[redacted]
[redacted], MI [redacted]

Date Mailed: July 29, 2020
MOAHR Docket No.: 20-002796
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 three-way hearing was held on May 26, 2020, from Clawson, Michigan. The Petitioner was represented by herself. The Department of Health and Human Services (Department) was represented by Brad Reno, Hearing Facilitator.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. A DHS 49 Medical Examination Report was received from Dr. [redacted] and marked into evidence as Exhibit B; Medical records were received from [redacted] and marked into evidence as Exhibit C. The record closed on June 29, 2020, 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 March 9, 2020, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program citing rule 202.13 (Exhibit A, pp.).

3. On March 10, 2020, the Department sent Petitioner a Notice of Case Action denying the application based on DDS' finding of no disability (Exhibit A, pp. 1932-1936).

4. On March 18, 2020, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 4-5).

5. Petitioner alleged disabling impairment due to a cerebral spinal fluid leak and surgery, cranial hypotension, Glaucoma, severe daily migraine headaches, high blood pressure, obesity and osteoarthritis in the back and bilateral knees. The Petitioner did not allege in her original November 4, 2019 application any mental impairments. On appeal to of her disability claim with the Social Security Administration, the Petitioner also added a new mental impairment claim of panic attacks and anger issues. Exhibit A, pp.28-35. It appears DDS may have considered the mental impairment claim. Notes indicate at initial claim denial no mental impairment was alleged. See p. 38 part I

6. On the date of the hearing, Petitioner was [redacted] years old with a [redacted], 1967 birth date, Petitioner is now [redacted] years of age; she is [redacted]' [redacted]" in height and weighs about [redacted] pounds with a BMI of 47.5.

7. Petitioner is *a* high school graduate with a Bachelor's Degree in Business Administration.

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

9. Petitioner has an employment history of work as a Direct Support Professional for individuals who are mentally challenged assisting in activities of daily living, including laundry, serving food, cleaning, and assisting with consumer care and behavioral assistance as needed to redirect behavior. Petitioner also worked as a [redacted] convenience and gas station cashier responsible for customer service, restocking shelves, and general cleaning of facility outside. The Petitioner also was a patient caregiver in an assisted living facility providing all aspects of client care. Petitioner was also a support specialist at a youth homeless shelter.

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

CONCLUSIONS OF LAW

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/not disabled for purposes of the MA and/or the SDA benefit program.

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

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

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

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

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

Step 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, s/he is not ineligible under Step 1, and the analysis continues to Step 2.

Step Two

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for SDA means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

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

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the de minimis standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs v Bowen, 880 F2d 860, 862-863 (CA 6, 1988), citing Farris v Sec of Health and Human Services, 773 F2d 85, 90 n.1 (CA 6, 1985).* A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28. If such a finding is not clearly established by medical evidence or if the effect of an impairment or combination of impairments on the individual's ability to do basic work activities cannot be clearly determined, adjudication must continue through the sequential evaluation process. *Id.; SSR 96-3p.*

The medical evidence presented at the hearing, *and in response to the interim order,* was reviewed and is summarized below.

Petitioner described the following symptoms. She has facial pain and pain on the right side of her head and faces and cannot sit or stand a long time. She has rapid heart beat and is assisted with household chores and cooking by her family and has interrupted sleep due to pain and uses a walker.

On July 18, 2019 Petitioner was seen in the ER due to chest pain. Her testing work up was negative and she was to follow up outpatient. The CT of the chest was unremarkable without definite evidence for pulmonary embolism. Chest x-ray was normal.

On July 23, 2019 the Petitioner was seen by her ophthalmologist due to eye pressure and was diagnosed with open angle glaucoma. At a prior visit the glaucoma condition was stable. On further testing a gonioscopy determined the primary open angle glaucoma for the right eye was severe. An increase in medications was ordered due to increased pressure. The left eye was moderate stage. When seen in August 2019 after sinus surgery right sided headaches were present and in right eye. Petitioner had a laser treatment on her right eye to reduce the pressure.

Petitioner saw a neurologist on June 1, 2019 for headaches accompanied with nausea without photophobia or phonophobia with retroorbital pain with eye movement. An MRI of the brain demonstrated low suspicion for infectious process/headache etiology was associated with cerebral spinal fluid (CSF) leak. No abnormalities seen with normal attention and concentration, normal speech and language, fund of knowledge and recent and remote memory intact.

Petitioner was seen by her primary care doctor on June 17, 2019 at which time notes indicate CFS resolved but Petitioner had ongoing symptoms of headache, joint swelling and neck pain. Notes indicate that headache is a chronic problem and reports sharp and throbbing pain. Osteoarthritis of the bilateral knees was diagnosed and joint swelling noted during physical exam. Both right and left knees had decreased range of motion and swelling with crepitus and clicking. Petitioner was to be seen back in two weeks and referral to PT for bilateral knee pain. On July 17, 2019 she was seen again for headache and advised to follow the hospital discharge plan and follow up due to her CFS surgery. Petitioner was first referred to a cardiologist in January 2019 by her primary care doctor. She was admitted for testing and observation on January 12, 2019. Petitioner did not stay for a scheduled stress test and left without testing. Petitioner had been scheduled a month earlier for a stress test and when she reported the treadmill was broken and could not complete the test.

On January 12, 2019 Petitioner had a chest x-ray due to chest pains which showed no acute disease. On January 14, 2019 a normal EKG was taken and the myocardial perfusion study results indicated no fixed or reversible perfusion defect seen with normal wall motion and 55% ejection fraction. A CTA of the chest, abdomen and pelvis was performed and noted no aneurysm or dissection, with major airway patent with no pleural or pericardial effusion. The kidneys were enlarged with multiple hypodensities identified as probable cysts suggesting polycystic kidney disease.

On May 30, 2019 the Petitioner had an MRI of the head. The result noted no acute stroke, benign intracranial hypertensions, no intracranial hemorrhage, no mass or abnormal enhancement and moderate right sphenoid sinus disease present. A CT performed on May 24, 2019 during a one day admission due to nasal drainage and headache, showed no acute stroke, with moderate mucosal thickening in the right sphenoid sinus. A CT of the face was also performed and showed soft tissue or fluid density opacification in the right portion of the sphenoidal sinus and frontal sinuses are hypoplastic. The diagnosis was acute non intractable headache with acute non recurrent sphenoidal sinusitis. Petitioner was given a beta 2 transferrin test to determine if the symptoms were CFS. The case history as of May 31, 2019 noted arthritis, chronic pain both knees, heart murmur, hyperlipidemia, hypertension, hyperthyroidism, obesity and osteopetrosis acro-osteolytica. Notes indicate that Petitioner was admitted to the hospital due to non intractable headache. Petitioner was to follow up with neurology and be seen by an ENT specialist in regards to CFS leak and the neurologist recommended further workup. MRI showed right sphenoid sinusitis as did CT scan with suspicion of defect of the bone of the roof of the right sphenoid sinus. Petitioner was transferred to U of M hospital in Ann Arbor. Petitioner had originally presented with this problem on January 12, 2019 with her primary care doctor and then went to the emergency department Petitioner was in addition to undergo a stress test and cardiology consult.

Petitioner was seen for a otolaryngology consult for CFS leak on June 4, 2019 and reported severe headache controlled with pain medications and positive CFS leak.

On June 13, 2019, Petitioner was seen for a consult with an Otolaryngologist (ENT). A CT showed opacification of the right sphenoid sinus, positive for CFS leak with runny nose and severe headaches with blurry vision when severe. On this date the Petitioner had an in-patient endoscopic repair of right sphenoid sinus cerebrospinal fluid leak, a right maxillary antrostomy, right total ethmoidectomy, right sphenoidotomy with removal of tissue. The following day the notes indicate that Petitioner was ambulating without evidence of CFS leak. She was discharged the following day with an additional referral for physical therapy (PT) for sore bilateral knees. At a post-op visit on June 28, 2019 Petitioner reported fatigue, and right sided headaches with bilateral finger tingling and expressed feeling woozy frequently and thought it might be the medications. At the check up the doctor perform a nasal endoscopy with debridement. Crusts, clots and debris were removed from right nasal cavity and all right paranasal sinus ostia were widely patent upon completion of debridement of right obstructing sphenoid crust and glue were carefully removed. The left sinus was clear. Petitioner was also referred to a neuro-optho. The Petitioner had a 3 day hospital stay.

Petitioner was seen on June 17, 2019 for hypertension and osteoarthritis of the bilateral knees with pain and radiating neck pain. The exam notes indicate normal range of motion of the neck with heart exam normal rate and rhythm. Petitioner had decreased range of motion in the bilateral knees, decreased range of motion and pain in cervical spine, crepitus in joints with mild clicking with no neurological deficits noted.

Petitioner was seen in the ER on July 18, 2019 with complaints of chest pain described as dull, aching, midsternal pain with shortness of breath and heart described as beating out of her chest. Petitioner describes chest pain occurring on a daily basis. There was no headache present. She had an EKG done at her primary care doctor's office that day and noted junctional tachycardia with a heart rate in the 140-150 range. On examination, tachycardia was present. Due to her existing conditions and moderate risk of pulmonary embolism (PE) and ACS cardiac labs were to be obtained and a CT for PE and reviewed for further cardiac consult and management. Petitioner was also seen in January 2019 for the same issue. The CT of the chest showed no evidence of PE. Petitioner chose to follow up with a cardiologist for an appointment.

On July 30, 2019 the Petitioner completed a form for Social Security Administration with complaints of headaches, facial pain and inability to sit/stand for any length of time. Also noted rapid heartbeat and pain on the right side of head and face. The Petitioner indicated she could shower and laid in bed for most of the day because of head pressure with several naps daily. The form also indicates Petitioner noted interrupted sleep due to pain waking her up and difficulty falling asleep. She also reported her personal care takes longer. Her meals were prepared by either her mother or her daughter. She also noted her daughter or grandson helps her with all the household chores and light cleaning and laundry. The form indicates that Petitioner is able to drive short distances only and does not do her grocery shopping as it is done by her daughter. She has contact with others by phone or in person and does attend church two times a month. Petitioner checked all of the following as affected due to her disabilities including lifting, squatting, bending, standing, reaching, walking, sitting, kneeling, stairclimbing, seeing, memory, concentration, and understanding. She also noted blurry vision and tingling in her hands and feet. The Petitioner could walk ½ block and then required a 15 minute rest and could pay attention for 10 to 20 minutes. She also noted an unusual fear of getting hit in the head or an accident. At the time Petitioner reported using a walker whenever she was out of bed and indicated it was prescribed in June 2019.

Petitioner was seen two weeks post operation for repair of CFS leak. Patient notes indicate she was doing ok with headaches on the right side. Also noted were some tingling in bilateral fingers.

Petitioner was seen on August 6, 2019 by her primary care doctor due to continued headaches. The notes describe headaches as a chronic problem occurring daily with onset more than one year ago. Pain is described as aching, sharp and throbbing. Current pain is described as moderate. Other chronic problems were obesity and vitamin D deficiency. Petitioner was counseled on healthy eating. Petitioner was negative for dizziness, syncope, weakness and numbness. On examination, the Petitioner exam was normal with no musculoskeletal edema. The Assessment was CSF Leak from nose, persistent headaches, hyperlipidemia, and obesity. The Plan was to refer the Petitioner to neurology for headaches and Vitamin D therapy.

Petitioner received SLT laser treatment for glaucoma on her right eye on August 20, 2019 and appears the pressure in the eye was reduced as well as the pressure in her left eye.

On July 18, 2019 the Petitioner was seen in the ER for complaints of shortness of breath and otherwise normal findings, with normal breath sounds and perfusing well to bilateral extremities with a CT of the chest negative.

On September 1, 2019 the Petitioner presented to the ER for headaches without relief from home medications. The Petitioner reported ongoing headaches for the last several months and is currently seeing a neurologist and she was to follow up with neurology if the CT exam was negative. The CT exam was otherwise normal. Petitioner's BMI was 47.55.

On October 22, 2019 the Petitioner presented for a consultative medical examination with complaints of headaches and dizziness. Notes indicate that Petitioner reported she was able to drive short distance, perform only some light housework and shopping. She could sit 30 minutes, stand 15 minutes, walk 1.2 blocks, lift 5 pounds and her weight was 260. Petitioner exhibits diminished air entry, with otherwise clear lung sounds, and normal heart rate and rhythm. These was no joint laxity found, crepitance or effusion in any joint. There was synovial thickening in bilateral knees, grip and dexterity was unimpaired. Petitioner could heel toe walk and stand on either foot for 3 seconds and perform a modified differential squat. There was synovial thickening at bilateral knees. Straight leg raising was absent, with mildly reduced cervical and lumbar range of motion, decreased flexion in the bilateral knees. The cervical range of motion was diminished for flexion, extension and right and left rotation. Range of motion in the dorsolumbar spine were diminished as were flexion in her bilateral knees. The conclusion of the exam also noted the CSF leak was the most significant ailment noted and whether she has hydrocephalus is possible, but not diagnosed. No neurological deficits were found during the exam. The notes indicate there was diminished range of motion to her cervical and lumbar spine attributed to deconditioning. Based on the examination continued neurological monitoring would be indicated. Petitioner's gait was guarded. The examiner concluded a walker was not necessary. Notes indicate the Petitioner needed assistance with squatting and arising and noted moderate difficulty as well climbing stairs. She could push less than 10 pounds and gait was guarded.

On October 22, 2019 an x-ray of cervical spine was taken with no abnormalities seen with well maintained disc spaces and no significant end plate spurring or eburnation.

The Petitioner was seen on November 4, 2019 by her neurologist regarding right sided headache.

Petitioner was seen on June 1, 2019 for a Neurological consult and demonstrated normal attention and concentration, speech and language as well as fund of knowledge, with memory, recent and remote intact. No psychological complaints were reported.

On October 22, 2019 the Petitioner had a consultative examination for her mental status. The exam was normal with memory intact, judgment and insight were appropriate, and memory was intact.

On November 15, 2019 Petitioner was seen by her mental health provider and expressed anger towards her mother, family and friends, decreased sleep, weight gain, occasional crying spells, and homicidal thoughts, difficulty controlling frustration, anxiety with fear that something bad will happen if she leaves her house. Petitioner reported no mental health treatment in 10 years. Petitioner said she feels more comfortable when secluding herself, but does go to church 1 or 2 times monthly. The notes indicate appearance and mood were normal, patient was cooperative with normal speech and calm behavior, with normal thought content but somewhat paranoid with some persecutory thoughts. The diagnosis was panic attacks, agoraphobia, and Major Depressive disorder.

On February 25, 2020 the Petitioner had a mental status exam arranged for by DDS. Petitioner described panic attacks due to fear of another CFS leak occurrence and heart racing. Petitioner described poor sleep and lack of appetite. Petitioner reported that she spends most of her time in bed on her phone playing games. She can complete simple chores and laundry but does not lift more that 5 pounds. Petitioner attends church twice a month and shops for food once a month. She can make a sandwich and tend to self-care and generally stays at home. The examiner noted low self-esteem, poor concentration and focus, fair insight, noted fatigue and organized thoughts. The examiner concluded that Petitioner was able to understand, remember and complete simple and repetitive tasks. The tasks may be completed at a mildly decreased rate of pace. In regard to complex tasks, Petitioner may complete them at a moderately decreased rate of pace due to fatigue and low motivation supported by depression. Panic attacks could spontaneously impact simple to complex tasks completion. We can expect a high level of absenteeism. Petitioner expressed suicidal ideation with no plan and presented with depressed mood. The prognosis was guarded.

DDS notes Petitioner attended mental health treatment appointment for service on December 6, 2019 at Catholic Services and her conditions was described as moderate.

The Petitioner's primary care doctor, a doctor of internal medicine, completed a Medical Examination Report on June 15, 2020. The doctor has treated the Petitioner since December 10, 2018. The current diagnosis was chest pain, CFS leak, headache, chronic pain in both knees, heart murmur, hypertension and obesity. The examination noted shortness of breath and heart murmur with sinus brachy cardia. The musculoskeletal review noted osteoarthritis of bilateral knees and osteopetrosis arco-osteolytica. The doctor imposed the following limitations and noted the Petitioner was improving. The Petitioner could not lift less than 10 pounds frequently. Assistive devices were not required. The doctor did not check or respond as to whether Petitioner had standing or sitting limitations. The doctor limited Petitioner's ability to use both hands for all activities including simple grasping, reaching, pushing/ pulling and fine manipulating and noted she was unable to use foot controls. The Medical Findings

noted that the doctor opined that when conditions flare up, the Petitioner is unable to perform all job duties. The doctor noted no mental limitations and that Petitioner could meet her needs in the home.

The Petitioner was seen by her eye doctor on March 18, 2020 and noted that her glaucoma (primary open angle) was moderate and the doctor stressed that compliance with eye drops is necessary to prevent further loss of vision, due to nerve fibre tissue. Petitioner also had cataracts which will require surgery at some point. Petitioner also has dry eye syndrome.

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 1.02, major dysfunction of a joint(s) due to any cause; 1.04 Disorders of the Spine; 4.04 Ischemic Heart Disease; 12.04 Depressive, bipolar and related disorders and 12.06 Anxiety and Obsessive-compulsive disorders were considered. The medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

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

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). This includes

consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities*. 20 CFR 416.929(c)(3).* The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, 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 conditions. Petitioner testified that she could stand 15 minutes, but experiences dizziness due to her chronic headaches, she could walk one half block, can sit several hours. The Petitioner could not perform a squat, is able to dress and shower by herself, can bend forward at the waist, can touch her toes, has difficulty climbing stairs, and is restricted by her doctor from carrying more than 10 pounds due to her cerebral fluid operation. Petitioner testified that her hands also cramped although she has not yet consulted a doctor about the problem. The Petitioner does not use a cane or a shower chair. She can climb the 5 stairs to her apartment but does have some difficulty climbing stairs and is also obese with BMI of 47.5. Petitioner also has a pain level of 8 due to her migraine headaches which she described as occurring daily. Petitioner's Primary Care Doctor has also imposed physical limitations which include inability to lift less than 10 pounds frequently. Assistive devices were not required. The doctor did not check or respond as to whether Petitioner had standing or sitting limitations. The doctor limited Petitioner ability to the use of both hands for all activities including simple grasping, reaching, pushing/ pulling and fine manipulating and noted she was unable to use foot controls. The Medical Findings noted that when conditions flare up the Petitioner is unable to perform all job duties. The doctor noted no mental limitations and that Petitioner could meet her needs in the home. The Petitioner also recently began treatment for depression and anxiety.

An October 2019 Consultative physical exam concluded range of motion in the dorsolumbar spine were diminished as were flexion in her bilateral knees. The conclusion of the exam also noted the CSF leak was the most significant ailment noted and whether she has hydrocephalus is possible, but not diagnosed. The notes indicate there was diminished range of motion to her cervical and lumbar spine attributed to deconditioning. Based on the examination continued neurological monitoring would be indicated. Petitioner's gait was guarded. The examiner concluded a walker was not necessary. Notes indicate the Petitioner needed assistance with squatting and arising and noted moderate difficulty as well climbing stairs. She could push/pull less than 10 pounds.

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

With respect to Petitioner's exertional limitations, it is found based on a review of the entire record that Petitioner maintains the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a). The Petitioner's obesity was also a consideration to a determination of her residual functional capacity.

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has depression and anxiety, and began receiving services through Catholic Services in December 2019. The Petitioner's recent treatment and lack of treatment records would support a mild to moderate limitation with respect to Depression and anxiety. A Mental Status consultative exam February 2020 concluded Petitioner had low self-esteem, poor concentration and focus, fair insight, noted fatigue and organized thoughts. Petitioner expressed suicidal ideation with no plan and presented with depressed mood. The prognosis was guarded.

Also Petitioner did not list any limitations due to her mental ability to perform basic work activities and did not claim disability based on depression and anxiety in her application and recently added these mental impairments at the time of her request for review/appeal. The DDS ordered a recent consultative mental status exam referred to above.

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

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

Step Four

Step 4 in analyzing a disability claim requires an assessment of Petitioner's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed by Petitioner (as actually performed by Petitioner or as generally performed in the national economy) within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1) and (2). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner's work history in the 15 years prior to the application consists of work most recently as a Direct Support professional for individuals who are mentally challenged and who live in a residential care facility assisting in activities of daily living, including laundry, serving food, cleaning, and assisting with consumer care and behavioral assistance as needed to redirect behavior. Petitioner last worked on May 28, 2019. In this position she was required to supervise consumers with mental challenges, including redirecting behaviors harmful to the consumer and others, serving meals, driving consumers to activities, doing laundry and managing 12 consumers with another direct

support employee. Petitioner also drove consumers to activities. In this position the Petitioner was required to perform light physical exertion standing 2 hours and walking two hours and sitting for 2 hours. She frequently lifted 10 to 15 pounds. Petitioner also worked as a Speedway cashier responsible for customer service, restocking shelves, and general cleaning of facility outside. In this job Petitioner testified that she was on her feet most of the day and had to restock shelves sometimes moving/carrying boxes weight up to 50 and on average 10 to 20 pounds. In this position, Petitioner was required to perform light physical exertion. The Petitioner also was a patient caregiver in an assisted living facility providing all aspects of client care including bathing, and transferring residents and was on her feet much of the day. In this position, the Petitioner was required to perform medium physical exertion due to patient transfers. See Exhibit A, Part 2 pp. 490

Based on the RFC analysis above, Petitioner's exertional RFC limits her to no more than sedentary work activities. As such, Petitioner is incapable of performing past relevant work. Petitioner also has mild to moderate limitations in her mental capacity to perform basic work activities. In light of the entire record, it is found that Petitioner's nonexertional RFC does not prohibit her from performing past relevant work.

Because Petitioner is unable to perform past relevant work, Petitioner cannot be found disabled, or not disabled, at Step 4, and the assessment continues to Step 5.

Step 5

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

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

When 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).

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 52 years old at the time of application and is currently 53 years old, and, thus, considered to be closely approaching advanced age (age 50-54) for purposes of Appendix 2. She is a high school graduate and has a Bachelor's Degree in Business Administration with a history of work experience as a caregiver at an assisted living facility, a cashier and a caregiver to mentally impaired individuals. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities.

In this case, the Medical-Vocational Guidelines result in a disability finding based on Petitioner's exertional limitations in accordance with Medical-Vocational Guidelines, Appendix 2, Rule 201.12.

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 **disabled** for purposes of the SDA benefit program.

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 July 2021.

LMF

Lynn M. Ferris
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

Via Email:

MDHHS-Genesee-Union-Hearings
BSC2 Hearing Decisions
L. Karadsheh
MOAHR

Petitioner – Via First-Class Mail:

[redacted], MI [redacted]