STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

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GOVERNOR

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DIRECTOR

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Date Mailed: July 1, 2019
MOAHR Docket No.: 19-003281
Agency No.:
Petitioner:

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 May 2, 2019, from Detroit, Michigan. The Petitioner was represented by himself. The Department of Health and Human Services (Department) was represented by Brandi Eiland, Assistance Payments Worker.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. A Medical Exam Report completed by Petitioner's primary care physician and University of Michigan records of chronic hernia pain evaluation were received and marked into evidence as Exhibit B. In addition, the undersigned did not receive a Mental Residual Functional Capacity Assessment and Psychiatric Assessment/Evaluation from the Petitioner's mental health care provider, Michigan Psychiatric Associates; or neurology exam records from Bay Medical Care. The record closed on June 3, 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 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 November 7, 2018, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On February 21, 2019, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 1-6).

3. On March 17, 2019, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit A, pp. 322).

4. On March 25, 2019, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 1b).

5. Petitioner alleged disabling impairment due to chronic groin pain due to hernia bilateral repair, lumbar back pain with degenerative disc disease, breathing problems due to pericarditis and severe depression with panic attacks and hears voices.

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

7. Petitioner is a high school graduate and attended special education classes throughout his education.

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

9. Petitioner has an employment history of work as a retail clerk stocking shelves with merchandise at ██████ and ██████ as well as a ██████████████ as a general laborer.

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 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 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, s/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, *and in response to the interim order,* was reviewed and is summarized below.

The Petitioner's primary care physician completed a DHS-49 Medical Examination Report dated ██████ 2019. The current diagnosis the doctor is treating is due to chronic groin pain resulting from surgery. The doctor noted that Petitioner's groin pain occurred with movement in the lower extremities and also noted that Petitioner was using a cane. The clinical impression was that the Petitioner was in stable condition, and the doctor

imposed the following limitations which she certified were expected to last more than 90 days. The Petitioner could lift/carry less than 10 pounds occasionally. The Petitioner could stand and/or walk less than two hours in an eight-hour workday. The Petitioner could perform simple grasping, reaching and fine manipulating with both hands, however, could not push or pull with either hand/arm. The Petitioner was evaluated as being unable to operate foot/leg controls. She noted assistive devices were not needed, however, noted that the medical findings supporting her physical limitations were based at least in part due to the fact that Petitioner walks with a cane. Mental limitations were also noted which included her observation that Petitioner has difficulty with sustained concentration as well as reading and writing. The Petitioner's doctor has treated Petitioner since ████████ 2018.

Petitioner's surgical history includes an appendectomy and removal of kidney stone (2016), cystoscopy with ureteroscopy with laser, lithotripsy with insertion of stent, herniorrhaphy inguinal laparoscopic unilateral in ████████ 2015, laparoscopy diagnostic right groin exploration with removal of mesh in ████████ 2017. Exhibit A, p. 124.

The Petitioner was seen at the ████████████████ General Surgery Clinic on ██████████ 2017. The reason for the visit was to evaluate bilateral groin pain status post bilateral in inguinal hernia repair. A problem list included severe right groin pain, cubital tunnel syndrome, bilateral, carpal tunnel syndrome, bilateral, low back pain radiating to right lower extremity with bulging lumbar disc at L5-S1 degenerative disc disease of the lumbar spine with positive Hoffman's reflex. The diagnosis was low back pain radiating to right lower extremity. The doctor's treatment notes indicate that Petitioner was counseled due to his complex neurologic system disease based on review of imaging studies, exam findings and scientific basis for the differential diagnosis. The recommendation/plan was to prescribe Neurontin, prescribed Petitioner wear bilateral neutral wrist splints and ordered imaging and diagnostic testing with instructions to apply ice to the lumbar spine location S1, 20 minutes daily. The Petitioner was to return in six weeks and was restricted to no work. A CT of the abdomen/pelvis was conducted on ██████ 2017. The findings noted no consolidation or nodules in the lung bases, 7 mm low density lesion in the posterior right lobe of the liver. Spleen was normal and as were both adrenal glands. There was no mass in the pancreas or inflammatory changes noted. Diverticulosis of left colon without evidence of diverticulitis noted with mild wall thickening involving the mid descending colon with no violent obstruction. There was no abnormal fluid collection in the abdomen or pelvis. The impression was 7 mm low density lesion in the posterior right lobe of the liver and diverticulosis of left: without evidence of diverticulitis.

On ████████ 2019, the Petitioner underwent a Consultative Psychiatric/Psychological Medical Examination arranged by the Department. Throughout his evaluation, the Petitioner presented his thoughts and feelings spontaneously and produce logical and rational responses. He disclosed to the examiner that sometimes when he wakes up, he sees things crawling or people or weird bodies. He also stated he repeats things in

his head all the time and feels he hears voices. He expressed feelings of worthlessness and that he has suicidal ideations all the time. He further stated he has sleep problems and constantly wakes up in the night. Petitioner presented as depressed with a sad affect and described experiencing both visual and auditory hallucinations. At the conclusion of the examination, the diagnosis was major depressive disorder, recurrent episode with psychotic features. The prognosis/medical source statement noted that Petitioner was currently receiving mental health treatment. The examiner noted Petitioner presented depressed with sad affect and described experiencing auditory and visual hallucinations which have increased as his level of depression has increased. He demonstrated adequate understanding of both simple and complex instructions. He demonstrated limited ability to interact appropriately with others due to his level of depression. At this time, his prognosis for improved psychological and adaptive functioning is poor.

On [redacted] 2018, Petitioner was seen in ER for chest pain and shortness of breath. Previous hospitalization for pericarditis and prescribed colchicine. Found to have elevated troponin and stress test performed which was positive and had a heart catheterization that was negative for cardiac abnormalities. Since July, chest pain and shortness of breath have not improved. Chest pain is described as sharp and in the center of his chest radiating to his pectoral muscles. Pain is worse with deep breath. CT of chest showed no signs of infiltrates and appearance of a nodule with no pulmonary embolism and doppler ultrasound negative for DVT. EKG was normal sinus rhythm. At that visit, the notes indicate it is unclear what is causing the patient's chronic shortness of breath and chest pain. Could be related to upper GI and acid reflux. Petitioner was discharged in stable condition. Previously, Petitioner was seen for similar symptoms, shortness of breath; and an x-ray noted normal x-ray of the chest in September 2018. An angiogram of the abdomen and pelvis noted no CTA evidence of acute arterial pathology in abdomen or pelvis. CT of Chest noted no evidence of thoracic aortic dissection or acute pulmonary pathology.

In [redacted] 2018, the Petitioner was seen by his primary care doctor with complaints of hernia area pain even after a second repair on right and removal of mesh on the left. Notes indicate that Petitioner was positive for depression and hallucinations with no substance abuse. Patient was nervous, anxious and has insomnia. The doctor thought chest pain was chest wall pain and referred patient to physical therapy. Notes indicate he received inguinal injections with no improvement. Report of panic attacks and suggest that a beta blocker may help with physical symptoms and reduce blood pressure.

In [redacted] 2018, the Petitioner was admitted to the hospital for acute chest pain. On discharge, the diagnosis was chest pain secondary to anxiety, pericarditis, anxiety disorder Major depressive disorder, insomnia, degenerative disk disease and chronic abdominopelvic pain and gastroesophageal reflux. A stress echo noted borderline LVEF of 50-55%. There was evidence of myocardial ischemia. Catheterization noted only very distal small vessel disease and left ventricular function was normal and

evidence of pericarditis. The Petitioner was discharged home in stable condition. Chronic ongoing abdominal pain was also noted.

The Petitioner also has experienced chest pain and was seen in the ER and for follow-up. At his last exam in August 2018, the notes indicate that his ECG was normal for sinus rhythm, LHS noted no significant coronary artery disease and his Echocardiogram noted normal LVEF 60%-65%. The assessment was atypical, recent diagnosis of pericarditis, acute with treatment of colchicine to relieve pain without any benefits. Degenerative joint disease, anxiety and elevated blood pressure and is taking beta blocker. All the test results were normal. Imdur therapy was recommended to help with blood pressure, if not helpful, and blood pressure is controlled then concluded chest pain not related to cardiac condition but suggested would like to have CTA (tomography angiography) chest result and to rule out aortic aneurysm or lung pathology.

In ██████ 2017, the Petitioner had a CT of abdomen and pelvis, bilateral lower quadrant pain, post hernia surgery with defect of mesh removed and right side remains feels like lump in groin. Impression was normal exam; no hernias are present no nodules or masses or fluid collection is seen.

The Petitioner was seen in ER on ██████ 2017 and by his primary care doctor ████████ 2017 for groin, flank and abdominal pain with a diagnosis of right inguinal pain. He was evaluated as stable. He was seen again on ██████ 2018 for low back pain radiating to right lower extremity, and paresthetica of right side.

The Petitioner currently is seen by Bay Area Behavioral Health. He was seen on ███████ 2019 by a Nurse Practitioner. Reported difficulty sleeping due to pain, with bizarre and vivid dreams about the past and dreams about falling down the stairs. Notes indicate that he has been reluctant to engage in therapy and continues to be very focused on mesh surgery. Patient noted to ambulate with steady gait was dressed and groomed appropriately and somewhat preservative. He reports being somewhat paranoid of healthcare providers. Insight was fair and judgment intact. Medications were reviewed and notes indicate that he has been on psychiatric medicine for over 10 years. Depression has significantly worsened since his work accident two years ago, multiple surgical procedures and inability to work.

In ███████ 2018 Petitioner received targeted case management and received assistance with his SDA application. He receives these services monthly during 2018.

In ██████ 2018, the Petitioner had a periodic review covering ███ 2018 through ██████ 2018. At the time of the assessment, the treatment plan was for him to be seen in his home a minimum of twice per month for 15- to 60-minute durations for purpose of monitoring, and providing guidance. He was depressed during the review because he had lost his SSI appeal. Notes indicate that Petitioner thinks he reads at a 7th grade level.

In ████ 2018, the mental status review noted that his memory was mildly impaired, and affect was mildly inappropriate, ability to learn new skills was mildly impaired, concentration was adequate with no hallucinations with thought content within normal limits. Affect was afraid, depressed, overwhelmed, withdrawn, guarded, worried, and irritable. Speech was pressured. Thought process, orientation, insight and self-direction were within normal limits and ability to engage socially was mildly impaired. Sleep difficulty was noted ability to perform household activities of daily living were moderately impaired as was ability to ambulate. Physical stamina for daily living was severely impaired. No suicidal thoughts expressed. Diagnosis was Major depressive disorder recurrent episode, severe and adjustment disorder with depressed mood. The assessment concluded that as regards personal hygiene, self-direction, ADL's learning and recreation, social transactions and interpersonal relationships were markedly limited. This evaluation is not consistent with the findings for some of these categories and mildly impaired as outlined above. Outpatient therapy and psychiatry were recommended. Exhibit A, p. 269.

At an examination on ████ 2018, Petitioner was diagnosed with major depressive disorder, recurrent episode severe, adjustment disorders with depressed mood. At the time of exam, he was walking with a limp with a steady gait and advised he uses a cane occasionally. Patient's mood was depressed, and affect is appropriate with fair insight with intermittent eye contact. Has thoughts of self-harm with no thoughts of acting on it. Pain level was 5.

Additional records for medical review in ████ ████████ 2018 are consistent in that Petitioner reports depression and pain with difficulty sleeping due to pain and stress regarding health issues and lack of income due to inability to work. During this period, it does not appear that Petitioner is participating in therapy but is seen by a registered nurse for follow-up and medication review.

During the hearing, the Petitioner described needing and relying on assistance from friends with grocery shopping, retrieving store items and carrying groceries into his home and he uses a scooter when he shops because he cannot walk far due to groin pain and uses a cane. In addition, the Petitioner gets help with house cleaning, cannot vacuum or do laundry. The Petitioner eats mostly sandwiches and TV dinners. He receives assistance from friends with lawn care, snow removal and cleaning. Petitioner does visit with a friend once or twice a month. Petitioner also watches TV for several hours daily. He does have trouble sleeping.

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; 12.06 Anxiety and impulse control disorder; 4.04 Ischemic heart disease; 1.02 Major dysfunction of a joint due to any cause; 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, 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. Petitioner testified that he needed assistance from friends with grocery shopping, retrieving store items and carrying groceries into his home and he uses a scooter when he shops because he cannot walk far due to groin pain and uses a cane. In addition, the Petitioner gets help with house cleaning, cannot vacuum or do laundry due to pain. The Petitioner eats mostly sandwiches and tv dinners. He receives assistance from friends with lawn care, snow removal and cleaning. Petitioner does visit with a friend once or twice a month. Petitioner also watches TV for several

hours daily. He does have trouble sleeping. He does not walk far but can walk around his house. He tends to wear sweats so he can dress himself, and he testified that he can stand 5-10 minutes and sit 10 to 30 minutes and then must move and reposition himself. He testified that he uses a recliner to sit because he can't sit at 90 degrees.

Petitioner's primary care doctor who has seen him and treated him since ██████ 2018 completed a Medical Examination Report DHS-49 noting chronic groin pain due to surgery the current diagnosis. She notes Petitioner uses a cane. The Petitioner was evaluated as stable, and had physical limitations expected to last more than 90 days. Per the doctor's evaluation, Petitioner could lift less than 10 pounds occasionally, could not push or pull with either arm and could perform other manipulations with his hands. He could stand or walk less than 2 hours in an 8-hour day and no restrictions were noted for Petitioner's ability for sitting. She noted that Petitioner could not operate foot/leg controls with either leg. In support of the findings for Petitioner's limitations, the doctor noted that patient walks with a cane. The doctor noted that sustained concentration was a limitation based upon her observation and that reading and writing was also limited. Her assessment regarding ADL's was based upon functional information strictly from the patient and not based upon medical findings regarding capacity to meet his needs in the home. In addition, the Doctor did not find that an assistive device was necessary or required in order for Petitioner to ambulate (walk). In addition, although the Petitioner cited degenerative disc disease no testing records were presented to document this condition.

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). The medical records do substantiate that Petitioner is treated with pain medications which seem to control the Petitioner's pain to a level 5. There is no ongoing objective evidence that lends a basis for his abdominal pain other than prior surgeries for hernias. His treating doctor places his limitations at sedentary and finds that he does not require an assistive devise for ambulation, nor does the doctor find that Petitioner needs assistance with activities of daily living. Exhibit B.

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has moderate limitations on his mental ability to perform basic work activities. It is noted that the evidence provided by his mental health care provider does not support that Petitioner is receiving individualized therapy, and his treatment includes case management and medications review. Nothing in the treatment notes indicate that Petitioner's depression is so severe that he cannot work and suggest his inability to

work is based upon the assumption that he physically cannot work. The independent medical examination requested by the DDS also places Petitioner's mental limitations at moderate.

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 consists of work as a working as a retail clerk stocking shelves at [redacted] and [redacted] and general labor work for [redacted]. Petitioner's work as a store clerk, which required standing much of the day and lifting up to 10-25 pounds regularly, sometimes up to 50 pounds on occasion, required light physical exertion.

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. Petitioner also has moderate limitations in his mental capacity to perform basic work activities. In light of the entire record, it is found that Petitioner's exertional 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).

When a person has a combination of exertional and non-exertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination **unless** there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969a(d).

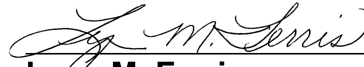
In this case, Petitioner was ██ years old at the time of application and ██ years old at the time of hearing, and thus, considered to be a younger individual (age 45-49) for purposes of Appendix 2. He is a high school graduate with a history of work experience as a store clerk shelving products and a general labor which is unskilled work. 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, 201.18, result in a finding that Petitioner is not disabled. It is also determined that Petitioner's non-exertional limitations moderately limit his ability to perform basic work activities and thus, do not support a finding that Petitioner is disabled on the basis of his mental impairments.

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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

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

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

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

DHHS

Kim Cates
MDHHS-Bay-Hearings

Petitioner

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

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