[redacted]

Date Mailed: September 9, 2020
MOAHR Docket No.: 20-002770
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 three-way telephone hearing was held on June 4, 2020, from Clawson, Michigan. The Petitioner appeared at the hearing. [redacted] also appeared as Petitioner's Authorized Hearing Representative. The Department of Health and Human Services (Department) was represented by Andrea Jones, Hearing Facilitator.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. The Interim order was extended to 45 days due to one of the medical facilities being closed until June. The DHS 49, Medical Examination Report requested to be completed by [redacted] was not received. In addition, the DHS 49 D, Psychiatric Evaluation and DHS 49 E, Mental Residual Functional Capacity Assessment was not obtained by the Department. The record closed on July 24, 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

1. On [redacted], 2019, Petitioner submitted an application seeking cash assistance on the basis of a disability. Exhibit A, pp 3-8

2. On March 7, 2020, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 14-21).

3. On March 27, 2020, the Department sent Petitioner a Notice of Case Action denying the application based on DDS' finding of no disability (Exhibit A, pp. 9-13).

4. On [redacted], 2020, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 1319-1324).

5. Petitioner alleged disabling impairment due to arthritis, osteoarthritis of left should and bilateral knees, neuropathic pain in feet, restless leg syndrome, obstructive sleep apnea, morbid obesity BMI 48.8, biceps tendonitis, gout, hyperlipidemia and type 2 diabetes. Petitioner also underwent a cervical fusion of his cervical spine at C3-C4.

6. On the date of the hearing, Petitioner was [redacted] years old with a [redacted], 1959 birth date; he is [redacted]" in height and weighs about [redacted] pounds.

7. Petitioner completed the 11th grade.

8. At the time of application in [redacted] 2019, Petitioner was not employed.

9. Petitioner has an employment history of work and last worked as a parts sorter counting and boxing nuts and bolts for shipping and worked 30 hours weekly. Petitioner also was a test driver for [redacted]r company for one year also working 30 hours weekly. The DDS file contained no information as to whether this work based on earnings was substantial gainful activity. Petitioner had no work history for the period December 2004 through September 2016.

10. At the time of his application in [redacted] 2019, the Social Security Administration intake caseworker for his application observed Petitioner demonstrating signs of pain, distress and fatigue, had difficulty standing and walking and was wearing a neck brace and walked with a cane.

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 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, s/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 reviewed and is summarized below.

A Consultative Physical Examination was conducted on [redacted], 2019. The exam notes indicate that cervical spine has full range of motion and 5/5 muscle power in all four limbs. Bilateral shoulders still have full range of motion, as do elbows, hips, knees and ankles. There is a mildly tender bicipital groove area on the left side, but no significant atrophy of the deltoid and trapezius border which is still symmetrical, without

tenderness. A C3 scar is noted posteriorly in the neck with some indentation and mild cervical muscle type fibrosis locally. The examiner noted Petitioner was mildly depressed due to his financial difficulties and due to health issues. There was no midline spine tenderness. No SI joint tenderness. SLR was negative bilaterally in the supine position. Bilateral hand grips are 5/5. Patient walked into the room with a wide gait and using a cane held in the right hand and was bearing more weight on the right side. During the review of systems, the Petitioner reported chronic paresthesia in feet, and complained of difficulty bending, squatting, kneeling and climbing due to knee pain and back pain. Petitioner also reported left shoulder pain after surgery for C3-C4 cervical disc disease and contusion of the left shoulder from a fall. The examiner noted that Petitioner has difficulty lifting heavy weight especially above the head. The examiner determined that Petitioner should be able to sit 2-4 hours and stand at least 2 hours, without use of a cane on walking short distances, but for long distances use a cane was acknowledged. He can push pull 20 pounds and avoid pushing and pulling above his head. During the exam the Petitioner complained of chronic shoulder pain after his laminectomy. His gait was evaluated as normal and walked with a wide gait and held cane in right hand with more weight bearing on right side. On testing, the Petitioner's range of motion was diminished for the lumbar spine for flexion, extension, right lateral flexion and left lateral flexion. The Impression was: Petitioner is obese, Type II diabetes, recently diagnosed for last 6 months; seems to be clinically well-controlled. History of hypertension for roughly 10 years, without history of MI, angina or uncompensated CHF at this point. No history of stroke or TIA. He had a recent fall in March 2019 causing left shoulder contusion. He possibly fractured C3, but he most likely had cervical disc disease that required surgical intervention due to cord compression and symptomatic left upper limb paresthesia at that time. The cervical discectomy procedure has healed. Postop, no complications developed such as infection or hematoma. He should also avoid operating machinery due to peripheral neuropathy in his feet and diabetic condition. He is now able to use his left upper limb without major difficulties for ADL's however he was restricted and should avoid lifting overhead. He is right hand dominant.

On [redacted], 2019, the Petitioner was seen for follow up and noted recent discharge from rehabilitation (PT) with improvement in activities of daily living (ADL) and ambulation. Continuing use of cervical collar. Range of motion limited in c-spine due to pain. There was no paravertebral muscle tenderness and no spasm noted. Global strength was 5 of 5. On [redacted], 2019 notes indicate cervical cord compression with decompression laminectomy and fusion performed on [redacted], 2019 and was discharged to in patient rehab on this date. An MRI of the C spine showed C3-C4 cord edema and early compression. Petitioner was admitted for surgery on [redacted], 2019. [redacted], 2019 post op follow up notes continuing to wean off cervical collar, and continue therapy and exercises

Petitioner reported his activities of daily living as watching TV, prepares meals, attends mental health therapy. Sleep interrupted 6-8 times a night with 4 hours sleep nightly. Can attend to his own personal care, cannot stand for long, does some laundry, and cleaning but cannot bend over. Petitioner can drive a car and reports using a cane,

walker, wheelchair, brace and uses a motor cart when shopping. On June 14, 2019 Petitioner also completed a Medica-Social questionnaire which indicated he continued toe wear a neck brace, and could not stand, walk or sit for long periods of time and also had arm weakness.

Notes indicate that at the time of SSA intake interview, Petitioner was observed as having difficulty standing and walking and was wearing a neck brace and used a cane. He also was walking slowly seemingly due to pain.

Petitioner's AHR and case manager at the Guidance Center completed a Function Report for the Social Security Administration (SSA) on July 23, 2019 at which time she had known Petitioner for two years. She indicated that she observed he cannot lift anything, mobility is limited and he has difficulty standing or sitting for long periods of time. She also noted that restless leg syndrome and pain affected his sleep and causes him to awaken. The report indicated that Petitioner could perform his ADLs and prepare meals which takes him awhile as he cannot stand for long periods and could do light cleaning and laundry slowly. She reported that Petitioner was unable to do yard work due to being unstable with standing or walking but can drive and uses a motorized cart when shopping which he does independently. The Notes indicate that his conditions affect his ability to lift, squat, bend, stand, reach, walk, kneel, stair climb and use his hands. She indicated that Petitioner could walk 25 feet and then needed to rest for five minutes. She reported that Petitioner can follow written and spoken directions and pay attention and felt that he handled stress well and changes in routine well. She noted the Petitioner used a cane, brace, walker and crutches after his fall and uses them all the time.

The Petitioner completed a Function Report for the SSA. Petitioner indicates that he has difficulty with walking, standing and working and that he wakes up 6-8 times a night due to pain and restless leg syndrome and can perform personal care of himself. He does not perform yardwork due to problems standing and bending over. When grocery shopping he uses a motorized scooter. Petitioner is able to talk to family and friends on a weekly basis and described himself as home bound. Petitioner indicated that he had difficulty with lifting, squatting, bending, standing, reaching, walking, kneeling, stair climbing, seeing and using his hands. Petitioner also indicated that he uses a walker, cane, wheelchair and a brace.

Petitioner was seen by his rheumatologist on [redacted], 2019 and [redacted], 2019 and received a steroid injection to his left shoulder and left knee and a knee brace was ordered. On [redacted] 2019 records note BMI of 50-55 morbid obesity and muscle spasm of both lower legs.

Petitioner was seen in the ER on [redacted], 2019 due to a fall on his left shoulder and knee while walking. The Petitioner's weight was 400 pounds with BMI of 54.25. Both left knee and shoulder were tender on palpation with reported pain level of 6 with positive distal pulses and neck was supple. A CT of the brain was performed and was normal with no acute intracranial process. X-rays of the left knee were also taken and

noted moderate to severe medial compartmental joint space narrowing with tricompartmental osteophytosis with no evidence of fracture. X-rays of shoulder were taken noted no fracture or dislocation with moderate should joint space narrowing with mild osteophytosis of humeral head. The discharge summary noted knee sprain. Petitioner was seen again on [redacted] 2020 with complaints of weakness in left knee and numbness in bilateral arms and fatigue and concern for stroke. At this visit the MRI of the brain was normal. An MRI of cervical spine was not normal and noted an Impression which indicated progressive degenerative spondylosis with C3-C4 most severely affected with severe canal stenosis, with mass effect on the cord and mild cord edema with early cord compression. The Petitioner was transferred and underwent a spinal fusion of his cervical spine at level C3-C4 on [redacted], 2019. After the operation and recovery the Petitioner participated in post-surgery in-patient rehabilitation for several weeks to improve strength and physical skills significantly. Petitioner was discharged from rehabilitation on April 5, 2019. The Petitioner was placed on Neurontin and Cymbalta for neuropathic pain. The Petitioner's record noted osteoarthritis on both knees and left shoulder with bilateral muscle spasms in both lower legs. Morbid obesity was noted 50.0-59.9

The Petitioner was recommended for 11-14 days of inpatient rehabilitation due to his multiple comorbidities as well as home safety concerns after his cervical spinal fusion. While in-inpatient rehabilitation, the Petitioner was instructed on the care of his feet for diabetes, hypoglycemia, use of insulin, use of an insulin pump and healthy diet for diabetes. Petitioner's in-patient rehabilitation included improving strength (right upper extremity for left shoulder, gait, mobility, balance, transferring as well as range of motion. At the time, the goal for discharge was to have standing tolerance increased to 5 minutes and stair climbing to up/down 4 steps at discharge with use of 1-2 rails. The Petitioner was discharged on April 5, 2019.

On [redacted] 2019 the medical hospital notes show a diagnosis for primary osteoarthritis of left shoulder, left hip and both knees at which time Petitioner received a steroid injection for his left shoulder.

On [redacted] 2019 the Petitioner was seen for follow up by his neurosurgeon which indicates Petitioner overall was doing quite well, denied any pain. Petitioner had numbness in his hand which was resolved. At the time of the visit, Petitioner was one week post discharge from in patient rehabilitation. The Petitioner was to be doing home exercises to work strength back up. Slowly weaning from cervical collar. The notes indicate improvement in ambulation and with completing activities of daily living. The Petitioner denied any pain postoperatively. There was noted limited range of motion of cervical spine due to pain inhibition. There was no paravertebral musculature tenderness or spasms noted. No joint effusion or gross deformity of the joints. Petitioner was able to ambulate without assistive devices. The diagnosis was cervical myelopathy.

On [redacted], 2019 the Petitioner was seen by his primary care doctor for diabetic follow-up. During the visit diabetes, hypertension and chronic pain were reviewed. At the time

of the visit, the Petitioner was still wearing BC-collar most of the time. The Petitioner requested additional pain medications due to pain in his knees, back and shoulder. The Assessment was spinal cord compression, diabetes under control, feeling weak, knee joint pain, restless leg syndrome, gout, lower back pain and chronic pain syndrome. At the time of the visit the Petitioner's BMI was 49.8.

The Petitioner was seen on [redacted], 2019 for diabetic follow-up and to obtain a handicap parking form. The Petitioner reported he had been losing weight through portion control and continued pain in his left shoulder. At the time of this visit his body mass index was 56.5 kg/m2. The examination was essentially normal except range of motion of the left shoulder was limited due to pain with most extreme range of abduction and hyper extension. The assessment also noted restless leg syndrome and moderate recurrent major depression. By way of history only, the Petitioner was seen on [redacted], 2018 at which time he was feeling well and denied any acute pain or other complaints. The musculoskeletal exam indicated arthralgias and stiffness localized to one or more joints. The Assessment noted shoulder pain elicited by motion and knee joint pain with restless legs syndrome and chronic pain syndrome. The notes further indicate the Petitioner complained of neck pain, feeling weak and lower back and knee joint pain and was taking opiate analgesics at the time.

The Petitioner engaged in mental health therapy at the Guidance Center in [redacted] 2018. His mental status was stable and health issues were noted including chronic pain and obesity. The goal expressed in the records was to alleviate depressed mood and return to previous level of functioning. Notes indicate Petitioner had low self esteem and was struggling with stress due to financial matters, transportation and day to day living. The Petitioner's needs were stable housing, income, pain management and weight loss. Petitioner was active, attentive, engaged and receptive during the session. The Petitioner was assigned the task of searching for employment at least 2 times a week. During the later months of 2018 the Petitioner was attempting for interview and find employment and attending therapy. At the time, prior to his fall and cervical fusion, Petitioner was working but not full time and income was not enough to sustain his rent. Petitioner was seen weekly for services including case management and therapy. Petitioner was in therapy for much of 2018. Notes in December indicate that he fell in the parking lot while grocery shopping.

The Petitioner was participating in therapy in 2019 on a regular basis in May at the Guidance Center. Prior to that time he attended briefly and then fell and had to have cervical spine fusion. On [redacted], 2019 the Petitioner had a mental health assessment. Symptoms were depression, chronic pain, obesity and self-esteem. After the evaluation he was recommended for Adult outpatient services. The evaluator noted that thought process presented as coherent, speech was with normal tone, volume and speed with fair eye contact. Petitioner was able to answer questions appropriately, insight, judgment and memory appear intact. Client is seeking services to deal with health, weight and depression exacerbated by health and weight. Presents as isolated, stressed with no friendships and family living far away. The diagnosis was Major

depressive disorder, recurrent episode, moderate. The exam was completed by a MA/llpc and signed by an MD/psychiatrist.

In [redacted] of 2019, the Petitioner expressed his problems during therapy as social anxiety and fear of judgment, self isolation and getting help with income. The treatment plan established for Petitioner included annual mental health assessment (non physician), individual therapy sessions weekly and treatment plan monitoring with psychiatric evaluation as needed. The Petitioner was seen at the Guidance Center on [redacted] 2019 for an individual therapy session. Notes indicate that Petitioner also participates in a support group and sees a case manager. At the session, Petitioner presented as oriented with logical and coherent thoughts, a low mood with congruent affect, average intellect, memory was intact, average ability to think abstractly, some judgment and insight into health and barriers for motivation but not acting. No suicidal or homicidal ideation. The patient plan was to continue therapy for two times a month at least, case management weekly and peer services. Petitioner was still wearing a neck brace. Petitioner also had a therapy session on [redacted] 2019. The Petitioner was described as quiet and withdrawn and mental status was noted as maintaining. Petitioner expressed looking for an orthopedic doctor for his shoulder and knee and applying for social security disability. The notes for the session outcome were essentially the same as described above as to mood, affect and abilities. At a session on [redacted] 2019 the Petitioner was concerned about obtaining resources for housing and some form of income and was concerned about the disability process. He also was taking gabapentin for pain and wanted to see an orthopedic doctor for his knee. He presented as tense and sad and as maintaining his mental status. The Petitioner was also looking into gastric surgery for his obesity and weight loss. Petitioner's insight and judgment were noted as improving and focus was on inability to move forward and being stuck. Petitioner's knee was also bothering him and he felt unsteady using his cane. After review of the therapy records presented, the sessions generally address financial difficulty, inability to motivate and health issues including pain and depression. In most instances the notes indicate mental status is maintained or stable. Updated records were not available and therapy was interrupted due to the Covid health emergency.

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; 1.04 Disorders of the spine; 12.04 Depressive, bipolar and related disorders and 11.14 Peripheral neuropathy 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 he could stand 20 minutes and had difficulty with his balance. He could walk 20 to 25 feet and then rest. Petitioner uses a cane when walking and when walking further than 25 feet definitely must use a cane. He could not perform a squat but could bend at the waist. He could touch his toes while sitting, and can shower himself and uses a shower chair. Petitioner testified that he can climb stairs very slowly one at a time with difficulty. Petitioner has pain in both his knees due to arthritis and gout, and neuropathy in his feet which causes swelling and pain. The Petitioner has a weak left shoulder and cannot lift his arm above shoulder height. His left arm is weak and he cannot lift more than 3 or 4 pounds with the arm. Petitioner has no problem using his hands. The consultative examiner found the Petitioner's range of motion was diminished for the lumbar spine for flexion, extension, right lateral flexion and left lateral flexion, that Petitioner was obese and that he could stand two hours and sit 2-4 hours and needed use of a cane while walking longer distance. The CE examiner also found that Petitioner should avoid climbing and machinery operation due to diabetic condition and peripheral neuropathy. Although the examiner found Petitioner could push pull up to 20 pounds, and made no finding on

lifting and carrying ability and limited pushing and pulling as not including any movement overhead.

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 non exertional limitations including lifting or reaching overhead with his left shoulder and mild to moderate limitations on his mental ability to perform basic work activities. Although Petitioner receives mental health treatment services for depression, the Petitioner's symptoms were moderate for depression. 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. Based upon the information available regarding Petitioner's mental functioning the Petitioner has mild to limitations in his ability to understand, remember and apply information; moderate limitation in his ability to interact with others; mild to moderate ability to persist or maintain pace and mild limitations to adapt or manage himself.

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

**Step Four**

Step 4 in analyzing a disability claim requires an assessment of Petitioner's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed by Petitioner (as actually performed by Petitioner or as generally performed in the national economy) within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1) and (2). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner's work history in the 15 years prior to the application consists of work as a part sorter and a vehicle test driver for [redacted]. The Petitioner indicated that in performing these jobs the sorting job required carrying and lifting up to 10 pounds and moving parts to a pallet and some lifting above shoulder height. As such, Petitioner

cannot given his restrictions in lifting above his shoulder continue to perform this work. In addition, for sedentary work a person must be able to sit up to 6 hours and the CE examiner limited his sitting ability to 2 to 4 hours. The Petitioner also drove cars and tested them for [redacted] As such he was required to drive up to 300 miles at times and is restricted by the CE examiner from operating machinery and as such can no longer drive cars for such extended periods of time due to his neuropathy in his feet and diabetic condition. Both these jobs involved sedentary type work which can no longer be performed by the Petitioner based upon his current restrictions.

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. 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 prohibit him from 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). However, if the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2).

When a person has a combination of exertional and nonexertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide

the disability determination **unless** there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969a(d).

In this case, Petitioner was [redacted] years old at the time of application and [redacted] years old at the time of hearing, and, thus, considered to be closely approaching retirement age (60-64) for purposes of Appendix 2. He did not graduate high school graduate completing only the 11th grade with an unskilled work history of work experience as a parts sorter and test driver. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities.

In this case, the Medical-Vocational Guidelines result in a disability finding based on Petitioner's exertional limitations pursuant to the Medical Vocational Guidelines Rule 201.01.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner disabled for purposes of the SDA benefit program.

## DECISION AND ORDER

Accordingly, the Department's determination is REVERSED.

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE THE ORDER WAS ISSUED:

1. Reregister and process Petitioner's [redacted] 2019 SDA application to determine if all the other non-medical criteria are satisfied and notify Petitioner of its determination;

2. Supplement Petitioner for lost benefits, if any, that Petitioner was entitled to receive if otherwise eligible and qualified;

3. Review Petitioner's continued eligibility in September 2021.

LMF

**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

**Via Email:**

MDHHS-Wayne-18-Hearings
BSC4 Hearing Decisions
L. Karadsheh
MOAHR

**Petitioner – Via USPS:**

[redacted]

**Authorized Hearing Rep. – Via USPS**

[redacted]