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GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: October 24, 2016
MAHS Docket No.: 16-010791
[redacted]

ADMINISTRATIVE LAW JUDGE: Vicki Armstrong

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 September 28, 2016, from Lansing, Michigan. Petitioner personally appeared and testified. Petitioner's father, [redacted], and [redacted], appeared and testified on Petitioner's behalf. Petitioner submitted five exhibits which were admitted into evidence.

The Department of Health and Human Services (Department) was represented by Family Independence Manager [redacted]. [redacted] testified on behalf of the Department. The Department submitted [redacted] exhibits which were admitted into evidence. The record was closed at the conclusion of the hearing.

ISSUE

Whether the Department properly determined 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 4, 2016, Petitioner applied for SDA. [Hearing Summary].

2. On July 11, 2016, the Medical Review Team denied Petitioner's SDA application indicating he was capable of performing other work. [Dept. Exh. 3-9].

3. On July 21, 2016, the Department issued a Notice of Case Action informing Petitioner his application for SDA had been denied effective April 1, 2016 ongoing. [Dept. Exh. 1-2].

4. On August 4, 2016, Petitioner submitted a Request for Hearing contesting the denial of SDA.

5. Petitioner has a history of chronic nausea, restless leg syndrome, obesity, bronchitis, chronic left knee pain, pneumonia, hepatomegaly, insomnia, anxiety, bipolar II, panic attacks, attention deficit hyperactivity disorder (ADHD), cannabis dependence, opioid abuse, cocaine abuse, amphetamine abuse and caffeine-induced anxiety disorder.

6. On [redacted], Petitioner was admitted to the hospital with bilateral pneumonia. The admitting physician noted that Petitioner had a long history of substance abuse. He also had years of excessive alcohol use. He reportedly stopped drinking three weeks ago. Petitioner was using methadone for restless leg syndrome and Xanax for anxiety. He was on Saphris for bipolar disorder. Petitioner reported having progressively worsening shortness of breath and coughing. He presented to the emergency department where he was diagnosed with bilateral pneumonia. The physician suspected the pneumonia was secondary to his chronic aspiration which was secondary to a chronic alteration in level of consciousness. The physician stopped Petitioner's methadone and started him on clindamycin and Levaquin and a low dose steroid. Petitioner acknowledged that he may have been using methadone for recreational reasons other than pain. He expressed a desire to visit a rehabilitation clinic to help him get off the methadone. Petitioner was discharged on [redacted] in stable condition with a diagnosis of bilateral pneumonia, possible underlying asthma with wheezing, coughing, chronic pain, occasional chest pain, substance abuse and bipolar disorder. Prognosis was guarded if Petitioner continued his high-dose polypharmacy and alcohol abuse. [Dept. Exh. 96].

7. On [redacted], Petitioner met with his therapist at [redacted] Petitioner reported that his mother thought he might have agoraphobia. The therapist discussed agoraphobia with Petitioner, telling Petitioner that exposure to the anxiety provoking stimuli was an important part of the treatment. Petitioner said that he heard that more anti-anxiety medications were the treatment. Petitioner's fear that his throat problem would make him gag and vomit in public was discussed. Petitioner had an upcoming appointment with an ear, nose and throat specialist and if no physical cause was found, then the therapist would be discussing a more structured behavioral approach to treat Petitioner's gagging and vomiting as a psychological problem. [Dept. Exh. 123-124].

8. On [redacted], Petitioner saw his primary care physician (PCP) complaining of breathing difficulties and requested an inhaler and a pneumonia vaccine. The physician noted that Petitioner presented with anxiety. His symptoms included anxiety, nervousness, and panic attacks. The onset was years ago. Petitioner

described this as improving. Associated symptoms included chest pain, a choking sensation and heart palpitations. His current treatment included benzodiazepine and Saphris. Petitioner reported that his anxiety was doing a little better and his bipolar symptoms had improved. Petitioner stated that he still used some benzodiazepine medications to help and he had recently tried some Vistaril and that seemed to be helping as well. Petitioner stated he would get short of breath with his anxiety and reported using an albuterol inhaler to help with the shortness of breath. He reported being diagnosed with asthma in the past. He also complained of fatigue and weight gain. The physician noted Petitioner had difficulty breathing and chest pain. Petitioner was diagnosed with dyspnea and respiratory abnormalities, and anxiety. The spirometry was normal. The physician opined that Petitioner's shortness of breath was likely caused by his anxiety. [Dept. Exh. 378-382].

9. On [redacted], Petitioner underwent a modified barium swallow for dysphagia. A review of the fluoroscopic images demonstrated some premature spillage of liquid contrast over the base of the tongue and a mild delay in initiating the swallow reflex. Otherwise, the pharyngeal phase of the swallow mechanism appeared intact. The epiglottis movement was normal. There was no penetration or aspiration seen. The esophagus was also normal in course and caliber. [Dept. Exh. 67].

10. On [redacted], Petitioner met with his therapist and reported that the swallow study did not reveal any problems. Petitioner's prescription for methadone was discussed and Petitioner believed he needed a higher dose. Petitioner was currently on 30 mg a day and stated he had been on a higher dose of 120 mg a day when he was in the methadone clinic. Petitioner insisted the methadone was for pain control and Petitioner did not want to go to the pain clinic for fear they would lower his dose of methadone. [Dept. Exh. 125-126].

11. On [redacted], Petitioner had an initial evaluation for physical therapy. Petitioner reported he had bilateral hip pain for the past two months. Petitioner stated he was hit while riding his bicycle in 2007 resulting in a left tibial fracture and meniscus tear. He had two knee surgeries and still had chronic knee pain. Petitioner stated that the hip and low back pain were worse when rolling around in bed which made the pain "radiate" down the sides of his legs to his knees. He also experienced pain walking, standing or during prolonged sitting. Petitioner reported he was prescribed methadone for the pain. He also reported he had gained 80 pounds since last summer when he diagnosed with pneumonia and his activity level had gone downhill. Petitioner stated that he fell at least once a week and his left knee "cracked" last week which caused him to fall. He also reported using a cane a few times a week for about an hour until he felt "stable" and then he would go out without it. [Dept. Exh. 75].

12. On [redacted], Petitioner reported for his medication review at [redacted] with his psychiatrist. Petitioner did not report any new health problems. He stated he occasionally had problems sleeping, but the Seroquel XR helped. Petitioner

denied any current feelings of depression, suicidal ideas or acute psychotic symptoms. The psychiatrist noted that Petitioner made good eye contact. He was calm and comfortable. There was no evidence of restlessness or agitation. His speech was coherent and rational. His medications were continued and he was told to report back in three months. [Dept. Exh. 127-131].

13. On [redacted], Petitioner met with his therapist. Petitioner discussed his methadone dose and what he thought he needed for pain management. The therapist mentioned the option of Petitioner attending a pain clinic, and Petitioner indicated he did not want to go because he was concerned his methadone dose would be lowered. [Dept. Exh. 132-133].

14. On [redacted] while attending physical therapy, Petitioner stated that his overall pain levels had decreased since starting therapy and he had also lost some weight. [Dept. Exh. 81].

15. On [redacted], during physical therapy, Petitioner reported he had been dealing with abdominal issues that had been going on for years, but he had recently begun vomiting 2-3 times a day. He was hoping to see a GI (gastroenterologist) doctor soon. He also stated that he just received his own bicycle and he had been going for short rides in his neighborhood. He reported he had had minimal improvement and his hip "catches" with some of the stretches. [Dept. Exh. 83].

16. On [redacted], Petitioner's therapist performed an assessment. Petitioner was appropriately dressed and well-groomed. The therapist noted that Petitioner's communication was normal, his mood cooperative, anxious, pessimistic, irritable and depressed. The therapist noted that Petitioner continued to have trouble regulating his mood and anxiety. Petitioner's affect was primarily appropriate and his speech was normal for age and intellect, and he was logical and coherent. He had flight of ideas. His behavior was normal, alert, agitated and tense. He was oriented to person, place and time. His insight was fair. His short-term memory was impaired. He appeared to be in contact with reality. Petitioner was diagnosed with bipolar disorder II, generalized anxiety disorder, cannabis dependence, and caffeine-induced anxiety disorder. Petitioner's GAF score was a 46, which indicated serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting), or any serious impairment in social, occupational or school functioning (e.g. no friends, unable to keep a job). The therapist noted that Petitioner continued to struggle with significant anxiety along with some mood instability. He experienced panic attacks and was often afraid to leave his home. When Petitioner would experience a lot of anxiety, he would often feel something uncomfortable in his throat and then would throw-up. Previous medical tests have not found a biological cause for this problem. Petitioner also had times of significant depression. The therapist indicated, however, that Petitioner's hypomanic symptoms appeared to be adequately suppressed by his psychiatric medications. Additionally, the therapist noted that Petitioner was at times quick to anger especially when under stress. [Dept. Exh. 136-146].

17. On [redacted], Petitioner underwent an esophagogastroduodenoscopy biopsy to rule out Helicobacter pylori. The biopsy showed histologically unremarkable gastric mucosa. The immunostain was negative for Helicobacter. [Petitioner's Exh. 3-4].

18. On [redacted], Petitioner was informed that his stomach biopsies were normal and did not show any infection with bacteria. [Dept. Exh. 542].

19. On [redacted], Petitioner met with his psychiatrist for a medication review. Petitioner denied any new health problems. Petitioner stated he was doing well with his medication, except the Seroquel XR made him tired in the morning. Petitioner reported that sometimes he could not fall asleep or he woke up several times a night. Petitioner asked to try the regular Seroquel. He denied any current substance abuse. Petitioner complained he was still having problems with his throat and he had seen a doctor and he was going to have other tests done. The psychiatrist noted that Petitioner made good eye contact. He was calm and comfortable. He was cooperative. His speech was coherent and rational. He did not verbalize any delusions or hallucinations. He denied any wish to harm himself or others. [Dept. Exh. 157-161].

20. On [redacted], Petitioner followed up with his gastroenterologist. Petitioner was last seen in June, 2015, regarding chronic nausea, vomiting and elevated liver enzymes. He had an esophagogastroduodenoscopy (EGD) which showed gastritis. His biopsies were normal. Petitioner reported he thought the trigger for feeling like his throat was closing then vomiting was his anxiety, but it could also happen around the time of his bowel movements. The gastroenterologist noted that Petitioner was alert and oriented to person, place and time with no focal deficits noted. His speech and behavior were appropriate. He was assessed with nausea with vomiting and elevated liver enzymes. The gastroenterologist told Petitioner that he was not sure that the vomiting symptoms were related to his GI tract or if they were a combination of anxiety and postnasal drip. Petitioner reported that methadone and Xanax seemed to help his symptoms and the gastroenterologist recommended he try to take the medications in the morning. [Dept. Exh. 539-541].

21. On [redacted], Petitioner had an ultrasound of the right upper quadrant. The results showed moderate to severe echotexture of the liver possibly related to fatty infiltration or hepatocellular disease. Otherwise, the ultrasound was negative. [Dept. Exh. 71].

22. On [redacted], Petitioner met with his therapist and spoke about how after numerous medical tests, his physicians had not been able to identify a cause for his repeated gagging and vomiting. They had indicated to him that it might have a psychological cause. Petitioner reported that he continued to vomit almost every time he left the house. Petitioner stated that he considered being away from his home as the cause of the symptom and could not identify any thoughts or emotions that preceded it. [Dept. Exh. 162-163].

23. On [redacted], Petitioner met with his therapist and discussed the increasing physical pain in his leg. Petitioner was upset that his physician would not increase his methadone. Petitioner stated that he was considering going back to the methadone clinic where he could get a higher dose of methadone. The therapist explained to Petitioner that methadone clinics tend to refer people who have chronic pain to pain clinics rather than serve them in a methadone clinic. Petitioner told his therapist that he would lie about his pain and leg injury in order to get more methadone. [Dept. Exh. 164-165].

24. On [redacted], Petitioner met with his therapist and discussed his fear of being unable to smoke his medical marijuana while under court supervision. The therapist suggested that there would be other methods Petitioner could use to manage his stress. However, Petitioner insisted he needed the medical marijuana for pain management. [Dept. Exh. 166-167].

25. On [redacted], Petitioner met with his therapist and discussed being sentenced to two years of probation with a [redacted] that cost [redacted] per day. Petitioner did not know how he or his family were going to get the money and he was worried about having to go to jail. The therapist suggested Petitioner use [redacted] to obtain a part-time job that he could do, considering his mental health and physical limitations. Petitioner reported he had not smoked marijuana for a few days. The therapist noted that Petitioner had a better attitude than the last session about his ability to quit. [Dept. Exh. 168-169].

26. On [redacted], Petitioner called his primary care physician and informed her that he had been stung by a bee and had to use his EpiPen. Petitioner reported his symptoms improved but he was concerned that he may have additional symptoms and requested another EpiPen. A prescription was issued. [Dept. Exh. 64].

27. On [redacted], an addendum was added to Petitioner's treatment plan by his psychiatrist. [redacted] was added to the treatment plan which involved Petitioner obtaining a part-time job in the community. Petitioner listed his strengths as a good cleaner with good attention to detail. He listed his barriers as his disabilities. The psychiatrist noted that Petitioner would need to increase his ability to regulate his mood and anxiety and increase his use of positive coping skills in order to work 10-20 hours per week at a job in the community that he enjoyed. [Dept. Exh. 170-173].

28. On [redacted], Petitioner met with his psychiatrist for a medication review. Petitioner denied any new health problems. He stated he was having trouble sleeping, but that he could sleep when he took his Seroquel. Petitioner was told that he would lose his medical marijuana card while on the tether program. Petitioner reported that he was going through some withdrawal symptoms struggling and having a hard time. The psychiatrist indicated that Petitioner appeared calm and comfortable. He made good eye contact. He was

not restless or agitated. His speech was coherent and rational. He did not verbalize any delusions, hallucinations or suicidal ideas. [Dept. Exh. 178-217].

29. On [redacted], Petitioner met with his therapist and discussed how irritable he had been feeling since he stopped using marijuana. Petitioner asked if his medications could be adjusted to compensate for this change in his substance use. The therapist explained to Petitioner that the longer he stayed clean, the less the urges he would have to use marijuana. Petitioner continued to feel that he needed more methadone and Xanax. The therapist indicated that Petitioner had very limited coping strategies and was unable to think of any non-drug alternative to deal with his irritability and stress. [Dept. Exh. 219-220].

30. On [redacted], Petitioner met with his therapist and requested an increase in his anxiety medication because he had significantly reduced his marijuana use. The therapist explained to Petitioner that there was not a medication for marijuana withdrawal and the longer he went without it, the less he would feel a need for it. [Dept. Exh. 221-222].

31. On [redacted], Petitioner reported that he continued to have increased irritability since he no longer smoked marijuana as much as he did before being put on probation. The therapist discussed the consequences of testing positive for marijuana with Petitioner. The therapist opined that Petitioner seemed to use his therapy time as a way to receive support but Petitioner did not seem especially interested in making changes in himself or his life. [Dept. Exh. 223-224].

32. On [redacted], Petitioner saw his psychiatrist for a medication review. Petitioner stated that he was under a lot of stress. Petitioner stated he was living with his father and his father was sometimes harsh and very critical of him. Petitioner reported he would get upset and have rage reactions. He stated that when he used to smoke marijuana, it helped. Petitioner explained that since he was no probation, he could no longer smoke marijuana and it was causing a problem. The psychiatrist opined that Petitioner was stressed, but stable with no clinical changes. [Dept. Exh. 225-228].

33. On [redacted], Petitioner met with his therapist and discussed working through his divorce. The therapist noted that Petitioner had been somewhat forced by his lack of financial resources to begin working part-time assisting with some construction related tasks. Petitioner also spoke of the conflict he had with his father. The therapist discussed Petitioner getting his own apartment, but Petitioner planned on continuing to live with his father. The therapist also discussed reapplying for social security and state disability assistance. Petitioner did not feel he could continue to work on a part-time basis long term. Petitioner continued to have significant anxiety and reported that on occasion, he would vomit due to anxiety. [Dept. Exh. 229-230].

34. On [redacted], Petitioner met with his psychiatrist for medication review. Petitioner reported that he was receiving 30 mg of methadone a day and 0.5 of

Xanax three times a day from his physician. Petitioner stated he was under a lot of stress. He stated he was having nightmares which he was discussing with his therapist. The psychiatrist opined that Petitioner was stable and having nightmares and anxiety because of his upcoming divorce and the difficult relationship with his father. [Dept. Exh. 231-234].

35. On [redacted], Petitioner met with his therapist. Petitioner reported that he was "doing alright." He did indicate that he was having conflict with his dad and his dad was critical and argumentative with him on a daily basis. The therapist noted that Petitioner has started reaching out to old friends and this had helped to improve his mood. [Dept. Exh. 236-237].

36. On [redacted], Petitioner asked his therapist to assist him in completing disability paperwork. The therapist helped Petitioner complete the paperwork during their session. The therapist and Petitioner discussed how Petitioner had been more social lately and communicating with others. Petitioner stated that he had reconnected with a couple of people he was once friends with. He was still having conflict with his dad and still struggling with anxiety about leaving the house. [Dept. Exh. 238-239].

37. On [redacted], Petitioner's therapist completed Petitioner's Activities of Daily Living on Petitioner's behalf. The therapist indicated that Petitioner had difficulty regulating his mood and managing anxiety. The therapist wrote that Petitioner would get so anxious that he vomited before leaving his apartment. The therapist noted that Petitioner could not go into stores, could not work, and he could not be around a lot of people. He added that Petitioner's chronic knee and back pain limit Petitioner's mobility. The therapist indicated Petitioner had difficulty falling asleep, staying asleep and waking up early. Petitioner was also unable to put his socks and shoes on by himself. The therapist added that Petitioner could not stand for long periods of time. The therapist listed Petitioner's interests as watching sports or other television and playing pool. The therapist indicated Petitioner was able to go outside alone and that he walked around the block every day. The therapist stated that Petitioner would get into conflicts with his neighbors. He also noted that Petitioner can only pay attention for five minutes before he gets distracted or started daydreaming. The therapist indicated that sometimes Petitioner was too anxious and was unable to leave the house. The therapist added that Petitioner handled changes in routine better than he handled stress. The therapist indicated that Petitioner had problems with lifting, following instructions, bending, completing tasks, concentrating, stair climbing, kneeling, getting along with others, understanding, squatting and standing. The therapist added that Petitioner wore glasses and used a cane when needed. [Dept. Exh. 33-40].

38. On [redacted], Petitioner followed up with his primary care physician for a medication recheck. Petitioner complained of chest congestion, wheezing and possible psoriasis. He also complained of chronic pain including back pain and lower extremity pain. Petitioner was diagnosed with acute bronchitis. The physician noted Petitioner was cooperative, well-groomed and oriented to person,

place, time and event. A positive screen for clinical depression was noted. [Dept. Exh. 60-62].

39. Petitioner is a [redacted]-year-old man whose birthday is [redacted]. He is [redacted] and weighs [redacted] pounds. He last worked in 2008 as a machine operator. He has a high school equivalent education.

40. Petitioner was appealing the denial of Social Security disability at the time of the hearing.

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 person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

Current legislative amendments to the Act delineate eligibility criteria as implemented by department policy set forth in program manuals. 2004 PA 344, Sec. 604, establishes the State Disability Assistance program. It reads in part:

> Sec. 604 (1) The department shall operate a state disability assistance program. Except as provided in subsection (3), persons eligible for this program shall include needy citizens of the United States or aliens exempt from the Supplemental Security Income citizenship requirement who are at least 18 years of age or emancipated minors meeting one or more of the following requirements:
>
> (b) A person with a physical or mental impairment which meets federal SSI disability standards, except that the minimum duration of the disability shall be 90 days. Substance abuse alone is not defined as a basis for eligibility.

Specifically, this Act provides minimal cash assistance to individuals with some type of severe, temporary disability which prevents him or her from engaging in substantial gainful work activity for at least ninety (90) days.

A person is disabled for SDA purposes if he or she:

> •Receives other specified disability-related benefits or services, see Other Benefits or Services below, or
>
> •Resides in a qualified Special Living Arrangement facility, or
>
> •Is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability.
>
> •Is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS), see Medical Certification of Disability. BEM 261, pp 1-2 (7/1/2014).

Federal regulations require that the Department use the same operative definition for "disabled" as used for Supplemental Security Income (SSI) under Title XVI of the Social Security Act. 42 CFR 435.540(a).

"Disability" is:

> . . . the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905. [SDA = 90 day duration].
>
> [As Judge] We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. 20 CFR 416.927(e).

Petitioner is diagnosed with a history of chronic nausea, restless leg syndrome, obesity, bronchitis, chronic left knee pain, pneumonia, hepatomegaly, insomnia, anxiety, bipolar II, panic attacks, attention deficit hyperactivity disorder (ADHD), cannabis dependence, opioid abuse, cocaine abuse, amphetamine abuse and caffeine-induced anxiety disorder.

In determining whether an individual is disabled, 20 CFR 416.920 requires the trier of fact to follow a sequential evaluation process by which current work activity, the severity

of the impairment(s), statutory listings of medical impairments, residual functional capacity, and vocational factors (i.e., age, education, and work experience) are assessed in that order. When a determination that an individual is or is not disabled can be made at any step in the sequential evaluation, evaluation under a subsequent step is not necessary.

First, the trier of fact must determine if the individual is working and if the work is substantial gainful activity. (SGA) 20 CFR 416.920(b). In this case, Petitioner testified that he was not currently working and that he had last worked in 2008. However, a review of Petitioner's medical records revealed that Petitioner was working part-time in construction as late as January, 2016. As a result, this Administrative Law Judge questions Petitioner's credibility. However, Petitioner is not disqualified for SDA at this first step in the sequential evaluation process because during the hearing the Department did not submit any evidence contradicting Petitioner's testimony that he was not working.

Second, in order to be considered disabled for purposes of SDA, a person must have a severe impairment. 20 CFR 416.920(c). A severe impairment is an impairment expected to last 90 days or more (or result in death) which significantly limits an individual's physical or mental ability to perform basic work activities. The term "basic work activities" means the abilities and aptitudes necessary to do most jobs. Examples of these include:

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting. 20 CFR 416.921(b).

The purpose of the second step in the sequential evaluation process is to screen out claims lacking in medical merit. *Higgs v. Bowen* 880 F2d 860, 862 (6th Cir, 1988). As a result, the Department may only screen out claims at this level which are "totally groundless" solely from a medical standpoint. The *Higgs* court used the severity requirement as a "*de minimus* hurdle" in the disability determination. The *de minimus* standard is a provision of a law that allows the court to disregard trifling matters.

In the present case, Petitioner alleges disability due to chronic nausea, restless leg syndrome, obesity, bronchitis, chronic pain of left knee, pneumonia, hepatomegaly, insomnia, anxiety, bipolar II, panic attacks, attention deficit hyperactivity disorder (ADHD), cannabis dependence, opioid abuse, cocaine abuse, amphetamine abuse and caffeine-induced anxiety disorder.

As previously noted, the Petitioner bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). Based on the medical evidence, Petitioner has presented some medical evidence establishing that he does have some mental and physical limitations on his ability to perform basic work activities. The medical evidence has established that Petitioner has an impairment, or combination thereof, that has more than a *de minimis* effect on the Petitioner's basic work activities. Further, the impairments have lasted continuously for 90 days; therefore, Petitioner is not disqualified from receipt of SDA benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Petitioner's impairment, or combination of impairments, meets or medically equals the criteria of an impairment listed in Appendix 1 of Subpart P of 20 CFR, Part 404. (20 CFR 416.920 (d), 416.925, and 416.926). This Administrative Law Judge finds that the Petitioner's medical record does not support a finding that Petitioner's impairment(s) is a "listed impairment" or is medically equal to a listed impairment. See Appendix 1 of Subpart P of 20 CFR, Part 404, Part A.

Listing 5.00 (digestive system) and Listing 12.00 (mental disorders) were considered in light of the objective evidence. Based on the foregoing, it is found that Petitioner's impairment(s) do not meet the intent and severity requirement of a listed impairment; therefore, Petitioner cannot be found disabled at Step 3. Accordingly, the Petitioner's eligibility is considered under Step 4. 20 CFR 416.905(a).

In the fourth step of the sequential consideration of a disability claim, the trier of fact must determine if the Petitioner has the residual functional capacity (RFC) to perform the requirements of Petitioner's past relevant work. 20 CFR 416.920(a) (4) (iv).

The term past relevant work means work performed (either as Petitioner actually performed it or as it is generally performed in the national economy) within the last fifteen years or fifteen years prior to the date that disability must be established. In addition, the work must have lasted long enough for the Petitioner to learn to do the job and have been substantially gainfully employed (20 CFR 416.960 (b) and 416.965.) If Petitioner has the residual functional capacity to do Petitioner's past relevant work, Petitioner is not disabled. 20 CFR 416.960(b)(3). If Petitioner is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth and last step.

Petitioner has a history of less than gainful employment. As such, there is no past work for Petitioner to perform, nor are there past work skills to transfer to other work occupations. Accordingly, Step 5 of the sequential analysis is required.

In the fifth step of the sequential consideration of a disability claim, the trier of fact must determine if the Petitioner's impairment(s) prevents Petitioner from doing other work. 20 CFR 416.920(f). This determination is based upon the Petitioner:

(1) residual functional capacity defined simply as "what can you still do despite your limitations?" 20 CFR 416.945;

(2) age, education, and work experience, 20 CFR 416.963-.965; and

(3) the kinds of work which exist in significant numbers in the national economy which the Claimant could perform despite his/her limitations. 20 CFR 416.966.

In Step 5, an assessment of the individual's residual functional capacity and age, education, and work experience are considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v). At the time of hearing, the Petitioner was 27 years old and was, thus, considered to be a younger individual for MA-P purposes. Claimant had a high school equivalent education. Disability is found if an individual is unable to adjust to other work. *Id.*

At this point in the analysis, the burden shifts from the Petitioner to the Department to present proof that the Petitioner has the residual capacity to 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). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, 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).

In this case, Petitioner testified that he haf daily nausea and panic attacks. He reported that he lost his driver's license because of his diagnosis of ADHD and the medications he takes. He stated he was unable to do any housekeeping and was bedridden during the day and may walk a couple of times a week. He testified that he had gained a 100 pounds in the last year and a half. He also had chronic pain and vomited "umpteen times a day."

Petitioner's testimony contradicts his therapist's comments on the Activities of Daily Living. Petitioner's therapist wrote that Petitioner walks every day, and there was no indication that Petitioner was bedridden.

In addition, the therapist indicated that Petitioner was unable to concentrate for more than 5 minutes, before his mind wandered and he started daydreaming. This Administrative Law Judge noted that Petitioner did not display any problems with focus or concentration during the hearing in the above captioned matter. [Dept. Exh. 33-40].

Therefore, the evidence of record does not support Petitioner's testimony. Petitioner applied for SDA on March 4, 2016. On [redacted], Petitioner told his therapist that he was "doing alright." The therapist noted that Petitioner reported reaching out to old friends which had improved his mood. On [redacted], Petitioner's therapist indicated that Petitioner had been more social lately and was communicating with others.

A review of the evidence revealed that the last time Petitioner complained or reported he was vomiting was on [redacted], when he told his therapist that he had had numerous medical tests and his physicians had been unable to identify the cause for his repeated gagging and vomiting. He also told his therapist that his doctors had indicated it might have a psychological cause. As early as [redacted], Petitioner's therapist had noted that Petitioner's gagging and vomiting may be a psychological problem. Therefore, it is the finding of this Administrative Law Judge that Petitioner was less than truthful in his testimony during the hearing regarding vomiting "umpteen times a day."

Petitioner is [redacted] years old, with a high school equivalent education. Petitioner's medical records are not consistent with Petitioner's testimony that he has been unable to engage in even a full range of sedentary work since his application. See Social Security Ruling 83-10; *Wilson v Heckler*, 743 F2d 216 (1986). Especially in light of Petitioner's lie to the Administrative Law Judge during the hearing in the above captioned matter, when Petitioner stated he had not worked since 2008, when there is evidence he was working in January, 2016 in the construction field.

In light of the foregoing, it is found that Petitioner maintains the residual functional capacity for work activities on a regular and continuing basis which includes the ability to meet the physical and mental demands required to perform at least sedentary work as defined in 20 CFR 416.967(a). After review of the entire record using the Medical-Vocational Guidelines [20 CFR 404, Subpart P, Appendix II] as a guide, specifically Rule 202.27**,** it is found that Petitioner is not disabled for purposes of the MA-P program at Step 5.

Petitioner's therapist indicated that Petitioner's chronic knee and back pain limit Petitioner's mobility. The therapist also wrote that Petitioner watches television and plays pool for 4-6 hours a day. While there was some evidence in the record that Petitioner is being treated for knee pain and bipolar disorder, there is nothing in the record indicating that Petitioner is or was unable to engage in substantial gainful work activity for at least 90 continuous days. Moreover, on [redacted], Petitioner's therapist found that Petitioner's hypomanic (bipolar II) symptoms appeared to be adequately suppressed by his psychiatric medications.

DECISION AND ORDER

Therefore, the Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, finds Petitioner not disabled for purposes of the SDA benefit program.

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

[redacted]

Vicki Armstrong
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]