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Date Mailed: January 30, 2020
MOAHR Docket No.: 19-011531
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 25, 2019, from [redacted] Michigan. The Petitioner was represented by herself. The Department of Health and Human Services (Department) was represented by Erica Boyer, Lead Worker.

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, consisting of a DHS-49 Medical Examination Report and a Fibromyalgia Medical Source Statement, were received and marked into evidence. Exhibit C, consisting of a Mental Residual Functional Capacity Assessment DHS-49-D, a Psychological Examination Report, DHS 49-E and Case Summary, were received and marked into evidence. The record closed on December 26, 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 25, 2019, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 248-254).

3. On September 27, 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. 285-281).

4. On October 15, 2019, the Department received Petitioner's timely written request for hearing (Exhibit A, p. 286).

5. Petitioner alleged disabling impairment due to fibromyalgia with severe pain, memory and concentration problems, Depression and Anxiety and PTSD.

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

7. Petitioner has a master's degree in counseling - education psychology and also obtained a certificate for substance abuse treatment.

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

9. Petitioner has an employment history of work as a therapist in the prison system, worked as a placement specialist placing individuals for substance abuse treatment. Petitioner last worked as a waitress in July 2018 for three weeks.

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 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, s/he 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] 2019, Petitioner's Primary Care Nurse Practitioner (PCNP) completed a medical examination report, DHS-49, listing Petitioner's diagnoses as fibromyalgia, depression/anxiety, migraine headaches and sleep disturbance. The doctor noted that Petitioner had weakness in her musculoskeletal system without specificity and noted mental issues with scattered thoughts and impaired memory. The PCNP concluded that Petitioner's condition was expected to last more than 90 days and identified the following limitations: (i) she could frequently lift and carry less than 10 pounds, occasionally lift and carry 10 pounds, and never lift and carry 25 pounds or more; (ii) she could stand and/or walk two hours in an eight-hour workday; (iii) she could sit less than five hours in an eight-hour workday; and did not require the use of an assistive device for ambulation; (iv) she could use both arms or hands to grasp, reach, fine

manipulate but could not use her hands for pushing and pulling; and (v) she could she could use both feet and legs for operating foot and leg controls. The medical findings noted weakness, paresthesia, sleep disturbance and chronic pain. She noted mental limitations of sustained concentration, comprehension, memory and social interaction, noting again scattered thoughts poor concentration impaired memory and social anxiety. The Petitioner needed assistance with laundry, and the basis for the determination was due to functional information completed the PCNP. The Petitioner's condition was noted as stable. The PCNP had seen and treated the Petitioner since October 2013 and last saw the Petitioner in December 2019. Attached to the Medical Examination Report was a Fibromyalgia Medical Source Statement completed by the PCNP. Petitioner is seen monthly by the PCNP, and the conclusion was that Petitioner met the 2010 American College of rheumatology preliminary diagnostic criteria as follows: history of widespread pain, 11 of 18 specific tender points, cognitive dysfunction (fog), irritable bowel syndrome, muscle pain, muscle weakness, frequent severe headaches, dizziness, shortness of breath, frequent urination, pain in upper abdomen, ringing in the ears, dry eyes, shortness of breath, fatigue, depression, anxiety disorder, waking not refreshed, numbness or tingling, abdominal pain/cramps, constipation, nausea, nervousness, diarrhea, dry mouth, heartburn, sun sensitivity, easy bruising, chronic fatigue syndrome, restless leg syndrome and temporomandibular joint disorder, migraines and panic attacks. The report also noted the location of the pain was in the lumbosacral spine, cervical spine and thoracic spine as well as hands fingers, hips, legs and knees, ankles and feet. The symptoms were noted as constant and daily with an 8/10 pain level. The factors that precipitated the pain included changing weather, fatigue, stress, movement overuse, sleep problems and static position. The doctor also noted emotional factors did contribute to the severity of the symptoms and functional limitations. The PCNP examiner further evaluated that Petitioner needed a job that would permit shifting positions at will from sitting, standing or walking and required no periods of walking around during an eight-hour day. In addition, the notes indicate that the patient will sometimes need to take unscheduled breaks during the workday, (on demand) and will have to rest 10 minutes standing due to muscle weakness, chronic fatigue and pain, paresthesia and numbness. The notes also indicate that with prolonged sitting, the Petitioner's legs should be elevated above her heart 50% of the working day; no significant limitations were noted with reaching, handling or fingering. The notes estimated that the Petitioner would likely be "off task" approximately 25% of the workday, and her off-task periods would likely be severe enough to interfere with attention and concentration needed to perform a simple work task. In addition, the degree of patient tolerance for work stress was noted as, incapable of even low stress work. Impairments were also likely to produce good days and bad days. Assuming Petitioner was trying to work full-time, she would need more than four days per month to be absent from work as a result of her impairments. In conclusion, the notes indicate Petitioner's impairments, physical and emotional, are reasonably consistent with symptoms and functional limitations described above. The prognosis was rated as fair, and a diagram indicating the tender points affected was also included, noting 12 tender points circled. The Fibromyalgia Medical Source Statement was dated November 6, 2019. (Exhibit B)

The Petitioner's Family Practice Nurse Practitioner saw Petitioner on [redacted] 2019, for review of rheumatology issues after attempting to exercise and anxiety issues. At the time of the exam, the Petitioner reported not using drugs or alcohol. The physical findings noted that the Petitioner's mood and affect were abnormal and dysthymic noting Petitioner was very tearful throughout the exam with scattered and impaired thought process. At the conclusion of the exam, the Assessment noted dermal candidiasis, fibromyalgia, anxiety/depression and vitamin D deficiency. Seroquel was added for anxiety; and Buspirone was increased to 30 mg twice daily; and Lyrica was also increased 100 mg twice daily.

The Petitioner was seen on [redacted] 2018, for discussion regarding Cymbalta. At the conclusion of the examination, the assessment was myalgias and arthralgias. The Petitioner appeared with normal affect, and her mood was dysthymic with neither thought processes nor thought content impaired. At the conclusion of the exam, Cymbalta was increased to 90 mg daily. On [redacted], 2018, the Petitioner was seen for an evaluation due to complaints of persistent abdominal pain, constipation, bloating and pain with or without food over the last six months. At the conclusion of the exam, further testing was to be performed for pelvic peroneal pain. An x-ray of the abdomen found fecal stasis with no soft tissue mass or suspicious densities evident. An ultrasound of the Pelvis performed on [redacted] 2018, noted an unremarkable ultrasound of the pelvis with possible underlying fibroid change.

The Petitioner was seen twice for appointments in [redacted] 2018 at which time pain throughout the body was reported. The assessments for both visits noted myalgias, mild cystitis, fatigue and depression and anxiety. Lyrica was added to the prescribed drugs.

The Petitioner was seen on [redacted] 2018, by her PCNP presenting with complaints of neck pain, upper back pain and bilateral foot pain and swelling for the past month. Petitioner reported it has become painful for her to walk on her feet due to the swelling. She denied any trauma to the feet or upper extremity weakness. A physical exam notes the extremities all had normal range of motion, were nontender with no pedal edema, foot swelling with strong pulses, capillary refill less than one second in the bilateral feet with no deformity. The bloodwork results were unremarkable as was the examination. The PCNP did not see any significant pedal edema and ruled out diuretics as being appropriate. Based on the lab results, there was no indication for an additional workup.

On [redacted] 2017, the Petitioner was seen in the emergency room accompanied by law enforcement after she had made statements to friends and family that she no longer wanted to live. Intake notes indicate she admits to these thoughts but cannot tell if she has a plan or not. The chief complaint was regarding her mother, and during the interview admitted to drinking a large amount of alcohol but was unable to describe exactly how much. The Notes indicate that the Petitioner smelled of alcohol. The physical examination was normal. At the conclusion of the visit, the primary impression

was depression with an additional impression of alcohol intoxication. The Petitioner reported being homeless at the time of the emergency room visit.

On [redacted] 2019, the Petitioner had a CT of the head due to an injury, trauma, laceration. The findings were soft tissue injury on right without evidence of an acute intracranial process.

The Petitioner was seen at advanced rheumatology by a rheumatologist on [redacted] 2019, for joint pain with a severity of 7/10 and that symptoms were constant. Primary symptoms were reported to include pain and stiffness. The Petitioner was being seen for evaluation as a new patient. The Petitioner described her condition as arising one year ago upon awakening, and she could not move due to pain throughout her whole body. The first symptoms and main complaint were pain and swelling in the bilateral feet and ankles. The pain has now progressed to fingers, hands, wrists, shoulders and back. Approximately six weeks ago, the Petitioner reported having pain in the bilateral knees as well and gets numbness in her toes. Prednisone was used to address pain but was reported as not helpful. The examination noted the following: the Petitioner was positive for fatigue, dry eyes, apnea, cough, dyspnea and swollen legs and feet. She was positive for chest pain, heart murmur and irregular heartbeat. The Petitioner was also positive for nocturia and polydipsia. She was negative for sensitivity of pain in the hands or feet. Psychologically, she was emotionally labile and positive for depression, anxiety, insomnia, sleep disturbance and excessive worrying. The Petitioner was positive for joint pain, stiffness, swelling, morning stiffness, muscle weakness and myalgia weakness. The physical exam was normal. The joint exam noted the following total tender points: Right foot MTP2 is positive; MTP3 is positive; Left foot MTP2 is positive; MTP3 is positive for joint tenderness; and MTP4 is positive for joint tenderness. The assessment at the conclusion of the exam was bilateral hand pain, bilateral foot pain and pain in left foot. Further diagnostic evaluations were ordered including foot x-rays and hand x-rays. The doctor's notes indicate that he was not sure what was causing the symptoms at the time of the exam and noted they did not seem consistent with an inflammatory arthritis or connective tissue disease. Additional testing was ordered, and notes indicate that Petitioner did have some tender points to suggest a possible fibromyalgia. Notes indicate Petitioner describes swelling and lower extremities/feet consistent with peripheral edema but had no swelling at the exam.

On [redacted] 2019, an x-ray of the right hand noted no radiographic evidence of acute fracture or dislocation. No cortical erosions or radiopaque foreign bodies indicating a negative study. An x-ray of the left hand noted a negative study as well. An x-ray of the left foot was also taken indicating no radiographic evidence of acute fracture or dislocation. No cortical erosions or radio pack foreign bodies. Tiny plantar and posterior calcaneal heel spurs. An irregularity involving the mid-shaft of the fifth metatarsal possibly related to an old healed injury. An x-ray of the right foot indicated no acute fracture or dislocation with tiny plantar and posterior calcaneal heel spurs. The ANA testing(Antinuclear Antibodies) was positive.

On [redacted] 2019, Petitioner's Licensed Professional Counselor, MA (LPC) completed a DHS-49-E Mental Residual Functional Capacity Assessment evaluation regarding Petitioner's mental impairments and how they affected her activities. The Therapist concluded as follows:

> With respect to Understanding and Memory:
>
> Petitioner had Moderate limitations in her ability to:
> remember locations and work-like procedures;
> understand and remember one or two-step instructions;
> understand and remember detailed instructions;
>
> With respect to Sustained Concentration and Persistence:
> The Petitioner was Moderately limited in her carry out detailed instructions and her ability to make simple work-related decisions.
>
> The Petitioner was Markedly limited in her ability to carry out detailed instructions; maintain attention and concentration for extended periods; perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; ability to work in coordination with or proximity to others without being distracted by them and the ability to complete a normal workday and worksheet without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.
>
> With respect to Social Interactions:
>
> The Petitioner was not significantly limited in her ability to ask simple questions or request assistance.
>
> The Petitioner was Moderately limited in her ability to accept instructions and respond appropriately to criticism from supervisors; and ability to get along with co-workers or peers without distracting them or exhibiting behavioral extremes.
>
> The Petitioner was Markedly limited in her ability to interact appropriately with the general public and the ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.

With respect to Adaption:

The Petitioner was Moderately limited in her ability to respond appropriately to change in the work setting; the ability to be aware of normal hazards and take appropriate precautions and the ability to set realistic goals or make plans independently of others.
The Petitioner was Markedly limited in her ability to travel in unfamiliar places or use public transportation.

The Petitioner's therapist also completed a Psychological Examination Report on [redacted] 2019. The notes indicate the general observation noted the Petitioner to be unfocused and reports a master's degree, however, unable to work due to mental health problems since [redacted] 2010. The history presented indicated Petitioner had severe depression and anxiety with symptoms of PTSD present. Client lacks focus and motivation and reports daily physical pain and extreme fatigue. Petitioner not able to obtain employment, transportation or housing due to her symptoms which are present daily. Petitioner's current treatment consists of weekly outpatient mental health counseling. With respect to daily functioning, the examiner noted client is unable to perform or participate in normal daily functioning. Client reports inability to do basic tasks such as shopping, going for a walk, maintaining personal hygiene, interacting with the general public, performing household chores or remembering tasks and instruction. The Beck depression inventory score was 44 with a notation that a score over 40 indicates extreme depression. The Beck anxiety inventory indicated a score of 51 with the notation that a score over 36 is cause for concern. The diagnosis was major depressive disorder recurrent, generalized anxiety disorder, posttraumatic stress disorder and alcohol use disorder moderate.

In addition, a case summary was also attached to the Psychological evaluation which reported the Petitioner reported an extensive history of physical and emotional abuse and symptoms of PTSD which worsened after issues working in the prison system. Also noted is that Petitioner has experienced severe undiagnosed physical health issues including sudden excruciating pain and inflammation which have significantly worsened her mental health issues. At the time of the case summary in [redacted] 2019, the Petitioner was homeless. The cognitive and behavioral symptoms indicate that the Petitioner reports substance abuse, isolation, fatigue, frequent daily crying episodes, anger, irritability, poor concentration and distractibility, loss of interest and motivation, low self-esteem, anxiety/fear, difficulty sleeping, racing thoughts, employment issues and past trauma with PTSD symptoms. Her symptoms indicate significant mental health issues which greatly impair her ability to function performing daily tasks or maintain employment.

A mental status exam was also completed on [redacted] 2019, and indicated Petitioner's speech was slow, eye contact was normal and motor activity was also slow; however, Petitioner presented with full affect. Her mood was noted as depressed. Her long-term memory was noted impaired and her attention was distracted. The comments section noted significant lack of focus and ability to retain and remember. No

hallucinations were reported. There were no thoughts of suicide, homicide or delusions. Her behavior was noted as withdrawn; her insight was fair; and judgment was also rated as fair.

Mental abilities and aptitudes needed to do unskilled work were also evaluated in a structure similar to the mental residual functional capacity assessment and of those were that were seriously limited included remembering work like procedures, understanding and remembering short simple instructions and carrying out short and simple instructions; no useful ability to function was noted with regard to being able to maintain for two-hour segment and complete a normal work day and work week without interruptions from psychologically based symptoms. Also noted was Petitioner's inability to meet competitive standards including ability to maintain regular attendance and be punctual within normal customary tolerances, work in coordination or close proximity to others, without being unduly distracted, perform in a consistent pace without an unreasonable number and length of rest periods and accept instructions and respond appropriately to criticisms of supervisors. The notes at the bottom of the form indicate significant impairment in attention, memory, comprehension and completing tasks due to mental health symptoms. Due to her PTSD, the Petitioner was rated as unable to interact with the general public or go to unfamiliar places due to a severe impairment based on her PTSD symptoms.

A Case Summary was also completed for [redacted] 2019, by Petitioner's therapist, [redacted] The diagnosis and the cognitive and behavioral symptoms are the same as the [redacted] 2019 report referenced above. The following medications were listed: Cymbalta, folic acid, Lyrica buspirone, Robaxin, Topamax, Trazodone, Hydroxyzine and Diclofenac.

An Intake Summary was also completed on [redacted] 2019. The presenting problems noted currently experiencing severe health issues, unable to work, homeless and significant increase in mental health issues, often not able to function. The Petitioner set the following goals: process/cope with past trauma and current mental health symptoms; Achieve emotional and physical stability and to identify toxic relationships and establish boundaries. Meeting with a physician for a consult was noted as an urgent need. The mental status exam noted in pertinent part IQ to be average, concentration to be distractible, memory was good both remote and recent, insight was fair and impulse control fair. During the exam, the examiner noted the Petitioner was restless and made loose associations being unable to focus and expressed thoughts of hopelessness and worthlessness. The Petitioner presented as depressed and anxious.

On [redacted] 2019, a friend of Petitioner's completed a Function Report for the Social Security Administration. The individual completing the report, [redacted] had known the Petitioner for nine years. The report indicates Petitioner cannot stand on her feet for more than an hour and cannot walk more than 1/8 of a mile. He reported Petitioner cooks two or three times a week and reads and can no longer do things that she used to enjoy such as workout physically and enjoy time with her friends. The Petitioner has difficulty sleeping and sometimes also needs to be reminded about taking

a shower. The Petitioner can make sandwiches, protein shakes and salads as well as frozen dinners and does so daily but does not cook complete meals. The Petitioner can clean and do laundry and needs to be reminded sometimes to do something she needs to do or keep an appointment. The report further indicates that Petitioner can drive a car and does so when she shops for groceries and generally needs to be accompanied because she gets paranoid. The report indicates that the Petitioner has difficulty and cannot pay bills, handle a savings account or use a checkbook as she gets frustrated and cries. The notes also indicate she gets frustrated at times and raises her voice and yells when having to deal with getting along with others and has no social activities. Also noted was that Petitioner cannot lift more than 7 to 8 pounds and cannot squat, bend or kneel as her feet are affected. The Petitioner does not have good memory, and the individual completing the form indicated he often has to repeat himself before she understands. The Petitioner's ability to pay attention varies, and she gets frustrated when given spoken instructions. The Petitioner's fears include loss of her memory as well as fear for the future.

The Petitioner also completed a Function Report on [redacted] 2019. The highlights of the report follow. The Petitioner reports inflammation of her fingers, wrists, hands, arms, elbows, feet, ankles associated with extreme pain and makes it difficult if not impossible for her to walk. In addition, she reports depression, anxiety and PTSD since childhood have been exacerbated by working in the prison system and abusive relationships. The Petitioner reports she can no longer exercise or work for several years due to the pain. The Petitioner recently used a memory pillbox so she can remember to take her medications. She also indicated she no longer prepares meals and is assisted by others due to pain in her hands, wrists, fingers, elbows, and arms. The Petitioner does not travel alone and indicates that she does not shop alone and that her friend assists her. Petitioner reports that in the past she used to attend support groups daily and mental health therapy weekly. The Petitioner also indicated that kneeling is impossible; her concentration has become poor; and she cannot walk distances due to pain. With respect to concentration, she is able to follow instructions but has difficulty starting and completing a task. She indicated she could follow spoken instructions. She also noted that she had no difficulty getting along with authority figures. Petitioner rated herself as fair in terms of handling changes in routine.

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 12.04 Depressive, bipolar and related disorders; Anxiety and Obsessive-compulsive disorders; and 1.02 Major dysfunction of a joint(s) (due to any cause) 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 10 or 15 minutes, and sit for an hour and that she sits most of the day or lays in bed. The Petitioner testified that she can walk an eighth of a mile and cannot perform a squat. The Petitioner can shower and dress herself and tie her shoes and touch her toes. The Petitioner's physical limitations are due to pain which she evaluated as 8/10 with her numerous mediations. The Petitioner has pain in both her hands and wrists and can write but not for a long time. Petitioner testified that she could carry less than 5 pounds and that her feet hurt all the time. Recently, her bilateral knees also began to hurt. In addition, Petitioner's PCNP has also imposed limitations regarding Petitioner's physical exertional limitations which are set forth in detail in the Step 2 analysis. The limitations include lifting/carrying frequently less than 10 pounds and occasionally 10 pounds; stand and or walk at least two hours in an 8-hour workday and cannot perform push-pull with either hand/arm. In addition, the Petitioner's Nurse Practitioner completed a Fibromyalgia Medical Source

Statement that further evaluated Petitioner's limitations with respect to exertional limitations and evaluated how her work abilities and participation are affected, which are also set forth in detail in Step 2 of this Decision.

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 less than sedentary work and cannot perform sedentary work as defined by 20 CFR 416.967(a) due to her exertional limitations.

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has moderate-to-marked limitations on her mental ability to perform basic work activities. The Petitioner was evaluated by her therapist, a Licensed Professional Counselor with a Master's Degree, who sees her weekly. The Mental Residual Functional Capacity Assessment demonstrates that the Petitioner was evaluated as having marked limitations in each of the four evaluation 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 Petitioner's PCNP also found deficits in the area of memory and concentration.

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 follows. The Petitioner was a placement specialist at a substance abuse treatment program for seven years from 2008 to 2015. After this job, Petitioner worked intermittently at restaurants as a server/waitressing which required her to be on her feet all day and carry food orders more than 10 pounds, which required light physical exertion. Petitioner also worked as

a therapist in the prison system for several years after 2004. Her job as a therapist required sedentary physical exertion consisting of sitting in groups and counseling. Petitioner also worked as a Placement specialist placing individuals for substance abuse treatment requiring sedentary physical exertion.

Based on the RFC analysis above, Petitioner's exertional RFC limits her to less than sedentary work. As such, Petitioner is incapable of performing past relevant work. Petitioner also has non-exertional limitations which include marked limitations including working in places requiring contact with the general public and concentration and memory resulting in a moderate to marked limitations in her mental capacity to perform basic work activities. Given Petitioner's non-exertional limitations, it is determined that Petitioner could not likely function as a therapist for others/ In light of the entire record, it is found that Petitioner's nonexertional 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.

In this case, the medical evidence presented demonstrated past alcohol abuse by Petitioner in 2010 for in-patient treatment due to alcoholism and an ER visit in 2017 referred to in Step 2 analysis in this Decision. In addition, the Petitioner credibly testified that she has been sober for one year and attends Alcoholics Anonymous (AA) five days a week. The medical records do not disclose any other incidents of alcohol abuse. Petitioner's therapist has diagnosed her with alcohol abuse disorder – Moderate which is not a primary diagnosis. As such, the medical records and Petitioner's testimony do not support a finding that alcohol is material and is a contributing factor material to the determination of disability. See Social Security Act, Sections 223(d)(2)(C) and 1614(a)(3)(J) of the Social Security Act (Act). Also considered is whether considering all the Petitioner's medically determinable impairments, whether the Petitioner would continue to be disabled if he/she stopped using alcohol; that is, it must be determined whether alcohol abuse (DDA) is material or significantly affects the Petitioner's other medical impairments. SSR 13 – 2p. Based upon the medical record the Petitioner's past alcohol abuse does not significantly affect Petitioner's other medical impairments.

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 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 45-49) for purposes of Appendix 2. She has a college education with a Master's Degree in Educational Counseling with a history of work experience as a therapist in the prison system and a Placement Specialist placing individuals in substance abuse treatment. As discussed above, Petitioner does not maintain the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities having been determined less than sedentary in her physical capacity.

In this case, the Medical-Vocational Guidelines, Appendix 2, do not address and, therefore, do not support a finding that Petitioner is not disabled based on her exertional limitations. The Department has failed to counter with evidence of significant numbers of jobs in the national economy which Petitioner could perform despite her limitations.

In addition, Petitioner also has impairments due to her mental health condition. As a result, she has a nonexertional RFC imposing moderate limitations in her activities of daily living; marked limitations in her social functioning; and marked limitations in her concentration, persistence or pace limitations.

The Department has failed to present evidence of a significant number of jobs in the national and local economy that Petitioner has the *vocational qualifications to perform in light of her nonexertional RFC, age, education, and work experience. Therefore, the evidence is insufficient to establish that Petitioner is able to adjust to other work.*

Accordingly, Petitioner is found disabled at Step 5 for purposes of the SDA benefit program. Therefore, the Department has failed to establish that, based on her 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 [redacted], 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 January 2021.

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

Dan Vendzuh
MDHHS-[redacted]Hearings
BSC1
L Karadsheh

Petitioner

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