



RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[REDACTED]
[REDACTED]
[REDACTED]

Date Mailed: April 27, 2017
MAHS Docket No.: 17-003679
Agency No.: [REDACTED]
Petitioner: [REDACTED]

ADMINISTRATIVE LAW JUDGE: Eric J. Feldman

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 [REDACTED], from Detroit, Michigan. Petitioner was present for the hearing and represented himself. The Department of Health and Human Services (Department) was represented by [REDACTED], Eligibility Specialist.

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit programs?

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 [REDACTED] Petitioner submitted an application seeking cash assistance on the basis of a disability.
2. On [REDACTED], the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program. Exhibit B, pp. 2-8.
3. On [REDACTED], the Department sent Petitioner a Notice of Case Action denying the application effective [REDACTED], based on DDS/MRT's finding of no disability. Exhibit D, pp. 1-4.

4. On [REDACTED], the Department received Petitioner's timely written request for hearing. Exhibit A, pp. 2-3.
5. Petitioner alleged disabling impairments due to spinal disorder, asthma, depression, and anxiety.
6. On the date of the hearing, Petitioner was [REDACTED] years old with a date of birth of [REDACTED]; he was [REDACTED]" in height and weighed [REDACTED] pounds.
7. Petitioner obtained his general educational development (GED).
8. At the time of application, Petitioner was not employed.
9. Petitioner has an employment history of work as a reclamation associate, sequence assembler, machine tech, and a cashier/food worker.
10. Petitioner has a pending disability claim with the Social Security Administration.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of 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 individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the *de minimis* standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs v Bowen*, 880 F2d 860, 862-863 (CA 6, 1988), citing *Farris v Sec of Health and Human Services*, 773 F2d 85, 90 n.1 (CA 6, 1985). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. SSR 85-28. If such a finding is not clearly established by medical evidence or if the effect of an impairment or combination of impairments on the individual's ability to do basic work activities cannot be clearly determined, adjudication must continue through the sequential evaluation process. *Id.*; SSR 96-3p.

In the present case, Petitioner alleges disabling impairments due to spinal disorder, asthma, depression, and anxiety. The medical evidence presented at the hearing was reviewed and is summarized below.

In an encounter date of [REDACTED], the doctor diagnosed Petitioner with umbilical hernia without obstruction and without gangrene; and depression. Exhibit B, pp. 25-27.

In an annual exam of Petitioner dated [REDACTED], the doctor diagnosed Petitioner with asthma, mild intermittent, uncomplicated; tinea pedis of both feet; annual physical exam; screen for sexually transmitted disease (STD); umbilical hernia without obstruction and without gangrene; and depression. Exhibit B, pp. 56-58.

In an emergency department notes/progress notes dated from [REDACTED], to [REDACTED], the doctor diagnosed Petitioner with fall down stairs, initial encounter; back strain, initial encounter; muscle strain; right upper quadrant (RUQ) pain; multiple contusions; fall down stairs, subsequent counter; needs flu shot; midline low back pain without sciatica; acute low back pain due to trauma (Physician Assistant (PA) diagnoses); and pain of right hand (PA diagnoses). Exhibit B, pp. 59-82.

In an examination of Petitioner's ribs, knee, and wrist dated [REDACTED], the doctor noted no acute osseous abnormality of the right ribs, left knee or left wrist. Exhibit B, p. 84.

In an examination of Petitioner's chest dated [REDACTED], the doctor noted no acute cardiopulmonary process and limited and incomplete evaluation of the ribs, no displaced rib fractures of the visualized ribs, dedicated rib series is recommended for the complete assessment if there is clinical concern for the rib fracture. Exhibit B, p. 87.

In an ultrasound of Petitioner's abdomen dated [REDACTED], the doctor noted no evidence of cholelithiasis or acute cholecystitis; increased hepatic echogenicity is suggestive of hepatocellular disease, most likely due to steatosis, correlate with liver function tests (LFTs); and pancreas is largely obscured by bowel gas and therefore cannot be adequately assessed. Exhibit B, pp. 88-90.

In an examination of Petitioner's chest dated [REDACTED], the doctor noted no acute cardiopulmonary process; and in a wrist examination dated [REDACTED], the doctor noted negative left wrist. Exhibit B, pp. 91-93.

In a lumber sacral spine view of Petitioner dated [REDACTED], the doctor noted normal alignment of the lumbosacral spine, unchanged on flexion and extension radiographs; partial sacralization of L5 on the left which can be a source of pain; mild facet arthropathy from L3-L4 through L5-S1; and mild anterior wedging of the T12 and, to a lesser extent, the T11 vertebral bodies, of uncertain acuity. Exhibit B, p. 94.

In an examination of Petitioner's pelvis dated [REDACTED], the doctor noted no acute fracture or dislocation and mild degenerative changes in the bilateral hips. Exhibit B, pp. 95-96.

In an magnetic resonance imaging (MRI) of Petitioner's lumbar spine dated [REDACTED] the doctor diagnosed him with degenerative disease with the lumbar spine, primarily at the L3-L4 and L4-L5 levels. Exhibit B, pp. 97-98.

In an examination of Petitioner's right hand dated [REDACTED], the doctor noted no acute process, if there is a mass or lump follow-up ultrasound or computed tomography (CT) or MRI would be more sensitive test. Exhibit B, p. 99.

In an emergency department treatment note of Petitioner dated [REDACTED], the doctor noted his disposition was that Petitioner was admitted in serious condition due to a diagnoses of acute exacerbation of chronic back pain. Exhibit B, pp. 144-145. With this form was a teaching physician addendum, in which the doctor diagnosed him with acute intractable back pain with acute exacerbation, with history of chronic back pain, and acute suspect urethritis. Exhibit B, pp. 147-149.

In a history and physical of Petitioner dated [REDACTED], the doctor diagnosed him with lower back pain, cannot rule out (r/o) herniation; mild asthma controlled; and pruritis affect the genital region (jock itch). Exhibit B, pp. 103-108. During his consultation exam dated [REDACTED], the doctor noted decreased range of motion of left lower extremity at hip and knee, pain limited; decreased lumbar range of motion due to pain; positive straight leg raise test or the left and decreased sensation of entire left

lower extremity when compared to the right, subjective; and negative Hoffman's and the doctor's impression was low back pain status post injury; left lower extremity weakness and pain status post injury; left lower extremity radicular pain; and gait dysfunction and impaired mobility. Exhibit B, pp. 135-136.

In a CT scan of Petitioner's cervical spine dated [REDACTED], the doctor indicated he had no acute fracture or dislocation of the cervical spine and no significant stenosis in spinal canal and neural foramen. Exhibit A, p. 4.

In a CT scan of Petitioner's lumbar spine dated [REDACTED], the doctor indicated he had no acute fracture or dislocation of lumbar spine and mild spondylotic change in L4-L5, no significant neural foraminal or spinal canal stenosis. Exhibit B, pp. 156-157.

In a CT scan of Petitioner's thoracic spine dated [REDACTED], the doctor indicated no acute fracture or dislocation of the cervical spine; and no significant spinal canal or neural foraminal stenosis. Exhibit B, p. 158.

In an MRI of Petitioner's lumbar spine dated [REDACTED], the doctor noted transitional lumbar anatomy with lumbarization of the S1 vertebral body; and left paracentral disc protrusion at L5-S1 compresses the traversing left S1 nerve roots. Exhibit B, p. 160.

In progress notes dated from [REDACTED], to [REDACTED], Petitioner was diagnosed by the doctor with lower back pain, cannot r/o herniation; mild asthma controlled; and pruritis affect the genital region (jock itch); low back pain status post injury in [REDACTED] with L4/L5 paracentral disc bulge on MRI; left lower extremity pain with resultant weakness status post injury; left lower extremity radicular pain; gait dysfunction and impaired mobility; and lower back pain likely due to compression of disc at L4-L5. Exhibit B, pp. 109-134.

In a neurosurgery consultation of Petitioner dated [REDACTED], the doctor noted Petitioner with acute onset back pain radiating to left leg slip and fall of heavy object on his head, MRI of lower spine with left L4-L5 paracentral disc bulger, patient intact neurologically; and other findings. Exhibit B, pp. 137-140.

On [REDACTED], Petitioner was admitted to the hospital. On [REDACTED], Petitioner was discharged with the following diagnoses: (i) abnormal MRI, lumbar spine; (ii) acute low back pain due to spinal disorder; and (iii) bulging lumbar disc. Exhibit B, p. 16.

In a discharge summary dated [REDACTED], the doctor's primary assessment of Petitioner was lower back pain, likely due to bulge of disk at L4-L5; asthma well controlled; and pruritis affect the genital region. Exhibit B, p. 141.

On [REDACTED], Petitioner had a psychiatric evaluation, in which the doctor diagnosed him with major depressive disorder, single severe without psychological; mild persistent asthma, uncomplicated; and chronic pain due to trauma. The doctor noted that he has economic problems; problem accessing healthcare; educational problems;

occupational problems; housing problems; problem with primary support group; and problem related to interaction with legal system. In the diagnostic summary, the doctor noted he is homeless and is presenting with depression, anxiety, loss of interest in things once enjoyed, episodes of frustration, poor concentration, and auditory hallucinations. The doctor noted that as of [REDACTED], his Global Assessment of Functioning (GAF) scale is 48. Exhibit B, pp. 178-181. In the Integrated Biopsychosocial Assessment dated [REDACTED], the Licensed Master Social Worker (LMSW) diagnosed him with similar findings as the doctor on [REDACTED], but included a diagnosis of cannabis abuse. Exhibit B, pp. 182-225. It should be also noted that Petitioner had similar diagnoses as the doctor did on [REDACTED], by a Limited Licensed Professional Counselor (LLPC) on or about [REDACTED], and another doctor on or about [REDACTED]. Exhibit B, pp. 227-238 and 257-262.

In a Notice of Determination letter mailed on [REDACTED], from the [REDACTED], it stated that he has indicated he is not able to work due to illness, injury or work restrictions; therefore he does not meet the ability requirements of the Michigan Employment Security (MES) Act. He is ineligible for benefits under the MES Act beginning [REDACTED] and continuing until this condition no longer exists and he will not receive benefit payments during this period. Exhibit A, p. 21.

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), 3.03 (asthma), 12.04 (affective disorders), and 12.06 (anxiety-related disorders) were considered. 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. 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 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.*

In this case, Petitioner alleges both exertional and nonexertional limitations due to his medical condition. Petitioner alleges disabling impairments due to spinal disorder, asthma, depression, and anxiety. He stated he suffers from asthma since birth and has a spinal disorder due to a slip and fall. He stated his spinal disorder causes paralyzing stages, and he cannot move or walk, which resulted in hospitalization. He stated he was given a walker, but it gave him more complications. He stated that he is unable to obtain unemployment compensation due to injuries from his slip and fall and that he would not be able to work. See Exhibit A, p. 21. He stated he can dress/undress, bathe/shower, use the bathroom, eat by himself, he can go grocery shopping, and he can do chores, but his back will hurt. He stated can lift a gallon of milk, but he cannot squat or kneel. He stated he can stand 1 ½ hours to 2 hours, he can sit for 1 ½ hours to 2 hours, he can walk up to a mile, and can lift up to 40 to 50 pounds, but all of these results he stated will result in hospitalization. Since [REDACTED] he stated he suffers from anxiety and depression. In fact, he stated that he just sitting there during the hearing, his back is in pain. He stated he would not be able to work because his mental conditions makes him "out-of-focus," he day dreams, communications shut down when dealing with people, and wants to be isolated. He stated he can remember, follow instructions, and work with others, but he is not able to complete tasks or concentration because he gets distracted.

A two-step process is applied in evaluating an individual's symptoms: (1) whether the individual has a medically determinable impairment that could reasonably be expected to produce the individual's alleged symptoms and (2) whether the individual's statement about the intensity, persistence and limiting effects of symptoms are consistent with the

objective medical evidence and other evidence on the record from the individual, medical sources and nonmedical sources. SSR 16-3p.

In regards to Petitioner's exertional limitations alleged, on [REDACTED], Petitioner was discharged from the hospital with the following diagnoses: (i) abnormal MRI, lumbar spine; (ii) acute low back pain due to spinal disorder; and (iii) bulging lumbar disc. Exhibit B, p. 16. Moreover, in an annual exam of Petitioner dated [REDACTED], the doctor diagnosed Petitioner with asthma, mild intermittent, uncomplicated. Exhibit B, pp. 56-58. This evidence was sufficient to support Petitioner's allegations of spinal disorder/back pain and asthma.

In regards to Petitioner's nonexertional limitations, in an encounter date of [REDACTED] the doctor diagnosed Petitioner with depression. Exhibit B, pp. 25-28. On [REDACTED], Petitioner had a psychiatric evaluation, in which the doctor diagnosed him with major depressive disorder, single severe without psychological; mild persistent asthma, uncomplicated; and chronic pain due to trauma. Exhibit B, pp. 178-181. Furthermore, in the diagnostic summary, the doctor noted he is homeless and is presenting with depression, anxiety, loss of interest in things once enjoyed, episodes of frustration, poor concentration, and auditory hallucinations. Exhibit B, pp. 178-181. This evidence was sufficient to support Petitioner's allegations of depression and anxiety.

With respect to the intensity, persistence and limiting effects of his symptoms, the medical evidence included emergency department notes/progress notes, clinical/laboratory findings, discharge summary, and other medical evidence showing how Petitioner maintains the physical capacity to perform light work as defined by 20 CFR 416.967(b). Beginning in [REDACTED], during an annual examination of Petitioner, the doctor diagnosed Petitioner with asthma, mild intermittent, uncomplicated; and other diagnoses. Exhibit B, pp. 56-58. Then, in emergency department notes/progress notes dated from [REDACTED], to [REDACTED], the doctor diagnosed Petitioner with fall down stairs, initial encounter; back strain, initial encounter; muscle strain; RUQ pain; multiple contusions; fall down stairs, subsequent counter; midline low back pain without sciatica; acute low back pain due to trauma (PA diagnoses); pain of right hand (PA diagnoses); and other diagnoses. Exhibit B, pp. 59-82. During the period of [REDACTED], to [REDACTED], Petitioner had examinations of his pelvis, ribs, knee, wrist, chest, hands, ultrasound of his abdomen, lumber sacral spine view, and an MRI of his lumbar spine. See Exhibit B, pp. 84-99. In a lumber sacral spine view of Petitioner dated [REDACTED], the doctor noted normal alignment of the lumbosacral spine, unchanged on flexion and extension radiographs; partial sacralization of L5 on the left which can be a source of pain; mild facet arthropathy from L3-L4 through L5-S1; and mild anterior wedging of the T12 and, to a lesser extent, the T11 vertebral bodies, of uncertain acuity. Exhibit B, p. 94. In an MRI of Petitioner's lumbar spine dated [REDACTED], the doctor diagnosed him with degenerative disease with the lumbar spine, primarily at the L3-L4 and L4-L5 levels. Exhibit B, pp. 97-98. The undersigned reviewed the above medical evidence and determined it does not show any severe disabling impairments based on his spinal disorder/back pain and asthma.

Additionally, Petitioner presented medical evidence from his hospitalization/inpatient that occurred in [REDACTED]. In an emergency department treatment note of Petitioner dated [REDACTED], the doctor noted his disposition was that Petitioner was admitted in serious condition due to a diagnoses of acute exacerbation of chronic back pain. Exhibit B, pp. 144-145. During his consultation exam dated [REDACTED], the doctor noted decreased range of motion of left lower extremity at hip and knee, pain limited; decreased lumbar range of motion due to pain; positive straight leg raise test on the left and decreased sensation of entire left lower extremity when compared to the right, subjective; and negative Hoffman's and the doctor's impression was low back pain status post injury; left lower extremity weakness and pain status post injury; left lower extremity radicular pain; and gait dysfunction and impaired mobility. Exhibit B, pp. 135-136. Furthermore, during his admission in the hospital, he had CT scans of his cervical spine, lumbar spine, thoracic spine, and an MRI of his lumbar spine. Exhibit A, p. 4 and Exhibit B, pp. 156-160. In a CT scan of Petitioner's cervical spine dated [REDACTED], the doctor indicated he had no acute fracture or dislocation of the cervical spine and no significant stenosis in spinal canal and neural foramen. Exhibit A, p. 4. In an MRI of Petitioner's lumbar spine dated [REDACTED], the doctor noted transitional lumbar anatomy with lumbarization of the S1 vertebral body; and left paracentral disc protrusion at L5-S1 compresses the traversing left S1 nerve roots. Exhibit B, p. 160. On June 24, 2016, Petitioner was discharged with the following diagnoses: (i) abnormal MRI, lumbar spine; (ii) acute low back pain due to spinal disorder; and (iii) bulging lumbar disc. Exhibit B, p. 16. Also, in a discharge summary dated [REDACTED], Petitioner's primary assessment of him was lower back pain, likely due to bulge of disk at L4-L5; asthma well controlled; and pruritis affect the genital region. Exhibit B, p. 141.

The undersigned reviewed the above medical evidence and determined it does not show any severe disabling impairments based on his spinal disorder/back pain and asthma. These findings do support Petitioner's statement that he suffers from spinal disorder/back pain and asthma. But, with respect to the intensity, persistence and limiting effects of his symptoms, the medical evidence does not show he is limited to perform less than light work. In fact, Petitioner indicated during the hearing that he can dress/undress, bathe/shower, use the bathroom, eat by himself, he can go grocery shopping, and he can do chores, but his back will hurt. He stated he can stand 1 ½ hours to 2 hours, he can sit for 1 ½ hours to 2 hours, he can walk up to a mile, and can lift up to 40 to 50 pounds, but all of these results he stated will result in hospitalization.

Accordingly, the undersigned Administrative Law Judge (ALJ) finds that based on a review of the entire record, including Petitioner's testimony, the evidence was sufficient to establish that Petitioner maintains the physical capacity to perform light work as defined by 20 CFR 416.967(b).

With respect to Petitioner's nonexertional limitations, he was diagnosed by his doctor with depression on [REDACTED]. Exhibit B, pp. 25-27 and 56-58. Moreover, Petitioner had a psychiatric evaluation on [REDACTED], in which the doctor diagnosed him with major depressive disorder, single severe without psychological and other medical findings. Exhibit B, pp. 178-181. The doctor noted that he has economic

problems; problem accessing healthcare; educational problems; occupational problems; housing problems; problem with primary support group; and problem related to interaction with legal system. Exhibit B, pp. 178-181. In the diagnostic summary, the doctor noted he is homeless and is presenting with depression, anxiety, loss of interest in things once enjoyed, episodes of frustration, poor concentration, and auditory hallucinations. The doctor noted that as of [REDACTED], his GAF scale is 48. Exhibit B, pp. 178-181. Overall, the medical evidence supports Petitioner's testimony that he suffers from depression and anxiety, but does not show any significant limitations or restrictions that would affect his ability to meet the demands of jobs.

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild to moderate limitations to his activities of daily living; mild to moderate limitations to his social functioning; and mild to moderate limitations to his concentration, persistence or pace. There is no evidence of episodes of decompensation.

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 reclamation associate, sequence assembler, machine tech, and a cashier/food worker.

Based on the RFC analysis above, Petitioner is limited to no more than light work activities and has mild to moderate limitations in his mental capacity to perform basic work activities. In light of the entire record and Petitioner's RFC, including his mental limitations, it is found that Petitioner is unable to perform past relevant work. Accordingly, Petitioner cannot be found disabled, or not disabled, at Step 4; and the assessment continues to Step 5.

Step 5

If an individual is incapable of performing past relevant work, Step 5 requires an assessment of the individual's RFC and age, education, and work experience to determine whether an adjustment to other work can be made. 20 CFR 416.920(a)(4)(v); 20 CFR 416.920(c). If the individual can adjust to other work, then there is no disability; if the individual cannot adjust to other work, then there is a disability. 20 CFR 416.920(a)(4)(v).

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(c)(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 ■ years old at the time of hearing, and, thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. Petitioner has a GED and a history of unskilled and/or semi-skilled and/or skilled work experience. 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 on Petitioner's age, education, work experience, and exertional RFC, the Medical-Vocational Guidelines, 202.20, and/or 202.21 (not transferable), and/or 202.22 (transferrable), result in a finding that Petitioner is not disabled based on his exertional limitations.

While the Medical-Vocational Guidelines do not result in a disability finding based on Petitioner's exertional limitations, Petitioner's medical record also shows nonexertional limitations resulting in mild to moderate limitations to his activities of daily living; mild to moderate limitations to his social functioning; and mild to moderate limitations to his concentration, persistence or pace. It is found that those limitations would not preclude him from being able to adjust to other work engaging in simple, unskilled work activities on a sustained basis. Therefore, Petitioner is able to adjust to other work and is not disabled at Step 5.


Accordingly, after review of the entire record, including Petitioner's testimony, and in consideration of Petitioner's age, education, work experience, physical as well as mental RFC, Petitioner is found not disabled at Step 5 for purposes of the SDA benefit program.

DECISION AND ORDER

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 not disabled for purposes of the SDA benefit program.

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

EJF/jaf



Eric J. Feldman
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

Petitioner

[REDACTED]
[REDACTED]
[REDACTED]

DHHS

[REDACTED]
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