[redacted]

Date Mailed: September 4, 2020
MOAHR Docket No.: 20-003838
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

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 hearing was held via telephone conference on August 5, 2020. Petitioner appeared and represented himself. The Department of Health and Human Services (Department) was represented by Myrna White, Eligibility Specialist.

ISSUE

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

FINDINGS OF FACT

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

1. On [redacted] 2020, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. Pursuant to emergency processes established by DHHS during the COVID-19 crisis, Petitioner was issued SDA benefits for April 2020 while the Disability Determination Service (DDS)/Medical Review Team (MRT) assessed Petitioner's medical evidence to determine whether he was disabled.

3. On May 7, 2020, DDS/MRT found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 5-11).

4. On May 16, 2020, DHHS sent Petitioner a Notice of Case Action denying his application based on DDS/MRT's finding of no disability, and Petitioner's SDA case was closed effective May 1, 2020 (Exhibit A, pp. 13-16).

5. On [redacted] 2020, DHHS received Petitioner's timely written request for hearing (Exhibit A, pp. 3-4a).

6. Petitioner alleged disabling impairment due to bilateral hip replacement, low back pain, epilepsy, finger injury, bipolar disorder, depression, attention deficit/hyperactivity disorder (ADHD), and anxiety. (Exhibit A, p. 38).

7. The medical evidence presented showed as follows:

   a. In his medical records dating back to [redacted] 2017, Petitioner reported pain, ambulation problems, backache, and range of motion issues (Exhibit A, pp. 538, 551-552).

   b. From [redacted], 2017 to [redacted], 2017 and [redacted] 2018 to September [redacted] 2018, Petitioner was in a residential treatment program for short term stabilization from heroin and cocaine use. His condition was "somewhat improved" at time of discharge. (Exhibit A, pp. 601-669.)

   c. On [redacted], 2019, Petitioner went to the emergency department because he ran out of Depakote used to treat his epilepsy (Exhibit A, pp. 672-675).

   d. The [redacted], 2019 notes from Petitioner's internal medicine doctor showed that Petitioner had a history of grand mal epilepsy treated with Depakote, which controlled his seizures, and chronic bilateral hip pain treated with Neurontin for pain and sleep. Petitioner was due for bilateral hip replacement. Petitioner had been in suboxone treatment but was discharged in [redacted] 2019 when his urine test revealed cocaine use. Petitioner admitted current cocaine use and denied any anxiety or depression. Notes from a [redacted], 2018 physical exam referenced a limping gait because of severe arthritis; reduced range of motion in the cervical, thoracic, and lumbar spine due to severe arthritis; normal mood; and appropriate affect, judgment, and insight. (Exhibit A, pp. 284-340.)

   e. On [redacted] 2019, Petitioner went to the emergency department after cutting his right little finger with scissors. He was diagnosed with laceration of the flexor tendon of the right little finger. (Exhibit A, pp. 204-215, 250-253, 579-581).

   f. On [redacted], 2019, Petitioner received a tendon repair of the right fifth digit. Exhibit A, pp. 204-215, 250-253, 579-581).

   g. On [redacted] 2019, Petitioner experienced a grand mal seizure and was brought to the emergency department. During the seizure, some of the stitches came out of the area of proximal interphalangeal joint of the right fifth digit. A physical exam showed visible flexor tendon, but Petitioner was able to flex the tendon and the doctor noted that the pulses and sensation were intact. A right-hand x-ray was negative for fracture or foreign body. The wound was irrigated at the site of discharge and additional stitches were added. Concerning the seizure,

the labs were unremarkable and it was concluded that, based on Petitioner's reporting that he was prescribed 1500 mg of Depakote but took only 1000 mg, the seizure was likely due to subtherapeutic treatment in conjunction with minimal sleep. (Exhibit A, pp. 159, 204, 676-688).

h. On [redacted] 2019, Petitioner returned to the emergency department because his finger continued to cause pain. He reported having completed his course of antibiotics. The finger wound was found to be healing as expected. It was cleaned and treated with mupirocin ointment and an ulnar gutter splint. Petitioner was also given a new prescription for treatment of his seizures. He also complained of rib pain that developed after his seizure on [redacted]. A chest x-ray revealed closed lateral fracture of the seventh, eight, and ninth ribs on the right side. (Exhibit A, pp. 197-198, 204-208, 249-250.)

i. On [redacted], 2019, Petitioner returned to the emergency department with finger pain. He had not filled the prescription for pain relief from [redacted] There was an open wound at the surgery site, but the doctor observed normal tissue matrix. (Exhibit A, pp. 200-203.)

j. In an [redacted] 2019 follow up with his primary care physician, Petitioner continued to report pain at his finger. The doctor observed a wound over the volar aspect of the small finger, no gross signs of infection, healing with scab, small finger flexion intact at PIP (proximal interphalangeal) and DIP (distal interphalangeal) joint levels, and good capillary refill time. A dorsal block finger cast was applied. The doctor also noted normal gait and station. (Exhibit A, pp. 582-596).

k. On [redacted] 2019, Petitioner went to the emergency department complaining of lower back pain. He stated that the pain was a flare up from an injury he incurred six years earlier. He also complained about mild discomfort in his right hand, fifth digit. A physical exam revealed decreased range of motion, tenderness, and pain and spasm in the lumbar back but no swelling or edema. Petitioner was able to ambulate at bedside without any noted ataxia and indicated improvement after Toradol/Norflex treatment. He was diagnosed with chronic bilateral low back pain without sciatica. The right hand was tender at the fifth digit but had normal range of motion, no bony tenderness, no deformity, and no swelling. The neurological exam was normal. (Exhibit A, pp. 194-199.)

l. On [redacted], 2019, Petitioner went to the emergency department complaining of suicidal ideations and swelling in the right fifth finger. He admitted to regular intravenous heroin abuse for the last seven months following a prolonged period on suboxone. The examining physician observed tenderness and swelling in the right hand, but Petitioner was able to move his finger actively and passively without significant pain or tenderness. The finger was observed to have normal range of motion; normal capillary refill, sensation and strength; minimal mucopurulent discharge; and no tenderness to palpation. It was concluded that

the puffiness in the finger was due to normal healing process, and the finger did not require antibiotic therapy or admission. Petitioner's urine drug screen was positive for cocaine, opiates, and THC. He was approved by [redacted] inpatient psychiatric placement. (Exhibit A, pp. 154-173, 231, 242-243.)

m. Petitioner was in inpatient psychiatric treatment from [redacted] to [redacted] 2019. He explained that he had a long history of mood swings, depression, anxiety, and ADHD and had been in rehab for heroin use twice. He reported major life stressors including the death of his father and brother, end of a 7-year relationship, the loss of his home, and regular intravenous heroin abuse for the preceding seven months. He denied auditory or visual hallucinations. His initial diagnosis was bipolar disorder, MRE mixed, substance use disorder, and ADHD but his primary diagnosis at discharge was substance-induced mood disorder, opioid use disorder with suicidal intent. On [redacted] 2019, Petitioner informed the doctor that he was no longer depressed or suicidal and wished to be released. The doctor noted that Petitioner was coherent in his speech with no evidence of psychosis that could impact his decision-making ability although he was concerned that Petitioner would resume heroin use upon release. (Exhibit A, pp. 170-194.)

n. On [redacted] 2019, Petitioner returned to [redacted] for a reevaluation by a psychiatrist for mental health treatment, explaining that he had been gone for over a year (his last treatment notes were from [redacted] 2018) due to being incarcerated and having hand surgery. There were no remarkable changes in behavior, functioning or thought process reported or identified. Petitioner's mood was identified as anxious and sad/depressed, but his behavior, speech, affect, thought process/content, perception, memory, and cognition were all identified as unremarkable. His judgment was identified as fair and his insight limited. Petitioner denied suicidal ideation. He reported a history of chronic pain in the back, hips, legs, and shoulder, with pain scoring 8 out of 10 scale, with 10 being the worst. Petitioner's diagnosis (as of [redacted] 2017) was identified as major depressive disorder, single episode, mild; anxiety disorder NOS (not otherwise specified); ADHD; opioid dependence; and, as of October 2019, cannabis abuse. His GAF (global assessment of functioning) score was 50. (Exhibit A, pp. 351-375, 393-429, 447-455.)

o. On [redacted], 2019, Petitioner went to the emergency department seeking a Depakote refill and a note stating that he has to be on the bottom bunk at the homeless shelter due to hip and back pain (Exhibit A, pp. 150-153).

p. On [redacted] 2019, Petitioner went to the emergency department because he lost his prescription for Depakote, stating that he takes Depakote 1500 mg a day, once daily, and although he had not missed a dosage, he needed a medication refilled. (Exhibit A, pp. 147-150.)

q. On [redacted] 2019, Petitioner was brought to the emergency department after having a seizure lasting about one minute at the homeless shelter where he was residing. Petitioner explained that he took Depakote for his epilepsy but had missed his dose the prior day. Petitioner refused any treatment or evaluation. (Exhibit A, pp. 144- 147.)

r. On [redacted], 2020, Petitioner went to the emergency department complaining of a seizure. He explained that he was taking Depakote, 500 mg three times daily, but had run out and had not taken his medication for a week. He was given intravenous Depakote and his prescription was refilled. (Exhibit A, pp. 138-143.)

s. On [redacted], 2020, Petitioner went to the emergency department complaining of back pain, explaining that he had been walking for 12 hours and had slipped and fallen on his left hip. Petitioner admitted to using methamphetamine. A [redacted], 2020 pelvis x-ray revealed severe osteoarthritis of the left hip but no acute fracture dislocation. A lumbar spine x-ray showed no evidence for acute fracture or subluxation but multilevel degenerative changes, most pronounced at L4-L5 and L5-S1. The pain was likely related to a muscle contusion. (Exhibit A, pp. 135-138, 218-224.)

8. On the date of the hearing, Petitioner was 36 years old with a [redacted], 1983 birth date; he is 6'2" in height and weighs about 215 pounds.

9. Petitioner is a high school graduate with some college credits. He can read, write, and do basic math.

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

11. Petitioner has a limited employment history of work as a fast food worker and manager.

12. Petitioner has a pending disability claim with the Social Security Administration.

CONCLUSIONS OF LAW

Department policies are contained in DHHS Bridges Administrative Manual (BAM), DHHS Bridges Eligibility Manual (BEM), and DHHS Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. DHHS administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180.

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (April 2017), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income

(SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity (RFC) to perform past relevant work; and (5) has the RFC 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 has not engaged in SGA during the period at issue. Therefore, Petitioner cannot be assessed as not disabled at Step 1, and the evaluation 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).

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 Servs*, 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, in consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, it is found to be 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), 11.02 (epilepsy), 12.04 (depressive, bipolar and related disorders), 12.06 (anxiety and obsessive-compulsive disorders), 12.08 (personality and impulse-control disorders), and 12.11 (neurodevelopmental 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 (RFC)

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 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). Where the evidence establishes a medically determinable mental impairment, the degree of functional limitation must be rated, taking into consideration chronic mental disorders, structured settings, medication, and other treatment. The effect on the overall degree of functionality is evaluated under four broad functional areas, assessing the ability to (i) understand, remember, or apply information; (ii) interact with others; (iii) concentrate, persist, or maintain pace; and (iv) adapt or manage oneself. 20 CFR 416.920a(c)(3). A five-point scale is used to rate the degree of limitation in each area: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. 20 CFR 416.920a(c)(4).

In this case, Petitioner alleges both exertional and nonexertional limitations due to his medical condition. Petitioner testified that he could nor walk more than ¼ mile; could not stand more than 15 minutes; could sit for 30 minutes but then had to stand because of back pain; could not bend or squat; and could go up steps only by setting each foot up one step before proceeding to the next step. He was able to bathe and care for his hygiene, dress himself, and cook and clean as long as he did not have to bend over. Because of his epilepsy, he could not drive. He used the electronic carts when he went grocery shopping. He testified that his medication usually controlled his seizures, but he still had breakthrough grand mal seizures averaging up to one every two months. His finger injury limited his ability to use his hands and sometimes to hold things.

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.

According to the medical documents, on [redacted], 2020, Petitioner went to the emergency department after a slip and fall, reporting that he had been walking for 12 hours before his fall. The imaging showed severe osteoarthritis of both hips. The record also indicated that Petitioner was due for bilateral hip replacement. There was also evidence of multilevel degenerative changes of the spine, most pronounced at L4-L5 and L5-S1. Although there was also evidence of surgery to Petitioner's fifth digit on the right hand, at the [redacted] 2019 examination at the emergency department, the doctor observed that the finger had normal range of motion; normal capillary refill, sensation and strength; minimal mucopurulent discharge; and no tenderness to palpation. It was concluded that the puffiness in the finger was due to normal healing process, and the finger did not require antibiotic therapy or admission. The medical record supports Petitioner's testimony of limitations due to his back and hip pain but does not support limitations to the use of his hands. 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).

The medical record also supported nonexertional limitations. Petitioner had a mental health history with diagnosis from [redacted] 2017 of major depressive disorder, single episode, mild; anxiety disorder NOS (not otherwise specified); ADHD; opioid dependence; and, as of [redacted] 2019, cannabis abuse. His GAF as of [redacted], 2019 was 50. Although Petitioner was placed in inpatient treatment for suicidal ideation from [redacted] to [redacted], 2019, his primary diagnosis at discharge was substance-induced mood disorder, and opioid use disorder with suicidal intent. Upon discharge, the doctor noted that Petitioner was coherent in his speech with no evidence of psychosis that could impact his decision-making ability although he was concerned that Petitioner would resume using heroin upon release. Based on the entire record, including Petitioner's testimony, it is found that Petitioner has a nonexertional RFC resulting in moderate limitations in his ability to understand, remember, or apply information; mild limitations in his ability to interact with others; moderate limitations in his ability to concentrate, persist, or maintain pace; and mild limitations in his ability to adapt or manage himself.

The record also supports Petitioner's history of grand mal seizures due to epilepsy and a finger injury. Petitioner acknowledged that his seizures were usually controlled with medication, and the medical record showed that the seizures requiring treatment were primarily due to Petitioner failing to comply with his prescribed treatment. Due to his seizures, Petitioner also has nonexertional RFC limiting his ability to work with machinery or to perform work requiring balance or from an elevated surface. However,

the evidence presented does not show that Petitioner had any limitations in using his hands to lift or to work with small objects due to the finger injury.

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 limited past relevant work experience from the past 15 years requires at a minimum light RFC. Because Petitioner's current exertional RFC limits him to sedentary work, Petitioner is incapable of performing any past relevant work. Therefore, 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 DHHS 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 36 years old at the time of application and 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 with some college but no relevant skilled work history. 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, 201.27, result in a finding that Petitioner is not disabled. Petitioner also has nonexertional limitations, with a nonexertional RFC that results in moderate limitations in his ability understand, remember, or apply information; mild limitations in his ability interact with others; moderate limitations in his ability to concentrate, persist, or maintain pace; and mild limitations in his ability to adapt or manage himself and he may not perform work with machinery, requiring balance, or on an elevated surface. It is found that those limitations would not preclude Petitioner from engaging in simple, unskilled work activities on a sustained basis. See SSR 83-14. Therefore, Petitioner is able to adjust to other work and is **not** disabled at Step 5.

DECISION AND ORDER

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.

Accordingly, DHHS's determination is **AFFIRMED.**

ACE/tm

Alice C. Elkin
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-Monroe-Hearings
BSC4 Hearing Decisions
L. Karadsheh
MOAHR

Petitioner - Via First-Class Mail:

[redacted]