RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]
MI [redacted]

Date Mailed: April 14, 2017
MAHS Docket No.: 17-002641
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Eric J. Feldman

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on March 23, 2017, from Detroit, Michigan. Petitioner was present for the hearing and represented himself. The Department of Health and Human Services (Department) was represented by Elizabeth Welke, Family Independence Manager.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. A Notice of Case Action dated January 5, 2017 was received and marked into evidence as Exhibit A, pp. 1-6 and; a Hearing Summary packet, including contained medical documents was received and marked into evidence as Exhibit C, pp. 1-973. The record closed on or about April 2, 2017, 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 continued State Disability Assistance (SDA) benefit program eligibility?

FINDINGS OF FACT

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

1. Petitioner was an ongoing recipient of SDA benefits.

2. On [redacted] 2015, Petitioner applied for SDA benefits and Medical Assistance (MA-P) based on disability or blindness, retroactive to February 2015. The Disability

Determination Service (DDS)/Medical Review Team (MRT) reviewed Petitioner's medical evidence and concluded that he was disabled and eligible for SDA and MA-P, retroactive to February 2015 for MA-P. DDS/MRT found Petitioner's residual functional capacity (RFC) assessment to be less than a full range of sedentary work on his ability to do other work based on section 201.00(h) of the Medical-Vocational Guidelines, resulting in a finding that Petitioner is disabled. DDS/MRT referred Petitioner's case for medical review in June 2016. Exhibit C, pp. 124-125.

3. In connection with an August 2016 review, DDS/MRT determined on December 1, 2016 that Petitioner's condition had significantly improved, that he had a residual functional capacity to perform light work, and that he was capable of substantial gainful activity. DDS/MRT concluded that Petitioner was no longer disabled. Exhibit C, pp. 9-31.

4. On January 5, 2017, the Department sent Petitioner a Notice of Case Action notifying him that his SDA case would close effective February 1, 2017 because DDS/MRT concluded that he was no longer disabled. Exhibit A, pp. 1-6.

5. On February 23, 2017, the Department received Petitioner's timely written request for hearing concerning the closure of his SDA case. Exhibit C, pp. 2-4.

6. Petitioner alleged disabling impairments due to bipolar, back problems, carpal tunnel syndrome (CTS), heart condition, arthritis, sleep apnea, depression, and anxiety.

7. At the time of hearing, Petitioner was 45 years old with a September 8, 1971 birth date; and he is 5'11" in height.

8. Petitioner completed high school.

9. Petitioner has an employment history of work as a car salesman.

10. Petitioner has a claim 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 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 lasting, or expected to last, 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).

Once an individual has been found disabled, continued entitlement to benefits based on a disability is periodically reviewed in accordance with the medical improvement review standard in order to make a current determination or decision as to whether disability remains. 20 CFR 416.993(a); 20 CFR 416.994(a). If the individual is not engaged in substantial gainful activity (SGA), the trier of fact must apply an eight-step sequential evaluation in evaluating whether an individual's disability continues. 20 CFR 416.994. The review may cease and benefits may be continued at any point if there is sufficient evidence to find that the individual is still unable to engage in SGA. 20 CFR 416.994(b)(5). In this case, Petitioner has not engaged in SGA at any time since he became eligible for SDA. Therefore, his disability must be assessed to determine whether it continues.

An eight-step evaluation is applied to determine whether an individual has a continuing disability:

> **Step 1.** If the individual has an impairment or combination of impairments which meets or equals the severity of an impairment listed in 20 CFR Appendix 1 of subpart P of part 404, the disability will be found to continue. 20 CFR 416.994(b)(5)(i).
>
> **Step 2.** If a listing is not met or equaled, it must be determined whether there has been medical improvement as defined in paragraph (b)(1)(i) of 20 CFR 416.994 and shown by a decrease in medical severity. If there has been a decrease in medical severity, Step 3 is considered. If there has been no decrease in medical severity, there has been no medical improvement unless an exception in Step 4 applies. 20 CFR 416.994(b)(5)(ii).
>
> **Step 3.** If there has been medical improvement, it must be determined whether this improvement is related to the individual's ability to do work in accordance with 20 CFR 416.994(b)(1)(i) through (b)(1)(iv); *i.e.*, there was an increase in the individual's residual functional capacity (RFC) based on

the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to the individual's ability to do work, the analysis proceeds to Step 4. If medical improvement *is* related to the individual's ability to do work, the analysis proceeds to Step 5. 20 CFR 416.994(b)(5)(iii).

Step 4. If it was found at Step 2 that there was no medical improvement or at Step 3 that the medical improvement is not related to the individual's ability to work, the exceptions in 20 CFR 416.994(b)(3) and (b)(4) are considered. If none of them apply, the disability will be found to continue. If an exception from the first group of exceptions to medical improvement applies, the analysis proceeds to Step 5. If an exception from the second group of exceptions to medical improvement applies, the disability is found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process. 20 CFR 416.994(b)(5)(iv).

Step 5. If medical improvement is shown to be related to an individual's ability to do work or if one of the first group of exceptions to medical improvement applies, **all** the individual's current impairments in combination are considered to determine whether they are severe in light of 20 CFR 416.921. This determination considers all the individual's current impairments and the impact of the combination of these impairments on the individual's ability to function. If the RFC assessment in Step 3 shows significant limitation of the individual's ability to do basic work activities, the analysis proceeds to Step 6. When the evidence shows that all the individual's current impairments in combination do not significantly limit the individual's physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature and the individual will no longer be considered to be disabled. 20 CFR 416.994(b)(5)(v).

Step 6. If the individual's impairment(s) is severe, the individual's current ability to do substantial gainful activity is assessed in accordance with 20 CFR 416.960; i.e., the individual's RFC based on all current impairments is assessed to determine whether the individual can still do work done in the past. If so, disability will be found to have ended. 20 CFR 416.994(b)(5)(vi).

Step 7. If the individual is not able to do work done in the past, the individual's ability to do other work given the RFC assessment made under Step 6 and the individual's age, education, and past work experience is assessed (unless an exception in 20 CFR 416.994(b)(5)(viii) applies). If the individual can, the disability has ended. If the individual cannot, the disability continues. 20 CFR 416.994(b)(5)(vii).

> **Step 8.** Step 8 may apply if the evidence in the individual's file is insufficient to make a finding under Step 6 about whether the individual can perform past relevant work. If the individual can adjust to other work based solely on age, education, and RFC, the individual is no longer disabled, and no finding about the individual's capacity to do past relevant work under Step 6 is required. If the individual may be unable to adjust to other work or if 20 CFR 416.962 may apply, the individual's claim is assessed under Step 6 to determine whether the individual can perform past relevant work. 20 CFR 416.994(b)(5)(viii).

Step 1

Step 1 in determining whether an individual's disability has ended requires the trier of fact to consider the severity of the impairment(s) and whether it meets or equals a listed impairment in Appendix 1 of subpart P of part 404 of Chapter 20. 20 CFR 416.994(b)(5)(i). If a listing is met, an individual's disability is found to continue with no further analysis required.

The medical record presented was reviewed and is briefly summarized below.

In progress notes dated from [redacted] 2015 to [redacted] 2016, Petitioner was diagnosed by his doctor with allergic rhinitis; dyspnea; rhythm disorder; cardiomyopathy; backache; low back pain; atopic dermatitis; arthralgia of the right hand; organic obstructive sleep apnea; and hypothyroidism. Exhibit C, pp. 497-525.

In progress notes and consultation notes dated from [redacted] 2015 to January 11, 2016, Petitioner's cardiologist diagnosed him with atypical chest pain syndrome with normal coronary anatomy by computed tomography (CT) imaging; systemic hypertension; peripheral neuropathy; history of mood disorders; New York Heart Association functional class 1 American College of Cardiology/American Heart Association (ACC/AHA) stage C congestive heart failure secondary to left ventricular (LV) systolic dysfunction; equivocal stress echocardiogram; and peripheral neuropathy, on Neurontin; acute-on-chronic decompensated congestive heart failure secondary to LV systolic dysfunction, most likely secondary to alcohol-related cardiomyopathy, but need to rule out ischemic heart disease. Exhibit C, pp. 596-608.

On [redacted] 2015, and [redacted] 2015, Petitioner had sleep study interpretations, in which the doctor diagnosed him with severe obstructive sleep apnea. Exhibit C, pp. 642-643.

Petitioner had a Psychiatric/Psychological Examination Report dated [redacted] 2015, in which the psychiatrist/psychologist diagnosed Petitioner with bipolar disorder, attention deficit disorder, back pain, financial constraints and unemployment and assigned with a Global Assessment of Functioning (GAF) score of 55. Exhibit C, pp. 161-163.

On [redacted] 2015, Petitioner had an intake assessment at the community mental health, in which the licensed master social worker (LMSW) diagnosed him bipolar 1 disorder, current or most recent episode unspecified; attention-deficit/hyperactivity disorder, predominantly inattentive presentation; and a GAF score of 55. Exhibit C, pp. 659-678. There were additional progress/medication review notes from the community mental health from [redacted] 2015 to [redacted] 2016, in which the doctor diagnosed him with bipolar disorder, most recent episode unspecified; attention-deficit/hyperactivity disorder, predominantly inattentive presentation; a GAF score of 55; unspecified diastolic (congestive) heart failure; and obstructive sleep apnea hypopnea. He was noted to have economic problems, problem accessing healthcare, occupational problems, problem related to social environment, problem related to interaction with legal system, and other psychosocial and environmental problems. Exhibit C, pp. 679-723 and 740-828.

On [redacted] 2015, Petitioner had an exercise echocardiography report, in which it was found that at rest, the left ventricular systolic function is mildly impaired with an ejection fraction (EF) between 45 to 50 percent. Exhibit C, pp. 612-613.

On [redacted] 2015, Petitioner had a CT angiogram of the chest with reformatting of coronaries, in which the cardiologist found normal findings. Exhibit C, pp. 609-610. There was also a limited CT of the chest, in which the doctor found irregular subpleural patchy and nodular opacities in the left upper lobe anterolaterally and a few small lung nodules at the left lung base. Exhibit C, p. 611.

In a Magnetic Resonance Imaging (MRI) of the right hand dated [redacted] 2016, Petitioner was assessed with attenuation of tendon with abnormal signal intensity of flexor digitorum, profundus tendons of second finger as described suggesting high-grade partial tear, no full-thickness tear or retraction, correlation with clinical examination and history is recommended; and severe arthritis changes at second metacarpophalangeal joint, probably osteoarthritis. Exhibit C, pp. 726-728.

On [redacted] 2016, Petitioner had imaging of his second digit of right hand, in which the orthopedic doctor diagnosed him with second metacarpophalangeal (MCP) arthritis. Exhibit C, p. 590. On that same date, the orthopedic doctor noted in his doctor's visit that he has post-traumatic osteoarthritis of right hand, worse. The doctor noted the right index finger demonstrates severe deformity about the metacarpal head, depression of the joint surface, and bone spurs; and carpal tunnel syndrome of left and right wrist, active. Exhibit C, pp. 593-594.

In an office note dated on [redacted] 2016, Petitioner's pulmonary doctor diagnosed him with asthma with objective improvement historically with bronchodilators and improved forced expiratory volume (FEV1); possible chronic obstructive pulmonary disease; pulmonary nodules noted on December CT of the heart; complex sleep apnea with both obstructive and central events; nonischemic cardiomyopathy, improved;

episodic healthcare; history of alcoholism; history of polysubstance abuse use historically; and a history of hemoptysis. Exhibit C, pp. 623-631.

On [redacted] 2016, Petitioner had a CT of the chest, in which the doctor diagnosed him with pulmonary nodules measuring up to 7mm, most of these are stable; few additional nodules measuring up to 7mm as well which are not included in the prior scan; and coronary artery calcifications. Exhibit C, p. 632.

On [redacted] 2016, Petitioner had a medical examination, in which the doctor diagnosed him with (i) back, hand and shoulder pain; and (ii) heart failure. Exhibit C, pp. 478-483. As to the back, hand and shoulder pain, the doctor noted that from an orthopedic standpoint, Petitioner appears relatively stable, his range of motion is relatively well preserved, he is able to do orthopedic maneuvers and his gait is stable, and at this point, continued pain management and activity as tolerated would be indicated. Exhibit C, p. 482. As to the heart failure, the doctor noted Petitioner's more significant ailment and he appears somewhat controlled at present, his blood pressure is stable, he has diffuse point of maximum impulse (PMI) but there are no findings of lower extremity edema, he states his ejection fraction has been around 30 percent, he may require cardio defibrillator or a pacemaker at some point in the near future if he continues to decline. Exhibit C, p. 482.

On [redacted] 2016, Petitioner had a psychiatric/psychological medical report, in which the doctor diagnosed him (i) unspecified bipolar disorder and related disorder; (ii) generalized anxiety disorder; (iii) panic disorder; and (iv) attention deficit hyperactivity disorder combine presentation. Exhibit C, pp. 470-473. The doctor noted that employment does not seem to be a viable option in light of his health and psychiatric issues at this time and any attempts at future employment may require some restriction or accommodations at the work site. Exhibit C, p. 472.

Based on the medical evidence presented in this case, listings 1.02 (major dysfunction of a joint(s) (due to any cause)), 1.04 (disorders of the spine), 4.02 (chronic heart failure), 12.04 (affective disorders), and 12.06 (anxiety-related disorders) were considered. The medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration.

Because 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, a disability is not continuing under Step 1 of the analysis, and the analysis proceeds to Step 2.

Step 2

If the impairment(s) does not meet or equal a Listing under Step 1, then Step 2 requires a determination of whether there has been medical improvement as defined in 20 CFR 416.994(b)(1). 20 CFR 416.994(b)(5)(ii). Medical improvement is defined as any decrease in the medical severity of the impairment(s) which was present at the time of the most favorable medical decision that the individual was disabled or continues to be disabled. 20 CFR 416.994(b)(1)(i). For purposes of determining whether medical improvement has occurred, the current medical severity of the impairment(s) present at the time of the most recent favorable medical decision that found the individual disabled, or continued to be disabled, is compared to the medical severity of that impairment(s) at the time of the favorable decision. 20 CFR 416.994(b)(1)(vii). If there is medical improvement, the analysis proceeds to Step 3, and if there is no medical improvement, the analysis proceeds to Step 4. 20 CFR 416.994(b)(5)(ii).

The most recent favorable decision finding Petitioner disabled is the May 2015 medical-social eligibility certification. Exhibit C, pp. 124-125. The medical evidence relied at that point included the following:

- A history and physical examination was done of Petitioner on [redacted] 2015, due to shortness of breath and he was admitted to the community health center. Exhibit C, pp. 940-942.
- On [redacted] 2015, Petitioner was discharged from the community health center with the following diagnoses: (i) acute congestive heart failure secondary to alcohol-related cardiomyopathy; (ii) depression; (iii) hypothyroidism; (iv) obstructive sleep apnea; (v) obesity; (vi) alcohol dependence – patient was counseled on stopping alcohol, he expressed his understanding; (vii) marijuana dependence - patient was counseled on stopping alcohol, he expressed his understanding; and (viii) chronic back pain. Exhibit C, pp. 223-224.
- An examination by Petitioner's doctor dated [redacted] 2015, in which it was reported that Petitioner had congestive heart failure and the doctor diagnosed him with the following: (i) severe dyspnea, improved, likely multifactorial including acute-on-chronic nonischemic cardiomyopathy and underlying chronic obstructive pulmonary disease; (ii) chronic obstructive pulmonary disease with phlegm production consistent with chronic bronchitis, may have a component of emphysema although diffusion abnormality may be related to heart failure; (iii) recent hemoptysis, may be possible from heart failure; (iv) nonischemic dilated cardiomyopathy with ejection fraction of 20%, improved with treatment, most likely alcohol in origin; (v) polysubstance use, issues and concerns regarding this were reviewed; and (vi) probable severe sleep apnea. Exhibit C, pp. 165-166.
- Progress notes dated from [redacted] 2014 to [redacted] 2015, in which Petitioner was diagnosed with sinusitis; allergic rhinitis; hypothyroidism; backache; carpal tunnel syndrome; prediabetes; intervertebral disc

degeneration; obesity; hyperglycemia; and rhythm disorder. Exhibit C, pp. 171-197.

The evidence presented in connection with the August 2016 review does show medical improvement in Petitioner's condition from that presented in the May 2015 medical-social eligibility certification, the most recent favorable decision finding Petitioner disabled. On or about [redacted] of 2015, Petitioner was diagnosed with congestive heart failure by his cardiologist. Exhibit C, p. 607. However, since his diagnosis, progress notes by his cardiologist shows medical improvements. Specifically, in a follow-up clinic note dated [redacted] 2015, his cardiologist stated that Petitioner's most recent echocardiogram (Echo) showed improvement in LV systolic function with an LV ejection fraction of 45% to 50%. Exhibit C, p. 597. The doctor noted that his Echo in 2015 showed severely reduced LV global systolic function, with an estimated ejection fraction of less than 20%. Exhibit C, p. 597. This medical evidence shows an improvement in Petitioner's LV systolic function. Additionally, his cardiologist diagnosed him with New York Heart Association functional class 1 ACC/AHA stage C congestive heart failure secondary to LV systolic dysfunction; equivocal stress echocardiogram; and peripheral neuropathy, on Neurontin. Exhibit C, p. 597. The AHA states that a class 1 stage C is a patient with minimal or no systems / no limitation of physical activity, but there is objective evidence of moderately severe cardiovascular disease. http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-Heart-Failure_UCM_306328_Article.jsp#.WOfGWk0zV9A. Furthermore, Petitioner had an exercise echocardiography report on [redacted] 2015, in which it was found that Petitioner at rest, his left ventricular systolic function is mildly impaired, with an EF between 45 to 50 percent. Exhibit C, pp. 612-613.

Based on the evidence presented, there has been a medical improvement as shown by a decrease in Petitioner's medical severity concerning his diagnosis of congestive heart failure. As such, because there has been a decrease in medical severity, Step 3 is considered.

Step 3

If there has been medical improvement, it must be determined whether there is an increase in the individual's residual functional capacity (RFC) based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to the individual's ability to do work, the analysis proceeds to Step 4. If medical improvement *is* related to the individual's ability to do work, the analysis proceeds to Step 5. 20 CFR 416.994(b)(5)(iii).

In this case, there has been an increase in Petitioner's RFC based on the impairment(s) that were present at the time of the most recent favorable medical determination. At the time of Petitioner's most recent favorable decision, DDS/MRT found Petitioner's RFC assessment to be less than a full range of sedentary work. Exhibit C, pp. 124-125.

However, due to Petitioner's medical improvement, the evidence is sufficient to establish an increase in Petitioner's RFC, resulting in his physical demands to perform sedentary work as defined by 20 CFR 416.967(a). Because Petitioner's medical improvement is related to his ability to do work, the analysis proceeds to Step 5.

Step 5

Where medical improvement is shown to be related to an individual's ability to do work, **all** the individual's current impairments in combination are considered to determine whether they are severe in light of 20 CFR 416.921. An individual's impairments are not severe only if, when considered in combination, they 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.

In this case, the evidence presented was sufficient to establish that Petitioner's impairments have more than a minimal effect on his ability to perform basic work activities. Therefore, the impairments are severe, and the analysis proceeds to Step 6.

Step 6

Under Step 6, the individual's RFC based on all current impairments is assessed to determine whether the individual can still do work done in the past. If so, disability will be found to have ended. 20 CFR 416.994(b)(5)(vi).

RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s), including those that are not severe, and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4); 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting,

carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b).

The exertional requirements, or physical demands, of work in the national economy are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a). Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools and occasionally walking and standing. 20 CFR 416.967(a). Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds; even though the weight lifted may be very little, a job is in the light category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. 20 CFR 416.967(b). Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. 20 CFR 416.967(e).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. *Id*.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). In addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of mental functional limitation. 20 CFR 416.920a(c)(3). The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. *Id*. The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. *Id*.

In this case, Petitioner alleges both exertional and nonexertional limitations due to his medical condition. Petitioner alleges disabling impairments due to bipolar, back

problems, CTS, heart condition, arthritis, sleep apnea, depression, and anxiety. He testified that his medical conditions have worsened. He testified he can lift a gallon of milk. He can stand for 20 to 30 minutes, he can sit for 20 to 30 minutes, he can walk up to half a block, and he can lift up to 10 pounds. He is able to dress/undress himself, bathe/shower, but he is limited in doing chores. He is limited in using his hands to do CTS and has trouble kneeling. He indicated that he suffers from depression and anxiety. He cannot remember well, he can concentrate, but not for long periods of time, he cannot complete tasks, and he can work with others.

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.

On [redacted] 2016, Petitioner had a medical examination, in which the doctor diagnosed him with (i) back, hand and shoulder pain; and (ii) heart failure. Exhibit C, pp. 478-483. On [redacted] 2016, Petitioner had imaging of his second digit of right hand, in which the orthopedic doctor diagnosed him with second metacarpophalangeal arthritis and the orthopedic doctor also noted that he had CTS of the left and right wrist, active. Exhibit C, pp. 590 and 593-594. Finally, in office note dated on [redacted] 2016, Petitioner's pulmonary doctor diagnosed him complex sleep apnea with both obstructive and central events, and other symptoms. Exhibit C, pp. 623-631. This evidence was sufficient to support Petitioner's allegation of back problems, CTS, heart condition, arthritis, and sleep apnea.

On [redacted] 2016, Petitioner had a psychiatric/psychological medical report, in which the doctor diagnosed him (i) unspecified bipolar disorder and related disorder; (ii) generalized anxiety disorder; (iii) panic disorder; and (iv) attention deficit hyperactivity disorder combine presentation. Exhibit C, pp. 470-473. This evidence was sufficient to support Petitioner's allegation of bipolar, anxiety, and attention deficit disorder.

With respect to the intensity, persistence and limiting effects of his symptoms, Petitioner had a medical examination on [redacted] 2016, in which the doctor diagnosed him with back, hand and shoulder pain, and heart failure. Exhibit C, pp. 478-483. Furthermore, Petitioner had progress notes from [redacted] 2015 to [redacted] 2016, in which his doctor diagnosed him with cardiomyopathy; backache; low back pain; atopic dermatitis; arthralgia of the right hand; organic obstructive sleep apnea; hypothyroidism; and other symptoms. Exhibit C, pp. 497-525. The medical record also contained progress notes from Petitioner's cardiologist, which, as stated in *Steps 2 and 3*, did show he had medical improvements, but the evidence still showed that he was being treated for his ongoing diagnosis of congestive heart failure. Exhibit C, pp. 596-608. Finally, the medical record showed that Petitioner suffered from CTS and arthritis. On [redacted] 2016, Petitioner had imaging of his second digit of right hand, in which the

orthopedic doctor diagnosed him with second metacarpophalangeal arthritis. Exhibit C, p. 590. On that same date, the orthopedic doctor noted in his doctor's visit that he has post-traumatic osteoarthritis of right hand, worse. The doctor noted the right index finger demonstrates severe deformity about the metacarpal head, depression of the joint surface, and bone spurs; and carpal tunnel syndrome of left and right wrist, active. Exhibit C, pp. 593-594.

Based on the medical record presented, including Petitioner's cardiologist and orthopedic specialists' diagnoses, the undersigned finds Petitioner's statements credible that he can stand for 20 to 30 minutes, he can sit for 20 to 30 minutes, he can walk up to half a block, and he can lift up to 10 pounds. As such, the evidence was sufficient to establish that Petitioner maintains the physical capacity to sedentary work as defined by 20 CFR 416.967(a).

With respect to Petitioner's nonexertional limitations, Petitioner had a psychiatric/psychological medical report (consultative exam) on [redacted] 2016, in which the doctor diagnosed him (i) unspecified bipolar disorder and related disorder; (ii) generalized anxiety disorder; (iii) panic disorder; and (iv) attention deficit hyperactivity disorder combine presentation. Exhibit C, pp. 470-473. The doctor noted that employment does not seem to be a viable option in light of his health and psychiatric issues at this time and any attempts at future employment may require some restriction or accommodations at the work site. Exhibit C, p. 472. The doctor noted that Petitioner's social functioning includes few supportive family members and a couple of friends and he was cooperative in the interview. Exhibit C, p. 470. As to Petitioner's activities, the doctor noted Petitioner's day is unstructured, he can dress, and also perform simple household chores, cooking, and shopping. Exhibit C, p. 470.

Furthermore, the medical record contained additional progress/medication review notes that addressed Petitioner's nonexertional limitations from May 31, 2015 to [redacted] 2016. Another doctor also diagnosed Petitioner with bipolar disorder, most recent episode unspecified; attention-deficit/hyperactivity disorder, predominantly inattentive presentation; and a GAF score of 55. Exhibit C, pp. 679-723 and 740-828. The doctor's diagnoses from the community mental health were similar as to Petitioner's consultative mental exam, and only bolster his claim that he suffers from bipolar, anxiety, and attention deficit disorders. From the period of June 2015 to August 2016, his doctor from the community mental health indicated that Petitioner has economic problems, problems accessing healthcare, occupational problems, problems related to social environment, problems related to interaction with legal system, and other psychosocial and environmental problems. Exhibit C, pp. 740-828. The doctor noted in some instances that Petitioner is overwhelmed and has been able to control his emotional state. See Exhibit C, p. 803. However, in other office visits with this doctor, it was noted that Petitioner continues to struggle with multiple stressors but coping well, despite the difficulty in concentration and in one of his last visits with this doctor, it was noted that Petitioner is unstable with increased stress due to the worsening situational stresses and financial difficulties, attention deficits still persist despite the medical

intervention. Exhibit C, pp. 795 and 827. Overall, the medical evidence supports Petitioner's testimony that he suffers from anxiety and bipolar disorders and that the medical evidence has a consistent diagnosis of Petitioner having bipolar, anxiety, and attention deficit disorders.

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

Additionally, it must also be assessed if Petitioner can do work done in the past under step 6. Past relevant work is work that has been performed within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner's work history in the 15 years prior to the application consists of work as a car salesperson, which required sitting and walking during the day and lifting 10 pounds maximum. Based on Petitioner's work history as a car salesperson, the undersigned finds that his work history results in light physical exertion.

Based on the RFC analysis above, Petitioner is limited to no more than sedentary work activities. In light of the entire record and Petitioner's RFC, it is found that Petitioner is unable to perform past relevant work. Accordingly, Petitioner is not able to do work done in the past and therefore, the assessment continues to Step 7.

Step 7

If the individual is not able to do work done in the past, the individual's ability to do other work given the RFC assessment made under Step 6 and the individual's age, education, and past work experience is assessed (unless an exception in 20 CFR 416.994(b)(5)(viii) applies). If the individual can, the disability has ended. If the individual cannot, the disability continues. 20 CFR 416.994(b)(5)(vii).

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, the Medical-Vocational Guidelines, 201.21 (not transferable) or 201.22 (transferable), do not result in a disability finding based on Petitioner's exertional RFC. However, Petitioner also has impairments due to his mental condition. As a result, he has a nonexertional RFC imposing mild limitations in his activities of daily living; marked limitations in his social functioning; and moderate limitations in his concentration, persistence or pace limitations. The Department has failed to present evidence of a significant number of jobs in the national and local economy that Petitioner has the vocational qualifications to perform in light of his nonexertional RFC, age, education, and work experience. Therefore, the evidence is insufficient to establish that Petitioner is able to adjust to other work. Accordingly, Petitioner is found disabled at Step 7 for purposes of the SDA benefit program.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Petitioner has continuing disability for purposes of the SDA benefit program. Therefore, Petitioner's SDA eligibility continues and the Department did not act in accordance with Department policy when it closed his SDA case.

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. Reinstate Petitioner's SDA case effective February 1, 2017;

2. Issue supplements to Petitioner for any lost SDA benefits that he was entitled to receive from February 1, 2017 ongoing, if otherwise eligible and qualified in accordance with Department policy;

3. Notify Petitioner of its decision; and

4. Review Petitioner's continued SDA eligibility in November 2017 in accordance with Department policy.

EF/tm

Eric J. Feldman
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

DHHS

Traci Croff
40 Care Drive
Hillsdale, MI
49242

Petitioner

[redacted] MI

cc: SDA: L. Karadsheh
AP Specialist-4