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Date Mailed: February 12, 2019
MAHS Docket No.: 18-012987
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 January 16, 2019, from Detroit, Michigan. The Petitioner was represented by himself. The Department of Health and Human Services (Department) was represented by Pamela Herman.

The record closed on January 16, 2019; 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 program?

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 October 8, 2018, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 18-19).

3. On October 12, 2018, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit A, pp. 9-10).

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

5. Petitioner alleged physical disabling impairment due to surgery and bladder and prostate cancer, in remission, and urostomy bag, bilateral shoulder pain (arthritis), left knee pain, left hip pain, neuropathy with numbness in left knee and shin. The Petitioner alleged mental disabling impairments due to Bipolar I and Depression.

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

7. Petitioner is a high school graduate.

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

9. Petitioner has an employment history of working at a book processing and scanning company, operating his own pest control company, working for a motel chain performing general maintenance and cleaning and as a cook.

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.

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.

The Petitioner attended an Independent Medical Examination on [redacted] 2018. The Petitioner self-reported chronic pain of left shoulder, left knee and left hip along with bladder and prostate cancer, which was in remission at the time of the exam. The Petitioner has a urostomy bag and reported frequent urinary tract infections. Patient reported a baseline pain level of 6. At the exam, notes indicate Petitioner advised he can walk 20 to 30 minutes and stand or sit for 60 minutes and carry about a gallon of milk with the right upper extremity and a cup of coffee with the left. Petitioner denied difficulty with grasping, opening items or dropping objects. Petitioner denied difficulty with dressing or bathing, cooking, cleaning or grocery shopping. Notes indicate the Petitioner does not use an assistive device and has had no physical therapy or steroid injections. Petitioner reported cancer diagnosis in 2014 and bladder and prostrate removal and six weeks of chemotherapy. The Petitioner had no trouble getting on and off exam table, straight leg raise was negative, no muscle spasm, noted limited range of motion of bilateral shoulders and grip strength 5/5. The patient affect was anxious. Gait was normal, and patient does not require an assistive device. X-rays of the left

shoulder were taken demonstrating degenerative changes present with no acute fracture or dislocation. Impression was left shoulder arthritis. The Petitioner had decreased range of motion of the bilateral shoulders more significant for the left shoulder. X-ray of lumbar spine noted intervertebral disc space narrowing with reactive endplate sclerosis and vertebral spurring with facet degenerative changes with no listhesis with the impression lumbar degenerative changes. X-rays of left hip note no obvious acute grossly displaced fracture and no significant degenerative changes. X-ray of right knee impression was no acute abnormality. Left knee X-ray findings noted degenerative changes present with previous tibial tunnel surgery with impression left knee arthritis. The Conclusion was at today's exam, the patient was able to complete all tasks asked of him without difficulty without any abdominal pain. Grip strength was 5/5 bilaterally as tested grossly with no digital dexterity loss. Cardiac and pulmonary examination is essentially normal.

Petitioner was admitted on [redacted] 2018, for a 5-day stay in the Veterans (VA) hospital due to depression and suicidal ideation with a plan to overdose on heroin and recent drug relapse for cocaine and heroin based upon positive urine drug screen. Petitioner was homeless. During stay, agitation and irritability decreased; and patient was able to work through psychosocial stressors. Medications were adjusted. On discharge, no suicidal ideation, intent or plan. The diagnosis was Mood Disorder with opiate use disorder, bipolar disorder and polysubstance use disorder. At the time of the admission, the Petitioner was homeless due to his discharge from a rescue mission due to possession of drug paraphernalia. Patient reported being sober for five months until the week prior. Noted patient's judgement was somewhat impaired and ambivalent about his substance use but believes he needs help for his psychiatric symptoms. On discharge, notes indicate patient declined referral to substance abuse treatment. Notes indicate, during stay he was irritable. The Patient was also seen for UTI, and his urostomy was changed. The history of drug and alcohol use notes history of serious alcohol abuse with two DUIs with loss of license. Reports cocaine use since 2014 using on and off with longest sobriety five months, recently. Began heroine 1.5 years ago and due to recent stressors was using daily.

A note during a month-long in-patient psychiatric admission in [redacted] 2018 notes that Petitioner admitted due to exacerbation of bipolar disorder symptoms, suicidal ideation and multi-drug abuse. Patient was also noted as noncompliant with psychotropic medications for over a year period prior to admission. In addition, the Petitioner was homeless, allegedly evicted due to two individuals overdosing in his apartment.

On [redacted] 2017, the Petitioner missed his intake for substance abuse treatment through the VA and was advised by letter to reschedule.

The Petitioner completed two months of inpatient treatment at Emanuel House Recovery Program on [redacted] 2018. He was admitted on [redacted] 2018, for substance abuse for crack cocaine. While at Emanuel House, he was seen by a VA psychiatrist for monthly medications review, and in [redacted] 2018, was diagnosed with

bipolar disorder, current episode depressed, mild and cocaine dependence, and opioid dependence. Petitioner improved while in treatment based on an evaluation by a clinical psychologist on [redacted], 2018, who noted that diagnosis of bipolar 1 current depressed, mild, and alcohol dependence in remission and opioid dependence in remission. Insight and judgment were good.

From notes in medical records, Petitioner self-reports sobriety/recovery for 5 1/2 years during 2008 to 2014.

The Petitioner was admitted on [redacted] 2018, for a month stay for in-patient treatment with diagnosis of depressive disorder, possible substance induced heroin and cocaine dependence, cannabis and amphetamine dependence and alcohol abuse and tobacco dependence. Notes indicate symptoms include suicide ideation with plans of overdosing on heroin, and poor compliance with meds/ongoing polysubstance use. Once on medications again, patient's mood stabilized and depression receded. Patient was discharged from this stay directly to Emanuel House, a residential drug rehabilitation facility. During this stay, Petitioner reported stabbing pain in left shoulder several times. During an exam, the following assessment was made, mood was depressed but less depressed and more relaxed, was able to make logical decisions, and understood need for treatment, anxiety denied, was able to socialize with peers, attended group programs, appetite good. Petitioner's high blood pressure was managed during his stay with medication.

On [redacted] 2018, the Petitioner had a chest x-ray with an impression of minor abnormality which noted mild degenerative changes are noted in shoulders along the thoracic spine. A CT of the abdomen and pelvis was performed on [redacted] 2018, noting Code 4 and a few sclerotic areas are seen involving pelvic bones mild degenerative changes thoracolumbar spine. Mildly enlarged portacaval and peripancreatic lymph nodes again seen. Petitioner also underwent a bone-imaging whole-body scan due to his bladder cancer on [redacted] 2018. The Impression was pattern of imaging compatible with diffuse degenerative arthritis involving the shoulder, elbows, knees, ankles and feet. Noted no evidence for metastatic disease to bone.

On [redacted] 2018, the Petitioner, while inpatient, was recommended for Paliperidone palmitate, a long-acting injection medication to treat his bipolar disorder and history of lack of drug compliance. Notes indicate that Petitioner has history of noncompliance with psychotropic medications for one year prior to admission. The request was approved to use this medication. Notes indicate that the Petitioner had not followed up for urology clinic review since [redacted] 2016 and was given a consult while in-patient on [redacted] 2018.

On [redacted] 2018, Petitioner presented at emergency room due to suicidal ideations and intent. He reported thought of jumping in river with his backpack on, jumping off the bridge, overdosing and or obtaining a gun and has multiple attempts by overdosing and two times with a gun. Cancer was reported as a major stressor, and Petitioner reported

he was homeless. Petitioner also reported as being non-compliant with his psychotropic medications since being released from the [redacted] VA. Patient reported not taking bipolar mediations for months.

On [redacted] 2017, the Petitioner was seen in the ER due to suicidal ideation and was brought to the ER by police due to suicidal comments. The Petitioner was not cooperative and did not want to be in ER or be examined. He was discharged without treatment with no specific medical complaint.

The Petitioner was admitted for psychiatric treatment and heroin cocaine dependence and depression on [redacted] 2017, and discharged on [redacted] 2017. The problem list included opioid dependence, stimulant dependence, Major depressive disorder and bipolar disorder. On admission, the Petitioner presented disheveled, with an unkept appearance with very-limited-to-poor judgement and insight. Petitioner was admitted for inpatient resident rehabilitation. Notes indicate that in [redacted] 2017 Petitioner was asked to leave a resident program due to his behaviors that week ([redacted] 2017) as he was an urgent safety risk to himself and others suggesting that he could receive a syringe of heroin delivered to him on the unit during classes and nightly NA meetings. During this admission, the Petitioner noted that he used crack cocaine daily and also admitted that he was non-adherent with medication and lied to his doctor about taking his medications to “get what you want”. The admission diagnosis was polysubstance dependence, major depressive disorder likely substance induced, rule out personality disorder.

On [redacted] 2017, the Petitioner was admitted to ER due to drug overdose. At time, he was unresponsive secondary to drug overdose. He was found by paramedics and awakened and taken to ER. Petitioner admitted to using heroin by injection, as well as snorting crack cocaine. The Petitioner left the ER without waiting for instructions without discharge. The Petitioner also reported to the ER on [redacted] 2017, due to a drug overdose due to heroin and cocaine. Petitioner was transported by ambulance. Petitioner was discharged home and was stable and wanted to leave. He tested positive for cocaine and an opiate.

The Petitioner was accepted for residential treatment on [redacted], 2017, after an interview.

The Petitioner was admitted for treatment on [redacted] 2017, due to substance use disorders.

On [redacted] 2017, Petitioner was taken to ER after police were called when he became unconscious. He was given Narcan by paramedics and brought to ER. The patient was discharged home with referral for outpatient follow up, and referral to VA.

On [redacted] 2018, the Petitioner had an echogram of the liver with the impression Mild hepatomegaly without focal mass identified, otherwise normal sonogram. The

Petitioner was counseled on Hepatitis C and its impact on the liver. The Petitioner was diagnosed with Hepatitis C in [redacted] 2018.

The Petitioner was admitted for inpatient treatment on [redacted] 2015, and discharged [redacted] 2015, for drug use with a diagnosis of cocaine dependence, cannabis abuse, alcohol abuse, mood disorder and tobacco dependence. Also noted was intermittent shoulder pain, hypertension, and bladder tumor. A prior in-patient treatment was completed in [redacted] 2009. The Petitioner was irregularly discharged on [redacted] 2015, due to anger management and multiple incidents of disrespectful, abusive behavior towards staff and peers. At discharge, notes indicate that Petitioner can be maintained on an outpatient basis.

On [redacted] 2016, the Petitioner underwent a radical cystoprostatectomy and removal of bilateral pelvic lymph nodes after two previous bladder surgeries due to tumors. The surgery was successful, and the Petitioner was discharged on [redacted] 2016. An earlier surgery was performed: a cystoscopy and a transurethral resection of bladder tumor. This surgery occurred after several resections on [redacted] 2015, and in [redacted] 2015.

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

Step 3

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

Based on the medical evidence presented in this case, listings 12.04 Depressive, bipolar and related disorders and 1.02 Major Dysfunction of a joint(s) due to any cause 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, non-exertional, 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 non-exertional 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 non-exertional limitations due to his medical condition. The Petitioner testified that he could walk to the store for groceries approximately a quarter mile, but also testified he can walk a mile. The Petitioner cannot drive due to his driver license revocation. He is able to cook his meals and can sweep and does his laundry by hand. He testified that his urostomy bag was 10" in length below his navel and that he cannot tuck in his shirt. He can stand an hour and sit approximately 2 to 3 hours. He testified that he could barely perform a squat; he is right handed; and has no problems with the use of his hands or arms. Petitioner also testified that he had to empty his urostomy every hour. He can shower and dress himself and can tie his shoes sitting down. Pain level was 6/10 due to left shoulder pain and sleeps 4 to 6 hours a night due to shoulder pain. The Petitioner also controls his pain for his shoulder and knees with acetaminophen. At the time of the hearing, the Petitioner testified to neuropathy in his left knee and shin. He further reported that his hands and arms were functional and that his back and neck were ok with no pain. There was no objective medical evidence to support neuropathy in his left knee and shin. He did complain of shoulder pain with the left shoulder worse than the right. Although he complains of hip pain, there was no objective evidence to support pain based upon x-ray. The Petitioner's blood pressure is better controlled due to weight loss. The Petitioner also openly testified that he quits taking his prescribed medications for his mental impairment (bipolar disorder and depression); and at the time of the hearing, he had been off his medications, was very depressed and had high anxiety and would check into the VA soon.

As regards his mental impairments, Petitioner testified that his anger is under control, as were his outbursts. He also testified that he had not been suicidal recently. With respect to his depression, he expressed that he has difficulty functioning including sleeping and keeping up with his hygiene. He stated his short-term memory was poor and needs assistance with completing forms. When asked overall how he was feeling, Petitioner testified that he was feeling very well.

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 light work as defined by 20 CFR 416.967(b).

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has moderate to at times severe limitations on his mental ability to perform basic work activities. However, the severe limitations result due to drug abuse being material as discussed hereafter.

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 as follows: The Petitioner worked as a book scanner, quality control inspector, and as such, he sorted books by condition and scanned or manually entered into a computer the UPC code and placed the book in the proper container. In that position, the Petitioner walked and stood seven hours a day and was required to crouch, handle and reach seven hours out of the work day. The heaviest weight he lifted was 50 pounds and frequently lifted 10 pounds. The Petitioner also worked as a housekeeper and maintenance man for a hotel chain. As such, he did general housekeeping, cleaning bathrooms, making beds, dusting, as well as, general maintenance including maintaining the pool, repairing HVAC units, changing light bulbs, faucets gaskets and maintaining the irrigation system. The heaviest weight he carried by 100 pounds and frequently lifted 20-25 pounds. He was required to stand/walk five hours a day and as well as stoop, kneel, crouch and reach. The Petitioner also worked as a pesticide tech for himself as an owner and as an employee of a pesticide company. The job required standing and walking eight hours a day, as well as climbing, kneeling, crouching six to four hours a day. The heaviest weight lifted was 50

pounds, and he frequently lifted 20-25 pounds. As a pesticide technician, he had to carry a 3-gallon sprayer around and lift frequently 20 to 25 pounds. This past work is considered light-to-medium for the hotel maintenance work.

During the independent medical exam, the Petitioner denied difficulty with grasping, opening items or dropping objects. Petitioner denied difficulty with dressing or bathing, cooking, cleaning or grocery shopping. Although x-rays showed shoulder arthritis and some range of motion diminishment, overall based upon medical records available, the pain level was controlled to a 3 with acetaminophen. Additionally, there was no treatment by Petitioner for back, hip or shoulder conditions and no surgery recommended. The Petitioner had no trouble getting on and off exam table, straight leg raise was negative, and no muscle spasm were present, noted limited range of motion of bilateral shoulders and grip strength 5/5. In addition, the Petitioner has not undergone physical therapy, or sought medical treatment for his shoulders and has not had steroid injections. In short, there is insufficient medical evidence to find that Petitioner is not capable of light work as determined above.

As regards the Petitioner's non-exertional mental impairment resulting from bipolar disorder and depression, the Petitioner is able to complete activities of daily living, his social functioning is more limited, but he testified he has a friend currently and a case manager, and concentration appeared to be adequate during the hearing with at most some moderate limitation. His persistence and pace are also moderately limited. No Mental Residual Functional Assessment was provided; but based upon the Petitioner's communication during the hearing, he demonstrated no apparent difficulty to remember one- or two-step instructions, and could carry out simple one- or two-step instructions; however, detailed instructions would be more difficult and would pose moderate limitations. Petitioner could make simple work-related decisions and interact appropriately with the general public and at most were moderately limitations. When in drug treatment, his judgment improved and was evaluated as good and depression evaluated as mild. It appeared that the Petitioner had an adequate fund of knowledge, and at one time owned and operated his own pest control company. The Petitioner also could ask simple questions or request assistance without any apparent limitations, did not appear to have difficulty getting along with others or accepting instructions other than his difficulty following prescribed medications for his bipolar symptoms and depression which posed a moderate limitation.

The housekeeping tasks previously performed for a hotel chain consist of light work, and the Petitioner did not have difficulty with those tasks and currently is able to manage his own sweeping, and hand laundry and is able to stand for an hour and walk to the store. Petitioner's work as a hotel housekeeper, which required standing and walking during a normal shift and lifting up to 20 pounds regularly, required light physical exertion. The work also performed as regards some hotel maintenance required lifting heavier items and exceeded light activity.

Based on the RFC analysis above, Petitioner's exertional RFC limits him to no more than light work activities. As such, Petitioner is incapable of performing past relevant work performing pest control activities and book scanning activities due to weight lifting requirements of 50 pounds on average and at times up to 30 pounds or more weight with the pest control job. Petitioner also has non-exertional limitations in his mental capacity to perform basic work activities. In light of the entire record, it is found that Petitioner's non-exertional RFC does not prohibit Petitioner from performing past relevant work performing housekeeping.

In short, Petitioner is found capable of performing past relevant work housekeeping for a hotel and thus, is found not disabled on that basis.

In this case, Petitioner was [redacted] years old at the time of application and [redacted] years old at the time of hearing, and thus, considered to be closely approaching advanced age (age 50-54) for purposes of Appendix 2. He is a high school graduate with a history of work experience performing housekeeping for a motel chain. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform light work activities. However, based solely on his exertional RFC and the lack of objective medical evidence to support that, the Petitioner is unable to perform light work, the medical-vocation Guidelines, Rule 202.13 also requires that Petitioner must be found not disabled.

Based upon his non-exertional mental impairments, it is determined that Petitioner is also not disabled based upon his mental impairments as drug and alcohol dependence are material; and in the absence of drugs and alcohol abuse, it is determined that the Petitioner would be able to complete simple routine repetitive work with occasional coworker and supervisor interaction.

The burden of proof to establish disability throughout the sequential evaluation process remains with the Petitioner. Drug and Alcohol abuse must be reviewed following the analysis found in SSR 13-2p to determine whether drug or alcohol abuse or addiction is a contributing factor material to the determination of disability. See Social Security Act, Sections 223(d)(2)(C) and 1614(a)(3)(J) of the Social Security Act (Act). Also considered is whether considering all the Petitioner's medically determinable impairments, whether the Petitioner would continue to be disabled if he stopped using drugs; that is, it must be determined whether drug abuse (DDA) is material. SSR 13 – 2p. A review of the five questions to determine materiality are answered as follows:

1. Does the Petitioner have DDA?
   Based upon the medical evidence the answer is yes and is replete with multiple ongoing outpatient and extended inpatient treatment for drug use of heroin and cocaine over a period of years, with a pattern of medication noncompliance for his bipolar disorder.

2. Is Petitioner disabled considering all impairments including DDA?
   No. The Petitioner did not meet the listing 12.04 or 1.02.

3. Is DDA the only impairment?
   No. The Petitioner has a diagnosis of bipolar disorder and depression as underlying mental impairments, but the symptoms once sobriety is attained by Petitioner are significantly reduced. The Petitioner's physical impairments including diffuse arthritis are not affected by DDA, nor would they improve.

4. Is the other impairment(s) disabling by itself while the Petitioner is dependent upon or abusing drugs or alcohol?
   No. See medical evidence summary found at Step 2 of this Hearing Decision. The Bipolar and Depression with treatment for DDA, reduce to mild.

5. Does DDA cause or affect the Petitioner's medically determinable impairments?
   Yes. As previously described upon sobriety, the majority of symptoms and signs for bipolar disorder and depression diminish and are adequately controlled by prescribed medications.

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/jaf

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

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

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

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

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

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

DHHS

Carisa Drake
MDHHS-Calhoun-Hearings

Petitioner

[redacted]
[redacted]
[redacted] MI [redacted]

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