[redacted]

Date Mailed: June 5, 2019
MOAHR Docket No.: 19-001993
Agency No.: [redacted]
Petitioner: [redacted]

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 April 3, 2019, from Detroit, Michigan. Petitioner appeared for the hearing with her Case Manager, [redacted] and represented herself. The Department of Health and Human Services (Department) was represented by Tracie Old, Hearing Specialist and Amanda Hubbell, Eligibility Specialist.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records, specifically, her updated mental health treatment and inpatient hospitalization records from [redacted]. Petitioner failed to submit any additional records to the undersigned Administrative Law Judge (ALJ) by the deadline identified on the Interim Order. The record was subsequently closed on May 6, 2019 and the matter is now before the undersigned for a final determination 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. Petitioner was previously approved for cash assistance (SDA benefits) on the basis that she was found to be disabled.

2. The Department asserted that Petitioner's SDA case closed effective July 2018 but was later reinstated with no lapse in coverage. This testimony was unverified.

3. On or around [redacted], 2018, Petitioner submitted a new application seeking cash assistance benefits on the basis of a disability. (Exhibit A, pp. 1-9)

4. The Department asserted that the application was used as an [redacted] 2018 redetermination for Petitioner's SDA case; however, this testimony was also unverified, as all documentary evidence indicated the application was processed as a new request for assistance and not an ongoing redetermination. Additionally, the Disability Determination Services (DDS) did not initiate a review of Petitioner's ongoing SDA eligibility, but rather as a new applicant.

5. On or around December 12, 2018 the DDS found Petitioner not disabled for purposes of the SDA program. (Exhibit A, pp. 11-44)

6. On March 6, 2019 the Department sent Petitioner a Benefit Notice informing her that her application for disability benefits had been denied. (Exhibit A, pp. 266-267)

7. On March 6, 2019 Petitioner submitted a timely written Request for Hearing disputing the Department's denial of her SDA application.

8. Petitioner alleged physically disabling impairments due to severe arthritis in both knees, failed knee replacement in left knee, and back pain. Petitioner alleged mental disabling impairments due to depression, anxiety, Post Traumatic Stress Disorder (PTSD), borderline personality disorder, and bipolar disorder. (Exhibit A, pp. 55-58)

9. As of the hearing date, Petitioner was [redacted] years old with an [redacted],1973 date of birth. She was 5'5" and weighed 277 pounds.

10. Petitioner is a college graduate with employment history of work as an education and training supervisor. Petitioner has not had substantial gainful employment since November 2008. (Exhibit A, pp. 82-88)

11. 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.

As a preliminary matter, although there was some testimony by the Department to indicate that Petitioner's SDA case was due for a redetermination and that she had been previously determined disabled, the documentary evidence presented at the hearing showed that Petitioner's [redacted], 2018 cash assistance application was processed as a new request for assistance and not a review of her continued or ongoing SDA eligibility. This was evidenced by the Medical – Social Eligibility Certification, the Physical Residual Functional Capacity Assessment, the Psychiatric Review Technique (Form SSA– 2506), the consultative examinations performed, and the Benefit Notice issued to Petitioner on March 6, 2019 advising her that her application for disability had been denied, rather than that her SDA case was being closed after a finding of no ongoing/continuing disability by DDS. As such, a five step evaluation to determine Petitioner's initial SDA eligibility at application will be applied in the present case, as opposed to the eight step sequential evaluation to assess whether Petitioner's previous disability continues.

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 [redacted], 2018, Petitioner participated in a consultative physical examination, during which, she presented with chief complaints of severe arthritis in both knees and failed knee replacement in her left knee. Petitioner indicated that she was diagnosed with osteoarthritis of the bilateral knees and underwent knee replacement procedure in 2016, for which she has had no improvement. Petitioner reported previous treatments which included physical therapy and injections. She indicated that her pain limits her and that she takes a long time to get dressed, showered, and prepare meals. She reported an ability to sit for one hour, stand for 10 minutes, walk for 10 minutes, and lift up to 10 pounds. Petitioner's medical record was reviewed and indicated multiple ER visits in 2018 for lower extremity swelling. Records indicated past hospitalizations for seizures in 2015 and 2018. Petitioner was observed to walk with a slight limp, was slightly pigeon toed in her gait, and used a walker to assist with ambulation. Her affect was flat and bizarre, and it was noted that she answered questions in an abrupt manner at times. Upon physical examination, Petitioner was able to bend forward, squat, and heel walk without difficulty. Her straight leg raise test did not elicit pain bilaterally in both the seated and supine positions and no long track times were present. Hoffmann and Tromner signs were negative bilaterally, Babinski signs plantar bilaterally, and no sciatic notch tenderness were noted. There was no ligamentous laxity of the knees or ankles, and the anterior/posterior drawer test was negative, as were Patrick and Faber's testing. There were no effusions of the joints, although she had enlargement of the bilateral knees, more so on the left where she has had the knee replacement. There is crepitus noted in the bilateral knees and Petitioner was assessed as having decreased range of motion of the left knee. The examining doctor concluded that Petitioner had difficulty toe walking and that a referral to physical therapy was recommended. Because of Petitioner's pigeon-toed gait, a referral to orthopedic surgery was also suggested. Based on the doctor's assessment, Petitioner did not appear to have any joint instability and had adequate strength and range of motion in all areas except for the left knee, with flexion that was observed to be about 120 degrees. Additional assessment indicates that Petitioner can sit or stand and bend, but she may have difficulty with stooping due to limited range of motion in the left knee. She was further assessed as being able to carry, push, and pull, bun clothing, tie shoes, dress and undress, dial a phone, open the door, make a fist, pick up a coin and pencil and write. She is not able to squat; however, the doctor believed that she was able to climb at least a few stairs to get in or out of the

building. Given Petitioner's weight, aggressive weight loss to minimize further damage of the corresponding joints was recommended. (Exhibit A, pp. 104-109)

On [redacted], 2018, Petitioner participated in an Adult Mental Status Examination during which, she reported an inability to work because of the following conditions: borderline personality disorder, bipolar depression, major anxiety, PTSD, arthritic knees and a failed knee replacement. Petitioner reported symptoms which included mood swings, going ballistic, flipping out for nothing, a lack of focus, major panic attacks, paranoid thoughts, worrying, and suicidal ideations which have not been present since 2012, when her son killed himself. She denied hallucinations. Petitioner reported that some of her symptoms began when she was [redacted] years old, and she spoke of an abusive marriage and a fractured skull that occurred in 2009. The examining doctor reviewed Petitioner's treatment records and determined that she has been in treatment for the past six years receiving case management and therapeutic services. She had been psychiatrically hospitalized a number of times, had received outpatient therapy, and prescribed medications for active diagnoses of adjustment disorder with mixed anxiety and depressed mood, recurrent major depression and partial remission, borderline personality disorder, generalized anxiety disorder, PTSD, alcohol use disorder and anxiolytic use disorder. Petitioner reported having a chore provider who assists her with meal preparation, errands and personal care. She was observed to be obese and using a walker to assist with ambulation. She was pleasant, cooperative and displayed insight. Her thoughts were organized, rational and associated, and her speech was of normal prosody. While she reported history of suicidal thoughts, she had no current ideation and denied any hallucinations or delusions. Her affect was broad with intermittent emotionality and she was oriented to time, person, place, and purpose. Petitioner was diagnosed with bipolar I disorder current episode depressed (severe), posttraumatic stress disorder (with panic attacks), unspecified personality disorder (with borderline and paranoid features) and tobacco use disorder. It was noted that she also had multiple physical impairments. The medical source statement indicates that Petitioner showed moderate limitations with memory, recall, and ability to manipulate information. There were moderate limitations with her task, persistence and concentration. She may have difficulty with procedures that involve more than two steps and there were marketed limitations with her social interaction as she has trouble being in public because of her posttraumatic symptoms. (Exhibit A, pp. 92-103)

Petitioner's mental health treatment records from [redacted] were presented for review. (Exhibit A, pp. 112-137). Medication Review Notes from [redacted], 2018 indicate that Petitioner has a long history of depression and anxiety symptoms, has experienced problems with sleep, nightmares, irritability, mood swings, increased appetite, has a history of chaotic relationships and a friend who just died of a heroin overdose. Petitioner was receiving mental health treatment for active diagnoses of adjustment disorder with mixed anxiety and depressed mood, recurrent major depression and partial remission, borderline personality disorder, generalized anxiety disorder, PTSD, alcohol use disorder and anxiolytic use disorder. (Exhibit A, pp. 112-119). Petitioner underwent an annual Psychiatric Evaluation on [redacted], 2018. Petitioner reported irritability, mood swings, weight gain related to medication side effects, a history of hair

pulling for the past 5 to 6 years, panic attacks when she is around a lot of people and in areas with a lot of noise. Petitioner reported feeling shaky, weak, and avoiding situations because she is unable to tolerate people. She reported history of nightmares, flashbacks and avoidance due to physical abuse as her husband reportedly tried to kill her. The Evaluation indicates that Petitioner has had more than nine inpatient hospitalizations, the first of which occurred at age 20 for one month and previous suicide attempts which included overdosing on medications that resulted in her inpatient hospitalizations. Petitioner reported family history of her son committing suicide in December 2012 as well as a significant other who died of an apparent drug overdose. She has family psychiatric and substance abuse history including a grandmother who was institutionalized for schizophrenia and two brothers one of whom was institutionalized between age 10 and 18 for violent tendencies including trying to kill his baby brother. She also reported that she had a suicide attempt at age [redacted]. Petitioner's speech was spontaneous, her eye contact good, her affect euthymic, her thought process was goal directed, she denied delusional thought content, denied hallucinations or perceptual disturbances, and denied suicidal and homicidal ideations. She was oriented times three, her memory, concentration and registration/recall were intact, and her abstract thinking was adequate. Her insight and judgment were limited to adequate. Petitioner continued her treatment with [redacted]. (Exhibit A, pp. 120-129).

Records from Petitioner's treatment in the Emergency Department (ED) of [redacted] in [redacted] were reviewed. On [redacted], 2018, Petitioner presented to the ED with complaints of a fall, back injury and alcohol intoxication. Petitioner was found outside a liquor store having repeated falls after having drank a fifth of hard alcohol earlier in the day. Records indicate that Petitioner reported drinking 1/5 of vodka every day since Friday after having been sober for a year and a half. Petitioner complained of upper back pain that is worse with movement of the upper extremities, she did not lose consciousness, is not on any blood thinning medications and denied any headache or change in vision. She reported increased stress at home due to multiple deaths in the family and her boyfriend being in the hospital. She denied any acute illnesses but stated she's been in relatively good physical health; however, she did report chronic left knee pain after a knee replacement but denied any chest pain, shortness of breath, abdominal pain, lower extremity injury or calf pain. Upon physical examination, she had midline upper thoracic vertebral tenderness without neurological deficit, no obvious signs of skin trauma or ecchymosis, no step off, crepitus or obvious deformity. Her range of motion was normal, however she exhibited mild tenderness of the left knee with range of motion and stated that this is chronic in nature. CT of the lumbar and thoracic spine showed no acute osseous abnormality involving the thoracic and lumbar spine, no high-grade spinal canal stenosis, but showed mild chronic depressions involving the upper T 11 endplate and L1 vertebral body. An MRI of the cervical spine was completed and showed focal C1 – C2 interspinous ligamentous strain without widening of the C1 – C2 interspinous distance. Otherwise, it was an unremarkable MRI of the cervical spine and the spinal cord was observed to be within normal limits. No acute intracranial abnormalities and no acute traumatic injury were found on the CT of the cervical spine. Petitioner was observed to be heavily intoxicated with an initial EtOH level of 0.38 and she was slurring her words. It was noted that

Petitioner had a history of significant bipolar disorder, anxiety and alcoholism. Petitioner was discharged after her treatment. On [redacted], 2018, Petitioner presented to the ED with complaints of bilateral leg swelling and pain radiating up her leg. She reported taking Norco without improvement in symptoms, described the pain as burning and reported redness over her lower legs. She further reported some shortness of breath while sleeping or after strenuous activity. Upon physical examination, it was noted that Petitioner had 1+ pitting edema in her lower extremities bilaterally, rales and her bilateral bases, and tenderness to palpation in the lower extremities. It was noted that she had venous stasis changes to her lower extremities bilaterally from the mid – tibial region, downward. Ultrasounds of the bilateral lower extremities ruled out DVT and additional testing was performed to rule out PE. Petitioner was discharged after her treatment in the ED. On [redacted] 2018 Petitioner returned to the ED with similar complaints of lower extremity swelling and shortness of breath. It was noted that Petitioner smokes a pack of cigarettes a day. She denied chest pain, cough, sputum production, fever, chills, nausea, vomiting or any other associated symptoms. Examination showed no cyanosis, 2+ pitting edema of the lower extremities, minimal erythema to dorsum of left foot distally with minimal tenderness, minimal tenderness to the toes and a good capillary refill. Petitioner was given a dose of doxycycline orally in the ED and discharged home with a prescription and instructions to follow up with her primary care physician as well as cardiology for further management. (Exhibit A, pp. 222 – 265).

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), 12.04 (depressive, bipolar and related disorders), 12.06 (anxiety and obsessive-compulsive disorders), 12.08 (personality and impulse-control disorders), and 12.15 (trauma and stressor related 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 very little strength and no cartilage in her knees making it very difficult to walk. She stated that she has arthritis in her knees and lower back and in 2015 she had a failed total knee replacement. Petitioner reported that she previously participated in physical therapy but was unable to continue, as she had no transportation. She further testified that she sees her primary care physician but is not currently being treated by any specialists. Petitioner testified that she is able to walk only 50 feet before needing to rest or sit down and that for the past one year she has been using a walker to assist with ambulation due to gait instability. She reported that she is able to sit for only ½ hour before her back and knees become stiff and that she is able to stand for only a few minutes at a time. She reported no problems with gripping or grasping items with her hands. Petitioner indicated that she is able to lift up to 5 pounds but is unable to bend, squat, or climb stairs. Petitioner testified that she lives in a small apartment and that her chair and bed are only a few feet apart from each other. She reported that she uses her walker to get to the bathroom, which has been modified with safety bars and handles to accommodate her impairments. Petitioner testified that she lives alone but has an approved DHHS chore provider who assist her with bathing, dressing, cooking and meal preparation as well as all household chores. Petitioner stated that once a month she and her case manager go for short shopping trips as her condition prevents her from being able to drive herself anywhere.

With respect to her nonexertional/mental impairments, Petitioner testified that she has been diagnosed with depression, anxiety, borderline personality disorder, bipolar

disorder, and PTSD for which she receives medication treatment. She reported suffering from anxiety attacks daily that can last up to one hour and consists of symptoms including heart racing, shortness of breath, sweating, and feeling like the whole world is caving in. She testified that her mental condition affects her ability to focus and that she can only concentrate for 5 to 10 minutes before being distracted. She reported problems with short-term memory recall and stated that she suffers from crying spells daily that last for a few hours at a time. Petitioner denied auditory and visual hallucinations. Petitioner testified that she has thoughts of hurting herself but not others, and that she has made multiple suicide attempts, the most recent being about 10 days prior to the hearing which led to her inpatient hospitalization for eight days. Petitioner reported that she is unable to take care of herself and can't go anywhere without her case manager due to her inability to function without assistance. Petitioner stated that in 2017 she was hospitalized for inpatient treatment on three separate occasions.

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 records, some of which are referenced above, with respect to Petitioner's exertional limitations, it is found, based on a review of the entire record, that Petitioner maintains the current 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 mild to moderate limitations on her non-exertional ability to perform basic work activities, with respect to performing manipulative or postural functions of some work such as stooping, climbing, crawling, or crouching. The records show that Petitioner was receiving mental health treatment for adjustment disorder, major depressive disorder, anxiety, bipolar disorder, PTSD and borderline personality disorder. It is found that Petitioner has moderate to marked limitations in her activities of daily living; 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 an education and training supervisor which required standing for 2 to 3 hours, sitting for about 6 hours daily, and frequently lifting from 10 to 25 pounds. 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 only sedentary work activities. However, Petitioner's additional nonexertional/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 [redacted] years old at the time of application and hearing, and thus, considered to be a younger individual (age [redacted]) 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 finding that Petitioner is not disabled.

However, as referenced above, Petitioner also has nonexertional impairments imposing additional limitations. As a result, and based on the evidence presented, she has a nonexertional RFC imposing moderate to marked limitations in her activities of daily living; marked limitations in her social functioning; and moderate to marked limitations in her concentration, persistence or pace, as well as mild to moderate limitations with respect to her ability to perform basic work activities including stooping, climbing, crawling or crouching. The Department has failed to present evidence of a significant number of jobs in the national and local economy that Petitioner has the vocational qualifications to perform in light of her RFC, age, education, and work experience. Therefore, the evidence is insufficient to establish that Petitioner is able to adjust to other work. 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 [redacted], 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 November 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 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

Via Email:

MDHHS-Jackson-Hearings
BSC4 Hearing Decisions
Policy-FIP-SDA-RAP
MOAHR

Petitioner – Via First-Class Mail:

[redacted]