GRETCHEN WHITMER
GOVERNOR

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

ORLENE HAWKS
DIRECTOR

Date Mailed: December 4, 2019
MOAHR Docket No.: 19-009886
Agency No.:
Petitioner:

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 with his mother, and his aunt, . Petitioner represented himself at the hearing. The Department of Health and Human Services (Department) was represented by Julie Bair, Hearing Facilitator; Lianne Scupholm, Eligibility Specialist; and Allison Butters, State Disability Assistance Worker.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records, specifically, updated mental health treatment records and 2019 psychiatric/psychological evaluations. Additional records were received, marked and admitted into evidence as Exhibit 1. The record was subsequently closed on November 6, 2019 and the matter is now before the undersigned for a final determination on the evidence presented.

ISSUE

Did the Department properly determine that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit program?

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On or around , 2018, Petitioner submitted an application seeking cash assistance benefits on the basis of a disability. (Exhibit A, pp. 1-6)

2. On or around [redacted], 2019, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. (Exhibit A, pp. 23-50)

3. On or around [redacted] 2019, the Department sent Petitioner a Notice of Case Action denying his SDA application based on DDS' finding that he was not disabled.

4. On [redacted], 2019, Petitioner submitted a timely written Request for Hearing disputing the Department's denial of his SDA application. (Exhibit A, pp. 85-86)

5. Petitioner alleged disabling impairments due to knee pain, closed head injury, diabetes and depression.

6. As of the hearing date, Petitioner was [redacted] years old with a [redacted], 1985 date of birth; he was [redacted]" and weighed [redacted] pounds.

7. Petitioner obtained a GED and has employment history of work as a driver, a factory worker, and in retail as a sales associate and customer service representative. Petitioner has not been employed since December 2016.

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 and in response to the interim order was thoroughly reviewed and is briefly summarized below.

On [redacted], 2019, Petitioner participated in a consultative physical examination, during which he reported that in January 2000, he sustained numerous injuries when he was involved in a motor vehicle accident including injury to his left knee, left arm and left leg. At that time, Petitioner also sustained a closed head injury and required surgery to repair fractures in his left arm and left leg. It was reported that two years later, he reinjured his left knee and required surgery to remove damaged cartilage. Petitioner reported that he is independent with his activities of daily living but on occasion will not perform them due to depression symptoms. He experiences pain in his left knee when climbing stairs but is able to walk a few blocks. There were no noted limitations with respect to sitting and Petitioner estimated that he can stand for about one hour. It is noted that Petitioner's mother, who accompanied him to the examination, stated that Petitioner can stand for only 15 to 20 minutes. Notes indicate that Petitioner was on several medications to treat his diabetes and high cholesterol. He was not observed to

wear a brace or use a cane or walker to assist with ambulation and Petitioner was able to open the door and use a telephone, as well as a writing utensil. Petitioner reported that he is deaf in his left ear, the cause of which is unknown. Upon physical examination, Petitioner's affect, mood, dress and effort seemed appropriate without obvious cognitive impairments. His hearing appeared normal and his speech was clear. His gait was stable and within normal limits and an assistive device was not used for ambulation. Musculoskeletal examination showed that grip strength was intact, graded at 5/5. Dexterity appeared unimpaired, and he demonstrated no difficulty getting on and off the examination table, no difficulty heel and toe walking, no difficulty squatting and arising, mild difficulty balancing on one foot and mild difficulty performing the tandem walk, which he and his mother attributed to an inner ear problem. Neurological examination showed that Petitioner's motor and sensory function appeared intact, Romberg testing was negative, straight leg raising was negative in the seated and supine positions and there was no radiating pain elicited. The examining physician concluded that while Petitioner had a history of closed head injury and diabetes, he did not appear to have developed significant associated side effects at this time. (Exhibit A, pp.229-232)

An ████████, 2019 letter drafted by Petitioner's treating primary care physician (PCP), Dr. ████████ indicates that since Petitioner's accident in 2000, Petitioner has had continuous problems with academics and learning, as well as multiple jobs which he has been unable to sustain due to problems with memory and processing. An evaluation from a neuropsychologist revealed that Petitioner had a mild neurocognitive disorder with cognitive impairment, causing problems with learning and processing information. Petitioner has a problem with attention deficit and sustaining focus or attention for more than a short period of time on any one task, resulting in his inability to learn new activities and be able to be successful at them. It was noted that Petitioner also has major depression requiring psychiatric counseling and medication. The doctor noted that although Petitioner can function and perform his activities of daily living, Petitioner's previous injuries from the motor vehicle accident have led him to be unsuccessful in maintaining any constant work history. (Exhibit 1)

Notes from a ████ 2019 visit with his PCP indicate that he was receiving treatment for hyperlipidemia, traumatic brain injury, and type II diabetes with multiple complications. Records indicate that Petitioner is deaf in his left ear. Physical examination showed that his mental status was alert and his affect was normal. He was oriented to time, place, and person, and his insight and judgment were good. There were no noted abnormalities upon physical examination. Petitioner had full range of motion to the neck and musculoskeletal system, his gait was normal, and his motor strength was normal. There was no joint tenderness or swelling observed. (Exhibit 1)

On █████████ 2019, Petitioner participated in a Psychiatric Evaluation as a new patient of ████████████. During the evaluation, Petitioner reported symptoms of depression for the last 20 years including sadness, lack of motivation, poor sleep, restlessness, fatigue and low self-esteem. He reported history of anger problems but indicated he has not

been physical since 2002. He also reported history of cutting and suicidal thoughts, although none were reported the day of the evaluation. He indicated he has not cut himself in many years but did overdose once 10 years ago and went to the emergency room. Petitioner reported that he was treated inpatient several times as a teen for cutting. Petitioner indicated that he has a traumatic brain injury (TBI) and since that time, has had depression and short-term memory issues. Difficulty concentrating was noted. He has not been hospitalized or treated psychiatrically since he was 18. Results of the mental status examination indicated that Petitioner made good eye contact, spoke clearly and coherently with regular rate and rhythm, denied suicidal or homicidal ideation, intent, desire or plan but admitted to chronic feelings of hopelessness and helplessness. He denied past or present auditory or visual hallucinations and denied paranoid or persecutory delusions. His thoughts were linear and future oriented and there was no evidence of tangentially. Petitioner was alert and oriented times four and his attention, focus, and concentration were adequate to the assessment by the doctor. His insight and judgment were limited to fair. Petitioner's prognosis was found to be guarded, depending on his engagement in treatment. He was diagnosed with major depressive disorder, recurrent episode: moderate. (Exhibit 1)

On ██████ 2018, Petitioner was referred for a Neuropsychological Evaluation of cognitive function and to assist with treatment recommendations, as he was struggling with depression. Petitioner was given a neuropsychological assessment battery (NAB) test, Wechsler adult intelligence scale – fourth edition (WAIS-IV) test, personality assessment inventory (PAI) test, Beck Depression inventory (BDI) test and Beck anxiety inventory (BAI) test. During the evaluation, Petitioner was restless and required multiple prompts to stay on task. Petitioner is deaf in his left ear and was unable to sit still, often changing his seated position during the evaluation, as there were observations of hyperactivity. The NAB test showed average language and executive functions abilities; below average spatial ability; mildly to moderately impaired memory ability; and moderately to severely impaired attention ability. Overall, the results suggested his cognitive functioning is in the mildly impaired range. The WAIS-IV testing showed that Petitioner's ability to sustain attention, concentrate and exert mental control is in the borderline range. This general weakness in attention, concentration, mental control, and short-term auditory memory may impede Petitioner's performance in a variety of academic areas but especially on tasks that require him to solve numerical problems mentally. Additionally, his ability to process simple or routine visual material without making errors is in the extremely low range, as he performed better than only 1% of his peers on the processing speed tasks. Processing speed is an indication of the rapidity in which Petitioner can mentally process simple routine information without making errors, thus a weakness in the speed of processing routine information may make the task of comprehending novel information more time-consuming and difficult. Thus, this weakness in simple visual scanning and tracking may leave him less time and mental energy. The conclusions and recommendations indicated that overall, the results suggest Petitioner's cognitive functioning is in the mildly impaired range and he meets the criteria for mild neurocognitive disorder due to traumatic brain injury as a result of experiencing impact to the head resulting in unconsciousness after a motor vehicle

accident, impairment into cognitive domains, and reported that he is still able to perform activities of daily living independently. He met the criteria for major depressive disorder due to experiencing significant sadness and complaints of weight loss, sleep disturbance, diminished ability to concentrate and recurrent suicidal ideation. His significant depression is likely due to his cognitive changes in physical limitations. His mild cognitive impairment, along with significant depression is likely contributing to his memory problems. It was recommended that he begin individual psychotherapy to address depression, suicidal ideation, life stressors and to learn strategies that aid with cognitive changes. He was also to consult with a psychiatrist for recommendations of psychotropic medications and to follow up with additional specialists to address other reported issues. It was also recommended that Petitioner utilize methods that will assist with his memory including using a planner or schedule, using mnemonic devices, writing down reminders and appointments, focusing on completing one task at a time and working in a designated quiet area or room. (Exhibit A, pp. 120-128)

Records from Petitioner's 2018 visits with his PCP were presented and reviewed. (Exhibit A, pp. 365-400). Notes indicate that Petitioner was receiving treatment for diabetes, hyperlipidemia and traumatic brain injury. During a ████████, 2018 visit, Petitioner reported fatigue, vomiting, and dizziness after running out of his medications. He reported no muscle aches and no joint pain, and physical examination showed he was morbidly obese. He was observed to ambulate normally with normal gait and station. His insight and judgment were good, his mood was normal, and affect was active and alert. Petitioner's musculoskeletal physical examination was normal in motor strength and tone with no additional abnormalities in the joints, bones, and muscles. Petitioner was advised to exercise, eat a prudent diet and lose weight to address his diabetes and hyperlipidemia. He was to take his medications daily. During an ██████, 2018 care management follow-up phone call, Petitioner reported that he walks about 2 miles in his neighborhood almost every other day, is taking his medications and has made modifications to his diet. Results of a █████, 2018 glucose testing showed a hemoglobin A1c level of 7.1 which was considered high, but an improvement from previous hemoglobin A1c level of 8.6. Notes from a █████, 2018 appointment indicate that he reported poor memory and inability to follow directions, however, Petitioner's physical examination was otherwise normal.

On ████, 2018, Petitioner presented to the emergency department of ██████████ ████████ with complaints of gradual onset headache and pain radiating down his neck. He denied symptoms of numbness or tingling, reported no changes to his vision other than slight photophobia. There were no noted abnormalities upon physical examination, his gait was even and steady and his cerebellar function was intact. His affect judgment and mood were normal and there was good range of motion in all major joints. Petitioner was discharged after being treated with medications. In ██████ 2018, Petitioner presented to the emergency department with cough and cold symptoms, as well as chills and body ache. He was treated for influenza like illness and released. Additional records from Petitioner's emergency department visits from 2016 through

2018 were reviewed; however, there was no indication of severe illness or impairment. (Exhibit A, pp. 416 – 474, 600 – 625)

The Petitioner underwent an excision of an atypical pigmented lesion to his right upper back and left ear. The lesions were completely excised, and margins were clear. (Exhibit A, pp.309 – 325, 337 – 364)

Records from Petitioner's [redacted] 2017 to [redacted] 2017 office visits at [redacted] indicate that he was receiving treatment for hyperglycemia, left knee pain, diabetes and high cholesterol. Notes indicate that in [redacted] 2017, Petitioner reported history of suicidal ideations and homicidal thoughts. He reported being hit by a car in 2000 resulting in a broken left arm, broken left leg and a closed head injury. He indicated he was previously living in [redacted] for the last eight years but returned to [redacted] 1 to 2 years ago. Petitioner reported chronic knee pain that is made worse by standing or walking for long periods of time. He also reported short-term memory issues since his TBI. X-ray results from [redacted], 2017 indicate minor arthritic changes and some enthesophyte formation related to the patellar tendon of the left knee interval development of slight medial joint space thinning and some anterior joint osseocartilaginous densities. In [redacted] 2017, Petitioner presented for constant earache with associated symptoms of ear popping, pressure, fullness and hearing deficit. In [redacted] 2017, Petitioner presented for a follow-up to check his stitches as he had melanoma removed from his back one week prior. In [redacted] 2017, Petitioner presented with symptoms of depression including depressed mood, difficulty concentrating, difficulty falling asleep, diminished interest and pleasure, fatigue, feelings of guilt, loss of appetite, paranoia, poor judgment, racing thoughts and thoughts of death or suicide. He was diagnosed with severe depression without psychotic features and was to continue medication. Petitioner began on the individual psychotherapy counseling in [redacted] 2017. (Exhibit A, pp.247 – 308).

Petitioner's medical records from 1997 through 2001 were also presented and reviewed. The medical documentation confirms that in [redacted] 2000, Petitioner was struck by a vehicle while walking to school and as a result, sustained multiple injuries including fracture of the tibia, fibula, and humerus. A Neuropsychological Evaluation from [redacted] 2001 indicates that Petitioner was diagnosed with attention deficit hyperactivity disorder, major depressive disorder recurrent, and personality disorder. (Exhibit A, pp. 475-597)

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)), 9.00 (endocrine disorders), 12.02 (neurocognitive disorders), and 12.04 (depressive, bipolar and related 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).

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). 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 exertional and nonexertional limitations due to his impairments. Petitioner testified that he was hit by a van at age 14 and as a result, suffered a brain injury. He indicated that he has been diagnosed with type II diabetes and that he takes a once a week injection but does not require the use of insulin on daily basis. He stated that he has left knee pain due to arthritis and loss of cartilage.

Petitioner testified that he can walk for 10 to 30 minutes depending on the terrain and his left knee pain. He does not require the use of a walking aid to assist with ambulation. He indicated that he has no limitations with respect to his ability to sit and testified that he is able to lift up to 50 pounds. Petitioner testified that he is able to stand for 1 to 1-½ hours before having severe knee pain. He reported that he is able to bend but is unable to squat. Petitioner reported no difficulty with gripping or grasping items with his hands. Petitioner testified that he lives with a roommate and is able to bathe and dress himself and care for his own personal hygiene; however, due to depression, he sometimes does not want to get out of bed. Petitioner reported that he performs household chores such as laundry and cleaning the kitchen and that he cooks simple meals for himself. He stated that he does his own shopping but often forgets items.

With respect to his nonexertional and mental limitations, Petitioner testified that he has been diagnosed with and receiving treatment for depression and ADHD since age 12. He stated that he now sees a therapist once a week and a psychiatrist once per month for medication treatment. He testified that his depression impacts his job duties, as he is not good with customers and often isolates himself because he does not like to talk to people. He reported that he has difficulty with concentration and often gets distracted after 5 to 10 minutes due to his ADHD. While Petitioner reported that he does not suffer from any crying spells, he testified that he isolates himself and hides in his room. Petitioner testified that he has no thoughts of hurting others but has thoughts of hurting himself a few times per week. He stated that he has made no attempts to hurt himself in the last 4 to 5 years. He denied any auditory or visual hallucinations and reported that his social interaction is limited. Petitioner testified that he was hospitalized for inpatient mental health treatment 3 to 4 times during his teenage years but none since that time. Petitioner stated that due to his closed head injury, he has severe issues with his memory, cannot maintain job instructions and has difficulty keeping daily tasks. He also stated that he is completely deaf in his left ear since childhood. It is noted that Petitioner had difficulty remembering information during the hearing and required assistance from his mother and aunt, who both provided testimony similar to Petitioner's with respect to his limitations.

His mother testified that he was enrolled in special education classes as a child and was placed in a juvenile group home where he received intensive in-home treatment. She stated that she must give him several reminders to complete tasks and that she accompanies him to all appointments. Petitioner's aunt testified that she is a human resource professional and that she has attempted to give Petitioner various jobs but because of his major memory problems, he cannot follow simple instructions or be left alone to complete the tasks without supervision. She stated that he has attended programs to develop life skills but was unable to complete the programs due to memory and cognitive issues.

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 May 2017 x-ray results of Petitioner's left knee showed arthritic changes and slight medial joint space thinning, there was no additional objective medical evidence or records documenting any 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 light to medium work as defined by 20 CFR 416.967(b).

Based on the medical records presented, as well as Petitioner's testimony, Petitioner has: moderate limitations with respect to his ability to understand, remember, or apply information; moderate limitations with respect to his ability to interact with others; moderate limitations in his ability to concentrate, persist, or maintain pace and mild limitations in his ability to adapt or manage oneself. It is found that Petitioner has mild to moderate limitations in his nonexertional ability to perform basic work activities.

Petitioner's nonexertional 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 driver, a fin press operator at a factory, and in retail sales. Upon review, Petitioner's past employment is categorized as requiring light exertion. 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. Additionally, as discussed above, Petitioner has a nonexertional or mental RFC imposing mild to moderate limitations in his nonexertional ability to perform basic work activities. After thorough review of the evidence presented, it is found that Petitioner's nonexertional limitations would not preclude him from engaging in simple, unskilled, light work activities on a sustained basis. Because Petitioner is capable of performing some of his past relevant work, it is found that Petitioner is not disabled at Step 4 and the assessment ends.

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 Department's 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

Carisa Drake
190 East Michigan
Battle Creek, MI
49016

Petitioner

[redacted]

cc: SDA: L. Karadsheh
Calhoun County AP Specialist (3)