[redacted]

Date Mailed: November 5, 2019
MOAHR Docket No.: 19-009539
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 October 7, 2019, from Detroit, Michigan. Petitioner appeared for the hearing and represented himself. The Department of Health and Human Services (Department) was represented by Mariah Schaefer Family Independence Manager.

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 [redacted], 2016, Petitioner applied for SDA benefits and alleged mental disabling impairments including posttraumatic stress disorder (PTSD), schizoaffective disorder, depression, and anxiety. In or around [redacted] 2017, Petitioner's application was approved based on a Disability Determination Service (DDS) finding that at the time, his condition met or equaled a listing under 12.03 (schizophrenia spectrum and other psychotic disorders). (Exhibit B, pp. 2-8)

2. Petitioner's SDA case closed effective [redacted] 2018 due to a failure to provide requested verifications. Petitioner has not received SDA benefits since that time.

3. On or around [redacted] 2019, Petitioner submitted an application for cash assistance on the basis of a disability.

4. On or around [redacted] 2019, the DDS found Petitioner not disabled for purposes of the SDA program. The DDS determined that Petitioner was capable of performing other work. (Exhibit A, pp. 4-21)

    a. The DDS determined that Petitioner had the residual functional capacity to perform sedentary work activities with additional occasional postural limitations including climbing, balancing, stooping, kneeling, crouching, and crawling. (Exhibit A, pp. 4-21)

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

6. On [redacted] 2019, Petitioner submitted a written Request for Hearing disputing the Department's denial of his SDA application.

7. Petitioner's case file indicates he also requested a hearing to dispute the Department's actions with respect to the Family Independence Program (FIP); however, Petitioner confirmed that there was no issue concerning his FIP benefits and thus, the request for hearing was withdrawn and will be dismissed.

8. Petitioner alleged physically disabling impairments due to back pain, bulging disc, arthritis, and degenerative disc disease (DDD). There was no evidence that Petitioner alleged any mental disabling impairments in connection with the [redacted] 2019 SDA application.

9. As of the hearing date, Petitioner was 35 years old with a [redacted], 1983, date of birth; he was 6'0" and weighed 280 pounds.

10. Petitioner obtained a GED and has reported employment history of work in construction at a concrete company, as a caregiver for his mother, and with a plumbing and electrical company. Petitioner has not been employed since June 2018.

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

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Health and Human Services Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the

SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180.

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

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If an individual is found disabled, or not disabled, at any step in this process, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled at a particular step, the next step is required. 20 CFR 416.920(a)(4).

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

Step One

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

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

Step Two

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

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

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

The medical evidence presented at the hearing was thoroughly reviewed and is briefly summarized below. It is noted that medical evidence presented in connection with Petitioner's [redacted] 2016 SDA application and documenting his mental health

treatment in 2016 and 2017 was presented with the prior DDS decision finding Petitioner disabled. Because Petitioner did not allege any mental impairments with his [redacted] 2019 application and because those records were already considered and reviewed by the DDS in its prior disability finding, they will not be considered for purposes of this Hearing Decision. (Exhibit B)

On August 9, 2019, Petitioner participated in a consultative physical examination, during which, he reported a history of chronic pain of the lumbar spine. He reported worsening pain in the lumbar spine since 2001, denied any injury, and stated he has not had any surgery. He denied radiation of the back pain and reported seeing a chiropractor in the past, along with physical therapy and steroid injections. Petitioner reported that his baseline pain level is up to 10/10, for which he takes Naprosyn. Petitioner reported that he uses a cane at times to assist with ambulation, that he can walk 300 feet, stand or sit for 1 to 2 hours, and is able to lift and carry the weight of a gallon of milk with either upper extremity. He reported difficulty putting on clothing below the waist but denied any issues with bathing. He reported living with his grandmother and uncle and that his grandmother does a majority of the cooking and cleaning. He does not own a vehicle and relies on friends and family for driving. Upon examination, Petitioner was observed to walk with a wide based gait and a mild right/left sided limp. He was without an assistive device for walking at the time of the examination. Physical examination of the extremities and musculoskeletal system indicated no edema, no paravertebral muscle spasms, limited range of motion of the lumbar spine, straight leg raise negative in the seated and supine positions and no erythema or effusion of any joint. Grip strength was 5/5 bilaterally as tested grossly and the hands had full dexterity bilaterally. Petitioner had mild difficulty getting on and off the exam table and moderate difficulty with heel and toe walking and squatting due to pain. (Exhibit A, pp.42-45)

Records from Petitioner's treatment at [redacted] in Indiana were presented and reviewed. (Exhibit A, pp.50 – 60). On [redacted] 2019, Petitioner presented with complaints of low back pain, stating that he can barely walk, has tried heat, massage, and muscle relaxers but nothing seems to help. He reported that his pain is a 10 and higher. Petitioner indicated that his pain stays mostly in his back but occasionally, he has an electric shooting pain into his right arm. He also reported that he is occasionally having some incontinence problems. Physical examination showed that his neck was tender and there was pain with motion. There was also tenderness over the right paraspinal muscles. Notes indicate that Petitioner was recently diagnosed as having a bulging disc and that he was receiving treatment for schizoaffective disorder, and PTSD. (Exhibit A, pp.50 – 60)

Records from Petitioner's treatment with his primary care physicians in Michigan were presented and reviewed. On [redacted], 2019, Petitioner presented with chief complaints of pain all over his body and insomnia. Petitioner was assessed as having arthralgia, myalgia, lumbar disc disease, and back pain. X-ray imaging of Petitioner's lumbar spine taken on [redacted] 2019 showed normal alignment, no compression fractures, minimal dextrocurvature of the lumbar spine, no degenerative disc disease, and no evidence of

facet arthropathy. Results show minimal spinal asymmetry but otherwise normal lumbar spine plain films. An MRI of Petitioner's lumbar spine was performed on [redacted] 2019. Results indicate that there was mild posterior disc bulging and mild bilateral degenerative facet hypertrophy at the L4 – L5 level with no significant spinal canal or neural foraminal stenosis. (Exhibit A, pp. 61-76)

On [redacted] 2019, Petitioner presented to the emergency department of [redacted] in [redacted], Indiana with complaints of neck pain and right shoulder pain for 1-½ weeks. Petitioner denied any trauma and reported that he has pain when he lifts his arm or turns his head. He has no chest pain, no shortness of breath, no numbness and no tingling in hand, no weakness in the upper extremities were reported. There was no tenderness in the back, and normal range of motion to the back. Normal range of motion, normal strength, no tenderness, no swelling and strong radial pulses were noted on musculoskeletal examination. Good range of motion was present to the right shoulder and no obvious deformity or bruising was noted. Pain over the right trapezius muscle was noted, but no pain over the midline of the neck, the thoracic or lumbar spine. On examination, it was determined that Petitioner was in no distress, and did not require any additional imaging studies, as there were no weakness or neurological symptoms. It was concluded that the symptoms were musculoskeletal in origin. He was discharged with a prescription for Flexeril and diagnosed with acute neck pain and shoulder pain. On [redacted] 2018, Petitioner presented to the emergency department with complaints of right-sided neck muscle spasms, back, neck, and foot pain, which he reported began approximately two days ago when he returned to work. He indicated he has been having difficulty moving since being back to work, as he does lift concrete at work. Petitioner reported that he has not lost control of his bowel or bladder and denied any issues with urination. Physical examination noted pain over the C-spine and posterior neck as well as pain over the ball of the left foot. Petitioner was observed to walk without assistance but with some difficulty noted. Musculoskeletal examination showed normal lower extremity exam, no contractures on limitation of movement, no joint laxity, no significant edema, no calf tenderness, intact sensation in the saddle region, tenderness on palpation of the right trapezius muscle distribution with some spasm appreciated, tenderness along the right paraspinous muscles of the lumbar spine, no midline cervical thoracic or lumbar spine tenderness step off deformity or crepitus noted, no evidence of ataxia, and the distal pulses were intact bilaterally. There was normal supple neck exam without masses, no significant local tenderness or spasm, full flexion and extension, good strength, no acute rash, and normal upper extremity exam. There was full range of motion at the wrist and elbow, good shoulder movement, no joint instability and normal muscle strength and tone. Petitioner was given a toradol injection and discharged. Petitioner presented to the emergency department on [redacted], 2018 with complaints of back pain, flank pain, abdominal pain, and bloody stools. Records indicate that he had history of Bell's palsy, lumbar disc bulge at the L4 – L5, and peptic ulcer disease. Records further indicate that Petitioner was admitted several weeks ago and had an MRI of his entire spine performed which showed mild L4 – L5 central and right-sided disc bulge, at which time Petitioner was evaluated by neurosurgery and it was recommended that he participate in physical and

occupational therapy, as there was no need for neurosurgical intervention at that time. Petitioner reported he has been unable to obtain physical and occupational therapy, that he is out of work and homeless. Petitioner reported that his pain is 10 out of 10, that it is aching in the right lower back and that it is worse with movement. He denied any numbness or weakness of his lower extremities and reported that six days ago, he had an episode where he accidentally urinated and lost control of his bowel movements. Petitioner reported that he's been able to walk without difficulty and he has no weakness in his lower extremities. Physical examination of the musculoskeletal system showed no extremity tenderness, full range of motion and all extremities, no edema and Petitioner had right-sided paraspinal tenderness to palpation in the lumbar region. His straight leg raise testing was negative bilaterally. There was no motor deficit and no sensory deficit upon neurologic exam. He was strong and his bilateral lower extremities had no sensory deficit. A CT scan of Petitioner's abdomen and pelvis showed a normal gallbladder, no evidence of kidney stones, no acute intra-abdominal pathology. Petitioner was discharged with instructions to take Tylenol and then tizanidine for muscle spasms. On [redacted] 2018, Petitioner presented to the emergency department with complaints of back pain that he indicated he has had for two months. He reported that he may have picked up something heavy but denied any direct trauma and denied numbness of the extremities. A CT scan of the lumbar spine performed on [redacted], 2018 showed right central to paracentral disc protrusion/spur at L4 – L5 with moderate central canal stenosis and moderate narrowing of the right lateral recess with possible compromise of the traversing right L5 nerve root and some of the right intrathecal nerve roots. There was no acute fracture or spondylolisthesis. He reported occasional weakness, but it is not constant, and it is intermittent over the past two months. Petitioner was transferred to [redacted] for evaluation by a neurosurgeon and for an MRI to be completed, the results of which are referenced above. (Exhibit A, pp. 78-136)

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner suffers from severe physical 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)), and 1.04 (disorders of the spine) were considered. A thorough review of the medical evidence presented does **not** show that Petitioner's

impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Steps 4 and 5, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s), including those that are not severe, and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4); 20 CFR 416.945(e).

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

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

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

objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. 20 CFR 416.967(e).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi).

In this case, Petitioner alleges both exertional and nonexertional limitations due to his medical conditions. Petitioner testified that he has been diagnosed with a bulging disc, arthritis and DDD. He stated that he has convulsions and his body spasms when he is sitting or standing. He reported going to physical therapy in [redacted] 2019 for only one day and stated he was informed they could not help him. Petitioner testified he has not been evaluated by an orthopedic surgeon but is working on getting an appointment for an evaluation. Petitioner testified that he lives with his grandma and uncle and he can only walk 20 feet before his back gives out on him and he needs to rest for several hours after walking. He stated that he recently started using a cane to assist with ambulation, however, this was not prescribed by a physician or other medical professional. Petitioner testified that he can sit for only a few minutes, then he needs to stand and stretch. It is noted that Petitioner readjusted positions while seated throughout the hearing, as observed by the Department representative present with him in the hearing room. Petitioner testified that he is able to stand for 30 minutes and can lift up to 20 pounds but is unable to bend or squat because he will not be able to get back up again. Petitioner reported that he is able to bathe himself and care for his own personal hygiene; however, he requires the use of a shower chair. He stated that he is able to dress himself but has difficulty with socks and shoes. Petitioner testified that he sometimes is able to help with cooking and dishes and some lawnmowing using a riding lawnmower. Petitioner stated that after performing chores, he must rest for a few days. He stated that he does his own shopping when he can get a ride to the grocery store, as he does not have his own vehicle. Petitioner did not report any issues with gripping or grasping items with his hands. It is noted that the Department representative testified observing Petitioner use a cane to assist with ambulation at the time of the hearing, and further observed him adjusting positions, as well as experiencing muscle spasms that radiated down the side of his body.

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. Although the CT of Petitioner's lumbar spine performed in [redacted] 2018 showed moderate central canal stenosis and moderate narrowing of the right lateral recess with possible compromise of the traversing right L5 nerve root, the June 18, 2019 MRI of Petitioner's lumbar spine confirmed that while he suffers from mild DDD at the L4 – L5 level, there was no significant spinal canal or neural foraminal stenosis at any level and no evidence of nerve root compression. Additionally, the records presented show negative straight leg raising tests and do not show that Petitioner had any documented significant limitations with respect to his ability to sit, stand, carry or lift. Thus, as referenced above, although Petitioner has medically determinable impairments that could reasonably be expected to produce symptoms, Petitioner's statements about the intensity, persistence and limiting effects of his symptoms are not fully supported by the objective medical evidence presented for review and referenced in the above discussion.

Therefore, based on a thorough review of Petitioner's medical records and in consideration of the above referenced evidence, with respect to Petitioner's exertional limitations, it is found that Petitioner maintains the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a). Petitioner has additional nonexertional limitations with respect to performing postural functions of some work such as stooping, climbing, crawling, or crouching, as evidenced by the results of the consultative physical examination and the diagnostic CT scan/MRI. Based on the medical evidence presented, as well as Petitioner's testimony, it is found that Petitioner has mild to moderate limitations on his nonexertional 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 home health care aide, in construction at a concrete company, and with a plumbing and electrical company. Upon review, Petitioner's past employment as a home health care aide is categorized as requiring medium exertion, his past employment in construction with the concrete company is categorized as requiring heavy exertion, and his past employment performing plumbing and electrical work is categorized as requiring medium to heavy exertion. Based on the RFC analysis above, Petitioner's exertional RFC limits him to sedentary work activities. As such, Petitioner is incapable of performing past relevant work. Because Petitioner is unable to perform past relevant work, he cannot be found disabled, or not disabled, at Step 4, and the assessment continues to Step 5.

Step 5

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

At this point in the analysis, the burden shifts from Petitioner to the Department to present proof that Petitioner has the RFC to obtain and maintain substantial gainful employment. 20 CFR 416.960(c)(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978).

When the impairment(s) and related symptoms, such as pain, only affect the ability to perform the exertional aspects of work-related activities, Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix 2, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

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

In this case, Petitioner was 35 years old at the time of application and at the time of hearing, and thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. He obtained a GED and has unskilled to semi-skilled work history that is not transferable. 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. Thus, based solely on his exertional RFC, the Medical-Vocational Guidelines, 201.27 and 201.28, result in a finding that Petitioner is not disabled.

Additionally, Petitioner has a nonexertional RFC imposing only mild to moderate limitations on his non-exertional ability to perform basic work activities with respect to performing postural functions of some work such as stooping, climbing, crawling, or crouching. Based on the evidence presented, at this time, it is found that the limitations identified would not preclude Petitioner from engaging in simple, unskilled, sedentary work activities on a sustained basis. Therefore, Petitioner is able to adjust to other work and is not disabled at Step 5.

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.

DECISION AND ORDER

Accordingly, the hearing request with respect to the FIP is **DISMISSED** and the Department's SDA determination is **AFFIRMED**.

ZB/tm

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

DHHS

Mariah Schaefer
3255 122nd Ave Ste 300
Allegan, MI
49010

Petitioner

[redacted]

cc: SDA: L. Karadsheh
FIP: B. Sanborn; M. Schoch
Allegan County AP Specialist (3)