STATE OF MICHIGAN
RICK SNYDER
GOVERNOR
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: October 5, 2018
MAHS Docket No.: 18-005900
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 6, 2018, from Detroit, Michigan. The Petitioner was represented by himself. The Department of Health and Human Services (Department) was represented by Lynda Brown, Hearing Facilitator and Nicole Perkins, Eligibility Specialist.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Lumbar discography results dated [redacted] 2018, Medical for complex left total shoulder arthroplasty and records confirming L5-S1 anterior lumbar interbody fusion to be performed to relieve lumbar pain were received and marked into evidence as Exhibit B consisting of 10 pages. The record closed on September 6, 2018, and the matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the Medical Assistance 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, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On May 29, 2018, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program.

3. On June 5, 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 alleged disabling impairment due to two right shoulder arthroscopy surgeries which requires replacement which is scheduled. Severe lumbar pain at L5-S1 with scheduled lumbar fusion. The Petitioner had a total left shoulder replacement on [redacted], 2018. A right shoulder replacement due to osteoarthritis is also scheduled already for [redacted] 2019. Nerve damage in right hand. The Petitioner alleges no mental impairment.

6. On the date of the hearing, Petitioner was 43 years old with a [redacted] 1974 birth date; he is 6'0" in height and weighs about 296 pounds.

7. Petitioner is a high school graduate and attended some college for one year and played football.

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

9. Petitioner has an employment history of work as a laborer for roofing and brick layer. As such he climbed ladders carrying shingles weighing 100-150 pounds and regularly carried garbage weighing 250 pounds and on average weighing 50-60 pounds. The Petitioner last worked in 2012.

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 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. 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).

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (July 2015), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If an individual is found disabled, or not disabled, at any step in this process, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In general, the individual has the responsibility to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

Step One

The first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and

productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Petitioner was not working during the period for which assistance might be available. Because Petitioner was not engaged in SGA, he is not ineligible under Step 1, and the analysis continues to Step 2.

Step Two

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for SDA means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the de minimis standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. Higgs v Bowen, 880 F2d 860, 862-863 (CA 6, 1988), citing Farris v Sec of Health and Human Services, 773 F2d 85, 90 n.1 (CA 6, 1985). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. 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 Petitioner alleges physical impairments which include a left shoulder total replacement in July 2018, severe lumbar pain with radiculopathy and S 1 joint dysfunction at L 5-S1 with scheduled lumbar fusion operation. Two right shoulder surgeries, (arthroscopies) with a total shoulder replacement scheduled for 2019, after lumbar fusion operation which is scheduled. Petitioner also alleges nerve damage to right hand.

The Medical evidence presented at the hearing and as part of the Interim Order is briefly summarized below.

The Petitioner was examined on [redacted], 2018 by his treating doctor for his lumbar back and shoulders regarding a preoperative diagnosis for lumbar discogenic pain. The Petitioner was given local IV sedation. The clinical notes indicate patient had undergone multiple injections but continues to have significant amount of back pain. As a result of severe lumbar pain, the Petitioner underwent lumbar medial branch blocks with only five hours of relief. A discogram, a test to determine the anatomical source of lower back pain for the patient was conducted. This procedure is most frequently used to determine if degenerative disc disease is the cause of a patient's pain (discogenic low back pain). Discograms are also performed to assist in preoperative planning for candidates for a lumbar spinal fusion.

At the time of the exam Petitioner underwent an elective diagnostic clinical discography. During the procedure clinical disc distention studies were conducted followed by automated injections with continuous intra-disco pressure monitoring. The procedure noted the following results: at the levels of L 2-L 3, L 3-L 4 and L4-L 5 the disc distention results and clinical responses were entirely unremarkable. They were noted to be quite firm, noncompliant with no concordant pain at the levels. At the level of L 2-L 3, PSI was 69, at level L 3-L 4, PSI was 63, at L 4-L 5 PSI was 78. The corresponding discogram images appeared normal for age at each level. At the level L 5-S 1, the patient reports increased pain and discomfort at this level the patient reported concordant pain. The disc was compliant to injection of fluid. There were elements of intra-disco disruption at each level. The level of PSI was 44. The Impression after the procedure was clinically significant positive and concordant discogram at the level of L 5-S 1. At the levels of L2-through L 5 the discogram was normal.

A Final report after an operation on [redacted] 2018 was also presented. The surgery was for left shoulder severe osteoarthritis with noted obesity and adhesions noted as complicating factors. Post-operative diagnosis was the same. During the operation the Petitioner had a complex left total shoulder arthroplasty (shoulder replacement), a bicep tentomy, biceps tenodesis, lysis of adhesions. At the time of the operation the patient weighed 300 pounds with a BMI of 39 making him obese and report noted that he was very muscular. This created for a very complex shoulder procedure and added dramatically to the challenge of the operation. During the operation the Petitioner's shoulder was dislocated so a new shoulder could be inserted. The notes indicate that the procedure took three hours due to the size and stiffness of the patient and his BMI.

The Petitioner was seen by his orthopedic doctor after the discogram with continuing reports of significant lower lumbar back pain that is rated seven of 10. With no to minimal leg systems. At that time the treating doctor discussed with the Petitioner a lumbar interbody fusion at L 5-S1. The Petitioner was to see his primary care physician for clearance and smoking cessation. The procedure was recommended to alleviate ongoing pain which was ongoing even with use of pain medications.

A computed tomography was performed on [redacted], 2018 of the Petitioner's lumbar spine which resulted in the following findings. At L5-S1, the contrast was located centrally in the disc and extended bilaterally into the outer annular fibers, the largest concentration of contrasts extension fissuring is present in the right dorsal lateral aspect of the disc extending into the outer annular fibers a small focus of fissuring/contrast collection noted in the left lateral outer annular fibers circumferentially. The impression the visualized findings are as follows at L3-L4 grade 4, at L4-L5 suspected annular injection. Anterior and lateral distribution of contrast material within the annulus. Relative paucity of centrally located contrast material. At L5-S1 grade 4 result should be correlated with qualitative data obtained by the operator during the disc stimulation in addition to intraoperative imaging and operative report.

The Petitioner was seen by an orthopedic and spine specialist who had been treating him on [redacted], 2018 at that time the notes indicate that the Petitioner had bilateral lumbar medial branch blocks of L 4, L 5 and sacral on January 9, 2018. Unfortunately, patient only experienced four hours of 100% pain relief. The treating doctor determined that he would prescribe bilateral S 1 joint injections. After the examination the diagnosis was bilateral S1 joint dysfunction, lumbar radicular pain and bilateral lumbar facet arthropathy.

The Petitioner was seen for follow-up on [redacted], 2018 for his left shoulder. The notes indicate that he continues to be in a lot of pain rated 7 on a scale of 0 to 10. The Petitioner was participating in physical therapy, but the benefits expired so he is unable to do any at this time. Pain has returned quite significantly with reduced range of motion after first left shoulder surgery. At the time of the exam the Petitioner weighed 239 pounds. He was able to ambulate independently. Examination of the left shoulder finds he can flex to about 90° and he can touch higher to about 140° with pretty significant pain. Difficulty noted with rotation both with internal and external. The impression was history of left shoulder arthroscopy with removal of loose bodies. Type II slap tear repair. Chrondoplasty with extensive debridement of the shoulder. Acromioplasty the with decompression, extensive bursectomy, debridement of rotator cuff. The doctor provided an updated prescription for physical therapy and noted that the Petitioner may most likely end up with some form of shoulder replacement moving forward. In September 2017 PT evaluation noted the Patient was after left shoulder rotator cuff repair was disabled from doing activities of daily living. In [redacted] 2017 the Left shoulder had flexion 45 degrees, extension 0 degrees, abduction 30 degrees, adduction 0 degrees and internal rotation 0 degrees with severe tenderness and left hand gross strength 3/5, left wrist 3/5, shoulder disability index 98% disability in left upper extremity shoulder.

On [redacted], 2018 the Petitioner was seen for low back pain after receiving bilateral S 1 joint injections on [redacted], 2018. Patient reported 50% relief that lasted roughly for three weeks. The patient is on opioid pain medications in combination with Valium. The doctor did agree to take over the opioid pain medications but told petitioner he would no longer take Valium and the plan was to wean him down from Norco. The doctor planned to repeat the bilateral S1 joint injections. The notes indicate that the low back pain began roughly 3 months ago with no inciting event however a prior injury to the back was noted 10 years ago. The diagnosis was bilateral S1 joint dysfunction, lumbar radicular pain and bilateral lumbar facet arthropathy. The bilateral S 1 joints were injected on [redacted] 2018. The doctor's office notes indicate no illicit drug use, no alcohol six months. On examination tenderness over lumbar paravertebral musculature as well as tenderness with palpation of S 1 joints bilaterally. An MRI of the lumbar spine dated [redacted] 2017, was reviewed noting bilateral L3-L4 and L4-L5 neural foraminal stenosis with facet hypertrophy at L4 L5 and L5-S1.

On [redacted] 2017 the Petitioner was first seen by his orthopedic and spine specialist for evaluation of low back pain. At the time of presentation the patient noted worsening back pain with pain traveling into the bilateral buttock regions, worse when lying flat or walking long distances at that time pain is down the legs, denied focal weakness or loss of bowel bladder control. The patient indicated no recent injury or trauma to back. The notes indicate Petitioner smokes a half pack a day and drinks a 12 pack of beer weekly. On examination there was tenderness to palpation over the lumbar midline and by lateral paraspinals, no active spasms noted. Petitioner had positive straight leg raise for pain bilaterally without radicular symptoms. The MRI dated [redacted], 2017 showed lumbar disc bulges without stenosis and bilateral neural foramin narrowing at L3-L4 and L4-L5. The impression was lumbago with lumbar radiculopathy. History of right shoulder arthroscopy and history of headaches.

The Petitioner was seen by his shoulder surgeon on [redacted], 2017, 3 ½ months out from his first left shoulder arthroscopic surgery. He rates pain to be an 8 out of 10. At the time the Petitioner was in physical therapy and continued to receive pain medications. Even though participating in physical therapy for the left shoulder he has difficulty sleeping at night secondary to shoulder pain and new onset of back pain. The Petitioner admitted some inconsistencies with the use of his medications. During the examination, the Petitioner was able to ambulate independently. Noted Petitioner flex forward to about 50° with increasing discomfort and stiffness passively he could be brought to 70 to 80° with increasing stiffness. The doctor recommended continuing physical therapy of the left shoulder due to fair amount of stiffness and discomfort.

The patient was seen by his orthopedic specialist and was found to have significant pathobiology on [redacted] 2017 he had significant torn labral tissues and a slap tear but he also had full thickness articular delamination of the humeral head over several regions. The left shoulder was in an arm sling and Petitioner could tolerate gentle motion to about 70°. At that time the Doctor had a guarded prognosis anticipating and opining that the joint will degenerate noting that during surgery he did remove a lot of articular fragments. At an earlier exam on [redacted] 2017, numbness and tingling that

goes down into his right hand on the ulnar fingers was reported. Condition does not appear to affect the left side.

Additional treatment notes from 2015 and 2014 show chronic shoulder pain and neuropathic pain for his right shoulder. Due to persistent pain the doctor believed pain management was appropriate. Records noted decreased range of motion. He suggested a second opinion about how to assist the patient for any additional shoulder treatment. If none are suggested then long-term treatments could be under care of pain management doctors. On [redacted] 2015 notes indicate persistent numbness about the third through fifth fingers that radiates up to the forearm as well as pain about the diffuse right shoulder. Noted a shoulder arthroscopic in 2013. On examination grip strength is slightly diminished in the right upper extremity secondary to weakness in the third through fifth fingers. Is able to oppose the first and second fingers to the thumb with resistance this is five out of five. Noted pain of the spine and is able to forward flexed to about 140° with increasing tenderness. A prior EMG noted bilateral carpal tunnel syndrome of the upper extremity. An earlier opinion by his treating orthopedic doctor in a letter dated [redacted] 2014, noted that since [redacted] 2012 they have treated him for a right shoulder injury and have performed two surgeries with persistent pain continuing. The possibility of further procedures through the pain clinic have been discussed during this time, noting he has persistent pain and limited use of his right upper extremity for which he is right hand dominant. The medical record indicates that since 2012 the Petitioner has had difficulty with his right shoulder after two shoulder arthroscopies.

An MRI of the lumbar spine was performed on [redacted] 2017 the Impression was disc bulges without spinal stenosis. Bilateral L3-4 and L4-5 neural foramin narrowing. Indicating that this may affect the exiting nerve roots. Less severe neural foramin narrowing is seen at other levels. At L3-L4 there was a diffuse disc bulge that compresses the anterior thecal sac. There is no spinal stenosis. There is bilateral neural foramin narrowing that may affect the exiting L3 nerve roots. At L4-L5 there is a right foraminal disc protrusion that contacts the exiting right L4 nerve root. There is constriction of the thecal sac due to diffuse disc bulge and facet osteoarthritis without spinal stenosis or compression of the transversing nerve roots.

An MRI of the left shoulder was performed on [redacted], 2017 the conclusion was in distinctness at the anterior inferior labrum suggesting a bankhurt lesion. Superior labral fraying and posterior labral tearing noted. Low-grade insertional tearing of the posterior portion of the infraspinatus, moderate to severe tendinosis of the infraspinatus, moderate to severe tendinosis of the long head of the biceps tendon. Mild to moderate tendosymnovitis noted.

On [redacted], 2017 the Petitioner underwent an arthroscopic, removal of loose bodies, repair of two slap tears and anterior inferior labrum. Crowned up last, he had an extensive debridement of shoulder with decompression. Extensive bursectomy and debridement of rotator cuff, the CA ligament was removed and a leading-edge

osteophyte and spur was removed. There was extensive debridement of humeral head removing all unstable articular flaps.

The Petitioner was seen in the ER on [redacted] 2017 for dizziness. The Petitioner was fully tested with complete systems review including a CT of head and EMG that were normal and no cause for the dizziness was noted, Petitioner was discharged and advised to follow up with his primary care physician.

On [redacted] 2018 the Petitioner was injected by his spine specialist in his lumbar disc S1.

On [redacted], 2018 a medical progress report was completed by Petitioner's treating spine specialist. The impression was Left Shoulder history of arthroscopy two times with underlying arthritis which is worsening. Right shoulder history of arthroscopy two times with evolving arthritis and overload. The doctor notes that changes were very significant at both times. Prognosis is poor. The doctor suggested a consult to see if there is an inflammatory arthritic explanation for arthritis. Patient was open to a shoulder replacement. A Hemiarthroplasty would probably be the most appropriate. In an earlier evaluation in [redacted] 2018 the notes indicated the treating doctor had a very guarded prognosis about his shoulders, but the left shoulder at the time was causing the greatest misery. He notes very real de-lamination at the time of the last surgery. Limited range of forward flexion and abduction. In completing a general pain questionnaire for his doctor the Petitioner noted lumbar pain of 8 of 10 and pain worsens, laying down or standing or sitting for a long period of time.

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step Three

Step 3 of the sequential analysis of a disability claim requires a determination if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920(a)(4)(iii). If an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

Based on the medical evidence presented in this case, listings 1.02 major dysfunction of a joint and 1.04 disorders of the spine were considered. The medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Steps 4 and 5, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s), including those that are not severe, and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4); 20 CFR 416.945(e).

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

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

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

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of

non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi).

In this case, Petitioner alleges both exertional and nonexertional limitations due to his medical condition. Petitioner testified that he could stand 30 minutes and sit 20 to 35 minutes with the time for these activities being restricted due to lumbar pain. The Petitioner could walk up to ¼ mile, could not perform a squat due to low back pain, and could bend very little at the waist. The Petitioner sleeps in a chaise lounge and has sleep disruption due to pain allowing him to sleep only 5-6 hours nightly. The Petitioner cannot dress himself and cannot tie his shoes or touch his toes. He can carry no weight with his left hand due to shoulder pain and left shoulder replacement and can carry a gallon of mild with his right. The Petitioner drives only very short distance due to taking medications, including pain medications daily for pain. Petitioner further testified that his right shoulder is requiring replacement after two earlier arthroscopies perform in 2012 and 2013 which has been scheduled for surgery. The Petitioner has attempted rehabilitation over many years consistently without significant improvement and with respect to his shoulders, no improvement and requiring shoulder replacement. It is also determined that there is a medical basis for the Petitioner's pain symptoms and the effects of pain on his abilities functionally based upon the objective medical evidence presented.

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, and the effects of ongoing pain in his shoulders and lower back and extensive use of monitored, prescribed pain medications and non-exertional limitations including requiring stooping, crouching, handling or grabbing big objects, reaching, sitting and standing it is found based on a review of the entire record that Petitioner does not maintain the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a) and thus can perform on a less than sedentary basis.

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

Step Four

Step 4 in analyzing a disability claim requires an assessment of Petitioner's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed by Petitioner (as actually performed by Petitioner or as generally performed in the national economy) within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1) and (2). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner's work history in the 15 years prior to the application consists of work performing general labor categorized as heavy work and very heavy work. Petitioner's work history was as a general laborer, performing roofing and brick laying and general labor cleaning up. The Petitioner performed heavy work and very heavy work. In these jobs the Petitioner was on his feet all day and was required to carry 100 pounds or more and frequently 100 pounds. As a brick layer Petitioner hauled wheel barrels full of debris weighing 75 pounds or more with heaviest weight up to 100 pounds as well as performed work with a sledge hammer breaking concrete. As a general laborer and roofer he was required to lift materials to skilled laborers weighing 50 pounds or more frequently and 100 pounds as the heaviest weight. In all the laborer jobs Petitioner was required to stand 8 hours or more, sit only 30 minutes, climb, stoop, kneel, crouch, and handle/grasp big objects as well as reaching as required.

Based on the RFC analysis above, Petitioner's exertional RFC limits him to less than sedentary work activities. As such, Petitioner is incapable of performing past relevant work. In light of the entire record, it is found that Petitioner's nonexertional RFC prohibits 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).

In this case, Petitioner was 43 years old at the time of application and 43 years old at the time of hearing, and, thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. He has a high school education with a year of college, with a history of work experience as a general laborer, performing roofing and brick laying and general labor cleaning up performing heavy work and very heavy work throughout his work history. In these jobs the Petitioner was on his feet most of the day, and required to carry 100 pounds or more and frequently 100 pounds. As a brick layer Petitioner hauled wheel barrels full of debris weighing 75 pounds or more with heaviest weight up to 100 pounds as well as work with a sledge hammer breaking concrete. As a general laborer and roofer he was required to lift materials to skilled laborers weighing 50 pounds or more frequently and 100 pounds as the heaviest weight. In all the laborer jobs Petitioner was required to stand 8 hours or more, sit only 30 minutes, climb, stoop, kneel, crouch, and handle/grasp big objects as well as reaching. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform less than sedentary activities.

In this case, the Medical-Vocational Guidelines, Appendix 2 do not support a finding that Petitioner is not disabled based on his exertional limitations. The Department has failed to counter with evidence of significant numbers of jobs in the national economy which Petitioner could perform despite his limitations. Therefore, the Department has failed to establish that, based on his RFC of less than sedentary and age, education, and work experience, Petitioner can adjust to other work. Therefore, Petitioner is disabled at Step 5 for purposes of the SDA program.

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 reregister the Petitioner's [redacted] 2018 SDA application to determine if all other non-medical criteria are satisfied and notify Petitioner of its determination.

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

3. Review Petitioner's continued eligibility in October 2019.

LF/cg

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

Via Email:

MDHHS-Macomb-20-Hearings
L. Karadsheh
BSC4- Hearing Decisions
MAHS

Petitioner – Via First-Class Mail:

[redacted]