GRETCHEN WHITMER
GOVERNOR

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

ORLENE HAWKS
DIRECTOR

Date Mailed: September 26, 2019
MOAHR Docket No.: 19-007033
Agency No.:
Petitioner:

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

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 October 13, 2014, from Detroit, Michigan. Participants on behalf of Petitioner included himself. Participants on behalf of the Department of Human Services (Department) included , Assistance Payments Worker.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Exhibit C was received and marked into evidence and contained a DHS-49 as well as treatment notes for Dr. . The remaining documents requested to be provided by the Interim Order including a DHS-49 from Dr. with testing and treatment records, a DHS 49 from Dr. and treatment records, and a DHS-49D and DHS-49E from the were not received.

The record closed on August 31, 2019, and the matter is now before the undersigned for a final determination based 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 January 24, 2019, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On April 29, 2019, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 4-10).

3. On April 30, 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. 4-10).

4. On July 8, 2019, the Department received Petitioner's timely written request for hearing.

5. Petitioner alleged disabling impairment due to low back pain with arthritis in his back, bilateral knees and left hip. The Petitioner also alleged congestive heart failure with blood clot in his right leg. The Petitioner also alleged COPD and uses a CPAP and BiPAP machine. The Petitioner has also alleged mental disabling impairments due to depression and is in therapy sees his psychiatrist once a month.

6. On the date of the hearing, Petitioner was ██ years old with a December 22, ████ birth date; he is ████ in height and weighs about ███ pounds.

7. Petitioner completed the ████ grade.

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

9. Petitioner has an employment history of work as operating heavy equipment at a gravel pit and also performed labor building roads.

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, s/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 May 29, 2019 the Petitioner was seen in the hospital for his pulmonary disease and discharged with congestive heart failure and shortness of breath. He was to follow up with his primary care doctor. These records were presented at the hearing.

On April 16, 2019 the Petitioner was tested to rule out deep vein thrombosis. The findings were that the results were not consistent with an acute deep vein thrombosis of the right lower extremity and thus negative for deep vein thrombosis. Findings were consistent with a small segment chronic, non-occlusive superficial vein thrombosis at the level of the medial proximal thigh tributary vein, 3.26 cm distal to the saphenofemoral junction. Findings were consistent with a chronic occluding thrombophlebitis at the level of the right medial proximal to mid-calf. The great

saphenous vein is noted to have been previously ablated in 2016 and is not visualized. Conclusion: compared to the previous study from an outside facility dated November 13, 2018 right superficial venous thrombosis of the thigh appears to be resolving.

On or about May 2, 2019 the Petitioenr's cardiologist completed a medical examination report (DHS 49). The current diagnosis was hypertension, venous insufficiency and palpitations. The Petitioner's weight at the time of the exam was ███ pounds. The exam noted lower extremity edema, occluding thrombosis and palpitations. The Petitioner's condition was stable. Limitations were imposed which were expected to last 90 days or more. No lifting or carrying restrictions were noted. The doctor limited the Petitioner to being able to stand and/or walk at least 2 hours in an 8 hour day and sit less than 6 hours in an 8 hour work day. No other physical limitations were imposed. No mental limitations were imposed. The doctor found that Petitioner could not meet his needs in the home but did not list any needs that he needed assistance with.

A Progress note was completed on May 2, 2019 after a visit regarding Petitioner's venous Doppler results for lower extremity. At the time of the visit the Petitioner reported fatigue, mild bilateral lower leg edema, leg pain and numbness and tingling in his legs. Risk factors for coronary artery disease include hypertension, hyperlipidemia, morbid obesity with a BMI greater than 50 and tobacco use. The Petitioner has a history of venous insufficiency. Petitioner also reported occasional palpitations described as a racing sensation in nature with no other symptoms. The episodes typically last five minutes in duration. Frequency is approximately once per week. At the visit Petitioner's blood pressure was well-controlled.

The Petitioner was seen in the emergency room on May 29, 2019 which was the second visit in May 2019. The Petitioner reported shortness of breath which has been worsening for the last several weeks. Patient has to take off his Bi-PAP to find relief with breathing. The Petitioner's blood pressure was elevated and he was referred for screening. The Petitioner was examined and no respiratory distress noted long breath sounds were normal with no wheezes, no rails no rhongi; the cardiovascular examination noted regular rate and rhythm, no murmur, pulses full and equal. The examiner noted that the exam was limited due to Petitioner's obesity. An EKG was also performed which noted a right bundle branch block with no comment. A chest x-ray was also given with no acute process shown or changes from the previous exam. Notes indicate that the diagnosis was acute chronic dyspnea; minimal chronic heart failure and morbid obesity. The Petitioner was discharged home in stable condition. An echocardiogram was also performed with an ejection fraction of 65% also noted mild left ventricular hypertrophy present and mild aortic stenosis. The discharge diagnosis was congestive heart failure.

A prior venous Doppler performed on March 11, 2019 with regard to right lower extremity indicated in occluding thrombus throughout most of the great saphenous vein throughout the proximal leg and distal thigh which could represent thrombophlebitis. An EKG dated January 22, 2019 revealed a normal sinus rhythm and was normal. The right

lower extremity Doppler dated March 11, 2019 indicated an occluding thrombosis throughout most of the greater saphenous vein throughout the proximal leg and distal thigh which could represent thrombophlebitis. There was no evidence of stress induced ischemia. The notes also indicate obstructive sleep apnea and use of a BiPAP machine. The Petitioner's calculated BMI was 54.56.

A radiographic study was done on the Petitioner's lumbar spine due to complaints of lower back pain chronic. A comparison to findings of an earlier x-ray taken September 15, 2016 were made. The findings were impression, mild facet arthropathy on the lower lumbar spine. No acute osseous abnormality. NO MRI's were presented as evidence.

On July 16, 2018 the Petitioner was seen regarding his obstructive sleep apnea test results for a routine clinic follow-up. The Petitioner was seen in March 2018 for increase shortness of breath. Notes indicate he had a nuclear stress test which was normal. At the follow-up exam the Petitioner reported that based on a breathing test he was switched from a CPAP to BiPAP machine. The Petitioner's active problem list included back pain, coronary artery disease history of seizure disorder, hypertension and lower extremity edema. At the date of the exam the Petitioner's BMI was calculated as 55.53. At the conclusion of the exam the assessment was obstructive sleep apnea treated with a BiPAP machine. Prior to a sleep study, the Petitioner was seen on March 29, 2018 for shortness of breath, dyspnea, exercise intolerance and chest tightness and wheezing. The Petitioner also indicated he had shortness of breath on exertion and awakening at night with all the upper back tightness shortness of breath. He reported not getting enough air upon awakening. The Petitioner's physical pulmonary exam was normal. A new nuclear stress test was ordered due to shortness of breath on exertion.

A chest x-ray taken on April 5, 2018 of Petitioner's lungs indicated no evidence of acute cardiopulmonary process. On June 12, 2018 the Petitioner had a myo-view perfusion scan due to coronary artery disease and chest pain. The exam compared a prior study performed in March 2016. The findings noted no fixed or reversible defects seen, cardiac wall motion normal, left ventricular ejection fraction is 55%. The result of a nuclear stress test in June 2018 noted ECG analysis indicating normal sinus rhythm normal ECG at rest, no abnormal ST/T wave changes with stress and no arrhythmias were observed during the test or Lexiscan.

On January 7, 2019 the Petitioner was seen at [redacted] due to complaints of dizzy spells, numbness and tingling, joint pain, neck pain and back pain also noted was respiratory wheezing frequent cough and shortness of breath. Petitioner reported bilateral knee pain right greater than left without recent injury. On examination both knees exhibited mild varus deformities with crepitus throughout the range of motion of his knees. There is a medial joint line tenderness and a mild flexion contracture to both knees. He is neurologically normal to all dermatomes and myotomes tested in the lower extremities. His symptoms are consistent with mild-moderate osteoarthritis to both knees. X-rays were performed in exhibit did mild medial joint line collapse and mild patellofemoral arthrosis. No fractures are dislocations were seen or signs of malignancy. The impression was mild-moderate degenerative osteoarthritis bilateral

knees, right greater than left. The plan noted Petitioner has advancing degenerative osteoarthritis to both knees. He is not yet a candidate for knee replacement surgery. Recommended weight loss as much as possible was discussed. Knees are painful and can be treated non-operatively. Cortisone injections to both knees were suggested. At the time of the exam injections to both knees were performed.

On May 24, 2018 the Petitioner underwent a digital polysomnography. The study included profusion scoring software and attendant additional testing. At the conclusion of the testing the diagnosis was obstructive sleep apnea with poor tolerance to CPAP. The recommendation was regular use during sleep of bilevel 20/14 applied via full faced medium cushion large headgear. Also recommended was weight loss.

The Petitioner is seen and treated by a pulmonologist doctor. Progress note taken May 29, 2018 indicates a pulmonary function test was normal and fewer issues with dizziness expected to be improved when a BiPAP machine is used.

The Petitioner was seen on September 8, 2018 with complaints of still gasping for air the diagnosis was obstructive sleep apnea. No additional treatment was ordered at that time by the doctor.

The Petitioner is treated for his mental health issues by the Lapeer County Community Mental Health organization. The Petitioner met with a support coordinator on January 10, 2019 and participated in an interview to discuss his service plan. The Petitioner had a DPS assessment on December 27, 2018 the notes indicate seven prior arrests/convictions related to alcoholism with no outstanding civil or criminal charges or probation. The notes indicate that Petitioner was independent of all activities of daily living. The Petitioner described his current symptoms as including sleep disturbance low self-esteem appetite changes, nightmares, mood swings inability to concentrate and acting without thinking. In addition he reported aggression, angry, anxiety, memory problems, obsessive thoughts, compulsive behavior, and seeing or hearing things. No prior treatment history was reported. The Petitioner reported drinking one or two days in the past week as of December 2018, reported as a few beers. The mental status exam noted that the Petitioner was essentially unremarkable except for exhibiting depressed mood and congruent affect. At the conclusion of the examination the Petitioner was diagnosed with major depressive disorder, recurrent episode, severe; alcohol use disorder, moderate and cannabis use disorder moderate. The designations note that the Petitioner has co-occurring substance use and mental health problems. No other records were provided for review.

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, was considered, however there was no radiographic evidence of a condition that would meet the listing requirements including nerve root compression. Listing 4.02 Chronic Heart Failure was not met based upon the Petitioner's ejection fraction and ability to complete his daily living activities. Listing 4.11 Chronic Venous Insufficiency was reviewed and was not met as there was no brawny edema, and no recurrent ulceration. Listing 3.02 Chronic Respiratory Disorders was reviewed and was not supported as no pulmonary function tests were provided. Listing 12.04 Depressive, bipolar and related disorders was reviewed and the medical evidence record did not demonstrate that Petitioner met the severity requirements of the listing. 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 condition. Petitioner testified that he could stand for four minutes and sit for a

couple of hours as long as he could move around and stand. He testified he could walk only 30 or 40 feet, could not perform a squat, could bend forward slightly and sideways. The Petitioner can shower and dress himself with difficulty putting his socks on, cannot touch his toes. His back pain was reported between 6-7 out of 10. His hands and arms were okay. He had pain in his right leg due to his vein condition. The Petitioner testified the heaviest weight he could carry would be 7 pounds and that he watches television from the couch or a chair most of the day. The Petitioner's cardiologists completed a DHS 49 medical examination report which imposed limitations with regard to standing and walking less than two hours in an eight hour workday and sitting less than six hours in an eight hour workday with frequent breaks. The limitations were expected to continue or last more than 90 days and the Petitioner's condition was noted as stable. No other limitations with regard to lifting, carrying, operating foot/leg controls or use of his upper extremities hands and arms were imposed. Although the doctor indicated client cannot meet his needs in the home, he did not list what assistance if any with these activities was needed.

As regards his mental impairment involving depression the Petitioner testified that he often has anxiety without crying spells and occasional anger issues. He did not report hearing any voices or seeing things and that his depression comes and goes some days are worse and his medications have helped. He eats one time a day and his memory is described as okay, but concentration was noted as losing track of things and drifting off. He continues to have some social interactions two or three times a week with family members and a few friends. The Petitioner's mental health provider which he has been seen since January 2019 has diagnosed the Petitioner with major depressive disorder, recurrent episode, severe.

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

With respect to Petitioner's exertional limitations, it is found based on a review of the entire record that Petitioner maintains the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a). The Petitioner's obesity and consistent BMI of over 50 were also considered when making the sedentary finding but the obesity was determined not to interfere with Petitioner's ability to perform at a sedentary level as it involves much sitting.

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild to moderate limitations on his mental ability to perform basic work activities. The mental health provider did not provide additional records and the medical evidence as regards mental health treatment was limited.

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 heavy equipment operator. The Petitioner was required to assist in construction activities and gas and grease equipment. Petitioner testified he could no longer climb the ladder is to reach the equipment controls. The most Petitioner had to lift was 25 pounds and when doing construction work was on his feet most of the time. The Petitioner's description of the work would indicate a medium physical exertion required to perform his prior work.

Based on the RFC analysis above, Petitioner's exertional RFC limits him to no more than sedentary work activities. As such, Petitioner is incapable of performing past relevant work. Petitioner also has moderate limitations in his mental capacity to perform basic work activities. In light of the entire record, it is found that Petitioner's nonexertional RFC prohibits him from performing past relevant work.

Because Petitioner is unable to perform past relevant work, Petitioner cannot be found disabled, or not disabled, at Step 4, and the assessment continues to Step 5.

Step 5

If an individual is incapable of performing past relevant work, Step 5 requires an assessment of the individual's RFC and age, education, and work experience to determine whether an adjustment to other work can be made. 20 CFR 416.920(a)(4)(v); 20 CFR 416.920(c). If the individual can adjust to other work, then there is no disability; if the individual cannot adjust to other work, then there is a disability. 20 CFR 416.920(a)(4)(v).

At this point in the analysis, the burden shifts from Petitioner to the Department to present proof that Petitioner has the RFC to obtain and maintain substantial gainful employment. 20 CFR 416.960(c)(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to

perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services, 587 F2d 321, 323 (CA 6, 1978).*

When 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 ██ years old at the time of application and ██ years old at the time of hearing, and, thus, considered to be a younger individual (age 45-49) for purposes of Appendix 2. He completed the ██ grade and has a history of work as a heavy equipment operator in a gravel operation and road building company. Petitioner is also grossly obese with a BMI of 50 or more, which while a limiting factor, does not cause the Petitioner by itself or in combination with his other physical exertional limitations to be unable to perform sedentary work. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities.

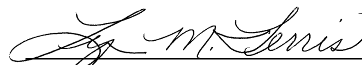
Based solely on his exertional RFC for sedentary physical exertion, the Medical-Vocational Guidelines, 201.18, result in a finding that Petitioner is not disabled.

However, Petitioner also has impairments due to his mental condition. As a result, he has a nonexertional RFC imposing moderate limitations in his activities of daily living; mild limitations in his social functioning; and moderate limitations in his concentration, persistence or pace limitations. It is found that those limitations would not preclude him from engaging in simple, unskilled work activities on a sustained basis**.** Therefore, Petitioner is able to adjust to other work and 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.**



LMF/tlf

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

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

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

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

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

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

Via Email:

Petitioner
- **Via First-Class Mail:**