[redacted]

Date Mailed: October 2, 2018
MAHS Docket No.: 18-006126
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 Corliss Tripp-Watson, Assistance Payments Supervisor, and Pamela Matoska, 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. Neither the Department nor the Petitioner returned any medical records by the due date. **The requested documents were NOT received.** 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 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 17, 2018, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program.

3. On May 22, 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 chronic tendinopathy bilateral ankles with a brace, chronic kidney disease, stage III with chronic urination 40 times a day. Diabetic neuropathy loss of feeling in bottoms of bilateral feet. Chronic mastoiditis with loss of hearing, alleged deaf. Malignant hypertension, stroke TIA and memory problems. The Petitioner did not allege a mental impairment.

6. On the date of the hearing, Petitioner was 43 years old with a [redacted] 1974, birth date; he is 5' 8" in height and weighs about 180 pounds.

7. Petitioner is a college graduate with a BA in nursing, psychology and associate degree in engineering.

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

9. Petitioner has an employment history as follows. The Petitioner last worked in October 2017 at a fast food restaurant preparing [redacted] sandwiches. The Petitioner also worked at [redacted] The Petitioner worked at [redacted] as a manager and also prepared food and did bookkeeping. The Petitioner attended nursing school and worked attending to patients. The Petitioner also worked outside at park processing paperwork.

10. Petitioner has a pending disability claim with the Social Security Administration.

CONCLUSIONS OF LAW

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

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (July 2015), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least 90 days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

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

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

Step 1

The first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

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

Step 2

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

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

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the de minimis standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. Higgs v Bowen, 880 F2d 860, 862-863 (CA 6, 1988), citing Farris v Sec of Health and Human Services, 773 F2d 85, 90 n.1 (CA 6, 1985). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28. If such a finding is not clearly established by medical evidence or if the effect of an impairment or combination of impairments on the individual's ability to do basic work activities cannot be clearly determined, adjudication must continue through the sequential evaluation process. Id.; SSR 96-3p.

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

Petitioner has alleged the following disabilities: chronic tendinopathy bilateral ankles with a brace, chronic kidney disease, stage III with chronic urination 40 times a day. Diabetic neuropathy loss of feeling in bottoms of bilateral feet. Chronic mastoiditis with

loss of hearing, alleged deaf. Malignant hypertension, stroke and memory problems. The Petitioner has not alleged a mental impairment.

On [redacted], 2018, the Petitioner underwent an independent medical examination at the request of the Department. The history reported to the examiner by Petitioner noted diabetic neuropathy in lower extremities and nephropathy. Petitioner advised the examiner that he cannot walk more than two blocks. Petitioner advised he had pins and needles in his feet at all times. Also reported was COPD with 10-year history. Petitioner advised the examiner that he gets short of breath walking fast three blocks and short of breath walking slow five blocks. The Petitioner reported he was trying to quit smoking. The Petitioner reported he had seen a pulmonologist in the past but does not regularly follow with one. The Petitioner also presented a history of coronary artery disease with a report of a myocardial infarction in [redacted] 2017. There was no cardiac catheterization at that time, and there were no residual or lingering effects. The Petitioner does not have follow-up treatment with a cardiologist. No chest pain was noted. The Petitioner also reported TIA/CVA. Petitioner reported 20 TIAs and about 5 CVA's, which are related to his hypertension. The examiner noted subjective left-sided weakness, which is greater than the right side. The report notes that Petitioner does not follow with a neurologist due to the CVA/TIA condition.

During the independent medical exam, the doctor noted the following conditions. The Petitioner did not use an assistive device for ambulation and exhibited a normal gait. Hearing appeared normal. The heart exam demonstrated a normal S1 and S2, no murmurs or gallops were appreciated and, heart did not appear to be enlarged clinically. The lungs were clear to auscultation without any adventitious sounds. With respect to extremities and musculoskeletal there was no deformity, range of motion of all joints is full, no tenderness, erythema or effusion in any joint. Straight leg raising was negative in seated and supine positions. No paravertebral muscle spasm, and peripheral pulses were easily palpated. No edema. No open wounds on feet. Grip strength was 5/5 bilaterally. Hands had full dexterity. Petitioner had no difficulty getting on and off exam table. No difficulty heel and toe walking or squatting. The heart S1 and S2 is normal. No murmurs or gallops are appreciated.

The following conclusions were made by the examiner: 1) Diabetes, with diabetes neuropathy and nephropathy; 2) COPD, uses albuterol and Advair; 3) Coronary artery disease; 4) History of TIAs/CVAs. The patient does not follow with a neurologist. In closing the evaluation, the examiner noted patient was able to complete all tasks asked of him. He did not have any difficulty with the orthopedic maneuver portion of the exam. An assistive device was not used. His digital dexterity was intact; there was no increased work of breathing. Prior to the exam, the Petitioner completed a questionnaire which noted no problems with frequent urination, numbness and tingling in arms or legs, headaches blurred vision, instability when walking, chest pain, swelling in the ankles and feet and heart skipping pounding.

The Petitioner was admitted on [redacted] 2017, to the hospital in the emergency room for a sore throat noted as moderate with congestion and an earache and a temperature of 101°. On examination, the notes indicate pain behind right ear with ear canal clear no drainage edema in canal. The Petitioner was discharged with a follow-up ENT exam for a mastoidectomy with pain improved. The Petitioner was also advised to follow up with nephrologist and his primary care physician.

The Petitioner was seen in the emergency room on [redacted], 2017. At the time, Petitioner presented with chest pressure and pain while he was making cookies with shortness of breath. After a complete workup, the Patient requested to go home and was advised to follow-up with his nephrologist at the [redacted] and to monitor his blood pressure at home. The final diagnosis at discharge was essential (primary hypertension), hypertensive emergency. The Discharge Summary notes that the Petitioner, after being admitted to the critical care unit, argued and wanted to leave against medical authority and would not discuss the consequences of leaving the hospital with high blood pressure and began using abusive language and would not listen. Ultimately, Petitioner did not leave the hospital, as when he tried to leave, felt dizzy. An echocardiogram was also performed; the ejection fraction was 55%, the left ventricle size was normal, mild concentric left ventricular hypertrophy was noted, globally normal left ventricular systolic function with a 55% ejection fraction. Left atrium was normal, right atrium is normal in size, and right ventricle is normal in size and function. Aortic valve was normal in structure and function with no evidence of aortic regurgitation noted. Normal mitral valve structure was noted with trace mitral regurgitation. Normal right ventricular systolic pressure. There was no evidence of pulmonic insufficiency noted in addition, a CT scan of the chest and abdomen was performed. The impression was CTA of the chest showed no evidence of significant occlusive arterial changes, aneurysm or dissection. CTA of the abdomen shows no evidence of an abnormal aortic or iliofemoral aneurysm or significant occlusive arterial changes in the major branches. Based on the x-ray taken, the heart size was normal with no pulmonary vascular congestion or pleural effusion. Emphysema was also noted. Additional treatment was provided to Petitioner and his blood pressure improved. Notes further indicate that the Petitioner kept refusing to stay. The notes indicate that Petitioner was also encouraged to quit smoking.

The Petitioner was seen in the emergency room on [redacted] 2018, with complaint of left-hand pain. The Petitioner reported that his hand was hard to the touch and had an absent or weaker pulse compared to the right side and had numbness and tingling in his first three digits. The Petitioner denied chest pain, headache, orthopnea or scapular pain as well as any trauma. The Petitioner reported discomfort in his left arm that radiated up his arm. An ultrasound was performed which showed no evidence of occlusion or stenosis. Blood work showed significant leukocytosis with no signs of cellulitis. The Petitioner's electrolytes were normal especially his BUN/creatinine considering complaints of some renal insufficiency. Notes indicate that the diagnosis was left arm discomfort of uncertain etiology and because of a white blood count a

nasal swab was requested which was refused by the Petitioner because he wanted to leave.

There was no supportive objective medical evidence presented with respect to Petitioner's testimony regarding malignant hypertension, diabetic neuropathy and chronic mastoiditis or to support any impairment of knees or back problems testified to by Petitioner during the hearing.

There were no medical opinions offered by any medical source who was treating the Petitioner other than those specifically referenced above. An Interim Order was issued to allow the Petitioner to present medical documents regarding the following medical conditions that Petitioner claims as impairments, which included diabetic neuropathy, malignant hypertension, enlarged heart, chronic tendinopathy, torn muscle affecting left knee, chronic kidney disease and chronic mastoiditis. In addition, the DHS-49 sent to [redacted] as part of the Interim Order was not returned to the undersigned.

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

Step 3

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

Based on the medical evidence presented in this case, listings 4.04 Ischemic heart disease, 9.00 5 diabetes mellitus and other pancreatic gland disorders; 3.02 Chronic Respiratory disorders and listings 6.03 and 6.05 Chronic kidney disease 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 less than 20 minutes and sit 30 minutes, could walk less than two blocks, could not squat, could not bend at the waist; there was nothing wrong with his hands or arms; and his feet had pins and needles due to neuropathy. Petitioner testified that he could drive short distances, but his driver's license needs renewal, so he does not drive. He can prepare sandwiches and microwave food, does not grocery shop due to it hurts to walk around, and does light housework picking up around the home but does not vacuum or do laundry. He is able to use a computer but does not do so. The Petitioner can shower and dress himself. The Petitioner testified that he cannot carry more than two pounds. The Petitioner continues to smoke even though his doctors have advised him to stop.

At the independent medical exam, the doctor found the Petitioner did not use an assistive device for ambulation and exhibited a normal gait. Hearing appeared normal. The examiner noted patient was able to complete all tasks asked of him. He did not have any difficulty with the orthopedic maneuver portion of the exam. An assistive device was not used. His digital dexterity was intact; there was no increased work of breathing. Grip strength was 5/5 bilaterally. Hands had full dexterity. Petitioner had no difficulty getting on and off exam table, no difficulty heel and toe walking or squatting. The heart S1 and S2 is normal. No murmurs or gallops are appreciated.

A two-step process is applied in evaluating an individual's symptoms: (1) whether the individual has a medically determinable impairment that could reasonably be expected to produce the individual's alleged symptoms and (2) whether the individual's statement about the intensity, persistence and limiting effects of symptoms are consistent with the objective medical evidence and other evidence on the record from the individual, medical sources and nonmedical sources. SSR 16-3p.

With respect to Petitioner's exertional limitations, it is found based on a review of the entire record that Petitioner maintains the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a).

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has no non-exertional limitations based on his hearing or memory. During the hearing and at the independent medical examination, no such problems were apparent or noted by the examining doctor.

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

Step 4

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

Petitioner's work history in the 15 years prior to the application is listed as the following jobs. The Petitioner last worked in [redacted] 2017 at a fast food restaurant preparing [redacted] sandwiches. The Petitioner also worked at [redacted] The Petitioner worked at [redacted] as a manager and also prepared for food and did bookkeeping. The Petitioner attended nursing school and worked attending to patients. He last worked as a nurse in 2008. The Petitioner also worked outside at park processing paperwork.

At [redacted] the Petitioner made submarine sandwiches, baked bread, cleaned up, did paperwork, received money from customers and made an inventory. The Petitioner was required to stand eight hours while working and lifted boxes weighing 20 to 25 pounds frequently, the heaviest weight carried was 30 pounds. In Petitioner's other fast food job for [redacted] he took orders, made change and handed out food to customers. This job required him to stand eight hours a day, and the heaviest weight lifted was less than 10 pounds. In his job working at a park as an operation manager, he walked four hours and stood four hours; the heaviest weight lifted was 10 pounds, As a staff nurse, the Petitioner took care of patients, administered medications, cleaned patients and documented patient progress. Petitioner was required to walk/stand six hours and frequently lifted up to 100 pounds moving patients. (Exhibit A, pp. 32-36.) The Petitioner also worker at [redacted] where he was a manager. In this job, Petitioner supervised other individuals, was able to hire and fire employees, kept records and also did food prep.

Based on the RFC analysis above, Petitioner's exertional RFC limits him to no more than sedentary work activities. As such, Petitioner is incapable of performing past relevant work.

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). The Petitioner's nonexertional limitations as discussed above were not supported by medical evidence.

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 is a college graduate with a history of work experience as a nurse, a manager of a chain restaurant and fast food services preparing and serving food. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities.

Based solely on his exertional RFC, the Medical-Vocational Guidelines, 201.29, result in a finding that Petitioner is not disabled.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner **not disabled** for purposes of the SDA benefit program.

DECISION AND ORDER

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

LMF/

Lynn M. Ferris
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

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

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

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MAHS Rehearing/Reconsideration Request.

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

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

DHHS

Renee Swiercz
MDHHS-Oakland IV-Hearings

Petitioner

[redacted]

Authorized Hearing Rep.

[redacted]

BSC4
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