GRETCHEN WHITMER
GOVERNOR

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

ORLENE HAWKS
DIRECTOR

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Date Mailed: December 5, 2019
MOAHR Docket No.: 19-011107
Agency No.:
Petitioner:

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 November 14, 2019, from Detroit, Michigan. The Petitioner was represented by his Authorized Hearing Representative (AHR). The Department of Health and Human Services (Department) was represented by Jennifer Depoy, Eligibility Specialist, Lead Worker.

The record closed on November 14, 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 , 2019, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On October 7, 2019, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 55-61).

3. On October 8, 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. 433-438).

4. On October 16, 2019, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 439-440).

5. Petitioner alleged disabling impairments due to a stroke, CVA, which occurred on [redacted] 2019, affecting his right side with a massive bilateral pulmonary embolism with right-side numbness and tingling, with symptoms of lightheadedness and dizziness. Petitioner alleges that the use of his right hand is also affected with use of thumb and pointer finger only and cannot grip with the hand or tie his shoe. Petitioner alleges daily headaches requiring him to lie down each day for at least 20 minutes. The Petitioner alleges that his speech is sometimes slurred. Petitioner is left-handed and is not physically affected on the left side from the CVA.

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

7. Petitioner has a GED.

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

9. Petitioner has an employment history of working as an assembler and packer of computer control parts (taping metal parts, cutting them) and using a computer in the process; once cut, the parts were sprayed and packed. He also worked lifting compressor parts on an assembly line and packaging. Petitioner also worked at a fast food restaurant cooking and as a cashier. He also worked performing maintenance/janitorial work cleaning various facilities.

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 90 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 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, 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 was reviewed and is summarized below.

The Petitioner was admitted to the ████████ Hospital on ████ 2019, after he was airlifted to the facility with cardiac arrest and syncope. The evening of ████ 2019, he had a syncopal event with seizure-like activity and was intubated and transported to an outside emergency department where he was pulseless on arrival. Patient required multiple doses of epinephrine before achieving return to spontaneous circulation; his CT revealed large bilateral pulmonary emboli. Petitioner was transported to this hospital for further evaluation. The notes indicated he was moving all extremities spontaneously and unable to follow commands as well as being intubated and sedated. At that time, his comprehensive metabolic panel was abnormal in many areas. His INR was 6.9. Exhibit, p. 189. The clinical impressions noted acute pulmonary embolism

with acute core pulmonale, cardiac arrest and shock. The Petitioner's hospital stay was for 10 days with the discharge on ██████ 2019.

Notes of the hospital admission after the pulmonary embolism indicate Petitioner had difficulty talking and possibly swallowing since coming off the ventilator. Speech of the patient was slow and imprecise with a note that intelligibility was 70% but was able to answer questions correctly and followed two-step commands. Petitioner was non-fluent, and labored groping for sounds and words and was frustrated could count from 1 to 10 but was unable to state the days of the week. Notwithstanding, the prognosis was good with continued improvement. The Petitioner was also neurologically examined and noted right lower face droop and face did not activate upon smiling. Petitioner was also unable to wrinkle his forehead on the right, and his speech was nearly unintelligible. As regards his swallowing difficulty, the progress notes indicate a diagnosis of oropharyngeal dysphagia. Several days after his admission, speech is only 70% intelligible; comprehension was impaired at the three-step command level and for paragraph comprehension. Throughout his hospital stay, the Petitioner received in-patient speech-language pathology services. A surface echocardiogram was performed on ██████ 2019, with the conclusion of normal right ventricular size and systolic function. Mild global hypokinesis on the left ventricle. Mildly decreased left ventricular systolic function. Right-to-left shunt noted consistent with a patent foramen ovale.

During his hospital stay, the Petitioner was transferred when ready to in-patient rehabilitation. Notes indicate patient was motivated to come to rehabilitation. The Petitioner was cleared by in-patient rehab to go home on ██████ 2019. The Petitioner was prescribed physical therapy and speech therapy on discharge and was told to purchase a shower chair. Petitioner was discharged home with Home Help Services.

The Petitioner participated in a consultative examination on ████████████ 2019, four months after his pulmonary embolism and hospitalization. The physical examination notes indicate that Petitioner walked without a limp and did not use an assistive device and is right-handed. For the most part, the physical examination was normal other than reduced grip strength on the right, which was 18.8 kg and left was 29.4 kg. Grip strength on the right (hand) was 3/5 and on the left was 5/5. The notes indicate Petitioner had decreased sensation to the right shoulder and upper arm area as well as the right side of his face along the jawline. The notes indicate Petitioner was able to ambulate with a normal steady gait. He was able to tandem walk without issue as well as go up onto his toes and rock back onto his heels. The examiner found he was able to sit/stand, bend, stoop, carry, push/pull, button clothes, tie shoes, dress and undress, dial a phone, open a door, make a fist, pick up a coin and pencil, and write. The examiner noted Petitioner could squat and arise from squatting, get on and off the exam table and climb stairs. The range of motion for the cervical, lumbar spines were normal. The ranges of motion for the shoulder, elbow, hip and knee were all normal ranges of motion as were the flexion and extension of his hands and fingers in both hands. The examiner concluded that the Petitioner was on Coumadin with regular labs and adjustments to his dosage. He determined Petitioner was left with right-handed weakness, decreased grip strength in the right hand, numbness to his right shoulder and numbness to the right side of his face, which causes him difficulty with swallowing.

The examiner also recommended that Petitioner seek out resources to obtain transportation so that he can begin physical therapy as this may help him with recovery from the stroke.

On ██████ 2019, the Petitioner met with his primary care physician as a new patient. During his physical examination, the Petitioner appeared nervous in mood with a flat affect. Petitioner was cooperative with preserved insight and judgment. No antalgic gait or posture was noted.

The Petitioner was seen again in the ER on ██████ 2019, due to a highly elevated INR level greater than 12. The Petitioner also presented with hypertension due to high blood pressure while in the emergency department. The Petitioner was discharged due to no source of bleeding noted or discovered. He was treated with oral vitamin K.

On ██████ 2019, the Petitioner, who is regularly tested for blood clotting, had an irregular INR goal. The Petitioner was seen in the emergency department presenting with lightheadedness, headache and unsteady gait on and off since being treated for his massive pulmonary embolism. The notes indicate that Petitioner is medication compliant taking his Coumadin as per prescribed, but has had issues with maintaining his INR levels. Petitioner described unsteadiness when standing and beginning to walk, however, denied any syncopal episodes or falls. The physical exam noted that he presented with a very flat affect. The physical exam was normal with no gross focal neurological deficits. The notes further indicate equal-grip strength bilaterally. A CT of the chest noted a small filling defect in the right lower lobe pulmonary artery. The CT noted marked improvement since the previous study which demonstrated extensive evidence of bilateral pulmonary emboli. An EKG noted a possible left ventricular hypertrophy. The final diagnosis was lightheadedness with sub therapeutic anticoagulation and anticoagulated on Coumadin. Petitioner was referred to follow up with his primary care physician. Petitioner had a CT of the head without contrast with no evidence of acute infarction hemorrhage, mass lesion, mass effect or midline shift. There was an area of cortical low attenuation in the left frontal region that is new from the prior exam. The impression was area of cortical low attenuation in the left frontal lobe new from prior study and may be related to an old infarct that has occurred in the interval or possibly related to previous trauma. No evidence of acute intracranial hemorrhage or acute infarct. A pulmonary angiogram was also performed with the following impression; there is a small filling defect in the right lower lobe pulmonary artery. The heart was normal in size with no significant coronary artery calcification. The Petitioner also had a 12 lead ECG performed which noted normal sinus rhythm with sinus arrhythmia minimal voltage criteria for LVH with a borderline ECG noted.

In ████████ 2019, the Petitioner was seen for follow-up regarding his pulmonary embolism. The notes indicate the examination was stable. Petitioner reported taking Coumadin as prescribed, with no antalgic gait/posture or movement disorder noted. The physical examination was normal. The INR levels again were above the goal but acceptable with a very low risk of bleeding. He was directed to continue taking Coumadin at the current dose/schedule due to the fact that his levels fluctuate quite a bit but are within the low risk of bleeding versus clotting. The next appointment was

within one week. A review of the records indicates that the Petitioner's INR levels fluctuate, and in ███ 2019 were outside the reference range of 2-3.

Since his pulmonary embolism in ███ 2019, the Petitioner has not participated in any out-patient physical therapy, although has been prescribed physical therapy. He has seen his primary doctor only three times since he was established as a patient with his doctor. The consultative examiner recommended physical therapy to assist the Petitioner in his recovery from his stroke.

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 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 4.00 Cardiovascular System and 3.00 Respiratory 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. 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. Petitioner testified that he could shower and dress himself with some added effort due to some right-sided numbness. He was able to boil water and microwave a meal but did no other chores, such as laundry or cleaning or grocery shopping which are performed by his grandmother who he lives with and his father who grocery shops for him. He also expressed concern about working around sharp objects or metals that could cut him as he is on blood thinners. He does not feel safe driving due to lightheadedness, but his doctor has not told him that he could not drive. Petitioner testified that he could lift 10 pounds with his right hand/arm and 25 pounds with his left hand/arm, the reason for the difference is his CVA affected the right side. Petitioner is also left-handed and testified that he can write. He also can lift his right arm over his head. The Petitioner testified that he does not use a cane or a walker and limps sometimes. His grip strength in the right hand is 3/5 and the left is 5/5. Petitioner testified that he has difficulty with his right hand reacting and moving and could not tie his shoes. Petitioner also testified that he has headaches daily and has to lie down for 15 or 20 minutes when he does. The Petitioner testified that he could walk 20 or 30 feet and then gets light-headed. Petitioner walked approximately 50 feet to get to the hearing room. The Petitioner testified that he could sit 30 minutes. Petitioner also testified that he has difficulty taking steps to accomplish certain tasks like making a doctor appointment.

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).

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has no medically documented limitations on his mental ability to perform basic work activities. Petitioner testified that he had depression as a result of his pulmonary embolism but was not in treatment for his depression. As regards his non-exertional limitations it is determined that based upon his ability to answer questions and comprehend the questions asked of him his non-exertional impairments are mild.

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 working as a factory worker doing assembly work packaging parts and at a fast food restaurant. Petitioner worked as a parts assembler assembling compressor parts, preparing the parts for packaging and packaging those parts, which required standing all day seven hours and lifting up to 18-20 pounds regularly, required light physical exertion. Petitioner's job as an assembler also required him to load racks, gauging the parts and packing them. He stood most of the day, and based upon his work history of this job, lifted 10 pounds frequently and required light physical exertion. Exhibit A, p. 102. Petitioner's work as a fast food worker required him to cook, run the register and unpack the truck delivering supplies. This work was considered light work. Petitioner also performed janitorial work lifting between 5 and 50 pounds and cleaning up steel parts and 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).

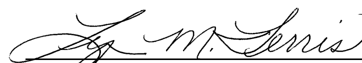
In this case, Petitioner was ██ years old at the time of application and ██ years old at the time of hearing, and thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. He is a high school graduate semi-skilled and unskilled work history with a history of work experience as a factory assembler and packager, maintenance work and fast food restaurant cook. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities.

Based solely on his exertional RFC, the Medical-Vocational Guidelines, 201.23, result in a finding that Petitioner is not disabled.

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**.



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)

Denise Croff
MDHHS-[REDACTED]Hearings
BSC4
L Karadsheh

Authorized Hearing Rep.
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[REDACTED]
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Petitioner
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