[redacted]

Date Mailed: August 27, 2018
MAHS Docket No.: 18-005715
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

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 August 2, 2018, from Detroit, Michigan. The Petitioner was represented by himself. The Department of Health and Human Services (Department) was represented by Zelia Cobb.

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], 2018, the Petitioner submitted an application seeking cash assistance on the basis of disability.

2. On May 25, 2018, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability. (Exhibit A, pp. 5-11.)

3. On May 29, 2018, The Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability.

4. On [redacted], 2018 the Department received Petitioner's timely written request for hearing.

5. Petitioner has alleged disabling impairment due to chronic back pain with disc problems in the lower back with radiating pain down the right leg diagnosed as

Lumbar spondylosis with neuropathy and cervical spondylosis. The Petitioner also alleges mental disabling impairment due to depression and Bipolar Disorder with most recent treatment diagnosis of Post-Traumatic Stress Disorder (PTSD) with depression and anxiety symptoms.

6. On the date of the hearing, the Petitioner was 23 years of age with an [redacted], 1994, birth date; he is 5' 4" in height and weights about 138 pounds.

7. Petitioner is a high school graduate and participated in special education classes and has no reading difficulty and cannot do multiplication or division math.

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

9. Petitioner has an employment work history of working for a staffing company picking vegetables.

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. 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.

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 1

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 2

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). Social Security Ruling (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.

The following medical evidence was provided at the hearing and is presented and summarized below.

The Petitioner was seen by his pain specialist for his back pain. The last visit was on [redacted] 2018, at which time the Petitioner received a lumbar/sacral facet injection and a paravertebral joint nerve block. The Petitioner was also prescribed a back brace in January 2018. The Petitioner had an EMG study, which was not presented but performed on [redacted], 2018. Petitioner also received an epidural on [redacted], 2018, and [redacted], 2018, for the lumbar/sacral area. On [redacted], 2018, and [redacted] 2018, Petitioner received a lumbar/sacral facet injection. (Petitioner Exhibit 2.)

The Petitioner was seen at the [redacted] for psychiatric services on [redacted], 2018, at which time a treatment plan meeting was held; and it was determined that he was to be seen by a psychiatrist every six months to monitor labs, medications symptoms, side effects and medication reviews. (Petitioner Exhibit 2.)

On [redacted] 2018, Petitioner was examined in a consultative examination arranged by the Department. Chief complaints were anxiety, depression, pain in back, shoulders and neck. The Petitioner's physical symptoms are described as resulting from a motor vehicle accident while riding a bus as a passenger resulting in radiating pain posteriorly

to his right knee, and neck pain with radiation to his shoulders bilaterally. Pain in all areas reported as constant. Petitioner's medical records were also reviewed by the examiner, as well as MRI's of cervical and lumbar spine completed one year prior to the exam. During the exam, the Petitioner advised that he requires help getting in and out of bed, dressing and bathing, and is not able to drive, cook or clean for himself and is assisted by his Godmother who he lives with. The Petitioner's sleep pattern was described as starting his day at 2:00 a.m. and going to sleep at 11:00 p.m. During the exam, the Petitioner was comfortable while seated, and arose to stand without assistance, appeared uncomfortable getting on and off exam table. Petitioner did not appear anxious and was appropriate. Romberg was negative, finger-nose was accurate on both sides, no heel-toe walk was performed, gait was normal and symmetric with use of a cane. Range of motion in cervical spine was able to be completed with mild discernible discomfort with normal ranges. The Petitioner's seated straight leg raising was negative and in supine position was positive when elevated 20 degrees bilaterally. The shoulder exam was completed with moderate discomfort. The exam of the spine noted mild cervical, thoracic and lumbar spinous process tenderness. Neurologic test indicated strength was 3/5 bilaterally.

At the completion of the exam, the diagnosis was lumbar spondylosis with right L4 neuropathy, cervical spondylosis with radiculopathy, bilateral shoulder pain, non-specified, anxiety and depression. The following functional assessment was made: seated, no recommended limitations, standing 6 hours in an 8-hour workday; walking 6 hours in an 8-hour workday; lifting frequently 15 pounds and occasionally 25 pounds. The amount of weight able to carry is about 15 pounds frequently and 25 pounds occasionally. Bending, stooping, squatting, crouching and or crawling activities should be feasible frequently. Manipulative limitations were not imposed. An assistive device, a can was determined to be warranted and used frequently for all activities. It is noteworthy that the examiner included the following statement after all evaluative statements where some limitation was imposed "He has lumbar spondylosis with right L4 neuropathy and diffuse weakness". (Exhibit A, p. 86.)

Petitioner was seen several times by an [redacted] for pain involving his shoulder and back. He was seen there on [redacted], 2017; [redacted] 2017; and [redacted], 2018. At the time of his last visit, he was seen for pain to shoulder and back 8/9 sharp pain with radiation to the lower extremities bilaterally with numbness and tingling. Reported pain due to motor vehicle accident in [redacted] 2017. Petitioner's medications and systems were reviewed, and the impression was a referral to physical therapy and pain clinic, a note regarding possible malingering noted "patient seem to exaggerate symptoms, and requesting to be on disability.

The Petitioner was seen at his [redacted] and medication review was conducted on [redacted], 2018, for chronic neck and back pain and pin in left shoulder, with chronic anxiety noted. The Petitioner was prescribed Gabapentin, Cyclobenzaprine, and Hydrocodone (Norco). The plan was to order physical therapy and chiropractic as well as back brace. Objective findings included straight leg raising was negative, paraspinal

muscle tenderness, muscle strength 5/5 all groups decreased ROM for lumbar facet loading increased pain with flexion and extension. On [redacted], 2018, another visit included review of MRI of lumbar spine with disc protrusion at L4-L5 and L5-S1. A visit in [redacted] 2018 indicated spinal injections were discussed.

An MRI of the lumbar spine was performed on [redacted] 2017. The impression was broad based disc protrusion seen at L4-L5 and L5-S1 causing flattening of the thecal sac and bilateral neural foraminal encroachment.

An MRI of the cervical spine was performed on [redacted] 2017. The impression was no significant disc abnormality with no evidence of fracture of subluxation. C2 through C7 noted no significant disc abnormality, canal stenosis or neuroforaminal narrowing.

The Petitioner was seen at the pain center for low back pain with radiation down right side to left leg to knees, numbness both feet notes Straight Leg Raising positive bilateral 30 degrees. A needle EMG was performed. The Conclusion of the exam, high L5 irritability suggesting radiculopathy not definitive, requires clinical correlation.

On [redacted] 2017, Petitioner was seen at [redacted] services complaining of low back pain, on the left and right buttock, right hip pain, headache and neck pain with paint in right shoulder. The Petitioner was seen for evaluation after his motor vehicle accident. The notes indicate that patient needs people to help him move around, and notes patient was visibly shaking in hands. The resulting diagnosis was Cervicalgia, low back pain, pain in thoracic spine and pain in unspecified shoulder. Petitioner was prescribed physical therapy three times per week for four weeks, was placed on work disability and granted housekeeping services. (Exhibit A, p. 195.)

The Petitioner was treated with [redacted] on [redacted] 2017, for cervical, thoracic and lumbar pain with radiation down the spine involving both legs. Muscle spasm was noted in cervical and lumbar spine. After the exam, the patient was referred to physical therapy, placed on work disability for four weeks, assistance with home services ordered and transportation services were ordered as patient could not drive, and disabled from gainful employment for four weeks. The Patient was seen consistently on a monthly basis through [redacted] 2017. In [redacted] 2017, the Petitioner was examined and advised to continue physical therapy to decrease pain, was noted as unable to drive, MRI was reviewed and Patient was warned about medication not being in his system; and his pain med tablets were decreased and a note was made that no true tenderness in back and shoulder, complains of pain when not being touched. Physical therapy was prescribed three times a week through July 2017.

On [redacted] 2017, Petitioner was seen for treatment for back and neck pain with a diagnosis of cervical/lumbar sprain/strain and prescribed heat and traction. The physical exam noted straight leg raising positive right and left at 30 degrees. (Exhibit A, p. 203.) In an [redacted] 2017 exam, straight leg raising was reported negative.

The Petitioner's records from [redacted] for psychiatric treatment were also reviewed. A psychiatric exam was conducted on [redacted], 2017. At that time the primary diagnosis was Post-Traumatic Stress Disorder and Depression. Petitioner had previously been seen at the clinic in [redacted] 2016, but no ongoing treatment was demonstrated by the records presented. Petitioner's exam notes indicate that he presented with depressed mood, decreased energy, irritability and anxiousness. Petitioner's attitude was cooperative, affect worrisome and constricted, mood was anxious and depressed and speech spontaneous. Motor activity was calm, thought process was intact, no hallucinations, delusions or suicidality were reported. Patient was oriented, and both recent and remote memory were intact as was concentration, abstract thinking, insight and judgment. Based on his symptoms of sadness, depression, anxiety and inability to sleep, as well as flashbacks about his auto accident, Petitioner was prescribed Remeron; and follow-up with psychotherapy was recommended. When initially seen in [redacted] 2016, the diagnosis was bipolar disorder depressed severe. After the [redacted] 2017 exam, PTSD became the primary diagnosis. (Exhibit A, p. 185.) The Petitioner's treatment plan called for individual therapy two times a month. A status report as of December 20, 2017, noted continued with improvement.

A medical review was conducted on [redacted], 2018, by [redacted] and noted that Petitioner reported sleep is fair and appetite fair that he was med compliant and was depressed and anxious off and on. In a prior medical review in [redacted] 2017, the notes indicate that psych meds are helping but feels life is worthless. The report noted gait is limping and speech is slow but normal, adequately groomed with insight and judgment fair, mood was anxious and affect blunted. A musculoskeletal impairment was noted. In [redacted] 2018, notes indicated that walking with cane and limp, and notes anxiety attacks and nightmares on and off, some crying spells and depressed mood. The exam noted moderate to severe lower back pain and shoulder pain with cane for activities of daily living. No impairments other than musculoskeletal were noted. (Exhibit A, p. 284.) Anxiety was reported as not an impairment at the time of the review meeting. Another medication review was conducted in [redacted] 2018 with no change in meds and with the same information as the January evaluation mentioned above.

In notes of individual outpatient treatment on [redacted] 2018, the Petitioner was alert, grooming appropriate, coherent speech with normal rate, good eye contact, no thoughts of harming self, medication compliant, behavior is calm and cooperative and no significant changes reported, no hallucinations but reports of depression and anxiety, good appetite and inadequate sleep. On [redacted] 2018, Petitioner met for therapy and the comments were all the same in the note, with the added report of auditory hallucinations.

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 3

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 12.04 Depressive, Bipolar and related disorders, 12.06 Anxiety and Obsessive-Compulsive Disorders and 12.15, Trauma and stressor related disorders (includes PTSD) were considered for Petitioner's mental impairment. In addition, listing 1.04 Disorders of the Spine was reviewed. 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 conditions. Petitioner testified that he could not stand too long, about 10-12

minutes, or walk too far (across the room) and can walk less than a block, and sit 15 to 20 minutes. The Petitioner does use a cane, and the independent medical evaluation noted for all activities evaluated that Petitioner was capable of doing those activities with use of a cane and further noted that "He has lumbar spondylosis with right L4 neuropathy and diffuse weakness" as an ancillary note to all activities. The exam also indicated positive straight leg raising when elevated 20 degrees bilaterally (supine position) (Exhibit A, p. 86.) Notwithstanding these notations and the MRI presented for the lumbar spine and the examiner's acknowledgement of use of cane as medically necessary, the examiner found that Petitioner was capable of lifting frequently 15 pounds and occasionally 25 pounds placing Petitioner at light work. In addition, since the exam the Petitioner has been receiving monthly injections for pain in the spine, several nerve blocs and epidurals which treatment records were not available to the examiner. Given this treatment, the medical evidence would support that Petitioner's residual functional capacity be evaluated as sedentary. This determination is also supported by the fact that the Petitioner testified that he sits most of the day and watches television.

The Petitioner's mental residual functional capacity must also be determined. In consideration of the medical records and the most recent diagnosis of PTSD and a somewhat stabilized condition with the prescribed medications, it is determined that the Petitioner's mental impairments do not significantly limit his judgment, insight, concentration and ability to understand short and simple instructions. The Petitioner appeared for his appointment with his mental health provider appropriately groomed and did not display any unusual or disruptive behavior. The psychiatric medical treatment records do not support that Petitioner had reported difficulties with activities of daily living; social functioning; concentration, persistence or pace; and did not episodes of decompensation. There was no evidence that Petitioner was markedly limited in any activity nor did any of the evaluations he participated in with his mental health care provider indicate serious limitations in his abilities due to his diagnosis of PTSD. Although Petitioner continued to be treated for depression and anxiety, there were no limitations expressed in the records that would indicate any limitations exceeding a moderate level.

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.

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 sedentary work as defined by 20 CFR 416.967(a). Petitioner has medically determinable impairments regarding his spinal pain which would account for pain as well; however, the Petitioner's

stated limitations which he testified to were not totally supported by the medical evidence.

Based on the medical evidence presented, as well as Petitioner's testimony, Petitioner has mild to moderate limitations on his mental ability to perform basic work activities.

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

Step 4

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 picking vegetables. Petitioner's testimony regarding working at [redacted] was unclear and was not full-time employment and thus, is not considered. Petitioner's work as picking vegetables required standing most of the time up to 12 hours and lifting and loading vegetables. Petitioner did not indicate what the lifting requirements were.

Based on the RFC analysis above, Petitioner's exertional RFC limits him to no more than sedentary work activities. As such, Petitioner is incapable of performing past relevant work as he cannot stand 12 hours a day. Petitioner also has mild to moderate limitations in his mental capacity to perform basic work activities. In light of the entire record, it is found that Petitioner's nonexertional including pain due to his back condition and his RFC of sedentary does prohibit him from performing past relevant work.

Because Petitioner is unable to perform past relevant work, 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).

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 23 years old at the time of application and 23 years old at the time of hearing, and thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. He is a high school graduate with a history of work experience picking vegetables as a laborer. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities.

Based solely on his exertional RFC, the Medical-Vocational Guidelines, rule 201.27, result in a finding that Petitioner is not disabled.

However, Petitioner also has impairments due to his mental condition. As a result, he has a nonexertional RFC imposing mild to moderate limitations in his activities of daily living; some limitations in his social functioning; and moderate limitations in his concentration. It is found that those limitations would not preclude him from engaging in simple, unskilled work activities on a sustained basis. A review of the most recent January 2018 visit with his mental health provider, the notes indicate that patient is depressed and anxious on and off, had average eye contact, speech was slow but normal, dressed and groomed appropriately, insight and judgment were fair and mood anxious, affect blunted, no impairment in thought process, no attention span impairment, and no impairment in language memory and thought content. In April 2018, notes indicate patient was the same as his prior exam, mood and affect were stable and congruent, with no impairment in speech, thought process, associations, orientation and attention span, including anxiety and fund of knowledge. Activities of daily living were reported as more severe limitations with no specific limitations noted. Therefore, Petitioner is able to adjust to other work involving simple and routine tasks on a

sustained basis in a lower stress environment and is **not** disabled at Step 5. During the hearing, the Petitioner was able to answer all questions, responded appropriately and did not appear to be having difficulty due to his described mental limitations.

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.

DECISION AND ORDER

Accordingly, the Department's determination is AFFIRMED.

LMF/

Lynn M. Ferris
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) 763-0155; 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

Denise McCoggle
MDHHS-Wayne-15-Hearings

Petitioner

[redacted]

BSC4
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