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[redacted], MI [redacted]

Date Mailed: April 24, 2023
MOAHR Docket No.: 23-000637
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Ellen McLemore

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250. After due notice, a telephone hearing was initiated on March 16, 2023, from Detroit, Michigan. Petitioner appeared at the hearing and was unrepresented. The Department of Health and Human Services (Department) was represented by Destiney Vann, Assistance Payments Worker.

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 April 8, 2022, Petitioner submitted an application seeking cash assistance benefits on the basis of a disability.

2. On November 30, 2022, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program.

3. On January 13, 2023, the Department sent Petitioner a Notice of Case Action informing her that her SDA application was denied.

4. On February 2, 2023, Petitioner submitted a timely written Request for Hearing disputing the Department's decision to deny her SDA application.

5. Petitioner alleged disabling impairments due to carpal tunnel in both hands, high blood pressure and a brain aneurysm in the past. Although not assessed by DDS, Petitioner did indicate in her Medical-Social Questionnaire, as well as at the

hearing, that she had disabling impairments due to depression and bi-polar (Exhibit A, p. 473).

6. As of the hearing date, Petitioner was [redacted] years old with an [redacted], 1964 date of birth.

7. Petitioner obtained a [redacted] degree. Petitioner has a reported employment history of work as a cashier and factory line worker. Petitioner has reportedly not been employed since October 2021.

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, for 90 or more days. 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). The

duration requirement for purposes of SDA eligibility is 90 or more days. BEM 261 (April 2017), p. 2.

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 was thoroughly reviewed and is briefly summarized below:

Petitioner was seeking care with her primary care physician (PCP), Dr. Sameer Sawalha at Appoline Medical Clinic (Exhibit A, pp. 194-310). On February 11, 2021, Petitioner had a telehealth medical appointment to refill her prescription for Adipex, a prescription medication used to treat obesity. Petitioner’s physician instructed her to control her blood pressure, adhere to antihypertensive medications, increase aerobic physical activity, increase the consumption of fruits, polyunsaturated fats, vegetables and whole grains. Petitioner was also advised to moderate the consumption of black and green tea, and to perform daily mindfulness and mediation for weight loss. On March 8, 2021, Petitioner presented for a follow-up related to a hospital discharge on March 6, 2021. Petitioner had breast reduction and liposuction procedures. Petitioner reported the presence of back pain and heartburn but denied the presence of sleep disturbance, fatigue, change in weight, change in vision, joint pain, depression, anxiety, change in hearing, headache, chest pain, shortness of breath, constipation, diarrhea, breast lump, or abnormal menses. Petitioner was also negative for dizziness, abdominal pain, nausea, vomiting, nocturia, parentheses, focal extremity weakness, and focal extremity numbness. Petitioner was advised to control her blood pressure and to adhere to antihypertensive medications. Petitioner was also encouraged to increase aerobic physical activity, reduce dietary sodium intake, perform home blood pressure checks, consume a balanced and healthy diet, and smoking cessation. On March 12, 2021, Petitioner had a follow-up visit for the management of her hypertension. Petitioner reported she did not have a headache, change in vision, difficulty speaking, chest pain, shortness of breath, numbness or tingling of extremities, or lower extremity edema. Petitioner reported that stress and excess salt intake had worsened. Petitioner’s hypertension was improving upon treatment. Petitioner did report pain in her cervical

region and numbness and tingling in her right hand. Petitioner reported the cervical pain was sharp and shooting in nature. Petitioner indicated that the pain was worse with movement, like bending and rotation of the spine. Petitioner indicated pain level was 6/10. Petitioner complained of pain when walking, climbing stairs, and bending at the knee. Petitioner reported swelling of her knee. Petitioner indicated that her pain improved with physical therapy, rest and medication. Petitioner was again advised to consume a balanced and healthy diet, low in fat and high in fiber. Petitioner was advised to find a regular exercise program, as tolerated. Petitioner was again prescribed Adipex. On April 12, 2021, Petitioner had a follow-up evaluation for the management of her hypertension. Petitioner reported the same ailments as the March 12, 2021 visit. Petitioner's prescription for Geri-Hydrolac, a medication to treat dry, scaly skin conditions, was refilled. On May 12, 2021, Petitioner had an appointment for complaints related to vaginitis. On July 12, 2021, Petitioner had a follow-up related to her hypertension management. Petitioner reported pain in her lower back. Petitioner was advised to rest if her joints were painful, apply ice or heat to the joint, elevate the joint and take medication on time. Petitioner was advised not to lift any heavy objects, practice mindfulness, try to lose weight, only to take medication for high levels of pain, exercise regularly, and have a healthy diet. On July 24, 2021, Petitioner presented with complaints of asthma. Petitioner's symptoms included wheezing, which was aggravated with factors including exercise. Petitioner reported factors were relieved at rest. Petitioner complained of back pain in her lower back. Petitioner was referred to a gastroenterologist. Petitioner was also cleared for hernia surgery. On August 2, 2021, Petitioner had a follow up visit after a hospital discharge from surgery for gastroesophageal reflux. Petitioner was diagnosed with gastroesophageal reflux disease (GERD). Petitioner was referred to pain management. On October 1, 2021, Petitioner had a follow-up visit for her treatment related to her hypertension. Petitioner reported back pain in her lower back, denied any numbness or tingling, and that her pain level was a 4/10. Petitioner reported she still had gastrointestinal problems. Petitioner's medication for Flexeril was refilled. On October 18, 2021, Petitioner presented with complaints of asthma and back pain. On December 20, 2021, Petitioner presented with gastrointestinal pain. Petitioner was prescribed Robitussin and Diflucan. Petitioner continued to be advised to lose weight, take her medication, exercise regularly, and practice a good diet. On January 14, 2022, Petitioner presented with chief complaints of asthma and gastrointestinal issues. Petitioner also reported continued pain in her lower back. On February 11, 2022, Petitioner presented with chief complaints of vulvovaginitis. On May 9, 2022, Petitioner presented with chief complaints of asthma, gastrointestinal problems, and lower back pain. Petitioner was referred to a pain management doctor and to get a computerized tomography (CT) scan of her neck. Petitioner was also referred to a psychiatrist. On June 11, 2022, Petitioner presented for a Wellness visit. Reviews of Petitioner's systems including her eyes, ears, nose, mouth, throat, musculoskeletal, genitourinary, cardiovascular, respiratory, gastrointestinal, neurological, psychiatric, endocrine, and hematologic count all presented as normal. On July 7, 2022, Petitioner complained of dizziness, asthma, and back pain. Petitioner reported her insomnia was treated with medication. Petitioner was prescribed Ambien, Antivert (an antihistamine used in the treatment of dizziness), and Diflucan. On July 8, 2022, Petitioner reported that her general health was OK and her emotional well-being

was good. Petitioner reported she could prepare her own meals, and complete housework and shopping without help. Petitioner reported she did not need help eating, bathing, dressing, or getting around the house. Petitioner denied having any memory problems that made it difficult to do daily activities. Petitioner indicated she had not fallen 2 or more times in the past year and was not afraid of falling. Petitioner reported she did not have trouble falling or staying asleep. Petitioner also indicated that she did not have trouble concentrating on things, such as reading the newspaper or watching television. Petitioner was counseled on diet, exercise, and preventative screening tests. On July 14, 2022, Petitioner presented for a follow-up related to her hypertension management. Petitioner had chief complaints of asthma, gastrointestinal issues, lower back pain, and high blood pressure. Petitioner was referred to a neurosurgeon. Petitioner was provided Fluconazole, and medications for skin issues. On August 1, 2022, Petitioner presented with chief complaints of lightheadedness, asthma and hypertension. It was indicated that Petitioner would be completing a diagnostic cerebral angiogram. Petitioner was referred to her neurosurgeon and pain management doctor. Petitioner's prescription for Antivert was increased.

Petitioner was also under the care of a neurologist (Exhibit A, pp. 313-350). On February 24, 2021, Petitioner presented with complaints of dizziness, numbness and tingling. Petitioner complained of paresthesia, with associated weakness in her bilateral upper and lower extremities. Petitioner reported persistent back pain. Petitioner also reported she had intermittent dizziness and denied any recent falls. Petitioner had a diagnosis of cervical spondylosis with radiculopathy and a was advised to obtain Magnetic Resonance Imaging (MRI) of her brain. In regard to the dizziness, Petitioner was advised to continue taking the Meclizine prescribed by her PCP. Petitioner had a diagnosis of an intracranial aneurysm. Petitioner had a previous 9-millimeter aneurysm involving the right internal carotid artery in its distal cavernous segment in 2017. In 2018, Petitioner had a videonystagmography (VNG) test and an electroencephalogram (EEG) both of which were normal. Petitioner also had bilateral carpel tunnel. On August 25, 2021, Petitioner had a CT scan of her cervical spine (Exhibit A, p, 98). Petitioner had advanced multilevel cervical spondylosis noted. Petitioner did not have acute cervical spine fractures, bony destructive process or prevertebral soft tissue swelling. Petitioner had no subluxation or spondylolisthesis. Petitioner's atlantoaxial relationship and odontoid process were intact. Petitioner had multiple levels of neural foraminal narrowing noted secondary to facet joint arthropathy. Petitioner did not have significant bony stenosis of the cervical spine. On March 15, 2022, Petitioner completed a brainstem auditory evoked response (BAER) test. Petitioner had normal bilateral brainstem auditory evoked responses, which indicated normal conduction between the acoustic nerve and lower pons bilaterally. On March 15, 2022, Petitioner also had a visual evoked potential (VEP) test. Petitioner had a normal reversal pattern visually evoked response study bilaterally, which indicated Petitioner had normal conduction along the prechiasmatic bilateral optic pathways. On March 17, 2022, Petitioner presented with chief complaints of dizziness, numbness and tingling, neck and back pain. Petitioner was not in acute distress, her neck and thyroid were supple, she had no skin rashes, her cardiovascular system was regular and rhythmic, and she had no edema in her extremities. Petitioner was alert and oriented to name and place.

Petitioner's speech was fluent. Petitioner had a pending MRI of her brain and C spine. To treat Petitioner's cervical spondylosis with radiculopathy, she was advised to continue her Medrol tablet therapy pack. Petitioner was also diagnosed with transient neurological symptoms due to subjective memory loss. On May 18, 2022, Petitioner had another EEG test. Petitioner's EEG test was normal, as there was no epileptiform activity or focal cerebral dysfunction noted. On July 14, 2022, Petitioner presented with complaints of dizziness, numbness and tingling. Petitioners MRI of the brain was discussed. Petitioners MRI completed on July 1, 2022, revealed no acute abnormality. Petitioner also had a Magnetic Resonance Angiography (MRA) completed on July 1, 2022. Petitioner had nearly complete occlusion of the right internal carotid artery at the cavernous segment with distal reconstitution, likely from the anterior circulation. Of note, this nearly complete occlusion was within the region of the previously noted right aneurysm on the CT dated September 8, 2017. No aneurysm was identified. Petitioner was advised to have a Montreal Cognitive Assessment (MOCA) at the next visit.

Petitioner was also under the care of Eastside Surgical Specialists in relation to gastrointestinal complications (Exhibit A, pp. 358-413). On April 22, 2021, Petitioner had a follow-up appointment. Petitioner had a sleeve gastrectomy in 2013 and repair of a hiatal hernia with anterior fundoplication on January 4, 2019. Petitioner's problem list included hypercholesterolemia, hyperlipidemia, obesity, hypertensive disorder, asthma, constipation, arthritis, joint pain, lower back pain, edema, dyspnea, heartburn and a former smoker. Petitioner reported vomiting and GERD but no abdominal pain or diarrhea or constipation. Petitioner reported muscle aches, muscle weakness and joint pain but reported no swelling in the extremities. Petitioner reported numbness but reported no weakness or seizures. Petitioner reported hair loss but no fatigue. Petitioner reported no nosebleeds, no nose problems, or sinus problems. Petitioner reported no sore throat or bleeding gums. Petitioner reported no chest pain or palpitations. Petitioner reported no cough, wheezing or shortness of breath. Petitioner reported no depression, sleep disturbances or feeling unsafe in a relationship. Petitioner was diagnosed with GERD and being overweight. It was advised for Petitioner to receive testing on her upper gastrointestinal tract to evaluate her anatomy. On May 19, 2021, Petitioner had an x-ray completed of her esophagus and upper gastrointestinal tract. Petitioner's esophagus demonstrated a mostly dilated character during most of the examination. Petitioner had diminished peristalsis identified and there appeared to be a small diverticulum at the gastroesophageal junction. There was gastroesophageal reflux with the water siphon test. Petitioner's stomach itself was somewhat tubular in character with a narrowed area in the mid portion of the body. Petitioner's peristaltic activity above this narrow area was diminished. Petitioners distal portion of the stomach responded with normal peristalsis and the duodenum was unremarkable. On June 3, 2021, Petitioner had an appointment regarding her upper gastrointestinal testing. Petitioner was notified of the risks and complications of the operation. On June 21, 2021, Petitioner had a follow up appointment related to her gastric sleeve and Petitioner was provided methods to avoid weight regain by watching the volume of the food she was eating. Petitioner was also advised to keep her calorie intake below 1000 calories to maintain the weight loss. On July 28, 2021, Petitioner had the anatomy testing surgery, a laparoscopic total abdominal colectomy (LTC). Petitioner's postoperative diagnoses

included recurrent paraoesophageal hiatal hernia, recurrent reflux, obesity and extensive abdominal adhesions. On July 28, 2021, Petitioner also had her hernia repair surgery at Ascension St. John Hospital (Exhibit A, pp. 100-168). Petitioner had a diaphragmatic hernia without obstruction or gangrene repaired. On August 5, 2021, Petitioner had a follow-up appointment. Petitioner denied any reflux and the incisions were well healed. On September 2, 2021, Petitioner had an additional follow-up visit. Petitioner denied any reflux and her incisions were well healed. On February 28, 2022, Petitioner had a follow up appointment related to her gastric sleeve and Petitioner was provided methods to avoid weight regain by watching the volume of the food she was eating. On June 2, 2022, Petitioner had a follow up appointment related to her gastric sleeve and Petitioner was provided methods to avoid weight regain by watching the volume of the food she was eating. Petitioner was also advised to keep her calorie intake below 1000 calories to maintain the weight loss. On July 5, 2022, Petitioner had a Fluoroscopy imaging performed on her esophagus. Petitioner's esophagus was normal in course and mildly patulous. The esophageal mucosal pattern was normal without evidence of erosion, fold thickening, stricture or filling defect. Petitioner had a small hiatal hernia. Petitioner had mildly decreased primary stripping wave with secondary wave propulsing the contrast bolus through the esophagus and lower esophageal sphincter. There were no tertiary contractions observed. Petitioner had severe gastroesophageal reflux to the upper 1/3 of the esophagus at the level of the thoracic inlet. Petitioner's stomach was small in caliber, due to prior sleeve gastrectomy changes. Petitioner had normal gastric rugal folds, without evidence of filling defect, stricture or ulceration. Petitioner's proximal small bowel, including the duodenum and visualized jejunum common, demonstrated normal mucosal folds without ulceration or filling defects. On August 1, 2022, Petitioner had a follow up to discuss her test results. Petitioner denied any reflux since the July 28, 2021 hernia repair procedure. Petitioner stated she had some reflux when drinking and eating too fast but learned to avoid causing the reflux. Although Petitioner reported no reflux, the imaging from July 5, 2022, revealed indications of reflux. It was recommended that Petitioner receive additional testing. Petitioner was ordered to receive an upper endoscopy preparation (EGD) with Bravo Ph monitoring for potential silent reflux. On November 14, 2022, Petitioner had an EGD with Bravo Ph monitoring completed at Ascension St. John Hospital (Exhibit A, pp. 51-95). It was ruled out that Petitioner had gastritis or helicobacter pylori, a bacterial infection of the stomach.

Petitioner was also under the care of a cardiologist (Exhibit A, pp. 420-444). On April 30, 2021, Petitioner had an appointment related to her hypertension. An electrocardiogram (ECG) was performed which showed sinus rhythm (SR) without ischemic changes. Previous testing from a previous cardiologist was also reviewed including an echocardiogram from 2016, which revealed mitral valve prolapse with moderate mitral regurgitation and mild pulmonary hypertension. Petitioner was advised to continue her current medical therapy including simvastatin (to lower cholesterol), nifedipine (for high blood pressure), enalapril (for high blood pressure), atenolol (for high blood pressure and prevent chest pain) and furosemide (to treat high blood pressure and edema). On May 28, 2021, Petitioner completed a stress test. Petitioner had normal myocardial perfusion at rest and stress. Petitioner had no evidence of significant

pharmacologically inducted left ventricle ischemia and she had preservation of resting left ventricular systolic function. On May 28, 2021, Petitioner also had a transthoracic echocardiogram. Petitioner's left ventricle, right ventricle, mitral valve and aortic valve were all normal. On May 13, 2022, Petitioner had a follow-up examination related to previous cardiac testing. Petitioner had an ECG performed which showed SR without ischemic changes. Petitioner's cardiovascular examination revealed oscillation was normal without murmurs, arterial pulses were normal with no bruits. Petitioner did not have any edema or evidence of chronic venous insufficiency. Petitioner was notified that clinically she was doing well and was reassured regarding the results of her most recent cardiac testing. No further testing was recommended at that time. Petitioner was advised to continue her medication. Petitioner had a dietary consult, as her body mass index (BMI) was out of range.

Petitioner was also under the care of a pain management clinic since 2014 (Exhibit 1, pp. 4-110). On January 20, 2021, Petitioner reported that she had increased lower back pain since her last visit. Petitioner had diagnoses of lumbar/sacral spondylosis and lumbar facet arthropathy without myelopathy. Petitioner had bilateral lumbar medial branch blocks under biplanar fluoroscopy. On March 18, 2021, Petitioner had a telehealth visit. Petitioner's prescribed pain medications were Percocet and Robaxin. Petitioner reported that her pain prior to the January 20, 2021 injections was 9/10 and that after the injections, her pain was 4/10. Petitioner complained of additional pain in her right shoulder. On May 20, 2021, Petitioner had a follow-up visit. Petitioner had reported she had a positive reaction to the previous injections and requested additional injections, due to severe chronic pain. Petitioner was unable to receive injections during the visit due to insurance purposes. On June 11, 2021, Petitioner had a CT scan of her lumbar spine completed. It was noted that Petitioner had erosive arthritis and facet arthropathy at several levels. There were varying degrees of spinal canal and neural foraminal comprise. On July 21, 2021, Petitioner had a follow-up appointment. Petitioner was unable to receive injections due to insurance purposes. Petitioner had an appointment on September 2, 2021. Petitioner had bilateral lumbar medial branch blocks under biplanar fluoroscopy. On December 1, 2021, Petitioner had bilateral lumbar medial branch blocks under biplanar fluoroscopy. On January 26, 2022, Petitioner had bilateral lumbar medial branch blocks under biplanar fluoroscopy. Petitioner had an office visit on March 23, 2022, but was unable to receive injections due to insurance purposes. On May 19, 2022, Petitioner had bilateral lumbar medial branch blocks under biplanar fluoroscopy. On May 20, 2022, Petitioner had a motor nerve, sensory nerve, F-Wave, H reflex and EMG study performed. Petitioner's sensory nerve action potentials, sural nerve, F waves and H reflex were all normal. Needle electrodiagnostic of the selected muscles of both lower extremities were abnormal. There was evidence Petitioner had chronic denervation at L2-L3, L4-L5, and L5-L6 at both sides. On August 3, 2022, Petitioner had bilateral lumbar medial branch blocks under biplanar fluoroscopy. Petitioner's physician indicated that Petitioner had been experiencing chronic pain for more than 9 years. Petitioner had failed to respond to non-invasive conservative treatment, such as physical therapy. Petitioner's functional capacity was indicated to be insufficient to return to work. Petitioner had bilateral lumbar medial branch blocks under biplanar fluoroscopy. On October 5, 2022, Petitioner had an

appointment but was unable to receive injections due to insurance purposes. Petitioner reported a pain decrease of 75% after receiving the injections. On December 1, 2022, Petitioner was unable to receive injections due to insurance purposes. On February 2, 2022, Petitioner had bilateral lumbar medial branch blocks under biplanar fluoroscopy. Petitioner also continued to be prescribed Percocet and Robaxin. Petitioner continued to report chronic pain that interfered with her daily activities. Petitioner reported some pain relief with injections.

On July 7, 2022, Petitioner had a psychiatric evaluation (Exhibit 1, pp. 2-3). Petitioner reported negative for suicidal thoughts, behavioral problems, fussiness, addiction, crying spells, homicidal thoughts, poor attention, mood swings, hallucinations, impulsiveness, self-harm, aggression or hearing voices. Petitioner indicated she was positive for irritability, worrying, anxiousness/stress, insomnia, anxiety, depression, stress and panic attacks. Petitioner was diagnosed with adjustment disorder with mixed anxiety and depressed mood. Petitioner reported reduced sleep and difficulty staying asleep. Petitioner was advised to begin Lexapro and follow-up in 1 month.

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 assessment date, listings 14.09 (inflammatory arthritis), 3.03 (asthma), 12.04 (depressive, bipolar and related disorders), and 12.06 (anxiety and obsessive-compulsive disorders) were considered. A thorough review of the medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

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

meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4); 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b).

The exertional requirements, or physical demands, of work in the national economy are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a). Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools and occasionally walking and standing. 20 CFR 416.967(a). Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds; even though the weight lifted may be very little, a job is in the light category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. 20 CFR 416.967(b). Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. 20 CFR 416.967(e).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or

postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi).

For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Where the evidence establishes a medically determinable mental impairment, the degree of functional limitation must be rated, taking into consideration chronic mental disorders, structured settings, medication, and other treatment. The effect on the overall degree of functionality is evaluated under four broad functional areas: (i) understand, remember, or apply information; (ii) interact with others; (iii) concentrate, persist, or maintain pace; and (iv) adapt or manage oneself. 20 CFR 416.920a(c)(3), to which a five-point scale is applied (none, mild, moderate, marked, and extreme). 20 CFR 416.920a(c)(4). The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. 20 CFR 416.920a(c)(4).

In this case, Petitioner alleges exertional and nonexertional limitations due to her impairments. Petitioner testified that due to her physical limitations, she is in chronic pain. Petitioner stated that she previously sought therapeutic treatment for her carpal tunnel and the pain in her back by getting steroid shots. However, Petitioner testified that she is extremely fearful of needles and can no longer use that form of treatment. Petitioner also testified that her prescription medication was increased to manage her carpal tunnel symptoms, but she felt increasingly dizzy and lightheaded. Petitioner had to return to her former dosage. Petitioner testified that she could walk without the assistance of any aides but that she cannot walk a far distance. Petitioner testified she cannot grip or grasp due to her carpal tunnel symptoms. Petitioner cannot sit up or stand for longer than 5 minutes before she begins to feel dizzy. Petitioner spends most of her time lying on her back. Petitioner stated she cannot bend or squat due to knee issues. Petitioner cannot ascend or descend more than two steps.

Petitioner testified that she sees a therapist on a weekly basis and is in the care of psychiatrist, who prescribes her medication. Petitioner stated she has chronic anxiety and panic attacks throughout the day. Petitioner has crying spells consistently throughout the day. Petitioner often feels angry but denied having thoughts of hurting herself or others. Petitioner stated she suffers from severe insomnia and is frequently consumed by negative thoughts. Petitioner testified she is fearful of leaving her house, as she may be attacked or suffer a fall.

Petitioner lives with her two daughters, who help her with house chores. Petitioner's children cook, clean and bring her food. Petitioner can drive but often requests that her daughters drive, as her mind often wanders. Petitioner can perform her own personal hygiene but wears braziers without clasps and pajamas the majority of the time to alleviate difficulties in dressing. Petitioner was formerly active in her church but no longer attends in-person service. Petitioner stated she only leaves the house to attend physician appointments. Petitioner stated she spends the majority of her time in her room, lying down, while reading her bible.

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. A thorough review of Petitioner's medical records, including records presented from Petitioner's treating physicians, was completed. Petitioner testified that she has sought treatment for her bilateral carpel tunnel, including steroid injections and surgeries. However, none of the medical evidence presented pertains to the treatment of Petitioner's carpal tunnel syndrome. At one of Petitioner's most recent visits with her PCP on July 8, 2022, Petitioner reported that her general health was OK and her emotional well-being was good. Petitioner reported she could prepare her own meals, and complete housework and shopping without help. Petitioner reported she did not need help eating, bathing, dressing, or getting around the house. Petitioner denied having any memory problems that made it difficult to do daily activities. Petitioner indicated she had not fallen 2 or more times in the past year and was not afraid of falling. Petitioner reported she did not have trouble falling or staying asleep. In regard to her gastrointestinal issues, Petitioner reported to her gastroenterologist on August 1, 2022, that her symptoms of reflux had been managed since the July 28, 2021 procedure. At Petitioner's most recent visit with her cardiologist, on May 13, 2022, Petitioner was notified that clinically she was clinically doing well and was reassured regarding the results of her most recent cardiac testing. No further testing was recommended at that time. Petitioner's neurologist completed a BAER and MEP test on March 15, 2022, both of which were normal. Petitioner's neurologist also performed an MRA and MRI of her brain on July 1, 2022. Petitioner's MRI was normal and her MRA testing revealed complete occlusion within the region where she previously had an aneurysm, but no aneurysm was found. Petitioner was diagnosed with cervical spondylosis with radiculopathy after a CT scan was performed of her spine and was being treated with a corticosteroid. On August 3, 2022, Petitioner's physician at the pain clinic indicated that Petitioner had been experiencing chronic pain for more than 9 years. Petitioner had failed to respond to non-invasive conservative treatment, such as physical therapy. Petitioner's functional capacity was indicated to be insufficient to return to work. Petitioner repeatedly received injections in her back, which provided temporary relief. However, due to insurance purposes, Petitioner was often not able to receive injections when she desired.

Petitioner continued to report struggles with symptoms of irritability, worrying, anxiousness/stress, insomnia, anxiety, panic attacks and depression. The only records presented related to Petitioner's nonexertional impairments was her initial assessment completed on September 1, 2022, at which she was diagnosed with adjustment disorder with mixed anxiety and depressed mood. The medical evidence presented was extremely limited to support Petitioner's testimony regarding her nonexertional

conditions. At the hearing, Petitioner was tearful but had no difficulty comprehending questions or concentrating on the hearing itself.

Due to Petitioner's physical limitations, she was unable to sit for long periods, had some difficulty walking, squatting and bending. There was evidence that Petitioner had chronic pain in her lower back. Petitioner's pain clinic physician indicated that Petitioner failed to respond to most noninvasive courses of treatment. Petitioner's physician indicated that she was not able to work. 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).

Based on the extremely limited medical records presented, as well as Petitioner's testimony, Petitioner has: mild limitations with respect to her ability to understand, remember, or apply information; mild limitations with respect to her ability to interact with others; mild limitations in her ability to concentrate, persist, or maintain pace; and mild limitations in her ability to adapt or manage oneself. Thus, Petitioner has mild limitations on her nonexertional ability to perform basic work activities.

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

Step Four

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

Petitioner's work history in the 15 years prior to the application consists of work as a cashier and line worker. Petitioner's employment as a cashier worker is defined by the Dictionary of Occupational Titles as requiring light work. Petitioner's employment as a line worker is classified as requiring medium work. Therefore, Petitioner's past employment requires light to medium work. Based on the RFC analysis above, Petitioner's exertional RFC limits her to sedentary work activities. As such, Petitioner is incapable of performing past relevant work. Because Petitioner is unable to perform past relevant work, she cannot be found disabled, or not disabled, at Step 4, and the assessment continues to Step 5.

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).

In this case, Petitioner was [redacted] years old at the time of hearing, and thus, considered to be a person of advanced age (55+ years) for purposes of Appendix 2. She completed a high school equivalency and had an unskilled work history. Petitioner had no recently completed education to provide her direct entry into sedentary work. 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. Thus, based solely on her exertional RFC, the Medical-Vocational Guidelines, 201.09, result in a finding that Petitioner is disabled.

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. Redetermine Petitioner's SDA eligibility as of December 1, 2021, 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 November 2023.

EM/tm

Ellen McLemore
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
Chelsea McCune
Macomb County DHHS Warren Dist.
13041 E 10 Mile
Warren, MI 48089
MDHHS-Macomb-20-Hearings@michigan.gov

Interested Parties
L. Karadsheh
BSC4

Via-First Class Mail :

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