STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

[redacted]

Reg. No.: 14-007844
Issue No.: 4009
Case No.: [redacted]
Hearing Date: October 20, 2014
County: Wayne-District 18

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

HEARING DECISION

Following Claimant'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; and 45 CFR 205.10. After due notice, a telephone hearing was held on October 20, 2014, from Detroit, Michigan. Participants on behalf of Claimant included the Claimant. Participants on behalf of the Department of Human Services (Department) included [redacted], Medical Contact Specialist.

ISSUE

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional records. Claimant was ordered to obtain DHS-49s, medical examination reports, from several doctors and a DHS49-D, psychiatric/psychological evaluation report and DHS 49-E, mental residual functional capacity assessment. A single DHS-49 was received on December 3, 2014. The record was closed, and the matter is now before the undersigned for a final determination.

ISSUE

Whether the Department properly determined that Claimant 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 March 5, 2014, Claimant submitted an application for public assistance seeking SDA benefits.

2. On July 11, 2014, the Medical Review Team (MRT) found Claimant not disabled.

3. On July 16, 2014, the Department sent Claimant a Notice of Case Action denying the application based on MRT's finding of no disability.

4. On August 1, 2014, the Department received Claimant's timely written request for hearing.

5. Claimant alleged physical disabling impairment due to foot and ankle trauma and pain.

6. Claimant alleged mental disabling impairment due to depression.

7. On the date of the hearing, Claimant was [redacted] years old with a [redacted], birth date; he is [redacted]" in height and weighs about [redacted] pounds.

8. Claimant graduated from high school.

9. Claimant has an employment history of work as laborer at a saw mill and restaurant worker in various capacities (line cook, sous chef, busboy and waiter).

10. Claimant's impairments have lasted, or are expected to last, continuously for a period of 90 days or longer.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Human Services Bridges Administrative Manual (BAM), Department of Human Services Bridges Eligibility Manual (BEM), and Department of 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.

A disabled person is eligible for SDA. BEM 261 (July 2014), 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).

To determine whether an individual is disabled for SSI purposes, the trier of fact must apply a five-step sequential evaluation process to consider the following:

> (1) whether the individual is engaged in substantial gainful activity (SGA);
> (2) whether the individual's impairment is severe;
> (3) whether the impairment and its duration meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404;
> (4) whether the individual has the residual functional capacity to perform past relevant work; and
> (5) whether the individual 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, a determination or decision is made with no need 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

As outlined above, 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, Claimant has not engaged in SGA activity during the period for which assistance might be available. Therefore, Claimant is not ineligible under Step 1 and the analysis continues to Step 2.

Step Two

Under Step 2, the severity of an individual's alleged impairment(s) is considered. If the individual does not have a severe medically determinable physical or mental impairment

that meets the duration requirement, or a combination of impairments that is severe and 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 regardless of age, education and work experience. 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, including (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).

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 minimus* 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).

In the present case, Claimant alleges physical disabling impairment due to foot and ankle trauma and pain and mental disabling impairment due to depression. The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

On September 6, 2013, Claimant completed an assessment with the [redacted]. Claimant reported (i) chronic pain due to a slip and fall injury while roofing 5 years previously that had not properly healed despite surgery and (ii) resulting depression following the injury and losses of his home, wife and child, and car. He reported that he was hospitalized for four days in 2011 for depression/suicidality. Claimant was diagnosed with major depressive disorder, recurrent, severe without psychosis, and given a global assessment function (GAF) score of 48. (Exhibit 1, pp. 29-38.) Claimant admitted being addicted to Vicodin and taking more than prescribed; substance abuse treatment was recommended. (Exhibit 1, pp. 40-41).

On October 1, 2013, a psychiatric evaluation was completed. The mental status examination showed intact attention, concentration and recent, remote and immediate memory but limited judgment and insight. The evaluator agreed with the diagnosis of major depressive disorder, recurrent, severe without psychosis and the GAF score of 48. His prognosis was guarded. It was noted that substance abuse was denied, with

Claimant reporting that he was not getting any additional Vicodin on the streets anymore. (Exhibit 1, pp. 42-52). Claimant's medical records include from his sessions at the [redacted] on September 25, 2013 (Exhibit 1, pp. 73-81, 83-90); November 12, 2013 (Exhibit 1, pp. 64-72); February 3, 2014 (Exhibit 1, pp. 55-63); and progress notes, contact notes, and medication reviews through April 30, 2014 (Exhibit 1, pp. 91-160).

Claimant's file also included medical records concerning Claimant's complaints of ongoing foot and ankle pain following a 2007 work accident. On February 19, 2014, Claimant visited his doctor, and the doctor noted ongoing pain in both feet. Claimant received medication for hypertension, which was well controlled, and for mood swings, as prescribed by a psychiatrist. The doctor noted use of assistive device (a cane) to walk and his examination confirmed instability in both feet. (Exhibit 1, pp. 163-165). Doctor's notes from Claimant's July 2, 2014 office visit show that Claimant complained of foot pain but a review of the musculoskeletal system showed normal range of motion of all joints tested in the upper and lower extremity (Exhibit 1, pp. 4-6). Claimant's records include additional doctor reports from visits on May 7, 2013 (Exhibit 1, pp. 172-173); June 3, 2013 (Exhibit 1, pp. 168-169); October 3, 2013 (Exhibit 1, pp. 166-167); April 2, 2014 (foot pain and observations for suspected gastrointestinal bleeding after Claimant reports noting rectal bleeding two to three times the past month month) (Exhibit 1, pp. 182-184); April 7, 2014 (foot pain but normal range of motion in all extremities) (Exhibit 1, pp. 176-178)

On June 10, 2014, Claimant participated in a mental status consultative examination at the request of the Department. Claimant reported to the examiner that his depression began after he was injured at work in 2007 when he fell off a roof and fractured both legs, ankles, and feet. He had reconstructive surgery on both feet and both ankles in 2011. The examiner noted that Claimant used a cane to ambulate and appeared to painstakingly take each step with unsteady caution and was unable to remain standing for more than a few minutes or ambulate more than several yards at a time without apparent difficulty. Claimant reported treatment from [redacted] since 2013 but that he no longer received outpatient treatment because his therapist was "out on medical." Claimant provided documentation from the [redacted] concerning a September 4, 2013 admission and September 6, 2013 and October 1, 2013 visits showing diagnosis of major depressive disorder, recurrent, severe without psychotic features. He also provided documentation that his attempts to return to work were thwarted by his pain and depression.

In his report, the evaluator confirmed the diagnosis of major depressive disorder, recurrent, severe without psychotic features, and identified a global assessment function (GAF) score of 50 and a prognosis of good. The evaluator noted that Claimant's symptoms caused clinical distress including disruption in appetite (reported weight gain of 40 pounds in the last year), sleep disturbance, social isolation, lack of energy or interest in hobbies, crying jags, and feelings of hopelessness. The evaluator concluded as follows: (i) Claimant would be unable to sustain suitable concentration to

meet the demands of any work-related activities; (ii) he would have severe difficulty behaving in an appropriate manner in a work place, especially if he is feeling pressured to perform work-related duties in a professional manner; and (iii) it was unlikely he would be able to cope well in a competitive work setting without undue anxiety. The evaluator noted that Claimant provided written documentation to support his medical history and a time line of events exacerbating his symptoms after his work-related accident and that there was no evidence of malingering (Exhibit 1, pp. 18-25).

On November 18, 2014 x-ray of Claimant ankles were taken. The x-ray of the right ankle showed no sizable ankle joint effusion; old hardware within the left calcaneus; severe posterior subtalar spurring, plantar and dorsal calcaneal spurring and moderate midfoot dorsal spurring; no acute fracture or dislocation; maintained ankle mortise; and deformity of the distal fibula which may relate to prior trauma. The x-ray of the left ankle showed no soft tissue swelling; mortise and solid or maintained ankle; hardware with the calcaneus with dorsal and plantar calcaneal spurring; libio-talar osteoarthrosis, subtalar osteoarthrosis, and dorsal spurring; no acute fracture or dislocation. The reviewing radiologist concluded that there were bilateral osteoarthritic changes about the ankle, presumably posttraumatic in etiology given the hardware within the left and right calcaneus and old lateral malleolus fractures.

On November 21, 2014, Claimant's treating physician, [redacted], completed a medical examination report, DHS 49. The legible portions of the DHS-49 identify Claimant's impairments as pain in right knee and both ankles, surgery all three joints, depression, and intermittent claudication of both calves and his diagnoses as hypertension, essential, pain in joint involving ankle, peripheral neuropathy, and mildly decreased palpitation in the toes of both feet. In his physical exam, the doctor noted a decreased range of motion of both ankles, small steps due to both pain and decreased range of motion (referencing x-rays), and mildly decreased palpitation in toes and both feet. Claimant's doctor indicated that Claimant's condition was stable but concluded Claimant could occasionally lift less than 10 pounds but could never lift 10 or more pounds. Where asked to identify any standing or sitting restrictions, the doctor notes that Claimant complains of an inability to stand for prolonged periods and an inability to ambulate without an assistive device. There were no limitations identified with respect to Claimant's ability to use any extremity for any repetitive action. The doctor also identified a limitation in Claimant's sustained concentration. The doctor stated there were potential self-care deficits due to Claimant's mental limitations but then indicated that Claimant could meet his needs in the home.

In consideration of the de minimus standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Claimant suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Claimant 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.

The evidence shows diagnosis of, and treatment for, ankle and foot trauma and depression. Based the medical evidence concerning Claimant's ankle and feet issues, Listings 1.00 (musculoskeletal system), particularly 1.02 (major dysfunction of a joint), was reviewed. To meet a listing under 1.00, the client must have a functional loss, which involves the inability to ambulate effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment, or the inability to perform fine and gross movements effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment. To support a listing for dysfunction of a joint under 1.02(A), the client must have a

> gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankyloses, instability) and chronic joint pain and stiffness with signs of limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With
>
> A. Involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in inability to ambulate effectively, as defined in 1.00B2b

In this case, Claimant's medical record established that he had ongoing complaints concerning his ability to ambulate effectively due to his foot and ankle pain. Claimant's doctor noted in the DHS-49 he completed on November 21, 2014 that Claimant complained of an inability to stand prolonged periods and to ambulate without an assistive device and the physical exam showed decreased range of motion in both ankles and limitations concerning his steps due to both pain and decreased range of motion. The doctor referenced November 18, 2014 x-ray of Claimant ankles. The x-ray of the right ankle showed no sizable ankle joint effusion; old hardware within the left calcaneus; severe posterior subtalar spurring, plantar and dorsal calcaneal spurring and moderate midfoot dorsal spurring; no acute fracture or dislocation; maintained ankle mortise; and deformity of the distal fibula which may relate to prior trauma. The x-ray of the left ankle showed no soft tissue swelling; mortise and solid ankle; hardware within the calcaneus with dorsal and plantar calcaneal spurring; libio-talar osteoarthrosis, subtalar osteoarthrosis, and dorsal spurring; no acute fracture or dislocation. The reviewing radiologist concluded that there were bilateral osteoarthritic changes about the ankle, presumably posttraumatic in etiology given the hardware within the left and right calcaneus and old lateral malleolus fractures.

While the x-rays are sufficient to support Claimant's complaints of pain and his inability to ambulate effectively, they are not sufficient to establish a gross anatomical deformity necessary to meet the listing. Therefore, Claimant's impairments from his ankle and feet trauma do not meet, or equal, the severity of a listing under 1.02.

Claimant's medical records also showed diagnosis of, and treatment for, severe depression. Listing 12.00, particularly Listings 12.04 (affective disorders), was reviewed. Claimant's medical records do not support a finding that the level of severity of impairments is sufficient to meet, or equal, the requirements in this listing.

Because Claimant's physical and mental conditions are insufficient to meet, or to equal, the severity of a listing, Claimant 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 Step 4, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. Impairments, and any related symptoms, may cause physical and mental limitations that affect what a person can do in a work setting. 20 CFR 416.945(a)(1). RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s) 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). The RFC takes into consideration the total limiting effects of all impairments, including those that are not severe. 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 applicants 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 the limitations and restrictions imposed by the individual's impairment(s) 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). To determine the exertional requirements, or physical demands, of work in the national

economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a).

> Sedentary work.
> 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. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.
>
> Light work.
> 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 this 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. To be considered capable of performing a full or wide range of light work, [an individual] must have the ability to do substantially all of these activities. If someone can do light work, . . . he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.
>
> Medium work.
> Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, . . . he or she can also do sedentary and light work.
>
> Heavy work.
> Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, . . . he or she can also do medium, light, and sedentary work.
>
> Very heavy work.
> 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. If someone can do very heavy work, . . . he or she can also do heavy, medium, light, and sedentary work. 20 CFR 416.967.

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., can't 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, Claimant alleges both exertional limitations due to his foot and ankle trauma and nonexertional limitations due to his mental condition. With respect to his exertional limitations due to his foot an ankle trauma, Claimant complained of swelling and dull, sharp pains in his knees and ankles and testified that he had experienced

these symptoms since falling off a roof at work six years prior. Because of his foot and ankle pain, he testified that he could walk about a ½ block and then need to rest; he could sit but his ankles would swell and he would have to lift them to keep down the swelling and the pain; he could not lift more than 10 pounds; he could stand for about 15 to 20 minutes then experience pain; and he could bend and squat and take stairs with difficulty. He did not have difficulty gripping and grasping items. He lived with a friend and was able to take care of his own personal hygiene and dressing; he cooked, cleaned and could do laundry if he could sit down; he shopped with a friend, using the cart to rest on; and he drove.

Claimant's medical records support his claims concerning his foot and ankle injuries. The November 2014 x-rays of both feet showed (i) hardware in both feet and osteoarthritic changes about both ankle, presumably posttraumatic in etiology, (ii) severe posterior subtalar spurring, plantar and dorsal calcaneal spurring and moderate midfoot dorsal spurring; and deformity of the distal fibula in the right foot and (iii) dorsal and plantar calcaneal spurring; libio-talar osteoarthrosis, subtalar osteoarthrosis, and dorsal spurring on the left foot. In his DHS 49, Claimant's treating physician noted that Claimant used a cane to walk and indicated an inability to stand for prolonged periods. The doctor limited Claimant to lifting/carrying up to 10 pounds occasionally (1/3 of an 8 hour day) but never 10 pounds or more. Based on Claimant's testimony of his pain and limitations and the medical record support for the impairments resulting in such limitations, Claimant is found to have exertional limitations limiting him to sedentary work activities as defined in 20 CFR 416.967(a).

Claimant also alleged nonexertional limitations due to his mental condition. 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). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). In addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of mental functional limitation. 20 CFR 416.920a(c)(3). The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. Id. The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. Id.

At the hearing, Claimant testified that his depression began after his accident. He stated that he experienced anxiety attacks, although those had decreased to about one every three to four months since he began taking medication; his memory was not as good as it used to be; he sometimes had crying spell; he has anger issues, primarily aimed at himself; and that he used to hear voices and see things but that treatment had helped reduce those episodes.

Claimant's medical records show that he was diagnosed with severe depression, recurrent without psychosis, in October 2013. In a June 10, 2014 consultative mental status report prepared at the request of the Department, the evaluator confirmed the diagnosis of major depressive disorder, recurrent, severe without psychotic features, and identified a global assessment function (GAF) score of 50 and a prognosis of good. Based on his mental status evaluation, the evaluator concluded that (i) Claimant would be unable to sustain suitable concentration to meet the demands of any work-related activities; (ii) he would have severe difficulty behaving in an appropriate manner in a work place, especially if he is feeling pressured to perform work-related duties in a professional manner; (iii) it is unlikely he would be able to cope well in a competitive work setting without undue anxiety. The evaluator noted that Claimant provided written documentation to support his medical history and a time line of events supporting the exacerbation of his symptoms after his work-related accident and that there was no evidence of malingering (Exhibit 1, pp. 18-25). The evidence presented was sufficient to establish that Claimant's mental impairments resulted in at least moderate limitations on his ability to perform basic work activities.

Claimant's RFC is considered at both steps four and five. 20 CFR 416.920(a)(4), (f) and (g).

Step Four

Step 4 in analyzing a disability claim requires an assessment of Claimant's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed 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). 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).

As determined in the RFC analysis above, Claimant is limited to no more than sedentary work activities and has at least moderate limitations in his mental capacity to perform basic work activities. Claimant's work history in the 15 years prior to the application consists of work as a laborer in a saw mill (heavy, semi-skilled) and restaurant employee (medium, unskilled and semi-skilled). In light of the entire record and Claimant's RFC, including his mental limitations, it is found that Claimant is unable to perform past relevant work. Accordingly, Claimant cannot be found disabled, or not disabled, at Step 4 and the assessment continues to Step 5.

Step 5

In Step 5, an assessment of Claimant's RFC and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v). If the individual can adjust to other work, then there is no disability. Disability is found if an individual is unable to adjust to other work.

At this point in the analysis, the burden shifts from Claimant to the Department to present proof that Claimant has the RFC to obtain and maintain substantial gainful employment. 20 CFR 416.960(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). 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, at the time of hearing, Claimant was [redacted] years old and, thus, considered to be a younger individual (age 45-49) for purposes of Appendix 2. He is a high school graduate with a history of semi-skilled work experience as a saw mill laborer and in the restaurant industry. Because Claimant's prior work experience involves significant standing and lifting, the skills from his prior employment are not transferable. 20 CFR 416.968. As discussed above, Claimant maintains the RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities and has moderate limitations on his mental ability to perform work activities. While the Medical-Vocational Guidelines do not result in a disability finding based on Claimant's exertional limitations, Claimant medical record also shows nonexertional limitations resulting in moderate restrictions in his ability to perform basic work activities. After review of the entire record, including Claimant's testimony, and in consideration of Claimant's age, education, work experience, physical as well as mental RFC, it is found that Claimant's exertional limitations, coupled with his nonexertional limitations, make him unable to adjust to other work. Therefore, Claimant is found disabled at Step 5 for purposes of 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 Claimant disabled for purposes of the SDA benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is REVERSED.

THE DEPARTMENT IS ORDERED TO BEGIN DOING THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE OF MAILING OF THIS DECISION AND ORDER:

1. Process Claimant's March 5, 2014, SDA application to determine if all the other non-medical criteria are satisfied and notify Claimant of its determination;

2. Supplement Claimant for lost benefits, if any, that Claimant was entitled to receive if otherwise eligible and qualified;

3. Review Claimant's continued eligibility in January 2016.

Alice C. Elkin
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: **12/22/2014**

Date Mailed: **12/22/2014**

ACE / tlf

NOTICE OF APPEAL: A party may appeal this Hearing Decision in the circuit court in the county in which he/she resides, or the circuit court in Ingham County, within 30 days of the receipt date.

A party may request a rehearing or reconsideration of this Hearing Decision from the Michigan Administrative Hearing System (MAHS) within 30 days of the mailing date of this Hearing Decision, or MAHS may order a rehearing or reconsideration on its own motion.

MAHS may grant a party's Request for Rehearing or Reconsideration when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion;

- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the client;
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The party requesting a rehearing or reconsideration must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date this Hearing Decision is mailed.

A written request may be faxed or mailed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

cc: [redacted]