[redacted]

Date Mailed: July 23, 2019
MOAHR Docket No.: 19-005441
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 24, 2019, from Detroit, Michigan. Petitioner appeared for the hearing with his wife, [redacted] and represented himself. The Department of Health and Human Services (Department) was represented by [redacted], Lead Worker.

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 January 7, 2019, Petitioner submitted an application for cash assistance on the basis of a disability.

2. On or around March 12, 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. 30-55)

3. On March 26, 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. 3-6)

4. On April 30, 2019, Petitioner submitted a written Request for Hearing disputing the Department's denial of his SDA application.

5. Petitioner alleged physical and mental disabling impairments due to Fournier's gangrene, arthritis, COPD, hepatitis C, and depression.

6. As of the hearing date, Petitioner was [redacted] years old with an October 16, [redacted] date of birth; he was [redacted] and weighed [redacted] pounds.

7. Petitioner completed high school and obtained a diploma. Petitioner has reported employment history of work as: a bus driver, heavy equipment operator, a welder, a construction laborer, and a small engine mechanic. Petitioner has not been employed since September 2018.

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 was thoroughly reviewed and is briefly summarized below:

A June 6, 2018 CT of the lumbar spine showed asymmetric loss of vertebral body height on the right side of the L5 vertebral body. There was diffuse mild disc space narrowing and mild/moderate anterior spurring. Moderate facet hypertrophy was seen, most significantly at L4 – L5 and L5 – S1. There were congenital abnormalities of the right L5 – S1 facet joint with hypoplastic right facet that is jumped anteriorly to the S1 facet, which appears chronic. Mild levoconvex curvature in the lumbar spine was noted. CT of the cervical and thoracic spine performed on the same date showed that the vertebral body height is maintained, aside from congenitally fused C6 and C7 vertebral bodies and posterior elements. There is an S shaped scoliosis in the cervical spine and severe disc space narrowing at C3 – C4 and C5 – C6. Mild facet hypertrophy was seen throughout the cervical spine. Dependent opacity in the right upper lobe, most likely representing atelectasis was seen, as was mild carotid calcification. (Exhibit A, pp. 1084-1089)

Petitioner participated in a consultative physical examination on January 11, 2019, during which he reported developing acute cellulitis gangrene in the left testicular area in September 2018. Petitioner reported sustaining a slip and fall injury resulting in an abrasion on the left buttock cheek that subsequently migrated into the soft tissue and developed cellulolytic disease that migrated to the scrotum. He underwent emergency surgery due to progressive fatigue, fevers, and rigors. He underwent extensive surgical debridement of the perineal area and antibiotic therapy and was reportedly hospitalized for six weeks. Since that time, he has complaints of chronic pain in the left groin and scrotal area and reported having further surgery due to scarring that has formed over the scrotum and the associated discomfort. Physical examination showed a 6-inch incision over the groin area, that Petitioner appeared mildly dyspneic, that moderate bronchial breath sounds and prolonged expiratory phases were noted, and that he had tenderness in the peri-incisional area in the perineal and scrotal area. Range of motion

studies were normal, and no abnormalities were noted in Petitioner's musculoskeletal system. Petitioner was observed to walk with a wide based gait and a mild limp on the left without the use of an assistive device. The doctor concluded that Petitioner was diagnosed with gangrene and there were no findings of active cellulolytic disease. Petitioner had difficulty doing orthopedic maneuvers mostly because of pain in the groin and because of such, he compensates with a wide based gait and a mild left limp but appears stable enough to not need an assistance device. Although there did not appear to be any infectious disease ongoing, it was noted that Petitioner will require further surgical intervention to relieve the scarring. It was noted that Petitioner appeared mildly dyspneic and has findings of emphysematous disease for which he should follow up with his primary care physician for inhaler therapy.

Records documenting Petitioner's September 2018 through October 2018 hospitalization, surgeries and treatment at [redacted], and [redacted] were reviewed. (Exhibit A, pp. 366-700). On or around September 12, 2018 Petitioner underwent emergent incision and debridement surgery to his scrotum and penis due to his Fournier's gangrene diagnosis and necrotic tissue. Due to the extent of the wound and Petitioner's pain, it was impossible to evaluate the tissue in the deepest portions of the wound outside the operating room. Thus, Petitioner underwent a second procedure under general anesthesia consisting of a perirectal debridement and perineal dressing change in the operating room on September 14, 2018, during which additional necrotic tissue was removed. On September 17, 2018, a third procedure was performed on Petitioner, during which the perineal and perirectal wounds were evaluated and found to have small amounts of necrotic tissue in the scrotal portion of the wound that needed to be removed, and wound VAC placement was completed. A similar procedure was performed on September 20, 2018. Petitioner remained in the hospital for continued treatment of the condition for several weeks, after which Petitioner returned to the hospital with complaints of worsening redness, warmth, discharge, and bleeding of the wound, with suspicions of infection. Petitioner was readmitted for treatment. (Exhibit A, pp. 366-700).

Office visit notes from Petitioner's appointments at the [redacted] show that on December 4, 2018, Petitioner presented for follow-up after emergency department treatment of diverticulitis. It was noted that he recently had his pulmonary function tests completed, results of which showed moderate obstruction with significant improvement after bronchodilator. Petitioner was instructed to use Qvar and albuterol daily as needed. Results of a December 3, 2018 complete pulmonary function test (PFT) were included with the records reviewed. Petitioner complained of occasional migraines located on the left posterior side of his head and behind his left eye which are associated with photosensitivity and nausea. (Exhibit A, pp. 312-331). On December 11, 2018, he presented for chronic left sided groin pain and left testicular and scrotal discomfort after Fournier's gangrene and prolonged hospitalization. Petitioner reported increased anxiety and depression due to chronic medical issues and being placed on Wellbutrin twice daily which has caused an increase in tremor, overall shakiness, and insomnia. He reported a recent suicide attempt for which he is under the care of the psychiatry department. Increase in scrotal and testicular discomfort with movement and

walking were noted. Physical exam of the genital area revealed both testicles to be descended without mass or swelling. There was no evidence of any scrotal hydrocele noted. Extensive scarring on the left side of the scrotum that extends from the base of the penis all the way to the perineum was observed and moderate tenderness to palpation of those areas was noted. There was no evidence of any active wound, erythema, warmth, or drainage. There was no evidence of recurrence of infection, however, records indicate that Petitioner had extensive scar tissue and residual pain. Petitioner was diagnosed with Fournier's gangrene of the scrotum, hypertension, moderate episode of recurrent major depressive disorder, and migraines. (Exhibit A, pp.223-229)

Petitioner was evaluated by Dr. [redacted] of the urology clinic at the [redacted] on January 4, 2019, with complaints of painful scarring in the scrotum to perineum. Much of the physical examination had normal findings, with the exception of a thick band of painful and chronic tender scarring in the left hemi scrotum towards the perineum. Petitioner was referred to Dr. [redacted] for evaluation and possible excision/revision and to the pain management clinic.

Petitioner was evaluated by the hepatology clinic at the [redacted] on January 4, 2019. Records indicate that Petitioner was screened for hepatitis C in November 2018 and had a positive HCV Ab and HCV RNA. Liver enzymes from December 2018 indicated ALT 16 AST 20, ALP 83. It was noted that in 2018, he had an inpatient psychiatric admission for a suicide attempt which Petitioner related to his use of the medication Chantix. Additional testing regarding his hepatitis C diagnosis was to be performed including a fiber scan, and genotype testing. Records indicate that prior to ordering treatment, the doctor wanted to ensure that Petitioner was not requiring frequent procedures or hospitalizations.

Petitioner's records from [redacted] were presented for review and show that on January 11, 2019, Petitioner was evaluated by a social worker due to decreased mood resulting from his chronic medical conditions which have made his social situation more difficult. His PHQ-9 score was 17. During the appointment, Petitioner reported that his health has always been good until September 2018 and since that time he has spent significant amount of time in the hospital and has not been able to work. Petitioner reported that he is not currently suicidal, however, he had a suicide attempt just a few months ago following the initiation of medication which he had never taken before. Progress notes from Petitioner's visit with Dr. [redacted] on January 11, 2019, indicate that he has a medical history which included diagnosis of Fournier's gangrene, COPD, depression, and hepatitis C. Petitioner reported continuing severe pain along the left scrotal scar from his previous Fournier's gangrene infection several months ago. This persistent pain over his scar was due to poor wound healing. His pain had been improving but now seems to be getting worse. He reported that it hurts to walk or to sit for long periods of time. He denied any drainage but sometimes notices a smell. It was noted that Petitioner was referred to a urology specialist and to a doctor for possible scar excision and revision surgery. A referral to pain management was also made. Petitioner complained of a productive cough for the last three weeks but denied any

shortness of breath or chest pain. He was using Qvar and albuterol daily. It was noted that Petitioner was seen by the hepatology department regarding his chronic hepatitis C and was scheduled for a liver elastography in February, as they wanted to hold off on starting treatment until Petitioner no longer needs any further surgeries for his Fournier's. (Exhibit A, pp. 223-227)

On January 14, 2019, Petitioner presented to the pain management department for evaluation and treatment/pain management options due to scar pain after the Fournier's/left hemi scrotal incision. Petitioner reported that his pain is along the scar to his scrotum, that it is worse with walking and climbing stairs and that he sleeps with a pillow between his legs to avoid compressing the testes/scrotum. Records indicate that in September 2018, Petitioner underwent incision and debridement of scrotum/penis, perirectal area and perineum with Dr. [redacted] in [redacted]. Examination showed large left scrotal scar, + bilateral scrotal hyperesthesia, and hyperesthesia to the penis. It was noted that Petitioner's pain was likely to be neuropathic rather than urologic in origin, especially given the hyperesthesia. (Exhibit A, pp. 227-230)

On January 21, 2019, Petitioner was evaluated by Dr. [redacted] and reported that his scrotal and perineal pain has been present ever since he underwent debridement for Fournier's gangrene in September 2018. Petitioner reported that his pain is a constant ache that is localized in the perineum and the left scrotum however he has generalized perineal and scrotal pain as well. The pain is worse with sitting and with activity. Petitioner reported having decreased stream and split stream, but denied prior history of UTI, prostatitis, urgency, frequency, or retention. Based on the examination, the doctor indicated that surgical intervention (which would consist of left orchiectomy and scar excision) does not seem likely to resolve his pain. Given Petitioner's prior lack of tolerance/response to neuropathic medications, it was recommended that he be referred to the pain clinic for further evaluation and pain management with possible treatment of a nerve block. If Petitioner continued to have persistent pain despite maximal medical therapy, surgical intervention would be considered. (Exhibit A, pp. 230-234)

Petitioner participated in a consultative Psychiatric/Psychological Medical Evaluation on March 4, 2019, during which he reported struggling with constant pain in his crotch due to gangrene which results in pain while walking, standing, sleeping, or sitting too long. He reported struggling from depressive symptoms that have been present for five months since the beginning of his illness. Since his disease, he has lost everything, including his home and his vehicles. He denied feelings of worthlessness but is devastated because he is unable to work Petitioner denied previous psychiatric hospitalizations or mental health treatment. Petitioner was observed to walk with a normal posture and gait, his mood was depressed, mannerisms were cooperative, and he appeared to be in contact with reality. His thoughts were spontaneous and well organized and there were no problems in pattern or content of speech. He denied the presence of any auditory or visual hallucinations, delusions, obsessions, persecutions, or unusual powers. He denied feelings of worthlessness or suicidal ideations, reported that there have been no fluctuations in his weight over the past year, and that his sleep

patterns are restless due to pain. Throughout the evaluation, his emotional reaction appeared depressed. Petitioner was unable to perform serial seven calculations. Results of the mental status examination revealed no abnormalities in his mental capacity. However, at the time, he was found to be struggling with depression related to his current medical problems, the resulting physical limitations, the loss of his job, vehicle and home. It was noted that he is able to relate and interact well with others, including coworkers and supervisors. His ability to understand, recall, and complete tasks and expectations did not appear to be significantly impaired in his ability to maintain concentration was good. It was further noted that Petitioner's limitations are largely due to his physical issues. Petitioner was diagnosed with adjustment disorder, with depressed mood as he struggles with ongoing medical issues including joint pain and his condition is further complicated by unemployment and subsequent financial hardships. His prognosis was determined to be fair. (Exhibit A, pp. 208 – 211)

Records from Petitioner's November 12, 2018 through November 16, 2018 inpatient hospitalization at [redacted] were presented and reviewed. (Exhibit A, pp. 234-269). Records indicate that Petitioner presented to the emergency room after a suicide attempt. Petitioner turned on his car in the garage and attached the hose from the exhaust pipe to the cracked open window and tried to commit suicide by suffocating himself. He was found in time by his wife. Petitioner's past surgical history was noted and included: debridement and wound vac placement, hernia repair, incision and debridement of scrotum/penis, perirectal area and perineum, incision and drainage of wound, wound debridement, and wound vac change all of which were performed in September 2018. Notes indicate that Petitioner was surgically treated for Fournier gangrene in September 2018, and that the wound had just healed about a week ago but opened up again and started bleeding after a fall. Petitioner complained of pain in the scrotal area and bleeding. Physical examination showed a bleeding open wound on the scrotum. The scrotal exam completed by the consulting urologist showed an area of granulation tissue in the median raphe of the scrotum and perineum. There was no infection noted. Petitioner was diagnosed with sepsis, COPD exacerbation, Fournier's gangrene, soft tissue infection, and bleeding from wound in scrotum. There was no need for surgical intervention noted. A psychiatry consultation was completed by Dr. Cao on November 13, 2018, during which Petitioner reported that he was drunk, and he put a hose in his car exhaust pipe and tried to suffocate himself. This was Petitioner's first reported suicide attempt and there was no evidence that he had prior inpatient psychiatric treatment. Petitioner was very upset and focused on leaving the hospital, as he had multiple complaints regarding [redacted] and [redacted] His mood was upset and his affect tense. He denied hallucinations, suicidal ideations and homicidal ideations. He was diagnosed with depressive disorder and requested that he be transferred to his primary care doctor in Michigan. A psychiatric evaluation was completed on November 14, 2018, during which Petitioner reported that he had made a big mistake and that he did not have any thoughts of harming himself or others but that he just wanted attention. On examination, Petitioner's mood was stable, and he strongly denied any thoughts of harming himself or others his thinking is well organized, and he denied hallucinations or delusions. He was alert and oriented, his memory intact and it was noted that his intelligence is within average range. Petitioner was diagnosed with

depressive disorder and discharged with outpatient treatment, as he reported receiving treatment at CMH in Adrian Michigan. (Exhibit A, pp. 234-269)

Petitioner's records from [redacted] were reviewed. During a November 21, 2018 assessment, Petitioner reported that in September of that year he had to have surgery and was in the hospital for 38 days, as he was diagnosed with Fournier's gangrene. He reported having surgery on his groin area and being in a lot of pain since then which has caused him added stress. He reported that he has not been able to work, that he has had to sell his truck and other personal items to pay the bills. He reported that this has all been piling up and he hit a boiling point, so he went into his garage and started his car. He indicated that he put a hose in his exhaust and fell asleep in the backseat until his wife found him and brought him to the hospital. He reported it was the dumbest thing he has ever done but it all happened so fast and he is still feeling down and having a hard time shutting off his brain. Petitioner indicated that he has constant fleeting thoughts of how bad everything is stating "I don't want to die I just want all of my damn problems to go away just take 10 things off my plate I have just gotten to the point where I cannot trust my thinking anymore, I thought I had it figured out and now I'm here, I couldn't even kill myself right." During a mental status examination, Petitioner's mood was hopeless, angry, helpless, irritable, and worthless. His affect was labile, his intellectual functioning was average, his insight and judgment were fair, and he reported difficulty falling and staying asleep. Based on the current reporting of his symptoms, level of interference, impact on functioning and locus score of 17, Petitioner was determined eligible for CMH services however he declined them indicating that he has an appointment for counseling scheduled for November 27, 2018 at [redacted]. Petitioner was diagnosed with unspecified depressive disorder. (Exhibit A, pp. 273 – 304)

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

Step Three

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

Based on the medical evidence presented in this case, listings 1.04 (disorders of the spine), 3.02 (chronic respiratory disorders), 8.04 (chronic infections of the skin or mucous membranes), and 12.04 (depressive, bipolar, and related 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 in constant pain in his groin and can walk only 150 yards before needing to rest. He stated that the scar tissue from his surgery has attached itself to his left testicle and when he walks, there is pulling and squeezing which causes extreme pain. He reported being able to sit for about one hour but moves around in his chair due to discomfort. He testified to being able to lift not more than 5 pounds and being able to stand for only 15 minutes. He is unable to bend or squat. Petitioner reported that he is able to dress himself and take care of his own personal hygiene, however, he does so with pain. Petitioner reported that he is no longer able to urinate normally. Petitioner stated that he was hospitalized in September 2018 for 38 days and in November 2018 for 17 days as a result of his physical and mental impairments. He reported that he was laid off from his prior employment as a result of his impairments and being unable to work. With respect to his mental impairments, Petitioner testified that he has been receiving treatment through counseling at [redacted] and that he has difficulty with concentration, crying spells, and anger issues. Petitioner recalled his suicide attempt from November 2018 and subsequent three-day inpatient hospitalization as a result.

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, 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). Petitioner has additional nonexertional limitations with respect to performing postural functions of some work such as stooping, crawling, or crouching. The medical records presented show that Petitioner had been diagnosed with and was receiving mental health treatment for depressive disorder. 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.

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

Step Four

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

Petitioner's work history in the 15 years prior to the application consists of work as a bus driver, heavy equipment operator, a welder, a construction laborer, and a small engine mechanic. Upon review, Petitioner's past employment required significant walking and standing and included among other tasks; lifting heavy materials such as asphalt, pipes, chains, and logs; hauling equipment; and repairing engines on lawn equipment. Thus, his past employment is categorized as requiring medium to heavy exertion. (Exhibit A, pp. 41-42, 134-141).

Based on the RFC analysis above, Petitioner's exertional RFC limits him to sedentary work activities. As such, Petitioner is incapable of performing past relevant work.

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 at the time of hearing, and thus, considered to be advanced age (age 55 and older) for purposes of Appendix 2. He is a high school graduate with skilled/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, with the noted additional nonexertional limitations. Thus, based solely on his exertional RFC, the Medical-Vocational Guidelines result in a disability finding based on Petitioner's exertional limitations and an analysis of the additional nonexertional/mental limitations will not be addressed. 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 January 7, 2019 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 twelve months from the hearing date, June 2020.

ZB/tlf

Zainab A. Baydoun
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

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]