[redacted]

Date Mailed: May 29, 2019
MOAHR Docket No.: 19-001714
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Jacquelyn A. McClinton

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; and 45 CFR 205.10. After due notice, a telephone hearing was held on March 28, 2019, from Detroit, Michigan. Petitioner was present and represented by Jane Warkentin, Esq. and [redacted], law student. Participants on behalf of the Department of Human Services (Department) included Eidra Burch, Assistance Payments Worker.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Records from [redacted] and [redacted] were received and marked into evidence as Exhibit 1; The record closed on April 29, 2019, and the matter is now before the undersigned for a final determination based on the evidence presented.

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 [redacted], 2018, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On November 25, 2018, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A3).

3. On November 29, 2018, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit B1).

4. On February 20, 2019, the Department received Petitioner's timely written request for hearing (Exhibit A).

5. Petitioner alleged disabling impairment due to complications with breast cancer diagnosis/treatment and major depressive disorder.

6. On the date of the hearing, Petitioner was [redacted] years old with a [redacted], 1982 birth date; she is 5'4" in height and weighs about 190 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 caregiver and a home health aide.

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

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of 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 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 reviewed and is summarized below. It should be noted that there were duplicative medical records contained in Exhibit C which were not numbered and were removed. Further, in the packet received at the hearing, Exhibit C was the only exhibit containing page numbers and the pagination began at 10 and continued through 194.

On November 23, 2016, Petitioner was seen at [redacted] for biopsy results. Petitioner was diagnosed with stage III right breast cancer. Petitioner was counseled on biopsy results in the need for surgical consultation. (Exhibit C, pp. 13-15).

On December 1, 2016, Petitioner was seen at [redacted] for surgical evaluation. The recommendation was a simple mastectomy of the right breast. Sentinel lymph node biopsy was also discussed. The records indicated that Petitioner would be recommended for chemotherapy following her surgery. Petitioner requested the next available surgery date. (Exhibit A, pp. 16-19).

On December 13, 2016, Petitioner was seen at [redacted]. Petitioner was taken to the operating room where she underwent right auxiliary Sentinel lymph node biopsy, which proved to be positive for metastatic disease. Petitioner's planned surgery for a simple mastectomy was changed to a modified radical mastectomy. Petitioner tolerated the procedure well. Petitioner was discharged the following day. (Exhibit C, pp. 24-31).

On January 23, 2017, Petitioner was seen at [redacted]. The reason for the visit was noted as Stage IIIA (pT2 N2A) hormone receptor negative, HER-2 positive (by FISH) coming for initial visit. The assessment indicated that it was unclear if Petitioner had received any anthracyclines in the past. Therefore, adjuvant chemotherapy with carboplatin, docetaxel in conjunction with anti-HER-2 therapy was scheduled. Petitioner was made aware of the side effects, scheduled, and the possibility and risk of recurrence of her cancer. (Exhibit C, pp. 34-36).

On February 7, 2017, Petitioner was seen at [redacted] relating to her breast cancer diagnosis. Petitioner reported that she was recovering well from her surgery. She indicated that she continued to have mild pain over the surgical site. She denied any other complaints. Her pain was listed as 2/10. (Exhibit C, pp. 41-44).

On February 13, 2017, Petitioner was seen at [redacted] for a follow-up visit for stage IIIA, pT3 N2a, ER/PR negative, HER-2 positive breast cancer prior to starting any chemotherapy. Petitioner reported no complaints. Petitioner denied any recent fevers, chills, or infections. Petitioner denied any bony pain. She denied any respiratory difficulties. Petitioner denied any abnormal weight loss, headaches, or neurological changes. Staging scans did not show any evidence of metastatic disease. (Exhibit C, pp. 50-52).

On March 6, 2017, Petitioner was seen at K[redacted] for follow-up for IIIA, pT3 N2a, ER/PR negative, HER-2 positive breast cancer, status post 1 cycle of chemotherapy with TCHP. Petitioner complained of nausea that had been present since her first chemotherapy. Petitioner was taking maximum doses at home of Compazine and Zofran with no relief. Petitioner was also complaining of left thigh pain ever since getting her Neulasta injection. Petitioner described the pain as starting in the left hip and radiating down the leg, not exacerbated with activity. Petitioner denied any fevers, chills, or infections or any respiratory difficulties. Petitioner's chemotherapy was post Paul on this date. (Exhibit C, pp. 54-56).

On March 13, 2017, Petitioner was seen at [redacted] for follow-up for IIIA, pT3 N2a, ER/PR negative, HER-2 positive breast cancer, status post 1 cycle of chemotherapy with TCHP. It was noted that Petitioner had a delay in cycle to due to a number of complaints. Petitioner indicated at this visit that the nausea and vomiting had completely resolved. Petitioner indicated that the numbness and tingling in her fingertips had completely resolved. There was no swelling present. Petitioner continued to complain of pain in her left hip. Petitioner was given cycle two of chemotherapy. (Exhibit C, pp. 57-59).

On April 3, 2017, Petitioner was seen at [redacted]. The reason for the visit was listed as history of Hodgkin lymphoma at age 18, currently IIIA, pT3 N2a, ER/PR negative, HER-2 positive breast cancer, status post 2 cycles of chemotherapy with TCHP. At this visit, Petitioner continued to complain of nausea and vomiting, unrelieved by maximal doses of Compazine and Zofran. Petitioner also continued to complain of left hip pain radiating down to her knee. Although initial staging scans were

negative for any static disease, repeat CT scans were ordered due to the consistency of the complaints. (Exhibit C, pp. 64-66).

On June 27, 2017, Petitioner was seen at [redacted] for her final chemotherapy treatment. Petitioner reported no chest pain, no swelling in her limbs, no constipation, and no nausea, (Exhibit C, pp. 89-92).

On July 24, 2017, Petitioner was seen at [redacted] to begin radiation therapy treatment. Petitioner's Karnofsky performance score was 80. Petitioner reported persistent neuropathy since she finished her chemotherapy. Petitioner indicated that she felt well overall. Her appetite and weight were stable. Petitioner denied any new lumps or bumps. Petitioner reported no other complaints. (Exhibit C, pp. 100-102).

On September 18, 2017, Petitioner was seen at [redacted]. It was noted that Petitioner had completed her treatment but did miss several days during the week from September 3, 2017 through September 9, 2017. Petitioner indicated that her pain had improved quite a bit and that she was feeling much better. It was noted that Petitioner had some hyperpigmentation at the end of the treatment. Petitioner did not have any moist desquamation; however, she did have some notable radiation dermatitis and some mild pruritus. (Exhibit C, pp. 103-105).

On October 12, 2017, Petitioner was seen at [redacted]. Petitioner was one month from completion of radiation therapy. Petitioner presented complaining of a pain level of 6/10. Petitioner described the pain as shooting primarily at the previous drain site from her mastectomy. Petitioner also complained of tightness with regard to range of motion in her right arm. Exhibit C, pp. 109-111).

On October 31, 2017, Petitioner was seen at [redacted]. Petitioner was originally being seen in the infusion center, but the treating physician was contacted relating to Petitioner having a new fall this past weekend due to increasing pain from the knee down to the feet. Petitioner complained of increasing pain from her knees down to her feet, stating that she had been having pain in her feet when she walks and that the pain has increased to her knee region. Petitioner denied hitting her head indicated that she fell forward. Petitioner admitted to having fallen while walking up the stairs a couple months prior. Petitioner denied any injury and described herself as clumsy. Petitioner indicated that she was having increasing hot flashes over the last several months. Petitioner also complained of pain at the base of her neck and shoulders. Petitioner noted urinary changes over the past month or so as well as increased diarrhea, though she stated that she goes between diarrhea and constipation. Petitioner indicated that she is able to hold her urine but finds that is increasingly more urgent. (Exhibit C, pp. 112-115).

On November 7, 2017, Petitioner was seen at [redacted] for checked x-rays. There was no acute process in the chest. (Exhibit C, pp. 116-117). Petitioner also

had a NM-Bone Scan-Whole Body. The impression indicated that there was no scintigraphic evidence of metastatic disease to bone. (Exhibit C, pp. 127-128).

On November 9, 2017, Petitioner was seen at [redacted] for MRI of the brain with and without contrast. There was no MRI evidence of acute intracranial process or CNS/calvarial metastasis. Incidental note of 1.3 cm peripherally enhancing cystic lesion in the pineal gland likely representing pineal cyst and less likely pineocytoma. There were a few scattered nonspecific punctate foci of FLAIR and T2 signal alteration the supratentorial white matter which may be due to sequelae of prior trauma and/or injury or migraine headaches. (Exhibit C, pp. 121-122).

On November 10, 2017, Petitioner was seen at [redacted] for an MRI of the thoracic spine with and without contrast; MRI of the lumbar spine with and without contrast. The findings included five lumbar type vertebral bodies that were identified. The vertebral heights alignment and enter spacing of the thoracic and lumbar spine was maintained. The thoracic and lumbar spinal canal was widely patent with focal disc herniation, canal stenosis or neural foraminal narrowing. There was no signal alteration or abnormal enhancement in the thoracic spinal cord, conus medullaris, caudal nerve roots, dura or leptomeninges. There were minimal disc bulges at L2-L3 and L3-L4 without canal stenosis or neural foraminal narrowing. L4-L5, mild broad-based disc bulge, facet arthropathy and ligamentum flavum hypertrophy without canal stenosis and mild bilateral neural foraminal narrowing. L5-S1 minimal broad-based disc bulge and facet arthropathy without canal stenosis and mild bilateral neural foraminal narrowing. No pre or paravertebral soft tissue abnormality. Subtle heterogeneous marrow signal alteration throughout the entire visualized thoracic, lumbar spine, sacrum and bilateral iliac bones without focal marrow signal alteration to suggest osseous metastasis. It was noted that the findings may be related to severe anemia and/or sequelae of chemotherapy. (Exhibit C, pp. 123-124).

On November 10, 2017, Petitioner was seen at [redacted] for an MRI of the thoracic spine; MRI of the lumbar spine, both with and without contrast. The impression indicated that there was no MRI evidence of osseous or CNS metastasis in the thoracic or lumbar spine. The thoracic and lumbar spinal canal were widely patent. Mild degenerative lumbar spondylosis without canal stenosis. Mild bilateral neural foraminal narrowing at the L4-L5 and L5-S1 levels. Mild heterogeneous marrow signal alteration throughout the visualized thoracic and lumbar spine, sacrum and bilateral iliac bones which was noted? to be possibly due to severe anemia and/or sequelae of chemotherapy. (Exhibit C, pp. 125-126).

On November 14, 2017, Petitioner was seen at [redacted]. After labeling Petitioner's red blood cells with 29.9 mCi of technetium-99m pertechnetate, dynamic images were obtained over the heart. The impression indicated that the left ventricular ejection fraction was 63%, from a previous ejection fraction of 54%. (Exhibit C, pp. 132-133).

On November 17, 2017, Petitioner was seen at [redacted] for results of here-staging CT and bone scan and brain MRI. There was no evidence of metastatic on body CT, bone scan or brain MRI. There was noted a small pineal cyst vs. pineocytoma on the brain MRI. (Exhibit C, pp. 129-131).

On January 23, 2018, Petitioner was seen at [redacted]. Petitioner indicated that she was still having quite a bit of difficulty with numbness and tingling in her legs. Petitioner indicated that it felt as if it started from the feet, worked his way up to the mid-thigh area, causing quite a bit of cracking. Petitioner indicated that the pain gets so bad that she has to use a cane at times. Petitioner indicated that she still continues to have loose stools and that this is been going on for quite some time. (Exhibit A, pp. 134-137).

On February 8, 2018, Petitioner was seen at [redacted]. After labeling Petitioner's red blood cells with 30 mCi of technetium-99m pertechnetate, dynamic images were obtained over the heart. The impression indicated that the left ventricular ejection fraction was 51%, from a previous ejection fraction of 63%. (Exhibit C, pp. 138-139).

On February 13, 2018, Petitioner was seen at [redacted]. The reason for the visit was noted as nausea and change in bowel habits. Petitioner indicated that the nausea has been persistent for about one year and started with the chemotherapy. Petitioner denied any associated blood in the stool. Petitioner uses Imodium as needed for the diarrhea with good relief. Petitioner denied any nighttime symptoms for her bowel movement. (Exhibit C, pp. 140-142).

On February 22, 2018, Petitioner was seen at [redacted] as a result of a consultative referral pursuant to RUE lymphedema and severe neuropathic auxiliary and arm pain since awakening on the morning of February 10, 2018. There has been no redness, fever, or chills. There is no history of DVT, cellulitis, or wound healing complications. Petitioner's pain was initially resolved but it reoccurred with throbbing, dull, sharp and shooting pain. Petitioner indicated that arm movement and hand function trigger the pain. The pain disturbed her sleep and inhibits most of her daily functions. Petitioner is a mother of four children and has no income. Petitioner indicated that she feels this is a great stress. Petitioner was eager to attend physical therapy. (Exhibit C, pp. 143-147).

On March 6, 2018, Petitioner was seen at [redacted] for a mammogram. The impression indicated that there was no mammographic evidence of malignancy. A one-year screening mammogram was recommended. (Exhibit C, pp. 148-149).

On March 27, 2018, Petitioner was seen at [redacted] for lymphedema follow-up since obtaining her compression sleeve and gauntlet. Thumb neuropathy was reduced, and thumb webbing pain was reduced 70 percent when wearing the gauntlet. (Exhibit C, pp. 157-159).

On March 29, 2018, Petitioner was seen at [redacted]. Petitioner had a stomach biopsy. The final diagnosis was severe active chronic gastritis. (Exhibit C, pp. 160-162).

On April 25, 2018, Petitioner was seen at [redacted] for a psychiatric evaluation. Petitioner initially denied feeling depressed, but as the session unfolded, she did admit to feeling quite down. Since the diagnosis that she had thoughts of wanting to harm herself. Petitioner indicated that right around the time of diagnosis, she took an excessive number of pills, but woke up the next morning and never told anybody. Since that time, she has only had passive ideation with no active ideation or intent. Petitioner reported that her concentration was diminished. Petitioner's appetite was fair, and she had gained weight recently. Petitioner stated that she was worried all the time and was afraid of not being able to care for her children and that they will be taken away from her. The mental health examination indicated that Petitioner had no psychomotor abnormalities. Petitioner's affect was dysthymic with tearfulness. Petitioner's thought processes were linear, and goal directed. There were no auditory or visual hallucinations. There was no delusional thinking. There were no suicidal or homicidal ideations. Petitioner's attention and memory were grossly intact. Petitioner's insight and judgement appeared good. The assessment indicated that Petitioner had major depressive disorder. (Exhibit A, pp. 163-165).

On July 31, 2018, Petitioner was seen at [redacted] for an NM bone imaging whole body. The findings indicated that no change was evident. There were no areas of abnormal tracer uptake to raise suspicion for neoplastic involvement of bone. Mild symmetric arthritic change persists in the shoulders, hip and knees bilaterally. (Exhibit C, pp. 170-171).

On August 9, 2018, Petitioner was seen at [redacted]. Petitioner listed her fatigue at 10. She also listed her pain at 10, specifically in the bilateral legs starting from the mid-thigh, shooting down toward her feet. Petitioner had previously been on gabapentin but has not been on that medication for quite some time. Petitioner indicated that she gets headaches, ongoing confusion, question memory loss, and continues to have pain and nausea. Petitioner indicated that she continued to have her bowels alternating between diarrhea and constipation since her chemotherapy. Petitioner indicated that she was regularly having 3 to 4 bowel movements a day and eating without any difficulty. (Exhibit C, pp. 172-175).

On August 16, 2018, Petitioner was seen at [redacted] for a psychiatric evaluation. Petitioner indicated that she continued to feel depressed, mostly related to her psychosocial circumstances. Petitioner continues to live with various family members due to no income. Petitioner continued to report decreased concentration and middle insomnia. Petitioner admitted to passive suicidal ideation but does not have an intent or plan. Petitioner feels helpless regarding her future. She continues to worry all the time. The mental health examination indicated that Petitioner had no psychomotor abnormalities. Petitioner's affect was dysthymic with tearfulness. Petitioner's thought processes were linear, and goal directed. There were no auditory or visual

hallucinations. There was no delusional thinking. There were no suicidal or homicidal ideations. Petitioner's attention and memory were grossly intact. Petitioner's insight and judgement appeared good. The assessment indicated major depressive disorder. (Exhibit C, pp. 179-181).

On August 21, 2018, Petitioner was seen at [redacted] for follow-up for chronic nausea and abdominal pain. The assessment indicated chronic nausea with epigastric pain. Change in bowel habits, but no complaints on this visit. Gastric lumen deformity. (Exhibit C, pp. 184-185).

On September 18, 2018, Petitioner was seen at [redacted] for lymphedema follow-up. Petitioner was utilizing a lymphedema compression sleeve and a gauntlet which was noted to be helping significantly reduce her swelling. Petitioner requested a prescription for physical therapy to assist with her right arm movement. Petitioner denied any redness, dramatically increased swelling and no new pain or dysfunction. (Exhibit C, pp. 191-193).

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 12.04 (depressive, bipolar and related disorders) and 13.10 (breast cancer) were considered. The medical evidence presented does not show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

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

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

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

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

If an individual has limitations or restrictions that affect the ability to meet demands of jobs other than strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of

non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). 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).* Where the evidence establishes a medically determinable mental impairment, the degree of functional limitation must be rated, taking into consideration chronic mental disorders, structured settings, medication, and other treatment. The effect on the overall degree of functionality is evaluated under four broad functional areas: (i) understand, remember, or apply information; (ii) interact with others; (iii) concentrate, persist, or maintain pace; and (iv) adapt or manage oneself. 20 CFR 416.920a(c)(3). For the first three functional areas, a five-point scale is applied (none, mild, moderate, marked, and extreme). 20 CFR 416.920a(c)(4). The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. 20 CFR 416.920a(c)(4).

In this case, Petitioner alleges both exertional and nonexertional limitations due to her medical condition. Petitioner testified that she is unable to dress/undress herself; bathe/shower herself; use the bathroom without assistance; complete chores; prepare meals; shop for groceries; squat; bend at her waist or kneel. Additionally, Petitioner testified that she is unable to stand for more than five minutes; walk for any significant distance or sit for more than 10-15 minutes without experiencing pain. Further, Petitioner testified that she experiences double vision; is unable to remember due to lack of focus; can only complete simple tasks and does not like people.

The medical evidence presented demonstrated that Petitioner has some periodic numbness and tingling. Petitioner's MRI results yielded normal results or mild abnormalities. Petitioner testified that the cyst on her brain is not being treated but is being monitored at this time. The lymphedema compression sleeve has significantly reduced the swelling in her arm. Petitioner complains of diarrhea. The most recent medical history in August 2018 indicated that she has three to four bowel movements per day. As of the date of the hearing, Petitioner had not sought treatment for any of her medical conditions for approximately six months, although she stated that she had upcoming medical appointments.

Petitioner was diagnosed with severe depressive disorder. However, both mental status examinations indicated no psychomotor abnormalities; Petitioner's thought processes were linear, and goal directed; no auditory or visual hallucinations; no delusional thinking; no suicidal or homicidal ideations. Further, the exams indicated that Petitioner's attention and memory were grossly intact and that her insight and

judgement appeared good. Additionally, as previously stated, Petitioner had not sought treatment for her mental health condition in the six months preceding the hearing.

While on April 26, 2019, [redacted] opined that Petitioner is incapable in engaging in meaningful vocation, it is unclear when [redacted] actually examined Petitioner. Further, [redacted] referenced the enclosed paperwork in support of her opinion that Petitioner is incapable of engaging in meaning vocation. However, the paperwork enclosed is dated [redacted], 2017, which predated Petitioner's completion of chemotherapy and radiation therapy. Further, the paperwork received from [redacted] dated March 27, 2019 largely included Petitioner's assessment of what she was able and unable to do, which was consistent with her testimony but not supported by the objective medical evidence presented in the record. Lastly, the MRI presented dated March 27, 2019, yielded normal results.

A two-step process is applied in evaluating an individual's symptoms: (1) whether the individual has a medically determinable impairment that could reasonably be expected to produce the individual's alleged symptoms and (2) whether the individual's statement about the intensity, persistence and limiting effects of symptoms are consistent with the objective medical evidence and other evidence on the record from the individual, medical sources and nonmedical sources. SSR 16-3p.

With respect to Petitioner's exertional limitations, it is found based on a review of the entire record that Petitioner maintains the physical capacity to perform light work as defined by 20 CFR 416.967(b). Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild to moderate 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 caregiver and home health aide. Petitioner's work in both capacities which required prolonged standing, walking, reaching, bending, pushing, pulling and lifting in excess of 50 pounds required heavy physical exertion.

Based on the RFC analysis above, Petitioner's exertional RFC limits her to no more than light work activities. As such, Petitioner is incapable of performing past relevant work. Petitioner also has mild to moderate limitations in her mental capacity to perform basic work activities. In light of the entire record, it is found that Petitioner's nonexertional RFC prohibits her from performing past relevant work. Although Petitioner is unable to perform past relevant work, Petitioner cannot be found disabled, or not disabled, at Step 4, and as the assessment is required to continue to Step 5 to determine whether Petitioner can adjust to other work.

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, if the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2). 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 [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 18-44) for purposes of Appendix 2. She is a high school graduate with a history of work experience as a caregiver and home health aide. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform light work activities.

Based solely on her exertional RFC, the Medical-Vocational Guidelines result in a finding that Petitioner is not disabled. However, Petitioner also has impairments due to her mental condition. As a result, she has a nonexertional RFC imposing mild to moderate limitations in the ability to understand, remember, or apply information; mild to moderate limitations in the ability to interact with others; mild to moderate in the ability to concentrate, persist, or maintain pace and mild to moderate ability to adapt or manage herself. It is found that those limitations would not preclude her from engaging in simple, unskilled work activities on a sustained basis. Therefore, Petitioner is able to adjust to other work and is not disabled at Step 5.

DECISION AND ORDER

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

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

JAM/tlf

Jacquelyn A. McClinton
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 Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

Via Email:	MDHHS-Macomb-20-Hearings BSC4 Hearing Decisions Policy-FIP-SDA-RAP MAHS
Petitioner - Via USPS	[redacted]
Counsel for Petitioner - Via USPS	People with Cancer Clinic 471 West Palmer St Detroit, MI 48202