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[redacted] MI [redacted]

Date Mailed: March 22, 2019
MAHS Docket No.: 19-000099
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250. After due notice, a telephone hearing was held on February 20, 2019, from Lansing, Michigan. Petitioner personally appeared and testified.

The Department of Health and Human Services (Department) was represented by Eligibility Specialist Veronica Bracy. Ms. Bracy testified on behalf of the Department. The Department submitted 1,248 exhibits which were admitted into evidence. The record was closed at the conclusion of the hearing.

ISSUE

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

FINDINGS OF FACT

The Administrative Law Judge, based on competent, material, and substantial evidence on the whole record, finds as material fact:

1. Petitioner applied for SDA on [redacted] 2018. [Hearing Summary].

2. On December 10, 2018, the Department received a decision from the Medical Review Team denying Petitioner's SDA application. [Hearing Summary].

3. On December 10, 2018, the Department issued Petitioner a Notice of Case Action informing him that his application for SDA had been denied. [Dept. Exh. 1-4].

4. On January 7, 2019, Petitioner submitted a Request for Hearing contesting the SDA denial. [Request for Hearing, 1/7/2019].

5. Petitioner has been diagnosed with asthma with chronic oxygen desaturation, asthmatic bronchitis, epilepsy, allergic rhinitis, acute pneumonitis, esophageal reflux, a lung nodule, pneumonia, respiratory failure with hypoxia, elbow pain, transcondylar fracture of distal humerus with nonunion-radial head fracture, right Achilles tendon tear, pre-diabetes, blood clots in his lungs, seizure disorder, migraines, nocturnal hypoxia, hyperlipidemia, lower extremity edema, hypertension, bronchitis, anemia, arthritis, depression, anxiety, restless leg syndrome, pancreatitis, shortness of breath during exertion, grade 2 dyspnea. He is also on oxygen 24 hours a day.

6. On [redacted] 2017, Petitioner was hospitalized for an exacerbation of asthma. Petitioner had an asthma attack that caused a syncopal episode and he fell directly on his right elbow. X-rays showed he had a right radial head fracture. He was placed in a long-arm splint. Petitioner was assessed with acute asthma exacerbation, AKI, HAGMA and metabolic alkalosis, right radial fracture, hyperlipidemia, hypertension, restless leg syndrome, epilepsy, left shoulder neuropathic pain, questionable IDA, questionable Vitamin D deficiency, DVT prophylaxis, nutrition and depression problems. He was discharged on January 25, 2017 in stable condition. [Dept. Exh. 739-760].

7. On [redacted] 2017, Petitioner met with his primary care physician to follow-up on his hospitalization. Petitioner was assessed with asthma, oxygen desaturation and a fracture of the right forearm. [Dept. Exh. 439-443].

8. On [redacted] 2017, Petitioner's primary care physician noted that Petitioner had been on oxygen since February 2017, for his asthma. Petitioner complained of shortness of breath and requested steroids as he has a hard time breathing without the steroids. He had been off steroids for the past three weeks. Petitioner was assessed with poorly controlled asthma and oxygen desaturation. [Dept. Exh. 430-438].

9. On [redacted] 2017, Petitioner was instructed to continue using oxygen 24 hours a day for his oxygen desaturation. [Dept. Exh. 425].

10. On [redacted] 2017, Petitioner was admitted to the hospital for elective surgery concerning a distal humerus nonunion takedown and repair. The procedure was conducted without complications and he was admitted overnight for observation. [Dept. Exh. 667-691].

11. On [redacted] 2017, Petitioner's CT Thorax results indicated rounded airspace opacity of the left upper lobe probably on the basis of pneumonia, and diffusely thickened bronchial walls likely from underlying asthma. [Dept. Exh. 492-493].

12. On [redacted] 2017, Petitioner saw his pulmonologist complaining of increased shortness of breath with increasing sputum production. On examination, the pulmonologist noted that Petitioner had an abnormal respiratory effort with air hunger and shallow respirations, dry cough and mouth breathing. His auscultation

of the lungs was also abnormal with rhonchi over both midlung fields, wheezing and diminished breath sounds over both lung bases. The pulmonologist indicated that Petitioner appeared tired, frustrated, empty and older than his stated age. Petitioner was assessed with pneumonia, allergic rhinitis, hypoxia, respiratory failure with hypoxia and asthmatic bronchitis with exacerbation. [Dept. Exh. 489-498].

13. On [redacted] 2017, Petitioner was admitted to the hospital with a diagnosis of pneumonia based on his chest X-ray. Petitioner had had recent issues with hypoxemia secondary to inflammation and pneumonitis changes of the lung. He had significant asthma and elevated IgE. He developed pneumonia in the left upper lobe that had been unresponsive to outpatient antibiotics. Petitioner was also seen by infectious disease while in the hospital for consultation. He had been on chronic oxygen 3 L related to his hypoxemia being evaluated. Petitioner was assessed with acute left upper lobe pneumonia with cavitary lesion, positive mycoplasma screening, acute exacerbation of asthma, allergic rhinitis, and hypoxia. He was discharged on [redacted] 2017, with a diagnosis of pneumonia. [Dept. Exh. 558-617].

14. On [redacted] 2017, Petitioner followed up with his pulmonologist after his hospitalization for upper lobe pneumonia and pneumonitis. Petitioner reported feeling tired, shortness of breath, cough, wheezing, shortness of breath during exertion, arthralgias and dizziness. During the physical examination, the pulmonologist noted that Petitioner's appearance was abnormal, as he appeared chronically ill, obese, tired and older than his stated age. Petitioner's respiratory effort was also abnormal with shallow respirations, wet cough, audible wheezing and mouth breathing. Auscultation of his lungs was abnormal with diffuse rhonchi bilaterally, wheezing over both midlung fields, diminished breath sounds over both apices and diminished breath sounds over both bases. The pulmonologist explained to Petitioner that he would need a new CT of the chest for a re-evaluation for left upper lob pneumonia with cavitary lesion and maybe a bronchoscopy pending the CT results. [Dept. Exh. 482-488].

15. On [redacted] 2017, Petitioner underwent a CT Thorax that revealed new pulmonary nodules in the right lung with mild bronchiectasis seen in all lobes, but mainly in the right middle lobe and lingula present in the lower lobes with very mild bronchial wall thickening. The largest of the new pulmonary nodules was 6.5 mm, too small to be assessed by PET CT or biopsy. [Dept. Exh. 470].

16. On [redacted] 2017, Petitioner met with his pulmonologist following a hospitalization. Petitioner was assessed with esophageal reflux, lung nodule, allergic rhinitis and acute pneumonitis. [Dept. Exh. 473-481].

17. On [redacted] 2017, Petitioner followed up with his primary care physician for his 6-month check-up. Petitioner saw an allergist who had added [redacted] to his medications in addition to Petitioner using nebulizers multiple times daily. The

physician prescribed [redacted] until he saw his pulmonologist again in eight months. Petitioner was also instructed to restart Symbicort. [Dept. Exh. 400-403].

18. On [redacted] 2018, Petitioner met with his pulmonologist to follow-up on his diagnosis of a lung nodule. A physical examination revealed abnormal auscultation of lungs with wheezing over both midlung fields. Petitioner was assessed with severe, persistent asthma, allergic rhinitis, and a lung nodule. Regarding the lung nodules and asthma, the differential diagnosis was granulomatous lung disease or sarcoidosis. Petitioner was instructed to continue tapering steroids, continue Symbicort, and use his albuterol nebulizer treatments four times a day. A repeat X-ray was ordered in addition to a repeat CT and PFT before the next visit. He was also instructed to continue Singulair, Claritin, Protonix and Flonase. [Dept. Exh. 462-472].

19. On [redacted] 2018, Petition was scheduled for a follow-up appointment with his pulmonologist for an evaluation of his severe asthma, right sided lung nodules, and bronchiectasis symptoms. Petitioner's lab results were negative. The pulmonologist also reviewed Petitioner's CT scan performed on May 4, 2018 and compared it to previous CT exams. There were multiple nodules in the right upper lobe, middle lobes and lower lobes with adjacent ground glass haziness and ill-defined margins. There were subcentimeter nodules. Most of the nodules were new since the prior studies. The left lung was mostly clear. Petitioner was scheduled for a bronchoscopy. [Dept. Exh. 955-960].

20. On [redacted] 2018, Petitioner followed up with his pulmonologist regarding his bronchoscopy. The pulmonologist noted that over a period of time, Petitioner's severe persistent asthma had worsened. There was also some degree of bronchiectasis in the previous CT scans and significant nodular changes in the most recent CT were observed. This was suspicious for ABPA causing a worsening of his asthma. The bronchoscopy results revealed an atypical cytology specimen with rare degenerated atypical cells located in the lateral right middle lobe lung. Neoplasm could not be completely excluded. [Dept. Exh. 948-954].

21. On [redacted] 2018, Petitioner underwent a Psychiatric/Psychological evaluation on behalf of the department. The examining psychologist noted that Petitioner attended outpatient and mental health treatment since [redacted] 2019 and on and off since the fifth grade. Petitioner presented as depressed with a sad affect and cried throughout the evaluation. He also identified significant stress and worry regarding his bills, his savings being gone, and his house being taken from him. Documents in Petitioner's chart identified a radial head fracture, depression, hyperlipidemia, hypertension, migraine, asthma, seizure disorder, arthritis, right distal humerous fracture, allergic rhinitis, elbow pain, hypoxia, nocturnal hypoxia, left shoulder pain and partial shoulder arthroplasty. He demonstrated adequate understanding of both simple and complex instructions. He demonstrated a limited to impaired ability to interact appropriately with others due to his high level of depression. The psychologist opined that Petitioner's prognosis for improved psychological and adaptive functioning was poor. [Dept. Exh. 1046-1050].

22. Petitioner is a [redacted]year-old man born on [redacted] He is [redacted]" and weighs [redacted] pounds. He is a high school graduate and last worked in October 2017.

23. Petitioner credibly testified during the hearing in the above-captioned matter, that he is able to walk a block, stand 10 minutes, and carry approximately eight pounds which causes him to get winded. Petitioner stated that he was last hospitalized two and a half weeks ago for blood clots. [Testimony of [redacted] 2019].

24. On [redacted] 2019, Petitioner was admitted as an in-patient at [redacted] with a diagnosis of pulmonary embolism. His condition was noted as "guarded." Petitioner was discharged on [redacted] 2019, with a diagnosis of bilateral pulmonary embolism. On discharge, Petitioner was referred to [redacted] and was to continue to use oxygen as directed. Petitioner's medications on discharge were albuterol, apixaban, atorvastatin, clonazepam, Dilantin, ferrous fumarate, fluoxetine, Lyrica, montelukast, pantoprazole, Symbicort, Tylenol with codeine, Ventolin, Vitamin D3 and oxygen. [Petitioner's Exh. 1-6].

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

26. Petitioner's impairments have lasted, or are expected to last, continuously for a period of 90 days or longer.

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 Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Department of Human Services) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

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 **90 days**. (Emphasis added). Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on

disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

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

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

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

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months [90 days for SDA]. 20 CFR 416.905(a). The person claiming a physical or mental disability has the burden to establish it 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 ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913. 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, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (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).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (e.g., age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, 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). If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3 to Step 4. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

As outlined above, the first step looks at the individual's current work activity. In the record presented, Petitioner is not involved in substantial gainful activity and credibly testified that he has not worked since October 2017. Therefore, he is not disqualified from receiving disability benefits under Step 1.

The severity of the individual's alleged impairment(s) is considered under Step 2. The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b). An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b). Examples include:

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

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

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

6. Dealing with changes in a routine work setting. *Id.*

The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). An impairment qualifies as non-severe only if, regardless of a claimant's age, education, or work experience, the impairment would not affect the claimant's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985).

In the present case, Petitioner has been diagnosed with with asthma with chronic oxygen desaturation, asthmatic bronchitis, epilepsy, allergic rhinitis, acute pneumonitis, esophageal reflux, a lung nodule, pneumonia, respiratory failure with hypoxia, elbow pain, transcondylar fracture of distal humerus with nonunion-radial head fracture, right Achilles tendon tear, pre-diabetes, blood clots in his lungs, seizure disorder, migraines, nocturnal hypoxia, hyperlipidemia, lower extremity edema, hypertension, bronchitis, anemia, arthritis, depression, anxiety, restless leg syndrome, pancreatitis, shortness of breath during exertion, grade 2 dyspnea. He is also on oxygen 24 hours a day.

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

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404.

Listing 3.00 (respiratory disorders) and 12.00 (mental disorders) were considered in light of the objective evidence. Based on the foregoing, it is found that Petitioner's impairments do not meet the intent and severity requirement of a listed impairment; therefore, Petitioner cannot be found disabled at Step 3. Accordingly, Petitioner's eligibility is considered under Step 4. 20 CFR 416.905(a).

The fourth step in analyzing a disability claim requires an assessment of the individual's residual functional capacity ("RFC") and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if he/she can perform past relevant work. *Id*.; 20 CFR 416.960(b)(3). Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). 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). RFC is assessed based on impairment(s) and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

To determine the physical demands (exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967. Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b). Even though weight lifted may be very little, a job is in this 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. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.* 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). An individual capable of performing medium work is also capable of light and sedentary work. *Id.* 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). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.* Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands (exertional requirements, e.g., sitting, standing, walking, lifting,

carrying, pushing, or pulling) are considered nonexertional. 20 CFR 416.969a(a). In considering whether an individual can perform past relevant work, a comparison of the individual's residual functional capacity to the demands of past relevant work must be made. *Id.* If an individual can no longer do past relevant work, the same residual functional capacity assessment along with an individual's age, education, and work experience is considered to determine whether an individual can adjust to other work which exists in the national economy. *Id.* 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 (e.g., can't 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). 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). The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.*

Petitioner's prior work history consists of working as a cashier and janitorial work which included the use of a floor cleaning machine. In light of Petitioner's testimony, and in consideration of the Occupational Code, Petitioner's prior work is classified as unskilled, medium work.

Petitioner testified that he is able to walk approximately a block and can lift/carry approximately 8 pounds. The objective medical evidence notes difficulties with shortness of breath on exertion. If the impairment, or combination of impairments, does not limit an individual's physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. 20 CFR 416.920. In consideration of Petitioner's testimony, medical records, and current limitations, Petitioner cannot be found able to return to past relevant work. Accordingly, Step 5 of the sequential analysis is required.

The fifth and final step of the analysis applies the biographical data of the applicant to the Medical Vocational Grids to determine the residual functional capacity of the applicant to do other work. 20 CFR 416.920(g). See *Felton v DSS* 161 Mich. App 690, 696 (1987). Once Petitioner reaches Step 5 in the sequential review process, Petitioner has already established a *prima facie* case of disability. *Richardson v Secretary of Health and Human Services,* 735 F2d 962 (6th Cir, 1984). At that point, the burden of proof is on the state to prove by substantial evidence that Petitioner has the residual functional capacity for substantial gainful activity.

The medical information indicates that Petitioner suffers from with asthma with chronic oxygen desaturation, asthmatic bronchitis, epilepsy, allergic rhinitis, acute pneumonitis, esophageal reflux, a lung nodule, pneumonia, respiratory failure with hypoxia, elbow

pain, transcondylar fracture of distal humerus with nonunion-radial head fracture, right Achilles tendon tear, pre-diabetes, blood clots in his lungs, seizure disorder, migraines, nocturnal hypoxia, hyperlipidemia, lower extremity edema, hypertension, bronchitis, anemia, arthritis, depression, anxiety, restless leg syndrome, pancreatitis, shortness of breath during exertion, grade 2 dyspnea.

Petitioner credibly testified that he is no longer capable of driving based on his seizures. He also has a severely limited tolerance for physical activities and is required to use oxygen 24 hours a day.

Petitioner is [redacted] years old, with a high school education. Petitioner's medical records are consistent with his testimony that he is unable to engage in even a full range of sedentary work on a regular and continuing basis. 20 CFR 404, Subpart P. Appendix 11, Section 201.00(h). See Social Security Ruling 83-10; *Wilson v Heckler*, 743 F2d 216 (1986).

Petitioner's complaints and allegations concerning his impairments and limitations, when considered in light of all objective medical evidence, as well as the record as a whole, reflect an individual who is so impaired as to be incapable of engaging in any substantial gainful activity on a regular and continuing basis.

A person is considered disabled for purposes of SDA if the person has a physical or mental impairment which meets federal SSI disability standards for at least 90 days. Receipt of SSI or RSDI benefits based upon disability or blindness or the receipt of MA benefits based upon disability or blindness automatically qualifies an individual as disabled for purposes of the SDA program. Other specific financial and non-financial eligibility criteria are found in BEM 261. Inasmuch as Petitioner has been found "disabled" for purposes of MA, he must also be found "disabled" for purposes of SDA benefits.

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

DECISION AND ORDER

Accordingly, the Department's determination is REVERSED.

THE DEPARTMENT IS ORDERED TO 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. The Department shall process Petitioner's April 5, 2018, SDA application, and shall award him all the benefits he may be entitled to receive, as long as he meets the remaining financial and non-financial eligibility factors.

2. The Department shall review Petitioner's medical condition for improvement in March 2019, unless his Social Security Administration disability status is approved by that time.

3. The Department shall obtain updated medical evidence from Petitioner's treating physicians, physical therapists, pain clinic notes, etc. regarding his continued treatment, progress and prognosis at review.

It is SO ORDERED.

VLA/nr

Vicki L. Armstrong
Administrative Law Judge
for Robert Gordon, 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

Kathleen Verdoni
411 East Genesee
PO Box 5070
Saginaw, MI 48607

Saginaw County DHHS- via electronic mail

BSC2- via electronic mail

L. Karadsheh- via electronic mail

Petitioner

[redacted]
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[redacted], MI [redacted]