[redacted]

Date Mailed: July 26, 2019
MOAHR Docket No.: 19-005296
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 June 27, 2019, from Detroit, Michigan. Petitioner appeared for the hearing and represented herself. The Department of Health and Human Services (Department) was represented by [redacted], 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 or around November 9, 2018, Petitioner submitted an application seeking cash assistance benefits on the basis of a disability.

2. On or around May 7, 2019 the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. (Exhibit A, pp. 2-27)

3. On or around May 9, 2019, the Department sent Petitioner a Notice of Case Action denying her SDA application based on DDS' finding that she was not disabled.

4. On or around May 22, 2019, Petitioner submitted a timely written Request for Hearing disputing the Department's denial of her SDA application.

5. Petitioner's case file indicates she also requested a hearing to dispute the Department's actions with respect to the Family Independence Program (FIP);

however, Petitioner confirmed that there was no issue concerning her FIP benefits and thus, the request for hearing was withdrawn and will be dismissed.

6. Petitioner alleged physically disabling impairments due to back pain from degenerative disc disease, arthritis in her knees and back, carpal tunnel syndrome (CTS) in her hands. Petitioner alleged mental disabling impairments due to depression, anxiety, bipolar disorder and post-traumatic stress disorder (PTSD).

7. As of the hearing date, Petitioner was [redacted] years old with a December 16, [redacted] date of birth; she was [redacted] and weighed [redacted] pounds.

8. Petitioner is a high school graduate with an associate degree and has employment history of work as a daycare worker, a housekeeper, a factory worker, and as a cashier, greeter, and food prep worker at fast food restaurants. Petitioner has not been employed since January 2017.

9. 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.

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 was thoroughly reviewed and is briefly summarized below:

It is noted that the documents contained within Exhibit A pages 1-1857 include Petitioner's medical records for treatment dates from 2015 to 2019, many of which are duplicates. A review of the evidence shows, and the Department's testimony indicates that Petitioner applied for Social Security disability benefits in or around January 2015 and her application was denied in June 2018. It was established that she filed an appeal of that denial, and in November 2018 her appeal was also denied. Petitioner reapplied for SDA benefits through the Department on November 9, 2018 and filed a new Social Security disability application in February 2019, the appeal of which was currently pending as of the hearing date. A March 2018 SDA application and September 2018 DDS and DHHS denial was also referenced, as was a September 2017 SDA application and subsequent November 2017 DDS and DHHS denial. (Exhibit A, pp. 1605 – 1638, 1820 – 1827)

On April 18, 2019, Petitioner participated in a consultative Psychiatric/Psychological Medical Evaluation, during which she had complaints of degenerative disc disease, arthritis, depression, and mood instability. Petitioner reported being under the care of a primary care physician; a psychotherapist; and a psychiatrist, Dr. [redacted] at [redacted] at which she is being treated for diagnoses of bipolar disorder, hoarding disorder, and PTSD. In 2009, Petitioner presented at [redacted] in Saginaw, Michigan with suicidal ideations and was transferred to [redacted] for five days. During the April 2019 evaluation, Petitioner recalled

her childhood as being difficult and abusive, indicating that from age 5 to age 12 she was sexually abused by her brother. She reported previous employment at a daycare center until she was no longer able to lift, stand, or carry. Petitioner reported that she usually does not leave her house unless she has an appointment, and that she does not cook any meals, relying upon microwave food and sandwiches. Petitioner was observed to walk with a normal gait without the use of an assistive device. She was observed to be capable of maintaining a strong and consistent contact with reality, she reported that her self-esteem was low, described herself as dependent and lacking motivation and there was no evidence of any excessive motor activity or unusual thoughts or behavior. Her insight appeared sound and reliable and there was no observable tendency by Petitioner to exaggerate or minimize her condition. During the Mental Status Evaluation, Petitioner denied the occurrence of any visual or auditory hallucinations, delusions, persecutions, obsessions, thoughts control by other people or possessing any unusual powers. She indicated she feels worthless but denied having any recent suicidal thoughts or intention. She indicated she has persistent lower lumbar back pain that that prevents her from standing and sitting for long periods of time, which frequently disrupts her sleep. She reported that her weight has remained consistent in her physical strength has declined. She further reported experiencing racing thoughts and anxiety at night and usually requires an hour or longer in which to fall asleep and may awaken 2 to 3 times per evening due to night terrors, panic or anxiety. Her affect was observed to be flat and labile. Petitioner was diagnosed with PTSD and bipolar I disorder – depressive – moderate. The prognosis/medical source statement indicated that Petitioner reported history of childhood sexual abuse and episodes of intrusive thoughts and flashbacks regarding past abuse that frequently disrupts her sleep and affects her mood. She indicated she experiences mood swings and is believed to be primarily dysthymic. Upon examination, Petitioner was fully oriented and exhibited reliable concrete cognitive skills that could allow for comprehension, recall, and completion of simple routine tasks or directions. She was recently provided a peer support through [redacted] and receives psychotherapy and psychotropic medications to assist with her mood instability. Based on the presentation of her psychological and adaptive functioning during the mental status evaluation, a poor to marked prognosis of her psychological and adaptive functioning was observed. (Exhibit A, pp. 356 – 360)

On August 24, 2018, Petitioner participated in a consultative Psychiatric/Psychological Medical Evaluation in connection with a prior disability application, during which she reported history of chronic back problems, arthritis, degenerative disc disease, pinched nerves in her lower back and sciatic nerve pain causing numbness, tingling and weakness in her legs. Psychologically, she reported symptoms of depression to include decreased sleep, crying spells and irritability. She no longer had feelings of hopelessness, worthlessness or thoughts of death that she had in the past. She identified two instances of suicidal ideations and reported that she may have PTSD as result of sexual abuse. She denied having nightmares due to difficulty sleeping and stated that the memories typically flashback to her during the evening hours. Symptoms of panic causing her to feel shaky, have difficulty breathing, trouble concentrating, shortness of breath, etc. were also reported. She reported receiving mental health treatment for the past four years including attending a trauma-based group therapy. She

indicated that she is able to bathe and dress independently but may need reminders to do so, that she occasionally will cook a meal and eat leftovers, and that she experiences back pain which limits her inclination to engage in household chores. She presented with an intact contact with reality and decreased levels of self-esteem. Overall it was noted that there may have been a tendency for her to minimize her psychological symptoms as an effort to put her best foot forward. Petitioner reported experiencing auditory hallucinations of sounds in the home as well as visual hallucinations that occur in her peripheral vision. Somatic complaints included decreased sleep, crying spells, and irritability. In the past she admitted to more extreme symptoms of depression such as feeling hopeless, worthless, and thoughts of suicide, however she denied any of those three letter symptoms lately. The medical source statement indicated that based on the evaluation, Petitioner would likely relate well to coworkers and supervisors. Tasks performed should be simplified due to decreased cognitive abilities and needing higher levels of supervision. Petitioner was diagnosed with persistent depressive disorder, and intellectual disability provisional. Her prognosis was fair. (Exhibit A, pp 685 - 689)

On April 24, 2019, Petitioner participated in a consultative physical internal medicine evaluation of back pain with degenerative disc disease and arthritis of the knee joints. Petitioner reported a six-year history of knee pain and lower back pain since 2010. Petitioner indicated that she was informed by her primary care physician that she has arthritis and degenerative disc disease that was diagnosed by x-ray imaging. Petitioner reported being told to get bariatric surgery to lose weight, which would improve her back pain. It was noted that Petitioner reported being able to do her own cooking and cleaning and attend to her own personal needs. Petitioner did not use a cane or walker to assist with ambulation. Past history of hyperlipidemia, restless leg syndrome, sinusitis, depression, sleep apnea, morbid obesity, and PTSD were noted, as was a 20-year history of CTS for which she experiences numbness in her hands occasionally. Physical examination indicated that Petitioner was morbidly obese and that she walks with a wide based gait. She is able to touch her toes but unable to squat completely, complaining of knee pain. Her knee joints are painful and tender with no joint effusion. She had normal range of motion of the knee joints. Pedal pulses were normal, and no cyanosis or clubbing were present. The lumbar area was tender with muscle spasms present. Straight leg testing was negative bilaterally and her hand grip was 34 pounds bilaterally. Tinel's and Phalen's signs were negative. She was able to open a jar, button clothing, write legibly, pick up a coin and tie shoelaces with either hand. Petitioner's medical records/chart was reviewed, in particular, family physician notes from March 27, 2019 which indicate among other things that Petitioner's general appearance was abnormal because of her obesity, that her thyroid was abnormal and enlarged on the left side with a 1 cm mass, her lung examination showed rales and crackles, her left knee and lumbar area were tender, skin exam showed aberration of the left foot, and she had acute persistent bronchitis, sinusitis and breast cancer screenings. After examination and upon review, the doctor indicated that Petitioner has had lower back pain since 2010 and the work up showed degenerative arthritis. There were no limitations of motion of the lumbar spine on clinical examination that day. Painful knee joints were reported, and tenderness was noted, although range of motion was normal.

It was noted that Petitioner is morbidly obese and unable to walk more than one city block, has restless leg syndrome and reported history of CTS although no clinical evidence was found. Petitioner had hyperlipidemia which is stable, as well as depression and PTSD secondary to being raped by her brother from ages 7 to 12. The doctor was of the conclusion that Petitioner did not have any physical limitations after examination. Notes further indicate she is contemplating bariatric surgery as well as receiving an evaluation for sleep apnea. (Exhibit A, pp.324 – 330)

Petitioner's mental health treatment records from 2017 to 2019 were thoroughly reviewed. A psychiatric evaluation completed on September 22, 2017 indicated that Petitioner was receiving treatment for bipolar disorder current episode depressed, severe with psychotic features, and major depression. It was noted that her current GAF score was 60 and her lowest recorded GAF score was 35 in 2008. She reported history of depression for which she was receiving medication treatment, denied auditory or visual hallucinations and reported a history of three suicide attempts by locking herself in a car in her garage, most recently in 2009. On the day of the evaluation, she denied suicidal or homicidal ideations but reported mild problems with sleep, interest, energy, concentration and appetite. She denied panic attacks and agoraphobia as well as reported no mood swings. A psychiatric evaluation was completed on January 30, 2018 showing that Petitioner continued to receive treatment for her bipolar disorder current episode depressed severe with psychotic features, hoarding disorder, and major depression. Petitioner reported that she had been going to [redacted] and taking Zoloft for depression and disclosed sexual abuse as a child, of which she experiences flashbacks. Petitioner was observed to be alert and somewhat friendly. She denied any suicidal ideations, mood swings, or impulsive behavior. She reported that her Zoloft is helping her. Her GAF score was noted to have increased to 70 and she was to be reevaluated in one month. Medication Review Notes from Petitioner's March 26, 2019 appointment with psychiatrist, Dr. [redacted], indicated she is currently being treated for PTSD with depression, and reported that she is still worried about her financial problems. It was noted that she was having difficulty getting the bariatric surgery. The doctor's narrative from the March 26, 2019 appointment indicates that Petitioner was mainly preoccupied with her financial problems, problems with sinusitis and back pain. It was noted that she is not able to deal very well, that her thought process is somewhat organized and that she feels somewhat helpless about her financial problems, as she applied for disability two or three times but was denied. Petitioner denied any suicidal ideations during the February 26, 2019 and December 28, 2018 medication review appointments with her psychiatrist. Notes indicate that Petitioner's problems are mainly due to her physical pain and financial issues. During an October 9, 2018 appointment, it was noted that Petitioner was preoccupied about past sexual abuse with her brother and that she complained to the [redacted] Police Department, but nothing has happened so far. Notes from Petitioner's prior visits with her psychiatrist (June 2018 to September 2018) had similar findings and conclusions. Notes from a September 27, 2018 Periodic Review of Petitioner's mental health treatment indicate that Petitioner continues to meet with a case manager, psychiatrist, community health worker, and attend the women's trauma group. She continued to report anxiety, back and knee pain, and expressed a lack of motivation to participate in self-care needs and get out into the community and

socialize. A Psychosocial Assessment completed on November 27, 2018 indicates that Petitioner struggles with keeping her home clean, that she utilizes the women's trauma group and individual therapy to assist with processing feelings relating to her sexual assault when she was a child, that she reported feelings of depression, anxiety, mood swings, impulsiveness, and pressured speech. She denied current suicidal thoughts but has experienced them in the past and has a history of hallucinations but denied them at the time of the assessment. She has a history of panic attacks and flashbacks of abuse but denied any recent panic attacks. It was noted that Petitioner will need psychiatry services to manage her mental health symptoms and remain stable on her medication. Therapist assessment notes from February 2019 indicate that Petitioner struggles with past trauma and sexual abuse, struggles with low self-esteem and depression symptoms. It was noted that she is lower functioning and struggles with hygiene and cleanliness. (Exhibit A, pp.366-435)

Petitioner's records from her visits with her treating primary care physician (Dr. [redacted]) at [redacted] were presented and reviewed. During a February 21, 2019 appointment, Petitioner complained of sinus headache, low energy, coughing, and right ear pain for which she was diagnosed as having sinusitis. Petitioner reported chills, feeling tired, earache and nasal discharge, chest pain, shortness of breath and cough, nausea, joint swelling and joint stiffness, numbness and tingling, anxiety and depression. Physical examination of the head and face revealed no abnormalities. Maxillary sinuses were tender to palpation on the right and tender to palpation on the left. The thyroid was observed to be abnormal as it was enlarged on the left side and had a 1 cm mass. Pulmonary examination showed no increased work of breathing or signs of respiratory distress; however auscultation of the lungs was abnormal and revealed rales/crackles. Left knee and mild lumbar tenderness to palpation were noted. Petitioner was diagnosed with walking pneumonia and treated for her symptoms following a January 4, 2019 visit with her doctor. On October 15, 2018, Petitioner presented with complaints of gradual onset of intermittent episodes of knee pain described as throbbing and having started two years ago. Associated symptoms included swelling, stiffness, and decreased range of motion, but no locking and no pain and other joints. Records show that she was being treated for primary osteoarthritis of the knees bilaterally, arthralgia of both knees, arthritis, back pain, joint pain, numbness and tingling, restless leg syndrome, among other conditions. The doctor noted that she has moderate to advanced arthritis in both knees. The doctor reported that Petitioner's weight and obesity is a contributing factor to her knee pain and arthritis as she was at least 130 pounds overweight. It was noted that she is having trouble with losing weight and was referred to a bariatric surgeon for consultation. On September 21, 2018, Petitioner was seen for a routine clinic for follow-up of her back pain which included back stiffness, decreased fine range of motion and decreased flexion. She reported bilateral lower back pain which radiates to the bilateral lower legs. Her current treatment included non-steroid anti-inflammatory drugs. Notes from her doctor indicate that while Petitioner's back problem is better, she does not do any exercises prescribed by physical therapy which she was encouraged to. It was noted that Petitioner needs to lose weight to help her back pain. Petitioner was asked to

increase her physical activity to five times a week 30 minutes of aerobic exercise and resistance exercise. (Exhibit A, pp. 441-451, 591-621)

On December 12, 2018, Petitioner was evaluated for a cardiac risk assessment prior to bariatric surgery (laparoscopic sleeve gastrectomy [LSG]). During the appointment, she denied complaints of chest pain, palpitations or syncope. Exertional dyspnea and chronic bipedal edema were noted. Her cardiac exam was normal. The impression of the doctor was that Petitioner had exertional dyspnea and morbid obesity. Mild sinus tachycardia was found, and it was noted that this is a benign cardiac arrhythmia. On November 15, 2018, Petitioner was evaluated for bariatric surgery by Dr. [redacted]. Comorbidities were noted to include hypertension, lumbago, diabetes, migraine headaches, bronchitis, obesity hypoventilation syndrome, osteoarthritis of the bilateral knees, GERD, dyslipidemia, anxiety, depression, and varicose veins. She complained of excessive daytime sleepiness and waking up at night frequently gasping for breath. She reported that she does not have a target weight and just wants to be healthy, specifically she wants to get down to weight that would allow her to be more mobile and healthier. Petitioner was assessed as being a good candidate for LSG and additional workup was recommended and included psychological clearance, EGD with biopsies, and the cardiac risk stratification. An EGD was performed on January 17, 2019 results of which showed no noted abnormalities. (Exhibit A, pp. 622-627, 644-645)

Records from Petitioner's September 2018 to April 2019 treatment at [redacted] were presented and reviewed. (Exhibit A, pp. 332-354). X-ray imaging of Petitioner's cervical, thoracic, and lumbar spine was performed on September 24, 2018. Cervical radiographic findings indicated no evidence of fracture or dislocation, bone density was adequate, straightening of the cervical lordosis was noted, mild decrease in the C4 – C5 and C5 – C6 intervertebral disc spaces with anterior osteophytosis was noted, and the soft tissues appeared within normal limits. Thoracic findings included no evidence of fracture or dislocation, adequate bone density, mild right thoracic curvature, decreased intervertebral disc spaces at T7 – T8, T8 – T9, T9 – T10 with anterior osteophytosis and lateral osteophytosis left at T7 – T8 and right at T8 – T9. Lumbar radiographic findings indicated again no evidence of fracture or dislocation, adequate bone density, pelvic on leveling, low on the left, with mild left lumbar curvature. Decreased intervertebral disc space at L2 – L3 and L4 – L5 with anterior osteophytosis was found, and the femoral acetabular joints appear to be within normal limits. Diagnosis included: degenerative changes of the cervical spine, most notably at C4 – C5 and C5 – C6; degenerative changes of the mid and lower thoracic spine; degenerative changes of the lumbar spine; thoracolumbar scoliosis; and biomechanical changes of the cervical, thoracic, and lumbar pelvic spine. Notes indicate that if Petitioner did not respond to conservative treatment or if neurological symptoms develop, further imaging including MRI may be considered. (Exhibit A, p. 332)

On May 2, 2018, Petitioner presented to her treating primary care physician at [redacted] (Dr. [redacted]) with complaints of sudden onset of intermittent episodes of left knee pain described as sharp and aching. She reported her pain was a 5/10 and her symptoms were a result of twisting her knee. The episode

reportedly started two weeks prior and her symptoms are made worse by walking, associated symptoms included swelling, decreased range of motion and difficulty bearing weight but no locking, no instability, no fever and no localized rash. Records indicate that Petitioner was participating in physical therapy which the doctor recommended that she continue. X-rays of the knees were ordered. (Exhibit A, pp. 1323-1328). May 14, 2018 X-ray images of Petitioner's knee showed mild to moderate degenerative changes with suspect tiny joint effusion. No significant joint space narrowing, and no discernible joint effusion or joint abnormality were noted. (Exhibit A, pp. 771-772). Notes from her March 21, 2018 visit indicate that she reported back pain, for which she was referred to physical therapy. (Exhibit A, pp. 1323-1353)

In March 2018 and April 2018, Petitioner participated in physical therapy for bilateral primary osteoarthritis of the knees. During her initial evaluation – examination on March 29, 2018, Petitioner complained of low back pain and bilateral knee pain, which has worsened over the last 12 months since she stopped working and isn't moving around as much. She reported that walking five minutes to the bus stop is painful and when she has to walk to and from her mailbox, walking back is very painful if she cannot take a rest in between. She reported that the pain is across her lower back and goes down into her thighs on both legs. She described the pain as burning and numb. Petitioner reported that she has to sit while microwaving her dinner for five minutes and that she has to sit and rest when performing self-care tasks such as styling her hair. Wearing her pants and socks and standing in her shower is getting more difficult. Her knee strength was determined to be within normal limits bilaterally, although tenderness to palpation of the bilateral patellar tendon in joint line were noted she had decreased bilateral hip and core strength, decreased lumbar pelvic stability, decreased balance reactions, decreased trunk range of motion, joint and soft tissue restrictions, abnormal gait and poor posture. During her April 6, 2018 appointment Petitioner reported her pain as 1/10 in her lower back and complained of hand pain secondary to carpal tunnel syndrome. After treatment, Petitioner rated her pain as 0/10. Records indicate that she participated in physical therapy through April 19, 2018 and was reevaluated on May 11, 2018 at which time she reported a 10% improvement from her initial evaluation. (Exhibit A, pp. 1289-1300, 1354-1355)

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 physical and mental 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), 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 suffers from back pain that radiates down to her legs as a result of a pinched nerve and degenerative disc disease, and bilateral knee pain due to arthritis. She reported that she is able to stand and walk for only five minutes before the pain in her back and left side become too much. She stated that she sometimes uses a cane to assist with walking, however, there was no indication that Petitioner was prescribed an assistive device. Petitioner reported being able to sit for only five minutes before needing to readjust positions and testified that she can lift up to a maximum of 10 pounds. It is noted that no evidence of a lifting restriction was found in the medical records reviewed. Petitioner reported that she has difficulty gripping and grasping items with her hands due to her CTS, that she frequently drops things, and has difficulty with removing lids. She indicated that bending and squatting is painful and that she uses a chair in the shower, as she is unable to stand for long periods of time. Petitioner testified that she is able to bathe herself and take care of her own personal hygiene, although

getting in and out of the bath is difficult. She also reported difficulty with dressing and indicated that she needs to sit while dressing herself. Petitioner reported that although she performs some chores inside the home, she has difficulty carrying laundry, and is required to sit every five minutes while cooking and cleaning. She reported that a friend sometimes comes over to assist her with cooking light basic meals and cleaning. Petitioner testified that she sees her psychiatrist once a month and participates in therapy with a counselor twice per month for treatment of her bipolar disorder, depression, PTSD, and anxiety. She reported difficulty functioning in stress related situations and that she suffers from anxiety attacks that include symptoms of panic. She stated that she is able to focus for only 5 to 10 minutes at a time before getting distracted and that she has memory issues including difficulty remembering basic math and simple tasks. She reported that she suffers from crying spells daily and that she sometimes has anger issues. Petitioner reported that she suffers from PTSD from her childhood sexual abuse and that she sometimes has thoughts of hurting herself, although, she has not had any attempts since 2009. There was no evidence that Petitioner had any inpatient hospitalizations for the treatment of her mental impairments since 2009.

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. The records presented do not show that Petitioner's treating physicians noted any significant limitations with respect to her ability to sit, stand, walk, carry or lift, including any restrictions that may be attributable to her obesity. Thus, as referenced above, although Petitioner has medically determinable impairments that could reasonably be expected to produce symptoms, Petitioner's statements about the intensity, persistence and limiting effects of her symptoms are not supported by the objective medical evidence presented for review and referenced in the above discussion.

Therefore, based on a thorough review of Petitioner's medical records and in consideration of the above referenced evidence, with respect to Petitioner's exertional limitations, it is found that Petitioner maintains the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a).

While records indicate that Petitioner has been diagnosed with and was receiving treatment for bipolar disorder, depression, and PTSD and she identified ongoing symptoms associated with the impairments, based on the medical records provided, as well as Petitioner's testimony, she has mild to moderate limitations on her mental and non-exertional ability to perform basic work activities. It is noted that Petitioner will have limited ability to push/pull and operate foot controls as a result of her knee impairments.

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 daycare worker, a housekeeper, and as a cashier, greeter, and food prep worker at fast food restaurants and a factory worker. Upon review, Petitioner's prior employment is categorized as requiring a range of light to medium exertion. Based on the RFC analysis above, Petitioner's exertional RFC limits her to sedentary work activities. As such, Petitioner is incapable of performing past relevant work. 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 at the time of hearing, and thus, considered to be a younger individual (age 45-49) for purposes of Appendix 2. She is a high school graduate with an associate degree and has 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. Thus, based solely on her exertional RFC, the Medical-Vocational Guidelines 201.21 result in a finding that Petitioner is not disabled.

However, as referenced above, Petitioner also has impairments due to her mental and non-exertional impairments which impose only mild to moderate limitations on her abilities to perform basic work activities and activities of daily living. Based on the evidence presented, at this time, it is found that those limitations would not preclude her from engaging in simple work activities on a sustained basis. Therefore, Petitioner is able to adjust to other work and is not disabled at Step 5.

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

DECISION AND ORDER

Accordingly, the hearing request with respect to FIP is **DISMISSED** and the Department's SDA determination is **AFFIRMED**.

Zainab Baydoun

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: [redacted]

Petitioner – Via First-Class Mail: [redacted]