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Date Mailed: August 21, 2019
MOAHR Docket No.: 19-004831
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250. After due notice, an in-person hearing was held on June 20, 2019, from [redacted] Michigan. The Petitioner was represented by herself. [redacted] her spouse, also appeared as a witness. The Department of Health and Human Services (Department) was represented by Alice Mosley, 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. At the hearing, the Petitioner presented a document which was admitted into the record as Exhibit B, which included the results of an eye examination as well as an EMG study from April 2019 completed by her neurologist as well as the test results and a medical needs form completed on [redacted] 2019, by her primary care physician; and also attached was a copy of a Medical-Social form. Exhibit C, a DHS-49, was received from [redacted] and marked into evidence. Exhibit D, a DHS-49 completed by [redacted] was received and marked into evidence.

In addition, after the admission of Exhibit A into the record, it was discovered that pages 148 through 230 were medical records of an individual who was not Petitioner [redacted] and, therefore, were removed from the exhibit. The record closed on July 22, 2019; and the matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

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

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 May 11, 2018, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On April 29, 2019, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program.

3. On May 10, 2019, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability.

4. On May 10, 2019, the Department received Petitioner's timely written request for hearing.

5. Petitioner alleged disabling impairment due to physical impairments including Fibromyalgia, Bilateral Carpal Tunnel, severe hypertension, coronary artery disease, kidney failure and heart attack with damage. The Petitioner also alleges Mental Impairment due to Bipolar disorder.

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

7. Petitioner completed the 11th grade and is not a high school graduate.

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

9. Petitioner has an employment history of work cleaning hotel rooms and a hair stylist and working at [redacted] preparing orders.

10. 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 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 90 days, which meets federal Supplemental Security Income (SSI) disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Determining whether an individual is disabled for SSI purposes requires the application of a five-step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If an individual is found disabled, or not disabled, at any step in this process, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In general, the individual has the responsibility to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

Step 1

The first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Petitioner was not working during the period for which assistance might be available. Because Petitioner was not engaged in SGA, she is not ineligible under Step 1, and the analysis continues to Step 2.

Step 2

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for SDA means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the *de minimis* standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs v Bowen*, 880 F2d 860, 862-863 (CA 6, 1988), citing *Farris v Sec of Health and Human Services*, 773 F2d 85, 90 n.1 (CA 6, 1985). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28. If such a finding is not clearly established by medical evidence or if the effect of an impairment or combination of impairments on the individual's ability to do basic work activities cannot be clearly determined, adjudication must continue through the sequential evaluation process. Id.; SSR 96-3p.

The medical evidence presented at the hearing, *and in response to the interim order,* was reviewed and is summarized below.

An adult mental status examination was conducted on [redacted] 2019. The examiner noted that patient self-reported she began ingesting Ajax Cleanser at a young age and as an adult had continued to eat Ajax but did also did not report receiving mental health treatment until she was in her 40s. Her current mental health symptoms, as self-reported, included her mood being described as “in the air” with racing thoughts, poor sleep and anxiety; and at the time of the exam, Petitioner reported that she continues to eat Ajax Cleanser 1 to 3 times a week. Records from [redacted] were reviewed where she was seen for mental health services in [redacted] 2018; she was diagnosed then with major depressive disorder recurrent severe and Pica. She was discharged there after three months for not attending appointments. She reported stopping work in 2011 because of her medical issues. She described herself as now socially isolated. At the time of the exam, she was receiving her psychiatric medications from her primary care physician with no history of inpatient psychiatric hospitalizations. The Petitioner reported daily functioning included reading the Bible and sleeping; she does not do any cooking or cleaning; and husband helps her with bathing from time to time. During the exam, she made little eye contact, speech was slow; and she appeared very drowsy. During the exam, her mood was described as dysphoric with a restricted range of affect. The thought process was logical, linear and goal-directed. During the exam, the Petitioner denied current suicidal and homicidal ideation, denied experiencing psychotic symptoms and did not appear paranoid or delusional. The Petitioner was oriented to situation, day, year, time, place and date. Her ability to perform calculations of a simple nature was rated as good. Her memory was fair, and recent memory was poor. Remote memory was rated as good as was her ability to present information. At the conclusion of the exam, the following Medical Source Statement was made: “this claimant reports a long history of experiencing significant mental health symptoms.” However, she has very little mental health treatment history. Today, she presented with symptoms consistent with a depressive disorder. Given the above information, the following can be said regarding this claimant’s psychiatric and/or cognitive impairments as they relate to her ability to function. Claimant may have moderate limitations in understanding remembering or applying information. Claimant may have moderate limitations in concentration, persistence or pace. Claimant may have moderate limitations in engaging in social interactions. Claimant may have moderate limitations adapting or managing herself. The diagnosis was major depressive disorder, recurrent moderate, Pica moderate. Her prognosis was guarded.

At the request of the Department, the Petitioner participated in a consultative Mental Status Examination on [redacted] 2017. The examination begins with the examiner observed that Petitioner was extremely inarticulate and had difficulty providing detailed information regarding her treatment. At the time of the exam, she and her husband had been homeless for much of the year. She also advised the examiner that she had an addiction to Ajax Cleanser since her childhood. She advised she had stopped eating Ajax approximately one year ago. Petitioner reported that she could use public transportation when necessary. Affect and mood were reported as subdued and euthymic displaying anxiety and low self-esteem. Throughout much of the examination, it is noted that Petitioner was unable to provide specific details of treatment or dates of

treatment. The notes also indicate that Petitioner's speech was somewhat locked and unclear with some articulation errors and was very vague in describing and responding to questions with slow speech but of normal volume. The examiner found that Petitioner had no apparent difficulty staying on task during the evaluation. Her immediate memory was intact, and she was able to do simple math calculations. At the conclusion of the exam, the diagnosis was adjustment disorder with anxiety and posttraumatic stress disorder. The Medical Source Statement concluded that Petitioner demonstrated no significant deficits in attention and concentration, memory, general information or ability to perform simple mental calculation. She did have some deficits in abstract thinking. The claimant appears to have some anxiety and an adjustment disorder. The examiner noted Petitioner exhibited only mild limitations in understanding, remembering and applying information with no significant limitations in concentration and persistence, only mild-to-moderate limitations in social interaction and moderate-to-marked limitations in adapting or managing oneself. Her ability to work may be further impacted by any other physical and medical limitations.

The Petitioner's neurologist completed a Medical Examination Report dated [redacted] 2019. The current diagnosis was carpal tunnel syndrome, fibromyalgia, memory loss and sleep difficulties. The neurological records indicated hand weakness and memory loss, and the doctor had the clinical impression that his patient was deteriorating; limitations were imposed indicating Petitioner could not lift or carry with her hands; she could stand and/or walk at least two hours in an eight-hour workday. No limitations were noted with regard to sitting ability. She could not use either hand or arms for simple grasping and reaching but could use both hands/arms for push pulling and fine manipulation with the right hand. She could operate foot/leg controls with both legs. The evaluation was based on NCS/EMG test results. The doctor indicated patient could meet her needs in the home.

The Petitioner's internal medicine doctor completed a Medical Examination Report on [redacted] 2019. The doctor has seen and treated the Petitioner for two years. The current diagnosis was fibromyalgia, diabetes mellitus, carpal tunnel syndrome, COPD, coronary artery disease and hypertension. The Petitioner's clinical impression was stable. The following limitations were imposed frequently lifting less than 10 pounds, occasionally lifting up to 20 pounds, never more than 25 pounds. The Petitioner could stand or walk less than two hours in an eight-hour workday and sit less than six hours in an eight hour workday. The Petitioner could perform simple grasping reaching, pushing/pulling and fine manipulate with both hands and could operate foot controls with both feet. The medical findings that supported the limitations noted multiple tender points slow-moving/changing positions due to pain. The notes also indicated that the patient needed a psych evaluation. Attached to the evaluation was an optical exam an EMG and NCV test results dated [redacted] 2019, with the test results attached.

The Petitioner's heart functioning was tested at the [redacted] Medical Center, which noted normal left ventricular function, moderate left ventricular hypertrophy. The ejection fraction of the left ventricle was 55%. The cardiac Doppler and color flow imaging noted

normal diastolic function and no hemodynamically significant valvular regurgitation appreciated. The testing was performed on [redacted] 2018. On [redacted] 2019, notes of an office visit indicate cardiovascular rate was normal, normal heart sounds and intact distal pulses with a note of tachycardia. The diagnosis for that visit was coronary artery disease involving native coronary artery of native heart without angina pectoris.

In August and July of 2017, the Petitioner was diagnosed with Pepcid ulcers for her esophagus and stomach due to eating Ajax powder for 35 years, which caused holes in her esophagus and stomach. Notes indicate that she does not pass bowel movements regularly and must go to the hospital for bowel movements.

The Petitioner was seen at the [redacted] in June 2017 for a diabetic eye exam. The impression was diagnosis, blurry vision. Notes indicate that blood sugar of patient is not under good control and is not checked at home; therefore, the exam may not be accurate if the blood sugar is high.

A Medical Needs form was completed on [redacted] 2019. At the time, the diagnosis was fibromyalgia, hypertension, diabetes, bilateral carpal tunnel syndrome and chronic low blood pressure. The doctor completing the form had seen the Petitioner for several years. The doctor noted that the patient was not non-ambulatory, however, needed help with her mobility as well as needed assistance with toileting, bathing, grooming, dressing, transferring, shopping, laundry and housework.

On [redacted] 2019, the Petitioner was examined for numbness and pain in the bilateral hands. An EMG was obtained noting impression was bilateral sensorimotor carpal tunnel syndrome. Ulnar neuropathy involving both arms. No clear electrophysiological evidence of radiculopathy.

The Petitioner has been seen by [redacted] who practices internal medicine. The doctor has treated Petitioner for several years and sees her monthly [redacted] The treatment records are summarized hereafter.

On [redacted] 2019, Petitioner was seen by the doctor for medication review. The physical exam noted no abnormalities. Petitioner was prescribed a complete blood count as well as a metabolic panel testing; inhalers were prescribed for chronic obstructive pulmonary disease. Petitioner was also prescribed medications for chronic constipation and GERD. A lipid panel was also ordered to review coronary artery disease involving the native coronary artery of native heart without angina pectoris. A methylprednisolone acetate injection was provided as well as a Ketorolac injection due to bilateral carpal tunnel. Petitioner was prescribed Gabapentin for her fibromyalgia as well as an additional medication for muscle spasms. The doctor also prescribed Tramadol for severe pain Lidocaine for her lower back to control pain.

During an office visit on [redacted] 2018, an in-office pulmonary function test was administered by her doctor. After the results were determined, notes indicate that there was a possible severe restrictive pattern; and samples of two inhalers as well as Symbicort was prescribed; and a follow-up with Endocrinology was ordered.

On [redacted] 2018, the Petitioner was seen and notes indicate that she had a motor vehicle accident on [redacted] 2018, and was struck on her side. Notes again indicate blood sugars are running high, and her blood pressure is still up. Her physical examination indicated the musculoskeletal system was negative for myalgias and joint pain, however, notes the Petitioner was slow in laying down and gets up quickly. The physical exam was essentially normal, except that Petitioner's blood pressure and blood sugar levels were both extremely high.

Petitioner was seen in [redacted] 2018 with report of AKI, (acute kidney injury) during an earlier ER admission. The notes of the visit indicate that AKI will be monitored, but last testing creatine was normal.

Medical records indicate that on [redacted] 2018, the Petitioner was examined for fibromyalgia; and also, her blood sugar which was tested the previous day by an endocrinologist and was over 500, the physical exam was normal. She also received an injection for her fibromyalgia, and her medications were reviewed, and notes indicate the Petitioner was not taking Lantus, a prescribed medication for diabetes.

Notes of a visit on [redacted] 2018, also indicate that Petitioner again did not take her full prescription for diabetes. Also, her testing for rheumatoid arthritis was negative. Notes further indicate that Petitioner does not have a glucometer (reported lost) at home, so she does not measure her blood sugars. The physical examination and review of systems were normal other than she was positive for myalgias with normal range of motion and no edema or deformity.

On [redacted] 2018, the Petitioner was seen at [redacted] Health System for cardiology follow-up due to a history of very severe hypertension. Her blood pressure at the visit was still uncontrolled, and the notes indicate the patient was anxious and nervous during the examination. The plan notes indicate patient blood pressure is really out of control again today 50/106. The patient's Clonidine pill was stopped and due to concern that Petitioner may have stopped taking the prescribed medication and a Clonidine patch was prescribed to avoid not taking the medication. Apparently, Petitioner stopped other medications on her own, but no further comments were listed. Blood sugar levels were checked and were 453. Based on her exam, she was taken to the emergency room from the clinic by wheelchair; apparently, multiple attempts in the past were made by the clinic to control blood pressure; but notes indicate that Petitioner does either not show up to follow-up visits and nursing medications reviews. Notes indicate Petitioner always appears at the clinic in a very hypertensive condition. Both her husband and patient confirmed taking all her medications, but notes indicate she is not taking many of the medications, that which have been prescribed. The doctor indicated he was unclear

what was affecting her. It was suggested that a patch would be preferable for Clonidine due to nonadherence.

Petitioner was discharged from [redacted] Center after failing to appear for appointments on [redacted] 2018. The last progress note indicates Petitioner appeared with depression, flat affect with her thought limit within normal limits and the session focused on controlling continuing eating Ajax. At her original psychiatric evaluation on [redacted] 2018, notes indicate she has been continuing to eat Ajax, even though spouse reports she stopped a year ago. The Ajax has been removed from the home, but patient reports that she opens cans while in the grocery store and shakes some into a container. She also will remove it from homes of family and friends. At the time of the exam, her last use was reported a month ago. Petitioner advised she wants to stop but has difficulty resisting the urge. Her appetite is reported decreasd but has had no weight loss. The Petitioner reported problems falling asleep and reports getting four hours of sleep. The Petitioner self-reported last inpatient admission was in 2012 with no suicide attempts. During the examination, the Petitioner was reported by the evaluator as cooperative depressed, with no reports of hallucinations, a thought process that was goal directed, with thought content within normal limits. During the exam, her attention/ concentration was noted as impaired; speech was soft. At the conclusion of the exam, the diagnosis was major depressive disorder, recurrent severe without Psychosis. The GAF score was 40.

The Petitioner participated in a consultative physical examination on [redacted] 2017. At the time of the examination, the Petitioner reported disability due to blindness, bilateral carpal tunnel syndrome, diabetes, depression, myocardial infarction, acute kidney failure and gastroduodenitis. The Petitioner's vision was tested and was 20/25 on right and 20/40 on left with glasses and reported she had diabetic retinopathy. The Petitioner also reported she was insulin-dependent and follows a diabetic diet. The Petitioner also reported a history of depression and is treating with a mental health specialist. She reported experiencing mood swings and sadness along with suicidal thoughts. The Petitioner reported a heart attack in 2014 with a cardiac catheterization with stenting. The report also indicates that Petitioner ate Ajax Cleanser for 34 years developing gastroduodenitis related to PICA. At the conclusion of the examination, the final impression was: Petitioner is not blind, bilateral carpal tunnel syndrome with use of braces as needed, diabetes history and insulin dependence. History of depression and needs a mental health evaluation per DDS. Based on examination, including history and physical exam, the Petitioner has multiple serious medical problems and is taking numerous medications for medical management. The exam concluded that Petitioner has occasional limitations with exertion which include lifting and walking due to her underlying heart disease. No other functional limitations or deficits are noted.

By way of history, Petitioner had a myocardial infarction (heart attack) and had a coronary artery disease diagnosis with placement of the stent. A stress echo test taken in 2014 was negative for ischemia with no evidence of ischemia other than a worsening of epical thinning at peak exercise. In addition, a nerve conduction test was performed

in 2006 which indicated testing indicated severe bilateral carpal tunnel syndrome of both examined upper extremities. An updated study done in June 2017 noted Bilateral Carpal Tunnel Syndrome, right more severe than left pursuant to an EMG.

Step 3

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

Based on the medical evidence presented in this case, listings 1.02 (B) Major Dysfunction of a joint(s), 4.00 cardiovascular system, 11.00 Neurological Disorders, 12.04 Depressive, Bipolar and related disorders were considered. The medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3, and the analysis continues to Step 4.

Residual Functional Capacity

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

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

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

carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b).

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

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

In this case, Petitioner alleges both exertional and non-exertional limitations due to her medical conditions. Petitioner testified that she could stand 30 minutes, sit long enough

to watch a TV show, walk one block, could not perform a squat, could bend forward and backwards and sideways. She testified that she needed assistance dressing when having to put on a pullover top and with drying off after showering due to carpal tunnel in both hand/wrists. Petitioner could not touch her toes. The Petitioner could carry two pounds. When describing her typical day, she testified that she needed assistance climbing stairs and assistance with sitting (getting into the chair). The Petitioner said she does not cook because she cannot stand long, and her husband does the laundry and vacuums. It was also observed by the undersigned that Petitioner presented with a depressed affect.

With respect to her mental impairments, the Petitioner indicated that she did not have anxiety attacks, and she cries about once a week depending on her emotional condition. She also testified that she has anger towards herself; she said she has attempted suicide in the past and does not hear voices and did say she does see things that are not there. She testified that she suffers from depression. Her memory was described as not good. She sees her family who she lives with daily. Her last inpatient hospitalization was in 2012 for a 5- to 7-day period. When asked how she felt, she stated that she was mad because she did not want to be at the hearing today. Petitioner said that she prefers not to see people or socialize. During the hearing, the undersigned noted that the Petitioner had a depressed affect and was not descriptive of her mental condition other than to say her condition was not good.

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 sedentary work as defined by 20 CFR 416.967(a), however, with limitations due to standing duration limitations, lifting and carrying and bi-lateral carpal tunnel syndrome and her neurologist's evaluation in that regard which restricts her from lifting. Her neurologist noted a restriction evaluating that Petitioner could not use either hand or arms for simple grasping and reaching, but could use both hands/arms for push pulling and fine manipulation with the right hand only. He based the restrictions on EMG testing noting severe carpal tunnel. He also found that Petitioner's condition was deteriorating. The Petitioner's internal medicine doctor also imposed limitations. The doctor's clinical impression was that Petitioner was stable. The following limitations were imposed frequently lifting less than 10 pounds occasionally lifting up to 20 pounds never more than 25 pounds. The Petitioner could stand or walk less than two hours in an eight-hour workday and sit less than six hours in an eight-hour workday. With respect to Petitioner's mental impairments, based upon the medical evidence and based upon two consultative exams, the Petitioner's limitations are moderate in all categories. This

mental impairment evaluation also considered the Petitioner's lack historical treatment, no recent hospitalizations, as well any no ongoing treatment for her mental health conditions.

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has moderate limitations based on her mental ability to perform basic work activities.

Petitioner's RFC is considered at both Steps 4 and 5. 20 CFR 416.920(a)(4), (f) and (g).

Step 4

Step 4 in analyzing a disability claim requires an assessment of Petitioner's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed by Petitioner (as actually performed by Petitioner or as generally performed in the national economy) within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1) and (2). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner's work history in the 15 years prior to the application consists of work cleaning hotel rooms, as a hair stylist braiding hair and working at [redacted] preparing orders. The Petitioner described the hair stylist job (self-employed) as requiring her to stand much of the day and required light physical exertion. The Petitioner's bilateral carpal tunnel in her hands would not allow her to perform hair braiding. Petitioner's work as a [redacted] cashier required her to stand eight hours. Petitioner's job cleaning required standing and cleaning multiple surfaces as well as floors and making beds and as such consisted of light work. The Petitioner was not very descriptive of what her jobs entailed at the hearing. Based upon her residual function capacity of sedentary with restrictions, Petitioner is unable to perform her past relevant work.

Based on the RFC analysis above, Petitioner's exertional RFC limits her to no more than sedentary work activities with restrictions as noted above. As such, Petitioner is incapable of performing past relevant work. Petitioner also has moderate limitations in her mental capacity to perform basic work activities. In light of the entire record, it is found that Petitioner's non-exertional RFC due to her mental impairments alone does not prohibit her from performing past relevant work.

Because Petitioner is unable to perform past relevant work, Petitioner cannot be found disabled, or not disabled, at Step 4, and the assessment continues to Step 5.

Step 5

If an individual is incapable of performing past relevant work, Step 5 requires an assessment of the individual's RFC and age, education, and work experience to

determine whether an adjustment to other work can be made. 20 CFR 416.920(a)(4)(v); 20 CFR 416.920(c). If the individual can adjust to other work, then there is no disability; if the individual cannot adjust to other work, then there is a disability. 20 CFR 416.920(a)(4)(v).

At this point in the analysis, the burden shifts from Petitioner to the Department to present proof that Petitioner has the RFC to obtain and maintain substantial gainful employment. 20 CFR 416.960(c)(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden*. O'Banner v Sec of Health and Human Services, 587 F2d 321, 323 (CA 6, 1978).*

When 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).

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

In this case, Petitioner was [redacted] years old at the time of application and [redacted] years old at the time of hearing, and thus, considered to be a younger individual (age 45-49) for purposes of Appendix 2. She is not a high school graduate, having completed the 11th grade. Petitioner's prior work history included work as a hair stylist, fast food cashier and cleaning. Her prior jobs are all considered unskilled jobs. 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 activities with restrictions including standing duration limitations, lifting and carrying and bi-lateral carpal tunnel syndrome and her neurologist's evaluation in that regard which restricts her from lifting. The Petitioner's doctors imposed serious limitations, which must be considered given the testing relied upon in making the limitation assessment and the medical records.

The Medical-Vocational Guidelines, for sedentary work, do not result in a disability finding based on Petitioner's exertional RFC alone, but Petitioner's doctors have both imposed serious restrictions with regard to Petitioner's abilities for lifting, standing, use of her hands based upon testing and her neurologist's evaluation. In addition, these doctors found that Petitioner's diagnosis included fibromyalgia, diabetes mellitus, carpal tunnel syndrome, COPD, coronary artery disease and hypertension, sleep difficulty and memory loss. 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 exertional 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 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 May 11, 2018, SDA application to determine if all the other non-medical criteria are satisfied, and notify Petitioner of its determination;

2. Supplement Petitioner for lost benefits, if any, that Petitioner was entitled to receive if otherwise eligible and qualified;

3. Review Petitioner's continued eligibility in August 2020.

LMF/jaf

Lynn M. Ferris
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

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

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

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

Via Electronic Mail
DHHS

Richard Latimore
MDHHS-Wayne-57-Hearings

BSC4
L Karadsheh

Via First Class Mail
Petitioner

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