[redacted]

Date Mailed: February 22, 2018
MAHS Docket No.: 17-015455
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. After due notice, a telephone hearing was held on January 3, 2018, from Detroit, Michigan. Petitioner was present and testified. The Department of Health and Human Services (Department) was represented by [redacted] Medical Contact Worker.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Petitioner's medical documents from the [redacted] were received and marked into evidence as Exhibit 3; Petitioner's hospital records from [redacted] for 2017 were received and marked into evidence as Exhibit C. The record closed on February 2, 2018, 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 May 8, 2017, Petitioner submitted an application seeking cash assistance based on a disability.

2. On October 17, 2017, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 8-14).

3. On October 17, 2017, the Department sent Petitioner a Notice of Case Action denying the SDA application based on DDS/MRT's finding of no disability (Exhibit A, pp. 3-6).

4. On November 9, 2017, the Department received Petitioner's timely written request for hearing (Exhibit A, p. 2).

5. Petitioner alleged disabling impairment due to diabetes, diabetic neuropathy, gastroenterology reflux disease (GERD) with difficulty eating and swallowing, sleep apnea, irritable bowel syndrome (IBS)/constipation, finger cramping in both hands, passing out, collapsing, and left pain and numbness.

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

7. Petitioner has a [redacted] degree.

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

9. Petitioner has an employment history of repairing and constructing wind turbines and working as a lab technician and batch maker for an automotive paint company.

10. Petitioner has a pending disability claim with the [redacted] (Exhibit B).

## CONCLUSIONS OF LAW

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

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

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.

June 29, 2016 notes from Petitioner's visit at the [redacted] show he complained of abdominal pain. Notes showed Petitioner had been extensively evaluated but extensive negative GI work-up showed no organic intra-abdominal disease. He did not respond to offered therapies. His diabetes was controlled on oral agents. He reported no known end-organ diabetic damage but noted numbness in feet and hands. The doctor concluded that Petitioner may well have diabetic thoracic neuropathy and recommended anesthesia pain therapy evaluation. (Exhibit 3.)

At a January 9, 2017 visit with a urologist for a renal cyst diagnosed in March 2016, Petitioner complained of frequency and nocturia (Exhibit A, p. 21: 41-44, 77-78). A January 29, 2017 kidney sonogram showed an essentially normal sonographic evaluation of the urinary bladder and a cyst with minimal complexity in the right kidney, but the defect did not appear to be increasing substantially in size; a follow-up was recommended in 3 to 4 months. (Exhibit A, pp. 21: 38, 79).

The medical record included office notes from Petitioner's visits with his primary care physician from February 21, 2017 and April 12, 2017. The notes show diagnoses of neuropathy, mixed hyperlipidemia, vitamin deficiency, essential hypertension with goal blood pressure less than 140/90, and type 2 diabetes mellitus with complication and without long-term current use of insulin. The doctor noted worsening neuropathy and controlled diabetes. His physical exam was normal other than tenderness in the abdomen and nausea. (Exhibit A, pp. 21: 58-76). The file included several letters prepared by Petitioner's doctor. In a March 31, 2016 letter, the doctor asked that Petitioner be excused from work from November 12, 2015 to May 12, 2016 due to his hypertension, GERD, OSA, IBS and diabetes (Exhibit A, pp. 21: 29). In a September 13, 2016 letter, the doctor stated Petitioner had severe neuropathy affecting his

stomach and could not work due to his symptoms (Exhibit A, p. 21: 31). An April 26, 2016 letter from the same doctor stated that Petitioner was diagnosed with IBS with constipation causing severe abdominal pain, distension and bloating and he had postural light-headedness causing dizziness and inability to bend, lift, and carry; nausea; and vomiting. The doctor concluded that Petitioner could not work until his condition improved. (Exhibit A, p. 21: 27). In an October 10, 2016 letter, he stated that Petitioner had severe neuropathy effecting his digestive system and causing nausea, vomiting, fatigue, and abdominal pain. The doctor concluded that Petitioner was being evaluated at the [redacted] and could not work due to his condition and was permanently disabled. (Exhibit A, pp. 21: 26.). Another letter dated February 21, 2017 from the doctor noted that Petitioner had severe neuropathy effecting his digestive system and causing nausea, vomiting, fatigue and abdominal pain. He also had diabetes and hypertension. (Exhibit A, pp. 21: 28, 21: 32, 21: 34.)

On August 24, 2017, Petitioner was examined by an independent medical consultant at DDS/MRT's request for complaints of sleep apnea, IBS, diabetes mellitus, diabetic polyneuropathy, and GERD. The doctor stated that Petitioner informed him that he was able to get in and out of bed, dress and bathe himself, drive and cook. The doctor observed that Petitioner sat comfortably during the exam, demonstrated no pain-mitigating movement and did not appear uncomfortable getting on and off the examination. The doctor noted that Romberg was negative; ambulation was observed and appeared normal and symmetric; no assistive device was brought or used; the range of motion for the cervical spine, dorso-lumbar spine, and knee, ankle, shoulder, elbow, wrist, and finger/thumb joints was "no discernible discomfort with these normal ranges." Strength was 5/5 bilateral upper and lower extremities, including grip and pincer. The diagnoses were hypertension on medications, diabetes on medications, diabetic neuropathy on medications, diabetic automonic dysfunction, hyperlipidemia on medications, IBS on medications, GERD on medications, sleep apnea on CPAP, and obesity. The doctor concluded that there was no limitation as to the number of hours Petitioner should be able to sit, stand, or walk in a normal eight-hour day. There were also no limitations regarding the amount of weight that he should be able to lift and/or carry during a normal eight-hour workday; no bending, stooping, squatting, crouching and/or crawling limitation; no manipulative limitation; and no assistive devices recommended. (Exhibit A, pp. 21: 18-24.)

On December 1, 2017, Petitioner was examined by another independent medical examiner who examined Petitioner at DDS/MRT's request and completed a second consultative evaluation. Petitioner complained of hypertension, hyperlipidemia, diabetes mellitus type II, GERD, irritable bowel syndrome (predominately constipation), peripheral neuropathy, obstructive sleep apnea, chronic back pain, and bilateral knee joint pain. Petitioner claimed blood sugar ranges from 79 to 130, hemoglobin A1c levels of 6.4 as of January 2016, and frequent passing out spells or near syncopal episodes because of blood sugar declines as a result of being unable to eat regularly because of his chronic abdominal pain with GERD. During the exam, Petitioner complained of a dizziness spell when he got up from the reclining position and it took him 5 minutes to

recover; his blood sugar at the time was 357. With respect to his GERD, he complained of poor appetite due to his abdominal pain that radiated to the back. He asserted he had visited several doctors, including gastroenterologist, who told him his pain could be from diabetic neuropathy. He alleged irritable bowel syndrome with constipation but admitted that a colonoscopy did not reveal any significant findings other than several polyps which were benign. He complained of numbness in his hands and feet and cramping in the fingers. He used a prescribed c-pap to treat his sleep apnea but complained of ongoing fatigue with occasional daytime somnolence. He stated that MRI and CAT scans did not show any significant findings, but he had sharp, shooting pain from his abdomen to his lower back which he was told might be form his neuropathy. He complained of bilateral knee pain that prevented him from being able to sit, stand, or walk for long periods of time; he had a history of falls and had been prescribed a cane.

The doctor observed that Petitioner had good bilateral handgrip (3/5); intact digital dexterity; a slow gait with some antalgia; a tendency to stagger, with use of a cane on the right; decreased range of motion of the lumbar spine and both hip and knee joints; straight leg raise of 70 degrees on both sides with complaints of back and leg pain; and no motor or sensory neurological defects. The doctor completed a medical source statement of ability to do work related activities and found that Petitioner could occasionally lift and up to 10 pounds but never more; could stand, sit, or walk not more than 1 hour in an 8-hour day; could ambulate not more than 200 feet without a cane; had limitations in using his hands to reach and finger; could never use his hands to push or pull due to his diabetic neuropathy and frequent episodes of hypoglycemia and near syncope episodes due to fluctuating blood sugar; had diabetic neuropathy of both feet and associated numbness and tingling with history of severe falls. The doctor recommended that Petitioner not be exposed to unprotected heights, operating a motor vehicle, extreme cold, or extreme heat. The doctor concluded that Petitioner could perform activities like shopping; traveling without a companion for assistance; walking a block at a reasonable pace on rough or uneven surfaces; preparing a simple meal; caring for his personal hygiene; and sorting, handling, or using paper or files but could not use standard public transportation. He found that the clinical evidence supported Petitioner's need for a walking aid to reduce pain and to prevent falls. Based on his physical examination and Petitioner's history, the doctor concluded that (1) Petitioner's hypertension was at goal; (2); his hyperlipidemia was being treated with a statin; (3) he had peripheral neuropathy due to his diabetes with frequent episodes of dizziness or near syncopal episodes and may also have gastric diabetic gastroparesis with nausea, vomiting and difficulty digesting food; (4) he had GERD or acid reflux; (5) he had irritable bowel syndrome, predominantly constipation; (6) he had obstructive sleep apnea, with fatigue, exhaustion and occasional daytime somnolence despite c-pap use; (7) he had chronic back pain with decreased range of motion of the lumbar spine but with negative MRI and studies and possibly associated with neuropathy; and (8) he had chronic bilateral knee joint pain, possibly secondary to degenerative joint disease, with decreased range of motion. The doctor concluded that Petitioner's physical and

functional limitations were associated with his conditions (other than hypertension and hyperlipidemia, which were asymptomatic) (Exhibit 1, pp. 2-16.)

Petitioner's hospital records from November 21, 2017 show that Petitioner had gone to the hospital for an outpatient radiology study for possible gastroparesis when he experienced nausea, vomiting and abdominal pain and was referred to emergency. Petitioner informed staff that he experienced the same problems at home. Abdominal x-rays showed no acute intrathoracic process. He was released when his symptoms completely resolved. (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 1.02 (major dysfunction of a joint), 3.02 (chronic respiratory disorders), 5.06 (inflammatory bowel disease), and 9.00 (endocrine 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) considering 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).

In this case, Petitioner alleges that he is limited to sitting not more than 45 minutes and standing not more than 3 1/2 minutes. He states that his legs give out if he walks more than 200 feet and he must use a cane or lean on a cart. He lives alone and admits that he can bathe and dress himself but states that his girlfriend sometimes helps him, and he sometimes passes out. Family and friends help with chores and shopping. He drives only when necessary because of concerns that he will pass out.

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.

Petitioner's medical record supports his diagnoses of diabetes mellitus, diabetic neuropathy, GERD, and abdominal pain, possibly due to gastric diabetic gastroparesis with nausea and vomiting. While Petitioner's first independent medical consultative exam on August 1, 2017 revealed very few limitations in connection with these conditions, the December 1, 2017 consultative exam, held less than four months after the first, though indicating that Petitioner could perform basic household activities, identified significant limitations: Petitioner could not stand, sit, or walk more than one hour in an 8-hour day; he could not sit more than 30 minutes, stand more than 5 minutes or walk more than 10 minutes at one time without interruption; he could not bend, lift, or carry more than ten pounds; he could not ambulate more than 200 feet without a cane; he needed a cane to avoid staggering; he had diabetic neuropathy of both feet with associated numbness and tingling with a history of severe falls; he has frequent episodes of dizziness or near syncope due to low blood sugar, as evidenced by the incident during the exam. Notes from Petitioner's doctor, though conclusory in finding that Petitioner was disabled, support the findings in the December 1, 2017 consultative report. Notes from Petitioner's hospital visit in November 2017 when he had to go to emergency during a diagnostic test after experiencing nausea and vomiting show that Petitioner reported that this behavior was common and further support Petitioner's testimony concerning the intensity, persistence and limiting effects of his symptoms.

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 less than sedentary work as defined by SSR 96-9p. Based on the medical record presented, as well as Petitioner's testimony, Petitioner has nonexertional limitations due to his conditions that require that he not be exposed to unprotected heights, extreme cold or extreme heat and not operate a motor vehicle.

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 by Petitioner (as actually performed by Petitioner or as generally performed in the national economy) 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) and (2). 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 repairing and constructing wind turbines and working as a lab technician and batch maker for an automotive paint company. Petitioner's past work required light to medium physical exertion. Based on the RFC analysis above, Petitioner's exertional RFC limits him to less than sedentary work activities. As such, Petitioner is incapable of performing past relevant work. Because Petitioner is unable to perform past relevant work, he cannot be found disabled, or not disabled, at Step 4, and the assessment continues to Step 5.

**Step 5**

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 [redacted] years old at the time of application and [redacted] years old at the time of hearing, and, thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. He has a college degree. He has a skilled work history tied to light to medium work. As discussed above, Petitioner's exertional RFC limits him to less than sedentary work activities. Under these circumstances, the Medical-Vocational Guidelines, Appendix 2 do not support a finding that Petitioner is not disabled based on his exertional limitations. The Department has failed to counter with evidence of significant numbers of jobs in the national economy which Petitioner could perform despite his limitations. Therefore, the Department has failed to establish that, based on his RFC and age, education, and work experience, Petitioner can adjust to other work. Therefore, Petitioner is disabled at Step 5.

## 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 **disabled** for purposes of the SDA benefit program.

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

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE THE ORDER WAS ISSUED:

1. Reregister and process Petitioner's May 8, 2017 SDA application to determine if all the other non-medical criteria are satisfied and notify Petitioner of its determination;

2. Supplement Petitioner for lost benefits, if any, that Petitioner was entitled to receive if otherwise eligible and qualified;

3. Review Petitioner's continued eligibility in August 2018.

AE/tm

**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]

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