STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

GRETCHEN WHITMER
GOVERNOR

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, MI

Date Mailed: August 14, 2020
MOAHR Docket No.: 20-003049
Agency No.:
Petitioner:

ADMINISTRATIVE LAW JUDGE: Zainab A. Baydoun

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250. After due notice, a telephone hearing was held on June 17, 2020, from Detroit, Michigan. Petitioner appeared for the hearing and was represented by her attorney, Victoria Wolcott. The Department of Health and Human Services (Department) was represented by Assistant Attorney General (AAG) Chantal Fennessey, who solicited testimony from Angela Clark, 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. Petitioner's attorney submitted additional records which were received, marked, and admitted into evidence as Exhibit 2. The record was subsequently closed on July 20, 2020 and the matter is now before the undersigned for a final determination on the evidence presented.

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 or around 2019, Petitioner submitted an application seeking cash assistance benefits on the basis of a disability.

2. On or around March 23, 2020, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. (Exhibit A, pp. 12-36)

3. On or around March 27, 2020, the Department sent Petitioner a Notice of Case Action denying her SDA application based on DDS' finding that she was not disabled. (Exhibit A, pp. 7-9)

4. On April 27, 2020, Petitioner submitted a timely written Request for Hearing disputing the Department's denial of her SDA application.

5. Petitioner alleged disabling impairments due to carpal tunnel syndrome (CTS) bilateral hip pain, cervicalgia, bunions on both feet, right and left shoulder pain, back pain, right knee pain, high blood pressure, asthma, osteoarthritis, gastroesophageal reflux disease (GERD), bipolar disorder, depression and anxiety.

6. As of the hearing date, Petitioner was ██ years old with an ██████ 1972 date of birth; she was ███ and weighed ███ pounds.

7. Petitioner completed high school and has employment history of various factory jobs, and most recently, in 2013, as a packager.

8. Petitioner has a pending disability claim with the Social Security Administration (SSA).

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 Health and Human Services Reference Tables Manual (RFT).

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 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 thoroughly reviewed and is briefly summarized below.

An after-visit summary from Petitioner's appointment with Promedica Physicians Neurosurgery with Dr. Reinard on [redacted], 2019 indicates that she was being treated for chronic pain of both shoulders and neck pain. Petitioner was receiving cervical injections for pain and was referred to an orthopedic surgeon, Dr. Assenmacher for evaluation. (Exhibit A, pp. 73-76)

On [redacted] 2019, Petitioner underwent a spinal corticosteroid injection as treatment for her back pain. (Exhibit A, pp. 78-87).

On October 28, 2019, Nick Wilson, PA-c, authored a letter indicating that Petitioner suffers from multiple painful musculoskeletal concerns and is unable to work at this time due to these issues. (Exhibit A, pp. 88)

Records from Petitioner's [redacted], 2020 consultative examination with Dr. Quereshi indicate that among other impairments, Petitioner was being treated for carpal tunnel syndrome, joint pain, and fibro myositis. Notes indicate that Petitioner has a history of neck and back pain that radiates to the right leg, foot pain and surgery for bunions, shoulder pain, depression, and anxiety. It was noted that Petitioner had nausea and abdominal pain due to GERD and while there was no muscle weakness or swelling in the extremities, she had muscle aches, arthralgias/joint pain, and back pain. Physical examination showed bony deformity in the musculoskeletal examination as well as halas valgus deformity. She was observed to have a resting tremor in her right hand.

She was diagnosed with myofascial pain, osteoarthritis, depressive disorder, and generalized anxiety disorder. (Exhibit A, pp.161 – 170)

On [redacted] 2020, Petitioner underwent a consultative Psychiatric/Psychological evaluation, during which she reported suffering from pain in her shoulders, hips, back, neck, wrists, and knees. She also reported struggling from depressive symptoms that have been present most of her life. She suffers from feelings of worthlessness, thoughts of suicide, and difficulty with motivation. She is isolated and rarely leaves her home, struggling with anhedonia, decreased concentration, sleep disturbances, and irritability. At the time of the evaluation, Petitioner was taking several medications including trazodone, tramadol, baclofen, HCTZ, atorvastatin, promethazine, pantoprazole, lamotrigine, sertraline, minocycline, alprazolam, oxybutynin, and albuterol. History of psychiatric inpatient hospitalization was noted in 2013 and 2015. Petitioner had been attending mental health treatment for most of her life and reported having undergone carpal tunnel release, foot surgery and tubal ligation. She was last employed in 2013 as a production worker at a factory but stopped because pain in her hands after three months. Petitioner's mood was noted to be depressed during the evaluation and she appeared to be in contact with reality. When asked how she felt about herself, she replied "worthless." Petitioner denied any presence of auditory or visual hallucinations, delusions, obsessions, persecutions, or unusual powers. She did report feelings of worthlessness and occasional suicidal ideations. She reported sleep patterns that are restless, causing her to sleep only six hours per night. Throughout the evaluation, her emotional reaction appeared to be depressed. She was oriented times three, correctly stated the year in her current address, was able to recall five digits forward and four digits backward and was able to recall two out of three objects after a three-minute interval. Petitioner was unable to perform serial seven or serial three calculations. Performance on single-digit calculation tasks were as follows: 9+8=17 and 12 -7=5. She incorrectly calculated 5×5=15 and was unable to calculate 8×7 or 36÷4. (Exhibit A, pp. 174-177)

In summary, the evaluating psychologist reviewed Petitioner's prior mental health intake assessment from Family Counseling and Shelter Services from 2019 in which she was diagnosed with adjustment disorder, three pages of a biopsychosocial assessment from 2019 in which she was diagnosed with depression, unspecified anxiety, and various substance use disorder. Family Medical Center provided medical notes from 2019. Throughout the evaluation, Petitioner was cooperative and attentive however, results of the mental status examination revealed abnormalities in concentration and calculation tasks. At this time, Petitioner met the diagnostic criteria for major depressive disorder. Her ability to relate and interact with others, including coworkers and supervisors is moderately impaired. Her depression could affect her interpersonal relationships in the workplace but her ability to understand, recall, and complete tasks and expectations does not appear to be significantly impaired. Her ability to maintain concentration was moderately impaired and as a result of her emotional states, she may often be distracted, and her effectiveness and performance will likely be limited and slowed. Her ability to withstand the normal stressors associated with a workplace setting was moderately impaired. Petitioner was diagnosed with major depressive disorder,

recurrent, moderate and it was noted that she also struggled with ongoing physical medical issues including pain in her shoulders, hips, back, neck, wrist, and knees. Her prognosis was moderate. (Exhibit A, pp. 174-177)

Records from Family Counseling and Shelter Services of Monroe County were presented and reviewed. (Exhibit A, pp.180 – 186). During a ██████ 2019 assessment, Petitioner indicated she was requesting counseling to help cope with symptoms of anxiety, depression, severely low self-esteem, and inability to cope with dysfunctional family. She appeared to have a very fragile self-image and to react to many things in an extremely intense, emotional manner. Petitioner's health history was noted to include diagnosis of major depressive disorder and bipolar disorder, as well as inpatient psychiatric treatment for a few weeks at Havenwyck. History of degenerative disc disease and sciatica was reported. Petitioner reported that she isolates in her room. She was observed to have a very flat affect; however, an evaluation of her cognitive functioning was not completed. Throughout the mental status evaluation, she appeared to have logical, although often irrational, coherent speech and seeing extremely angry and depressed. She was very tearful and wiping her armpits, stating that she was sweating horribly. Her mood was sad, angry, and agitated. Her intelligence was below average to average, her judgment was poor, her attitude was defensive, invasive, and cooperative, and her thoughts were irrational. She had no suicidal or homicidal ideations at that time. Further counseling and interventions were recommended. (Exhibit A, pp.180 – 186).

Petitioner's ████████ 2018 through ████████ 2019 treatment records from Family Medical Center were presented and reviewed. (Exhibit A, pp.192 – 208) On █████████, 2019, Petitioner presented to discuss her recent neurology consultation and medications. Records indicate that Petitioner had been evaluated by neurosurgery and underwent injections in her lower back. She was to follow-up with surgery for possible injections for neck pain. Notes indicate that Petitioner was assessed to have intervertebral disc degeneration for which she was taking long-term medication, as well as lumbago with sciatica. Records further indicate that Petitioner was unable to work due to the debilitating nature of her back pain. Petitioner was treated for back pain on ██████ 2019 and reported increased anxiety. While she did not have suicidal ideations, Petitioner was highly irritable and depressed. Petitioner was diagnosed with bipolar one disorder, most recent episode, depressed and overanxious disorder. She was to follow up with her therapist for additional mental health treatment. In ████ 2019, she was referred to physical therapy. Throughout the course of her visits, Petitioner was treated for hip joint pain, carpal tunnel syndrome, back pain, shoulder pain elicited by motion, ankle joint pain, generalized osteoarthritis, and atherosclerosis of the extremities with intermittent claudication, among other impairments. Petitioner had various appointments to discuss the results of diagnostic imaging. The doctor noted that Petitioner's MRI of lumbar spine showed marked degeneration in the spine with pinched nerves and that her cervical spine MRI showed minor arthritic changes. Petitioner was referred to neurosurgery for consultation. (Exhibit A, pp.192 – 208)

A [redacted] 2018 MRI of Petitioner's lumbar spine showed moderate diffuse disc bulge asymmetric to the left with mild facet arthropathy at the L3 – L4. There is mild left but no significant right neural foraminal narrowing and no spinal canal stenosis at the L3 – L4. At the L4 – L5, mild diffuse disc bulge asymmetric to the left with mild facet arthropathy was seen, as was moderate left and mild right neural foraminal narrowing. At the L5 – S1, mild diffuse disc bulge with broad based right foraminal and extraforaminal disc protrusion with disc material impinging on the existing right L5 nerve root was found but no spinal canal stenosis was seen. There was multilevel degenerative spondylosis with varying degrees of neural foraminal narrowing, the most severely affected being L5 – S1 with a disc protrusion impinging on the existing right L5 nerve root. (Exhibit A, pp .209 – 210)

Also on [redacted], 2018, Petitioner underwent MRI of the cervical spine for her chronic neck pain which showed minor degenerative spondylosis at the C4 – C5, C5 – C6, and C6 – C7 without spinal canal or neural foraminal narrowing at any cervical level (Exhibit A, p.211)

On [redacted] 2018, Petitioner underwent EMG testing of her right lower extremity due to throbbing pain over the right anterior thigh. Results showed no definitive electrodiagnostic evidence of a lumbar radiculopathy or generalized peripheral neuropathy. (Exhibit A, p.213 – 214)

In [redacted] 2018, Petitioner underwent various x-ray image testing, which showed no acute fracture or widening of the ankle mortise and preserved joint spaces in the left ankle. X-ray imaging of Petitioner's cervical spine performed in [redacted] 2018 showed no significant abnormalities. There were minimal acromioclavicular degenerative changes seen upon imaging of the right and left shoulder. (Exhibit A, p.215 – 221)

Petitioner's mental health treatment records from Monroe Community Mental Health Authority were also presented and reviewed. (Exhibit A, p. 229-248). During an assessment on [redacted], 2019, Petitioner identified several previous inpatient hospitalizations and suicide attempts. She reported symptoms of depression and anxiety including difficulty sleeping, poor hygiene, tearfulness, low self-esteem, difficulty getting out of bed and functioning, difficulty focusing, isolating and not wanting to leave home due to increased anxiety. In diagnosing Petitioner with severe major depression and unspecified anxiety disorder, the following was considered: depressed moods, mood swings, decreased energy and motivation, inability to concentrate, panic attacks when leaving the home, being in large open spaces and around a lot of people. Her panic attacks are accompanied by profuse sweating, trouble catching her breath, increased agitation, and irritation as well as racing thoughts.

In [redacted] 2019, Petitioner was referred to a pain management specialist for her second cervical and lumbar spine epidural steroid injection for her pain. Notes indicate that Petitioner had previous epidural steroid injections to the areas in [redacted] 2019. Prior to receiving the injections, Petitioner was evaluated by Dr. Kevin Reinard on [redacted] 2019. Progress Notes indicate that Petitioner presented as a [redacted] year-old

obese female with previous suicide attempts and complicated social history who was currently homeless and for three years suffered from neck, back, and generalized limb pain. She reported numbness and tingling all throughout her limbs but could not determine the specific dermatome that affected her the most. She denied history of trauma and has not experienced weakness, or changes in her balance or coordination. The epidural steroid injections were recommended, and Petitioner was referred to orthopedic surgery for evaluation of her chronic shoulder pain. (Exhibit A, pp. 254-316)

In ███ 2020, Petitioner was treated by Dr. Madhira for gastrointestinal conditions of H pyloroi, GERD, functional dyspepsia and irritable bowel syndrome with both constipation and diarrhea. She was to undergo an EDG and colonoscopy in 8 weeks. (Exhibit 1)

Petitioner was referred to the rheumatology division of Promedica Physicians and on ██████, 2020, was evaluated by Dr. Mustafa for a positive ANA test. Notes indicate that her history dated back to 2010 with diffuse pain in hands, feet and joints. Fatigue, poor sleep and exhaustion were also indicated. Mild tender trigger point was noted on physical examination. Petitioner was assessed as having chronic fatigue syndrome with fibromyalgia, osteoarthritis of the spine with radiculopathy, lumbar region. The doctor indicated that at that time, there was no evidence of lupus of other connective tissue disease; however, chronic fatigue and fibromyalgia were present. (Exhibit 2)

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), 3.02 (chronic respiratory disorders), 3.03 (asthma), 12.04 (depressive, bipolar and related disorders), and 12.06 (anxiety and obsessive compulsive disorders) were considered. A thorough review of 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). 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), to which a five-point scale is applied (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 exertional and nonexertional limitations due to her impairments. Petitioner testified that due to back and hip pain, she is unable to walk far distances and walks with a limp. She is able to stand for only 15 minutes but can sit for longer periods of time, as long as her legs and feet are elevated. She is able to lift a gallon of milk but unable to bend or squat, as she testified her legs go numb. Petitioner stated that she lives with her roommate and although she does her own shopping, she shops at night to avoid crowds. She indicated that before she leaves the home, she must take a Xanax for her anxiety. She is able to wash dishes with difficulty and while she able to do laundry, she is unable to carry the laundry basket due to pain in her shoulders, neck, and back. Petitioner reported that she bathes and showers only once a month, that her hygiene is poor, and that she only brushes her teeth if she is going somewhere. She further testified that she suffers from GERD, has frequent diarrhea and difficulty emptying her bladder. Petitioner testified that she has more bad days than good days and that she often has difficulty sleeping. Petitioner testified that she has difficulty with comprehension and must reread books or watch movies multiple times in order to understand and remember what happened. She has problems with concentration and can only focus for short periods of time. Petitioner testified that she has difficulty gripping and grasping items with her hands and that she wears wrist guards daily. Petitioner indicated that she suffers from anxiety attacks and crying spells that vary in duration and severity. She further reported having verbal and physical anger issues during which she has previously hit walls and other items. While she reported no visual or auditory hallucinations, Petitioner testified that she has thoughts of hurting herself and that she has twice intentionally overdosed in the last two years. Petitioner reported that she was diagnosed with bipolar disorder and depression 20 years ago.

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 evidence presented is considered to determine the consistency of Petitioner's statements regarding the intensity, persistence and limiting effects of her symptoms. Based on a thorough review of Petitioner's medical record and in consideration of the reports and records presented from Petitioner's treating physicians, the MRI of Petitioner's lumbar spine showing multilevel degenerative spondylosis with varying degrees of neural foraminal narrowing, the most severely affected being L5 – S1 with a disc protrusion impinging on the existing right L5 nerve root, 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). However, Petitioner is unable to perform the full range of sedentary work thus, the occupational base is eroded by her additional limitations or restrictions. SSR 96-9p.

Based on the medical records presented, as well as Petitioner's testimony, Petitioner has moderate limitations on her non-exertional ability to perform basic work activities, with respect to performing manipulative or postural functions of some work such as reaching, handling, bending, climbing, crawling or stooping. Additionally, records indicate that Petitioner suffers from daily symptoms associated with major depressive disorder, bipolar disorder and anxiety which have resulted in more than one attempt at suicide and for which she has received inpatient psychiatric treatment on several occasions. The records from the consultative psychiatric evaluation indicate among other things, abnormalities in concentration and moderate impairments to her nonexertional abilities. It is found that Petitioner has moderate to marked limitations in her ability to understand, remember, or apply information; in her ability to interact with others; in her ability in her ability to concentrate, persist, or maintain pace and in her ability to adapt or manage oneself.

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 bartending, factory work, and most recently, in 2013, as a packager for [redacted] [redacted]. Upon review, Petitioner's past employment is characterized as requiring light to heavy exertion, depending on the type of factory work. Based on the RFC analysis above, Petitioner's exertional RFC limits her to sedentary work activities. As such, Petitioner is incapable of performing past relevant work. Because Petitioner is unable to perform past relevant work, she cannot be found disabled, or not disabled, at Step 4, and the assessment continues to Step 5.

<u>Step 5</u>
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, 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 [redacted] for purposes of Appendix 2. She completed high school and has semi-skilled work history that is nontransferable. 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, however, as referenced above, the occupational base

is eroded by additional limitations or restrictions. Thus, based solely on her exertional RFC, the Medical-Vocational Guidelines, result in a finding that Petitioner is not disabled.

However, as referenced above, Petitioner also has nonexertional impairments imposing additional limitations. As a result, and based on the evidence presented, she has a nonexertional RFC imposing moderate limitations on her non-exertional ability to perform basic work activities, with respect to performing manipulative or postural functions of some work such as reaching, handling, bending, climbing, crawling or stooping and moderate to marked limitations in her ability to understand, remember, or apply information; in her ability to interact with others; in her ability in her ability to concentrate, persist, or maintain pace and in her ability to adapt or manage oneself.

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 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.

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

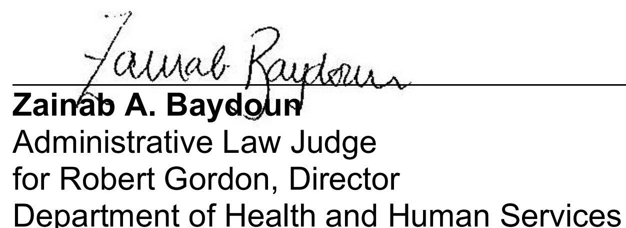
Accordingly, the Department's determination is **REVERSED**.

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; and

3. Review Petitioner's continued eligibility in March 2021.



ZB/tm

Zainab A. Baydoun
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

Counsel for Petitioner
Victoria Wolcott
898 S. Telegraph Road
Monroe, MI 48161
Via US Mail and Email

Counsel for Respondent
Chantal B. Fennessey
P.O. Box 30758
Lansing, MI 48909

DHHS
Pam Farnsworth
903 Telegraph
Monroe, MI 48161

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

cc: SDA: L. Karadsheh
Monroe County AP Specialist (4)