RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: September 13, 2016
MAHS Docket No.: 16-007911
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 July 28, 2016, from Detroit, Michigan. Petitioner was present and represented himself. [redacted], his case manager at [redacted], appeared as his witness. 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. A DHS-49D, psychiatric/psychological evaluation, and DHS-49E, mental residual functional capacity assessment, completed and signed by Petitioner's psychiatrist were received and marked into evidence as Exhibit C; an accompanying letter dated July 28, 2016 from Petitioner's outpatient therapist was not signed and is not considered. The record closed on August 26, 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 31, 2016, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On April 11, 2016, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 3-13).

3. On June 8, 2016, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit A, pp. 1-2).

4. On June 15, 2016, the Department received Petitioner's timely written request for hearing.

5. Petitioner alleged disabling impairment due to back and leg pain, balance issues, dizziness, headaches, numbness in hands, blurred vision, irritable bowel syndrome (IBS), and depression.

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

7. Petitioner is a high school graduate with some college.

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

9. Petitioner has an employment history of work as environmental services supervisor, assistant manager at an auto parts store; and hearth industry salesperson.

10. Petitioner has a pending disability claim with the Social Security Administration (Exhibit A, 25-26).

CONCLUSIONS OF LAW

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

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180.

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (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 engaged in SGA, 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.

The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

A December 10, 2013 lumbar spine MRI showed broad-based left paracentral foraminal disc protrusion resulting in narrowing of the left lateral recess and moderate left foraminal stenosis at L4-L5 as well as moderate right foraminal stenosis and mild left foraminal stenosis at L5-S1 but no evidence of nerve compression. The doctor noted that this explained Petitioner's radicular pain from his lower back down his right leg. (Exhibit A, PP. 465, 480-481.)

On January 2, 2014, Petitioner fell and hit the back of his head, resulting in lost consciousness. Two CT scans after the fall were both unremarkable for into intracranial process; an MRI of the entire spine was also unremarkable. Petitioner returned to the hospital the next day complaining of nausea, vomiting, severe headache, and inability to maintain hydration. Repeat imaging did not reveal any immediate or acute intracranial hemorrhage. The doctor believed Petitioner had a closed head injury and suffered a moderate to moderately severe concussion and recommended hospitalization. He lost his vision for several weeks after the concussion and complained of continued vision disturbances as of January 8, 2016. On January 11, 2014, he returned to the emergency department complaining of headaches but refused any further scans. (Exhibit A, PP. 319-325, 340, 390, 391, 392-393, 394-402, 424-453, 49-491).

A January 4, 2014 cervical spine MRI showed multilevel degenerative changes with mild central canal stenosis at C4-C5 and C5-C6 and moderate to severe bilateral foraminal stenosis at C4-C5 and moderate to severe right and moderate left foraminal stenosis at C5-C6 and C6-C7. The foraminal stenosis might impinge bilateral C5 and right C6 and C7 nerve roots. (Exhibit A, PP. 394-395, 495-496.) A January 4, 2014 lumbar spine MRI showed (i) no acute fracture, marrow edema, or ligamentous injury;

(ii) left subarticular recess stenosis at L4-5 level, which might impinge on the left L5 nerve root with recommendations of clinical correlation for left L5 radiculopathy; (iii) multilevel degenerative changes with mild central canal stenosis at L3-4 and L4-5 levels; and (iv) no significant change compared with the previous study. (Exhibit A, PP. 396-397).

In June 2014, Petitioner had an open appendectomy. On July 5, 2014, he went to the emergency department complaining of a discharge and foul odor from the incision. Abdomen and pelvis CT showed no acute findings. (Exhibit A, PP. 342-348). On November 11, 2014 he had in incisional herniorrhaphy and a small bowel resection for incarcerated right lower quadrant incisional hernia. (Exhibit A, PP. 326-330). A December 24, 2014 CT of the abdomen and pelvis taken in response to mid and lower abdominal pain showed small bowel obstruction. (Exhibit A, PP. 378-379).

At a March 3, 2015 visit with his doctor, Petitioner indicated that his right lower quadrant abdominal pain had almost completely resolved but he had continued intermittent blood with forced defecation, which was diagnosed as symptomatic. (Exhibit A, PP. 326-330.) September 11, 2015 he had on esophagogastroduodenoscopy which showed ulceration of the distal esophagus as well as a stricture at the GE (gastroesophageal) junction and a small hiatal hernia. (Exhibit A, pp. 376-377, 385.). He was diagnosed with diverticulitis. At a September 24, 2015 follow up office visit he reported doing much better with no pain at the time. (Exhibit A, PP. 339-340).

On October 1, 2015, Petitioner went to the emergency department complaining of abdominal pain worse with movement or palpitation and different than prior diverticulitis. He was diagnosed with a small bowel obstruction. (Exhibit A, PP. 380-384). He was treated with conservative measures, his issue resolved, and he was discharged. (Exhibit A, PP. 385-387).

On April 20, 2015, Petitioner went to the emergency department complaining of anxiety, depression, and suicidal ideation. He was assessed a GAF score of 30. He was admitted for inpatient psychiatric hospitalization. He was diagnosed with major depressive disorder, recurrent, severe without psychotic features; generalized anxiety disorder; and PTSD with a notation that anxiety secondary to traumatic brain injury could not be ruled out. He was discharged on April 27, 2015, strongly denying suicidal ideation or auditory or visual hallucinations. The doctor noted that Petitioner had good eye contact at discharge, and his thought process was more clear and coherent. (Exhibit A, PP. The 352-373).

Petitioner began treatment at a community mental health treatment facility on May 1, 2015. (Exhibit A, pp. 78-89). At a May 5, 2015 psychiatric evaluation, he was diagnosed with major depressive disorder, recurrent, severe without psychotic features and possibly posttraumatic stress disorder (PTSD) and assigned a global assessment of functioning (GAF) score of 48. (Exhibit A, pp. 90-95). Petitioner's records from his mental health provider include treatment plans, medication reviews, and service plans

from May 22, 2015 to May 20, 2016, showing Petitioner's ongoing adjustment to decreased cognitive skills following his accident but good response to medication. (Exhibit A, pp. 106-317). It was noted that when Petitioner was more depressed, he had considerably more trouble following through with tasks, including even thinking or planning, and appeared to have more trouble with organizing his thoughts and with vision "as if there is a correlation between his brain injury and depression." (Exhibit A, PP. 179, 301-302).

In an April 28, 2016 assessment, Petitioner, who suffered from symptoms of negative self-talk, anhedonia, and lethargy after his January 2014 concussion, was found to have made significant progress over the past year, reducing the amount of medication he took and stating that he was "more stable than ever" after "learning a new normal" following his brain injury. In an assessment of daily living activities on a scale of 1 to 7 where 1 indicated none of the time, with extremely severe impairment or problems in functioning and pervasive level of continuous paid supports needed, and 7 indicated all of the time, with no significant impairment or problems in functioning requiring paid supports, Petitioner scored a 5, 6, or 7 on all activities except for problem-solving, which assessed his ability to resolve basic problems of daily living and asking questions for clarity and setting, where he scored a 4 (indicating some of the time, with evidence of moderate impairment or problems in functioning and low levels of continuous paid supports needed). It was noted that he needed assistance in asking questions and clarifying expectations and advocating for himself. Petitioner was observed to have appropriate affect; normal speech; unremarkable thought content; normal behavior; orientation to person, place, and time; good insight; and impaired long-term memory. His GAF score was listed at 58. (Exhibit A, PP. 294-303).

In August 2016, Petitioner's psychiatrist completed a psychiatric evaluation diagnosing him with DSM-IV 296.33 (major depressive disorder) and assigned him a GAF score of 40. The psychiatrist observed that Petitioner came to appointments accompanied by his case manager and was easily confused and overwhelmed and often tearful. He noted that Petitioner's concentration was poor, and he was unable to follow spoken directions with more than three directives. (Exhibit C).

Petitioner's psychiatrist also completed a mental residual functional capacity assessment, DHS-49-E, regarding Petitioner's mental impairments and how they affected his activities. The psychiatrist concluded that Petitioner had **no, or no significant,** limitations regarding his ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances and to get along with co-workers or peers without distracting them or exhibiting behavioral extremes. The psychiatrist concluded that Petitioner had **moderate** limitations regarding his ability to understand and remember one or two-step instructions; carry out simple one or two step instructions; sustain an ordinary routine without supervision; interact appropriately with the general public; ask simple questions or request assistance; maintain socially appropriate behavior and adhere to basic standards of neatness and cleanliness; and travel in unfamiliar places or use public transportation.

The psychiatrist concluded that Petitioner had **marked** limitations regarding his ability to remember locations and work-like procedures; understand and remember detailed instructions; carry out detailed instructions; maintain attention and concentration for extended periods; work in coordination with or proximity of others without being distracted by them; make simple work-related decision; complete a normal workday and worksheet without interruptions from psychologically based symptoms and perform at a consistent pace without an unreasonable number and length of rest periods; accept instructions and respond appropriately to criticisms from supervisors; respond appropriately to change in the work setting; be aware of normal hazards and take appropriate precautions; and set realistic goals or make plans independently of others. (Exhibit C.)

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 1.04 (disorders of the spine), 2.02 (loss of central visual acuity), 5.06 (inflammatory bowel disease (IBD)), 11.18 (cerebral trauma), 12.02 (organic mental disorders), 12.04 (affective disorders), and 12.06 (anxiety-related disorders) were considered.

Because there was no medical evidence of a positive straight leg raising test, spinal arachnoiditis, or pseudoclaudication, Petitioner's condition does not meet a listing under 1.04. Although Petitioner complained of blurred vision, there was no assessment of his vision to support a listing under 2.02. Because there was no obstruction of stenotic areas in the small intestine or colon requiring hospitalization or surgery and occurring on at least two occasions at least 60 days apart within a consecutive 6-month period as described in 5.06A or lab results, physical examination, perineal disease, involuntary weight loss exceeding 10%, or a need for supplemental nutrition via a gastrostomy or a central venous catheter as described in 5.06B, Petitioner's condition does not meet either of the two listing options under 5.06.

Petitioner's medical record does not reflect marked restrictions of activities of daily living; marked difficulties in maintaining social functioning; marked difficulties in maintaining concentration, persistence, or pace; repeated episodes of decompensation,

each of extended duration; a residual disease process where even a minimal increase in mental demands would cause him to decompensate; or an inability to function outside a highly supportive living arrangement. Therefore, Petitioner's condition does not meet a listing under 12.02, 12.04, or 12.06. Because Petitioner's condition does not satisfy the requirements of 11.02 (convulsive epilepsy), 11.03 (nonconvulsive epilepsy), 11.04 (central nervous system vascular accident), or 12.02, it does not meet the requirements for 11.18.

Because the medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration, 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).

In this case, Petitioner alleges both exertional and nonexertional limitations due to his medical condition. Petitioner testified that he could walk no more than a couple of blocks, stand no more than one hour, and sit no more than 30 minutes. Because of numbness in his hands, he had difficulty gripping and grasping and lifting any weight more than a gallon of milk. He lived with his brother and sister-in-law. He was generally able to groom and dress himself. He cooked and did his own laundry. He did other chores, such as washing dishes, in stages.

A January 4, 2014 cervical spine MRI showed multilevel degenerative changes with mild central canal stenosis at C4-C5 and C5-C6 and moderate to severe bilateral foraminal stenosis at C4-C5 and moderate to severe right and moderate left foraminal stenosis at C5-C6 and C6-C7, with the foraminal stenosis possibly impinging on the bilateral C5 and right C6 and C7 nerve roots. His January 4, 2014 lumbar spine MRI showed left subarticular recess stenosis at L4-5 level possibly impinging on the left L5 nerve root, and multilevel degenerative changes with mild central canal stenosis at L3-4 and L4-5 levels. The evidence also shows a surgery to repair a ruptured body cavity wall, bowel obstructions, and a diagnosis of diverticulitis. This evidence was sufficient to establish Petitioner's complaints of back and leg pain and gastrointestinal issues.

With respect to Petitioner's exertional limitations, it is found based on a review of the entire record that Petitioner maintains the physical capacity to perform light work as defined by 20 CFR 416.967(b).

Petitioner also alleged nonexertional limitations. 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 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.*

Petitioner testified that he had blurred and double vision, balance issues, and constant headaches. His mental ability to function was limited by his depression and his problem processing and troubleshooting.

Petitioner was diagnosed with major depressive disorder on May 5, 2015 after an inpatient voluntary psychiatric hospitalization from April 20, 2015 to April 27, 2015 during which he complained of anxiety, depression, and suicidal ideation. Petitioner participated in consistent, ongoing psychiatric treatment, meeting with a psychiatrist, case manager, and a therapist, from May 2015 to August 2016. An April 2016 assessment noted that Petitioner had made significant progress over the past year. However, in the August 2016 psychiatric evaluation, Petitioner's psychiatrist noted that Petitioner's concentration was poor and he was unable to follow spoken directions with more than three directives; he was assigned a GAF score of 40. A review of treatment notes shows that Petitioner had periods of stability but when his depression increased, it also affected his ability to organize his thoughts and follow through with tasks. There is medical evidence indicating that Petitioner suffered a closed head injury in following his January 2014 slip and fall that resulted in a moderate to moderately severe concussion, supporting the psychiatrist's findings that the closed head injury resulted in a cognitive loss. The DHS-49E completed by Petitioner's psychiatrist indicated Petitioner had marked limitations regarding his ability to understand and remember detailed instructions; carry out detailed instructions; maintain attention and concentration for extended periods; work in coordination with or proximity of others without being distracted by them; make simple work-related decision; complete a normal workday and worksheet without interruptions from psychologically based symptoms and perform at a consistent pace without an unreasonable number and length of rest periods; respond appropriately to change in the work setting; be aware of normal hazards and take appropriate precautions; and set realistic goals or make plans independently of others.

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild limitations on his activities of daily living; mild to moderate limitations on his social functioning; and marked limitations on his concentration, persistence or pace. There was one episode of decompensation when he was hospitalized in April 2015. Petitioner also has postural limitations due to balance and vision issues.

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 an environmental services supervisor, assistant manager at an auto parts store; and hearth industry salesperson. Each of Petitioner's prior positions required that he stand most of the day and lift up to 100 pounds regularly. As such, these positions required heavy or very heavy physical exertion.

Based on the RFC analysis above, Petitioner's exertional RFC limits him to no more than light work activities. As such, Petitioner is incapable of performing past relevant work and he cannot be found disabled, or not disabled, at Step 4. Therefore, 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 [redacted] years old at the time of hearing, and, thus, considered to be closely approaching advanced age (age [redacted]) for purposes of Appendix 2. He is a high school graduate with some technical school training. While his past employment includes supervisory positions, they were all tied to heavy or very heavy physical exertion and, as such, the skills from those jobs are not transferable. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform light work activities. Based solely on his exertional RFC, the Medical-Vocational Guidelines, 202.13, result in a finding that Petitioner is not disabled. However, Petitioner also has nonexertional limitations due to his impairments. As a result, he has a nonexertional RFC imposing mild limitations on his activities of daily living; mild to moderate limitations on his social functioning; and marked limitations on his concentration, persistence or pace. The Department has failed to present evidence of a significant number of jobs in the national and local economy that Petitioner has the vocational qualifications to perform in light of his nonexertional RFC, age, education, and work experience. Therefore, the evidence is insufficient to establish that Petitioner is able to adjust to other work. Accordingly, Petitioner is found disabled at Step 5 for purposes of the SDA benefit program.

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

DECISION AND ORDER

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

THE DEPARTMENT IS ORDERED TO 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 31, 2016 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 March 2017.

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

DHHS

[redacted]

Petitioner

[redacted]

Via Email:

[redacted]