GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM

ORLENE HAWKS
DIRECTOR

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Date Mailed: February 1, 2019
MAHS Docket No.: 18-011274
Agency No.:
Petitioner:

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 November 29, 2018, from Detroit, Michigan. The Petitioner was represented by herself. The Department of Health and Human Services (Department) was represented by Michelle Morley, Assistance Payments Supervisor, and Margaret Smith, Family Independence Manager.

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 January 2, 2019, 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 2018, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On September 24, 2018, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 12-18).

3. On September 25, 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. 8-11).

4. On October 15, 2018, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 3-5).

5. Petitioner alleged disabling impairment due to diabetes with neuropathy, migraine headaches with auras and chemical sensitivity and extreme pain due to finger nerves, multiple hand (trigger finger surgeries) and wrist surgeries, diabetes insulin dependent with neuropathy, club foot with multiple surgeries, low back pain and hip pain on right due to left foot deformity. The Petitioner also alleged mental disabling impairments due to PTSD, self-injury of her body, borderline personality disorder, anxiety and depression.

6. On the date of the hearing, Petitioner was ██ years old with a ██████████, birth date; she is ███" in height and weighs about ███ 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 a cashier at Walmart and convenience stores which also included stocking shelves, and factory work as a part inspector.

10. Petitioner has a pending disability claim with the Social Security Administration.

<u>CONCLUSIONS OF LAW</u>

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 [redacted], 2018, the Petitioner underwent surgery on her right middle finger for trigger release. On [redacted] 2018, the Petitioner underwent a release of first dorsal compartment left hand.

On [redacted], 2017, Petitioner was reported as pain in back left heel better and right heel and ankle are no longer very painful. Need to use a roll-about to work in store to get to back of store and rest her left leg. Leg sensation irregularly decreased along left sural nerve and lateral heel right foot sensation intact bl strength 4/5, with lateral

calcaneal neuritis left heel stable, type II diabetes ulceration left heel, painful scar, with Haglund's deformity of the left heel.

On [redacted], 2018, the Petitioner was seen by her neurologist, and noted weakness left foot muscles, reflexes reduced at ankles, tendency to drag left food and get botox injection for migraines which have been helping. An MRI taking [redacted] 2017, showed no acute intracranial pathology. Noted some weakness in sa distal muscles of left foot and decreased pinprick sensation to distal lower extremities. Can walk without assistance and tendency to lean to left. Decreased pinprick sensation to distal lower extremities suspect autonomic diabetic neuropathy, diabetic peripheral neuropathy and chronic back pain.

The Petitioner was seen at McLaren Pain Management on J[redacted] 2018, and complex regional pain syndrome type 1 with legs not responding to ketamine infusions. Testing on [redacted], 2018, based on a duplex venous study noted legs are negative for DVT. Also noted numbness and tingling both feet with multiple surgeries on both feet and six trigger-finger surgeries. Also noted were very fluctuant blood glucose numbers, signs of diabetic neuropathy. Also, tile table test was positive.

An MRI taken at [redacted]Medical Center notes cervical spine, moderate disc protrusion at C5-C6, with moderate deformity right anterior aspect of cervical cord, mild disc protrusion at C7-C7 with only mild effacement of the thecal sac.

Petitioner was seen for wound care on [redacted] 2018, due to left calcaneus, pressure ulcer, diabetic would of lower extremity with multiple reconstructions of left heel, with large callus with longitudinal horizontal fissure through it with some crusted blood at base of fissure, removal of approximately 50% of hyperkeratotic tissue.

The Petitioner does use an assistive device when walking more than 30 feet or for stairs due to limp and left club foot.

Environmental limitations due to chemical sensitivity and migraines.

The Petitioner was seen in the emergency room on [redacted] 2018, due to a fall down the basement stairs injuring her right arm. During the emergency room, treatment for pain was described as constant, sharp and aggravated by movement and alleviated by rest. The diagnosis was right arm shoulder strain. The Petitioner was discharged in stable condition. X-rays of the shoulder, elbow, and humerous noted no acute osseous abnormality. The Petitioner was also seen in the emergency room on [redacted] 2018, with complaints of diabetic ketoacidosis, dehydration and vomiting. The diagnosis for this admission was hyperglycemia and diabetes mellitus. The Patient was discharged home and ordered to return if conditions worsen within 24 hours.

The Petitioner was seen for hyperglycemia in the ER on [redacted] 2018, with complaints of extreme fatigue and high blood sugars. She was discharged improved.

Petitioner's medical records contain multiple notes of hand surgeries for trigger release on [redacted] 2018 left hand and was diagnosed with cubital tunnel syndrome, left elbow and dequervain's syndrome of left wrist forearm.

On [redacted] 2018, the Petitioner underwent a trigger release of the right middle finger of the right hand. The surgery involved aftercare of the left hand for suture removal hand notes indicate patient was unable to move the middle finger. The notes in the patient file indicate multiple surgeries of the right hand for trigger digit release and left foot surgery in 2015 of the third, fourth and fifth toes due to club foot.

On [redacted] 2018, the Petitioner was seen by her orthopedic surgeon for large joint arthrocentesis and primary osteoarthritis of right knee with transient synovitis of right knee. MRI was reviewed. Right knee was injected with steroid and aspirated.

On [redacted] 2018, Petitioner was seen by her surgeon for index finger on left hand with extreme pain, reports finger snaps and catches. Petitioner had just had a left thumb trigger finger release. Release of trigger finger left index requested, notes indicate that she should consider arthroscopy but too many sores at the time of exam.

On [redacted] 2018, the Petitioner was seen again by her surgeon for suture removal and aftercare. On [redacted] 2018, seen for follow-up on right knee for arthritis and synovitis. Left index finger swollen and swelling of her other fingers with difficulty bending. Patient received an injection of the knee. On [redacted] 2018, left trigger follow-up with numbness getting worse and reports that injection relief only last a few days. The right knee exhibit effusion. Consideration of arthroscopic surgery for knee. MRI results note large effusion with synovitis of knee, mild medial mild deep patellar with no meniscal tear. (Some of the MRI was not readable due to copy clarity).

The Petitioner was seen on [redacted] 2018, for suture removal due to small joint arthrocentesis and trigger finger of left thumb, and pain of finger of right hand. The Petitioner was also seen due to right knee pain, resulting from a fall down stairs with swelling since and knee pops when walking. The Patient was positive for depression, and gait problem, joint swelling and stiffness. Exam of knee notes effusion, with tenderness in the medial joint line with range of motion rated 5, abnormal extension, and flexion 70 abnormal with painful arc of motion with pain with Varus stress without instability.

Petitioner was seen at ER for migraine twice in [redacted] 2017 and as well as swollen lower extremities. Petitioner was seen again in ER for suicidal ideation and picking of her skin sore, in [redacted] 2017 and [redacted] 2017. In September the sores were multiple and self-inflicted. The Petitioner was also seen in the ER in [redacted] 2017 for Migraines with vomiting after backing into a pole; notes CT of head no acute intracranial findings and was released with finding of migraine and trapezius muscle strain. The Petitioner was also given [redacted] 2017, a transthoracic echocardiogram, which was normal, with 60%-65% ejection fraction. The Petitioner was also seen in [redacted] 2017 for multiple ER visits due to migraine. In [redacted] 2017, the

Petitioner was seen at ER due to cracking skin on left heel worsening concern due to diabetes. Notes also indicate picking of skin. In an ER visit in 2017, multiple scars, bilateral upper arms, were noted with referral to follow up with psychiatric treatment for self-picking and anxiety.

Petitioner has been seen ongoing since 2016 in for continuing anxiety, and skin picking.

Her left hand on 2018, notes indicate left wrist surgery, right wrist surgery and left-hand surgery trigger release approximately 10 years earlier. In addition, the diagnosis noted tunnel syndrome left elbow and dequervain's syndrome of the left wrist and forearm. On 2018, the Petitioner underwent release of the first dorsal compartment of the left wrist due to instant no seen tenosynovitis of the first dorsal compartment. During her multiple ER visits, the Petitioner was treating at least monthly with her therapist. Petitioner also became homeless in 2017. In June, Petitioner was identified as having poor impulse control, self-harm behavior and previous suicide attempts. An Annual clinical assessment was completed in of 2017 and was diagnosed with generalized anxiety disorder and was mildly impaired for self-care and had moderate difficulty with social relationships. Petitioner's therapy was extended for an additional three months to address anxiety and was classified as an adult consumer with serious mental illness.

The Petitioner had an MRI of lumbar spine on 2018. The Impression was no significant findings with no focal disc herniation or canal stenosis.

On January 24, 2018, Petitioner was reevaluated at the Pain Clinic and was diagnosed with chronic pain syndrome, and Complex Regional Pain Syndrome (CRPS) of bilateral feet. The Petitioner was receiving Ketamine infusions and discontinued them as well as discharged herself from the pain clinic. The pain clinic formally withdrew as Petitioner's personal physicians. Petitioner began ketamine infusion on 2017 and 2017 and 2018, due to CRPS. The Petitioner also underwent a standard tilt protocol with blood pressure drop to 69/42. Noted positive tilt by hemodynamics with a drop in blood pressure.

The Petitioner was seen for an independent medical exam on 2018. Chief complaints were club left foot, diabetes, multiple hand surgeries due to trigger fingers, elbow surgery and carpal tunnel syndrome. Petitioner reported use of a cane or crutches when walking more than 30 feet and difficulty doing any tasks that requires squatting or kneeling. A limp was noted while walking. Petitioner was unable to heel or toe walk or squat, straight leg raising was negative and no paravertebral muscle spasm. Grip strength was slightly diminished and difficulty typing a shoelace but able to manipulate her wrist splints the diagnoses was major depression, recurrent in partial remission, somatic symptom disorder, social anxiety, PTSD, borderline personality disorder and Insomnia. Range of motion in ankles was diminished on the left. The Conclusion was history of congenital left club food status post multiple surgical repairs

with callus formation on the bottom of foot. Patient has diminished range of motion in left ankle, and could not heel and toe walk or squat. History of bilateral carpal tunnel syndrome and trigger fingers. Patient does have diminished grip strength with loss of digital dexterity.

Petitioner was seen on [redacted] 2018, and treated for an open diabetic ulcer on left posterior heel. The wound was described as a large callus with longitudinal and horizontal fissure through it, with some crusted blood. Diagnosis was diabetes foot ulcer and type I diabetes with neuropathy. Testing of monofilament not detected on the plantar surface of right foot.

On [redacted] 2018, the Petitioner was administered a lower limb venous duplex study due to edema. The Final Impression was bilateral legs negative for deep vein thrombosis. There was spontaneous phasic flow with good response to distal augmentation with no evidence of superficial reflux. The Petitioner has been diagnosed with lateral calcaneal neuritis right heel and medial and lateral calcaneal neuritis of left heel with callus with fissure of left heel with painful scar left heel. The lower extremity sensation is irregularly decreased along the left sural nerve and lateral heel.

In [redacted] 2017, the Petitioner was tested for sleep problems and was found to have obstructive sleep apnea and was prescribed a CPAP machine.

An MRI of the cervical spine was performed on [redacted] 2018, with Impression of moderate posterior disc protrusion centrally and to the right at C5-C6 with moderate deformity of the right anterior aspect of the cervical cord, mild disc protrusion at C7-7 with only mild effacement of thecal sac. An MRI of the thoracic spine was performed on the same date with the impression of mild degenerative changes throughout. Endplate hypertrophic changes with associated disc bulging in the mid thoracic region with no acute abnormality. The MRI were performed due to chronic neck and back pain.

On [redacted] 2018, the Petitioner had a CTA of the head due to complaints of dizziness. The impression was no evidence of any residence at the interior communicating artery, bifurcation both middle cerebral arteries or basilar tip. No evidence of large enhancing mass lesions in the brain parenchyma. Mucosal thickening in the white oak air cells, both maxillary sinuses with retention cysts/polyps in both maxillary sinuses.

The Petitioner was seen on [redacted] 2018, by her mental health provider and was last seen [redacted] 2018. Petitioner reports are very difficult for her. She has presented to the emergency department several times because she feels like she wants to die. She does not act on the feelings. Reports struggling with skin picking behavior, obsessively, reports worse than every before, struggles with her mind racing about everything going on. Patient carries a mask due to multiple chemical sensitivity. The patient presented walking with crutches and wrist brace with a metal splint on one of her fingers with sores on her arms and her face. The diagnosis was Major Depression, recurrent. Somatic

symptom disorder, with traits of borderline personality disorder, and social anxiety. Skin picking id OCD in nature. The Cymbalta was increased. Notes indicate skin picking is sever, likely due to anxiety being worse.

The Petitioner was seen on [redacted] 2018, by her psychiatrist for review and follow-up. Patient reported anxiety and depression with occasional fleeting thoughts of suicide with denial of ever acting on it, continues to have anxiety and body pain. At the conclusion, the diagnoses were major depression, recurrent in partial remission, somatic symptom disorder, social anxiety, PTSD, borderline personality disorder and insomnia.

The Petitioner was seen on [redacted] 2018, for follow-up with her psychiatrist. Petitioner reports panic attacks when in stores and chronic musculoskeletal pain. Also reports multiple surgeries on right hand and one of her heels due to congenital defect. The notes indicate that she walks with crutches, numerous metal splints on right hand. The diagnoses were major depression, recurrent in partial remission, somatic symptom disorder, social anxiety, PTSD, borderline personality disorder and Insomnia. Remeron was increased.

The Petitioner was seen on [redacted] 2017, and reported depressed with thoughts of suicide not acted upon. At the time, the Petitioner was on methadone. The Petitioner expressed concerns about her mother who she is living with harming her. Anxiety is reported as high with PTSD flashbacks of a past car accident and pain reported 7/10 due to ketamine infusions for pain in her foot with insomnia. Reports spending two hours picking her skin. Diagnosis was generalized anxiety disorder, Major Depression recurrent sever without psychotic features.

The Petitioner was seen by her endocrinologist on [redacted] 2018, for diabetes control. The notes indicate based on testing with glucose sensor for two weeks that she has hypoglycemia at nighttime and hyperglycemia during the day most of the time and has fluctuating number and hypoglycemia unawareness. The Petitioner had a Medtronic insulin pump, with very fluctuant blood glucose numbers. The exam noted signs of diabetic neuropathy.

Petitioner was seen by her neurologist on [redacted] 2018, for migraine headaches. Notes indicate that botox injections were received which have been helpings. The impression also noted positive tilt table test and symptoms are most likely due to autonomic neuropathy from diabetes mellitus and chronic back pain maintained on Lyrica. Botox to be continued. Findings also included decreased pinprick sensation to the distal lower extremities and reflexes are decreased. Patellar and ankle reflexes are decreased. Able to walk without assistance by tendency to lean towards left. The Impression was migraine, positive tilt table test, suspect autonomic diabetic autonomic neuropathy, diabetic peripheral neuropathy, severe, chronic back pain abnormal brain MRI with developmental vascular anomaly in the left frontal region and Migraine headaches with aura, intractable to medication, under good control with botox. Midodrine for treatment of autonomic neuropathy.

Petitioner also underwent physical therapy for neck pain and left shoulder numbness with pain beginning in January 2018 as prescribed by her neurologist. Notes indicated that that patient ambulates with a limp on the left side.

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, 1.04 Disorders of the Spine, 9.00 Endocrine Disorders Diabetes; Mental Disorders, including 12.04 Depression, 12.06 Anxiety disorders and 12.15 Trauma and stressor related disorders as well as 11.14 Peripheral Neuropathy 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 only several minutes due to pain, and walk less than a block and requires use of crutches. The Petitioner cannot perform a squat and can sit for varying lengths of time about one or one and a half hours, she uses a scooter to grocery shop and bathes once a week with difficulty washing her back and hair, and problems with buckling her pants. She can carry about a pound and has pain and wears braces due to carpal tunnel and trigger finger releases. The Petitioner also has knee pain, bilateral heel pain and has a congenital club foot.

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 does not maintain the physical capacity to perform sedentary work due to her bilateral carpal tunnel and finger splints and difficulty walking and use of crutches work as defined by 20 CFR 416.967(a).

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has moderate to severe anxiety and self-injury which places 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 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 serving as a cashier at ██████ and convenience stores, and light factory work inspection parts.

Petitioner's work in these positions involved light work, which required standing 6-8 hours and lifting up to 10-20 pounds regularly, required light physical exertion.

Based on the RFC analysis above, Petitioner's exertional RFC limits her to no more than less than sedentary work activities. As such, Petitioner is incapable of performing past relevant work. Petitioner also has moderate to severe 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 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 ██ years old at the time of application and ██ 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 with a history of work experience as a cashier and light factory work. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform less than sedentary work activities.

In this case, the Medical-Vocational Guidelines, Appendix 2, do not support a finding that Petitioner is not disabled based on her exertional limitations. The Department has failed to counter with evidence of significant numbers of jobs in the national economy which Petitioner could perform despite his limitations. Therefore, the Department has

failed to establish that, based on her RFC and age, education, and work experience, Petitioner can adjust to other work. Therefore, Petitioner is 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 disabled for purposes of the MA and/or the SDA benefit program.

DECISION AND ORDER

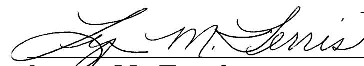
Accordingly, the Department's determination is **REVERSED**.

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 ████████, 2018, 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 February 2020.



LMF/jaf

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	Michelle Morley MDHHS-Roscommon-Hearings
Petitioner	[redacted] [redacted] [redacted] MI [redacted]
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