GRETCHEN WHITMER
GOVERNOR

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

ORLENE HAWKS
DIRECTOR

Date Mailed: July 30, 2019
MOAHR Docket No.: 19-005898
Agency No.:
Petitioner:

ADMINISTRATIVE LAW JUDGE: Jacquelyn A. McClinton

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; and 45 CFR 205.10. After due notice, a telephone hearing was held on July 3, 2019, from Detroit, Michigan. Petitioner appeared on his own behalf. Petitioner's ex-wife also appeared at the hearing. Participants on behalf of the Department of Human Services (Department) included Eligibility Specialist.

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 November 14, 2018, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On March 7, 2019, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 6-12).

3. On March 11, 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. 1-4).

4. On May 28, 2019, the Department received Petitioner's timely written request for hearing (Exhibit A, p. 618).

5. Petitioner alleged disabling impairment due to seizures, neck pain, back pain, migraine headaches, depression, pancreatitis, anxiety, insomnia and chronic joint pain.

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

7. Petitioner is a high school graduate.

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

9. Petitioner has an employment history of work as truck driver.

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 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 under 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 reviewed and is summarized below.

On June 24, 2018, Petitioner was seen at ████████████████ for opiate abuse. Petitioner was treated with the Catapres protocol. Petitioner was discharged the same day with instructions to follow up with his primary care physician.

On June 27, 2018, Petitioner was seen at ████████████ emergency room with a chief complaint of breathing problems. Petitioner admitted that he was addicted to pain medications; admitted to buying illicit drugs and to drinking alcohol. Petitioner’s physical examination was normal. (Exhibit A, pp. 268-270).

On June 29, 2019, Petitioner was seen at ██████████████████ for follow up for asthma and alcohol addiction. Petitioner wanted a prescription for Norco but that request was denied due to his cocaine and alcohol abuse. (Exhibit A, pp. 437-442).

On July 6, 2018, Petitioner was seen at ███████████████████ due to a fall the prior week which caused a broken rib on left side and sprain right ankle. Petitioner indicated that the ankle pain was improving but not the rib pain. (Exhibit A, pp. 432-436).

On July 11, 2018, Petitioner was seen at ███████████████████ for pain from a broken rib. Petitioner was still having pain from broken rib and requested something to help him sleep. Impression was rib pain. (Exhibit A, pp. 424-431).

On July 19, 2018, Petitioner was seen at ███████████████████ with a chief complaint of abdominal pain. Petitioner reported that he was in the hospital four days

prior for abdominal pain and was told that if he did not stop drinking, he would die. Impression included acute pancreatitis without necrosis or infection and alcohol withdrawal. (Exhibit A, pp. 419-424).

On October 6, 2018, Petitioner was seen at [redacted] with a chief complaint of neck pain. Petitioner stated that the pain began 1 to 4 weeks prior to the visit. Petitioner did not know the source of the pain. Petitioner was diagnosed with neck pain and muscle spasm. (Exhibit A, pp. 271-273).

On October 27, 2018, Petitioner was seen for a consultative examination at [redacted] with a complaint of recurrent seizures and possible alcohol withdrawal. Petitioner stated that he believes that he has had a dozen seizures. During the visit, his ex-wife indicated that she believes he has had three or four episodes. Petitioner's ex-wife reported that she believed the seizures occurred when Petitioner attempts to stop drinking on his own. Petitioner does not have any unprovoked seizures. Petitioner's prior CT Scan was reviewed, which did not show any underlying structural lesions. An EEG was ordered and yielded normal results. (Exhibit A, pp. 275-280).

Petitioner is taking Coumadin and was seen at [redacted] for several Coumadin Management appointments. The records indicated that Petitioner's Coumadin start date was October 27, 2018. The Coumadin reviews indicated that Petitioner did not have any bleeding or unusual bruising. (Exhibit A, pp. 310-330; 334-349; 352-360).

On November 20, 2018, Petitioner was seen at [redacted] for a follow up. Petitioner was admitted to the hospital on October 27, 2018 for seizures due to alcohol abuse. The note indicates that during the hospital stay, Petitioner developed DVT in his left arm and left leg. Petitioner stated that he has been anxious since his discharge on November 16, 2018. The impression indicated acute thrombosis of other specified deep vein of left lower extremity, Coumadin therapy – long term use, deep vein thrombosis of left upper extremity, depression/anxiety and alcohol abuse. (Exhibit A, pp. 408-414).

On November 28, 2018, Petitioner was seen at [redacted] with a chief complaint of blood clots in his legs. The assessment included acute thrombosis of other specified deep vein of left lower extremity and deep vein thrombosis of left upper extremity. (Exhibit A, pp. 403-408).

On November 30, 2018, Petitioner had lab work completed at Great Lakes Bay Health Centers. Petitioner was positive for Opiates. (Exhibit A, p. 292).

On December 5, 2018, Petitioner was seen at [redacted] for first injection for alcohol and opiate abuse. His last drink was 30 days prior to the visit. It was noted that Petitioner's labs were reviewed, and it was suspected that Petitioner had a false positive for benzodiazepines due to taking naltrexone. Petitioner underwent a

depression assessment. His PHQ-9 score was 13, which correlates to a depression severity of severe major depression. (Exhibit A, pp. 397-402).

On December 10, 2018, Petitioner was seen at [redacted] for his first Vivitrol injection. Petitioner was given a Vivitrol bracelet, necklace and ID Care. Petitioner denied alcohol use in past 24 hours. Petitioner did not voice any questions or concerns. (Exhibit A, p. 349).

On January 2, 2019, Petitioner was seen at [redacted] for his second Vivitrol injection. Petitioner denied any alcohol or opiate use. Petitioner stated that he was doing okay and was 90 days sober. Petitioner did not voice any questions or concerns. (Exhibit A, p. 331). Petitioner underwent a depression assessment. His PHQ-9 score was 16, which correlates to a depression severity of moderately severe. Petitioner was noted to have a previous score of 6 and a baseline score of 13. (Exhibit A, p. 396).

On January 4, 2019, Petitioner was seen at [redacted] with a chief complaint of low back pain. Petitioner was also complaining of diarrhea. Petitioner was given Tylenol for pain. (Exhibit A, pp. 387-392).

On January 6, 2019, Petitioner had an x-ray of his abdomen completed which yielded normal results. (Exhibit A, pp. 281).

On January 7, 2019, Petitioner had lab work completed at [redacted] Centers. Petitioner was positive for Benzodiazepines. (Exhibit A, p. 287).

On January 17, 2019, Petitioner was seen at [redacted] for pain management. Petitioner indicated that he suffers from low back pain stemming from four vehicle accidents while in his 20's. Petitioner stated that he drank a lot and had a lot of crashes. Petitioner indicated that he started having seizures three years prior and lost his trucking license. Petitioner had not had physical therapy. Petitioner's physical exam did not yield any abnormalities. Petitioner underwent a depression assessment. His PHQ-9 score was 5, which correlates to a depression severity of mild. Petitioner was noted to have a previous score of 5 and a baseline score of 13. (Exhibit A, pp. 380-386).

On January 18, 2019, Petitioner was seen at [redacted] for treatment of [redacted] (OMT). Petitioner complained of low back pain and indicated that he drives trucks for a living. (Exhibit A, pp. 374-379).

On January 30, 2019, Petitioner was seen at [redacted] for his third Vivitrol injection. Petitioner denied opioid or alcohol use. Petitioner indicated that he was doing well but struggled with cravings at the end of four weeks. (Exhibit A, p. 309).

On January 30, 2019, Petitioner was seen at [redacted] for his annual Depression assessment. Petitioner reported little interest or pleasure in doing things lasting for several days; feeling down, depressed, or hopeless for several days; trouble falling or staying asleep or sleeping too much for several days; feeling tired or having little energy for several days; feeling bad about himself for several days; no trouble concentrating on things; not being fidgety or restless; and no thoughts of hurting himself or that he would be better off dead. Petitioner reported that these problems have made it somewhat difficult for him to do his work, take care of things at home or get along with other people. Petitioner's PHQ-9 score was 6, which correlates to a depression severity of mild. Petitioner was noted to have a previous score of 5 and a baseline score of 13. (Exhibit A, pp. 373-374).

On January 31, 2019, Petitioner was seen at [redacted] for treatment of OMT. Petitioner complained of low back pain after shoveling snow for the past few days. Petitioner also complained of neck stiffness. Following the physical exam, there were no physical restrictions related to OMT. Petitioner was scheduled to follow up in two weeks. (Exhibit A, pp. 361-362).

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 1.02 (major dysfunction of a joint); 1.04 (disorders of the spine); 11.02 (epilepsy); 12.04 (depressive, bipolar and related disorders); and 12.06 (anxiety and obsessive-compulsive disorders) were considered. The medical evidence presented does not show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Steps 4 and 5, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s), including those that are not severe, and takes into consideration an individual's ability to

meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4); 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b).

The exertional requirements, or physical demands, of work in the national economy are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a). Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools and occasionally walking and standing. 20 CFR 416.967(a). Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds; even though the weight lifted may be very little, a job is in the light category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. 20 CFR 416.967(b). Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. 20 CFR 416.967(e).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing,

crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). 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). Where the evidence establishes a medically determinable mental impairment, the degree of functional limitation must be rated, taking into consideration chronic mental disorders, structured settings, medication, and other treatment. The effect on the overall degree of functionality is evaluated under four broad functional areas: (i) understand, remember, or apply information; (ii) interact with others; (iii) concentrate, persist, or maintain pace; and (iv) adapt or manage oneself. 20 CFR 416.920a(c)(3). For the first three functional areas, a five-point scale is applied (none, mild, moderate, marked, and extreme). 20 CFR 416.920a(c)(4). The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. 20 CFR 416.920a(c)(4).

In this case, Petitioner alleges both exertional and nonexertional limitations due to his medical condition. Petitioner testified that he could dress/undress himself; bathe/shower himself; eat and use the bathroom unassisted; and prepare simple meals. Petitioner indicated that he could not squat due to back pain; kneel because he has no power in his legs; reach with his left arm; stand or sit more than one hour due to back pain; and walk more than 60 feet, due to pain and because he looses his breath.

Petitioner indicated that he has a difficult time remember and further indicated that he was enrolled in special education classes while in school. Petitioner testified that he received his high school diploma. Petitioner further indicated that it is difficult for him to concentrate because he forgets things. Petitioner testified that he has difficulty completing tasks. Petitioner acknowledged that he could follow simple instructions. Petitioner explained that he does not work well with others because he gets upset with people.

Petitioner testified that he was claiming a disability due to seizures, neck pain, back pain, migraine headaches, depression, pancreatitis, anxiety, insomnia and chronic joint pain. While the medical records provided referenced that Petitioner had a history of pancreatitis, there were no treatment records provided specifically for this condition. There were instances in which Petitioner indicated that he was unable to sleep, however, there were no medical records provided indicating any ongoing treatment for this medical condition. There was also no evidence provided that Petitioner is being treated for migraine headaches.

On July 1, 2019, [redacted] licensed social worker, indicated that Petitioner was being treated for the medical conditions in which Petitioner stated that he was claiming a disability. [redacted] indicated that in her opinion, due to his many health issues, Petitioner was unable to work at this time. (Exhibit 1, p. 1).

The medical evidence provided did indicate that Petitioner has had a number of depression screenings. On January 2, 2019, Petitioner's PHQ-9 score was 16, which correlates to a depression severity of moderately severe. However, on January 17, 2019, Petitioner's PHQ-9 score was 5, which correlates to a depression severity of mild. Likewise, on January 30, 2019, Petitioner's PHQ-9 score was 6, which correlates to a depression severity of mild.

The medical evidence provided did reveal treatment for neck and back pain. Petitioner was treated for neck pain on October 6, 2018; however, there does not appear that any follow up care was sought immediately following this treatment. Petitioner was treated for back pain on January 4, 17, and 18, 2019. However, Petitioner was not admitted for any sustained treatment. Additionally, there were tests such as an x-ray or MRI indicating that there was any substantial injury to either Petitioner's neck or back. Petitioner was also treated for neck and back pain on January 31, 2019; however, the source of the injury was noted to be shoveling snow.

The medical evidence provided indicated that Petitioner had a history of seizures. However, it appears that most, if not all, of the episodes occurred when Petitioner attempted to cease drinking on his own without medical intervention. There was no indication that Petitioner had unprovoked seizures or that he continued to have seizures once his alcohol addiction was treated by medical professionals.

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

With respect to Petitioner's exertional limitations, it is found based on a review of the entire record that Petitioner maintains the physical capacity to perform light work as defined by 20 CFR 416.967(b). Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild 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 truck driver. Petitioner's work as a truck driver, which required prolonged sitting and lifting up to 50 pounds regularly, required medium physical exertion.

Based on the RFC analysis above, Petitioner's exertional RFC limits him to no more than light work activities. As such, Petitioner is incapable of performing past relevant work. Petitioner also has mild limitations in his mental capacity to perform basic work activities. 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).

However, if the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2).

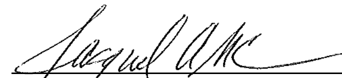
When a person has a combination of exertional and nonexertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination unless there is a rule that directs a conclusion that the individual is disabled based upon strength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

In this case, Petitioner was 47 years old at the time of application and 47 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 truck driver. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform light work activities. Based on his exertional RFC, the Medical-Vocational Guidelines result in a finding that Petitioner is not disabled. Further, Petitioner's nonexertional RFC imposing mild limitations on his mental ability to perform basic work activities does not preclude him from being able to adjust to other work. Accordingly, Petitioner is not disabled at Step 5.

DECISION AND ORDER

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.

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



JAM/tlf

Jacquelyn A. McClinton
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:

MDHHS-Saginaw-Hearings
BSC2 Hearing Decisions
Policy-FIP-SDA-RAP
MOAHR

Petitioner – Via First-Class Mail: