[redacted]

Date Mailed: September 25, 2019
MOAHR Docket No.: 19-007994
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 August 26, 2019, from Detroit, Michigan. Petitioner appeared for the hearing with his mother, [redacted] and represented himself. The Department of Health and Human Services (Department) was represented by [redacted], Assistance Payments Supervisor.

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 March 2, 2019, Petitioner submitted an application for cash assistance on the basis of a disability. (Exhibit A, pp. 380-394)

2. On or around June 20, 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. 356-378)

3. On June 25, 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. 395-399)

4. On July 23, 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 chronic pain, chronic fatigue, autism, irritable bowel syndrome (IBS), agoraphobia, Tourette's syndrome, anxiety and ADHD.

6. As of the hearing date, Petitioner was [redacted] years old with a May 28, [redacted] date of birth; he was [redacted] and weighed [redacted] pounds.

7. Petitioner testified that he obtained a high school diploma. Petitioner has reported employment history of work as a gas station attendant and a store clerk. Petitioner has not been employed since 2017.

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 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 was thoroughly reviewed and is briefly summarized below:

Records from Petitioner's treatment with his primary care physician (PCP) Dr. [redacted] through [redacted] were presented and reviewed. (Exhibit A, pp.11 – 47,166-177, 191-222). Petitioner presented for follow-up of his hypermobility syndrome which met the criteria for Hypermobile Ehlers-Danlos syndrome (hEDS) and chronic pain. A review of his neuropsychological testing indicated that Petitioner met the criteria for an autism spectrum disorder. He was to begin working with the psychologist who specializes in patients with autism. Records indicate that he endorsed significant worsening of his mood symptoms, and revealed a history of tics, ADHD and agoraphobia. The PCP recommended neuropsychological testing to determine the role of mood, pain, ADHD on Petitioner's memory and functioning. Multiple joint pains and low back pain was reported and Petitioner was referred to physical therapy at [redacted]. It was noted that Petitioner had significant pes planus with navicular drop and would benefit from custom orthotics. A referral to psychiatry at [redacted] was made to assess Petitioner's anxiety, depression, ADHD and history of agoraphobia. A February 2019 annual examination showed that Petitioner reported a 20-pound weight gain and lack of energy, episodes of diarrhea, joint pain, bilateral knee issues more on the left than right, hypermobility, eczema, autism, sleep disturbances in sporadic hours, and fatigue. During an April 2019 appointment, Petitioner reported weight loss of 5 pounds but no significant weight gain. He reported no arm pain on exertion, no shortness of breath when walking, and no palpitations. No abdominal pain was reported. Records indicate that Petitioner's neuropsych testing showed that he met the criteria for autism spectrum disorder and would be working with a psychologist who specializes in patients with autism. Records indicate that Petitioner's primary medical history for which she received medical treatment included elevated blood pressure, Tourette's syndrome, steatosis of the liver, obesity, depression, anxiety, autism spectrum disorder, sleeping disorder, IBS, hEDS, ADHD inattentive type, agoraphobia, chronic pain syndrome, hypermobility syndrome and tic disorder.

Petitioner was evaluated by Dr. [redacted], gastroenterologist in March 2018. During the evaluation, Petitioner reported a history of anxiety disorder and GERD with symptoms of diarrhea several times per week going back to middle school. He reported that his symptoms are always worse with stress and anxiety, that he has frequent abdominal cramps and diarrhea. He has been on a strict gluten-free diet for the past 10 years, although he has not been tested for celiac disease. It was reported that currently, he still has trouble when he feels anxiety and he will have postprandial urgency, cramps, and loose stools. He reported that he gets gas pains with high-fiber foods and has chronic GERD. Petitioner reported that he is unemployed, and he cannot imagine going to work because he is fearful, he would have diarrhea there. There was no history of pancreatitis or hepatitis although mild elevation in liver enzymes two years ago was noted but has since resolved. There were no significant abnormalities noted on physical examination and Petitioner was diagnosed with classic symptoms of IBS, chronic GERD, and a one-time colonoscopy to exclude Crohn's or ulcerative colitis was scheduled. In regard to managing Petitioner's IBS, the doctor recommended diet modification, stress management, and judicious use of medications. The doctor outlined some goals, including having Petitioner manage the IBS well enough to pursue further schooling or job training or at least be able to go to work. Seeing a counselor to work on daily stress and anxiety would also be of benefit. On April 12, 2018, Petitioner underwent a colonoscopy due to abdominal pain in the left lower quadrant, chronic diarrhea, and suspected IBS. Findings indicated that the perianal and digital rectal examinations were normal, the entire examine portion of the colon appeared normal, the terminal ileum appeared normal, and small non-bleeding external and internal hemorrhoids were found. There was no evidence of Crohn's disease or colitis. (Exhibit A, pp. 183-184, 298 – 301)

On June 5, 2019, Petitioner was evaluated for physical therapy outpatient treatment at [redacted] for chronic pain syndrome, joint stability, chronic back pain, lower extremity pain and conditioning as well as a history of for shoulder dislocations. Petitioner's chief complaint was chronic pain, most notably in the lower back, knees, shoulders, neck, and decreased activity tolerance, as well as fatigue. Petitioner reported a history of hEDS and chronic pain for many years. He reported stiffness and soreness in his neck, shoulders, and knees and that his lower back is the most sensitive but any muscle in his body is prone to pain. He indicated his left shoulder has been dislocated multiple times and he also has had some trouble with the joints in his fingers and hands dislocating. He reported that he had physical therapy sometime last year, doing both pool and land therapy. He reported that household chores are difficult but denied any difficulty with balance, noting that he gets fatigued very easily. When his knees are bent, and he is weight-bearing, he gets sharp shooting pain. Petitioner's PCP clinic notes were reviewed by the physical therapist and indicate that Petitioner continued to have trouble with IBS and has a very restrictive diet, that his symptoms seem to fluctuate with the weather, that his sleep is poor, and that he has seen mild increases in pain since his last evaluation. Petitioner had reported palpitations but no chest pain, as well as abdominal pain and constipation but no diarrhea. He reports frequent or severe headaches but no difficulty with balance. A loss of interest and sleep disturbances were also noted. (Exhibit A, pp. 140-152). Records from

Petitioner's 2018 physical therapy evaluation and treatment were also presented and reviewed. Notes indicate that Petitioner presented with complaints of widespread pain most markedly in his shoulders, lumbar spine, knees and ankles. (Exhibit A, pp.275 – 292)

After assessment, Petitioner's rehabilitation potential was noted to be fair due to the severity of his impairment. The clinical assessment summary physical therapy indicates that Petitioner presented with complaints of chronic pain secondary to hEDS. He demonstrated weakness throughout the bilateral lower extremities, left greater than right, as well as significantly limited hamstring flexibility. His community ambulation tolerance is impaired as evidenced by 6MWT distance of 1179 feet, and functional quad strength deficits noted. His cervical spine range of motion is somewhat hypermobile, with pain present with many motions. Functionally, pain is impacting his ability to perform normal daily tasks, and overall decreased activity tolerance is present. He will benefit from skilled PT to address the above impairments to aid in maximizing ability to participate in normal age-appropriate tasks with decreased pain. (Exhibit A, pp. 140-152).

Petitioner participated in psychological evaluations on September 14, 2018, September 21, 2018, and September 24, 2018 at the [redacted] through [redacted]. Petitioner was referred for a psychological evaluation to determine if he has ADHD and for more general difficulties related to neurological and emotional problems. He acknowledged having difficulty remembering tasks, reported that he often feels confused, that he fears rejection and endorsed "feeling empty inside." The psychological history was provided by Petitioner and his mother. There was no history of traumatic brain injuries or unexpected losses of consciousness. History indicates that in second grade he began exhibiting tics, was frequently distracted and was distracting to other students. In ninth grade, he suffered worse gastrointestinal problems perhaps related to being extremely stressed. At one point, Petitioner did not leave the house nearly for a full year as a tutor began coming to the home for schooling. It was reported that Petitioner worked at [redacted] for a few months stocking shelves and organizing materials, but the entire experience was very frustrating for him. His tics increased in frequency and his health deteriorated, as he reported others at the store staring at him while he was having his tics. When asked to complete simple tasks around the house he frequently forgets or otherwise neglects to do them. He acknowledged having thoughts of suicide which he indicated was not connected to episodes of depression. He acknowledged that he had panic attacks which are associated with times of gastrointestinal distress and when he is extremely anxious, he is more likely to exhibit tics. He reported that compulsions cause him to blurt out whatever comes into his head. Petitioner was observed to be oriented to person, place, and time. His long-term and short-term memory seemed quite accurate, his speech was notably formal, normal in rate and volume, but somewhat choppy and rhythm. He did use emphatic gestures and his answers to questions were frequently very long and over incorporated. His thought process seemed somewhat tangential but there was no evidence of auditory or visual hallucinations. During the evaluation, he denied any intent or plan for suicide. Petitioner was administered the Kaufman Brief

Intelligence Test which showed his verbal score of 92 at the 30th percentile and his nonverbal score of 115 at the 84th percentile. The IQ composite score of 104 is at the 61st percentile and it was noted that the 23-point discrepancy between his verbal and nonverbal IQ scores is statistically significant and may suggest a lot better nonverbal fluid reasoning as opposed to crystallize and verbal intelligence. Petitioner was administered the Wisconsin Card – Sorting Test for which he struggled significantly. In 64 cards, he was able to complete only one category which is well below average for a person his age. Furthermore, his total number of errors score was better than that of only 3% of persons his age. A summary of the evaluation indicated that Petitioner is socially disengaged, has low social motivation, and generally impaired in social communication. His intelligence is estimated to be in the average range, but he struggled severely on a computerized measure of executive functioning. He performed in the average range on computerized measure of concentration and personality testing suggested fairly severe somatic problems, as well as depression. On the Autism Diagnostic Observation Schedule second edition, he performed in a way that would fit spectrum disorder. He has exhibited features of various behavioral health problems and in reviewing his record and current functioning, the psychologist was of the opinion that the common thread is likely related to his experience of autism. He did exhibit symptoms consistent with ADHD and has had episodes of depression and significant anxiety. Petitioner was diagnosed with autism spectrum disorder without intellectual impairment, without speech language impairment, requiring support and social communication. He was restricted from repetitive behavior. Diagnosis of ADHD predominantly inattentive presentation, major depressive disorder, recurrent, moderate severity, and generalized anxiety disorder disorder were also noted. It was recommended that Petitioner participate in psychotherapy as well as a targeted approach to psychiatric intervention in light of his autism diagnosis. (Exhibit A, pp. 48–50).

Records from Petitioner's mental health treatment with [redacted]t were presented and reviewed. (Exhibit A, pp.150 – 164, 240 – 269). Therapy Progress Notes from April 22, 2019 indicate that during the therapy session, Petitioner discussed feeling frustrated with people online and being unsure how to handle his feelings of frustration. He worked on distress tolerance and finding visual cues to remind himself to think before he speaks. He denied suicidal and homicidal ideations and has engaged in no suicide attempt or self-injury since his prior session. Notes indicate that Petitioner was receiving treatment for generalized anxiety disorder and depression, major, recurrent, moderate. Therapy progress notes from a March 27, 2019 visit indicate that Petitioner presented with symptoms of anhedonia, depressed mood, fatigue, and feelings of worthlessness/guilt, anxiety and agitation, as well as chronic pain. Records indicate the symptoms continue throughout the duration of his therapy sessions. Petitioner's functional impairments consisted of impaired occupational functioning, impaired emotional functioning, as evidenced by poor emotional regulation, an impairment inability to complete daily self-care tasks, symptoms negatively impacting his physical health and symptoms that negatively impact his motivation. In session, Petitioner discussed issues with anxiety, depression, chronic pain and autism spectrum disorder. He noted the impact of his symptoms and how they affect his life, including the inability

to work. He showed good progress in treatment and was to follow up with his individual therapist concerning his readiness to begin group sessions. He did note some existential suicidal ideation in the possible future event that all of his family and friends died but denied any significant suicidal ideations at current. During a March 6, 2019 session, he expressed symptoms of anxiety, agitation, depressed mood, slowed speech and poor eye contact as well as the above noted presenting symptoms. During a March 28, 2018 therapy session, Petitioner discussed his recent panic attack experience and worked on identifying his symptoms of panic as well as understanding the biology behind the panic attack. (Exhibit A, pp. kqp8150 – 164, 240 – 269).

Psychiatric progress notes from a November 26, 2018 office visit indicate that Petitioner's history of present illness included autism spectrum disorder for which he reported he had been spending more time in social settings with both friends and family members. He reported he continues to struggle with loud and high-pitched noises when he is in social settings and continues to spend most of his days online doing research about "the evolution of humanity." For his diagnosis of depression, Petitioner reported improved mood for four weeks which he attributed his use of psychotropic medications, psychotherapy, and more social interactions. With respect to his anxiety, Petitioner reported that he is no longer worried about his medical conditions and that he attributes this to more consistent sleep schedule, psychotropic medications, and psychotherapy. He reported no concerns for anxiety during the appointment. Regarding his sleep issues, Petitioner reported that he started using marijuana at that time to help himself fall asleep and that he is able to better fall asleep and stay asleep. However, he reported that he continues to nap for 5 to 6 hours per day and indicated that he believes he has undiagnosed narcolepsy. Petitioner reported taking his medication as prescribed, having no adverse effects of medication, that he is attending therapy appointments, that he reports that he does not see a continued disrupted sleep pattern as a concern, and he denied passive or active thoughts of suicide or homicide and does not have a suicide plan. ~~H~~He reported gastrointestinal symptoms including loose stools and diarrhea, as well as constipation and abdominal pain. Musculoskeletal symptoms included joint pain and swelling. During the mental status examination, it was noted that Petitioner was alert and awake, that his behavior and attitude were engaged, aloof, and appropriate to the clinical setting, his eye contact was poor, and his motor/cycle motor was calm. He was observed to have a steady gait, his posture up right, and his arm swing normal. He was fully oriented times four and his speech was normal in volume, prosody, articulation, spontaneity and was non-pressured. It was noted however, that he provided vague answers to questions. His affect was stoic, his thought process logical/linear, he did not appear to be responding to internal stimuli and thus had no hallucinations, there was no evidence of delusional framework, he was observed to have diminished insight based on his age and ability level and was unable to see how his sleep schedule negatively impacts his life goals. His judgment was appropriate and intact for his age and abilities and it was noted that there were no prominent memory concerns or prominent intellectual/executive functioning. Petitioner denied suicidal and homicidal ideations. Notes from a September 26, 2018 psychiatric evaluation indicate that Petitioner had not received any previous psychiatric treatment, although he saw a therapist for several sessions but was not currently engaged in therapy services. He

reported no history of mania, psychosis, trauma, or eating disorder behaviors. There was no evidence of any inpatient psychiatric hospitalizations and no history of suicide attempts or self-harming behaviors. Petitioner's primary encounter diagnosis was noted to be depression, major, recurrent, moderate; autism spectrum disorder, adult ADHD, and generalized anxiety disorder. It was recommended that he continue with medication treatment for his depression and anxiety, continue the use of melatonin at bedtime for the treatment of insomnia, and to continue with psychotherapy services. Petitioner was instructed to discontinue marijuana use as it had a negative impact on his sleep patterns and was informed that his current sleep patterns may negatively impact his goals of increased social interaction, increase productivity throughout the day and pain management. Notwithstanding the recommendation, Petitioner indicated that he did not intend to make any adjustments to sleep schedule. (Exhibit A, pp.150 – 164, 240 – 269).

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(s) (due to any cause)), 5.06 Inflammatory bowel disease (IBD), 12.04 (depressive, bipolar and related disorders), 12.06 (anxiety and obsessive-compulsive disorders), 12.07 (Somatic symptom and related disorders), 12.10 (Autism spectrum disorder), and 12.11 (Neurodevelopmental 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, 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). 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). 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), to which 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 conditions.

Petitioner testified that he suffers from chronic pain, chronic fatigue and that he is at a heightened risk of injury due to his hEDS. He testified that his fatigue takes over his whole body and he must sleep it off. He reported that his IBS flares up frequently and

results in discomfort, gas buildup, diarrhea and anxiety which last 1 to 2 weeks in duration. He testified that he has been diagnosed with a connective tissue disorder that causes pain all over his body. He stated that he can walk for only 5 to 10 minutes before needing to stop and rest due to muscle pain in his thighs, knees, and ankles. He reported that on bad days he uses a cane to assist with ambulation. Petitioner testified that he can sit for only five minutes due to his physical conditions, and that he is hyperactive and needs to move around frequently to keep from having joint pain. He testified that he can lift up to 20 pounds, but he avoids heavy lifting in order to prevent injury. Petitioner stated that he has difficulty gripping and grasping items such as bags of groceries with his hands. He stated that he can stand for 5 to 10 minutes and that he can bend and squat but with great difficulty. He reported that he wears corrective lenses for his vision, has sensory sensitivity due to his autism, and sees an audiologist for hearing issues. Petitioner reported that he lives in a home with his parents and that he is able to bathe and dress himself. Petitioner cares for his own personal hygiene. Petitioner testified that he does not perform household chores such as cooking, cleaning, or laundry and that he shops with his mother. He reported that while he has a valid driver's license, he does not drive due to his impairments.

Petitioner testified that he has suffered from depression and anxiety since he was a teenager and autism since he was a child. He stated that he has not received psychiatric treatment for his mental health impairments since last year and that his anxiety medication is prescribed by his primary care physician. He reported that he previously attended counseling at [redacted] but has not been in treatment since March 2019. Petitioner testified that his anxiety attacks are provoked by his G.I. symptoms and that his concentration is variable. He reported having difficulty with his memory and problems remembering details. He indicated that he often gets stuck on words and becomes obsessed, therefore, he cannot develop new patterns. He stated he has difficulty remembering to pay bills and his rent. Petitioner testified that he sometimes has meltdowns/anger outbursts, but they do not turn physical. He stated that he has no thoughts of hurting himself or others and denied any auditory or visual hallucinations. He testified that his social interaction is poor. Petitioner prepared a written statement that he read into the record during the hearing which explained in detail the symptoms of his impairments and how they interact together impacting his daily life. (Exhibit 1). It is noted that Petitioner had significant difficulty answering the undersigned Administrative Law Judge's questions during the hearing and required the assistance of his mother. Petitioner appeared to have difficulty understanding the questions being asked and was easily distracted by the background noises he heard in the hearing location.

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

The evidence presented is considered to determine the consistency of Petitioner's statements regarding the intensity, persistence and limiting effects of his symptoms. Based on a thorough review of Petitioner's medical record and in consideration of the reports and records presented from Petitioner's treating physicians, some of which are referenced above 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 moderate to marked limitations in his ability to understand, remember, or apply information; to interact with others; and in his ability to concentrate, persist, or maintain pace. He has mild limitations in his ability to adapt or manage oneself. Petitioner's nonexertional RFC is considered at both Steps 4 and 5.

Step Four

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

Petitioner's work history in the 15 years prior to the application consists of employment as a gas station attendant and a store clerk. Upon review, Petitioner's prior employment is categorized as requiring light exertion. Although based on the RFC analysis above, Petitioner's exertional RFC limits him to light work activities and thus he is not precluded from performing past relevant work due to the exertional requirement of his prior employment, Petitioner has additional nonexertional limitations that would prevent him from being able to perform past relevant work. Therefore, 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 [redacted] years old at the time of hearing, and thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. He is a high school graduate who has unskilled to 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 light work activities. Thus, based solely on his exertional RFC, the Medical-Vocational Guidelines, result in a finding that Petitioner is not disabled.

However, as discussed above, Petitioner has moderate to marked limitations in his ability to understand, remember, or apply information; to interact with others; and in his ability to concentrate, persist, or maintain pace as well as, mild limitations in his ability to adapt or manage oneself. The Department has failed to present evidence of a significant number of jobs in the national and local economy that Petitioner has the vocational qualifications to perform in light of his nonexertional RFC, age, education, and work experience. Therefore, the evidence is insufficient to establish that Petitioner is able to adjust to other work. Accordingly, Petitioner is found disabled at Step 5 for purposes of the SDA benefit program.

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

DECISION AND ORDER

Accordingly, the Department's 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 March 2, 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 in March 2020.

ZB/tlf

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

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

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

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

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

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

Via Email:

[redacted]

Petitioner – Via First-Class Mail:

[redacted]