[redacted]

Date Mailed: August 9, 2019
MOAHR Docket No.: 19-004890
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Zainab A. Baydoun

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 June 12, 2019, from Detroit, Michigan. Petitioner appeared for the hearing with his son, [redacted] and represented himself. The Department of Health and Human Services (Department) was represented by [redacted], Family Independence Manager.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records, specifically, his updated medical records from his primary care physician and records from his May 2019 ear surgery. There were no additional records submitted to the undersigned Administrative Law Judge (ALJ) by the July 12, 2019 deadline identified on the Interim Order. The record was subsequently closed on July 12, 2019 and the matter is now before the undersigned for a final determination on the evidence presented.

ISSUE

Did the Department properly determine 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 or around June 11, 2018, Petitioner submitted an application for cash assistance on the basis of a disability.

2. On or around February 7, 2019, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. The DDS determined that Petitioner was capable of performing other work. (Exhibit A, pp. 4-10)

3. On February 13, 2019, the Department sent Petitioner a Notice of Case Action denying his SDA application based on DDS' finding that he was not disabled. (Exhibit A, pp. 1-2)

4. On May 13, 2019, Petitioner submitted a written Request for Hearing disputing the Department's denial of his SDA application.

5. Petitioner alleged physically and mentally disabling impairments due to back, shoulder, and knee pain; cervical spondylosis; nerve issues; osteoarthritis; migraines; loss of balance; hearing loss; depression; and anxiety.

6. As of the hearing date, Petitioner was [redacted] years old with a February 21, [redacted] date of birth; he was [redacted] and weighed [redacted] pounds.

7. Petitioner obtained a GED and has reported employment history of work as a maintenance worker, customer service representative, a satellite installer, and a construction laborer. Petitioner has not been employed since November 2016.

8. Petitioner has a pending disability claim with the Social Security Administration (SSA).

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.

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (April 2017), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has

the residual functional capacity to perform past relevant work; and (5) has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If an individual is found disabled, or not disabled, at any step in this process, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled at a particular step, the next step is required. 20 CFR 416.920(a)(4).

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

Step One

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

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

Step Two

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

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity

to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

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

The medical evidence presented at the hearing and in response to the interim order was thoroughly reviewed and is briefly summarized below:

On January 25, 2019, Petitioner participated in a consultative physical examination, during which she reported that his chief complaints were neck pain, lower back pain, knee pain, left shoulder pain, headaches and hearing loss. Petitioner reported undergoing arthroscopic surgery to his left knee two years prior as well as surgical treatment for his cervical spine and 2013. He also reported surgery on at least two occasions to his left shoulder arthroscopically, reported participating in physical therapy, difficulty with climbing ladders, reaching overhead, shoveling snow, and standing or walking more than 30 minutes. Petitioner reported daily headaches since adolescence with occasional aura, concomitant photophobia and phonophobia without nausea and emesis and no emergency room visits or hospitalizations in the last year. With respect to his hearing loss, Petitioner reported past surgery for cholesteatoma, as well as tympanostomy tubes placed. Intermittent vertigo was also reported. Physical examination showed normal intensity, clarity, and sustainability of speech without stutter. He was able to hear conversational speech at 4 feet. He was observed to walk with a slightly small step gait with a mild limp on the left side. An assistive device was not used at the time of the examination. Musculoskeletal examination showed no joint instability, enlargement, or effusion. Grip strength was intact, Jamar Dynamometer testing revealed compressions of 108 pounds in the right hand and 86 pounds in the left hand, dexterity was unimpaired. Petitioner was able to pick up a coin, button clothing,

and open the door. He had no difficulty getting on and off the examination table, no difficulty heel & toe walking, and mild difficulty squatting. Motor strength and function were normal, sensory function was intact and there was no shoulder girdle atrophy or spasm. Romberg testing was negative. The examining doctor made the following conclusions: there was no overt evidence of ongoing nerve root impingement with respect to the neck and lower back, there did not appear to be evidence of active synovitis involving the smaller joints, atrophy was not apparent around the shoulder girdles, grip strength was well maintained, due to the discomfort and the left knee, he was known to walk with a mild limp on the left side and a small step gait, she has some degree of difficulty with squatting secondary to knee discomfort. A cane was brought to the examination, however, Petitioner appeared to be able to ambulate without the use of such, one might be a benefit for distances past 100 to 200 feet or on uneven surfaces. Additional conclusions included: Petitioner was able to hear conversational speech at 4 feet, headaches suggestive of mixed migraines and likely analgesic withdrawal headaches, as the neurological examination was within normal limits. (Exhibit A, pp 279 – 283)

On February 4, 2019, Petitioner participated in a consultative mental status examination and the examiner completed a psychiatric/psychological report. During the examination, Petitioner reported that he is depressed and angry. He indicated that he had some masses removed from his head in 2018 and now must have reconstructive surgery done before he is able to use hearing aids. He stated that he started falling and was losing his balance about a 1 ½ years ago which led to a CAT scan and the discovery of the masses. In October 2017 he requested time off from work to have knee surgery and at the time was working as a maintenance person at an apartment complex. He reported having bad arthritis in his spine and back pain, as well as, trouble getting to sleep and staying asleep due to pain. He reported no recent medical or psychiatric hospitalizations and stated that he currently sees an outpatient psychotherapist biweekly and is prescribed medications for his mental health conditions. Petitioner reported that he does his own dishes and laundry, that he showers and dresses himself, but does no other household chores. Petitioner was observed to walk with a cane and his posture was normal. His attitude/behavior was assessed as follows: he was oriented with reality, he had low self-esteem, he stood up once to stretch during the examination, he did not exaggerate or minimize the symptoms, and his insight was fair. His stream of mental activity was spontaneous, but it was not blocked, illogical, vague, slowed, and he had no pressure of speech. His judgment was poor, and his concentration was good. He denied hallucinations, delusions, delusions, persecutions, obsessions/compulsions, denied suicidal ideations, intent, and attempts but expressed feelings of worthlessness. His emotional reaction was tearful, depressed, and angry, and his affect was flat. Petitioner was diagnosed with major depressive disorder – recurrent – without psychosis and nicotine dependence. He was also diagnosed with migraines, spondylosis, status post multiple surgeries, hearing loss, occupational social health and financial problems. His GAF score was 55 and his prognosis was guarded. (Exhibit A, pp. 260-265)

Petitioner's treatment records from [redacted] were presented and reviewed. (Exhibit A, pp. 285- 314, 410 – 434). During a September 14, 2018 visit, Petitioner reported back and arm pain. It was noted that he had initial spine surgery in 2001 when a 32-foot extension ladder fell onto his shoulder, facet injections in 2003 without any relief, and spinal fusion surgery in 2012/2013. It was noted that Petitioner had been previously addicted to opiates and did not want to be prescribed any opiates. He reported chronic neck pain and left arm pain which limits his ability to move his head, as well as frequent falls due to dizziness that is related to his inner ear. Records indicate that range of motion to the left shoulder was limited, as Petitioner was unable to raise his arm above 90°. Range of motion was also limited on the right lateral rotation. A referral to neurosurgery was made. On June 21, 2018, Petitioner was treated for recurrent severe migraine with associated symptoms of blurred vision, dizziness, photophobia, and vertigo. A Patient Health Questionnaire (PHQ -9) was completed and resulted in a score of 26 for severe depression. Records indicate that he had been receiving treatment for chronic pain of the left knee, severe episodes of recurrent major depressive disorder without psychotic features, and persistent migraines with aura. During a May 10, 2018 visit, Petitioner complained of migraines and ear infections since his ear tubes were inserted. He reported that he continues to get migraines, that they are getting worse, that the occipital area of his head is affected, and he gets very dizzy and nauseous. He also reported symptoms of vertigo and loss of balance which resulted in two falls over the last six months, one of which caused a fracture of his left wrist. It was noted that he does use a cane for stability and assistance. Records indicate that Petitioner suffers from tension headaches, vertigo, muscle weakness in the left and right lower extremities, and loss of balance. Notes show that he had weak knee muscles and moderately reduced range of motion to the right knee. An MRI of the head was ordered. Petitioner was treated during more than one visit for complaints of musculoskeletal pain with and associated throbbing, pain aggravated by pushing and walking, joint instability, joint tenderness, limping, popping and weakness of the left knee, ear infections, ear drainage, and his depression. In August 2017, Petitioner's left knee had tenderness, and moderate pain with range of motion, palpation of medial meniscal area was noted as was pain with abduction of lower leg and knee extension. An x-ray performed on August 14, 2017 showed the bony structures of the knee maintaining normal alignment without evidence for fracture or dislocation. The joint spaces were well maintained, there was no calcific intra-articular loose body or supra-patellar knee joint effusion. No focal bony destructive process or periostea reaction were found. A December 2017, surgical pathology report following a left knee arthroscopic procedure showed meniscus with the degenerative change in benign synovium, has numerous fragments of meniscal tissue were present joint degenerative changes. He was diagnosed as having a torn medial meniscus of the left knee. (Exhibit A, pp.410 – 434)

A September 2017 MRI showed a tear of the left posterior medial meniscus and Petitioner underwent an arthroscopic knee surgery and torn medial meniscus repair of the left knee on December 13, 2017. During a January 18, 2018 follow-up appointment at [redacted], Petitioner reported mild postoperative pain and persistent weakness which was present preoperatively in the left

knee and has remained unchanged. Petitioner reported that the medial pain has changed to an achy pain instead of the sharp pain that it was prior to surgery. He reported that the lateral aspect of the knee is not bothering him, stating that it feels like a sharp burning muscle pain and that he is concerned about the knee buckling. He reported feeling he's going to hyperextend his knee and when out on uneven surfaces, uses a cane to walk. Physical examination showed tenderness to palpation of the knee with no swelling, range of motion was active flexion and extension full and painless with no evidence. There was no instability, his strength was improving, all tests for stability were normal. His lower leg had no tenderness, no swelling, no deformities and all other examined systems were normal. After examination, it was noted that Petitioner's knee had improved and that he should continue to work on strengthening it. A one month follow-up was ordered. (Exhibit A, pp. 359-369,435-437, 441-448)

On April 20, 2018, Petitioner underwent bilateral tympanostomy with ventilation to placement due to middle ear fluid in both ears and conductive hearing loss. Operative notes indicate that Petitioner had right ear 20% myringosclerosis, no middle ear effusion and left ear severely thickened hyperemic TM with serous middle ear effusion. (Exhibit A, pp. 275-277, 467-485)

Records from his treatment with [redacted] were presented and reviewed. In March 2018, Petitioner presented with complaints of hearing loss in both ears, ear ache in his left ear, that his left ear feels full, that there is discharge from his ears, foul smelling discharge from his ears, popping noises in his ears, tinnitus occurring intermittently in his left ear, and vertigo with difficulty balancing requiring the use of a cane. After examination, Petitioner was assessed as having conductive hearing loss of both ears, cerumen impaction in the right ear, chronic serous otitis media of both ears which is inadequately controlled and temporomandibular joint pain dysfunction syndrome leading to ear pain and fullness. Results of a May 14, 2018 pure tone audiometric test showed speech reception threshold (SRT) testing at 45 decibels (dB) on the right and 55 dB on the left. The word recognition/word discrimination testing showed 100% at 80 dB on the right and 100% at 85 dB on the left. (Exhibit A, pp. 275-277, 315-318, 324-375-383, 396- 404, 467-485)

Petitioner underwent an MRI of his brain on June 7, 2018, which showed no abnormal enhancements or masses. There was fluid/debris within the bilateral mastoid air cells including material with enhancement and diffusion restriction in the left mastoid antrum and aditus at antrum. While these findings may represent proteinaceous contents from chronic infection/inflammation, a temporal bone CT was recommended to evaluate integrity of the bony structures. There was a mildly expansile T2 hyper intense structure within the left posterior ethmoid air cells, raising the possibility of mucocele, also requiring additional evaluation through temporal CT. Patchy signal abnormalities within the supratentorial white matter was nonspecific. In this patient with history of smoking, this finding may represent mild chronic small vessel ischemic changes or other possibilities such as sequela of chronic migraine headaches or residuals of a prior infectious/inflammatory process could have similar findings. (Exhibit A, pp. 275-277, 315-318, 324-375-383, 396-404, 467-485)

A July 9, 2018 CT scan of Petitioner's temporal bone showed extensive bilateral cholesteatomas, with bilateral ossicular destruction. The right malleus and bilateral stapes appeared present, however, the remaining bilateral ossicles were essentially completely destroyed. The left tympanostomy tube was occluded and the right was patent. There was partial coalescence of the left mastoid air cells and apparent patchy dehiscence of the bilateral tegmen mastoideum. Mildly expanded, opacified left posterior ethmoid air cell with dehiscence of the lateral wall/lamina papyracea likely representing a chronic mucocele was also noted. (Exhibit A, pp. 275-277,315-318, 324-375-383, 396 – 404, 467-485)

In November 2018, Petitioner was diagnosed with bilateral eustachian tube dysfunction, right retracted tympanic membrane with left conductive hearing loss with erosive cholesteatoma causing dizziness and hearing loss, and purulent otorrhea of the left ear secondary to cholesteatoma. He underwent a left canal wall down tympanomastoidectomy, fascia grant through a separate incision from the temporalis muscle, reconstruction of the external auditory meatus, and a 22 modifier on the tympanomastoidectomy canal wall down. Notes/records indicate that Petitioner has chronic drainage in his ears with conductive hearing loss and recent dizziness, and vertigo. A CAT scan showed an erosive cholesteatoma with complete erosion of the ossicular chain. The recommendation was the canal wall down tympanomastoidectomy for extirpation of disease with possibly a second look in six months to reconstruct the hearing based upon how the first surgery went. Operative notes indicate that inter-operatively, it was discovered that Petitioner had a large 4 mm lateral canal fistula with cholesteatoma eroding into the lateral canal and the facial nerve was dehiscent in the tympanic segment, supporting the decision to use a 22 modifier. (Exhibit A, pp. 275-277, 315-318, 324-375- 383, 396-404, 467-485)

Petitioner was receiving mental health treatment for his diagnosis of major depressive disorder, recurrent, moderate through [redacted] and records were presented from his April 2018 to July 2018 visits with [redacted] MA, LLP. (Exhibit A, pp. 487-513). During his initial intake appointment on April 30, 2018, Petitioner reported that he comes to counseling because he feels miserable. He indicated that he has had knee surgery, ear surgery, back surgery, spinal surgery, two shoulder surgeries, that he has water on his brain, and has had a few falls as a result of dizzy spells. Petitioner reported a history of addiction to opiates and that he has been clean for six months. His mood was assessed as being depressed and anxious, his affect was full, his speech was clear, his thought process was logical, he denied hallucinations, and his perception, thought content, cognition, insight and judgment were within normal limits. There were no delusions reported and his intelligence estimate was average. Petitioner reported having suicidal ideations however, he also indicated that his boys are what keeps him going in life. The interpretive summary indicates that Petitioner was encouraged to stay away from antianxiety medications and to work on life in a more natural way. It was noted that he is depressed, lonely, isolated, overwhelmed, suffers from crying spells, feels lost and as if he has lost the most important things in his life. His GAF score was 65. In May 2018, there were no

significant changes to Petitioner's assessment and he had made minimal progress. He again denied hallucinations, delusions, and suicidal ideation, plan, intent and/or attempt. It was noted that Petitioner is an angry person, that he feels angry at the legal system, people around him, and has little joy in his life. He reported an inability to work due to his physical and mental conditions. It was noted that Petitioner was labile with tears when talking about his father and angry when talking about the legal system. Notes from his June 2018 visit indicate that Petitioner is very much a pessimist, that he sees the world in a negative way, that he is angry at his neighbor and does rebel against authority. He was observed to use a walking stick to assist with ambulation and felt that his health-related problems have taken away the quality of his life. He indicated he was a builder and now that he has physical limitations, his health problems have taken away his identity and self-worth. He struggles emotionally and feels overwhelmed with no income, few friends, and physical limitations. Similar findings and assessments were made throughout the duration of Petitioner's treatment. (Exhibit A, pp. 487-513)

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 physical and mental impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step Three

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

Based on the medical evidence presented in this case, listings 1.02 (major dysfunction of a joint(s) due to any cause, 1.04 (disorders of the spine), 2.07 (disturbance of labyrinthine – vestibular function), 2.10 (hearing loss not treated with cochlear implantation), 12.04 (depressive, bipolar and related disorders), and 12.06 (anxiety and obsessive-compulsive disorders) were considered. A thorough review of 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). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). In addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of mental functional limitation. 20 CFR 416.920a(c)(3). The degree of limitation for the first three functional areas is rated by a five-point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). A four-point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. Id. The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. Id.

In this case, Petitioner alleges both exertional and nonexertional limitations due to his medical conditions.

Petitioner testified that he is able to walk for only five minutes then needs to sit down due to pain in his back, hip, left knee and ankles. He stated that his knees buckle and that he requires the use of a cane on a daily basis to assist with ambulation. He reported that he is able to sit for only 30 minutes before needing to readjust positions, lie down, or stand. He testified that he can stand for at most 10 to 20 minutes and that he is unable to bend or squat due to left knee pain. He reported that he is able to lift a gallon of milk with his right hand but is unable to do any lifting with his left hand. Petitioner testified that he is unable to grip or grasp items with his left hand, as he has no grip strength which is related to nerve issues and resulting from an injury to his left arm in years prior. Petitioner reported that in 2013 he had a spinal fusion surgery to his cervical and thoracic spine and since that time has had upper and lower back pain. He reported a history of two shoulder surgeries on his left shoulder and one knee surgery, all of which have been unsuccessful, as he continues to report constant pain. Petitioner stated that he has been diagnosed with osteoarthritis in all his joints. Petitioner testified that he has had to make some modifications to the bathroom in the home he shares with his mother, including a higher toilet seat. Petitioner stated that he is able to bathe himself without assistance, however, the hot water causes dizziness. He stated that he is able to dress himself in a seated position but is unable to use zippers or buttons. Petitioner reported that his mother performs most of the household chores and cooking in the home, but he tries to assist with laundry when he is able. He stated that he goes shopping with his mom and son because he is unable to drive due to his medical conditions including vertigo. Petitioner testified that he suffers from migraines on a daily basis and has balance issues which were reportedly related to problems with his middle/inner ear.

With respect to his nonexertional/mental impairments, Petitioner testified that he has been diagnosed with depression and anxiety for which he receives medication treatment and counseling for the last year. He testified that he is unable to be around

people and that he suffers from panic attacks daily, which include symptoms of difficulty breathing and loss of oxygen. Petitioner stated that he has difficulty concentrating for more than a few minutes at a time, that he has problems with his memory in particular, remembering new information. He stated that he suffers from crying spells daily lasting hours, and that he has verbal anger outbursts on a continuing basis. Petitioner reported thoughts of hurting himself on a daily basis but denied thoughts of hurting others. He stated that his depression has affected his appetite and social interaction. Although he reported auditory and sometimes visual hallucinations, this was not supported by the medical evidence in the record. Petitioner testified that he is unable to bend or squat, and as referenced above, has difficulty gripping and grasping items with his left hand in particular. He also reported that he is unable to reach due to his shoulder impairment. Petitioner further testified that he has 80% hearing loss in both ears and has had multiple surgeries which have been unsuccessful. It is noted that Petitioner had difficulty hearing the undersigned ALJ's questions during the hearing.

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.

The evidence presented is considered to determine the consistency of Petitioner's statements regarding the intensity, persistence and limiting effects of his symptoms. Based on a thorough review of Petitioner's medical record and in consideration of the reports and records presented from Petitioner's treating physicians, some of which are referenced above, and which document among other things, decreased range of motion in the knee, decreased cervical range of motion in flexion, extension, bilateral lateral flexion and bilateral rotation, decreased shoulder range of motion bilaterally and abduction, exertional rotation and forward elevation, 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). However, Petitioner is unable to perform the full range of sedentary work thus, the occupational base is eroded by his additional limitations or restrictions. SSR 96-9p.

Based on the medical records presented, Petitioner has moderate to marked limitations on his non-exertional ability to perform basic work activities, with respect to performing manipulative or postural functions of some work such as gripping, reaching, handling, stooping, climbing, crawling, or crouching. The medical evidence reviewed also supports the conclusion that Petitioner has nonexertional impairments relating to his ears and suffers from hearing loss that requires further treatment.

The medical records presented show that Petitioner had been diagnosed with and was receiving mental health treatment for depressive disorder and anxiety. Based on the medical evidence presented, as well as Petitioner's testimony, it is found that Petitioner

has mild to moderate limitations on his mental ability to perform basic work activities and in his activities of daily living, social functioning, and in his concentration, persistence or pace.

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

Step Four

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

Petitioner's work history in the 15 years prior to the application consists of employment as a maintenance worker, customer service representative, a satellite installer, and a construction laborer. Upon review, Petitioner's prior employment is categorized as requiring light to heavy exertion. Based on the RFC analysis above, Petitioner's exertional RFC limits him to only sedentary work activities. Because Petitioner is unable to perform past relevant work, he 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).

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

In this case, Petitioner was [redacted] years old at the time of application and hearing, and thus, considered to be a younger individual (age 45-49) for purposes of Appendix 2. He obtained a GED and has semi-skilled work history that is nontransferable. 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, however, as referenced above, the occupational base is eroded by additional limitations or restrictions. Thus, based solely on his exertional RFC, the Medical-Vocational Guidelines, result in a finding that Petitioner is not disabled.

However, as referenced above, Petitioner also has nonexertional impairments imposing additional limitations. As a result, and based on the evidence presented, he has a nonexertional RFC imposing moderate to marked limitations in his ability to perform basic work activities, with respect to performing manipulative or postural functions of some work such as gripping, reaching, handling, stooping, climbing, crawling, or crouching, as well as hearing loss. He also has mild to moderate limitations on his mental ability to perform basic work activities and in his activities of daily living, social functioning, and in his concentration, persistence or pace. The Department has failed to present evidence of a significant number of jobs in the national and local economy that Petitioner has the vocational qualifications to perform in light of his RFC, age, education, and work experience. Therefore, the evidence is insufficient to establish that Petitioner is able to adjust to other work. Accordingly, Petitioner is found disabled at Step 5 for purposes of the SDA benefit program.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner disabled for purposes of the SDA benefit program.

DECISION AND ORDER

Accordingly, the Department's SDA determination is **REVERSED**.

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE THE ORDER WAS ISSUED:

1. Reregister and process Petitioner's June 11, 2018 SDA application to determine if all the other non-medical criteria are satisfied and notify Petitioner of its determination;

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

3. Review Petitioner's continued eligibility in June 2020.

ZB/tlf

Zainab A. Baydoun
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

Via Email:

[redacted]

Petitioner – Via First-Class Mail:

[redacted]