[redacted]

Date Mailed: January 15, 2020
MOAHR Docket No.: 19-011332
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 November 14, 2019, from Detroit, Michigan. The Petitioner was represented by herself. [redacted] also appeared as a witness. The Department of Health and Human Services (Department) was represented by Candice Benns, Hearing Facilitator.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. The Interim Order issued on November 14, 2019, ordered that Petitioner provide a completed DHS-49 Medical Examination Report from [redacted] which was received and marked as Exhibit C. The Department was requested to obtain the medical treatment records and any testing records from Dr. [redacted], a neurologist who was examining Petitioner on [redacted], 2019. The requested documents which included treatment record of the visitation on [redacted] 2019, were received; there were no testing records provided. The record closed on December 16, 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 [redacted] 2019, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On September 27, 2019, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 14-20).

3. On October 9, 2019, the Department sent Petitioner a Notice of Case Action denying the application based on DDS' finding of no disability (Exhibit 2, pp. 1-5).

4. On [redacted], 2019, the Department received Petitioner's timely written request for hearing (Exhibit 1, pp. 1-2).

5. Petitioner alleged disabling mental impairment due to depression. The Petitioner also alleges physical impairments due to back pain, neck pain and shoulder pain, with a should tear and injections in cervical spine. Petitioner also has irritable bowel syndrome; required multiple trips to urinate.

6. On the date of the hearing, Petitioner was [redacted] years old with an [redacted] 1976 birth date; she is [redacted] in height and weighs about [redacted] pounds and has recently lost [redacted] pounds.

7. Petitioner completed the 11th grade and can read and write and perform basic math.

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

9. Petitioner has an employment history of work as a caregiver (home health provider for the [redacted]). She has also worked in a call center for a temp employer. Petitioner also worked in a warehouse putting video cassettes in cases. Petitioner also worked in a medical cost center, billing and coding medical bills for collection.

10. Petitioner has a pending disability claim which is on appeal 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 90 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.

The Petitioner presented a note regarding her psychotherapy at the [redacted] and her therapist has recommended that she continue to be off work due to her medical problems. No other treatment records were provided to support ongoing treatment for mental health issues.

The Petitioner was recently seen for an initial examination by a neurologist on [redacted] 2019, with complaints of dizziness/ringing in the ears. After the exam, a CT of the brain was ordered; but no results of the CT scan of the brain were provided. There was no diagnosis made regarding the visit. A referral was also made to ENT/Otorhinolaryngology and Neuropsychology.

A Medical Examination Report was completed by Petitioner's treating doctor, [redacted]. The diagnosis was closed-head injury, depression, cervical and lumbar pain and left-shoulder contusion. The doctor imposed restrictions/limitations noting that Petitioner was improving. The doctor found Petitioner could lift/carry occasionally less than 10 pounds(1/3 of an 8-hour day). No restrictions were imposed with regards to sitting or walking, and the doctor also notes that an assistive device was not required. The Petitioner could also not use her hands/arms for simple grasping, reaching, pushing pulling and fine manipulation. The Petitioner could operate foot controls with both feet and legs. In support of the restrictions, the doctor attached monthly clinical impression reports which began in [redacted] 2019 based upon a motor vehicle accident on [redacted], 2018. The Clinical Impression in all of the reports is left shoulder contusion, cervical radiculitis, lumbar radiculitis and history of hyperlipidemia. Petitioner has been referred to physical therapy and was placed on an aggressive home exercise program to improve strength and range of motion. Initially prognosis was guarded. Petitioner was prescribed Zanaflex, Naproxen and Prednisone, and taken off Norco. The doctor prescribed Petitioner joining a health club facility with a pool for walking on a daily basis and for core strengthening. In February 2019, the doctor felt a neuropsychiatric exam should be scheduled. The diagnosis and joining a gym continue the same through June 2019; and in July 2019, closed head injury is diagnosed; no basis for the diagnosis was stated. In [redacted] 2019, the Petitioner saw a pain management specialist who recommended an epidural injection; and Petitioner had been pool walking. In [redacted] 2019, the Petitioner received a Toradol injection that helped somewhat. Headaches were reported but were more associated with the death of Petitioner's mother. If headaches continue, a referral to a neurologist will be made. In [redacted] 2019, Petitioner had regressed due to not attending physical therapy due to family issues. The doctor restarted physical therapy finding medically necessary.

On [redacted] 2019, Petitioner was seen in the emergency department for back spasm and prescribed medications and advised to follow up with [redacted].

The Petitioner was prescribed physical therapy due to cervical and lumbar pain after an automobile accident. She began therapy on or around [redacted], 2019. At the hearing, she had not continued therapy due to her depression causing her to miss appointments. At therapy, she was seen for neck pain, lower-back pain and left-

shoulder pain. Therapy notes indicate level of pain fluctuates. Petitioner demonstrated guarded mobility when standing from sitting and getting in and out of treatment table. On [redacted] 2019, notes indicate that given her difficulty getting to therapy due to her medical conditions and pain, Petitioner's therapy was put on hold for several weeks. Petitioner also received replacement services for housework and driving due to left shoulder RCT and cervical and lumbar radiculopathy. [redacted] has continued to certify an employment disability with replacement services at least through October 2019.

Petitioner had an MRI of cervical spine on [redacted] 2018. The conclusion of the MRI was disc bulging as above. The only area of the cervical spine that was affected was C5-C6, which noted diffuse bulging is present with partial anterior CSF effacement. Left foraminal narrowing is noted. Right foramen were unremarkable. All other vertebra noted no disc disease present, and central canal and foramina were unremarkable. A CSF effacement occurs when something is noted to have extended into the spinal canal and is pressing on the meninges (the outer covering of the spinal cord causing displacement of the cerebrospinal fluid which protects the spinal cord.

An MRI of the lumbar spine was conducted on [redacted] 2019. The Conclusion notes spondylosis at L4-L5 and L5-S1. The findings note at L4-L5 diffuse disc bulging present. Central canal narrowing noted with bilateral degenerative facet arthropathy present. No substantial foraminal narrowing identified. At L5-S1, findings indicate diffuse disc bulging with a right paracentral foraminal protrusion. Right foraminal narrowing present. Left foramen appears unremarkable. Relative central canal narrowing present.

An MRI of the left shoulder was performed on [redacted], 2019. The conclusion was mild bursal surface fraying of the supraspinatus with mild tendinosis. Low grade interstitial insertional tearing of the infraspinatus and mild subacromial subdeltoid bursitis. The specific findings note the terrace minor and scapularis are unremarkable; the AC joint demonstrates mild to moderate joint space narrowing with small under surface osteophytes present. The acromion appears neutral in position without evidence of lateral down sloping. A type I acromion is present. Subacromial subdeltoid bursitis is identified. The rotator interval demonstrates mild edema. The inferior capsule demonstrates thickening without evidence of acute edema. No discrete labral is identified. The long head of the biceps tendon appears unremarkable, and the deltoid appears unremarkable. The infraspinatus demonstrates a low-grade interstitial tearing at the insertion. The muscle demonstrates no evidence of volume loss or macroscopic fatty change. The minimal supraspinatus tendinosis with bursal surface fraying is present the muscle appears unremarkable.

On [redacted] 2019, the Petitioner underwent a transabdominal and transvaginal pelvic ultrasound which found a 3 cm fibroid on the right side and a 5 cm fibroid on the left with no adnexal mass or of normal fluid collection. The fibroids were surgically removed on an outpatient basis in [redacted] 2018.

The Petitioner participated in an independent medical examination arranged for by the DDS on [redacted] 2019. The Petitioner presented disability due to back, neck and shoulder injury, irritable bowel syndrome, high blood pressure, sleep apnea, asthma, memory loss, low blood pressure and depression. The examiner noted that Petitioner uses a cane for support. The examiner also notes Petitioner advised she has had injections in her left shoulder and uses a tens unit. After the physical examination, the final impression noted neck shoulder and back pain with mild tenderness to palpation in the paracervical and paralumbar areas as well as pain in the left shoulder. Irritable bowel syndrome history with prescribed medications for the problem. Symptoms reported include nausea, vomiting and diarrhea. Petitioner stated she was admitted on one occasion for chest pain and possible G.I. disorder. No dates specified. Petitioner was examined for hypertension and the blood pressure taken during the exam was 120/80. Sleep apnea was noted, and using CPAP machine at least 50% of the time. Asthma is treated with use of inhalers. Memory loss was noted with no neurological examination to date. Notes indicate examiner believes she needs further investigation; a history of depression was also noted and recommended a mental health evaluation. The medical source statement noted based on today's exam including the history and the physical exam, the examinee has occasional limitations with standing, walking, lifting, bending due to findings noted above which includes paracervical and paralumbar back disorders along with left shoulder pain, along with tenderness to palpation in paracervical and paralumbar areas, the use of a cane for balance and support, slow execution of tandem walk, heel walk and toe walk and slightly decreased range of motion in the left shoulder joint. Straight leg raise 90 degrees negative with range of motion in the left shoulder 140 out of 150 degrees. The examiner also noted the evidence did support use of a cane for walking to reduce pain.

On [redacted] 2019, the Petitioner was seen for an Independent Mental Health Examination as scheduled by the DDS. Some medical history records were reviewed by the examiner. The history taken by the examiner notes depression symptoms starting approximately three years ago. Petitioner reports her depression is based on her physical disorders and symptoms include not wanting to talk to anyone, isolating, with depressed mood, irritation and poor concentration. At the time of the exam, Petitioner reported she had never attended therapy for her depression. No inpatient treatment has been received. At the time of the exam, she also was not on any medication for depression. Petitioner reports awakening throughout the night due to uncontrolled pain. Petitioner's social history notes that she denies any social activities and does not have a GED. The Petitioner did attend the National Institute of Technology for medical billing and coding. She completed the program. The examiner noticed Petitioner was guarded and irritated during the entire exam. Petitioner was reported to ruminate throughout the exam with linear thought content which was goal directed and relevant. Hallucinations, paranoia, delusion or psychotic behavior were not noted. Petitioner was able to follow directions as well as complete tasks with no re-direction. Petitioner denied any self-harm behaviors, suicide ideation and homicidal ideation. The diagnostic impression was adjustment disorder with depressed features, mild. The Medical Source statement noted the following: the patient displays no mental

limitations during the exam. She provided her best effort during the exam with continuous encouragement during the entire exam. She performed well during the mental status exam. She would benefit from consistent therapy. She had some difficulty with immediate memory questions and digital span backwards testing. She has the ability to conduct simple and complex mental tasks. She displays the ability to understand, carry out and remember instructions. She displayed the ability to concentrate and persist in work related activity at a reasonable pace. She behaved and interacted as guarded and aggressive at times. She complained of pain, and stood up several times during the exam. She complains continuously about DDS not obtaining her medical records from [redacted] She has the ability to deal with work-related pressures. She displays the ability to avoid environment and work-related hazards.

On [redacted], 2019, Petitioner's treating doctor placed her on disability from work for the period November 2019 through December 2019 and certified she was in need of assistance with housework and driving as needed as a result of a motor vehicle accident in 2018. The Petitioner was also prescribed the use of a cane as approved by her [redacted] for arthritis.

The Petitioner was seen on [redacted], 2019, due to atypical chest pain with a negative stress test in 2012. The past history notes chest pain syndrome and arrhythmia. The office visit notes indicate Petitioner was negative for depression, dizziness and memory loss. The impression was atypical chest pain unchanged in character over several years. Offered stress test, but Petitioner wished to defer at this time due to other issues that are being addressed in her life. Daily exercise encouraged. Patient's hypertension is well-controlled on medical therapy.

The Petitioner was seen by [redacted] on [redacted] 2019, with complaints of left-shoulder pain, emergency room visit due to tachycardia, and crying, with note to evaluate blood pressure. Petitioner reported full range of motion of the left shoulder, but she has pain. Two weeks prior, she fell on her left elbow in the bathtub. Imaging studies showed no fractures. Doctor advised to rest her arm and ice it. Petitioner also reported depression and was tearful during the exam. Petitioner also reported her IBS was worse with frequent diarrhea after eating; nausea, vomiting and constipation were denied. The assessment at the conclusion of the visit was labs were ordered, Tylenol 3 was prescribed for pain, and Petitioner was referred to a sports medicine doctor. The depression was described by Petitioner as due to her daily pain and aches which keep her from doing certain activities. Petitioner was advised to call the number of the back of her insurance if she would like to see a mental health specialist. Petitioner was also referred to a gastroenterologist. Due to arthritis of lower extremity joints, a walking cane was ordered. Petitioner's BMI was [redacted], she was [redacted]" and weighed [redacted] pounds. The Petitioner was seen again on [redacted] 2019. The visit was for referrals and to evaluate blood pressure and other chronic conditions. During the exam, the Petitioner complained of memory problems and frequent headaches and wanted to see a neurologist. Symptoms of memory problems were due to missing appointments, and she forgets where she placed her keys. The examination results were normal. The

assessment noted headaches and forgetfulness with a neurology referral. Petitioner was to follow up in a month.

On [redacted], 2017, the Petitioner was diagnosed with severe obstructive sleep apnea after a sleep study was conducted with recommendations for weight loss, alcohol avoidance, sleeping on side and continuous positive airway pressure (CPAP). In [redacted] 2018, the Petitioner was fitted with a CPAP mask and disordered sleep breathing and snoring were eliminated. In July 2018, Petitioner was seen for a follow-up and was not using CPAP consistently four hours per night rather than seven hours. Petitioner noted improvement with CPAP use. Petitioner was counseled on losing weight due to the connection of sleep apnea and obesity; Petitioner's obesity was class 3 severe obesity.

On [redacted] 2019, the Petitioner was seen for irritable bowel syndrome (IBS) and rectal bleed episodes which were possibly due to hemorrhoids; but improvement in bowel pattern was noted with use of Metamucil. Petitioner also complained of upper abdominal pain. The diagnosis was upper abdominal pain. Petitioner was to follow up in three months. An H Pylori breath test was to be performed. Petitioner was also seen earlier on [redacted] 2019, for IBS follow-up. There was no blood in stools reported, and notes indicate she was not compliant with Metamucil. Petitioner reports being mostly constipated and having intermittent diarrhea. Petitioner was also seen for IBS follow-up and reported constipation and diarrhea in June 2018. The diagnosis was IBS mixed type, diarrhea and constipation, improves with use of fiber but not used daily.

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; 1.02 major dysfunction of a joint(s) (due to any cause); 12.04 Depressive, bipolar and related disorders; 3.02 Chronic respiratory disorders; and 5.06 Inflammatory Bowel Disease were considered. The medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3; and the analysis continues to Step 4.

Residual Functional Capacity

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

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

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b).

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

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). In addition, four broad functional areas (understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself) 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 condition. Petitioner testified that she could stand 5 to 10 minutes and sit an hour. She could walk 20-30 feet and could not perform a squat. She testified that she had limited range of motion with bending at the waist. Petitioner could shower and dress herself and could touch her toes. Petitioner is right handed and there was no limitation with respect to the use of her right hand or arm. Petitioner testified that she had pain in the left shoulder but could move it. Petitioner testified that she could lift 1 to 2 pounds. During the day the Petitioner watches TV, naps, prays and talks to her son on the phone. Petitioner also uses a cane. She can microwave food for herself and cannot do laundry. Petitioner does have IBS flare-up which cause diarrhea at times.

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, her doctor's evaluation in the Medical Exam Report was considered, as was the independent medical examiner's assessment which noted Petitioner's occasional limitations with standing, walking, lifting and bending

due to findings noted during the exam with reference to the paracervical and paralumbar back disorder along with left shoulder pain. Therefore, based on a review of the entire record if is determined that Petitioner maintains the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a).

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has moderate limitations on her mental ability to perform basic work activities. The Petitioner testified during the hearing that she had not been in treatment for depression during the time prior to hearing, and at the time of the hearing had been in therapy for three weeks. She did not appear to be on medications for her mental problems. It is also noted that the Petitioner's depression was also due in large part due to the recent passing of her mother in August 2019 and her pain. After the hearing, Petitioner presented a note dated [redacted] 2019 from her therapist that recommended she continue to be off work due to her medical problems and cited no diagnosis regarding Petitioner's mental health issues. The results of the Independent Psychological Exam and Mental Status Exam, conducted at the request of DDS, noted positive results with respect to the Petitioner's abilities and diagnosed adjustment disorder with depressed feature, mild; and displayed no mental limitations during her exam. The details and conclusions of this exam is set forth in Step 2 above. Based on the four areas used to evaluate mental disorders it is determined that Petitioner is not limited in her ability to understand remember or apply information; moderately limited in her ability to interact with others; moderately limited in her ability to concentrate, persist or maintain pace; and moderately limited in her ability to manage herself.

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 caregiver (home help provider), performing medical coding and collections, work as a call center operator and a warehousing job packaging videos in boxes. Petitioner's work as a caregiver required her to lift and carry groceries, driving patients, assisting patients getting out of bed, grocery shopping, changing bed linens, and household cleaning which required standing and lifting up to 20 pounds regularly, and standing and

walking much of the day and required light physical exertion. Petitioner's job doing medical coding and call center phone work and collections phone work required that Petitioner sit much of the day with no lifting or carrying or standing/walking while performing this work. These jobs are considered as requiring sedentary physical exertion. As such it is determined that Petitioner could perform this past relevant work, as a call center operator and collections of medical bills as they do not require standing or walking or lifting and no such restrictions were imposed regarding sitting by her doctor or the independent medical examiner. Petitioner could not perform the factory packaging job because it required standing and walking 8 hours and is not sedentary work.

Based on the RFC analysis above, Petitioner's exertional RFC limits her to no more than sedentary work activities. As such, Petitioner is capable of performing past relevant work performing call center telephone work and telephone collections work. Petitioner also has mild to moderate limitations in her mental capacity to perform basic work activities, with no limitations in her concentration, persistence or pace and no limitations in her ability to understand remember or apply information. In light of the entire record, it is found that Petitioner's nonexertional RFC does not prohibit her from performing past relevant work doing call center and collections phone work.

Because it is determined that the Petitioner is able to perform past relevant work, Petitioner is determined to be not disabled at Step 4 and the assessment ends.

Step 5

A Step 5 analysis in included as Petitioner would be determined not disabled at Step 5 as well.

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 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 [redacted] years old at the time of hearing, and, thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. She completed the 11th grade with a history of work experience as a home care provider, a call center job and medical billing and collections job as well as factory packaging work. 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.

Based solely on her exertional RFC, the Medical-Vocational Guidelines, Rule 201.24, result in a finding that Petitioner is not disabled.

However, Petitioner also has impairments due to her mental condition. As a result, she has a nonexertional RFC imposing no limitations in her activities of daily living; mild to moderate limitations in her social functioning; no limitations in her concentration, persistence or pace limitations and no limitations in her ability to understand remember or apply information. It is found that those limitations would not preclude her from engaging in simple, unskilled work activities on a sustained basis. Therefore, Petitioner is able to adjust to other work and is not disabled at Step 5.

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 Department's determination is **AFFIRMED**.

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

DHHS

Deborah Little
MDHHS-Wayne-49-Hearings
BSC4
L Karadsheh

Petitioner

[redacted]