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
DIRECTOR

[redacted]
MI [redacted]

Date Mailed: June 12, 2024
MOAHR Docket No.: 24-000684
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 April 11, 2024, from Detroit, Michigan. Petitioner appeared for the hearing and represented herself. The Department of Health and Human Services (Department) was represented by Kendra Hall, Medical Contact Worker.

Exhibit A, pp. 1-1,185 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 from her treatment at Northland Radiology. On or around May 8, 2024, Petitioner submitted 72 pages of medical records. The documents were received, marked, and admitted into evidence as Exhibit 1, pp. 1-72. The record was subsequently closed on May 14, 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.

2. On or around November 9, 2023, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. (Exhibit A, pp. 14-21)

3. On or around December 1, 2023, 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. 5-10)

4. On or around January 22, 2024, Petitioner submitted a timely written Request for Hearing disputing the Department's denial of her SDA application. (Exhibit A, p.3-4)

5. In connection with the application, Petitioner completed a Medical Social Questionnaire, on which she alleged disabling impairments due to chronic pain in her neck, back, legs, and hip. She also alleged sciatic nerve pain and arthritis pain, as well as diabetes, mini stroke, and joint pain. Petitioner confirmed that she did not allege any mental impairments. (Exhibit A, pp.23-29)

6. As of the hearing date, Petitioner was [redacted] years old with a [redacted] 1964, date of birth. She was [redacted] and weighed [redacted] pounds.

7. Petitioner's highest level of education is an associate degree. Petitioner has employment history of work as a secretary, an administrative assistant, and a juvenile detention specialist. Petitioner was last employed in 2023.

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:

Petitioner was evaluated at Northland Radiology on [redacted] 2023, and reported that she was involved in a motor vehicle collision on [redacted] 2023. She reported that she was a restrained driver when she was hit broadside on the driver side and pushed into a tree on the passenger side. She was taken to Henry Ford Hospital and discharged after evaluation. She reported that she was employed as a juvenile detention specialist prior to the accident. Since the motor vehicle collision, she has been experiencing neck pain, mid back pain, low back pain, right shoulder pain, right hand pain, bilateral hip pain, pelvic pain, bilateral ankle pain, bilateral foot pain, and bilateral knee pain. The neck pain travels into her right upper extremity and can reach 10/10 at its worst and 8/10 at its best. The neck pain is an aching, sharp, shooting, stiff, and throbbing pain that is constant and worsened with turning head and range of motion. The neck pain is improved with inactivity and rest. The mid back pain is aching, sharp, stiff, and throbbing pain that is constant and worse with bending, lifting, walking, mobilizing stairs, and prolonged sitting or standing. Petitioner's low back pain traveled into both lower extremities and reach a pain level of 10/10 at its worst. The pain was aching, sharp, shooting, stiff, and throbbing. Low back pain was improved with assistive devices, and rest. Petitioner reported constant aching and throbbing pain in her right shoulder that is made worse by lifting and with motion. Petitioner reported chronic pain in her hands,

hips, and pelvic area, as well as identified pain in her bilateral knees during the assessment. Examination of Petitioner's musculoskeletal system showed painful range of motion of the cervical spine with flexion, extension, rotation, and lateral flexion as well as tenderness over the cervical paravertebral and trapezius muscles bilaterally. Spurling's maneuver appeared positive on the right and radiated to the hand. Painful range of motion and tenderness of the thoracic spine was noted in all planes. Straight leg raise was positive on the right and left, radiating to both feet. Examination of the shoulders revealed painful range of motion bilaterally with tenderness to palpation bilaterally. There was impingement positive on the right and pain with rotator cuff muscle testing positive on the right as well. Weakness with rotator cuff testing appeared positive on the right. Painful range of motion, tenderness with palpation, and weakness with muscle testing on the right wrist were found. Tenderness over the bilateral sacroiliac joints was positive bilaterally as was tenderness over the greater trochanters of the bilateral hips with pain present upon range of motion. Diffuse tenderness of the bilateral knees and pain were present with range of motion, as was pain present with valgus and varus stress. Petitioner was wearing a back brace during the assessment and the doctor noted that her gait was slow and antalgic. Follow-up MRI imaging was recommended as well as physical therapy, EMG/MCV on the upper and lower extremities, along with medications and consultations with neurology and interventional pain management physicians. (Exhibit 1)

On [redacted] 2023, Petitioner presented to Northland Radiology for a follow-up appointment during which she continued to describe pain 10 out of 10 at times. She was participating in physical therapy and receiving medication treatment. Upon examination, there was pain with range of motion of the cervical spine in all planes, as well as tenderness with palpation over the cervical paravertebral muscles and trapezius muscles bilaterally. There was pain with range of motion of the lumbosacral spine in all planes and tenderness with palpation over the lumbosacral paravertebral muscles and gluteal muscles bilaterally. She was able to mobilize to a standing position with some visible pain behavior and difficulty. Her gait was slow and antalgic. Similar findings were noted during Petitioner's [redacted], 2023, follow-up appointment. Also on [redacted] 2023, Petitioner's doctor completed a limitations certificate indicating that as a result of injuries sustained in an accident dated [redacted] 2023, Petitioner is disabled and/or limited from work and other household activities from [redacted] 2023, through [redacted] 2024. The limitations certificate also indicates that Petitioner is unable to drive more than 10 miles a day and requires transportation services. During Petitioner's [redacted] 2024, follow-up appointment, petitioner reported that her pain is severe and that the medications she had been prescribed were not providing enough pain relief. Records indicate that Petitioner was scheduled to have a shoulder surgery within the next month with Dr. Holcomb. Petitioner reported pain in her left hand, wrist, and elbow pain indicating that the pain is increased when picking things up. Petitioner was observed to be in mild distress. Petitioner's work and home activity restrictions were extended through [redacted] 2024. During petitioner's [redacted] 2024, follow-up visit, notes indicate that Petitioner was cleared by her orthopedic surgeon to begin physical therapy post rotator cuff surgery. Petitioner continued to describe occasional 10/10 pain in all areas previously noted. Petitioner's work and home activity restrictions were

extended through [redacted], 2024, and records indicate that Petitioner Was recommended to be off work, avoid household activities and limit driving to no more than 10 miles per day. (Exhibit 1)

Petitioner presented results of an MRI of her thoracic spine performed on [redacted], 2023, which showed thoracic disc bulges and protrusions contributing to multilevel mild spinal canal stenosis and multilevel mild, moderate, and severe foraminal stenosis. Narrowed disc spaces and facet joint arthrosis were found at multiple levels, as were moderate foraminal stenosis at the T9-T10, T10-T11 and severe bilateral foraminal stenosis at the T11/T12. (Exhibit 1).

On [redacted], 2023, Petitioner underwent EMG and nerve conduction studies which had abnormal findings. There was electrodiagnostic evidence of a severe lower extremity sensorimotor peripheral neuropathy with axonal loss and demyelination consistent with long history of diabetes. There was no evidence of lumbosacral radiculopathy. (Exhibit 1)

On [redacted] 2023, Petitioner underwent EMG and nerve conduction studies of her bilateral upper extremities and bilateral cervical paraspinal muscles which had abnormal findings and revealed increased duration, increased amplitude and decreased recruitment in the bilateral abductor pollicis brevis muscles. There was evidence of a moderate bilateral carpal tunnel syndrome and evidence of a generalized upper extremity sensory peripheral neuropathy present consistent with Petitioner's long history of diabetes. There was no evidence of an ulnar neuropathy at or across the elbow and no evidence of a cervical radiculopathy. (Exhibit 1)

MRIs of Petitioner's right and left hip as well as her brain, also completed on [redacted] 2023, had normal findings. MRI of Petitioner's right ankle show tiny degenerative spurring at the talonavicular joint. (Exhibit 1)

Results from a [redacted] 2023, MRI of Petitioner's left knee showed no evidence of a meniscus tear, minimal joint effusion, and mild proximal patellar tendinopathy. An MRI of her right knee had similar findings. (Exhibit 1)

On [redacted], 2024, Petitioner underwent a neurological evaluation, during which she reported memory problems, headaches, dizziness, balance problems, neck pain, back pain, right sided shoulder pain, left elbow pain, numbness, and tingling. Petitioner reported that following her motor vehicle accident on [redacted], 2023, during which she had a direct head injury, she has been experiencing headaches five days a week with throbbing pain to the temporal area lasting for hours and a pain scale of 10 out of 10. She reported photosensitivity and phonophobia but denied nausea or vomiting. Her neck pain was also described as 10 out of 10, as was her back pain and right sided shoulder pain. Records indicate that Petitioner was diagnosed with a torn rotator cuff and will be undergoing rotator cuff surgery next week. Records show that Petitioner has memory problems and difficulty with her short-term memory and losing her train of thought. An MRI of the brain was performed, showing chronic moderate microvascular

ischemic changes. An EEG was recommended to evaluate cognitive slowing and cognitive therapy. Moderate carpal tunnel syndrome and diabetic polyneuropathy were found upon EMG testing and records indicate that Petitioner has wrist splints and receives median nerve block injections. Petitioner continued to follow up with the neurologist and records indicate she had an appointment on [redacted], 2024, which included similar findings of those previously identified.

An EEG was completed on [redacted] 2024, and showed abnormal results because of excessive beta activity seen throughout the recording. The waveforms described in the study were not epileptiform in nature and could be seen with encephalopathy with or without medication effects like benzodiazepine and antipsychotics or excessive sleepiness related to sleep disorder. Mild amount of focal activity was seen from the left central parietal area, which could be related to a structural or functional abnormality of the brain from the left hemisphere. There was no definitive seizure activity seen. Background EKG rhythm is irregular at 86 BPM. Petitioner did have history of heart blocks but may need monitoring by her PCP or cardiologist regarding any heart abnormality. (Exhibit 1)

On [redacted] 2024, Petitioner presented for an initial interventional pain management consultation at Northland Radiology with Dr. Joshi. Petitioner was present at the appointment wearing a right shoulder sling, as she underwent right shoulder surgery on [redacted] 2024, with Dr. Holcomb. Petitioner complained of 10/10 pain in her right shoulder, and pain in her mid back, low back, right hand, bilateral hip, pelvic, bilateral ankle, bilateral foot, and bilateral knee pain with stiffness that worsens with inclement weather, in the morning, and at night, as well as with prolonged sitting, standing, transferring, or walking. Petitioner's physical examination which included evaluation of her musculoskeletal system was documented in the records and found painful range of motion and tenderness with palpation, flexion, and extension in all systems and extremities tested. Petitioner had a follow-up appointment with Dr. Joshi on [redacted] 2024, which included similar findings. (Exhibit 1)

Prior to her motor vehicle accident, Petitioner attended physical therapy for her back pain and was discharged on [redacted] 2022, with records indicating that she has not seen any significant changes to her neck, low back, upper or lower extremity pain and does not notice any changes with tolerance to her activities of daily living or household tasks. Petitioner was referred to physical therapy in [redacted] 2021 after having a history of low back and neck pain resulting from a fall in 2018. (Exhibit A, pp. 160-166, 978-1010)

Petitioner's records from her treatment with Primary Care Doctor Eboni Martin were presented and reviewed. During her [redacted] 2022, appointment, notes indicate that Petitioner has history of hyperlipidemia, hypertension and type II uncontrolled diabetes. Records indicate that Petitioner requested a referral for back and neck pain to receive physical therapy. Additional records from Petitioner's 2021, 2022 and 2023 visits with Dr. Martin were also reviewed. (Exhibit A, pp. 167-170, 565- 701, 836-932)

Petitioner was treated at the Michigan Head and Spine Institute on [redacted] 2023, and records show she had a known history of a fall which resulted in two herniated discs at C5 and C6 of the cervical spine. Records also show a small central disc protrusion at the L4 – L5 area. Most recently, Petitioner was involved in a motor vehicle accident on [redacted] 2023, and has since then had progressive neck and back pain. The neck pain radiates down to the arm and down to the right first digit. Back pain is associated with left leg pain and she uses a back brace. Some numbness, tingling in her hands, dropping objects, and handwriting changes were also reported. A reviewed MRI showed moderate to severe spinal canal stenosis at C5 – C7 and disc protrusions at C3 – C5. MRI of the shoulder and lumbar spine were ordered as well as a referral to a pain management specialist. (Exhibit A, pp. 349-354, 491-495)

Results of Petitioner's [redacted], 2023, MRI of the lumbar spine showed a disc bulge with a disc herniation of the L4 – L5 causing mild to moderate canal stenosis and neural foraminal narrowing bilaterally, worse towards the right side, as well as facet arthropathy moderate to marked in severity. A disc bulge was present at the L5 – S1 with facet arthropathy. Loss of lumbar lordosis was noted. A disc bulge was present at the T 11 – T 12 level with foraminal narrowing identified as moderate to severe towards the right and mild to moderate towards the left. (Exhibit A, pp. 352-353)

Results of Petitioner's [redacted], 2023, MRI of the right shoulder showed a full thickness tear of the supraspinatus tendon with a 1.5 cm defect identified. A superior labrum tear, SLAP type-II with a tear at the biceps labral junction was found as was a long head of the biceps tendon full thickness tear proximally was discovered. Arthrosis of the AC (acromioclavicular) joint, moderate to marked in severity is likely causing impingement as well as AC joint edema with strain and joint effusion. (Exhibit A, pp. 354-355)

A [redacted] 2023, MRI of Petitioner's cervical spine showed acute cervical disc herniations at C3-C4 through C6-C7 causing moderate severe central stenosis and marked neural foraminal narrowing with exiting nerve root compression at C5-C6 and C6-C7. Associated radiculopathies warrant clinic consideration with EMG/NCV correlation. (Exhibit A, pp. 372-373)

Records from Petitioner's treatment with the Otolaryngologist were also presented and reviewed. Petitioner was evaluated for a thyroidectomy due to an enlarged thyroid.

Records from Petitioner's treatment at Henry Ford Hospital Emergency Department following her motor vehicle accident on [redacted], 2023, were presented and reviewed. (Exhibit A, pp. 747- 792)

An Independent Medical Examination Report from an examination completed on [redacted] 2023, was reviewed. Following the assessment, the doctor noted that there were no recommended limitations with respect to Petitioner's ability to sit, stand, walk, weight bear, and no manipulative restrictions or limitations. There were postural

recommendations of only occasional bending, stooping, squatting, crouching, and/or crawling. (Exhibit A, pp. 798-811)

Prior to her motor vehicle accident, Petitioner was also receiving treatment from a physical medicine and rehabilitation doctor. Records were presented and reviewed which document this treatment from [redacted] 2023 through [redacted] 2023. (Exhibit A, pp. 815- 825)

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), and 9.00 (endocrine 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).

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. (Exhibit A, pp. 58-65). Petitioner's testimony during the hearing was fairly consistent with the information she provided in her functional report. Petitioner testified that in [redacted] 2022 she had a stroke and prior to that time, had an accident which resulted in herniated discs and sciatic

nerve pain. Petitioner testified that on [redacted], 2023, she was involved in a motor vehicle accident after which her impairments worsened. Petitioner testified that she recently had right shoulder surgery and has not fully recovered. She testified that she can walk for five minutes and requires the assistance of a cane. She is unable to grip or grasp items with her hands as she has numbness. She testified that she is able to sit for 10 minutes and then has to stand up or move around. She is unable to lift even a gallon of milk. Petitioner testified that she cannot bend or squat and can only stand for five minutes at a time. Petitioner testified that she struggles with bathing herself, and has installed a higher toilet seat in the bathroom of her home. Petitioner stated that her daughter assists her with dressing and bathing. She testified that her daughter performs all household chores and cooking. Petitioner testified that her daughter comes to her home every other day and that her daughter performs all of her shopping. She stated that her daughter cooks all of her food for the week on Sunday.

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. Petitioner's statements are supported by the extensive medical records presented for review and documented impairments. 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). However, Petitioner is unable to perform the full range of sedentary work thus, the occupational base is eroded by her additional limitations or restrictions. SSR 96-9p; SSR 85-15. 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, handling, stooping, climbing, crawling, bending, or crouching.

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 secretary, an administrative assistant, and a juvenile detention specialist. Petitioner's reported past employment can be classified as requiring sedentary to light exertion. Based on the RFC analysis above, Petitioner's exertional RFC limits her to sedentary work activities, with additional mild to moderate nonexertional limitations. As such, Petitioner is incapable of performing past relevant work. Because Petitioner is unable to perform past relevant work, she cannot be found disabled, or not disabled, at Step 4, and the assessment continues to Step 5.

Step Five

If an individual is incapable of performing past relevant work, Step 5 requires an assessment of the individual's RFC and age, education, and work experience to determine whether an adjustment to other work can be made. 20 CFR 416.920(a)(4)(v); 20 CFR 416.920(c). If the individual can adjust to other work, then there is no disability; if the individual cannot adjust to other work, then there is a disability. 20 CFR 416.920(a)(4)(v).

At this point in the analysis, the burden shifts from Petitioner to the Department to present proof that Petitioner has the RFC to obtain and maintain substantial gainful employment. 20 CFR 416.960(c)(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978).

When the impairment(s) and related symptoms, such as pain, only affect the ability to perform the exertional aspects of work-related activities, Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix 2, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

However, when a person has a combination of exertional and nonexertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination **unless** there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969a(d).

In this case, Petitioner was [redacted] years old at the time of application and at the time of hearing, and thus, considered to be advanced age and closely approaching retirement for purposes of Appendix 2. Petitioner obtained an associate degree and has semi-skilled work history that is not transferable. 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. 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 [redacted] 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
Keisha Koger-Roper
Wayne-District 31 (Grandmont)
17455 Grand River
Detroit, MI 48227
MDHHS-Wayne-31-Grandmont-Hearings@Michigan.gov

Interested Parties
BSC4
L Karadsheh
MOAHR

Via First Class Mail:

Petitioner
[redacted]
MI