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

IN THE MATTER OF:

[redacted]

MAHS Reg. No.: 15-018988
Issue No.: 4009
Agency Case No.: [redacted]
Hearing Date: December 03, 2015
County: Wayne-District 15 (Greydale)

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

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; and 45 CFR 205.10. After due notice, a telephone hearing was held on December 3, 2015, from Detroit, Michigan. Petitioner and his mother, [redacted] were present and testified. [redacted] also served as Petitioner's authorized hearing representative. The Department of Health and Human Services (Department) was represented by [redacted], Assistance Payment Worker.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. The requested documents were received and marked into evidence as Exhibit 2. The record closed on January 4, 2016, and the matter is now before the undersigned for a final determination based 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 March 13, 2015, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On September 18, 2015, the Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 4-11).

3. On September 21, 2015, the Department sent Petitioner a Notice of Case Action denying the application based on MRT's finding of no disability.

4. On October 8, 2015, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 2-3).

5. Petitioner alleged disabling impairment due to arthritis, asthma, vision problems, and mental conditions.

6. On the date of the hearing, Petitioner was [redacted] years old with a [redacted], birth date; he is 5'8" in height and weighs about 115 pounds.

7. Petitioner was enrolled in special education classes in high school. He completed the 9th grade and can read, write, and do basic math.

8. At the time of application, Petitioner was not employed.

9. Petitioner has no employment history.

10. Petitioner has a pending disability claim with the Social Security Administration.

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 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 2015), 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 that meets federal SSI disability standards for at least ninety days. BEM 261, pp. 1-2; 20 CFR 416.901.

A person is disabled for SSI purposes if the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. 20 CFR 416.905(a). To determine if this standard is met, a five-step sequential evaluation process is applied that considers whether (1) the individual is engaged in

substantial gainful activity (SGA); (2) the individual's impairment is severe; (3) the impairment and its duration meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) the individual has the residual functional capacity to perform past relevant work; and (5) 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 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 has not engaged in SGA activity during the period for which assistance might be available. Therefore, Petitioner 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 and includes (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. 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.

In the present case, Petitioner alleges disabling impairment due to arthritis, asthma, vision problems, and mental condition. The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

On [redacted], Petitioner went to the emergency department complaining of generalized fatigue, deceased appetite, and inability to sleep and alleging being suicidal. Documentation indicated that he had been previously seen in the emergency department on [redacted], for suicidal and homicidal ideation. There was no history of suicide attempts, and Petitioner denied any plans to act on any thoughts. Blood tests were positive for cannabinoids. It was determined that Petitioner suffered from depression, history of ADHD, and cannabis abuse and had a global assessment functioning (GAF) score of 40 but did not meet the criteria for inpatient psychiatric admission. A psychiatric evaluation concluded that Petitioner was at his baseline and was stable for discharge. Petitioner was advised to contact Development Center, his psychological treatment facility, to arrange for a follow-up appointment and to attend Narcotics Anonymous (NA) meetings given the fact that substance abuse played a large part in his symptoms and could affect the use of psychotropic medications. (Exhibit A, pp. 130-149.)

From [redacted], to [redacted], Petitioner was hospitalized after he threw his and his mother's possessions in the street and began breaking them because he felt his mother's boyfriend was insulting him. It was noted that he had a four year history of similar behavior and a history of paternal relatives with the same behavior. Records indicated that this was his fourth admission to the hospital's mental health unit. Though Petitioner reported a history of bipolar, there was no evidence of manic episodes. Petitioner informed hospital staff that he was seeing a psychiatrist at Development Center and had been prescribed Risperdal and Benadryl, but he admitted being noncompliant with his medication. It was noted that Petitioner had a history of

depression, marked by poor mood, low appetite, poor sleep, and occasional suicidality and reported sporadic hallucinations. He denied smoking or drinking but admitted using cannabis on a regular basis beginning at age [redacted]

In examining Petitioner on the date of discharge, the doctor noted flat and restricted affect, linear thought process and goal-directed speech with no evidence of tangentiality or circumstantiality, no current suicidal or homicidal ideations, good attention and concentration based on his participation in the interview, grossly intact memory, and fair insight and judgment, though poor by history. There was no evidence of impaired judgment, cognitive impairment, hallucination, delusions, or disorder of thought formation. He was diagnosed with depression, adult antisocial behavior, and cannabis abuse. His GAF score was 25 at admission and 30 at discharge. It was noted that he had poor social skills, family support, employment, and communication skills but good motivation for treatment. His status at discharge was fair. It was recommended that he abstain from cannabis use. (Exhibit A, pp. 35-61, 82.)

On [redacted], Petitioner went to the emergency department complaining of difficulty urinating. The presiding doctor did not measure any significant amount of urine in Petitioner's bladder, and no renal function abnormality was noted. Petitioner was able to urinate unaided while at the emergency department and asked to be released. (Exhibit A, pp. 115-126.)

Beginning [redacted], Petitioner received injections of Invega Sustenna to assist with increasing motivation, decreasing lonesomeness, increasing sleep quality, and decreasing temper tantrums. (Exhibit A, pp. 76, 78.)

An [redacted], Development Center annual psychiatric evaluation showed that Petitioner had been a patient at the center since [redacted]. At the evaluation, Petitioner was noted as having good grooming, good hygiene, cooperative behavior, mildly depressed mood, intact recent and remote memory, constricted affect, normal tone and volume, organized and coherent thought process, no hallucinations or ideations, intact fund of knowledge, and fair concentration, insight, and judgment. Petitioner had been prescribed Remeron for depression and Risperdal for impulsivity and agitation but indicated he did not regularly take the medication. A primary diagnosis of dysthymic disorder and antisocial personality disorder and secondary diagnosis of cannabis abuse were made. Petitioner's GAF score was 60, which was noted to be his highest GAF score in the past 12 months. He was encouraged to remain free from cannabis and alcohol use. His prognosis was fair depending on remaining substance free and compliance with medications and therapy. (Exhibit A, pp. 65-75.)

On [redacted], Petitioner's primary care physician, who had been his doctor since [redacted], completed a medical examination report, DHS-49, listing Petitioner's diagnoses as asthma, allergic rhinitis, antisocial disorder, and dysthymic disorder. The doctor concluded that Petitioner's physical condition was stable and he had no physical

limitations. He referred to psychiatric records for additional limitations. (Exhibit A, pp. 17-19) An [redacted], electroencephalogram (EEG) in response to reported seizure history showed results within normal limits. (Exhibit A, pp. 113-114.)

On [redacted], Petitioner was examined by a psychiatrist at the Department's request. The doctor noted that Petitioner reported feeling paranoid and hearing voices and he stopped taking his medication. The doctor observed that his contact with reality appeared to be marginal; he had some thought-blocking when he responded, and had slight problems with memory and abstract thinking. Petitioner complained of poor focus, concentration, and outbursts. The doctor concluded that, based on information provided by Petitioner and her observation of Petitioner, Petitioner was not able to function on a fully sustained basis. She diagnosed Petitioner with schizophrenia, nicotine use disorder, history of cannabis use disorder and learning disability (based on his history of special education classes). (Exhibit A, pp. 155-157.)

On [redacted], [redacted] a psychiatric mental health nurse practitioner at Development Centers, completed a psychiatric evaluation of Petitioner diagnosing him with schizoaffective disorder, intermittent explosive disorder, cannabis abuse, and personality change due to known physiological condition. The therapist also noted anti-social personality disorder, learning disorder, and rheumatoid bursitis of the knee. She assigned Petitioner a GAF score of 42. The nurse practitioner suspected frontal lobe problems due to his lack of motivation to keep himself clean, his inability to get thoughts together to write a simple letter, failure to obtain and maintain employment or do anything all day, and psychomotor retardation. She recommended a referral to neurology to rule out encephalopathy and frontal lobe issues and to assess memory testing. [redacted] noted no suicidal or homicidal ideation and stable mood. Petitioner was doing well on Invega Sustenna, with no angry outbursts and no psychosis. She also noted that he had marginal grooming and hygiene, impaired remote memory, dull awareness, fair judgment, limited insight, delayed response and slowed stream of mental activity, and unremarkable thought process, speech, presentation, and emotional state. (Exhibit 2.)

A DHS-49D, psychiatric/psychological examination report, completed with the evaluation, was consistent with the evaluation and concluded that Petitioner was unable to function independently, noting that his mother had full guardianship and his history of special education classes since age [redacted] In the DHS-49E completed with the evaluation, Petitioner's abilities in understanding and memory; sustained concentration and persistence; social interaction; and adaption were all identified as markedly limited. (Exhibit 2.)

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.

In this case, Petitioner alleged a disability due to arthritis, asthma, vision problems, and mental disorder. There was no medical evidence of vision problems. Based on the medical record presented, listings 1.02 (major dysfunction of a joint) and 3.03 (asthma), were reviewed. There was no medical evidence that Petitioner was unable to ambulate effectively to support a listing under 1.02 or that he had chronic asthmatic bronchitis or attacks to support a listing under 3.03.

Several listings for mental disorders were considered, specifically 12.03 (schizophrenic, paranoid and other psychotic disorders), 12.04 (affective disorders), and 12.06 (anxiety-related disorders), 12.08 (personality disorder), and 12.09 (substance addiction disorders). Although the psychological evaluation, DHS-49D, and DHS-49E completed on [redacted], indicate that Petitioner has substantial limitations in his ability to engage in work-related activities, because these documents were completed by a psychiatric mental health nurse practitioner, they are not considered an acceptable medical source under 20 CFR 416.913. Accordingly, the information in those records, while relevant in evaluating Petitioner's ability to function, cannot be used to support a listing under any of the mental disorder listings considered. See SSR 06-03.

Because there is not sufficient evidence from acceptable medical sources to establish 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, 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 Step 4, 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).

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). 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 alleges both exertional and nonexertional limitations due to his medical condition. With respect to his exertional limitations, Petitioner testified that he could walk two blocks without difficulty, stand for up to 30 minutes daily before his knees hurt and he would have to sit, and lift up to 50 pounds. He testified that he had no limitations in his ability to sit, grip or grasp, bend or squat, or take stairs. He lived with his mother and stepfather and cared for his own grooming and dressing. His mom did most of the chores in the home and drove him. He could shop and stay at home on his own.

There was no medical evidence to support that Petitioner had any exertional limitations. To the contrary, Petitioner's primary care physician, while identifying Petitioner as having asthma and allergic rhinitis, indicated that Petitioner's physical status was stable

and he had no physical limitations. The only reference to Petitioner's arthritis was in the [redacted], psychiatric evaluation indicating Petitioner had bursitis of the knees. Because to Petitioner's complaints of exertional limitations on his ability to stand are not supported by the medical evidence, Petitioner is found to have no exertional limitations on his ability to perform basic work activities. Accordingly, he is found to be capable of performing heavy work as defined in 20 CFR 416.967(d).

Petitioner also alleged nonexertional limitations due to mental disorders and vision problems. There was no medical evidence of any vision problems as alleged by Petitioner. Therefore, the record does not support any nonexertional limitations due to vision problems. 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. 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 this case, Petitioner testified that he liked to stay to himself and did not have any friends. He had problems with anger and would get violent about once a month when someone made him mad or if he got frustrated. He testified that he was depressed, had difficulty concentrating and remembering things, and had problems sleeping. He stated that his medications helped with his mental condition but made him dizzy. He denied any past or current cannabis use. His mother testified that she was concerned about the safety of others if Petitioner was in the workplace when he was off his medication and his ability to function if he was on medication.

Petitioner's medical record shows that Petitioner went to the emergency department due to his mental condition on [redacted], and [redacted], and was admitted from [redacted], until [redacted], with the hospital records showing that Petitioner had a history of depression, marked by poor mood, low appetite, poor sleep, and occasional suicidality and reported sporadic hallucinations. His condition appeared to slightly improve at the time of the [redacted], psychiatric evaluation, with a finding of good grooming, good hygiene, cooperative behavior, mildly depressed mood, intact recent and remote memory, constricted affect, normal tone and volume, organized and coherent thought process, no hallucinations or ideations, intact fund of knowledge, and fair concentration, insight, and judgment. At that time, Petitioner was assigned a GAF score of 60, a substantial increase from the 30 he was assigned at his [redacted], discharge.

However, Petitioner's condition appears to have worsened by the time of his [redacted] application. in the [redacted], consultative psychiatric report completed at the Department's request, the examining psychiatrist noted that Petitioner reported feeling paranoid and hearing voices, and she observed that his contact with reality appeared to be marginal, he had some thought-blocking when he responded, and had slight problems with memory and abstract thinking. Petitioner complained of poor focus,

concentration, and outbursts. The doctor concluded that, based on information provided and her observation of Petitioner, Petitioner was not able to function on a fully sustained basis. She diagnosed him with schizophrenia, nicotine use disorder, history of cannabis use disorder and learning disability (based on his history of special education classes).

The DHS-49D, DHS-49E, and psychiatric evaluation completed on [redacted], by a psychiatric mental health nurse practitioner at Development Centers, the facility that treated Petitioner, confirmed ongoing concerns about Petitioner's mental condition and are relevant to show how Petitioner's mental impairments affect his ability to work. 20 CFR 416.913(d). In those documents, Petitioner was diagnosed with schizoaffective disorder, intermittent explosive disorder, cannabis abuse, and personality change due to known physiological condition as well as anti-social personality and learning disorders and was assigned a GAF score of 42. It was noted that, while Petitioner had no suicidal or homicidal ideation, no psychosis, stable mood, no angry outbursts, and unremarkable thought process, speech, presentation, and emotional state, he had marginal grooming and hygiene, impaired remote memory, dull awareness, fair judgment, limited insight, delayed response and slowed stream of mental activity. In the DHS-49E completed with the evaluation, the nurse practitioner identified Petitioner's abilities in every category under understanding and memory, sustained concentration and persistence, social interaction, and adaption as markedly limited.

Based on the medical record presented, particularly the DHS-49E, as well as Petitioner's testimony, Petitioner has significant limitations on his mental ability to perform basic work activities and to participate in a work environment.

Petitioner'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 Petitioner's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Because Petitioner has no work history, he 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 Petitioner'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 Petitioner to the Department to present proof that Petitioner 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). However, if the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2). 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 a younger individual (age [redacted]) for purposes of Appendix 2. He completed the 9th grade and has no work history. As discussed above, Petitioner maintains the RFC for work activities on a regular and continuing basis to meet the physical demands to perform heavy work activities. While the Medical-Vocational Guidelines do not result in a disability finding based on Petitioner's exertional limitations, Petitioner has significant nonexertional limitations in his ability to perform basic work activities. These nonexertional limitations preclude him from engaging in even simple, unskilled work on a full-time, persistent basis. Therefore, after review of the entire record, including Petitioner's testimony, and in consideration of Petitioner's age, education, work experience, and mental RFC, Petitioner is found incapable of adjusting to other work. As such, he is found disabled at Step 5 for purposes of SDA benefit program.

Notwithstanding the conclusion that the medical evidence shows that Petitioner is disabled at Step 5, 42 USC 423(d)(2)(C) of the Social Security Act provides that an individual is not considered disabled if alcoholism or drug addiction is a contributing factor material to the determination that the individual is disabled. Because evidence in the medical record showed that Petitioner used marijuana, 20 CFR 416.935(a) requires a determination of whether drug addiction or alcoholism (DAA) is a contributing factor material to the determination of disability. The key factor in determining whether DAA is a contributing factor material to the determination of disability is whether the client would be disabled if he or she stopped using drugs or alcohol. 20 CFR 416.935(b)(1). This requires consideration of whether the current disability determination would remain if the client stopped using drugs or alcohol. 20 CFR 416.935(b)(2). If the remaining limitations would not be disabling, the DAA is a contributing factor material to the determination of disability. 20 CFR 416.935(b)(2)(i). If the remaining limitations are

disabling, the individual is disabled independent of the DAA and, as such, the individual's DAA is not a contributing factor material to the determination of disability. 20 CFR 416.935(b)(2)(ii). The client continues to have the burden of proving disability throughout the DAA materiality analysis. SSR 13-2p(5)(a).

In this case, there is evidence that Petitioner was advised in 2014 to abstain from marijuana use, which could affect his condition. However, the [redacted], psychiatric evaluation, which identifies significant limitations to Petitioner's mental ability to engage in work activities, acknowledges Petitioner's ongoing use of marijuana and fails to indicate that Petitioner's mental impairments would be resolved if he stopped using marijuana or that his mental impairments are cannabis-induced or cannabis-related. Therefore, there is insufficient evidence that Petitioner's marijuana use is a contributing factor material to the determination that he is disabled.

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

DECISION AND ORDER

Accordingly, the Department's 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. Reregister and process Petitioner's March 13, 2015, 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;

3. Review Petitioner's continued eligibility in August 2016.

Alice C. Elkin
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Signed: 1/22/2016

Date Mailed: 1/22/2016

ACE / jaf

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: