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

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MOAHR Docket No.: 21-001894
Agency No.:

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 May 20, 2021, from Detroit, Michigan. Petitioner appeared for the hearing with her Advocate, and represented herself. The Department of Health and Human Services (Department) was represented by Princess Ogundipe, 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 submitted additional records which were received, marked, and admitted into evidence as Exhibit 1 and Exhibit 2. The record was subsequently closed on June 21, 2021 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 2020, Petitioner submitted an application seeking cash assistance benefits on the basis of a disability. (Exhibit A, pp. 4-9)

2. On or around January 28, 2021, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. (Exhibit A, pp. 11-34)

3. On or around February 3, 2021, 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. 36-41)

4. On April 8, 2021, Petitioner submitted a timely written Request for Hearing disputing the Department's denial of her SDA application. (Exhibit A, p. 3)

5. Petitioner alleged disabling impairments due to muscle and joint pain/weakness/numbness, nerve pain, dizziness, insomnia, substance abuse, major depressive disorder, sleep apnea, high blood pressure, autoimmune disorder, bipolar disorder, anxiety, and post-traumatic stress disorder (PTSD). Although not reflected on the Medical Social Questionnaire completed at the time of the SDA application, during the hearing, Petitioner also alleged she has received a confirmed diagnosis of muscular dystrophy disease.

6. As of the hearing date, Petitioner was ██ years old with a ████████ 1984 date of birth; she was ██" and weighed ███ pounds.

7. Petitioner obtained a high school diploma and has reported employment history of work as a cashier in retail and food sales, a waitress, a food prep worker and baker at a restaurant, a driver, and a laborer at a factory. Petitioner has reportedly not been employed since October 2019. (Exhibit A, p. 114)

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).

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 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.

On ████████ 2021, Petitioner underwent a consultative physical examination and evaluation. Petitioner reported a history of chronic anxiety, depression, and substance abuse, as well as history of hypertension and possible nonspecific neuromuscular disorder. She reported being treated for chronic anxiety, depression, and PTSD symptoms after undergoing difficult relationships with her previous husband and boyfriends. She provided history of previous abusive relationships during which she endured physical injury including being hit on the head requiring treatment at St. Joseph Mercy Hospital for traumatic brain injury and thoracolumbar contusion. Petitioner reported using Suboxone for chronic substance painkiller and narcotic addiction which has since stabilized. Petitioner asserted that she has pain in both wrists, hands, and feet with prolonged use. Walking reportedly gives Petitioner severe spasms in her feet, toes, and when she has to do any heavy-duty work, her hands and fingers also spasmed. She denied any anginal chest pain and has no history of stroke. Petitioner reported that she is not currently employed, as she is unable to concentrate with chronic

severe depression. Petitioner's family history was reported and indicates that her mother was killed in 2010 by her stepfather. She reported having no relationship with her biological father and indicated that she has two children who are being raised by their paternal grandparents from her first marriage and she has no information on where the children are now. A review of systems were reported as follows: nonspecific headaches and dizzy spells, no difficulty hearing, swallowing or speaking, history of hypertension being treated for at least 3 to 4 years but no other cardiorespiratory impairment, no gastrointestinal or genitourinary impairments reported, and no history of diabetes or thyroid disorder. Petitioner reported pain in the thoracolumbar muscles as well as pain in the wrists, hands, ankles, and feet chronically related to the development of muscle spasm with heavy duty lifting or constant walking. EMG's have shown nonspecific abnormalities and Petitioner was being evaluated for autoimmune neuromuscular disorder through a neurologist, Dr. Menkes at Beaumont Hospital. Petitioner's neurologic exam showed that she was extremely depressed, cheerful during her interview, and unable to concentrate. She was alert and oriented to time, place, and person. Babinski signs were negative and her muscle power was 5/5 in all four limbs. Reflexes were symmetrical, 2+ bilaterally and sensations were intact for pain, touch, sense of joints, and vibration. Her gait was observed to be normal. Examination of Petitioner's musculoskeletal system showed cervical spine had full range of motion and thoracolumbar spine flexion was 0 to 60, extension 0 to 10, rotation 0 to 20. Shoulders, elbows, wrists, hands, hips, knees, ankles and toes had full range of motion. Examination of her bilateral feet showed chronic spasm of the toes, and tenderness on the bilateral MTP joint. No swelling or redness on the dorsum of the feet was observed. Petitioner's bilateral wrist similarly showed CMP and MCP joint tenderness and wrists were tender on the snuffbox bilaterally. Her grip was equal at 5/5 and she was able to get on and off the exam table. Her straight leg raise was negative bilaterally in the supine position. There was no significant tenderness on palpation of the trochanteric area or knee joint but tenderness of the thoracolumbar muscles was noted. The examining physicians medical source statement indicated that Petitioner was physically independent at least four activities of daily living and noted that she was able to sit, stand, walk, partially bend occasionally, and push/pull at least 10 pounds for 4 to 6 hours daily. It was recommended that Petitioner avoid cognitive activity and climbing heights. Additionally, a neuro-psych exam was recommended for clearance. (Exhibit A, pp. 212-219)

On ████████ 2020, Petitioner underwent a nerve conduction study/EMG of her bilateral upper extremities due to myotonia and carpal tunnel syndrome (CTS). (Exhibit A, pp. 222-231).

Records from Petitioner's treatment with Brooks, Lyon, Brooks DO's P.C., her previous primary care physicians (PCP) were presented and reviewed. The documents indicate that Petitioner had received treatment for various conditions including hypertension, opioid dependence, gastroesophageal reflux disease (GERD), obesity, paraesthesia, anxiety disorder, major depressive disorder, chronic obstructive pulmonary disease (COPD), pain in right and left legs, cramps and spasms. On ████████ 2020, Petitioner was seen for a telemedicine visit as in office visits had been suspended to

restrict exposure to COVID-19. It was noted that Petitioner had EMG testing which showed diffuse myotonic discharges and all muscles and a recommendation for a neurology referral was made. Petitioner reported a long history of numbness and cramping all over. Petitioner was referred to neurology for her abnormal EMG results and her Suboxone dosage was increased to three times per day. During her ██████ █ 2020 telemedicine appointment, Petitioner reported that she was recently seen by a pulmonologist for shortness of breath and began using Advair daily. She further reported that a chest x-ray was ordered but had not been completed yet. Petitioner was seen on ██████ 2020 for a telemedicine appointment, during which she reported increased difficulty with anxiety and depression, and that she is continuing to see her counselor regularly. Petitioner reported that the psychiatrist recently changed her medications and suggested that she begin to wean off of her Seroquel. Petitioner further reported increased pain all over her body. On ████ 2020, Petitioner had an in person appointment and described her long history of addiction and treatment in several rehabilitation programs through the years. She reported history of methamphetamine and heroin use and that she has been purchasing Suboxone off the street for the last two months but is otherwise staying clean of other drugs. She remains in contact with her counselor through Lighthouse. Petitioner complained of numbness in her arms. Records indicate that Petitioner had full range of motion bilaterally in her upper extremities. An EMG was ordered. (Exhibit A, pp. 232-241). Petitioner underwent repeated drug screenings throughout her treatment with Dr. Lyon. (Exhibit A, pp. 242-266)

Records from Petitioner's mental health treatment with Community Care Services were presented and reviewed. Petitioner was receiving psychotherapy, case management, and psychiatry services. Progress notes from Petitioner's ████████ 2020 telehealth psychotherapy visit indicate that Petitioner's affect was appropriate, her thought content was logical and coherent, her speech was appropriate in rate, volume, and pace. She was verbal and forthcoming throughout the session. Petitioner reported that she had a really good week last week, and felt better after she discontinued the Chantix medication. She reported that she is doing okay right now but any drop of a hat could make her tearful. She reported that her home is her safe place and she tends to feel all right but when going in the community and doing much interacting with people, she experiences problems and high anxiety. She reported that being on the phone with a DHS worker the other day made her cry. Petitioner reported that she's feeling physically exhausted but still unable to sleep through the night because her nervous system is activated. She reported suffering from flashbacks on Saturday which has not happened for her in a while and were triggered by a picture of a male face which reminded her of the perpetrator who beat and injured her face severely. She stated "I flipped out for 45 minutes. It took me back to 2005." Petitioner wrote down some of what she experienced during the flashback, and it was a lot of somatic sensations, headache, and tightness in her chest/throat. Notes indicate that Petitioner previously had EMDR therapy with a previous therapist. The therapist facilitated exploration of best coping practices, self-care, and processing around her challenges. Psychiatric progress notes from Petitioner's ████████ 2020 appointment, indicate that she last had a psychiatric evaluation on July 24, 2020. As of September 17, 2020, Petitioner's PHQ –9

score was zero in her depression screening was negative. Notes indicate that Petitioner reported feeling better and that she sleeps through the night. She reported that she is filing for disability for her physical and psychological impairments. She further indicated that she is fighting her eviction and recently lost her food stamps. Petitioner's mood was stable, she denied suicidal and homicidal ideation, she denied psychosis, concentration and anxiety are stable. She had a normal gait, her grooming and hygiene were observed to be good, her attitude was pleasant and cooperative, and she had good eye contact. Petitioner had normal cycle motor activity, her speech was fluent, spontaneous, normal in rate and tone. Her thought process was goal directed, there were no perceptual disturbances evident, her insight and judgment were intact, and she had full range of affect and congruent mood. Petitioner was diagnosed and treated for PTSD, major depressive disorder, recurrent, severe without psychosis, and generalized anxiety disorder. Petitioner's GAF score as of June 2020 was a 55. Psychiatric progress notes from a visit on ███████ 2020, had similar findings as those from September 17, 2020, and summarized above. During a psychotherapy appointment on ███████ 2020, Petitioner's mood was noted to be depressed and she exhibited self sabotaging behaviors. Petitioner reported having a difficult couple of days and being overemotional. She reported that she believes her medications might be a factor in her mood and sleep changes. Petitioner indicated that she strained her shoulder and it was noted that she was tearful as she described how she is always in some type of pain and has physical limitations. Petitioner discussed that she puts off going to the doctor because her "mom lived at the doctor and [she doesn't] want to. There is a stigma. Most of it was in her head. She made herself sick." Notes indicate that Petitioner has engaged in others self sabotage type behaviors, including avoiding appointments and phone calls as to not attend to her problems. This sabotage seems to stem from guilt Petitioner had in her treatment of her boyfriend in February. Petitioner reported that in a manic episode that involved drugs, she left him for her ex-husband and ran through the resources they had saved, and as a result they were struggling because of her. (Exhibit A, pp. 274-307)

Petitioner underwent a psychiatric evaluation on ██████ 2020 that was conducted via video due to COVID-19. During the evaluation, Petitioner appeared older than her stated age, was in good hygiene, cooperative, but a poor historian. She was labile, depressed, and tearful. She reported that she has been receiving psychiatric treatment since age 8 and has been prescribed Geodon, Seroquel, Lamictal, Saphris, Remeron, Celexa, all SSRIs and Abilify with mixed results. She reported anhedonia, increased sleep (12 hours and naps), panic attacks, no energy, and poor appetite, she denied current suicidal ideations, auditory and visual hallucinations, and denied delusions. She reported having four children who were not in her life. She endorsed long history of substance abuse including snorting heroin and cocaine, as well as stimulants. She reported entering rehab for treatment at Lighthouse in November 2019 but relapsed in March 2020 with illicit drug use. Petitioner reported that she abused meth for 10 years and suffers from tremors and poor memory due to prior drug use. Petitioner reported chronic medical conditions including hypertension, dyslipidemia, GERD, and is currently being worked up for autoimmune disorder. She reported past psychiatric hospitalizations in 2017 for a two week period due to psychosis, as well as outpatient psychiatric treatment dating back to age 8, and additional treatment with counseling and

medications from 2017 to 2019 at Hegeira. She reported having a rough childhood as an only child and disclosed verbal and physical abuse. Petitioner's recent and immediate memory were impaired, her concentration was normal, her judgment was fair, her thought process was unremarkable, her stream of mental activity was circumstantial, her character of speech was unremarkable, her presentation was dramatic, and her emotional state/affect/reaction was depressed/crying. Petitioner's depression screening was positive and indicated signs and symptoms of depression. She had no thoughts, plan, or intent of suicide. Petitioner had an AXIS I diagnosis of PTSD, major depressive disorder, recurrent, severe without psychosis, and generalized anxiety disorder. Diagnostic summary notes indicate that based on Petitioner's depressive mood record for years, history of suicide attempt, change in functioning socially and occupationally, depressed mood listing every day, for most of the day, markedly diminished interest and pleasure and almost all activities most of the day, nearly every day, insomnia, appetite disturbance, psychomotor agitation, fatigue, feelings of worthlessness, excessive guilt and diminished ability to think or concentrate, it was the impression of the clinician that Petitioner's symptoms support a diagnosis of major depressive disorder. Based on reliving the event due to triggering memories, having nightmares and flashbacks, avoiding situations that remind of the event including avoiding crowds, because they feel dangerous combined with negative changes in beliefs and feelings (now paranoia) and hyperarousal, it was the impression of the clinician that Petitioner symptoms support PTSD. Her prognosis was guarded. (Exhibit A, pp. 308-318)

Psychotherapy progress notes from Community Care Services on July 21, 2020 indicate that Petitioner sought to reestablish ongoing care and related symptoms of depression, anxiety, PTSD which are impacting her functioning to the point that she is applying for disability. She reported being in and out of counseling several times throughout her lifetime and found it to be helpful. She previously received EMDR treatment at Lighthouse and would like to continue. She reported history of trauma, which has been complex and lifelong. She lost her mother to murder about 10 years ago at which point, addiction became an issue. In 2017, she left Indiana with an abusive/alcoholic boyfriend and they were homeless together for a while until a church paid for them to get to Michigan. She reported that he beat her nearly to death with a hammer and she was left at a hospital. She suffered two closed head injuries due to abuse. She reported previously working at Grand Traverse Pie Co., but had difficulty standing and severe anxiety being around people. Head injuries and damage from prior drug use has hurt her confidence. Targeted case management notes from several treatment dates were also reviewed. An initial integrated biopsychosocial assessment was completed on June 25, 2020. Petitioner's presenting need was a chief complaint of depression. She has been in dual diagnosis facilities, most recently in 2018 at Oakdale Recovery after an overdose on phenobarbital. There were no suicidal or homicidal ideations reported at that time. Petitioner describes self-injurious behaviors including cutting since age 8. Although she reported having stopped in November 2019, she reported history of cutting her chest, stomach, and legs. Her last suicide attempt and ideation was in 2018. Mental status exam indicated that Petitioner's awareness was alert, her concentration normal, her judgment was fair, she had limited insight, there

were no hallucinations or, her thought process was unremarkable, she had a normal stream of mental activity, her speech was unremarkable, her emotional state and affect were sad, irritable, and anxious and she reported that her mood was numb. Outpatient psychiatry with psychiatric evaluation, medication management and psychotherapy for co-occurring disorders was recommended. (Exhibit A, pp. 318-368)

Pulmonary medicine progress notes from Petitioner's ██████████ 2020 visit at the Raslan Clinic and Dr. Raslan indicate that Petitioner received treatment for diagnosis of obstructive sleep apnea. Encounter diagnosis also indicated that Petitioner received treatment for borderline personality disorder, depression, sciatica of the left side, and obesity. Notes indicate that Petitioner was to continue using her CPAP nightly. Records indicate that Petitioner was last seen 18 months ago for a history of obstructive sleep apnea for which she received CPAP for home use. Petitioner reported still having issues with snoring even with CPAP use. She denied morning headaches, denied feeling sleepy, and denied having tiredness during the day. She further reported that she does not take naps during the day. Physical examination showed that her pulmonary and chest exam effort was normal, she had normal range of motion to her musculoskeletal system and no noted abnormalities in the neurological and psychiatric exam. Progress notes from Petitioner's █████████ 2020 visit indicate that an x-ray was ordered to evaluate Petitioner's reported dyspnea and she was to continue using her CPAP nightly. Petitioner was prescribed additional medications for her wheezing and a pulmonary function test was to be completed at her next visit. Petitioner reported having a hard time catching her breath and a sharp pain when she takes a breath. She walks ½ to 1 mile daily, is not doing any weightlifting, but has wheezing. (Exhibit A, pp. 374-381)

Records from Petitioner's treatment at Samaritan Center and LaSalle Behavioral Health in the State of Indiana, dating back to 2011 were presented and reviewed. (Exhibit A, pp. 382–502)

Petitioner presented her medical records from Beaumont Hospital showing a problem list as of March 13, 2021 of abnormal EMG, acute midline low back pain with left sided sciatica, anxiety, borderline personality disorder, depression, hypertension, GERD, homelessness, insomnia, lumbar disc herniation with radiculopathy, obesity, spinal stenosis of the lumbar region, syncope, and seizure like activity. Her current medications were noted to be albuterol, Norvasc, Cogentin, Rexulti, Cymbalta, Norco, prinzide/zestoretic, omeprazole, Medrol Dosepak, Norflex, and Seroquel. A diagnosis of moderate persistent asthma was noted. (Exhibit 1)

Petitioner presented to the emergency department from her neurologist's office, Dr. Menkes on March 12, 2021, for further workup regarding her ongoing sciatica/lumbar radiculopathy and also possible myotonic syndrome. Petitioner reported worsening back pain over the last couple of weeks with radicular symptoms down her left leg. She also recently had significantly abnormal EMG testing. Petitioner was noted to have past medical history including asthma, depression, borderline personality disorder, sciatica, and spinal stenosis with an MRI of the lumbar spine from March 12, 2021, showing lumbar disc disease. Petitioner's neurologist wanted her evaluated and admitted to the

hospital with multiple consults: neurosurgery, cardiology, ophthalmology, pulmonology, and physical therapy/occupational therapy. Petitioner reported having constant, shooting and throbbing pain, currently 10 out of 10 down her left leg affecting her ambulation and activities of daily living. Petitioner reported currently taking Suboxone for her pain. Physical examination of Petitioner's musculoskeletal system showed tenderness but no swelling or signs of injury, normal range of motion to the cervical back, tenderness and bony tenderness present with decreased range of motion to the thoracic back, and spasms, tenderness and bony tenderness of the lumbar back. Decreased range of motion to the lumbar back was noted and straight leg test was positive bilaterally. Petitioner's pain was stabilized in the emergency department and she was admitted for pain control and consults by neurosurgery, cardiology, ophthalmology, pulmonology, and physical and occupational therapy. The final impression at disposition in the emergency department was sciatica, generalized myalgias, rule out myotonic dystrophy. (Exhibit 1)

Beaumont Hospital records from Petitioner's ██████ 2021 admission were also presented and reviewed. Petitioner had limited movement of the left lower extremity due to pain and decreased sensation in the left lower extremity. Urinary urgency and urinary incontinence were also noted and records indicate that Petitioner reportedly had an injection in her back last week with improvement in pain for only two days. No noted abnormalities were noted in Petitioner's upper extremities. Records indicate that MRI of the lumbar spine showed multilevel spondylotic and discogenic changes in the lumbar spine, most pronounced at the L3 – L4 level were found. The consulting orthopedic surgeon reviewed Petitioner's MRI of the lumbar spine, which was completed on ████ █ 2021, and indicated that it showed central canal and foraminal stenosis on the left greater than right most significantly at the L3 – L4 and L4 – L5 levels. Petitioner reported that she is interested in surgery. (Exhibit 1)

Results from Petitioner's █████ 2021 MRI of the lumbar spine showed straightening of the normal lordotic curvature of the lumbar spine, with conus terminating at T12, there is intervertebral disc height loss of L4 – L5 and L5 – S1. There is intervertebral disc desiccation of L2 – L3 through L5 – S1. Endplate degenerative changes are noted at L4 – L5. At the L2 – L3 level, broad-based central disc protrusion indented the ventral thecal sac with minor facet arthropathy and ligamentum flavum thickening with mild spinal canal stenosis and mild right neural foraminal narrowing. Central disc annular fissure was found at the L3 – L4 along with circumferential disc bulging with a superimposed broad-based disc protrusion. Facet arthropathy and ligament thickening was found, resulting in moderate to severe spinal canal stenosis. There was also moderate severe right neural foraminal narrowing at the L3 – L4 level. Circumferential disc bulging, facet arthropathy and ligament of flavum thickening with mild spinal canal stenosis was found at the L4 – L5 level. As was severe left and moderate right neural foraminal narrowing with a mass effect upon the exiting left L4 nerve roots. At the L5 – S1 level, there was circumferential disc bulging with a shallow superimposed central disc protrusion. Facet arthropathy and ligamentum flavum thickening with mild right and severe left neural foraminal stenosis and mass effect on the exiting left L5 nerve root was found. (Exhibit 1, pp. 25-26)

While admitted to Beaumont Hospital, Petitioner underwent a consultation by a neurologist on [redacted] 2021. Petitioner reported muscle spasms and cramps for a long time, with the feeling that her arms and shoulder muscles are weak. She reported difficulty relaxing her muscles after contraction and reported being referred to Dr. Menkes, a neuromuscular specialist for evaluation of myotonic dystrophy. She reported worsening lower back pain extending to the left, along with weakness in the left knee and the feeling that her legs would collapse on her. The neurologist reviewed Petitioner's EMG/nerve conduction studies, which were conducted in October 2020 and showed diffuse myotonia in the lower extremity and lumbosacral paraspinal muscles. Bilateral carpal tunnel syndrome was also reported. A neurological examination conducted showed that Petitioner's muscle tone and bulk were normal, and her bedside muscle power testing did not reveal definitive weakness. It was noted that Petitioner has some giveaway (likely due to pain) weakness in the left hip flexors and knee movements. No fasciculations, or abnormal movements were noted and there were no extrapyramidal features. Her reflexes were 2+ and symmetric in the arms, 3+ in the right knee and 2+ in the left knee, her ankle jerks were symmetrical, and no ankle clonus were found. Her plantar responses were flexor bilaterally. There was sensory impairment in the left leg and no abnormalities to finger to nose touch. The conclusion of the examining physician was that no evidence of myotonia could be found that day. The impression/decision-making notes indicate that Petitioner's acute and subacute low back pain with radiation in the left lower extremity and symptoms suggestive of left L – four radiculopathy. Contribution from the L-5 could not be excluded, and it was noted that Petitioner's pain was better with current medication management, although evaluation by a spine surgery team was pending. Petitioner's symptoms and EMG results were consistent with myotonic dystrophy and while she otherwise denied cardiac, respiratory, and endocrine systems, involvement of such is the usual with this muscle disorder. (Exhibit 1, pp. 32-35)

Results of an echocardiogram completed on [redacted] 2021, showed that Petitioner's left ventricular ejection fraction was estimated to be in the normal range at 65%. Her wall thickening was normal, as was the left ventricular diastolic function. There was no pericardial effusion. (Exhibit 1, pp. 47-48)

Petitioner presented to the emergency department of Beaumont Hospital Annapolis via EMS on [redacted] 2021 with complaints of lower back pain, difficulty ambulating and moving. She was unable to get up without pain during triage. She reported shooting and stabbing pain in the lumbar spine that radiates to the left posterior upper leg. There was tenderness present upon musculoskeletal examination and straight leg raising pain on the left side. After undergoing a CT scan of the lumbar spine, Petitioner was assessed as having a lumbar disc herniation with canal stenosis at the L3 – L4 level causing radicular pain. Notes further indicate that Petitioner's midline lower back pain radiates on both sides and down her legs, that she leans to the side to be able to stand, that she had multilevel degenerative and discogenic changes based on the results of the CT scan. An MRI of Petitioner's brain was performed and found no evidence of abnormalities or acute intracranial processes. Petitioner underwent an epidural steroid

injection while at the hospital and was discharged in stable condition. (Exhibit 1, pp. 51 – 116)

Petitioner presented a May 27, 2021 prescription from her PCP for a cane for ambulation assistance due to muscular dystrophy. (Exhibit 1, p. 117)

Petitioner presented a letter from Molly Bato, her therapist at Community Care Services indicating that Petitioner receives treatment for conditions which are severe and persistent and include diagnosis of PTSD, major depressive disorder, and generalized anxiety disorder. The letter further indicates that Petitioner's condition is expected to last at least one year or more and that her treatment team advises that she is unable to work. (Exhibit 2)

Petitioner also presented the results of her [redacted] 2020 Nerve Conduction Study and EMG Report. Results showed that there was electrodiagnostic evidence of moderate left and mild right carpal tunnel syndrome as well as diffuse myotonic discharges and all muscles tested on needle EMG, including bilateral arms and legs. There was no electrodiagnostic evidence of lower extremity peripheral neuropathy or tarsal tunnel syndrome. A recommendation for an evaluation by a neuromuscular specialist was made. (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 and the listing criteria applicable at the time of Petitioner's application date, listings 1.02 (major dysfunction of a joint(s) due to any cause), 1.04 (disorders of the spine), 3.03 (asthma), 9.00 (endocrine disorders), 11.00 (neurological disorders), 12.04 (depressive, bipolar and related disorders), 12.06 (anxiety and obsessive compulsive disorders), 12.08 (personality and impulse control disorders), and 12.15 (trauma and stressor related 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 she has been diagnosed with muscular dystrophy disease and that on ██████ 2021, she was scheduled to have spine surgery for her spinal stenosis. Petitioner testified that she is in constant pain, that she walks at a 90° angle and that for the last 2 ½ months has required the use of a cane that was prescribed by her PCP to assist her with ambulation. She testified that she is able to walk for up to 15 minutes on a good day, but some days she is unable to walk at all. Petitioner testified that she is able to sit for one hour before her whole body tightens up. She stated that she can lift a maximum of 10 pounds but not regularly and is able to stand for up to 15 minutes. She testified that she is unable to bend or squat and does not climb stairs because her legs get weak and shaky. Petitioner testified that she lives with her partner in a one level trailer and although she is able to shower herself, she is unable to wash her back and feet and requires the assistance of her boyfriend, as she is unable to bend. Petitioner testified that she is able to wash dishes and change the cat litter. While she indicated she is unable to load and unload the laundry, she is able to fold clothes with assistance. She testified that she can cook basic meals using a toaster oven and electric skillet. With respect to shopping, Petitioner testified that she does not go to the store alone because of her physical and mental impairments, including her inability to walk and frequent need to take breaks. Petitioner testified that she has difficulty with driving and does not drive often because her hands and legs lock up. Petitioner stated that she has difficulty gripping and grasping items with both hands, and that her condition is worse in her right hand, which is her dominant hand. She testified that she often drops items and cannot grip the steering wheel. Petitioner stated that she has been diagnosed with PTSD, major depression, and anxiety, and that she has suffered from mental health conditions since childhood. She testified that she attends

biweekly therapy sessions and psychiatry appointments monthly, which monitor her psychotropic medications. Petitioner reported that she stutters, and has anxiety going out in public alone. She stated that she suffers from anxiety attacks that consists of convulsions and shaking multiple times per week which can last at least one hour. Petitioner testified that she is unable to focus for longer than 10 minutes, has trouble with her short-term memory, suffers from daily crying spells lasting 5 to 15 minutes and although she does not have auditory or visual hallucinations, she last had suicidal thoughts in January 2019.

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 among other findings, broad-based central disc protrusion indented the ventral thecal sac with minor facet arthropathy and ligamentum flavum thickening with mild spinal canal stenosis and mild right neural foraminal narrowing at L2-L3, central disc annular fissure at the L3 – L4 along with circumferential disc bulging with a superimposed broad-based disc protrusion and facet arthropathy and ligament thickening, resulting in moderate to severe spinal canal stenosis and moderate to severe right neural foraminal narrowing at the L3 – L4 level, circumferential disc bulging, facet arthropathy and ligament of flavum thickening with mild spinal canal stenosis at the L4 – L5 level with severe left and moderate right neural foraminal narrowing with a mass effect upon the exiting left L-4 nerve roots, and at the L5 – S1 level, circumferential disc bulging with a shallow superimposed central disc protrusion and facet arthropathy and ligamentum flavum thickening with mild right and severe left neural foraminal stenosis and mass effect on the exiting left 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 including the Nerve Conduction Study and EMG report, Petitioner's MRI of the lumbar spine and neurological evaluation, as well as Petitioner's testimony, Petitioner has moderate to marked 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 PTSD, major depressive disorder, and anxiety which

have resulted in at least one prior attempt at suicide and for which she has received inpatient psychiatric treatment on several occasions. The records from the Petitioner's mental health treatment indicate, among other things, mild to moderate limitations in her ability to understand, remember, or apply information; in her ability to interact with others; 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 employment as a cashier in retail and food sales, a waitress, a food prep worker and baker at a restaurant, a driver, and a laborer at a factory. Upon review, Petitioner's past employment is characterized as requiring light exertion. 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.

Step Five

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 36 years old at the time of application and 37 years old at the time of hearing, and thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. She completed high school and unskilled 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 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 to marked 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 mild to moderate limitations in her ability to understand, remember, or apply information; in her ability to interact with others; 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

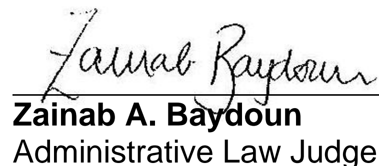
Accordingly, the Department's SDA determination is **REVERSED**.

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] 2020 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 SDA eligibility in January 2022.



ZB/jm

Zainab A. Baydoun
Administrative Law Judge

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-Wayne-18-Hearings
BSC4-HearingDecisions
L. Karadsheh
MOAHR

Petitioner – Via First-Class Mail:

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