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Date Mailed: August 7, 2019
MOAHR Docket No.: 19-005514
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, a telephone hearing was held on June 26, 2019, from [redacted] Michigan. The Petitioner was represented by herself. The Department of Health and Human Services (Department) was represented by Rebecca Ferrill, Assistance Payments Supervisor.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Exhibit B was received after the hearing and marked into evidence. In addition, medical records were returned pursuant to the Interim Order and marked into evidence as Exhibit C. The record closed on July 11, 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 January 7, 2019, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On May 7, 2019, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 23-29).

3. On May 13, 2019, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit A, pp. 151-155).

4. On May 29, 2019, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 2-3).

5. Petitioner alleged disabling impairment due to mental disabling impairments caused by severe anxiety and depression. The Petitioner alleges physical disabling impairments due to somatic dysfunction of the ribs. She also has pain in her thoracic spine due to intercostal neuralgia (nerve pain).

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; the Petitioner has lost [redacted] pounds in the last 6 months.

7. Petitioner is *a high school graduate.*

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

9. Petitioner has an employment history of work as cashier for the U.S. Census Bureau, a bank teller, and a Medical Assistant in a doctor's office.

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

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Human Services Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180.

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (July 2015), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

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

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

Step 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.

On [redacted] 2016, the Patient was seen at the neuromuscular and rehabilitation [redacted] for segmental and somatic dysfunction of rib cage due to slipping rib syndrome. At the time of the visit, the Petitioner was on Alprazolam, Gabapentin, Norco for pain. At the time, the Petitioner was prescribed an elastic rib support. The Petitioner was examined by the doctor who found pertinent positives including left anterior rib pain flaring with any activity, without radicular arm pain. The Impression was left anterior rib segmental dysfunction with sleeping rib syndrome. At the conclusion of the visit, the doctor prescribed a rib support and follow-up if no change in symptoms for possible CT of the ribs or bone scan.

The Petitioner was seen at neuromuscular rehabilitation on [redacted] 2015, at which time she was examined due to a rib injury. The impression during the examination was almost certain sprain of the left lower extremity costochondral junction producing pain. Also noted was musculoskeletal/musculartendinous right shoulder as a major problem.

Right ischial bursitis amenable to intervention. Also noted posterior neck pain anticipated to be improved after reductive mammoplasty to be performed in three days. The notes indicate that this type of injury is known for its ability to persist for long periods of time. At the time, the Petitioner presented with a six-month history of left lower Paris sternal chest pain which began abruptly while lifting objects. At the time, with regard to the costochondral issue, the physical examination was noted as completely consistent with an injury to the costochondral junction at the lower left sternum. The injury caused pain on a daily basis interfering with her ability to do substantial work and produce some mild sleep disturbance nightly. Based on the physical examination, there was marked palpable tenderness in lower left costochondral junction, moderate irritability of the right shoulder to ranging and resisted motion and moderate palpable tenderness over the right ischial tuberosity.

In [redacted] 2018, the Petitioner's treating doctor, Dr. [redacted] completed a Residual Functional Capacity assessment. The assessment indicated that the doctor saw her once a month to every three months depending on her pain due to her ribs and her anxiety and depression. The symptoms noted that Petitioner had left rib pain with any rotational movement as well as lifting stooping and reaching. The clinical findings noted multiple imaging studies done without objective findings consistently with rib pain. The diagnosis was intercostal neuralgia rib pain anxiety and depression; the current prognosis for the patient was that she was currently stable but unable to see improvement in functioning. The doctor believed the disability or impairment was to last one year or more and had already lasted one year. The doctor believes that the disability and impairment prevented the Petitioner from standing 6 to 8 hours but could stand about 30 minutes. The doctor agreed that the Petitioner could sit but required moving around periodically to improve her symptoms and that she could not sit upright for 6 to 8 hours. The reason for her inability to stand and/or sit upright for 6 to 8 hours noted rib symptoms would flare up requiring the need to move or sit or stand or lie down. The doctor further noted that the disability/impairment required the patient to lie down during the day to adjust position to improve pain. The doctor was unaware how far the patient could walk. An evaluation of the frequency with which the patient could perform various activities was also made by Dr. [redacted] all activities were rated rarely 0 to 30% and included reach up above shoulders, reach down to waist level, reach down towards floor, carefully handle objects and handle with fingers. He noted her weight restriction was less than 5 pounds during an 8-hour period and regularly/daily. The doctor noted that Petitioner had difficulty bending, squatting, kneeling and turning any parts of the body. The doctor did not opine that the impairment prevented Petitioner from traveling alone. The doctor also addressed Petitioner's pain symptoms and complaints noting it occurred daily and multiple times a day with severe pain at times and that he rated the patient's credibility with regards to her claims of pain as credible and that an objective medical reason for the pain was due to intercostal neuralgia. The doctor further opined that she could no longer continue or resume work at her current or previous position. The doctor further concluded that he expected the Petitioner's diagnosis/disability was not likely to change over time and that it was unknown in his opinion when his patient would be able to return to work without restrictions.

The Petitioner was seen at [redacted] for anxiety and depression having been referred on July 5, 2018. Her current therapist in a letter dated April 15, 2019, noted that she has received treatment since [redacted] 2018, for depression and anxiety and was seen 12 times. The therapist notes that Petitioner has a commitment to ongoing therapy and addressing her medical diagnosis as a top priority.

On [redacted] 2018, the Petitioner underwent an MRI of her thoracic spine. The MRI was compared to two prior x-rays of the chest/ribs in 2015 and 2018. The findings noted vertebral heights are preserved. No worrisome bone marrow edema. Discs demonstrate preserved height and signal. No significant disc herniations with no spinal canal stenosis. Note is made of facet degenerative change on left at T6-T7 which does mildly narrow the T6 neural foramen on the left. Remaining thoracic neural foramen are preserved. Spinal cord demonstrates normal caliber and signal. Imaged soft tissues do not demonstrate significant acute findings. No evidence of displaced rib to the limitations of the study. Impression: mild facet arthropathy on left at T6-T7 with mild T6 neural foraminal narrowing.

On [redacted] 2018, the Petitioner was seen by her treating doctor, Dr. [redacted] due to injuring her rib while at the gym stretching, causing the rib to pop out and currently restricting her ability to bend or twist or pick things up as well as difficulty walking. The doctor started Amitriptyline and also noted a referral for an MRI and injections will be set up for her intercostal neuralgia. In a follow-up on April 17, 2018, it was noted the left rib pain continued; and Patient reports unable to do anything workwise due to acute pain most of the day. Notes also indicate that narcotic therapy was not the way to go and that she agreed with this assessment. This condition continued through July 2018. Subsequently, on August 27, 2018, notes indicate that the shots for pain did not help and actually made it worse. Notes further indicate that the patient is reducing her Norco prescription for pain relief.

On [redacted] 2018, the Petitioner was seen by her primary care doctor at the [redacted] medicine and pediatrics clinic. The reason for the appointment was to discuss and review medications. The assessments noted rib pain as the primary assessment and also included depression with anxiety generalized anxiety disorder and ADHD.

On [redacted] 2018, the Petitioner was seen at M[redacted] office. After a thorough evaluation, the assessment was injury consistent with intercostal neuralgia and myofascial pain likely centralize pain without evidence of CRPS. An MRI of the thoracic spine to rule out radiculopathy was prescribed. Notes difficult to know full extent of disability due to being a new patient, but pain appears to be limiting her movements; and she is unable to work. Symptoms listed included poor sleep, feeling of left arm weakness due to pain with certain movements. Aggravating factors listed include moving left arm, carrying things on left, bending the back forward or backward, coughing and sneezing and wearing a bra. The Impressions were intercostal neuralgia and myofascial pain with likely centralized pain without evidence of CRPS (centralized regional pain syndrome) on [redacted] 2018, the Petitioner received

and intercostal nerve block for the upper body/abdomen at the T6, T7, and T8 levels. The injections were based on an MRI of the thoracic spine.

On [redacted] 2019, the Petitioner was seen at the [redacted] with complaints of left thoracic pain. The Petitioner was previously seen at the clinic in 2018 with complaints of left rib pain thought to be due to intercostal neuritis. Since an injury at work in [redacted] 2015, the notes indicate that Petitioner has had a dull ache pain at her anterior chest with intermittent burning pain radiating to her posterior thoracic region. Patient reports aggravation with cough and laughing or using left arm. Relief has primarily been with rest. The notes indicate a prior nerve block injection on [redacted] 2018. An examination of the thoracic/back noted posterior ribs 5, 7-10 on the left with increased tenderness along the lower trapezius. Negative CT VJ thump. Tender along the anterior costal margin but negative slipping rib. An MRI done in 2018 of the thoracic spine was negative for thoracic radiculopathy. The notes indicate that due to the presence of severe pain, it was determined patient could not tolerate consistent rib physical therapy; therefore, a home exercise program was provided. Recommendation was, as symptoms improve, patient should engage in global strength conditioning program targeting 8-10 muscle groups about the upper and lower extremities. Discouraged use of abdominal brace due to limitations in the area of concern as well as limiting overall motion. Neuropathic pain medications were discussed and or rotten was selected.

On [redacted] 2019, the Petitioner was given a psychological evaluation with regard to her mental health and ADHD as well as for depression and anxiety being referred by [redacted] her nurse practitioner. As part of the testing, a self-reporting longer version test was completed by the Petitioner and resulted in an ADHD index score of 74 noting significant elevation and identified her as an individual at risk for ADHD. She also took a test identified as the Minnesota Multiphasic Personality Inventory designed to assess major patterns of personality and emotional disorders. With respect to depression, the Beck Depression Inventory resulted in a score of 23, which indicated to the examiner that Petitioner is currently experiencing a moderate level of clinical depression. A similar assessment for anxiety also resulted in a score of 23, which would seem to indicate that Petitioner is experiencing a moderate level of anxiety. Based on the testing, the diagnosis was attention deficit/hyperactivity disorder combined presentation and generalized anxiety disorder. The recommendation noted that Petitioner was a good candidate for psychotropic medication for ADHD noting Adderall made her jittery and gave her heart palpitations so a different medication was suggested. Individual cognitive behavioral therapy was also recommended to address both ADHD and her anxiety.

In [redacted] 2019, the Petitioner was seen at the [redacted] to establish a new patient relationship. A full examination was conducted; and the assessment included Renal insufficiency, history of ADHD, rib pain and anxiety. With respect to her anxiety, the Petitioner was advised to schedule an appointment for long-term management as well as referred to a psychological examiner for evaluation of ADHD.

The Petitioner was seen by her primary care physician on [redacted] 2019, for intercostal neuritis and depression with anxiety. The doctor referred the Petitioner to [redacted] bed rehabilitation [redacted] clinic.

The petitioner was seen by her primary care physician on [redacted] 2019 due to rib pain and generalized anxiety disorder and depression. At the time of the visit the Petitioner's rib pain was stable and she was taking Tylenol and Aleve notes indicate she was to see [redacted] Rehabilitation on [redacted] 2019; Petitioner deferred additional pain medications until after her appointment at [redacted]. The notes indicate moderate anxiety and moderate depression.

The Petitioner was seen on [redacted] 2019, for a psychotherapy treatment session of one hour for major depressive disorder, recurrent moderate and generalized anxiety disorder. The goal was to increase engagement and value activities, pain coping and pain acceptance as well as effective stress management related to the pain and decreased perception of pain, depression rated related to pain and anxiety related to pain. The Patient received Act Therapy with a good response to pain management. At the session, Petitioner presented with a depressed mood and subjective feelings of helplessness and hopelessness. The Petitioner was provided instructional handouts on the chronic pain cycle and the pain and recovery cycle. The plan was to continue treatment for a 10-week outpatient chronic pain program.

On [redacted] 2019, the Petitioner was evaluated for pain psychology intake. At the time of the evaluation, the Petitioner was not currently prescribed any opioid medication. Notes indicate she had tried treatments for chronic pain which included nerve blocks, steroid injections physical therapy/occupational therapy, chiropractic and massage.

During her interview to obtain background and history, the notes indicate that Petitioner's morning routine involves getting dressed, eating breakfast, doing light housework; and in afternoon, she cares for her pets, watches television and exercises. In the evening, she makes dinner and watches television and movies and denies any hobbies or friends. She currently resides with her ex-husband and admits to being sexually active. At the time of the exam, the Petitioner reported she had never received any outpatient psychotherapy. She presented with symptoms of depression and anxiety. The Petitioner disclosed during her evaluation that she does use cannabis/cannabis-related products and smokes cannabis four times per day at present. Petitioner reports she walks two miles daily and has lost 120 pounds since her accident in 2015. She presented at the session with a depressed mood and sad affect. Average pain was reported to be a 7/10 with the lowest pain at level 4 and the worse at level 10. The pain level reported over the past week was within the normal range with pain-related life interference in the severe range and external manifestations of pain in the moderate range. Both her physical health related quality of life and mental health quality of life were in the moderately impaired range. She rated her overall health as good and reported fair satisfaction with social activities and relationships. At the time, the Petitioner was seeking treatment to address her chronic rib pain and related problems/adjustment difficulties including behaviors of withdrawal from social activities,

sleep disturbance, anxiety, ADHD, and depressed mood. At the conclusion of the evaluation, it was determined that Petitioner was a good candidate for participation in a comprehensive interdisciplinary pain management program. The Patient expressed fear that her pain would take over her whole life and prevent her from doing what she wanted to do. The following factors were activities that increased pain: bathing/showering, sitting, sexual activity, chores, fatigue, driving and damp weather. The following activities and environmental modulation neither increase nor decrease her pain: walking, standing, sleeping are distracting activities. The diagnosis was major depressive disorder recurrent moderate; generalized anxiety disorder, and attention deficit/hyperactivity disorder combined type. The Petitioner plan recommended to start a pain program for chronic intractable headaches with treatment 1 to 2 times a week for 10 to 12 weeks.

The Petitioner was seen on [redacted] 2019, for a pain recheck rehabilitation meeting. At the time of the evaluation, the pain was 7 to 8/10 in the left rib area radiating into the back. Pain causes significant sleep problems. The pain is chronic, constant and variable in intensity. Pain negatively impacts concentration, daily life, emotions relationship sleep, and work. Alleviating factors are noted as repositioning and rest. At the conclusion of the visit, the impression was noted as rib pain on left side, depression with anxiety; program goals were reviewed including physical therapy relaxation therapy, pain psychology and other options for improving sleep follow-up medical appointments every two weeks were scheduled with multi-disciplinary pain treatment program with medication appointments physical therapy and pain psychology. The notes indicate the Petitioner uses marijuana daily. At the conclusion of the visit, the following impression noted rib pain on left side, depression with anxiety and other chronic pain. The evaluator noted that Petitioner has failed a treatment for chronic pain with medications, injections and individual therapies and is at risk for chronic disability; therefore, multidisciplinary treatment is medically indicated and appropriate. A 10-week multidisciplinary pain program was recommended and prescribed. The notes indicate that the Petitioner underwent three breast reductions and had lost 130 pounds and reported that twice monthly her pain is so bad that she will stay in bed all day. The Petitioner was off all pain medications involving controlled substances and was glad to be off them and did not want to go back on them.

On [redacted] 2018, the Petitioner's primary care doctor noted restrictions of 5 pounds and found that she was able to walk at work and sit at work. She is unable to bend or squat or stoop.

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step 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 1.04, Disorders of the Spine and 12.04 Depressive, bipolar and related disorders and 12.06 Anxiety and obsessive-compulsive 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 condition. Petitioner testified that she could stand approximately an hour to an hour and a half, and sit 20 minutes. She testified that her ability to bend was restricted due to her left side rib pain. Petitioner could bathe using her right hand. She could carry between 2 and 5 pounds and had restrictions regarding use of her left hand to reach or pull objects. The Petitioner could walk up to two miles, could not perform a squat or bend at her waist. In addition, the impact of Petitioner's pain was also considered.

Petitioner's primary care doctor, who has overseen both her physical and mental health concerns, also completed a form regarding his observations and restrictions based on his records and clinical observations. The diagnosis was intercostal neuralgia rib pain anxiety and depression. The current prognosis for his patient was that she was currently stable, but he unable to see improvement in functioning. The doctor stated the Petitioner's disability or impairment was to last one year or more and had already lasted one year. The doctor opined that the disability and impairment prevented the Petitioner from standing 6 to 8 hours but estimated that she could stand about 30 minutes. The doctor agreed that the Petitioner could sit, but required moving around periodically to improve her symptoms and that she could not sit upright for 6 to 8 hours. The reason for her inability to stand and/or sit upright for 6 to 8 hours noted rib symptoms would flare up requiring the need to move or sit or stand or lay down. The doctor further noted that the disability/impairment required the patient to lie down during the day to adjust position to improve pain. The doctor was unaware how far the patient could walk. An evaluation of the frequency with which the patient could perform various activities was also made by Dr. [redacted] all activities were rated rarely 0 to 30% and included reach up above shoulders, reach down to waist level, reach down towards floor, carefully handle objects and handle with fingers. He noted her weight restriction was less than 5 pounds during an 8-hour period and regularly/daily. The doctor noted that Petitioner had difficulty bending, squatting, kneeling and turning any parts of the body. The doctor did not opine that the impairment prevented Petitioner from traveling alone. The doctor also addressed Petitioner's pain symptoms and complaints noting it occurred daily and multiple times a day with severe pain at times and that he rated the Patient's credibility with regards to her claims of pain as credible and that an objective medical reason for the pain was due to intercostal neuralgia.

As regards Petitioner's non-exertional limitations due to her mental impairments, the evaluations contained in the medical records indicate that her diagnosis for depression and anxiety do affect her at times but were both rated as moderate in the medical records presented. Based upon a review of the medical evidence supporting her mental impairments it was not demonstrated that Petitioner's condition exceeded a moderate limitation in her activities of daily living, social functioning, concentration, persistence or pace, and episodes of decompensation which none were evident. The Petitioner is currently receiving treatment for her mental impairments and receives ongoing treatment for her chronic pain.

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) with the following restrictions including lifting/carrying

no more than 5 pounds, reaching, pushing, pulling with her hands and the necessity to lie down to relieve her pain during a normal workday as well as reach up above shoulders, reach down to waist level, reach down towards floor, carefully handle objects and handle with fingers. He noted her weight restriction was less than 5 pounds during an 8-hour period and regularly/daily. The doctor noted that Petitioner had difficulty bending, squatting, kneeling and turning any parts of the body.

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

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

Step 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 as a cashier for the Census Bureau, a part-time bank teller and a medical office assistant. Petitioner's work as a cashier required that she stand much of the day and use her hands. The Petitioner's work as a bank teller also required her to lift and carry coin boxes frequently weighing up to 25 pounds. Her work as a medical office assistant also required lifting boxes frequently to review inventory, take patient's blood pressure and complete their charts and be on her feet between 8 and 10 hours a day. These jobs required light physical exertion.

Based on the RFC analysis above, Petitioner's exertional RFC limits her to no more than sedentary work activities. As such, Petitioner is incapable of performing past relevant work. In light of the entire record, it is found that Petitioner's non-exertional RFC prohibits 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 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 completed a GED with a work history as a cashier, a bank teller and a medical office assistant. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities with restrictions including lifting/carrying no more than 5 pounds, reaching, pushing, pulling with her hands and the necessity to lie down to relieve her pain during a normal workday as well as reach up above shoulders, reach down to waist level, reach down towards floor, difficulty bending, squatting, kneeling and turning any parts of the body.

In this case, the Medical-Vocational Guidelines, Appendix 2, do not support a finding that Petitioner is not disabled based on her exertional limitations as she is found to be capable of sedentary work however with significant restrictions which include both exertional and non-exertional restrictions. The Department has failed to counter with evidence of significant numbers of jobs in the national economy which Petitioner could perform despite her limitations. Therefore, the Department has failed to establish that, based on his RFC and age, education, and work experience, Petitioner can adjust to other work. Therefore, Petitioner is 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 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 January 7, 2019 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 First Class Mail
Petitioner

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

Via Electronic Mail
DHHS

Eileen Asam
MDHHS-Grand Traverse-Hearings

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