STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

Date Mailed: May 31, 2019
MOAHR Docket No.: 19-003248
Agency No.:
Petitioner:

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 May 1, 2019, from Detroit, Michigan. Petitioner appeared at the hearing on her own behalf. , Petitioner's mother also appeared on behalf of Petitioner. Participants on behalf of the Department of Human Services (Department) included Amanda Mullen, Hearing Facilitator and Tammy Smith, Eligibility Specialist.

ISSUE

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

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

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

2. On February 19, 2019, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 47-53).

3. On February 21, 2019, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit A, pp. 1148-1151).

4. On March 29, 2019, the Department received Petitioner's timely written request for hearing (Exhibit A, p. 1157).

5. Petitioner alleged disabling impairment due to spinal stenosis; disc bulging; pots syndrome; bipolar disorder; depression; and back pain.

6. On the date of the hearing, Petitioner was [redacted] years old with a [redacted], 1998 birth date; she is 5'8" in height and weighs about 370 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 cashier.

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.

On February 6, 2017, Petitioner was seen [redacted] with a chief complaint of dizziness. A CT brain without contrast was performed. The results indicated a normal noncontrast CT scan of the head. The final diagnoses indicated right sided weakens and paresthesias. (Exhibit A, pp. 633-637).

On March 6, 2017, Petitioner was seen at [redacted] with a chief complaint of headache and head injury. Petitioner presented at the emergency room following a fall during choir practice in which she lost consciousness and fell from the risers. The record noted that she had been seen in the emergency room the day prior for a similar episode. The record further noted that Petitioner had been feeling dizzy and lightheaded a few weeks prior and fell over. She was seen by the emergency department at that time. A CT spine cervical without contrast was performed. There was no evidence of fracture. The results also noted nonspecific reversal of the cervical spine lordosis most commonly represents positioning or cervical strain. (Exhibit A, pp. 628-630).

On March 10, 2017, Petitioner was seen at [redacted] for a consult for dizziness. Petitioner was referred for lightheadedness and weakness in her legs. During choir, Petitioner felt palpitations, shortness of breath and then lightheadedness lasting on and off for 30 minutes. Petitioner indicated that she had been feeling very depressed but had no suicidal ideations. A CT brain was performed. The results were unremarkable. (Exhibit A, pp. 626-628).

On March 28, 2017, Petitioner was seen at [redacted] for a psychiatric evaluation. Petitioner reported being depressed and having suicidal ideation. Petitioner expressed some suicidal statements to her counselor at school. The final diagnosis included depression, unspecified and suicidal ideation. (Exhibit A, pp. 623-625).

On April 4, 2017, Petitioner was brought to [redacted] by EMS after texting a friend and indicating that she was going to overdose on pills. The record noted that Petitioner had a history of overdose and had been hospitalized at [redacted], [redacted] as an adolescent. The record further indicated that Petitioner had a diagnosis of bipolar mood disorder and had not been taking her medication for the past six months. Petitioner was discharged on April 10, 2017. Petitioner's condition at time of discharge was listed as stable; however, her prognosis was listed as poor. Petitioner's diagnoses included bipolar, mixed, schizoaffective disorder, psychotic disorder NOS, and generalized anxiety disorder. Petitioner had a GAF score of 35 at discharge. (Exhibit A, pp. 571-617).

On May 1, 2017, Petitioner was seen at [redacted] with a chief complaint of light headedness. Petitioner indicated that the problem had been occurring once per week since February. The diagnosis included syncope, unspecified. (Exhibit A, pp. 564-565).

On May 19, 2017, Petitioner was brought to [redacted] by ambulance due to suicidal thoughts and depression. The record noted that Petitioner was being treated for major depression and was currently taking Abilify. Petitioner was under the care of a psychiatrist. It was noted that Petitioner was stable and cooperative throughout her emergency room visit. Petitioner's parents were contacted and agreed to monitor her closely at home. The final diagnosis included mild single current episode of major depressive disorder. (Exhibit A, pp. 561-564).

On May 23, 2017, Petitioner was seen at [redacted] with a chief complaint of dizziness/near syncope. Petitioner was brought to the hospital by EMS. Petitioner indicated that she felt dizzy, lightheaded, shaky and fell when getting ready to go on stage to perform in a play. Final diagnosis was near syncope. (Exhibit A, pp. 565-568).

On July 10, 2017, Petitioner was seen at [redacted] at 9:10 a.m. due to a drug overdose. Petitioner stated that she was suffering from depression and was involved in arguments the previous day. Petitioner indicated that she took 10-15 150 mg Seroquel at around 10:30 p.m. She was brought to the emergency room after posting information on Facebook mentioning the pills. Petitioner indicated that her last suicide attempt was four years prior. Petitioner was scheduled to attend therapy the next day. Petitioner was discharged from the hospital. (Exhibit A, pp. 557-561).

On July 10, 2017, Petitioner was seen at [redacted] with a chief complaint of back pain at 10:15 p.m. Petitioner indicated that her back pain was exacerbated when she fell down some stairs on the same day. Petitioner reported tumbling down 9 or 10 steps. Petitioner further reported shooting pain down both her legs including numbness

and tingling in her legs. Petitioner was diagnosed with a lumbar sprain. (Exhibit A, pp. 555-557).

On July 15, 2017, Petitioner was seen at [redacted] for a psychiatric evaluation. Petitioner stated that she was seen at the hospital a few days prior and attempted to overdose on Seroquel that same day. Petitioner denied plan or attempt on the day of this hospital visit. However, Petitioner stated that she felt depressed and suicidal. Final impression included depression, unspecified and suicidal ideation. (Exhibit A, pp. 552-554).

On July 18, 2017, Petitioner was seen at [redacted] in the emergency room with a chief complaint of feeling depressed and suicidal. The record noted that Petitioner had two recent Seroquel overdose attempts and was scheduled to begin dialectical behavior therapy on August 2, 2017. Petitioner presented as depressed helpless and hopeless. Petitioner stated that after her last overdose attempt, she stopped taking the Seroquel. Petitioner indicated that she had been feeling suicidal for approximately one month. Petitioner was discharged on July 25, 2017 with a discharge diagnosis of depressive disorder. (Exhibit A, pp. 510-548).

On September 27, 2017, Petitioner was seen at [redacted] with a chief complaint of back pain. Petitioner reported that she has chronic back pain that had been present for at least one year. Petitioner described the back pain as aching, sometimes sharp sensation across her lower back with radiation down her left leg. Final impression included acute bilateral low back pain with left-sided sciatica. (Exhibit A, pp. 501-503).

On October 4, 2017, Petitioner was seen at [redacted]. Petitioner arrived by EMS due to a syncopal episode and ground level fall hitting her head. It was noted that Petitioner had a history of the same. Petitioner stated that prior to passing out, she felt lightheaded, woozy and nauseous. She indicated that she fell backwards, hit her head against the wall and then fell to the floor. At the time of the emergency room visit, Petitioner complained of a headache. Final diagnoses included syncope and head injury, initial encounter. (Exhibit A, pp. 497-501).

On October 13, 2017, Petitioner was seen at [redacted] with the chief complaint of anxiety. Petitioner arrived via EMS from home with reports of anxiety after Friday with her mother on the telephone this evening. Petitioner stated that she cried for about an hour and then felt like she could not breathe. Petitioner noted that she felt better while at the hospital because the EMS staff helped calm her down. Petitioner indicated that her last panic attack was one month prior. Petitioner did not have any medication for anxiety. (Exhibit A, pp. 490-491).

November 14, 2017, Petitioner was seen at [redacted] with the chief complaint of back pain. It was noted that Petitioner slipped and fell on July 10, 2017. Petitioner indicated that the pain had been gradually worsening since onset. It was noted that Petitioner had been treated with physical therapy without resolution of her

symptoms. The diagnosis of lumbar radiculopathy was discussed with Petitioner. The findings included right L5-S1 disc herniation and write L4-5 lateral recess stenosis. (Exhibit A, pp. 477-486).

November 21, 2017, Petitioner was seen at [redacted] with a chief complaint of back pain. It was noted that Petitioner had back surgery the previous Tuesday and had increased pain and now numbness to bilat legs. An MRI of the lumbar spine with and without contrast was ordered, the final result included interval postoperative change compatible with hemilaminectomies at L4 and L5 on the right. There was residual degenerative change of the lumbar vertebral column. It was noted that additional findings raising the possibility of recurrent disc extrusion which effaces the thecal sac at L5-S1. (Exhibit A, pp. 434-469).

On December 7, 2017, Petitioner was seen at [redacted] for a physical therapy evaluation. Petitioner was noted to be a 19-year-old obese female who comes in post lumbar herniated disc and pulse lumbar laminectomy in November 2017. Petitioner was brought in a wheelchair and reported that in the previous few days she has been unable to walk. Petitioner demonstrated weakness in her core muscles. The therapist was unable to take any AROM measurements of the lumbar spine due to 8/10 pain and inability to stand. (Exhibit A, pp. 432-433).

On March 18, 2018, Petitioner was seen at [redacted] with the chief complaint of back pain. Petitioner stated that she had not been on chronic pain medicine since late January mid-February. On physical examination, Petitioner was found to be resting comfortably in no distress with diffuse back tenderness to the lower back with focal tenderness and no neural deficits. (Exhibit A, pp. 425-428).

On March 29, 2018, Petitioner was seen at [redacted] with the chief complaint of sciatica. Petitioner stated that she had back surgery to remove discs four months prior and was having sciatica pain. An MRI of the spine lumbar with and without contrast as well as an MRI pelvis with contrast were ordered. The MRI pelvis results were negative. The MRI of Petitioner's lumbar spine showed a possible slight change in disc protrusion at L3-L4. Otherwise no acute changes and findings consistent with postsurgical changes. (Exhibit A, pp. 421-425)

On March 30, 2018, Petitioner had an MRI Pelvis without contrast. The impressions indicated that the MRI of the pelvis was unremarkable. There were no conclusive imaging findings to support piriformis syndrome as the etiology for the left lower extremity symptoms and degenerative and post-surgical changes of the lumbar spine. (Exhibit A, pp. 746-753).

On April 1, 2018, Petitioner was brought to [redacted] by EMS with a chief complaint of back pain. Petitioner stated that she recently had back surgery on her lower back and that she had numbness in her lower legs that is new with increased pain in her hips and back. Final diagnosis included chronic right-sided lower back pain with right-sided sciatica. (Exhibit A, pp. 418-420).

On May 9, 2018, Petitioner was seen at [redacted] in the emergency room department with a chief complaint of headache which started the previous night. Petitioner denied any falls or any recent head injuries. Petitioner denied fever, nausea, vomiting, or neck discomfort. A CT scan was ordered. There was no evidence of intracranial hemorrhage or acute intracranial abnormality. (Exhibit A, pp. 409-413).

On May 23, 2018, Petitioner was seen at [redacted] for an electromyography. There was no electrophysiologic evidence of neuropathy, plexopathy, nor radiculopathy as tested in the right lower extremity. (Exhibit A, pp. 406-409).

On June 20, 2018, Petitioner was seen at [redacted] for a therapy session. Petitioner presented to clinic on May 14, 2018 with complaint of gait difficulty due to chronic lower back pain with bilateral sciatica. Petitioner attended two therapy treatment sessions on May 23, 2018 to June 20, 2018 with two cancellations and three no-shows. Petitioner reported poor attendance due to difficulties with transportation, severe back pain, and mental health issue. The physical therapy assessment was gait difficulty due to chronic lower back pain with bilateral sciatica. (Exhibit A, pp. 403-405).

On June 28, 2018, Petitioner had an MRI Spine Lumbar with and without contrast. The impression included postoperative changes at L4-L5. Enhancing soft tissue in the laminectomy surgical defects. Enhancing soft tissue along the dorsal lateral aspect of the descending right L5 nerve root in the lateral recess and surrounding the proximal descending right S1 nerve root, as on a prior study. Interval decrease in disc protrusion at L3-L4, residual disc protrusion at L4-L5 and L5-S1 compared to prior study 3/30/2018. Stable mild spinal canal narrowing at L3-L4. (Exhibit A, pp. 702-703)

On September 19, 2018, Petitioner was seen at [redacted] with a chief complaint of abdominal pain; asthma; back pain; and diabetes. The abdominal pain was noted to be located in the right upper quadrant and left upper quadrant. The location of the back pain was noted as lower back. The assessment included moderate persistent asthma with acute exacerbation; type II diabetes mellitus without complication; upper abdominal pain; chronic bilateral low back pain with bilateral sciatica; exercise and dietary counseling. (Exhibit A, pp. 338-344).

On September 26, 2018, Petitioner was seen at [redacted] with a chief complaint of asthma, diabetes, abdominal pain and back pain. The assessment indicated moderate persistent asthma with acute exacerbation; type II diabetes mellitus without complication; chronic bilateral low back pain with bilateral sciatica; upper abdominal pain; abnormal TSH; exercise and dietary counseling. (Exhibit A, pp. 331-337).

On October 18, 2018, Petitioner was seen at [redacted] with a chief complaint of weight gain and abdominal pain. This was an emergency room visit. Petitioner stated that she went to the emergency room twice in the past week. Petitioner was frustrated about her weight gain. Petitioner acknowledged that she was engaging in not healthy food choices and not drinking water during the day. It was noted that Petitioner's

gastritis was getting worse and that she was unable to use her back brace due to stomach pain. The assessment indicated article; upper abdominal pain; and weight gain. (Exhibit A, pp. 324-330).

On October 3, 2018, Petitioner was seen at [redacted] for an evaluation of a sleep problem. It was noted that Petitioner had been admitted to [redacted] a couple weeks prior to the visit due to an asthma attack. The physician at that time recommended that Petitioner see a sleep specialist due to history of snoring and excessive daytime sleepiness. The assessment included a discussion relating to the correlation between morbid obesity and prediabetes. The plan was to conduct a second night of home sleep study before ESG if non-diagnostic. (Exhibit A, pp. 369-373).

On October 13, 2018, Petitioner was seen at [redacted] with a chief complaint of fatigue, dizziness, abdominal pain, nausea, dental pain, and back pain. Petitioner had a CT of the brain, x-ray of the lumbar spine an x-ray of right knee. CT brain showed no acute intracranial abnormity and sinus disease. X-ray of right knee in the lumbar spine were unremarkable. Final diagnoses included malaise and fatigue as well as acute viral syndrome. (Exhibit A, pp. 396-400).

On October 29, 2018, Petitioner was seen at [redacted] with a chief complaint of abdominal pain and back pain. Petitioner indicated that the abdominal pain had been bothering her for the past month and the back pain for years. Petitioner stated that nothing seems to be getting any better and she requested to have them both evaluated. Petitioner noted her pain as 8/10 in regard to the abdomen as well as 10 out of 10 the lower back. The final diagnosis included abdominal pain, epigastric. On examination mild epigastric tenderness was found with no guarding, no rebounding, no distention. (Exhibit A, pp. 391-395).

On October 30, 2018, Petitioner was seen at [redacted] with a chief complaint of back pain, abdominal pain, and dizziness. Petitioner indicated that the pain was in her lower back. The location of the abdominal pain was epigastric. The dizziness began approximately three months prior to the visit. The assessment indicated upper abdominal pain; a referral for evaluation of the gallbladder; chronic bilateral lower back pain with bilateral sciatica; and vertigo. Exhibit A, pp. 316-323).

On November 6, 2018, Petitioner was seen at [redacted] for a CT head without IV Contrast. The findings included that there was no intracranial mass, midline shift, extra-axial fluid collection or hemorrhaging. The ventricles, sulci, and cisterns were normal. There was no suspicious area of altar attenuation. There was no fracture. The visualized aspects of orbits, paranasal sinuses, and mastoid air cells were unremarkable except for moderate inflammation in the left maxillary sinus. (Exhibit A, pp. 366-368).

On November 6, 2018, Petitioner was seen at [redacted] for a baseline home sleep study. The record noted that home sleep testing in October 2018 was

nondiagnostic as there was only 18 minutes of data sleep study. Petitioner reported feeling tired during the day. Comorbidities included morbid obesity, pre-diabetes, and depressive disorder. The impression indicated nondiagnostic sleep study for obstructive sleep apnea. There were some episodes of inspiratory flow with limitations suggestive of partial upper airway obstruction as well as some events suspicious for hypopneas without arousals that could not be scored because they did not meet oxygen desaturation criteria for unattended portable home sleep testing. The impression also indicated moderate to severe accident desaturation in the mid to low 80s observed with respiratory events. (Exhibit A, p. 362).

On November 7, 2018, Petitioner had a CT Brain without contrast. The impression included no acute intracranial hemorrhage, mass lesion or mass effect and moderate inflammation in the left maxillary sinus. (Exhibit A, p. 674).

On November 14, 2018, Petitioner was seen at [redacted] with a chief complaint of a urinary tract infection and weight gain. The assessment indicated that Petitioner had a urinary tract infection without hematuria. (Exhibit A, pp. 310-315).

On November 28, 2018, Petitioner underwent an MRI of the brain without contrast. The impression included normal MRI of the brain was visualized and multiple prominent lesions within and adjacent to the parotid gland bilaterally measuring up to 13 mm x 10 mm in long and short axle dimensions. (Exhibit A, p. 277).

On March 11, 2019, Petitioner was seen at [redacted] due to a referral from her primary care physician related to dizziness. Petitioner indicated that she may go a few months without an event but then may have a couple of events within a span of a few weeks. The assessment indicated syncope – likely vasovagal and pots. The record indicated that further assessment with tilt table test was recommended as well as an echocardiogram to rule out structural heart disease.

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.

<u>Step Three</u>

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) 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, 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 could dress/undress herself; bathe herself but not shower without assistance; use the bathroom unassisted; lift a gallon of milk; reach and use her hands. Petitioner further testified that she could not complete chores because she is unable to sit or stand for long periods of time. Additionally, Petitioner indicated that she could not squat or bend at the waist due to back pain. Petitioner stated that she could not stand for more than 10 minutes or walk very far without experiencing pain. Petitioner testified that she could only climb about two to three stairs. Petitioner stated that she regularly uses a cane as prescribed by her doctor. Ms. Muller testified that Petitioner was able to sit during the hour-long hearing.

Petitioner has a lengthy and frequent record of hospital visits. While there was some evidence of disc protrusion and mild narrowing, most of Petitioner's objective testing yelled results which were unremarkable or had mild abnormalities. For instance, on March 29, 2018, following back surgery four months prior, Petitioner had an MRI of the lumbar spine and an MRI pelvis. The MRI of the lumbar spine showed slight disc protrusion and the MRI pelvis was unremarkable. On May 23, 2018, Petitioner was seen for an electromyography in which there was no electrophysiologic evidence of

neuropathy, plexopathy, nor radiculopathy as tested in the right lower extremity. Petitioner was participating in therapy from May to June 2018 and had missed several therapy appointments. Additionally, on November 7, 2018, Petitioner had a CT of the brain without contrast. The impression included no acute intracranial hemorrhage, mass lesion or mass effect and moderate inflammation in the left maxillary sinus.

Petitioner also asserts that her mental health conditions prevent her from working. Although Petitioner had an extensive history of attempted overdoses and depression, the medical record presented relating to treatment end in July 2017. At the hearing, Petitioner testified that she had not treated with her psychiatrist since October 2018, seven months prior to the hearing. Additionally, Petitioner testified that she could remember, complete task and follow instructions; however, she did state that she became tired when attempting to concentrate.

On March 5, 2019, [redacted] authored a letter which indicated that Petitioner had a Functional Capacity Test completed through [redacted] in August 2018 which yielded the following restrictions:

- No standing for more than 7 minutes continuously;
- No sitting for more than 15 minutes continuously;
- No walking for more than 0.1 miles continuously;
- No pushing more than 30lbs.
- No pulling more than 20lbs;
- No balance activities that require walking or crouching;
- No crouching, stooping or crawling. (Exhibit A, pp. 1160).

The letter does not identify any lifting restrictions. It should be noted that the document does not provide an occupation for [redacted]. Further, the actual test completed by [redacted] was not provided.

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 cashier. Petitioner's work as a cashier required prolonged standing as well as a significant amount of bending and reaching. Petitioner was also required to consistently lift between 15-50 pounds, requiring medium 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. Petitioner's nonexertional RFC does not prohibit 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).

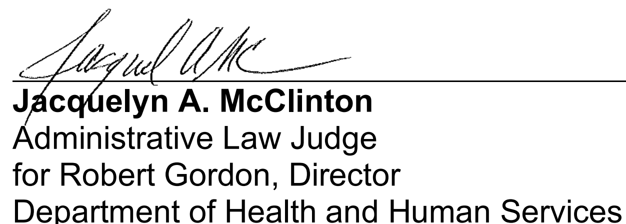
In this case, Petitioner was 20 years old at the time of application and 20 years old at the time of hearing, and, thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. She is a high school graduate with a history of work experience as a cashier. As discussed above, Petitioner 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

NOT DISABLED: 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-Calhoun-Hearings
BSC3 Hearing Decisions
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MOAHR

Petitioner – Via First-Class Mail: