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

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

Date Mailed: March 22, 2019
MAHS Docket No.: 18-013526
Agency No.:
Petitioner:

ADMINISTRATIVE LAW JUDGE: Zainab A. Baydoun

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 January 23, 2019, from Detroit, Michigan. Petitioner appeared for the hearing with her Authorized Hearing Representative, . The Department of Health and Human Services (Department) was represented by , Family Independence Specialist.

ISSUE

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

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 or around April 9, 2018 Petitioner submitted an application seeking cash assistance benefits on the basis of a disability.

2. On or around September 26, 2018, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. (Exhibit A, pp. 1-7)

3. On October 16, 2018, the Department sent Petitioner a Notice of Case Action denying her SDA application based on DDS' finding that she was not disabled. (Exhibit A, pp. 482-485)

4. On or December 26, 2018, Petitioner submitted a timely written Request for Hearing disputing the Department's denial of her SDA application.

5. Petitioner alleged physically disabling impairments due to chronic cough, chronic diarrhea, high blood pressure, diabetes, sleep apnea, chronic obstructive

pulmonary disease (COPD), allergies, fibromyalgia, back and ankle pain, and nerve damage/neuropathy. Petitioner alleged mental disabling impairments due to depression, anxiety and borderline personality disorder.

6. As of the hearing date, Petitioner was ██ years old with a ████████, ████ date of birth; she was ███ and weighed ███ pounds.

7. Petitioner is a college graduate with employment history of work as a financial officer at the ██████████████ and as a deputy court clerk. Petitioner has not been employed since April 2017.

8. Petitioner has a pending disability claim with the Social Security Administration (SSA).

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.

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (April 2017), 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, she 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 thoroughly reviewed and is briefly summarized below:

On June 11, 2018 Petitioner participated in a consultative mental status examination during which she reported history of chronic cough, frequent diarrhea, frequent neck pain and pain all the way down to her back. She reported that she is always tired, has significant body pain and has difficulty walking due to the pain that she feels. She also reported history of depression and borderline personality disorder. It was noted that the examiner had difficulty establishing a rapport with Petitioner, as she was somewhat angry. She reported that she has difficulty interacting with others and does not feel good about herself. Petitioner denied the presence of auditory or visual hallucinations, delusions, persecution, obsessions or unusual powers. She further denied significant feelings of worthlessness, suicidal ideations. Petitioner’s emotional reaction was observed to be depressed and angry. The examiner noted that Petitioner met the criterion for a diagnosis of borderline personality disorder, that she had difficulties in her interpersonal relationships, intense emotions including chronic and intense anger. It was further noted that Petitioner will have difficulty sustaining consistent work based on her health conditions. Her prognosis was fair, and she was diagnosed with borderline personality disorder. (Exhibit A, pp. 67-70)

In August 2018 Petitioner participated in an IME during which mildly diminished breath sounds were found upon physical exam. Poor balance and weakness were noted as was Petitioner’s use of a walker for distances greater than a few steps. Petitioner was observed to have a wide based gait, range of motion to the lumbar spine was slightly decreased, as was range of motion to the knee.

In May 2018 Petitioner had a physical therapy evaluation which showed range of motion to the cervical spine was decreased and heavily compensated gait pattern with unsteadiness was observed.

Records from Petitioner's 2016-2017 visits at the [redacted] with Dr. [redacted] show that she was being treated for the following conditions: low back pain, major depressive disorder recurrent unspecified, allergic rhinitis, hypertension, COPD, type 2 diabetes, gastroesophageal reflux disease (GERD), chronic fatigue, chronic cough and chronic diarrhea. Records indicate that Petitioner reported diarrhea which occurs in up to four episodes per day for many years and severe cough which causes her to lose control of her bladder. Petitioner reported continuing symptoms of depression and threatened to kill herself if she does not get better. During many of her visits, Petitioner received allergy injections. In June 2017 her A1c was 6.1H and in March 2017 it was 6.3H. In January 2017, Petitioner reported that she fell in October 2016 and landed on her back and since then has had problems with her legs giving out on her which has occurred several times per month. A CT of Petitioner's chest taken on May 19, 2017 showed stable subcentimeter pulmonary nodules of the right lung nearly demonstrating one year of stability. (Exhibit A, pp. 84-141)

A Medical Source Statement completed by Dr. [redacted] on October 23, 2017 indicates that Petitioner was diagnosed with diabetes, hypertension, lumbago with sciatica, and allergic rhinitis. Her prognosis was noted to be fair, her symptoms included lower back pain (occasionally severe) with radiation down her legs, severe cough, diarrhea, and fatigue. The doctor indicated that Petitioner's pain was severe enough to interfere with the attention and concentration needed to perform simple work tasks frequently or two thirds of an 8-hour work day. It was further noted that Petitioner experiences problems with stooping, crouching, and bending and that out of an 8-hour work day, Petitioner needs to lie down/recline for about 1 hour, that she can sit and stand for only 1 hour before needing to stand up, walk around or lie down. The doctor noted that Petitioner had difficulty climbing stairs and ladders, that she was able to sit for 3 hours, stand for 2 hours, frequently lift 5 pounds or less, occasionally lift 10-15 pounds and less than occasionally lift 20 pounds. Based on her combined physical and mental limitations, Petitioner would be off task or unable to perform work more than 30% of the time and that she could perform a job for 8 hours a day, 5 days per week on a sustained basis less than 50% of the time. (Exhibit A, pp. 415-419)

A pulmonary function test (PFT) from January 2017 showed FVC 2.32 and FEV1 1.79. (Exhibit A, p. 148, 391)

Results of an April 4, 2017 MRI of Petitioner's lumbar spine showed degenerative changes, mild bulging, mild spurring, a small foraminal extrusion at the L4-5 and some narrowing but no nerve root compression, no spinal canal or significant stenosis noted. Results of a September 2016 MRI had similar findings. (Exhibit A, p. 147-152, 276-282)

In March 2017 Petitioner had a neurological evaluation at [redacted]r during which she complained of chronic back and leg pain, numbness and tingling of the bilateral legs for the last five years. She reported foot and ankle pain daily, that her right ankle gives out on her and results in her falling. She reported using a walker at times to assist with ambulation and instability. Nerve conduction studies were performed on both

legs. The needle EMG of both legs was normal, but studies revealed evidence of distal peripheral neuropathy of both legs. (Exhibit A, pp. 153-157)

An April 27, 2017 Upper GI endoscopy showed Petitioner had normal esophagus, small hiatus hernia, and normal examined duodenum. (Exhibit A, p. 159)

Records from Petitioner's visits to the hospital emergency department and urgent care centers were also presented and reviewed. Petitioner presented on various occasions between 2016 - 2018 with reports of chronic cough, abdominal pain, contusion to the head after a fall, acute sinusitis, fever, sinus congestion, sore throat, left shoulder neck ear and head pain. (Exhibit A, pp. 169-181,235-268,269-)

In April 2017 Petitioner was evaluated by a speech pathologist for her chronic cough. It was noted that Petitioner's speaking voice is mildly rough and strained but the intensity is normal, examination of the larynx demonstrated normal gross vocal fold mobility, and bilateral mid vocal cord swellings, as well as diffuse erythema and hypervascularity of the vocal folds. Speech therapy was recommended. (Exhibit A, pp. 182-185)

Progress Notes and additional records from Petitioner's October 2016 – November 2017 visits with Dr. ████ at ████████████████████ show that she has been a long time smoker and was being treated for chronic cough, dyspnea on exertion, pulmonary nodules, morbid obesity (BMI of 44-47), obstructive sleep apnea (OSA) and on CPAP, asthma and GERD. Notes from her November 13, 2017 office visit indicate that Petitioner reported dyspnea on exertion, walking upstairs and walking uphill. She reported wheezing, mostly at night, denied chest pains, has no frequency, dysuria or urgency, no headache or syncopal episodes, no skin rashes or itching. Petitioner takes Breo/Advair Diskus, Atrovent, ProAir and albuterol as needed. Spirometry showed FVC of 2.16 (75% predicted), FEV1 of 1.60 (75% predicted) with a ratio of 74. Petitioner was diagnosed with mild restrictive lung disease with a component of obstruction. Her PFT in May 2017 was within normal limits. (Exhibit A, pp. 360-390)

Petitioner's records from her visits with the gastroenterologist at the ██████ ████ were reviewed and indicate that she was being evaluated for her 10-15-year chronic diarrhea and that she has history of COPD, obesity, type 2 diabetes complicated by neuropathy, chronic low back pain, OSA on CPAP, chronic cough, hypertension, hyperlipidemia, and GERD. (Exhibit A, pp. 219-234). Results of a January 31, 2018 colonoscopy showed an abnormal digital rectal exam with decreased sphincter tone, one 3 mm polyp benign mucosal fold in the cecum, and diverticulosis in the sigmoid colon. A January 31, 2018 upper GI endoscopy had normal findings. During follow-up appointments in March 2018 and May 2018, Petitioner reported having 10-12 pasty stools per day, experiencing urgency and frequent need to pass stool, fecal incontinence, nighttime symptoms, and rare blood per rectum. Records indicate that Petitioner had a 38-pound weight loss over the last 10 months. (Exhibit A, pp. 219-234).

On April 25, 2017 Petitioner underwent physical therapy evaluation at ██████ ███, during which she reported chronic low back pain, bilateral ankle instability,

bilateral lower extremity neuropathy secondary to diabetes, difficulty ambulating, and that she cannot sit or stand for more than 5 to 10 minutes without significant increase in right lower extremity pain. She had diminished sensation in a stocking pattern of the right lower extremity halfway down the right tibia, left lower extremity sensation within normal limits, but slight numbness in the left foot secondary to neuropathy. Increased pain with range of motion at all ends was noted and Petitioner was observed to demonstrate an antalgic gait with increased swing time on the right without the use of an assistive device. Petitioner demonstrated impaired dynamic balance, requiring touching inanimate objects for stability during ambulation with increased abnormal sway without the use of an assistive device. Piriformis testing was positive for right piriformis involvement, but negative for left lower extremity. Straight leg raise test was positive for possible lumbar involvement, neural tension testing was positive on the right lower extremity for sciatic nerve involvement. After thorough assessment, Petitioner's impairments were noted to include decreased right lower extremity strength, decreased functional strength and endurance, decreased range of motion of the lumbar spine, impaired ability to ambulate up and down stairs and impaired ability to stand for significant periods of time, impaired ability to ambulate measurable distances and perform ADLs due to pain. Her prognosis was determined to be fair due to her age, health and motivation to return to her prior functioning. It was recommended that Petitioner be seen by physical therapy 2-3 times per week for 4 weeks. (Exhibit A, pp. 287-309)

Petitioner presented a letter from her treating physician Dr. [redacted] who reported that Petitioner has been under his care since July 2018 for medical conditions that limit her ability to work. He indicated that Petitioner's conditions include but are not limited to difficulties walking, sitting, or standing for long periods of time and depression and further that because of these conditions, Petitioner has a hard time doing normal day to day activities that would be needed to work a full forty-hour work week. (Exhibit 1)

Petitioner presented a Department of Health and Human Services Approval Notice showing that her application for Adult Services was approved effective June 21, 2018 and that she would be receiving home help services. A Time and Task Management chart was also presented and shows that Petitioner's adult home help provider assisted from 1 to 7 days per week her with the following tasks: bathing, dressing, grooming, mobility, housework, laundry, medication, meal preparation, shopping for food/meds, and travel for shopping. (Exhibit 2)

Petitioner presented [redacted] documents showing that in January 2011, Petitioner was diagnosed with major depressive disorder recurrent moderate, post-traumatic stress disorder (PTSD), borderline personality disorder and that she had a GAF score of 48. Petitioner presented a Psychiatric Assessment from February 2003 with similar findings. A mental health assessment performed on October 9, 2018 with CMH was also presented and indicates that Petitioner presented with symptoms including mild anger and irritability; moderate anxiety, agitation, poor concentration, restlessness; moderate depression, anhedonia, fatigue agitation, diminished self-esteem, hopelessness, and appetite disturbance; and

mild impulse control issues including chronic self-harm (picking at skin). She reported infrequent suicidal thoughts, denied a suicide plan, denied homicidal ideations, but reported past history of childhood trauma. Psychotropic medications included Zyprexa and Lexapro. Petitioner was diagnosed with major depressive disorder recurrent episode moderate, PTSD and borderline personality disorder. (Exhibit 2)

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), 1.04 (disorders of the spine), 3.02 (chronic respiratory disorders), 3.03 (asthma), 9.00 (endocrine disorders), 11.14 (peripheral neuropathy), 12.04 (depressive, bipolar and related disorders), 12.06 (anxiety and obsessive-compulsive disorders), and 12.08 (personality and impulse-control disorders) were considered. A thorough review of 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). 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 nonexertional limitations due to her medical conditions.

Petitioner testified that she has constant nerve pain and can walk and stand for only 5 minutes before needing to rest. She reported that she has high risk of falling and that she uses a cane or walker daily to assist with ambulation. The Department representative present with Petitioner in the hearing room observed Petitioner to use a cane the day of the hearing. Petitioner stated that she can sit for two hours but has pain due to the problems with her nerves, sciatica and back pain. Petitioner reported that she can sometimes lift her grandson but is unable to frequently lift a gallon of milk because of her problems with grasping/gripping items as they slip out of her hands. Petitioner stated that she lives with her daughter who is her home help provider. Petitioner requires assistance with bathing, dressing, personal hygiene. Petitioner's home help services provider performs all the household chores, shopping, and cooking. Petitioner indicated that she sometimes makes eggs or oatmeal herself. She testified that she receives medical treatment from various doctors including a pulmonologist, an allergist, a gastroenterologist, and her primary care physician. She reported suffering from chronic cough and chronic diarrhea.

With respect to her mental impairments, Petitioner testified that she has been diagnosed with depression, anxiety, and borderline personality disorder for which she receives medication treatment and counseling at CMH. She reported suffering from anxiety attacks daily that last 5 to 20 minutes and include shortness of breath and hyperventilating. She reported difficulty with concentrating more than a few minutes at a time and reported that she has problems with her memory including missing doctor appointments and forgetting to take her medications. Petitioner indicated that she has developed problems with comprehension and that it is difficult for her to understand many things. This was evident during the hearing and throughout Petitioner's responses to questions. She stated that she suffers from crying spells daily that last 2 minutes to 1 hour, that she has verbal issues with anger and further that she has had thoughts of hurting herself, with an attempt one month ago but that she does not have thoughts of hurting others. It is noted that the undersigned ALJ had to go off the record in order to give Petitioner a break due to her crying. She further reported that she suffers from auditory and visual hallucinations, however, the medical evidence in the record does not support this testimony. With respect to her nonexertional impairments, Petitioner reported that she cannot bend or squat because her legs and ankles give out, and further that she is unable to grip or grasp items with both of her hands due to her nerve impairments and neuropathy.

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.

The evidence presented is considered to determine the consistency of Petitioner's statements regarding the intensity, persistence and limiting effects of her symptoms. Based on a thorough review of Petitioner's medical record and in consideration of the reports and records presented from Petitioner's treating physicians, 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 records presented, as well as Petitioner's testimony, Petitioner has moderate to marked limitations on her non-exertional ability to perform basic work activities, with respect to performing manipulative or postural functions of some work such as handling, bending, or stooping. Additionally, records indicate that Petitioner suffers from chronic diarrhea with 10-15 bowel movements daily as well as fecal incontinence. The records show that Petitioner was diagnosed with and has a history of major depressive disorder, anxiety, borderline personality disorder and PTSD. It is found that Petitioner has moderate to marked limitations in her activities of daily living; moderate to marked limitations in her social functioning; and moderate to marked limitations in her concentration, persistence or pace.

Petitioner's nonexertional 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 employment as a financial officer at the [redacted] and as a deputy court clerk, which involved sitting for up to 7 hours, standing for 1 hour, frequently lifting boxes of files up to 25 pounds, and frequent reaching, handling and stooping. Upon review, Petitioner's prior employment is categorized as requiring sedentary to light exertion. Based on the RFC analysis above, Petitioner's exertional RFC limits her to sedentary work activities. However, Petitioner's additional nonexertional limitations identified above and mental

limitations would prevent her from performing her past relevant work on a sustained, regular and continuing basis. Because Petitioner is unable to perform past relevant work, she 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).

However, when a person has a combination of exertional and nonexertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination **unless** there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969a(d).

In this case, Petitioner was ██ years old at the time of application and at the time of hearing, and thus, considered to be advanced age (age 55 and older) for purposes of Appendix 2. She is a college graduate with skilled/semi-skilled work history that is nontransferable. 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, with the noted additional nonexertional limitations. Thus, based solely on her exertional RFC, the Medical-Vocational Guidelines result in a disability finding based on Petitioner's exertional limitations and an analysis of the additional nonexertional/mental limitations will not be addressed. Accordingly, Petitioner is found disabled at Step 5 for purposes of the SDA benefit program.

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

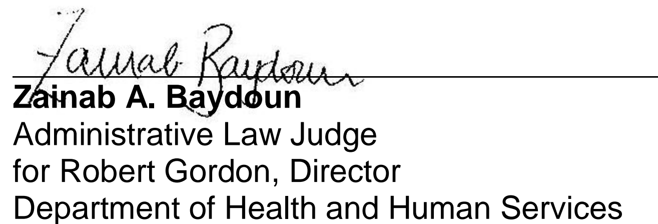
Accordingly, the Department's SDA determination is **REVERSED**.

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 April 9, 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; and

3. Review Petitioner's continued eligibility in August 2019.



ZB/tlf

Zainab A. Baydoun
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

Via Email:

Authorized Hearing Rep.
- **Via First-Class Mail:**

Petitioner
- **Via First-Class Mail:**