STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
SUZANNE SONNEBORN
EXECUTIVE DIRECTOR

MARLON I. BROWN, DPA
ACTING DIRECTOR

[redacted]
MI [redacted]

Date Mailed: April 9, 2024
MOAHR Docket No.: 23-009996
Agency No.: [redacted]
Petitioner: [redacted]

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 February 28, 2024, from Detroit, Michigan. Petitioner appeared for the hearing and represented herself. The Department of Health and Human Services (Department) was represented by Charese Hull, Eligibility Specialist.

Exhibit A, pp. 1-56 was admitted into the record as evidence on behalf of the Department.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records, including the entirety of Petitioner's medical records as relied upon by the Disability Determination Services (DDS) in issuing its November 2023 disability determination, as well as any updated medical records from Petitioner's treating medical providers. On or around February 28, 2024, the Department submitted the medical records relied upon by DDS which totaled 502 pages. The documents were received, marked, and admitted into evidence as Exhibit B, pp. 1-502. Petitioner did not submit any additional records for consideration. The record was subsequently closed on March 13, 2024, and the matter is now before the undersigned for a final determination on the evidence presented.

ISSUE

Did the Department properly determine that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit program?

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On or around [redacted], 2023, Petitioner submitted an application seeking cash assistance benefits on the basis of a disability. (Exhibit A, pp.6-11)

2. On or around November 21, 2023, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. (Exhibit A, pp. 34-56)

3. On or around November 27, 2023, the Department sent Petitioner a Notice of Case Action, denying her SDA application based on DDS' finding that she was not disabled.

4. On or around December 7, 2023, Petitioner submitted a timely written Request for Hearing disputing the Department's denial of her SDA application. (Exhibit A, p.27-32)

5. In connection with the application, Petitioner completed a Medical Social Questionnaire, on which she alleged disabling impairments due to chronic back, hip and leg pain, fatigue, nerve damage, high blood pressure, and diabetes. Petitioner also alleged post-traumatic stress disorder (PTSD), depression, anxiety and sleep disturbances. (Exhibit A, pp.20-26)

    a. With Petitioner's request for hearing, she included a handwritten letter on which she identifies several other impairments and symptoms associated with such conditions. (Exhibit A, pp. 27-32)

6. As of the hearing date, Petitioner was [redacted] years old with an [redacted], 1971, date of birth. She was [redacted] and weighed [redacted] pounds.

7. Petitioner's highest level of education is a GED. Petitioner asserted that she had no employment history in the 15 years prior to her SDA application. Petitioner asserted that she had employment history of more than 15 years ago consisting of work as a housekeeper, a janitor, and truck driver. Petitioner has reportedly not had significant employment since 2004.

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 416.922(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.

The medical evidence presented at the hearing and in response to the Interim Order was thoroughly reviewed and is briefly summarized below:

On [redacted] 2023, Petitioner's treating physician Dr. William Jacobs completed a physical medical source statement indicating that Petitioner recently started physical therapy and has a diagnosis of chronic low back pain requiring ongoing treatment. Petitioner's symptoms were noted to be fatigue, pain, leg and hip cramping, sleepiness with medications, and headaches. Petitioner's pain was characterized as severe with walking or sitting for long periods of time. Clinical findings and objective signs relied upon included MRI, CT, EMG, and bloodwork. Petitioner's side effects to her medications included sleepiness and lack of energy. Her impairments were expected to last at least 12 months and emotional factors were noted to contribute to the severity of her impairments and functional limitations. Anxiety was identified as a psychological condition that affected Petitioner's physical condition. Petitioner's impairments were reasonably consistent with the symptoms and functional limitations that were described in the evaluation. The doctor indicated that Petitioner was likely to be "off task" 25% or more of a typical workday due to symptoms severe enough to interfere with attention and concentration. Petitioner was found to as a result of her impairments, the doctor noted that Petitioner could walk less than one block, could sit 30 minutes at one time before needing to get up, could stand 45 minutes before needing to sit down or walk around, and during an eight hour working day Petitioner would sit for four hours and stand/walk for about two hours. It was indicated that Petitioner should walk five minutes every five minutes and would need to take unscheduled breaks during an eight hour workday every 45 to 60 minutes requiring a rest period of 10 minutes. While engaging in occasional standing/walking, Petitioner was to use a cane as an assistive device. Petitioner was assessed as being able to frequently lift less than 10 pounds and occasionally lift 10 pounds. Petitioner was never to lift 20 or more pounds. Additional limitations were noted as Petitioner was never to twist, stoop/bend, crouch/squat, climb ladders or climb stairs. Petitioner was unable to push/pull. Petitioner was likely to be absent from work as a result of her impairments/treatment more than four days per month. (Exhibit A, pp. 15-18)

On [redacted], 2023, Dr. Jacobs also completed a Diabetes Mellitus Residual Functional Capacity Questionnaire on which Petitioner symptoms were identified to be fatigue, difficulty walking, sensitivity to light/heat/cold, general malaise, vascular disease, muscle weakness, difficulty thinking/concentrating, dizziness/loss of balance occasionally with blood sugar fluctuations, and headaches. Petitioner was to avoid exposure to extreme heat and extreme cold. All other findings were noted to be the same as the above referenced medical source statement. (Exhibit A, pp. 12-14)

Progress notes from Petitioner's [redacted] 2023 virtual telehealth visits with Ascension Eastwood Behavioral Health indicate that Petitioner was receiving mental health treatment for her diagnoses of mild recurrent major depression and generalized anxiety disorder. During both the [redacted] 2023, and [redacted], 2023, visits Petitioner's mood, affect, thought process, and thought content were appropriate. She had no perception distortion, denied active and passive suicidal ideations, had no homicidal ideations, and no anger outbursts or violent behaviors. (Exhibit B, pp.24-25)

On [redacted], 2023, Petitioner was evaluated by Dr. Jacobs following a hospitalization from [redacted] 2023, to [redacted], 2023. Progress notes indicate that Petitioner had an abscess and was fighting and infection at the time of her hospitalization. She had elevated blood sugar with an A1c of 15. Due to Petitioner's uncontrolled diabetes, she was placed on insulin. Petitioner reported that she had not been treated by a physician in years, had not been watching her diet or properly managing her diabetes. Petitioner had history of high blood pressure, anxiety disorder, diabetes, and chronic pain with a history of a back injury. It was reported that Petitioner has trouble sleeping. Petitioner's insight was noted to be good, and she had normal mood, affect, memory, and presented as active/alert. Petitioner's musculoskeletal examination was normal. Petitioner was diagnosed with uncontrolled type II diabetes, insomnia, anxiety, essential hypertension, low back pain and was referred to physical therapy. On [redacted] 2023, Petitioner had a follow-up appointment with Dr. Jacobs. Upon physical examination, Petitioner's foot, skin, vascular, neurological, and psychiatric examinations were all normal. Musculoskeletal examination showed normal motor strength and tone, and regarding the joints, bones, and muscles, no extremity cyanosis or edema, no contractures, malalignment, tenderness or bony abnormalities were observed. There was normal movement of all extremities. Petitioner's thoracolumbar spine was normal in appearance and curvature. During her [redacted], 2023, follow-up appointment, Petitioner reported that she continues to have trouble sleeping but reported that she is progressively making extensive changes to her diet and increasing her fruit and vegetable intake in order to manage her diabetes. Petitioner's physical and mental examination was normal. (Exhibit B, pp.26-28, 219-247)

Petitioner presented to the emergency department on [redacted] 2023, with a history of hypertension and type II diabetes. Petitioner presented with an abscess and pain in the left groin area and was diagnosed with a vulvar abscess. Petitioner was admitted to the hospital for further management of her abscess and titration of insulin for poorly controlled diabetes. She underwent diagnostic imaging and treated with antibiotics. She was started on insulin due to her severely elevated HbA1c and subsequently deemed stable for discharge on [redacted], 2023, and outpatient follow-up. (Exhibit B, pp. 71- 76, 323-502)

On [redacted] 2023, Petitioner participated in a consultative internal medicine examination, during which her chief complaints were diabetes, nerve damage, high blood pressure, anxiety, PTSD, and muscular skeletal disorder. Petitioner's medical history includes insulin-dependent diabetes for which she has received treatment since 2000. Her highest A1c level was 19 and has never been evaluated by an endocrinologist. Petitioner is receiving treatment for glaucoma and cataracts. Petitioner has nerve damage in her back since 2015 following a vehicle collision where she was the driver and taken to the hospital by EMS. Petitioner denied ever having back surgery but reported that she was involved in another accident while a passenger, also in 2015. Petitioner continues to experience paresthesia in her bilateral lower extremities and was last evaluated by a pain management doctor in 2015. She underwent chiropractic treatment and in [redacted] 2023, physical therapy. Petitioner reported to the examiner that she had difficulty standing too long, lying down, and sitting for prolonged periods of

time. Petitioner reported being unable to lift more than 20 pounds. History of hypertension was reported and being managed by medication since 2000. Petitioner reported diagnoses of anxiety and PTSD. Petitioner was seen by a psychiatrist in 2000, and most recently in 2023. She denied having been admitted for inpatient mental health treatment but did report that she takes medication for anxiety daily. Petitioner has a history of chronic back pain with the musculoskeletal disorder related to her back. Petitioner was awake, alert, and oriented x3. She answered questions without difficulty and there were no deficits noted and range of motion on her muscle exam or orthopedic/neurological supplemental report. Petitioner's respiratory, cardiovascular, gastrointestinal, and skin examinations were normal. There was no obvious spinal deformity, swelling, or muscle spasm noted in Petitioner's extremities. Petitioner's pedal pulses were 2+ bilaterally. There was no calf tenderness, clubbing, edema, varicose veins, brawny erythema, stasis dermatitis chronic leg ulcers, and no muscle atrophy or joint deformity or enlargement noted. During the examination, Petitioner did not use a cane or walking aid for support with ambulation. Her gait and stance were stable and within normal limits. Petitioner's tandem walk, heal walk, and toe walk were performed slowly. She was able to squat to 70% of the distance and recover, as well as bend to 90% of the distance and recover. The medical examiner determined that upon the examination, including the history and physical examination, as well as the documents reviewed, Petitioner has occasional limitations with standing, walking, stooping, squatting, lifting, and bending due to the findings noted including a history of diabetes, nerve damage with neuropathy in the bilateral lower extremities resulting from a back injury, as well as chronic low back pain. The examiner ordered frontal and lateral views of Petitioner's lumbosacral spine for review. Results showed no evidence of gross fracture or dislocation deformity identified as well as no evidence of gross acute injury involving the lumbosacral spine (Exhibit B, pp. 190-202).

On or around [redacted] 2023, Petitioner participated in a consultative psychiatric examination. The examiner reviewed telehealth notes from Petitioner's mental health treatment indicating that she was in psychotherapy for generalized anxiety disorder and major depressive disorder. Petitioner did not have any psychiatric hospitalizations. With respect to daily activities and functioning, Petitioner reported that she is able to take care of her own personal hygiene but relies heavily on her son for food preparation, shopping, and cleaning. With respect to her attitude and behavior, petitioner was groomed without any unconventional piercings or tattoos, there were no abnormal involuntary movements or tics. Her stream of mental activity was spontaneous with a regular rhythm and rate and was without pressured speech or psychomotor retardation. Her perceptions were normal without hallucinations or delusions. Her thought processes were normal and logical without fault blockage, thought insertion, thought broadcasting, or ideas of reference. She denied any obsessions and compulsions but reported suffering from claustrophobia. Petitioner's affect was pleasant, she denied suicidal thoughts or plans, and denied history of self-harm. She complained of sleep disturbance and appetite disturbance, but no weight change. Petitioner was oriented to person, place, date, day of the week, month, and year. The medical source statement indicates that with respect to understanding and memory, Petitioner had no impairment. She also

had no impairment with respect to concentration, persistence, and pace, as well as social and adaptation. Her prognosis was noted to be fair. (Exhibit B, pp.204-206)

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), 1.16 (lumbar spinal stenosis resulting in compromise of the cauda equina), 1.18 (abnormality of a major joint(s) in any extremity), 4.00 (cardiovascular system), 9.00 (endocrine disorders), 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 alleged exertional and nonexertional limitations due to her impairments. In connection with her application, Petitioner completed a function report detailing how her illnesses or conditions limit her daily activities. Petitioner described that she is unable to sit or stand for long periods of time, that she has fatigue and chronic pain which make it very difficult to bend, stoop, and reach. Petitioner indicated that she also has a fear of people and suffers from weakness in her legs and hips with limited range of motion. She described pain that interrupts her sleep and indicated that she needs constant reminders from her son to take her medications. She reported that she does not complete any indoor or outdoor chores and her son performs all of the chores in and out of the home. Petitioner indicated that she only drives in limited situations in case her legs give out and that she must be monitored in the event blood sugar drops too low. (Exhibit B, pp. 61-66).

Petitioner's testimony during the hearing was fairly consistent with the information she provided in her functional report. Petitioner testified that in 2015, she was involved in a vehicle accident and suffered a back injury, specifically bulging discs, pinched nerves, leg weakness, and chronic pain. Petitioner testified that there are some days she cannot get out of bed because of her back pain. She stated that her legs cramp up and she has to sit down. Petitioner testified that she is in pain every day. Petitioner testified that she can walk for 10 to 15 minutes before needing to sit down due to pain and cramping in her back and legs. She testified that she sometimes uses a cane to assist with walking. She is able to sit for 30 minutes to one hour and testified that she can lift no heavier than a gallon of milk. Petitioner testified that she is able to stand for up to 45 minutes but is unable to squat, reach, or stretch. She is able to bend with limitations. Petitioner testified that she lives with her son and her bedroom is on the first floor of the house. Petitioner testified that she can bathe herself and care for her own personal hygiene; however, modifications to her bathroom were made, including the installation of handrails. Petitioner is able to dress herself, but only wears slide in shoes because she is unable to bend to put her shoes on. Petitioner testified that although she is able to fold clothes while sitting, she does not perform any other household chores, as her son completes the chores and cooking at home. Petitioner testified that she only does online shopping and she does not drive because she has no car, and she is limited because she cannot sit for long periods of time. She testified that she has no difficulty gripping or grasping items with her hands. Petitioner confirmed that her diabetes is now controlled with insulin that she takes three times a day.

Petitioner testified that she was diagnosed with anxiety, depression, and PTSD in 2006. While she testified that she has been in therapy since 2008, there were very limited mental health records presented with the current review. Petitioner testified that she also receives medication treatment for her mental health impairments. Petitioner stated that she suffers from anxiety attacks, that she gets extremely fidgety in large groups of people and has difficulty breathing in crowds. She testified that her body is sensitive to

hot and cold temperatures and cannot be in a closed room as she indicated she has to be able to leave the room. Petitioner testified that she has difficulty with concentration and is able to focus for only 30 minutes at a time. She reported having short-term memory problems and it was noted during the hearing that Petitioner had difficulty recalling dates and specific details and responses to questions asked by the undersigned. Petitioner confirmed that she does not suffer from suicidal or homicidal ideations and does not have any issues with anger management. Petitioner confirmed that she has had no inpatient psychiatric hospitalizations.

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

The evidence presented is considered to determine the consistency of Petitioner's statements regarding the intensity, persistence, and limiting effects of her symptoms. Based on a thorough review of Petitioner's medical record and in consideration of the reports and records presented from Petitioner's treating physicians, 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 medical records presented, as well as Petitioner's testimony, 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, stooping, climbing, crawling, bending, or crouching. Additionally, records indicate that Petitioner suffers from major depressive disorder, PTSD, and anxiety. However, Petitioner's limitations are mild with respect to her ability to understand, remember, or apply information; in her ability to interact with others; and in her ability to adapt or manage oneself.

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

Step Four

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

relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner had a limited work history in the 15 years prior to the application with brief periods of employment. 20 CFR 416.965(a). Because Petitioner does not have a past relevant work history, Petitioner 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 52 years old at the time of application and 53 years old at the time of hearing, and thus, considered to be closely approaching advanced age (50-54) for purposes of Appendix 2. Petitioner obtained a GED and has unskilled work history. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities. Thus, based solely on her exertional RFC, the Medical-Vocational Guidelines result in a disability finding based on Petitioner's exertional limitations. Additionally, although an analysis of the additional nonexertional/mental limitations is not necessary for the evaluation, it is noted that 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, stooping, climbing, crawling, bending or crouching and mild limitations with respect to her ability to understand, remember, or apply information; in her ability to interact with others; 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, notwithstanding the disability finding based on the medical vocational guidelines, the evidence would also be insufficient to establish that Petitioner is able to adjust to other work. Accordingly, Petitioner is found disabled at Step 5 for purposes of the SDA benefit program.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner disabled for purposes of the SDA benefit program.

DECISION AND ORDER

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

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE THE ORDER WAS ISSUED:

1. Re-register and process Petitioner's [redacted] 2023, 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 July 2024.

Zainab Baydoun

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

Interested Parties
BSC4
L Karadsheh

Via First Class Mail:

Petitioner
[redacted]
[redacted] MI [redacted]