RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

MIKE ZIMMER
DIRECTOR

[redacted]

Date Mailed: May 12, 2016
MAHS Docket No.: 16-000157
Agency No.: [redacted]
Petitioner: [redacted]

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 March 14, 2016, from Detroit, Michigan. Petitioner appeared and represented himself. The Department of Health and Human Services (Department) was represented by [redacted], Family Independence Manager.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Petitioner's medical records from [redacted] were received and marked into evidence as Exhibit D, and Petitioner's medical records from [redacted] were received and marked into evidence as Exhibit E. The record closed on April 13, 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 September 4, 2015, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On November 18, 2015, the Medical Review Team (MRT)/ Disability Determination Services (DDS) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 1-8).

3. On November 30, 2015, the Department sent Petitioner a Notice of Case Action denying the application based on MRT's finding of no disability (Exhibit A, pp. 171-172).

4. On January 11, 2016, the Department received Petitioner's timely written request for hearing (Exhibit C).

5. Petitioner alleged disabling impairment due to left leg fracture and crushed heel; degenerative disc disease (DDD); hand numbness; left knee replacement; right leg ache; facial numbness; toothlessness; right shoulder pain; depression; and anxiety.

6. On the date of the hearing, Petitioner was [redacted] years old with an [redacted] birth date; he is [redacted] in height and weighs about [redacted] pounds.

7. Petitioner is a GED recipient.

8. Petitioner has an employment history of work as a home health aide and construction laborer.

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

10. Petitioner has a pending disability claim with the Social Security Administration (Exhibit A, pp. 157-169; Exhibit B).

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.

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 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 working, he has not engaged in SGA. Therefore, he is not ineligible under Step 1, and the analysis continues to Step 2.

Step Two

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration

requirement for SDA means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

In the present case, Petitioner alleges disabling impairment due to left leg fracture and crushed heel; DDD; hand numbness; left knee replacement; right leg ache; facial numbness; toothlessness; right shoulder pain; depression; and anxiety. The medical evidence presented at the hearing and in response to the interim order was reviewed and is summarized below. It is noted that some of the documents submitted in response to the interim order are duplicative of those included with the medical packet submitted to DDS/MRT and admitted at the hearing.

In June 2011, Petitioner had arthroscopic surgery of the knee for a torn lateral meniscus (Exhibit A, pp. 110-111, 124-25). In October 2012, he had a left total knee arthroplasty for his left knee degenerative arthritis (Exhibit A, pp. 106-109). X-rays of the knees six weeks after arthroplasty showed no sign of stress fracture, subsidence, loosening or malalignment (Exhibit A, pp. 120, 145-147). In February 2014, an eroding plate that was inserted in Petitioner's face 15 to 20 years earlier following severe facial trauma in a motor vehicle accident was removed (Exhibit D, pp. 30, 61-62, 104-113).

Beginning July 2014, Petitioner complained of severe right shoulder pain (Exhibit A, pp. 25-27). A September 11, 2014 x-ray showed right rotator cuff tears and associated rotator cuff tendinosis and mild joint osteoarthritis (Exhibit A, pp. 118-119). On October 29, 2014, Petitioner had a right shoulder arthroscopy and arthroscopic sub-acromial decompression and bursectomy (Exhibit D, pp. 63-65, 70-73). At Petitioner's February 12, 2015 visit with his orthopedic doctor, the doctor indicated that Petitioner would reach maximal medical improvement of his right shoulder cuff repair approximately one year following surgery and about 70% to 80% in six months (Exhibit A, p. 141; Exhibit D, pp. 156). On May 28, 2015, Petitioner went to a six-month post-cuff repair appointment with his orthopedic doctor who observed that Petitioner was able to easily get his arm overhead, behind his back, and behind his head and had demonstrable strength and tone with resisted strength testing (Exhibit A, p. 140; Exhibit D, p. 160).

A January 6, 2015 CT of the neck showed a parotid mass in the left parotid gland (Exhibit D, pp. 27, 95). On April 10, 2015, Petitioner went to the hospital for severe and chronic left parotid sialadenitis. Because prior incision and drainages to dilate the ducts beginning April 2014 did not resolve the issue, Petitioner underwent a parotidectomy. (Exhibit A, pp. 70-77, 80-88; Exhibit D, pp. 113-148.) One month after surgery, the ear, nose, throat doctor concluded that Petitioner was doing well and had no problems (Exhibit D, pp. 147-148).

On June 16, 2015, Petitioner went to his orthopedic doctor complaining of left shoulder pain. The doctor noted positive impingement of the left shoulder but full range of motion (Exhibit A, p. 139). (Exhibit A, pp. 139-144; Exhibit D, p. 161.)

Petitioner's medical history as of September 2015 showed active osteoarthritis, depression, high cholesterol, anxiety, hearing loss, DDD, chronic low back pain, resolved history for facial injuries resulting from a 1992 motor vehicle accident, knee degenerative joint disease, and seasonal allergies. It was noted that he was at risk for falls. His surgical history included a February 2015 local anesthetic nerve block in the back, an October 2014 shoulder rotator cuff repair, and a 2012 left knee joint replacement. (Exhibit A, pp. 44-45, 106-109.)

Petitioner's medical record shows ongoing treatment for low back pain beginning May 2011 (Exhibit D, pp. 98-103; Exhibit E, pp 27-29, 68-69, 95-97, 101-104, 112-126). A June 23, 2015 lumbar spine x-ray showed multilevel progression and the appearance of DDD from L1 through L4 with mild multilevel facet arthrosis, no fracture or subluxation, minor right convex lumbar scoliosis (Exhibit A, p. 69). A July 5, 2015 lumbar spine MRI showed mild narrowing of the L1-L2, L2-L3, L3-L4 discs with some loss of signal intensity consistent with DDD, and mild osteophyte formation, narrowing of the lower lumbar facet joints with osteophyte formation, mild posterior bulging of the L1-2, L2-3, L3-4, and L4-5 discs. No disc herniation, spinal canal stenosis, or narrowing of the nerve root neural foramina was evident. There was little interval change from a June 22, 2011 MRI. (Exhibit A, p. 66; Exhibit D, p. 32.) In October 2011, November 2011, January 2012, November 2012, March 2013, May 2013, July 2013, October 2013, and January 2014, Petitioner had back injections (Exhibit D, pp. 37-60). On May 17, 2015, June 29, 2015, August 12, 2015, he underwent bilateral lumbar facet injections for diagnoses of low back pain, bilateral lumbar facet arthropathy, bilateral lower extremity pain, lumbar DDD (Exhibit A, pp. 64-65, 67-68, 78-79).

Petitioner was hospitalized from August 29, 2015 to September 1, 2015 following a 6 to 8 foot ladder fall that resulted in a left grade 2 open distal tibia and segmental fibular fracture. X-rays showed acute open, comminuted, displaced fractures involving the distal tibia and fibula, with maintenance of the ankle mortise and acute fracture of the calcaneus disrupting the subtalar joint. Petitioner underwent an ORIF (open reduction, internal fixation) surgery and irrigation and excisional debridement of the open tibia and fibula fractures. (Exhibit A, pp. 38-63, 116-117.) Post-surgical notes indicated that a

determination of whether the calcaneus fracture warranted operative intervention would be discussed in the future (Exhibit A, pp. 52, 104-105).

On September 17, 2015, Petitioner was hospitalized and underwent ORIF and subtalar fusion surgery to address a left calcaneus and plafond fracture. He was discharged on September 18, 2015 (Exhibit A, pp. 33-35, 101-103). An October 12, 2015 x ray of the left ankle showed good position of the two subtalar screws and no evidence of loosening or failure. Although the doctor indicated there was not a significant amount of healing, he added that this was not necessarily unexpected. (Exhibit A, p. 112.) At his October 12, 2015 office visit, Petitioner indicated he had no complaints. The doctor observed no calf erythema or edema or foot tenderness. He advised Petitioner to remain non-weight-bearing. (Exhibit A, p. 131; Exhibit D, p. 167). At a November 23, 2015 office visit, the doctor suggested Petitioner begin physical therapy so he could transition into a shoe when able. The doctor noted that Petitioner continued to complain of back pain. (Exhibit D, p. 168). At his January 4, 2016 exam, the doctor noted that Petitioner had heel discomfort and his range of motion was probably 20 degrees. The doctor noted that the x-rays showed some collapse of the talus into the calcaneus. He could not see past the plate to see if it was solidly fused but the fracture of the tibia appeared healed. (Exhibit D, p. 169.)

A January 6, 2016 CT scan of the left foot showed limited bridging of 25% or less of the tibial fracture; mild degenerative changes of the tibiotaler joint; bone graft packing in the subtalar joint space and within the calcaneal fracture lines which are also incompletely bridged with at least 50% of the fracture demonstrating no bridging; and osseous demineralization (Exhibit D, pp. 91-92).

Petitioner's record included notes from office visits with his primary care physician from May 2, 2011 to January 21, 2016 that show ongoing complaints of depression (Exhibit E, pp. 27-126). In notes from the January 2015 office visit, the doctor noted that Petitioner was oriented to person, place, and time with appropriate mood and affect; was able to articulate well within normal speech/language, rate, volume and coherence; and showed no evidence of hallucinations, delusions, obsessions, or homicidal/suicidal ideation. He had been prescribed Cymbalta, Abilify, and trazodone but stopped taking the prescriptions in July 2014. (Exhibit A, pp. 21-22.) On March 23, 2015, he restarted Abilify, Cymbalta and Wellbutrin (Exhibit A, pp. 17-20.) A licensed professional counselor at the practice diagnosed Petitioner with major depressive disorder recurrent moderate and generalized anxiety disorder noting that he had met the criteria for severe depression but did not have any suicidal thoughts. Petitioner reported feeling depressed, feeling bad about himself, insomnia, poor appetite or overeating, trouble concentrating, and trouble sleeping. He acknowledged that his medications helped manage his depression, mood swings, and anger reactions. (Exhibit E, pp. 5-13.)

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, listings 1.02 (major dysfunction of a joint), 1.03 (reconstructive surgery or surgical arthrodesis of a major weight-bearing joint), 1.04 (disorders of the spine), 1.06 (fracture of the femur, tibia, pelvis or one or more of the tarsal bones), 12.04 (affective disorders), and 12.06 (anxiety-related disorders) were considered.

The evidence presented does not support a listing under 12.04 or 12.06. Because the evidence does not show that Petitioner's nerve root or spinal cord was compromised, the evidence does not support a finding that Petitioner's impairments meet or equal a listing under 1.04.

A listing under 1.02 requires a gross anatomical deformity and chronic joint pain and stiffness with (i) signs of limitation of motion or other abnormal motion of the affected joint and (ii) findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankyloses of the affect joint with (iii) involvement of one major peripheral weight-bearing joint (hip, knee, or ankle) resulting in an inability to ambulate effectively or involvement of one major peripheral joint in each upper extremity (shoulder, elbow, or wrist-hand) resulting in an inability to perform fine and gross movements effectively. A listing under 1.03 requires reconstructive surgery or surgical arthrodesis of a major weight bearing joint with inability to ambulate effectively and return to effective ambulation did not occur, or is not expected to occur, within 12 months of onset. A listing under 1.06 requires that the fracture (i) have no solid union evident on medically acceptable imaging show and not be clinically solid and (ii) result an inability to ambulate effectively and return to effective ambulation has not occurred and is not expected to occur within 12 months of onset.

A listing under 1.02, 1.03, and 1.06 all require an inability to ambulate effectively or to perform fine and gross movements effectively. An inability to ambulate effectively means an extreme limitation of the ability to walk, i.e., an impairment that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities and is generally defined as having insufficient lower extremity functioning to permit independent ambulation without the use of a hand-held assistive device that limits the functioning of both upper extremities. Listing 1.00B2(b). For SDA purposes,

the period considered is a 90 day period rather than the 12 month period considered in connection with SSI listing.

In this case, Petitioner fell 6 to 8 feet off a ladder on August 29, 2015 resulting in a left grade 2 open distal tibia and segmental fibular fracture as well as an acute fracture of the calcaneus disrupting the subtalar joint. He had ORIF and subtalar surgery. A January 4, 2016 CT scan of Petitioner's left foot showed tibial and fibular hardware, as well as talocalcaneal fusion screws; limited bridging, less than 25%, involving the tibial fracture; and the subtalar joint space within the calcaneal fracture line incompletely bridged with at least 50% of the fracture demonstrating no bridging. The surgeon's notes indicate that Petitioner's injury was healing; as of the November 23, 2015 office visit, the doctor noted that Petitioner had started bearing weight on the foot. At the hearing, Petitioner acknowledged that he only sometimes used a cane. The worker at the hearing noted that Petitioner walked with a stiff leg and appeared not to want to put weight on his left foot. Because Petitioner was able to ambulate independently without the use of a hand held assistive device that limited functioning of both upper extremities, he failed to establish that he lacked an ability to ambulate effectively. . Accordingly, the medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of the listings under 1.02, 1.03 or 1.06.

Although Petitioner also complained of right shoulder pain, notes from his May 28, 2015 six-month post-cuff repair appointment with his orthopedic doctor showed that Petitioner was able to easily get his arm overhead, behind his back, behind his head, and had demonstrable strength and tone with resisted strength testing. At the June 16, 2016 office visit, Petitioner complained of left shoulder pain; although the doctor noted positive impingement of the left shoulder, he observed full range of motion. There was no evidence in the record that Petitioner was unable to perform gross and fine movements effectively. Accordingly, the medical evidence presented does **not** show that Petitioner's shoulder impairments meet or equal the required level of severity of the listing under 1.02.

Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Steps 4 and 5, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s), including those that are not severe, and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4); 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s)

provided by the individual or other persons. 20 CFR 416.945(a)(3). This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b). The exertional requirements, or physical demands, of work in the national economy are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a). Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools and occasionally walking and standing. 20 CFR 416.967(a). Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds; even though the weight lifted may be very little, a job is in the light category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. 20 CFR 416.967(b). Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. 20 CFR 416.967(e).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). 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 alleges both exertional and nonexertional limitations due to his impairments. Petitioner testified that he could walk not more than a half block, sit not more than one hour before having to reposition himself or lay down, stand not more than a few minutes, mostly on his right leg, and lift not more than 10 pounds. He also testified that he experienced numbness and tingling in his hands and numbness in his face. He lived alone, and cared for his own personal hygiene and dressing himself. He had a friend or family member do his household chores and shopping. He was able to drive. The Department pointed out that Petitioner walked with a stiff leg, and it was clear that he was uncomfortable putting any weight on his left foot.

Although Petitioner complained of facial and hand numbness and pain and right shoulder pain, Petitioner's testimony concerning ongoing limitations due to those impairments is not supported by the medical evidence. The medical record supports Petitioner's testimony concerning limitations on his ability to walk effectively. His August 2015 ladder fall resulted in a left grade 2 open distal tibia and segmental fibular fracture. He had ORIF and subtalar fusion surgery resulting in hardware and screws in his left leg and foot. The January 6, 2016 CT scan of the left foot showed that fractures had not healed completely. Petitioner also complained of back pain, and a July 5, 2015 lumbar spine MRI showed mild narrowing of the L1-L2, L2-L3, L3-L4 discs with some loss of signal intensity consistent with DDD, mild ostephyte formation, narrowing of the lower lumbar facet joints with osteophyte formation, and mild posterior bulging of the L1-2, L2-3, L3-4, and L4-5 discs.

With respect to Petitioner's exertional limitations, it is found based on a review of the entire record that Petitioner is unable to maintain the occasional walking and standing requirements necessary to the satisfy the requirements of sedentary work as defined by 20 CFR 416.967(a). See SSR 96-9p. While it is anticipated that Petitioner's exertional RFC will improve, particularly once his leg and heel have additional time to heal, Petitioner is found at present to have the exertional RFC to perform less than sedentary work.

Petitioner also alleged that he had nonexertional limitations due to depression and anxiety. He testified that he suffered from memory and concentration problems. He saw a therapist twice monthly at his primary care physician but no psychiatrist. His family doctor prescribed medication to treat his conditions.

Petitioner's record from his office visits with his primary care physician from 2011 to January 2016 show ongoing complaints of depression. A licensed professional counselor diagnosed Petitioner with major depressive disorder, recurrent, moderate and general generalized anxiety disorder. Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild to moderate limitations on his mental ability to perform basic work activities.

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

Step Four

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

Petitioner's work history in the 15 years prior to the application consists of work as a home health aide, a job that, based on weight lifting requirement, is properly categorized as involving medium work exertion, and construction laborer, a job based on weight lifting requirement is properly categorized as involving heavy work exertion. Based on the RFC analysis above, Petitioner is limited to less than sedentary work activities. Because Petitioner lacks the exertional RFC to perform past relevant work, 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). 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, at application and at the time of hearing, Petitioner was [redacted] years old and, thus, considered to be a younger individual ([redacted]) for purposes of Appendix 2. He

received a GED and has a history of unskilled work experience. As discussed above, Petitioner's exertional RFC limits him to less than sedentary work. He also has mild to moderate limitations on his mental ability to perform work activities.

In this case, the Medical-Vocational Guidelines, Appendix 2 do not support a finding that Petitioner is not disabled based on his exertional limitations. The Department has failed to counter with evidence of significant numbers of jobs in the national economy which Petitioner could perform despite his exertional and nonexertional limitations. Therefore, the Department has failed to establish that, based on his RFC and age, education, and work experience, Petitioner can adjust to other work. Therefore, Petitioner is disabled at Step 5.

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 September 4, 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 October 2016.

ACE/tlf

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

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 Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS 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. MAHS will not review any response to a request for rehearing/reconsideration.

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

[redacted]

[redacted]

[redacted]