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Date Mailed: November 27, 2019
MOAHR Docket No.: 19-009581
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

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 [redacted] Michigan. The Petitioner was represented by himself. The Department of Health and Human Services (Department) was represented by Michelle Morley, Assistance Payments Supervisor.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. A DHS-49 completed [redacted] was received and marked into evidence as Exhibit B. The record closed on November 7, 2019; and the matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit programs?

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 May 29, 2019, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On August 16, 2019, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 11-17).

3. On August 21, 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. 6-9).

4. On September 5, 2019, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 4-5).

5. Petitioner alleged disabling impairment due to high blood pressure uncontrolled at times, seizures, lumbar pain, degenerative disc disease, right knee pain with injections, multiple thoracic stress fractures, right shoulder displacement needs surgery, arthritis, osteoporosis, stomach pain, and vomiting. The Petitioner claims no mental impairment but is treated with medication for depression.

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

7. Petitioner is a high school graduate.

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

9. Petitioner has an employment history of work as handyman, maintenance worker at an apartment complex, surveyor, cashier at a convenience store/gas station, farm worker at a dairy farm tending milk cows and laborer at a sawmill.

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 Supplemental Security Income (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 1

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, she/he is not ineligible under Step 1; and the analysis continues to Step 2.

Step 2

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.

A DHS-49, Medical Examination Report was completed on [redacted], by Petitioner's primary care doctor. The current diagnosis was hypertension, depression and hyperlipidemia. During the physical examination, the exam notes indicate right arm and shoulder with deformity/defect. The Petitioner's condition was stable, and the doctor imposed limitations that were expected to last more than 90 days. The Petitioner could stand and/or walk less than two hours in an eight-hour workday and could occasionally lift up to 20 pounds and never more than 25 pounds. The Petitioner was evaluated as capable of simple grasping, reaching, pushing, pulling, and fine manipulating with a notation regarding right shoulder dislocation. The Petitioner could operate foot/leg controls with both feet. No assistive devices were medically required and/or necessary for ambulation; however, the notes indicate some sort of an assistive

device for the shoulder dislocation (arm sling). The doctor imposed no mental limitations and found that the Petitioner could meet his needs in the home.

A Medical Source Statement was also completed [redacted] by the Petitioner's primary care doctor. The doctor's evaluation noted the following limitations. The Petitioner could occasionally lift 10 pounds and frequently lift less than 10 pounds. He could stand or walk less than 2 hours in an 8 hour workday. The doctor notes that Petitioner must periodically alternate sitting and standing to relieve pain or discomfort. Pushing and pulling was limited in upper extremities due to history of compression fractures and repair and right shoulder deformity from a fall. The Postural limitations including never climbing, crouching or crawling, and frequently balancing and kneeling. Petitioner's manipulative limitations were reaching in all directions due to should impairment but could handle, finger fine manipulation and feeling skin receptors. No visual limitations were imposed and environmental limitations noted extreme temperature limitation due to shoulder and knee pain.

On [redacted], the Petitioner was seen in the emergency room having fallen off his bike in some gravel and pain to right shoulder. The Petitioner presented with multiple abrasions to right forearm, shoulder and right hand; the pain in his shoulder was 9/10. The Petitioner was given an arm sling and an instruction sheet for AC separation. X-rays were taken; there was no fracture evident but malalignment at the joint was noted.

The Petitioner was admitted to the hospital with a diagnosis of Barrett's esophagus and had a laparoscopic para-esophageal hernia repair. The [redacted] October 22, 2018, when he experienced continuing abdominal pain. The Petitioner also underwent a renal artery doppler. A previously discovered abdominal aortic aneurysm measuring up to 3.0 cm was better; no evidence of significant renal artery stenosis shown and a one 1.8cm simple cyst of right kidney noted. The Petitioner was previously seen in the ER on [redacted] for vomiting in epigastric pain. The Petitioner was released home in stable condition after some treatment.

On [redacted] the Petitioner had an MRI of the brain after two seizures. The impression noted mild edema within the bilateral parietal lobes and occipital lobes that is nonspecific, transient edema can be seen with seizures, however, also raises concern for possible PRES (posterior reversible encephalopathy syndrome). Recommend clinical correlation.

On [redacted], a CT scan of the cervical/upper thoracic spine was performed. The impression was mildly displaced fracture of the spinous process of T3 that is of uncertain acuity. It may be on a remote basis, however, recommend correlation with point tenderness. Mild emphysematous changes in the lungs. On the same date, the Petitioner underwent a CT scan of the head with no evidence of intracranial hemorrhage, masses or mass effect with no evidence of an acute infarction. The impression was normal non-contrast had CT. An x-ray of the thoracic spine was also performed noted multiple compression deformities in the mid-dorsal spine. There is

loss of approximately 40 to 50% body heights involving what appear to be T7 and T8 and 30 to 40% loss of body height at T6. Milder loss of height may be present 5-10% at T4 and T5. Mild dextro-convex bending is evident. Generalized demineralization. The impression was multilevel thoracic compressions. An x-ray of the abdomen was also performed on August 27, 2018; the impression was nonspecific nonobstructive bowel gas pattern and no acute cardiopulmonary process. The report noted high density left mid-lung nodular likely calcified granulomas. On [redacted] 2018, an x-ray of the abdomen was completed; the impression noted degenerative changes are noted in the lumbar spine with the impression no acute process in the chest, abdomen or pelvis.

On [redacted] an x-ray of the right shoulder was performed. Four views of the shoulder were taken noting a widening and malalignment at the acromioclavicular joint consistent with AC separation. No fracture evident. No glenohumeral dislocation.

On [redacted] a CT scan of the abdomen and pelvis with contrast was performed. The findings note that the surrounding pancreatic neck and body had some low density fluid, raises the possibility of acute pancreatitis. There was a mild fusiform dilation of the infra-renal abdominal aorta with no evidence of hemorrhage or adenopathy. The impression was suggestion of some fluid at the mesenteric base surrounding the pancreatic head. The appearance is suspicious for acute pancreatitis although underlying pancreas itself does not appear abnormal. Also noted small bilateral simple appearing renal cysts are seen with splenic granulomas. A three-point 2 cm fusiform infrarenal abdominal aortic aneurysm was noted and bilateral scrotal hydroceles.

On [redacted] the Petitioner was seen in the emergency room with abdominal pain, nausea and vomiting with pain described 8/10. After treatment with IV and a G I cocktail, the Petitioner was discharged with a diagnosis of acute exacerbation of peptic ulcer disease. During this ER visit, the Petitioner also had a resting ECG which noted an impression of normal sinus rhythm with sinus arrhythmia. Left anterior vesicular block abnormal ECG when compared with that of [redacted] The ventricular rate has decreased by 47 BPM. An ECG was conducted the following day and noted a septal infarct and was an abnormal ECG.

On [redacted] the Petitioner underwent surgery for his thoracic spine at T6. Prior to surgery, the surgeon diagnosed him likely to have osteoporosis because he has four fractures of the thoracic spine, three which are old in nature and one new. The Petitioner underwent a kyphoplasty at the T6 fracture site. The purpose of the surgery was to accomplish some height restoration at that level by the insertion of plastic fill. During this hospital stay from [redacted] Petitioner was treated for seizure, hypertensive emergency and compression of thoracic vertebrae. While hospitalized, the Petitioner was started on an antiseizure drug Keppra based on MRI imaging of his brain which demonstrated swelling around the parietal and occipital lobes. The Petitioner was also treated for non-intractable nausea noted cyclical vomiting syndrome versus cannabis-related hyperemesis. A prior medication for gastritis had been not helpful. Also considered was the cerebral edema as contributing to nausea as well. The planned outpatient right shoulder surgery was delayed at doctor's

suggestion due to multiple new medications and his recent hospitalization due to seizure. The Petitioner was to have a follow-up MRI at one month and follow-up with his primary care provider regarding assistance in reducing cannabis use and nicotine use.

On [redacted] the Petitioner had a seizure which required hospitalization causing incontinence of bowel and eyes rolling in the back of his head lasting two minutes or more. The Petitioner was taken to the hospital; the Petitioner had no recollection of the seizure and did have some headache post seizure. Upon arrival at the hospital, he had another seizure. The Petitioner's alcohol level was zero.

Reconstruction surgery was decided by the Petitioner after a consult with his surgeon on [redacted] and had determined to move forward with reconstruction at that time. On [redacted] the Petitioner was seen for an evaluation of his right shoulder having suffered an AC joint separation 10 months prior. He was seen previously; however, surgery repair was postponed given his recent hospitalization. He has a severe deformity and surgery options were discussed. The physical examination noted severe prominence over the AC joint. Full range of motion of the shoulder with superiorly migrated distal clavicle. Neurovascularly intact. He has 5/5 strength. X-ray imaging were reviewed demonstrating a grade 5 AC joint separation. There was some caution by the surgeon about the possibility of a continued prominence or failure of the graft fixation due to the fact that it has been such a severe deformity as long as it has. On [redacted] the Petitioner was seen for a right-knee injection based on right knee pain, internal derangement and mild osteoarthritis. The Petitioner received a cortisone injection.

The Petitioner had a follow-up MRI of the brain on [redacted] The impression was no acute intracranial findings and resolution of previously identified symmetric abnormal white matter signal within the parietal and occipital lobes.

The Petitioner had a bone density test on [redacted] the impression was a low bone density (osteopenia) based on the world health organization classification. The areas affected included the lumbar spine, left femoral neck, left total hip, right femoral neck and right total hip. The Petitioner was diagnosed with age-related osteoporosis with current pathological fracture.

On [redacted] the Petitioner was seen in the emergency department presenting with abdominal pain for four days. On examination, it was determined that the Petitioner had no discernible tenderness to abdomen, lab assessment lipase was in normal limits and EKG non-ischemic. The Petitioner was discharged home in stable conditions with directions to follow up if symptoms reoccur.

On [redacted] the Petitioner had an MRI of the thoracic spine. The findings noted re-demonstration of moderate anterior wedging T6 through T8. Both T7 and T8 were new findings from a CT taken in [redacted] 2017. There was increased height loss at T6 based on a recent x-ray. There was also mild associated edema signal. There were no associated disc herniations. No edema was identified within the T7 and T8 vertebral

bodies or elsewhere in the thoracic spine. There were no significant disc herniation's, no central spinal canal stenosis, and spinal cord demonstrates normal caliber and signal. The thoracic neural foramina are maintained. The impression was there was edema signal and fracture plane within T6 likely reflecting an acute component. At T7 T8 compression deformities appear remote. No listhesis, disc herniation or cord compression.

On [redacted] the Petitioner had an MRI of the lumbar spine. The impression was developing disc degeneration at the L4-L5 level with central annular measuring and a right paracentral disc protrusion contributing to moderate right lateral recess narrowing. No other abnormalities were appreciated.

The Petitioner was seen in the ER due to an assault on [redacted] with chief complaint left shoulder pain and left rib pain. On exam, he had pain with range of motion of left shoulder and palpation of the left chest wall. There was no acute fracture to left shoulder or left ribs.

The Petitioner was admitted to the hospital on [redacted] with complaints of vomiting. He had also been seen a day earlier with similar symptoms. He was discharged in stable condition on [redacted] While in the hospital, the notes indicate that Petitioner has had cyclic vomiting consistent with a THC hyper nemesis syndrome. The conditions reported were hypertension, Barrett's esophagus, chronic back pain and a recent diagnosis of PRES due to two seizures in [redacted] 2018. He reports with abdominal pain in the left upper quadrant and palpitations. In the ER, he was hypertensive with mild tachycardia, with elevated white blood cell count and hematuria. After testing and treatment, symptoms of nausea continued; and he was admitted. A CT of the Abdomen noted atheromatous aorta with stable small fusiform infrarenal abdominal aneurysm previously reported. There was thickening of colon wall observed, noting colitis cannot be excluded. An ECG was abnormal and notes sinus arrhythmia with left anterior fascicular block, septal infarct.

The Petitioner treated with a chiropractor consistently during the period [redacted]. When seen on [redacted] the notes indicate muscle spasms in upper thoracic, mid and lower thoracic spine, right anterior shoulder and lumbar curve to left with short right leg pelvic deficiency. Due to compression fracture at T5, chiropractic care was contraindicated. Petitioner's chief complaints were pain in upper, mid and lower thoracic spine and posterior cervical neck and right anterior shoulder with pain level 6 of 10. Notes of testing further indicate bone density decreased in cervical and thoracic spine with disc space narrowing at C3-4 and internal disc derangement at C6-C7, compression fracture at T5 and separation of the AC joint right shoulder. With a month of treatment, the Petitioner showed a 14% improvement. The Petitioner also self-evaluated and noted increased pain after standing one half hour and walking one half mile and diminished capacity to do work to 25%. The x-rays further note discogenic spondylosis of the cervical and thoracic spine.

The Petitioner is treated for depression with medications and is not enrolled in treatment for his depression or anxiety at the time of the hearing. The Petitioner's mental impairments were not alleged as disabling.

Step 3

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 5.0 Digestive System , 11.02 Epilepsy, 1.02 Major dysfunction of a joint(s), 1.04 Disorders of the spine and 4.00 Cardiovascular System listings were considered. The medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3, and the analysis continues to Step 4.

Residual Functional Capacity

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

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

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

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

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). In addition, four broad functional areas (understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself) 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. The nonexertional limitation would be due to seizure history the Petitioner is unable to climb or work at heights. Petitioner testified that he could that he tires quickly and cannot drive due to back pain and his dislocated right shoulder and that he also suffers from digestive problems and gets light-headed and dizzy. He

suffers pain dressing, putting his shirt on due to his arm which also affects his ability to wash himself, cannot wash his hair and can toilet himself with his left hand. He does watch his grandchildren a few hours a week. The Petitioner only prepares his breakfast, a meal of toast with a banana; and his other meal is prepared by his daughter-in-law; and he tires easily. He does not do yard work due to his shoulder limitation, and does not drive due to seizures. Petitioner described himself as being homebound and isolated. He could walk about one quarter mile and then required a rest due to pain and fatigue. He described being able to follow written and spoken instructions. He could carry up to seven pounds and stand about one half hour and sit one hour and then must move. He is prescribed a right-arm sling and a knee brace by his doctor. His primary care doctor has limited his ability to stand and/or walk less that two hours in an eight-hour workday. In light of his continued right shoulder joint separation, the Petitioner is also limited with pushing and pulling and reaching. The shoulder surgery was medically delayed after Petitioner's two seizures in [redacted] 2018.

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).

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

Step 4

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 maintenance handyman for a 20-unit apartment complex, a sawmill stacker, concrete polisher, a herdsman at a milk farm, a cashier at a convenience store/gas station and crew leader property surveyor. In his job as a maintenance handyman Petitioner was on his feet eight hours a day, shoveled snow and used a snow blower, climbed ladders and lifted 50 pounds and frequently 10 to 25 pounds, which required light to medium

physical exertion. As a sawmill stacker, he stacked different sizes of 10-foot cut logs to the proper stack, lifting 25 pounds frequently and up to 100 pounds and was on his feet all day. This job required medium physical exertion. As a dairy herdsman, he was on his feet 10 hours a day, climbed in and out of tractor all day, handled feed bags weighing 50 pounds and frequently lifted 10 pounds and was required to kneel, crouch, handle, grab or grasp big objects 10 hours out of the day. This job required light-to-medium physical exertion. In his job as a concrete polisher, he was on his feet 12 hours a day and carried up to 50 pounds, carried equipment to job site and carrying sanding pads and hand tools and drove the sander machine all day. This job required light-to-medium physical exertion. Petitioner's work as a cashier at convenience store required bending, twisting reaching and stooping to fill coolers lifting up to 20 pounds and frequently lifted 10 pounds and was on his feet all day. This job required light physical exertion. Petitioner's work as a crew leader surveyor assistant required walking and standing six hours a day, carrying up to 50 pounds and frequently 10 to 25 pounds and supervised one person on the job. This job required medium physical exertion.

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.

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

Step 5

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

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

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

In this case, Petitioner was [redacted] years old at the time of application and [redacted] years old at the time of hearing; however, Petitioner is currently [redacted] years of age and thus, considered to be advanced age (age 55 and over) for purposes of Appendix 2. He is a high school graduate with a history of work experience as a maintenance handyman, cashier, surveyor, concrete polisher, sawmill stacker and dairy farm herdsman. 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. In this case, the Medical-Vocational Guidelines result in a disability finding based on Petitioner's exertional limitations, Rule 201.04. Therefore, Petitioner is 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 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 [redacted], 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;

3. Review Petitioner's continued eligibility in November 2020.

LMF/jaf

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

DHHS (via electronic mail)

Sheila Crittenden
MDHHS-[redacted]Hearings
BSC1
L Karadsheh

Petitioner (via first class mail)

[redacted]
[redacted]
[redacted] MI [redacted]