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

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Date Mailed: November 3, 2022
MOAHR Docket No.: 22-003685
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 October 5, 2022, from Detroit, Michigan. Petitioner appeared for the hearing and represented herself. The Department of Health and Human Services (Department) was represented by Valerie Davis, Eligibility Specialist and Ashley Soper, Family Independence Manager.

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 2022, Petitioner submitted an application seeking cash assistance benefits on the basis of a disability.

2. On or around May 10, 2022, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program.

3. On or around May 18, 2022, 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.6 – 9)

4. On or around , 2022, Petitioner submitted a timely written Request for Hearing disputing the Department's denial of her SDA application. (Exhibit A, p. 3-5)

5. Petitioner alleged disabling impairments due to hip dysplasia, back and neck pain, spasms, hiatal hernia, immune deficiency, anal fissure, gastroesophageal disease, irritable bowel syndrome (IBS), obsessive compulsive disorder (OCD), anxiety/panic attacks, depression, and restless leg syndrome.

6. As of the hearing date, Petitioner was [redacted] years old with a [redacted] 1981, date of birth; she was [redacted] and weighed [redacted] pounds.

7. Petitioner obtained a high school diploma and received a vocational certificate as a cosmetologist. Petitioner has reported employment history of work as a cook/general utility dishwasher in a restaurant, a waitress, cashier and stocker in retail store, a data entry specialist, and a customer service representative. Petitioner has reportedly not been employed since October 2021. (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 was thoroughly reviewed and is briefly summarized below.

Records and clinical encounter summaries from Petitioner's treatment with her primary care physician (PCP) Dr. Aronov were presented and reviewed. The records show that Petitioner was receiving treatment for bilateral dysplastic hip disorder, depressive disorder, mood disorder, anxiety, and stress. On ███████ 2021, Petitioner was seen for a physical examination, and it was noted that she had a history of anxiety, depression, OCD, restless leg syndrome, bilateral hip and neck pain, and a recent shingles flareup. Petitioner appeared for the appointment with her mother, who reported that Petitioner was in a very bad mental health state and cannot function on her own, nor can she maintain any employment. During the appointment, Petitioner was constantly crying, agitated, anxious and complained of fatigue, tiredness and an inability to do basic home chores. Petitioner's mother reportedly comes to her home on a daily basis to make sure that Petitioner is eating and assists her with household chores and preparing her meals. A review of systems showed shortness of breath, chest pain, increased frequency of urination, muscle pain, muscle weakness, joint pain, and joint stiffness, although no swelling was noted. Petitioner reported suffering from sleep disturbance and more recently stress. Physical examination showed that Petitioner appeared obese and that her level of distress was chronically ill. She had good judgment but her mental status was anxious and agitated. Examination of Petitioner's musculoskeletal system showed abnormal range of motion to her back and lower extremities, bilateral, tenderness of the back was also present. The doctor indicated that Petitioner has a plethora of underlying psychiatric issues that need to be resolved, that

she is suffering from depression, anxiety, and OCD which are interfering with her ability to function on a daily basis. Notes indicate that petitioner requires daily assistance from her mother just to get through the day, that petitioner is very teary, and anxious, and presented with multiple complaints including chest pain, urinary frequency, bilateral hip and neck pain, as well as back pain Petitioner was referred to neurology and was instructed to follow up with her psychiatrist to see if she would benefit from inpatient psychiatric placement due to her very poor functional status. The doctor indicated that Petitioner's chest pain was likely not cardiac and most likely secondary to her underlying anxiety issues. During an [redacted], 2021 visit, Petitioner presented with complaints of severe anal pain due to an anal fissure which began after she was hospitalized for shingles and treated with narcotic pain medication subsequently developing constipation. Physical examination showed a visible posterior anal fissure without active bleeding. Petitioner reported feeling night sweats, fatigue, headaches, problems with her teeth and gums, chest pain and palpitations, and shortness of breath. She also reported abdominal pain, changes in bowel movements, nausea, constipation/painful bowel movements and rectal bleeding. Petitioner continued to report muscle and joint pain as well as dizziness and lightheadedness. Records from a [redacted] 2021, visit show that Petitioner was seen for multiple medical issues including mood disorder, depression, anxiety, and recent shingles which resulted in postherpetic neuropathy. Petitioner complained of new onset malaise and fatigue that she has been experiencing after her shingles flareup, as well as complaints of restless leg issues and urinary frequency. She also had complaints of pain in her left wrist and left ankle. Petitioner's mental status was noted to be anxious, agitated, and abnormal. On [redacted] 2021, Petitioner presented to her doctor for follow-up, indicating that she was hospitalized for one day due to facial shingles. Petitioner's rash had improved and was healing well without signs of infection. Petitioner reported persistent facial pain, describing it as a shooting hot pain as if a hot metal rod was stabbing her in the face. Petitioner was observed to be in severe distress, tearful, appeared to be in pain, and had a very labile mood. Petitioner was treated with medications. On [redacted] 2021, petitioner presented with complaints of severe pain in her neck that she reportedly developed last week while lifting heavy dishes at work. She described her pain as sharp, with significantly reduced range of motion in her cervical spine. Petitioner complained of insomnia and indicated that she has been experiencing intermittent chest pains as well as occasional pulsatile tinnitus. Physical examination of Petitioner's musculoskeletal system was normal with the exception of tenderness at the neck. Results of bilateral hip x-rays taken on [redacted] 2021, showed no fracture or malalignment and minimal bilateral hip osteoarthritis, slightly worse on the left. A [redacted] 2021, ultrasound of Petitioner's neck showed a normal thyroid gland, with no abnormal cervical lymph nodes. A [redacted], 2021, x-ray of Petitioner's left wrist was unremarkable, showing no fracture or malalignment, no erosions or periosteal reactions, the joint spaces were maintained, and no focal soft tissue abnormality was found. X-ray of Petitioner's left ankle also taken on [redacted] 2021 showed no acute osseous abnormality or significant degenerative changes. An x-ray of Petitioner cervical spine performed on [redacted], 2021, showed no significant degenerative changes or acute abnormality of the cervical spine, although a straightening of the cervical spine which was noted to be either positional in nature or due to muscular

spasm was noted. There was no compression deformity, disc heights were preserved, and facet joints were unremarkable. (Exhibit A, pp. 64-108)

On [redacted] 2021, Petitioner underwent consultation at Newland Medical Associates with Dr. Leo Parsons II and was present for hospital follow-up for herpes ophthalmicus. Dr. Parsons reviewed hospital records, which indicate that Petitioner presented to the hospital on [redacted], 2021, complaining of rash to the right side of her face for three days prior to her admission. Petitioner reported that her pain started on [redacted] 2021, and her right forehead and right side of her face but did not notice anything especially different with her skin. She reported that the next day, the pain got worse, and she started having what she thought were pimples pop up on her forehead. At the time she presented to the emergency department, Petitioner noticed the same pimples on her eyelid and was subsequently diagnosed with herpes ophthalmicus (shingles in the V1 distribution, and was started on medications. The emergency department noted that there were a few lesions on the orbit and ophthalmology was going to see the patient outpatient because she had no visual changes at that time. Petitioner reported that she is still having sharp electric shock like pain in the right side of her face, but no fevers, chills, sweats, chest pain, abdominal pain, or diarrhea. She denied headache and infectious disease was consulted. Petitioner was discharged from the hospital and given a 14 day course of steroids and Valtrex. While at the hospital on or around [redacted] 2021, Petitioner was evaluated by the infectious disease department and treated with steroids and other medications. During her [redacted], 2021 visit with Dr. Parsons, Petitioner reported complete resolution of all the skin lesions on her face, and denied any changes in her vision. She did report significant fatigue, but it was noted that she has a major problem with anxiety. Petitioner's physical examination was normal and no further antivirals were indicated, as complete resolution of right facial shingles was noted. Petitioner was counseled to see ophthalmology if needed and was recommended for psychiatric treatment due to her severe anxiety. Petitioner was informed that the likelihood of her developing another shingles infection was low, considering the recent outbreak, however if she remains extremely anxious, this will lower her immune system and it would become more possible for reinfection. (Exhibit A, pp. 132-141)

Records from Petitioner's mental health treatment with Dr. Robert Garcia MD with Novi Psych and Psychology were presented and reviewed. Progress notes from a [redacted] 2022, follow up appointment with Dr. Garcia show that Petitioner's mood was noted to be obsessive, that she is constantly rechecking things and has thoughts that lead her to think bad things will happen during certain activities. Her energy was poor, she couldn't do much and is weak, her sleep was noted to be poor and although she sleeps for 6 to 7 hours per night, she can't get up until 1 PM and is not refreshed. Her focus was noted to be poor and she cannot focus on more than one thing at a time as she has racing thoughts and poor motivation. Notes indicate that Petitioner suffers from panic attacks where she cannot leave the house, that she has obsessive thoughts that trigger anxiety attacks, that she has nightmares where she wakes up screaming and feels like people don't understand her. Petitioner's mood was anxious, her speech spontaneous, and her affect was labile. Petitioner was being treated for OCD,

depression, and anxiety. Similar findings were made after Petitioner's [redacted] 2021, and [redacted] 15, 2021, sessions with Dr. Garcia, and her medications were adjusted. An evaluation from [redacted] 23, 2021, showed that Petitioner was diagnosed with depression and OCD in 2019, that her OCD symptoms include counting, symmetry, attention to detail, irrational fears, and fear of catastrophic events. Notes indicate that Petitioner presented with a depressed exhausted mood, had low-energy, suffered from racing thoughts, and poor completion of tasks, that she had poor decision-making skills and difficulty staying asleep. Notes indicate that Petitioner has constant fear of people and pets in danger and while she did not have any suicidal or homicidal ideations at present, had history of suicidal ideations in her early 30s. Records show that Petitioner's past treatment was 12 years of therapy and was taking medications for her mental health impairments. Petitioner's social history indicated she suffered from verbal abuse and harassment from a previous significant other. Her GAF score was 40 and her prognosis was guarded. Petitioner's OCD symptoms also indicated she suffered from constant worry, obsessions and compulsions, routines, and has panic attacks several times per day. (Exhibit A, pp. 146-156)

A [redacted] 2022 letter from Petitioner's treating psychiatrist Dr. Garcia, referenced a psychosocial assessment completed by Petitioner's psychotherapist Margot Bloomfield, MA, LLP on [redacted], 2021, and indicates that the attached assessment is in accordance with his diagnosis of Petitioner's mental condition and inability to function in a work environment. (Exhibit A, p.180)

The [redacted] 2021, psychosocial assessment was also presented for review and indicates that Petitioner has been receiving individual psychotherapy sessions and treatment for OCD with panic attacks and persistent depressive disorder. The assessment indicates that the symptoms Petitioner struggles with are the presence of both obsession and compulsions: recurrent and persistent thoughts, urges, or images that are experienced as obtrusive and unwanted and marked by anxiety and distress, attempts to suppress or neutralize thoughts with other thoughts or actions, repetitive behaviors driven by the obsessive thoughts, behaviors or thoughts aimed at reducing the anxiety though not connected in a realistic way with what they are trying to prevent; the obsessive compulsive symptoms are time-consuming and cause clinically significant distress and impairment in social, occupational, and other areas of functioning. The assessment indicates that Petitioner also experiences panic and anxiety attacks with an abrupt surge from a calm state to an anxious state and which include the following symptoms: palpitations and accelerated heart rate, trembling/shaking, chest pain/discomfort/muscle tension, shortness of breath, abdominal distress, excessive worry about the future and losing control. Petitioner struggles with the symptoms on a daily basis and are not the result of substance use or abuse of any medications. For the last two years, and most of the day, more days than not, Petitioner struggles with depressed mood and symptoms including low-energy, low self-esteem, difficulty making decisions, feelings of hopelessness and it is noted that the symptoms have never been absent for more than two months over the past two year period. Petitioner reported a history of chronic anxiety and depression with onset prior to age 18. The excessive compulsive symptoms have become more pronounced in the past two years, which

cause her clinically significant distress and impairment in social, occupational, and other areas of functioning. It was noted that Petitioner has difficulty with leaving her apartment for any reason and while Petitioner had been working until July 2021, she had to leave that employment due to her impairments. Petitioner symptoms have become much worse the past several months, as she has lost her ability to deal with life changes in stress, and struggles to complete her every day activities and responsibilities. Thus, the compensation is taking place. The therapist indicated that Petitioner has been having weekly psychotherapy sessions with her since ██████ 2018 and since Petitioner was in her ███ she has been receiving outpatient therapy. With respect to Petitioner's trauma history, it was noted that Petitioner experienced abusive romantic relationship while in her ███ and as a result, the trauma seems to have influenced her ability to maintain healthy relationships and feel safe. The assessment indicates that Petitioner has an exaggerated startle response to loud noises such as door closing, which was witnessed by therapist and others. Petitioner has also experienced flashbacks of abuse by her former boyfriend and she tries to be vigilant in knowing his whereabouts. Notes indicate that Petitioner lives in an apartment with her cat and has great difficulty leaving her home to engage in social activities, and activities of daily living. Petitioner's mother delivers her groceries and medications, as well as drives Petitioner to all medical appointments. Petitioner had a diagnosis of obsessive-compulsive disorder with panic attacks and persistent depressive disorder, the symptoms of which she struggles with on a daily basis and which affect her physical health, social relationships, ability to perform activities of daily living independently, and her ability to provide financially for herself. (Exhibit A, pp. 181-185).

Petitioner's PCP, Dr. Aronov, drafted a letter dated December 15, 2021, indicating that Petitioner has been a patient of his for the last few years and has multiple medical issues including chronic low back pain, chronic neck pain, and iron deficiency which are significantly overshadowed by her underlying psychiatric issues. The doctor indicated that Petitioner has significant issues with anxiety, depression, OCD, and that she is unable to function on her own. Petitioner requires daily assistance from her mother to function throughout the day and is unable to perform activities of daily living, and cannot maintain employment. (Exhibit A, p.186)

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 1.15 (disorders of the skeletal spine resulting in compromise of a nerve root), 1.18 (abnormality of a major joint(s) in any extremity),12.04 (depressive, bipolar and related disorders), 12.06 (anxiety and obsessive compulsive 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 suffers from recurrent muscle spasms, neck, back, and hip pain. She stated that standing, walking, or sitting for too long cause extreme pain and that she has been recently participating in physical therapy due to her exertional impairments. Petitioner testified that she cannot walk for more than a few minutes without having sharp hip pain and reported that when she is able, she uses a motor scooter to assist with ambulation. She testified that she can sit not longer than 10 minutes before having hip pain and has to shift her weight because her neck locks up. While Petitioner reported no issues with gripping or grasping items with her hands, she testified that she is able to lift only a gallon of milk and can stand for about 15 minutes. She is unable to bend or squat. Petitioner reported that she lives alone and her mother comes over to her home every day because she cannot complete any long tasks. While Petitioner indicated that she can bathe herself and care for her own personal hygiene, she is unable to perform any household chores. Petitioner testified that her mother performs most household chores for her and that her mother stays at her home for

about 4 to 5 hours every day to ensure Petitioner's household chores are completed and meals are being prepared. While Petitioner testified that she can sometimes load the dishwasher, she is unable to unload the dishwasher as she cannot reach to put the dishes away due to pain. She requires assistance with shopping and stated that she is able to do very minimal chores because she has obsessive and compulsive thoughts.

With respect to her mental impairments, Petitioner testified that she was diagnosed with depression and anxiety over a decade ago in or around 2008. Petitioner testified that in 2019, she was diagnosed with OCD and has been receiving psychiatry treatment since that time. Petitioner testified that her symptoms include obsessions and compulsive thoughts, and beliefs that make her scared. She testified that she is unable to interact with others and depending on the type of thoughts she's having, sometimes unable to leave her home. Petitioner testified that she suffers from intrusive thoughts that are outside the scope of reality and re-checks things multiple times. She testified that she is not functional, has sensitivity to sound, and that she has consuming fears and thoughts. Petitioner testified that she suffers from panic/anxiety attacks that occur several times per week and while she was working, occur daily. Symptoms included racing thoughts, outbursts, being on edge, her chest races, and she begins to hyperventilate. Petitioner testified that she sometimes lacks focus and other times is hyper focused, repeating tasks over and over again. Otherwise, she is easily distracted due to sound sensitivity and she obsesses over the tasks that she needs to complete. While Petitioner testified that she has no issues with her memory, she suffers from crying spell several times per week that last anywhere from one half an hour to one hour of uncontrollable crying. It is noted that throughout the duration of the hearing, Petitioner presented as very tearful and cried. Petitioner testified that although she takes her medications, they have not fully helped her conditions and that she suffers daily from symptoms related to her OCD. Petitioner also testified that her restless leg syndrome causes uncontrollable kicking and jerking, which she was informed could be a side effect to her medications. A function report completed by Petitioner's mother corroborates Petitioner's testimony as to her exertional and nonexertional limitations.

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 with respect to her muscle spasms, neck, hip, and back pain and testimony as to her exertional limitations. The records presented for review do not contain significant findings that identify exertional limitations with respect to Petitioner's ability to perform strength demands of jobs including sitting, standing, walking, lifting, carrying, pushing, and pulling as alleged. Based on a thorough review of Petitioner's medical record and in consideration of the reports and records presented from Petitioner's treating physicians,

while physical examinations showed that Petitioner's upper and lower extremities had normal function, strength, and range of motion, Petitioner's morbid obesity and mild osteoarthritis to the hips could be potentially limiting. Therefore, based on a thorough review of Petitioner's medical records and in consideration of the above referenced evidence, with respect to Petitioner's exertional limitations, it is found that Petitioner maintains the physical capacity to perform light work as defined by 20 CFR 416.967(b). Petitioner has mild to 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, anxiety, and OCD for which she has been receiving consistent mental health treatment for years. Petitioner's medical record clearly document symptoms associated with these conditions including depressed mood, sleep disturbance, difficulty concentrating, crying spells, fatigue, muscle tension, panic attacks, and disproportionate fear or anxiety of leaving her home. Petitioner also has been receiving documented treatment for OCD, which is characterized by involuntary and time-consuming preoccupation with intrusive and unwanted thoughts, as well as repetitive behaviors. Furthermore, Petitioner's mental health treatment records show that her symptoms have worsened, and she has lost her ability to deal with life changes, and that she is struggling to complete her everyday activities and responsibilities. Petitioner's testimony was supported by the records from her treating psychiatrist and psychotherapist. Therefore, Petitioner has moderate to marked limitations in her mental functioning including 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).

<u>Step Four</u>
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 cook/general utility dishwasher in a restaurant, a waitress, cashier and stocker in retail store, a data entry specialist, and a customer service representative. Upon review, Petitioner's past employment is characterized as requiring sedentary to light exertion. Although based on the RFC analysis above, Petitioner's exertional RFC limits her to

light work activities and thus, she is not precluded from performing past relevant work due to the exertional requirement of her prior employment, Petitioner has additional nonexertional limitations noted above that would prevent her from being able to perform past relevant work. Therefore, 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 ██ years old at the time of application and ██ years old at the time of hearing, and thus, considered to be a younger individual (age ████) 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 light work activities. 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. Petitioner has mild to 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, Petitioner has moderate to marked limitations in her mental functioning including 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. Re-register and process Petitioner's [redacted] 2022, 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 from the application date, ongoing; and

3. Review Petitioner's continued SDA eligibility in May 2023.

ZB/ml

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 Electronic Mail :

DHHS
Linda Gooden
Oakland County Southfield Disctrict III
25620 W. 8 Mile Rd
Southfield, MI 48033
MDHHS-Oakland-6303-Hearings@michigan.gov

Interested Parties
BSC4
L. Karadsheh
MOAHR

Via First Class Mail :

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