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

Date Mailed: January 24, 2020
MOAHR Docket No.: 19-011928
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 December 4, 2019, from [redacted] Michigan. The Petitioner was represented by himself. The Department of Health and Human Services (Department) was represented by Marci Walker, Lead 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. Exhibit B, Petitioner's medical records from [redacted] was received and marked into evidence; Exhibit C, medical records from [redacted] was received and marked into evidence; Exhibit D, medical records from [redacted] was received and marked into evidence; and Exhibit E, medical records from [redacted], PAC, were received and marked into evidence. A DHS-49 Medical Examination Report requested to be complete by [redacted] was not received. The record closed on January 6, 2020, 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 June 3, 2019, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On October 28, 2019, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 488-497).

3. On October 31, 2019, the Department sent Petitioner a Notice of Case Action denying the application based on DDS finding of no disability.

4. On October 31, 2019, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 1a and 1b).

5. Petitioner alleged disabling impairment due to epilepsy, diagnosed as juvenile myoclonic epilepsy and absence seizures, acid reflux, bowel irritation, abdominal pain, diarrhea, memory loss, social anxiety, migraines and depression. The Petitioner is being followed by a neurologist who has recently performed an operation for insertion of a vagal nerve stimulator (VNS) that stimulates the vagus nerve with electrical impulses to treat epilepsy and lessen frequency of seizures. The Petitioner also alleged back pain with radiation to his legs.

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 is a high school graduate and attended special education classes in elementary school and early middle school.

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

9. Petitioner has an employment history of work of building pontoon boats and installing wiring. He also worked as an auto detailer, and at Taco Bell, a fast food restaurant, cooking and unloading trucks and for a staffing company building wood lawn chairs.

10. The Petitioner can grocery shop and does laundry and cleaning at his home.

11. 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 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, *and in response to the interim order,* was reviewed and is summarized below.

The Petitioner was seen for a neurosurgical evaluation and consultation on [redacted] 2019. During the appointment, Petitioner was evaluated for a vagal nerve stimulator. The notes indicate Petitioner began having seizures at age [redacted] but had not had a tonic-clonic seizure for six months. He has been having absence seizures weekly lasting about 30 seconds and is not aware of seizure onset. Petitioner also reported headaches and visual disturbances. Petitioner also complains of bilateral lumbar pain that radiates occasionally to buttocks and legs. An examination of the lumbar region was normal with normal range of motion with straight leg raising negative bilaterally. Reflexes were normal, as was motor strength with no weakness, atrophy or fasciculation. The Impression was seizure disorder with surgery recommended. The neurologist recommended insertion of a vagal nerve stimulator. The diagnosis was intractable partial complex seizures without status epilepticus.

By way of seizure history, the Petitioner, while at work, had a seizure and was taken to the ER by ambulance and was seen in the ER on [redacted] 2017. The Petitioner reported medication compliance. The seizure appeared to be a grand mal seizure, and Petitioner complained of left shoulder pain with abrasions on his arm and did bite his tongue. At the time of the ER evaluation, Petitioner reported two past seizures in the prior two years. The notes indicate a refractory seizure which was not controlled by medication and was not post ictal. Petitioner was discharged home in stable condition and was to follow up with his neurologist. The seizure was described as a break-through seizure. Another seizure occurred in [redacted] 2017 while playing a video game; a friend described observing Petitioner being out of it for two minutes; and he had bit his tongue and was discharged home. Another seizure and ER visit occurred in [redacted] 2018. The seizure occurred while sleeping, and notes indicate he forgot to take his medications and had smoked marijuana. Petitioner was discharged to home to follow with his neurologist.

The Petitioner described his condition as epilepsy, juvenile, myoclonic starting at age 15.

On [redacted] 2018, Petitioner was seen in the ER due to difficulty focusing and occasional confusion with onset eight days. Petitioner reported an increase in frequency of his seizures over the past few month with most recent seizure on [redacted] 2018, with report of last seizure about one week ago and reported being postictal but can do his daily activities and was discharged in stable condition. At the time of the most recent seizure, an Electroencephalogram was consistent with idiopathic generalized epilepsy.

On [redacted] 2019, the Petitioner had a left vagus nerve stimulator (VNS) surgery for placement/insertion of stimulator. The operation was successful.

The Petitioner was seen on [redacted] 2019, at the Institute for Neurosciences and Multiple Sclerosis for a follow-up visit. The Petitioner reported problems with his medications; Briviact made him very agitated, and Zonisamide caused cognitive issues and speech problems with difficulty finding his words. Petitioner also was taking

Depakote and reported double vision with the medications which has worsened over the last six months. Vision bothers him when reading. Petitioner also reported that some days he has no issues. The Petitioner reported brisk walking for exercise. Medications were continued until VNS was placed. The diagnosis was epilepsy unspecified not intractable, without status epilepticus.

The Petitioner was seen again at the Institute on [redacted] 2019, for follow-up with VNS turned on. The Petitioner reported that the VNS causes him to feel a pulling sensation in his neck/chest, irritating his voice and causing him to clear his throat. The Petitioner's examination noted blurry vision, with diplopia with eye pain. Petitioner reported abdominal pain with diarrhea and nausea; back pain and headaches with memory loss. The Petitioner also reported convulsions and seizure-like activity and anxiety, with difficulty concentrating and depression and abnormal sleep pattern. There was no change to the medications, and the VNS overall was doing well. Hoarseness and hypophonia was discussed and suspected to be procedure related. Petitioner was seen on [redacted] 2019, for adjustment to VNS. The settings were adjusted. The Petitioner presented with no confusion. Another visit on [redacted] 2019, for adjustment of the VNS was made and Petitioner reported it was getting easier to get used to. Petitioner reported that migraines were coming back and were located in the back of his head and on left side. Petitioner reported 3 to 4 migraine headaches weekly with light sensitivity. Depression and anxiety were reported with difficulty concentrating and memory loss. Notes indicate suspicion that back and neck pain are triggering headaches. Petitioner was seen again for VNS adjustment on [redacted] 2019; Long-term memory was noted more affected than short-term memory. His mother also attended the exam and noted that Petitioner has become more depressed. The physical and neurological exams were normal. The exam notes do not indicate absence seizures or other seizure activity.

The Petitioner was seen at Arnold Medical Center on [redacted] 2019, for a surgical clearance for insertion of the VNS and was cleared with the comment, "patient is low risk and may proceed given his EKG is within normal limits".

Petitioner was seen by a gastroenterologist on [redacted] 2019, for a follow-up due to diarrhea. Petitioner reported loose stools 2 to 3 times per day and reported that a prescribed drug, Levsin, has helped his abdominal pain. Symptoms included cramping, abdominal pain, chills and fatigue. At the conclusion, the plan was to continue Levsin and take fiber supplement and complete fecal calprotectin. If no improvement, may consider colonoscopy. The Petitioner has been diagnosed with acute gastroenteritis since [redacted] 2019. At an adult annual health examination, the results indicated no abnormal findings.

The Petitioner was also seen in [redacted] 2019 and [redacted] 2019 by his gastroenterologist who recommended a high-fiber diet and to complete a stool study as well as a hida scan, which was normal. In [redacted] a polyp was noted on his gall bladder with note that abdominal pain and diarrhea have been improving. Petitioner had an ultrasound of his abdomen with

Impression small 2.2mm gallbladder polyp within minimally distended gallbladder with no evidence of gall stones or gallbladder wall thickening. Common bile duct not dilated, and no focal hepatic lesion. No Hydronephrosis involving the right kidney.

Petitioner was seen by a gastroenterologist on [redacted] 2019, with complaints of abdominal pain located in right upper quadrant and right lower quadrant and has had this condition for many years with increasing intensity. The abdominal pain was described as sharp and stabbing and crampy. Symptoms are aggravated by fatty foods. Symptoms were diarrhea and heartburn with abdominal pain and loose stools. The plan was to treat diarrhea with a drug taken before meals and to run labs for abdominal area.

The Petitioner participated in a Psychological Evaluation arranged by the DDS on [redacted] 2019. During the exam, Petitioner said he had difficulty interacting with people and also expressed self-doubt and self-blame, and that everything was his fault, and he was a failure. Petitioner also expressed having anger issues; he expressed that he bottles everything up and then tends to lash out on the person he cares about most. No psychiatric hospitalizations were reported. The Petitioner reported having two friends but described that he was increasingly isolated socially. Petitioner reported doing chores and maintaining his one-bedroom apartment. He does not drive and does do his own grocery shopping being driven by his mother. The examiner described the Petitioner's demeanor as pleasant and cooperative with no inappropriate behavior. He was not significantly distracted or inattentive. Insight was adequate and Petitioner did not minimize or exaggerate his symptoms. His thought process was logical and coherent with no evidence of thought disorder. Petitioner reported intermittent suicidal ideation but denied any intent. Petitioner had a full range of affect and appeared capable of regulating his emotions. He did not present with significant anxiety, anger or suspiciousness. He did not exhibit vegetative signs of depression. Petitioner rated his depression as between a 6 or 7 out of 10 with 10 being most intense. His anxiety was rated as a 10, expressing that he is stressed about everything, meeting new people, appointments, having to talk to new people and new things and doesn't like change. A Beck Depression Inventory test was administered to evaluate Petitioner's mood. The score was 35 which is in the range of severe (29-63). During the test, Petitioner reported hopelessness, worthlessness, guilt, reduced capacity to experience pleasure, feelings of failure, self-loathing, intermittent suicidal ideation, crying, restlessness and agitation, irritability, reduced interest in people and things, reduced appetite, indecisiveness, significant concentration difficulty, fatigue, reduced energy, sleep disturbance and loss of interest in sex. Mental capacity evaluation noted that he could recall only one of three objects after a three-minute time lapse and could complete serial 7's without mistakes and was able to name five cities, famous people and current events. The exam was summarized as follows: 1) Petitioner was mild to moderately limited but could follow simple instructions; 2) Concentration/persistence/pace (mild to moderate) limitations; 3) Social Interaction (general public, request assistance, respond to criticism, socially appropriate behavior, asking for help when needed (moderate) limitations; 4) Adapt or Manage oneself (changes in the work setting, travel to unfamiliar

places/public transportation, set realistic goals) (Mild to Moderate). The diagnosis was Major Depressive Disorder, Recurrent, Moderate and Generalized Anxiety Disorder. The prognosis was Guarded.

In [redacted] 2018, the Petitioner was seen after losing medical insurance and being off his epilepsy medications for several months and had experienced 4 to 5 grand mal seizures. Notes indicate that Petitioner has had no seizure for over one year while on medication with the breakthrough seizures occurring while Petitioner was off his medications. After the visit, the medications were adjusted with a follow-up in six weeks. At a follow-up visit on [redacted] 2019, Petitioner reported he was medication complaint and had had three absence seizures on [redacted] 2018, which may have been due to sleep deprivation. At the end of the examination, the Petitioner was given information on a VNS device. In a follow-up visit in [redacted] 2019, the Petitioner was vomiting after taking his Depakote medication and reported some small seizures where he loses awareness. At the conclusion of the visit, a referral was made for a VNS device consultation and a referral to a gastroenterologist to evaluate nausea and stomach upset. The Petitioner's Depakote levels were also to be evaluated by another doctor.

On [redacted] 2018, the Petitioner had neuro-diagnostic services for an electroencephalogram. The impression was abnormal awake and sleep electroencephalogram. The generalized 4 to 6 spike and wave activity is consistent with an idiopathic generalized epilepsy. Clinical correlation is required during the procedure hyperventilation was performed by the Petitioner; and during this period, Petitioner experienced what is recorded as a generalized seizure with electro graphic correlate lasting 13 seconds followed by a brief period of generalized suppression.

On [redacted] 2019, the Petitioner was seen for a follow-up visit regarding his anxiety and depression by his primary doctor. During the examination, notes indicate that symptoms include anxiety, excessive worry and panic attacks. The notes indicate Petitioner has changed jobs and is working on quitting smoking and is under less stress and feels 50% improved from the last visit. Of note was the Petitioner's BMI, which was documented below normal parameters with a BMI of 19.66kg/m2.

The Petitioner provided information that he last had a grand mal seizure in [redacted] 2018 when he had two seizures. The Petitioner reported he first had a seizure in [redacted] 2015, and his last seizure was in [redacted] 2018. He also noted they had become more violent and affect his memory more. The information was completed on [redacted], 2019.

The Petitioner was seen in the ER due to a breakthrough seizure on [redacted] 2018, having had a tonic-clonic seizure while at a friend's house. He was discharged home with instructions to increase his Depakote medications. In [redacted] 2018, the Petitioner was seen in ER arriving by ambulance for evaluation of having a seizure while at work and fell and hit his head. Petitioner was discharged after a CAT scan of head and neck were normal and in stable condition. The Petitioner had run out of his epilepsy

medications, which were refilled. He was ordered not to drive or operate heavy equipment until cleared by neurology.

On [redacted] 2018, the Petitioner was seen in the ER after having a seizure and noted he fell down, could not walk, and felt confused and had been taking his medications. A CT of the head was negative for any injury. Petitioner was discharged in stable condition and was seeing his neurologist the following day.

On [redacted] 2019, the Petitioner was seen in the ER due to abdominal cramping, diarrhea, nausea and vomiting during the past four days. The visit was to ensure that due to Petitioner's seizure disorder, that the electrolytes were not abnormal. The abdominal exam was benign, and lab work was entirely unremarkable; and after being administered Zofran, Petitioner felt improved.

Petitioner completed an Activities of Daily Living form on [redacted] 2019. In the report, he indicates he needs no help with grooming or bathing or dressing. Petitioner reported difficulty sleeping and fixes his own meals and tries to gain weight to get over 130 pounds. His medications affect his appetite at times. He is able to do laundry, cleaning, vacuuming, dishes, shoveling of snow from porch and stairs, and sometimes spends an hour and a half at this work. Petitioner is able to make a grocery list and shop for groceries. Petitioner reported when reading for a long time, he gets a severe migraine, usually after reading for an hour or more. Petitioner spends time with his mother and father, and on weekends sees two friends. He helps his mother with yard work and cleaning. Petitioner has no organized activities such as clubs, church or other group activities.

On [redacted] 2019, the Petitioner completed a seizure report detailing his seizures. He reported that his seizures began in [redacted] 2015; and at the time of the report, he reported his last seizure on [redacted] 2018. The Petitioner also gave a history of seizures that occurred during each month of the last 12 months: for [redacted] 2018 he reported one grand mal seizure; for [redacted] 2018, no seizure; for [redacted] 2018, no seizure; for [redacted] 2018, one grand mal seizure; for [redacted] one grand mal seizure; for June 2018, one grand mal seizure, for [redacted] 2018, two grand mal seizures; for [redacted] 2018, nothing reported, for [redacted] 2018, nothing reported; and for [redacted] 2018, one grand mal seizure; for [redacted] 2018, last seizure as above. He described his symptoms as loss of awareness, confusion, glassy eyes with dilated pinpointed eyes and white as a ghost with an empty stomach feeling. He also reported that at the time his memory was affected. He indicated that the seizures come without warning. His after-seizure activity includes nausea and vomiting, dizziness and weakness, long-lasting headache, long period of sleep and muscle soreness. The Petitioner's seizure report does not document any seizures after [redacted] 2018. And was completed in [redacted] 2019.

The Petitioner presented no medical evidence which established back and neck problems other than reports of some pain symptoms, and no testing, other than a

physical exam with no positive sign for straight leg raising or significant treatment was reported to establish these medical complaints.

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 11.02 Epilepsy, 5.06 Inflammatory Bowel Disease 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. Therefore, Petitioner is not disabled under Step 3; and the analysis continues to Step 4.

With respect to the requirements of the epilepsy, after a review of the medical evidence provided, dyscognitive seizures as defined in 11.00H1b were considered; however, the evidence presented no record by Petitioner or his neurologist that supported seizures occurring at least once a week for at least three consecutive months despite adherence to prescribed treatment.

In addition, the medical neurology evidence presented did not diagnose dyscognitive seizure which are characterized and defined as alteration of consciousness, without convulsions or loss of muscle control. During the seizure, blank staring, change of facial expression and automatisms, such as lip smacking, chewing or swallowing or repetitive simple actions such as gestures or verbal utterances) may occur. During its course, a dyscognitive seizure may progress into a generalized tonic-clonic seizure. Petitioner's more seizures did appear to fit this description, but the record of occurrences required to meet the listing were not demonstrated.
See 11.00H1a, Social Security Administration Listing of Impairments. https://www.ssa.gov/disability/professionals/bluebook/11.00-Neurological-Adult.htm#11_02
https://www.ssa.gov/disability/professionals/bluebook/11.00-Neurological-Adult.htm#11_00H1a

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.*

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 nonexertional limitations due to his medical conditions including depression and epilepsy. There was no medical evidence of exertional limitation other than back pain with minimal treatment records and no testing. Petitioner testified that he could stand at least an hour and sit about thirty minutes and would have to stand due to back pain. He could walk a mile and squat and was able to bend at the waist and did not mention restrictions. Petitioner can shower and dress himself, tie his shoes, and touch his toes. The Petitioner could carry up to 25 pound and was limited to 15 pounds with the left hand arm and 20 pounds with the right hand/arm. The Petitioner is able to clean his apartment and helps his mother with yard work and shoveling snow. The Petitioner did testify that he did have back pain with some radiation to the left leg.

The Petitioner's seizure activity of late did not appear to be tonic-clonic in nature with loss of consciousness and convulsions but were described as absence seizures which cause Petitioner to lose awareness of his surroundings for short periods "like spacing out" with shorter duration and no loss of consciousness or falling. As such, Petitioner's ability to perform work that allowed him to sit and walk throughout the day could be performed. Given the Petitioner's seizure history, any work he performs should not include climbing ladders, require working at heights or working on scaffolding and should not include operating or being around heavy equipment both which could cause possible injury to Petitioner and others in the work place.

As regards Petitioner's mental impairments resulting in depression and anxiety, the consultative psychological examination found the following: 1) Petitioner was mild to moderately limited but could follow simple instructions; 2) Concentration/persistence/pace (mild to moderate) limitations; 3) Social Interaction (general public, request assistance, respond to criticism, socially appropriate behavior, asking for help when needed (moderate) limitations; 4) Adapt or Manage oneself (changes in the work setting, travel to unfamiliar places/public transportation, set realistic goals) (Mild to Moderate). The diagnosis was Major Depressive Disorder, Recurrent, Moderate and Generalized

Anxiety Disorder. The prognosis was Guarded. Petitioner's consultative psychological examination did not establish significant functional deficits with respect to the four broad categories referenced above and were rated mild to moderate limitations.

In addition, the Petitioner has had no treatment for his mental health issues. Based upon the examination the medical evidence does not support a finding that Petitioner mental impairments would markedly impact his ability to function performing simple/routine work tasks.

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 nonexertional limitations, such as climbing ladders, avoiding heights and heavy equipment it is found based on a review of the entire record that Petitioner maintains the physical capacity to perform light work as defined by 20 CFR 416.967(a).

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild to moderate limitations on his mental ability to perform basic work activities and as such he is capable of performing simple, routine tasks.

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 in a fast food restaurant stocking items and cooking, boat building installing electrical wiring systems and working with fiberglass, auto detailing requiring cleaning, vacuuming autos, and waxing which required standing and stooping and reaching and temp labor jobs. Petitioner's work as a boat builder required standing and stooping to install equipment and it appears he could perform this job testifying that he was very good at it,

but added that was not allowed to return to this job based upon his testimony that he could not return to this job due to his seizure and not due to reasons regarding his performance. The fast food job also required standing and lifting; the Petitioner did not specify the weights involved in these jobs. It is determined that Petitioner could working in fast food restaurant doing simple tasks and perform boat wiring installation and auto detailing work and as such is capable of performing past work and lifting up to 20 pounds with restrictions to work around heavy moving equipment, scaffolds and heights.

Based on the RFC analysis above, Petitioner's nonexertional RFC limits him to no more than light work activities. Petitioner also has mild to moderate limitations in his mental capacity to perform basic work activities. In light of the entire record, it is found that Petitioner's nonexertional RFC does not prohibits him from performing past relevant work. As such, it is determined that Petitioner is capable of performing past relevant work and, accordingly, 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 MA and/or 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

Marci Walker
MDHHS-[redacted]Hearings
BSC2
L Karadsheh

Petitioner

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