bowel gas. Walks with a limp. Unable to bear weight on her heels. Apprehension noted. She is unable to step up with her right leg. Lateral patellar tilt, good stability and lymphedema distally. The Impression was right frontal militia patella right knee. Obesity due to excess calories and Bakers cyst of the right knee. The doctor explained to Petitioner surgical intervention is not recommended to treat her pain. A knee brace was provided for stability. Physical therapy was prescribed strength and her knee.

The Petitioner was seen for follow-up on May 10, 2018, and presented with complaints of burning pain in her knee and difficulty walking on the right leg and was interested in an injection. Meloxicam and prednisone as prescribed for pain has given with little relief. Patient noted she may have POTS syndrome and is going on disability. Patient reported that she has started to fall regularly. History of vitamin D deficiency and blood pressure heart rate problems also reported. Due to continuing pain, a cortisone injection into the right knee was completed. Rheumatoid arthritis bloodwork was also ordered. Patient was instructed to wear the knee brace as needed for comfort. The doctor instructed the patient to quit smoking and emphasized crucial to her treatment. At a follow-up exam on May 17, 2018, cortisone injection did not help. Knee was swollen and worse. The exam notes indicate that patient walks with a limp and is unable to bear weight on her heels. The patient's lab results were abnormal including low vitamin D levels. Patient was referred to rheumatology to seek additional treatment options.

The Petitioner was admitted to the hospital on April 2, 2018, symptoms of rapid heart rate the prior day; the symptoms were highly suggested a vagally mediated presyncope. At the time of the examination and history, patient reported two-week history of increasing near syncope. Patient reported having sweats and cold after urination, feeling flushed, weak and mildly confused. She does not report losing complete consciousness. Recovery was about 20 to 30 minutes to feel like herself again. She was aware about what was going on but was groggy. She monitored her blood pressure, which was stable in the 110 to 120 systolic range. The night prior to reporting to the ER, Petitioner's heart rate was elevated; and her primary care physician told her to go to the ER. The ER labs were unremarkable, troponin levels were negative; and EKG noted normal sinus rhythm without ischemic changes. During her ER stay, heart rate dipped to the low 40s while sleeping. Cardiology is asked to consult regarding near syncope. Petitioner was seen for a cardiac evaluation; notes indicate that episodes appear to be vagal and recommendation was to remain well hydrated, avoid caffeine, lie down and elevate legs. A 30-day EVM was scheduled. Patient remained in the hospital overnight so she could consult with a cardiologist in the morning. The diagnosis was near syncope. The Petitioner was discharged with continued monitoring to be given later. The Petitioner had an echocardiogram, which was essentially normal in the ejection fraction of 55%.

In October 2017, the Petitioner was seen by her DO for chills and fatigue and arthralgia(s) of right knew with no back pain. MRI was reviewed. Findings were pain with movement and swelling. The MRI showed marrow edema and subcortical fluid that could be related to trauma or osteomyelitis. BMI was 42.6. The right knee laceration healing. On October 5, 2017, the pain is dull with tenderness which moderately limits activities. (Exhibit E, p. 57.)

On September 25, 2017, the Petitioner injured her knee on a fence gate which entered a portion of her right knee, resulting in nine stiches. She was seen three days later at her DO's office and noted complaints of sharp pain, with daily pain, which moderately limits activities and unable to perform activities without pain. Pertinent findings included bruising, limping, pan with movement, redness, stiffness and swelling. Range of motion was decreased and pain with flexion and extension. Medication for swelling was prescribed.

In June of 2017, the Petitioner was seen by her PCP DO for headache (migraine without aura and anxiety brought on by stress. The Petitioner was given Xanax refill and Topiramate.

Finally, a thorough review of the medical records did not provide evidence of POTS syndrome diagnosis.

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 1.02 Major dysfunction of a Joint(s) due to any cause and 12.06 for anxiety 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 cook things in the microwave, grocery shop using a scooter, sit and watch television for two hours, can use the internet and Facebook, could not vacuum, sweep or do laundry, but can wash dishes and pick up. The Petitioner further testified that she could sit for 10 or 20 minutes and was then required to move around, she could stand 20 minutes and then sit due to her blood pressure; she can walk 20 feet with a cane, could tie her shoes and touch her toes, sometimes needs assistance with dressing and experiences pain in right leg when walking. Petitioner can carry 5 to 7 pounds. Petitioner also reported a drinking problem which ended in January 2017. The Petitioner also experiences ongoing pain with her knee and has received multiple steroid injections. The Petitioner also uses a cane sometimes for walking. With respect to Petitioner's anxiety, she has not treated with a mental health provider and is given medications for her anxiety, which based on the medical records is treated with medications and is stress induced. Also considered was Petitioner's ongoing complaints of nausea and abdominal pain; however, based upon the objective medical evidence and the multiple test results which failed to substantiate a basis for these symptoms, the pain associated with these symptoms was not determined to be medically substantiated. The Petitioner's knee pain was considered and supported in the medical documentation. Also, no objective medical evidence was shown to support seizures including the MRI of the brain that is part of the medical record.

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).

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild limitations on her mental ability to perform basic work activities.

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 working as a receptionist for a physical therapy facility setting charts, greeting patients, working at the computer, setting up equipment for the therapists, and managing the patient flow of the office. The position required the Petitioner to be up and down all day and at times moving heavy boxes weighing between 25 to 30 pounds. Petitioner's work as a receptionist and assistant at the physical therapy office required some sitting, lifting of boxes and movement walking to set up equipment and setting up patient electrodes, which required standing and sitting all day and lifting up to 25 to 30 pounds regularly, required light physical exertion.

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. Petitioner also has mild limitations in her mental capacity to perform basic work activities. In light of the entire record, it is found that Petitioner's non-exertional RFC prohibits her from 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).

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 32 years old at the time of application and 32 years old at the time of hearing, and thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. She is a high school graduate and had a CNA certificate with a history of work experience as a receptionist and assistant at a physical therapy facility. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities.

Based solely on her exertional RFC, the Medical-Vocational Guidelines, Rule 201.27, result in a finding that Petitioner is not disabled. Petitioner's non-exertional RFC imposing mild limitations on her mental ability to perform basic work activities does not preclude her from being able to adjust to simple, unskilled work activities on a sustained basis. Accordingly, Petitioner is not disabled at Step 5.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner not disabled for purposes of the SDA benefit program.

DECISION AND ORDER

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

LMF/jaf

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

DHHS

Tiffany Flemings
MDHHS-Washtenaw-Hearings

Petitioner

[redacted]
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