[redacted]

Date Mailed: January 24, 2020
MOAHR Docket No.: 19-011778
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

HEARING DECISION

Following Petitioner's request for a hearing, a hearing on this matter was scheduled pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on November 27, 2019, from Detroit, Michigan before Administrative Law Judge (ALJ) Jacquelyn McClinton. Petitioner appeared and represented herself. Participants on behalf of the Department of Human Services (Department) included Dawn Mastaw, Eligibility Specialist.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. After the undersigned became aware that the Department had not received the first interim order extending the record, a second interim order extending the record was issued, ordering the Department to request documents from [redacted] of [redacted]. No documents were received in response to the two interim orders, and the record closed on February 14, 2020 for preparation of a final determination based on the evidence presented. Because ALJ McClinton is no longer employed with the Michigan Office of Administrative Hearings and Rules (MOAHR), the evidence presented in this matter, as well as the testimony at the hearing, has been reviewed by the undersigned ALJ and a decision rendered in accordance with Mich Admin Code, R 792.101106.

ISSUE

Did the Department properly determine that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit program?

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On [redacted], 2019, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On October 3, 2019, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 16-22).

3. On October 9, 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. 6-10).

4. On [redacted] 2019, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 3-5).

5. Petitioner alleged disabling impairment due to lupus, epilepsy, adrenal insufficiency, posttraumatic stress disorder (PTSD), chronic pain, and depression.

6. On the date of the hearing, Petitioner was 43 years old with a [redacted] 1976 birth date; she is 5'3" in height and weighs about 300 pounds.

7. Petitioner testified that she had a GED, but the record showed a BSN (Bachelor of Science in Nursing).

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

9. Petitioner does not have a work history for the 15 years preceding her application.

10. Petitioner has a pending appeal of the Social Security Administration's denial of her disability application.

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 (April 2017), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must

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

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

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

Step One

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

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

Step Two

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration

requirement for SDA means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

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

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the de minimis standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs v Bowen*, 880 F2d 860, 862-863 (CA 6, 1988), citing *Farris v Sec of Health and Human Servs*, 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.

Although there was reference on the record and in the DDS/MRT decision (Exhibit A, p. 21) to Petitioner's SDA application being denied due to her failure to cooperate, the Notice of Case Action sent to Petitioner on October 9, 2019, expressly specified that the SDA application was denied based on a finding that Petitioner was not disabled (Exhibit A, p. 7). The Department did not present any evidence at the hearing to support a finding that Petitioner failed to cooperate. Accordingly, the medical evidence presented at the hearing was reviewed for a disability assessment and is summarized below.

On [redacted], 2017, Petitioner participated in a Disability Determination Examination and the examining doctor prepared a report. The doctor found that there were clinical exam findings that supported Petitioner's complaints of pain related to lupus, cervical radiculopathy, and adrenal insufficiency although it was noted that there were no cervical radicular pain symptoms with any of the exam testing maneuvers. There was

some decreased sensory perception to touch and pressure in the left arm and forearm and moderate limitations to the left hand. Bilateral grip strength was normal. There were limitations in the range of motion of the cervical spine and the right shoulder and flexion of the dorsolumbar spine, but the hip, knee and ankle range of motion was normal. The doctor noted that Petitioner did not use an ambulatory device, could sit and/or stand for at least 30 minutes without complaint, and could stand up from a seated position and get on and off the examination table without difficulty.

Petitioner was hospitalized at [redacted] in Colorado on [redacted], 2018 due to suicidal ideation and was discharged to [redacted] due to medical complications on [redacted], 2018. At the time of discharge, her medical status examination showed constricted affect; non-pressured speech; logical, relevant and goal-directed thought processing; orientation to time, place, person and situation; good attention and concentration; and endorsing suicidality with a plan to hang herself or overdose. (Exhibit A, pp. 446-477, 515-519.) She returned to voluntary inpatient psychiatric treatment at [redacted] on [redacted] 2018, and when she was discharged on [redacted], 2018, it was noted that there was no evidence to support her claims that she was suicidal while she was there. (Exhibit A, pp. 478-513.)

On [redacted] 2018, upon arrival from Colorado to [redacted], Petitioner went to the [redacted] emergency department complaining of abdominal pain and suicidal thoughts. On physical exam, her vital signs were stable, and she was transferred to the psychiatric emergency department. She was admitted to the psychiatric unit on [redacted], 2018. At the psychiatric unit, she was diagnosed with depressive disorder, NOS, and suicidal ideation and borderline personality disorder. She reported sexual assault by her husband in Colorado causing her to flee to Michigan. She indicated that she was last hospitalized in Colorado and attempted suicide while hospitalized. She was diagnosed with mood disorder, PTSD, and cluster b personality disorder. She complained of chronic, diffuse body pain related to her underlying lupus, but, although she consistently endorsed severe psychiatric symptoms and high levels of pain, it was noted that she did not appear overtly depressed, anxious, or uncomfortable. It was noted that she exhibited some medication seeking behavior and had a lengthy history of using medications intended for acute pain management. She was discharged from the psychiatric unit on [redacted], 2018. (Exhibit A, pp. 735-776.)

Petitioner was hospitalized at [redacted] around [redacted], 2018 for suicidal ideation. From [redacted], 2019 to [redacted] 2019, she was hospitalized at [redacted] due to suicidal ideation. She reported having been stable on her home medication but having run out of medications and since then experiencing suicidal ideations. The doctor who performed a [redacted] 2019 physical exam noted chronic neck pain with C2 and C4 damaged disc with a history of motor vehicle accident and a history of upper back and lower back pain and neuropathy in both her arms and feet. The exam showed mildly tender C-spine with normal range of motion; mildly tender thoracic and lumbar spine with normal range of motion; 5/5 motor strength; and intact sensation all over. The doctor expressed concerns of drug abuse and drug

dependence. Petitioner was diagnosed with major depressive disorder, recurrent, severe with questionable psychotic features and borderline personality traits. She was stabilized on psychotropic medications and discharged in stable condition. (Exhibit A, pp. 552-577.)

On [redacted], 2019, Petitioner went to the emergency department at [redacted] complaining of abdominal pain. She returned the next day complaining of continued pain. A CT scan showed colitis. There was also a yeast rash in the perineal area. (Exhibit A, pp. 702-728.)

Petitioner was hospitalized at [redacted] from [redacted] 2019 to [redacted], 2019 with suicidal ideation, reporting an alleged rape by her ex-husband on [redacted] 2019 following several years of domestic violence. She was voluntarily admitted to the inpatient psychiatry unit for safety, medication management and stabilization. Her discharge diagnosis was unspecified mood disorder and unspecified personality disorder with borderline features. (Exhibit A, pp. 600-701.)

Petitioner's medical record includes several visits to the [redacted]

- On [redacted] 2019, she voluntarily admitted herself following an evaluation at the [redacted] after she disclosed increasing suicidal thoughts over the past three days to [redacted] with a plan to overdose on pills. Petitioner reported that she was living in a homeless shelter and was being stalked by her husband, who had raped her twice. The history showed prior admissions at [redacted] from [redacted] to [redacted], 2019, from which Petitioner believed she was discharged too early, and at [redacted] in [redacted] 2018. In addition to diagnosis of depression, borderline personality disorder, bipolar disorder, and PTSD, Petitioner self-reported a motor vehicle accident in 2004 with traumatic brain injury, a history of seizure with the last seizure 6 months ago, lupus, adrenal insufficiency (Addison's), lower back pain, and epilepsy. She complained of muscle and joint pain all over and requested pain medication. In the physical examination, it was noted that her muscle strength was 5/5 and her gait was upright and steady. A psychiatric evaluation found that she was alert and oriented times 3; was appropriately dressed; had intermittent eye contact; was cooperative, engaged, friendly and pleasant; had fluent speech; had linear, coherent, goal-directed speech; denied any auditory or visual hallucinations; and had grossly intact concentration, attention span, and memory. The diagnostic impression was major depressive disorder, recurrent, acute, moderate to severe, with suicidal ideation; PTSD; borderline personality disorder; and history of bipolar disorder. Her anticipated stay was five days, and her prognosis was fair. She was treated. At discharge on [redacted] 2019, it was reported that she was performing activities of daily living without difficulty, sleeping 7 to 8 hours per night, and had a considerably brightened affect. Her suicidal ideation was resolved. Her discharge diagnosis was major depressive disorder, recurrent, acute, moderate to severe with suicidal ideation, improving; PTSD; borderline personality disorder; history of bipolar disorder. Her prognosis was fair to good if she was able to

establish in a community and remain consistent with her providers. Her condition at discharge on [redacted] 2019 was alert and oriented times three; no psychomotor agitation or retardation present; anxiety rating 3/10; bright and cheerful affect; organized, linear, goal-directed thought process; and denying suicidal or homicidal ideation. (Exhibit A, pp. 413-420, 421-424, 426-428, 429-431, 434-437.)

- On [redacted] 2019, she complained of abdominal pain with difficulty keeping food down. It was noted that Petitioner had multiple episodes of lysis of adhesion and extensive abdominal surgeries. A CT scan of the abdomen and pelvis did not show any abnormalities. Petitioner was treated and discharged in stable condition. (Exhibit A, pp. 393-412.)
- On [redacted], 2019, Petitioner complained of nausea, vomiting, and diarrhea with intermittent pain secondary to adhesions. She was treated for dehydration and given medication for the nausea and discharged (Exhibit A, pp. 377-392).
- On [redacted] 2019, she returned to the emergency department and continued to complain of nausea, vomiting and diffuse abdominal pain that had gotten worse over the preceding four days. Her history noted several abdominal surgeries (Roux-en-Y and ensuing complication because the pouch enlarged, cholecystectomy, appendectomy, hysterectomy, and separate oophorectomy (tubal ligation)). An abdominal x-ray showed a significant amount of stool throughout the colon which was potentially the cause for the pain. She was offered a CT scan of the abdomen but declined. She was discharged in stable condition. (Exhibit A, pp. 364-376.)
- On [redacted] 2019, she reported continuing nausea, vomiting and abdominal pain as well as diarrhea since she was given an enema at her last emergency visit. The doctor noted that her appearance did not suggest that she had not eaten or drank in a week as reported. Lab results were unremarkable, and the CT scan showed no acute process. She was advised to schedule a colonoscopy. (Exhibit A, pp. 349-363.) She went to a follow up at the [redacted] general surgical care and complained of feeling bloated and requesting a referral to pain management. A colonoscopy was performed, which revealed no evidence of diverticulosis, diverticulitis, polypoid tissue, vascular abnormalities, or active bleeding. (Exhibit A, pp. 330-348.)
- On [redacted] 2019, she complained of abdominal pain and cramping, with some nausea and cramping. An EKG showed sinus tachycardia. A CAT scan did not show any signs of acute abnormality other than colonic spasm on the left which may have caused her symptoms. (Exhibit A, pp. 308-329.)
- On [redacted] 2019, she complained of abdominal pain and was found to have a urinary tract infection (Exhibit A, pp. 297-307).
- On [redacted] 2019, she complained of a bladder infection with lower back pain. She was treated for yeast vaginitis and discharged. (Exhibit A, pp. 289-296.)
- On [redacted] 2019, she was transported via EMS, complaining of a seizure. She stated she had run out of her antiseizure medication and had stretched out her medication for lupus and adrenal insufficiency and sought a medication refill and relief from her headache following the seizure. The treating physician noted no obvious external injury and doubted any intracranial process. Her prescriptions were refilled. (Exhibit A, pp. 278-288.)

On [redacted], 2019, Petitioner presented for her initial intake at [redacted] but she was discharged from services on [redacted] 2019 for failure to participate. (Exhibit A, pp. 525-545.)

Petitioner requested a pain management referral on [redacted] 2019. At the visit, the doctor noted left ulnar 1 1/2 digit paresthesia and a bmi (body mass index) of 46.95 kg/m2. (Exhibit A, pp. 594-598.)

Following a [redacted] 2019 intake interview with [redacted], Petitioner had an initial BPS assessment on [redacted] 2019. She reported having resided in a domestic violence shelter but then having an apartment. She stated having no relationships with family, being physically abused and exposed to substance abuse by her father, being sexually abused during her childhood, having a diagnosis of PTSD, and having days she was unable to get out of bed. She presented with impaired judgment with thoughts of suicide which she was able to manage at the time. (Exhibit A, pp. 61-71, 196-204, 240-252, 254-271). Petitioner continued to meet with her caseworker on [redacted] 2019 (Exhibit A, pp. 224-226, 233-239). At the [redacted] meeting she was angry at the worker because she was not hospitalized and had no medication but then had inconsistent statements about what medication she was taking (Exhibit A, p. 234). Petitioner did not respond to calls on July 8, 9, 12, and 15 (Exhibit A, pp. 236-239).

On [redacted], 2019, Petitioner underwent a psychiatric evaluation and a report was prepared. Petitioner reported a long history of a mood disorder and trauma as well as multiple medical problems for which she planned to visit a rheumatologist and endocrinologist. She reported being currently in a domestic violence situation and having a history of multiple suicide attempts and multiple medical problems. She also reported being hospitalized six months out of the last year for suicide ideation, with her last hospitalization in [redacted] 2019. With respect to the mental status examination, it was noted that Petitioner was pleasant and cooperative, appropriately attired with good grooming and hygiene, had good range of affect, and displayed no evidence of psychomotor agitation or retardation. She was alert and oriented times three. Her memory appeared grossly intact. She denied hallucinations and suicidal or homicidal ideation or plan, and there was no evidence of delusions or of a formal thought disorder. It was also noted that she did not have any gait abnormalities. The diagnosis was major depressive disorder, recurrent episode, severe; borderline personality disorder; and PTSD. (Exhibit A, pp. 227-232.)

Notes from Petitioner's [redacted] 2019 medication review at [redacted] showed that Petitioner's assessment was for major depressive disorder, severe; borderline personality disorder; and PTSD. In the mental status examination, she was found to be pleasant and cooperative, appropriately attired with good grooming and hygiene. She described her mood as "fair," her affect showed good range, and her eye contact and interest were good. Her memory appeared grossly intact, and she was alert and oriented times three. She denied hallucinations, and there was no evidence of delusions or of a formal thought disorder. She denied suicidal or homicidal ideation or plan. DBT

(dialectical behavioral therapy) was recommended to her. The records noted that Petitioner's LOCUS functional assessment score as of [redacted] 2019 was 24. (Exhibit A, pp. 177-180.)

Petitioner's record included visits with [redacted] Notes from a [redacted] 2019 visit showed that Petitioner requested evaluation and treatment for chronic headaches and aching, gnawing, throbbing pain in the thoracic and cervical muscle region. She reported a history of Addison's disease for which she was taking steroids. She also reported that she had previously undergone multiple cervical facet injections as well as radiofrequency ablation of the third occipital nerve which she stated were helpful. Her medical history included chronic lupus, morbid obesity, OSA (obstructive sleep apnea), and seizure. The doctor reviewed a [redacted] 2015 MRI of the cervical spine that showed mild multilevel disc desiccation and disc bulge, no spinal stenosis, no neural foraminal narrowing at any level, and normal spinal cord signal. A [redacted] 2015 cervical spine x-ray showed mild anterolisthesis of C3 on C4 with evidence of ligamentous instability with flexion and extension. The physical exam showed that range of motion of the c-spine was limited due to pain and motor strength was 5/5. The doctor concluded that Petitioner's pain was due to chronic myofascial pain involving the neck and upper back region and cervical facet arthropathy. (Exhibit A, pp. 210-217.)

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 Three

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

Based on the medical evidence presented in this case, listings 1.04 (disorders of the spine), 9.00 (endocrine disorders), 12.04 (depressive, bipolar and related disorders), 12.08 (personality and impulse-control disorders), 12.15 (trauma- and stress- related disorders), and 14.02 (systemic lupus erythematosus) 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). Where the evidence establishes a medically determinable mental impairment, the degree of functional limitation must be rated, taking into consideration chronic mental disorders, structured settings, medication, and other treatment. The effect on the overall degree of functionality is evaluated under four broad functional areas: (i) understand, remember, or apply information; (ii) interact with others; (iii) concentrate, persist, or maintain pace; and (iv) adapt or manage oneself. 20 CFR 416.920a(c)(3). A five-point scale is used to rate the degree of limitation in each area: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. 20 CFR 416.920a(c)(4).

In this case, Petitioner alleges both exertional and nonexertional limitations due to her medical condition. Petitioner testified that she could dress herself and care for her personal hygiene. She could prepare meals but was limited in her ability to do chores due to her depression. She could shop but had problems pushing the shopping cart or lifting heavy bags. She could not squat or kneel because of the pain in her knees. She had no problem using her hands or climbing stairs, but she could stand only up to 10 minutes because of her knee pain and could not reach overhead due to her shoulder pain. She stated she could only walk 300 to 400 feet and regularly used a walker. She testified that she was forgetful and had difficulty concentrating due to her depression. She could follow instructions but had difficulty working with others, particularly men.

A two-step process is applied in evaluating an individual's symptoms: (1) whether the individual has a medically determinable impairment that could reasonably be expected to produce the individual's alleged symptoms and (2) whether the individual's statement about the intensity, persistence and limiting effects of symptoms are consistent with the objective medical evidence and other evidence on the record from the individual, medical sources and nonmedical sources. SSR 16-3p.

The record supports Petitioner's diagnosis of lupus, cervical radiculopathy and adrenal insufficiency, as well as obesity and seizure. Petitioner is prescribed steroids for her lupus. The [redacted] 2015 cervical spine MRI and x-ray reviewed by the pain management doctor on [redacted], 2019 showed mild multilevel disc desiccation and disc bulge, no spinal stenosis, no neural foraminal narrowing at any level, and normal spinal cord signal and mild anterolisthesis of C3 on C4 with evidence of ligamentous instability with flexion and extension. Although there was some ulnar paresthesia identified by the doctor at the [redacted], 2019 doctor visit, a [redacted], 2019 physical exam showed 5/5 muscle strength and upright and steady gait. Petitioner's testimony showed that she could care for her personal needs and that limitations with respect to her performing chores were due to depression rather than a physical inability to perform them. In light

of the medical evidence, as well as Petitioner's testimony, 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 light work as defined by 20 CFR 416.967(b).

Petitioner also alleged nonexertional limitations due to her mental impairments. The record supports Petitioner's testimony that she had six hospital admissions due to suicidal ideation between [redacted] 2018 to [redacted] 2019 during which time she was homeless and fleeing from her abusive husband. Although Petitioner has mental health diagnosis and has a history of suicidal ideation, her hospitalizations appear to be tied to her circumstances at the time, when she was fleeing an abusive husband and was homeless. In a J[redacted], 2019 psychiatric evaluation, she was diagnosed with major depressive disorder, severe; borderline personality disorder; and PTSD, but the examiner observed that Petitioner was pleasant and cooperative, appropriately attired with good grooming and hygiene, had good range of affect, displayed no evidence of psychomotor agitation or retardation, and did not have any gait abnormalities. She was alert and oriented times three. Her memory appeared grossly intact. She denied hallucinations and suicidal or homicidal ideation or plan, and there was no evidence of delusions or of a formal thought disorder. It was noted that Petitioner had procured housing in the month before the evaluation. Based on the medical record presented, and taking into consideration Petitioner's testimony, Petitioner has limitations on her mental ability to perform basic work activities as follows: mild limitations in her ability to understand, remember or apply information; moderate limitations in her ability to interact with others; mild to moderate limitations in her ability to concentrate, persist, or maintain pace; and mild limitations in her ability to adapt or manage herself. Because her lupus limited her shoulder range of motion, Petitioner was also limited in her ability to reach overhead.

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 identified no past relevant work in the 15 years prior to the application. Because she cannot be assessed for her ability to perform past relevant work, she cannot be found disabled, or not disabled, at Step 4, and the assessment continues to Step 5.

Step 5

If an individual is incapable of performing past relevant work, Step 5 requires an assessment of the individual's RFC and age, education, and work experience to determine whether an adjustment to other work can be made. 20 CFR 416.920(a)(4)(v); 20 CFR 416.920(c). If the individual can adjust to other work, then there is no disability; if the individual cannot adjust to other work, then there is a disability. 20 CFR 416.920(a)(4)(v).

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

When the impairment(s) and related symptoms, such as pain, only affect the ability to perform the exertional aspects of work-related activities, Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix 2, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). However, if the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2). 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 42 years old at the time of application and 43 years old at the time of hearing and, thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. She has a GED but no work history. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform light work activities. Based solely on her exertional RFC, the Medical-Vocational Guidelines, 202.2, 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 mild limitations in her ability to understand, remember or apply information; moderate limitations in her ability to interact with others; mild to moderate limitations in her ability to concentrate, persist, or maintain pace; and mild limitations in her ability to adapt or manage herself. Petitioner also has limitations to reaching overhead due to limited shoulder range of motion. It is found that those limitations would not preclude Petitioner from engaging in simple, unskilled work activities on a sustained basis requiring light or sedentary exertional demands. Therefore, Petitioner is able to adjust to other work and is not disabled at Step 5.

DECISION AND ORDER

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.

Accordingly, the Department's determination is **AFFIRMED.**

ACE/tm

Alice C. Elkin
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

(Via Email: MDHHS-906EUHearings@michigan.gov)
Andrea Stevenson (Chippewa DHHS)
463 East 3 Mile Rd.
Sault Ste. Marie, MI 49783

Petitioner

[redacted]

cc: SDA: L. Karadsheh
AP Specialist (1)