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Date Mailed: June 17, 2019
MOAHR Docket No.: 19-000784
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 March 4, 2019, from Detroit, Michigan. The Petitioner was represented by herself. The Department of Health and Human Services (Department) was represented by April Nemee, Hearing Facilitator.

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit programs?

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Additional medical records were received at the hearing produced by Petitioner and were marked as Exhibit B. Medical records received pursuant to the Interim Order included a Psychosocial Assessment Intake Examination by Hope Network. Pulmonary testing results and records and notes for 2013-2017 were received and marked into evidence as Exhibit C. The Mental Residual Functional Capacity Assessment by Hope Network, Pulmonary testing documents for testing on March 14, 2019, and DHS-49's (Medical Exam Report) for [redacted], Dr. [redacted], Dr. [redacted] and Dr. [redacted], as well as, EMG testing records from [redacted] were not received. The record closed on April 3, 2019; and the matter is now before the undersigned for a final determination based on the evidence presented.

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 October 8, 2018, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On December 27, 2018, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 7-12).

3. On January 22, 2019, the Department sent Petitioner a Notice of Case Action denying the application based on DDS' finding of no disability (Exhibit A, pp. 985-987).

4. On February 4, 2019, the Department received Petitioner's timely written request for hearing (Exhibit A, p. 3).

5. Petitioner alleged disabling impairment due to COPD/emphysema, low-back pain lumbar spine with degenerative disc disease, degenerative disc disease in cervical spine, and carpal tunnel syndrome in wrists. The Petitioner also alleges mental impairments due to anxiety, post traumatic stress disorder, and depression.

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

7. Petitioner completed a 10th grade education.

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

9. Petitioner has an employment history of work doing janitorial work cleaning apartments and nursing homes.

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, *and in response to the interim order,* was reviewed and is summarized below.

At the hearing, the Petitioner presented an MRI of the lumbar spine dated [redacted] 2018. The findings noted the lumbar vertebral body heights are maintained with early degenerative endplate change at L4-L5, early facet arthropathy at L4-L5 and L5-S1 and disc desiccation at L4-L5 and L5-S1 demonstrating mild disc height loss. Early disc

disease desiccation at T 12-L1 and L1-L2 demonstrating mild disc height loss. The paraspinal-prevertebral soft tissues were normal except at L4-L5 there was a circumferential disc bulge with central subligamentous disc extrusion with disc material extending 4 mm caudal to superior L5 endplate. There is moderate central canal stenosis with residual diameter thecal sac measuring 6 mm. There is mild foraminal stenosis bilaterally from the intraforaminal disc bulge. At L5-S1 circumferential disc bulge with shallow central disc protrusion measuring 3 mm in AP dimension which effaces the ventral epidural space. There is no central canal stenosis. The neural foramin are patent. The final conclusion was circumferential disc bulge with central subligamentous disc extrusion at L4-L5 resulting in mild to moderate central canal stenosis and mild bilateral foraminal stenosis with no evidence of nerve root impingement. Shallow disc protrusion at L5-S1 which effaces the ventral epidural space resulting in no central canal or foraminal stenosis. Mild degenerative changes at T12-L1, L1-L2, L4-L5 and L5-S1 with early degenerative endplate change at L4-L5. Early facet arthropathy at L4-L5 and L5-S1.

A CT of the cervical spine was also performed on [redacted] 2018 due to severe cervical neck pain and radicular pain. The pertinent findings included minimal narrowing of the C4-C5 disc space, with disc bulging at C2-C-3 without canal or foramin are widely patent. At C3-C4 noted mild disc bulging with small spurs with the canal widely patent. At C4-C5, a small central disc herniation suggested near midline making contact with the anterior margin of the cord near midline. Lateral recesses and neural foramen appear patent. At C6-C7 slight calcification posterior longitudinal ligament above this level minimal disc bulging at the disc level the canal and foramina are patent. The conclusion was there are small central protrusion type disc herniation's at C4-C5 and C5-C6. An earlier CT of the cervical spine taken in [redacted] 2015 noted only mild cervical spondylosis which would indicate some deterioration. At that time, only mild endplate and posterior facet degenerative changes were noted with slight disc bulging at C4-C 5 level with no significant canal stenosis. An earlier MRI of the spine performed in [redacted] 2016 noted mild endplate and posterior facet degenerative changes with slight bulging of the inter-vertebral disc at C4-C5 level. There is no significant canal stenosis. The impression was mild cervical spondylosis.

Medical records from [redacted] indicate Petitioner was prescribed a walker with wheels for osteoarthritis, naproxen and Norco for pain as well as a humidifier for chronic oxygen therapy and bilateral wrist splints for bilateral carpal tunnel syndrome. The records also establish that the Petitioner participates in physical therapy biweekly. She was also prescribed an EMG consult, a CT of the thoracic spine and home help services in 2018. The following diagnosis are indicated in the records including carpal tunnel syndrome, numbness in hand, degenerative disc disease of the cervical spine and lumbar spine, lumbar radiculopathy, COPD with acute exacerbation, anxiety disorder, and treatment for chronic pain.

In [redacted] 2018 the Petitioner's primary care physician noted back pain in the thoracic region and left hip pain as well as degenerative disc disease in the lumbosacral spine

with radiculopathy. Patient reported 10 out of 10 pain at the time Petitioner was having epidural steroid injections and had a series of two with some improvement of lower-back pain but still requires hydrocodone for pain. Current pain level on hydrocodone is 7 of 10. The Petitioner's medical records indicate she has been drug compliant.

On [redacted] 2018, the Petitioner had a CT of the chest region. The findings noted a 17 mm complex nodule of the posterior inferior right lobe of the thyroid gland. Confirmation with an ultrasound exam is recommended. With regard to the lungs, there are multiple variable size calcified upper-, mid- and lower-lung zone smoothly marginated granulomas. There are no soft tissue nodules, lung opacities or other abnormalities. There is mild central lobular emphysema. The thoracic aorta and great vessels of the pulmonary arteries noted mild atheromatous calcification plaquing of the aortic arch. There was no evidence of a large central pulmonary embolism. The heart and pericardium appeared normal. The thoracic spine and chest wall were unremarkable with normal vertebral body heights with anterior spondylosis of the mid and lower thoracic vertebral bodies. A follow-up recommendation was an ultrasound study of the thyroid gland to better characterize the right thyroid nodule. There were multiple calcified granulomas throughout the bilateral lungs consistent with prior granulomatous infection otherwise a normal enhanced CT study of the chest.

On [redacted] 2018, an ultrasound of the thyroid gland was performed resulting in benign right thyroid lobe cyst measuring 3 x 2 x 2 cm. There was a follow-up recommendation that a thyroid ultrasound should be performed in one year to ensure stability of the right thyroid lobe nodule.

On [redacted] 2018, an echocardiogram was performed. The report notes the study was technically difficult without further explanation. The conclusions were left ventricular ejection fraction estimated by 2 D at 40%. Mild mitral annular calcification. A stress test was performed as well, and the findings were Spect images demonstrate normal perfusion during stress. Spect images demonstrate normal perfusion at rest and normal wall motion. The calculated ejection fraction is 52%. The notes indicate that test tolerance resulted in dizziness, flushing, warm sensation, lightheaded, fatigue symptoms which were relieved by passage of time. The Petitioner saw her primary care physician on [redacted] 2018, for a follow-up visit with regard to a cardiology work-up with a negative persantine stress test. The cardiologist letter stated an ejection fraction of 40% (etiology). Also noted, Petitioner was continuing to smoke one pack of cigarettes per day and qualified for nocturnal oxygen. The patient also requested patches so she could continue to attempt to stop smoking. Notes indicate pain due to osteoarthritis and anxiety are controlled on her current dose of hydrocodone and alprazolam. Patient was not having trouble with any breathing issues on current dose of hydrocodone. At the conclusion of the examination, the impression and recommendations were that the patient was strongly encouraged to stop smoking and that nicotine patches were prescribed. Also noted was that patient currently meets criteria for nocturnal oxygen, and Norco was prescribed for back pain.

A CT of the thoracic spine was performed on [redacted] 2018, and the impressions were mild to moderate degenerative change without acute process and noted multiple calcified granulomas throughout the lungs with mild to moderate multilevel anterior osteophytic spurring mild to moderate disk space narrowing.

The Petitioner has treated with a pulmonary specialist regarding her symptoms diagnosed as COPD. On [redacted] 2019, she was seen and examined by the doctor who has treated her for several years. The Petitioner reported with complaints of progressive worsening of shortness of breath noting she is unable to afford her inhalers due to the insurance company limitations. She notes quitting smoking two weeks ago. She has been placed on nocturnal supplemental oxygen. There were no complaints of chest tightness or pain and is using her Ventolin inhaler six times a day. She has lost 13 pounds since her last visit here when a chest x-ray was done in [redacted] 2018 the report notes the CT was also done on [redacted] 2018, demonstrating emphysema changes with chronic granulomatous changes. The Petitioner was physically examined with cervical and super clavicle nodes present. There was increased resonance to percussion of her lungs and chest and diminished air exchange with prolonged expiratory phase with no wheezes.

A pulmonary function test (PFT) was completed and noted that forced expiratory flows are very severely reduced. The actual PFT testing document was not available but was evaluated by the doctor in his notes as reported hereafter. FEV1 was reported as 920 cc which was 32% of predicted, this is decreased from a prior study conducted in [redacted] 2017. Also noted was a decrease in the FEV1/FVC ratio. There is increased total lung capacity with significant air trapping. There is severe decrease in diffusion capacity. Airway resistance is increased. Flow volume loop demonstrates obstructive ventilatory defect. The impression was severe/very severe obstructive ventilatory defect. The six-minute-walk test noted Petitioner able to walk 525 feet in six minutes. She does not desaturate below 93%. She does become severely dyspneic. At the conclusion of the exam, the doctor made the following recommendations: COPD with the impression FEV1 is 920 mL 32% of predicted. The doctor prescribed weight gain diet due to severe weight loss. Notes indicate that Petitioner quit smoking in [redacted] 2017 and continues to smoke intermittently. Last smoking at the time of the exam approximately two weeks ago. The Patient was educated by the doctor regarding ways to quit smoking. Regarding the pulmonary granuloma shown on CTs of the lungs the diagnosis was most likely histoplasmosis based on a CAT scan done in [redacted] 2018 with no change. The Petitioner's breathing test was reviewed with her, and she was advised that there has been significant deterioration from a prior study on [redacted] 2017. The decline may well be due to natural progression of disease or the fact that she cannot use her baseline inhalers due to insurance problems. The weight loss was described as an ominous finding in a patient with severe chronic lung disease. Patient was prescribed to attend pulmonary rehab. If the Petitioner's condition worsens, she may be a candidate for lung transplant.

The pulmonary function test results from [redacted] 2017 were available and reported the following. Forced expiratory flows are severely reduced. FEV 1 is 1.34 liters which is 46% of predicted. There is no significant improvement with bronchodilators. There is increased total lung capacity with significant air trapping. There is severe decrease in diffusion capacity. Airway resistance is normal. Flow volume loop demonstrates obstructive ventilatory defect. There is no significant change from prior study dated [redacted] 2015. Impression was Severe obstructive ventilatory defect.

The Petitioner was seen in [redacted] 2018 at [redacted] and noted still smoking and has tried numerous meds without success. History notes chronic anxiety and depression, COPD, Chronic low back pain secondary to heavy lifting in the past with epidural steroids and pain management. The exam noted diminished breath sounds bilaterally with expiratory wheezing of left upper lobe, coughing during exam with mild respiratory distress. Pain to palpation over thoracic spine. Absent Achilles reflexes bilaterally. Petitioner was prescribed nicotine patches and Effexor, for treatment of anxiety and depression. Notes further indicate that Petitioner is to begin mental health treatment in [redacted] 2019. Also noted was absent Achilles reflexes bilaterally, notes further indicate that Petitioner stopped smoking in 2017 but had resumed again one-half pack per day. (Visit [redacted] 2018). Due to lumbar radiculopathy, Lyrica was increased, and Zoloft was additionally prescribed for anxiety and depression. The Petitioner was also referred to neurosurgery for evaluation for her back pain.

Notes also indicated in the [redacted] 2018's, office visit that Petitioner underwent a rhizotomy in 2016 due to chronic back pain to destroy problematic nerve root in the spinal cord.

The Petitioner participated in a psychological evaluation consultative examination on [redacted] 2018. The examination was arranged for by the Michigan Disability Determination Service. At the time of the examination, the examiner did not have any mental health records available. The Petitioner had been seen by the examiner in 2014 for a prior examination. At the time of the examination, the Petitioner denied ever having received mental health services or psychiatric hospitalization. The Petitioner used a wheeled walker when reporting for her examination. Her energy level appeared to be below average. At the conclusion of the exam, the following medical source statement was made, Petitioner did not exaggerate or minimize symptoms during the examination. The examiner found that the Petitioner's mental abilities to understand, attend to, remember and carry out instructions of work-related behaviors are not overtly impaired. It was the examiner's impression that Petitioner's ability to perform activities within a schedule, at a consistent pace, maintain regular attendance, be punctual within customary tolerances and complete a normal workday and work week without interruptions from psychological symptoms are mildly impaired. It was the Examiner's further impression that Petitioner's abilities related to social interaction, such as responding appropriately to coworkers, supervision and others in the workplace are mildly impaired. The Examiner concluded that based on today's exam, it was his

impression that Petitioner's abilities relating to adaptation and self-management, such as traveling to unfamiliar places and adapting to change and stress in the workplace are mildly impaired. The prognosis related to mental health was guarded.

The Petitioner was given a psychosocial evaluation and assessment by her mental health care provider, [redacted] Network on [redacted] 2019. The exam notes indicate Petitioner has a 10th grade education, and has adequate communication abilities. The Petitioner was described as engaged and cooperative, capable of maintaining eye contact with hesitant speech. The notes indicate that Petitioner did not have insight into her illness at the time of the examination. Petitioner was diagnosed with major depressive disorder, recurrent severe without psychotic features as well as anxiety disorder due to known physiological condition.

By way of history in 2014, the Petitioner was seen regarding a CT of the chest which noted moderate emphysema and degenerative changes of the spine were noted. Calcified pulmonary granulomas were again noted. Also, by way of history x-rays taken in 2014 due to low-back pain noted that the vertebral body heights and alignments are maintained with mild endplate and facet degenerative changes seen.

Petitioner was seen by her pain management doctor on [redacted] 2018, with severe lower-back pain radiating to the left hip and leg, mid-back pain and neck pain with low-back pain the worse. Pain increased with physical activity, standing, sitting and sexual activity. Pain is rated by patient as a 10. Positive findings during exam were depression, nerve damage, neck stiffness, asthma, hoarseness of voice, polyps, leakage of urine with coughing and arthritis. Noted decrease in lumbar spine flexion and extension, severe pain with extension of spine and lateral bending. Straight leg raising is negative bilaterally with paraspinal muscle spasms. Recommendations were made noting no neurosurgical emergency symptoms or indication for surgery. Spinal injections were suggested. The patient was given a spinal injection at left L3-L4, L4-L5 transforaminal epidural.

The Petitioner was seen on [redacted] 2017, for follow-up with Dr. [redacted] after an MRI due to low-back pain with radiation of the right leg. The assessment included intervertebral disc degeneration lumbar region, PTSD, unspecified osteoarthritis and age-related osteoporosis. The doctor concluded that there was degenerative disc disease at L4 to S1. He did not recommend surgery at that time and referred patient to pain management.

On [redacted] 2018, the Petitioner was seen at [redacted] for an initial assessment for mental psychiatric illness and treatment. Notes indicate that Petitioner has used Xanax for about eight months for anxiety and has been effective. Petitioner reports she has positive relationships with her father and her eldest daughter. During the examination, the Petitioner was tearful, cooperative and spoke in a soft tone, her quality of thought was distractible and her content of thought was demoralized, insight was good, as was judgment. A review of symptoms noted depressed mood was

moderate, decreased energy was moderate, hopelessness was mild, thought disruption mild, panic attacks severe, anxiety severe and irritability mild due to chronic pain from degenerative disc disease. Problems that were noted were unresolved grief, smoking, insomnia, anxiety and depression and fatigue during the examination patient reported hyperventilating and standing in front of a freezer or having to take cold showers to get control of her panic attacks. Reports crying all the time and feels sad with poor appetite generally one meal per day. Smokes one pack of cigarettes per day. Petitioner was still grieving the loss of her mother of two years. Petitioner was receptive to counseling to address unresolved issues.

On [redacted] 2018, the Petitioner was seen for review and reported chronic back pain and requested an MRI. The diagnosis was acute exacerbation of chronic back pain, and Petitioner was prescribed Toradol. The Petitioner was seen at [redacted] and was prescribed Lyrica due to her lumbar radiculopathy to better control pain. Notes indicate patient not a candidate for surgery at the time of the exam and also noted was she had a rhizotomy surgery in 2016, and doctor did not feel epidural steroids would be of benefit. The Petitioner's current pain medications were also continued. Petitioner also reported that she was ready to quit smoking, and smoking cessation options were discussed. Depressed affect was also noted. In an exam on [redacted] 2018, the Petitioner was prescribed Lexapro for both anxiety and depression and was to begin seeing a behavioral health organization.

The pages numbers 656 through 770 provided by the Department as part of the medical packet were blank.

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step 3

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

Based on the medical evidence presented in this case, listings 1.04 Disorders of the spine; 3.02 Chronic Respiratory Disorders; 12.06 Anxiety and obsessive-compulsive disorders; and 12.04 Depressive, bipolar and related disorders were considered. The medical evidence presented does not show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as

disabling without further consideration. Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

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

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

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

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

If an individual has limitations or restrictions that affect the ability to meet demands of jobs other than strength, or exertional, demands, the individual is considered to have only non-exertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). In addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of mental functional limitation. 20 CFR 416.920a(c)(3). The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. Id. The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. Id.

In this case, Petitioner alleges both exertional and non-exertional limitations due to her medical condition. Petitioner testified that she could stand for 5 minutes without the aid of a prescribed walker and 10 minutes with the aid of a walker. The Petitioner could sit 30 minutes and then had to relieve her back; she testified that she could walk with the aid of a walker 30 feet and then has to stop due to breathing difficulties; the Petitioner could not perform a squat, and can bend at the waist, but the range is limited due to back pain; she uses a shower chair to shower and can tie her shoes. The heaviest weight she can carry is 4 or 5 pounds and has carpal tunnel syndrome in both hands which restricts her ability to do crafts or sew, and she has no feeling in her left ankle. Petitioner further testified that she spends most of her day laying on a heating pad to relieve her pain. She is prescribed trazadone to help her sleep due to pain causing sleep difficulties.

Petitioner's treatment records support a basis for the pain experienced by Petitioner based upon her MRI's of the lumbar and cervical spine, treatment with steroid injections to the spine without relief, prescribed pain medications for her back and referral to a pain management doctor. The Petitioner also underwent a Rhizotomy to relieve a nerve causing pain in 2016. In addition, the Petitioner's most receive pulmonary function test notes indicate severe to very severe obstructive ventilatory defect and that Petitioner may at some point be a candidate for a transplant.

The Petitioner further testified that she suffers from panic attacks 4 or 5 times weekly and began treatment for her anxiety and depression in [redacted] 2019.

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 and physical non exertional limitations, it is found based on a review of the entire record that Petitioner maintains the physical capacity to perform less than sedentary work. See SSR 96-9p and DI 25015.020, [redacted] 2017.

Based on the medical record presented, and the independent psychological consultative exam, Petitioner's ability to express herself at the hearing 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 work performing janitorial work and cleaning apartments. Petitioner's work as a cleaning janitorial worker required standing most of the workday and lifting up to 50 pounds regularly which required a medium physical exertion work level and required her to crouch, crawl bend and lift carry 40 to 50 pounds and push a mop bucket and vacuum requiring medium physical exertion. In addition, due to very serious advanced COPD based upon her last pulmonary examination and use of required inhalers and prescribed night oxygen Petitioner is limited to a work environment without fumes and other air borne particles.

Based on the RFC analysis above, Petitioner's exertional RFC limits to a less than sedentary capacity for 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 exertional and 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 [redacted] years old at the time of application and [redacted] years old at the time of hearing, and, thus, considered to be a younger individual (age 45-49) for purposes of Appendix 2. She completed the 10th grade with a history of work experience as a janitor and cleaning apartments and nursing homes. As discussed above, Petitioner does not maintain the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform work activities as her residual functional capacity is evaluated as less than sedentary.

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 his 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 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 October 8, 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 June of 2020.

LF/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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention:
MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

DHHS

Tamara Morris
MDHHS-Genesee-UnionSt-Hearings

Petitioner

[redacted]
[redacted]
[redacted] MI [redacted]

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