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Date Mailed: February 2, 2023
MOAHR Docket No.: 22-004809
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Zainab A. Baydoun

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250. After due notice, a telephone hearing was held on December 1, 2022, from Detroit, Michigan. Petitioner appeared for the hearing with his Authorized Hearing Representative (AHR) [redacted] and friend, [redacted] who testified on Petitioner's behalf. The Department of Health and Human Services (Department) was represented by Angela Clark, Assistance Payments Worker.

Exhibit A, pp. 1-1,231 was admitted into the record as evidence on behalf of the Department.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. On December 12, 2022, Petitioner submitted additional records (27 pages total) which were received, marked, and admitted into evidence as Exhibit 1. The record was subsequently closed on January 3, 2023, and the matter is now before the undersigned for a final determination on the evidence presented.

ISSUE

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

FINDINGS OF FACT

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

1. On or around [redacted] 2022, Petitioner submitted an application seeking cash assistance benefits on the basis of a disability.

2. On or around September 29, 2022, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. (Exhibit A, pp. 9-24)

3. On or around October 3, 2022, the Department sent Petitioner an Application Eligibility Notice denying his SDA application based on DDS' finding that he was not disabled. (Exhibit A, pp. 27–28)

4. On or around October 11, 2022, Petitioner submitted a timely written Request for Hearing disputing the Department's denial of his SDA application. (Exhibit A, p.4)

5. Petitioner alleged disabling impairments due to seizures, spinal stenosis, shoulder and neck pain, heart complications, learning disability, traumatic brain injury, posttraumatic stress disorder, bipolar disorder, depression, anxiety, Attention-Deficit/Hyperactivity Disorder (ADHD), and schizoaffective disorder.

6. As of the hearing date, Petitioner was [redacted] years old with an [redacted] 1988, date of birth; he was [redacted] and weighed [redacted] pounds.

7. Petitioner's highest level of education is the 11th grade. Petitioner did not receive a high school diploma or GED. Petitioner has reported employment history of work as a foundation water proofer, a steel cutter, a stocker at a fruit and vegetable market, and an oil change technician. Petitioner has reportedly not been employed since January 2022; however, it was established that each of Petitioner's previous employment lasted only a few months at a time.

8. Petitioner has a pending disability claim with the Social Security Administration (SSA).

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Health and Human Services Reference Tables Manual (RFT).

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

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (April 2017), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability

standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If an individual is found disabled, or not disabled, at any step in this process, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In general, the individual has the responsibility to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

Step One

The first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Petitioner was not working during the period for which assistance might be available. Because Petitioner was not engaged in SGA, he is not ineligible under Step 1, and the analysis continues to Step 2.

Step Two

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for SDA means that the impairment is expected to result in death or has

lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.922(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.

The medical evidence presented at the hearing and in response to the Interim Order was thoroughly reviewed and is briefly summarized below.

Petitioner presented a Psychiatric Evaluation on [redacted] 2022, through the Monroe Community Mental Health Authority and Dr. Gutterman. According to the Psychiatric Evaluation, a review of Petitioner's records indicated that Petitioner had been previously receiving mental health treatment for diagnosis of schizoaffective disorder bipolar type, PTSD, learning disability, among other things. Symptoms included mood swings between depression and mixed states with irritability and disorganization, poor concentration due to untreated psychosis/mood swings, borderline intellectual function, and IQ of 80. The records show that Petitioner lived a marginal, disorganized life, had several hospitalizations, and 2 to 3 stays at Fairview where he was most recently kicked out due to accusations of stealing. The records indicate that following Petitioner's mental health treatment in 2018, he suffered a closed head injury and traumatic brain injury from a falling branch or log in 2021 and has since then lost 30 pounds. He endorsed symptoms of depression, mood swings, nightmares, flashbacks, and anxiety. During the evaluation, Petitioner reported that he is homeless and lives in the woods. Petitioner reported that he is on psychiatric medication now, and has been

seeing a psychiatrist at ProMedica outpatient but has been off and on medications due to missed appointments because he lacks transportation. He did not know the names of his medications and reported difficulty finding the bottles. Records also show that Petitioner has a history of suicidal ideation and suicidal attempts with reported mood disorder problems beginning at age 12. Petitioner has history of going without sleep for up to two days and reported in the past having manic episodes with no sleep, no appetite, loss of energy, inability to focus, and wanting to "go, go, go until he is worn out and can't sleep." He reported history of depressive symptoms including not eating, not taking care of himself, sleeping 10 hours when he is very depressed, feelings of worthlessness, hopelessness, and thoughts of wishing he were dead. Records indicate that since 2016, Petitioner has reported paranoia when he is around people and fast motions make him wonder if someone is going to hurt him. Petitioner reported seeing a black dot floating when he is in a manic state. He most recently reported having flashbacks 1 to 5 times per week and frequent nightmares. During previous appointments he admitted to having a history of physical altercations and fighting with others, a history of impulsivity and reckless behavior dating back to childhood, and being held in juvenile detention as a teenager 5 to 6 times. Records show that Petitioner participated in special education classes in school due to his ADHD, and medication review documentation reviewed by the doctor indicate that Petitioner had borderline intellectual functioning with an IQ score of 80. (Exhibit 1)

Petitioner presented progress notes from a [redacted] 2022 visit with neurologist Dr. Rapp. Petitioner was seen for a three month follow-up evaluation for traumatic brain injury. Records show that Petitioner had an MRI of the brain on [redacted], 2022 and while no acute intracranial process was identified, there is a single focus of susceptibility in the left cerebellar hemisphere. The finding was nonspecific and could represent a cavernoma or chronic hemosiderin deposition from a remote insult. Petitioner reported continuing to experience left arm weakness and records show that he was receiving treatment for conditions including, bipolar disorder current episode mixed, severe, with psychotic features; chronic PTSD; homelessness; anxiety; right leg pain; chronic left shoulder pain; degenerative disc disease and cervical disc disease; external hemorrhoids; rectal bleeding; chronic right-sided low back pain with right-sided sciatica; traumatic brain injury with loss of consciousness; numbness and tingling in the left arm and on the left side of the face; chest pain and palpitations; abnormal EKG; cervical radiculopathy; and cervical stenosis of the spine. Petitioner's muscle strength was noted as follows: strength is 4/5 over the left triceps, -2/5 over the left biceps, and 5/5 over the left deltoid. Strength is 5/5 over the right upper extremity and right lower extremity. Records show that Petitioner will be scheduled for an MRI of the brachial plexus and will receive an EMG of the left upper extremity, as well as starting physical therapy for his left arm weakness. Petitioner was to return for follow-up in three months. (Exhibit 1)

Records show that Petitioner was hospitalized for inpatient psychiatric treatment from [redacted] 2021 to [redacted], 2021. Petitioner presented to the emergency department due to suicidal ideations. Petitioner reported significant past psychiatric history of bipolar disorder and depression, as well as previous suicide attempts by hanging. Petitioner

reported having increased thoughts of hurting himself and suicidal ideations of hanging. He denied visual and auditory hallucinations, denied chest pain, abdominal pain, and shortness of breath. Petitioner reported a long history of depression beginning around age 18, with Attention Deficit disorder (ADD) as a child, and an Individualized Education Program (IEP) in school. Petitioner last attempted suicide, reportedly, three years ago by hanging, and most recently was admitted for inpatient psychiatric treatment at Flower Hospital during the first part of 2021. Petitioner endorsed signs and symptoms of depression including tiredness, poor energy, feelings of hopelessness and worthlessness, poor and erratic sleep, poor appetite, and 30 pound weight loss in the past year. Petitioner reported lack of motivation and energy and recurrent suicidal thoughts with being tearful much of the time. Petitioner also reported anxiety signs and symptoms including nervousness, pacing, inability to focus and occasional panic attacks associated with palpitations and feelings of impending doom and racing thoughts. Petitioner reported most of the symptoms are precipitated by a history of incidents with law enforcement, and serving a little over two years in the penitentiary, and thus is hypervigilant of surroundings and sounds. Petitioner reported that he has not followed up with outpatient care after previous inpatient hospitalizations. He reported several prior admissions for inpatient psychiatric treatment. Reports of mania and hypomania as well as recurrent mood swings with irritability were reported, as were panic attacks, but no hallucinations. Petitioner was treated and monitored daily, and upon discharge, improvement was noted following medication treatment. Petitioner was discharged in stable condition with a diagnosis of bipolar one disorder, recurrent headache, bipolar disorder current episode mixed, severe, with psychotic features, chronic PTSD, and major depression. Petitioner was to follow up with outpatient treatment and continue with prescribed medications.

Results of a CT scan of Petitioner's cervical spine performed on [redacted], 2022 showed straightening of the cervical lordosis, progression of degenerative disc disease at C6-C7, disc osteophyte protrusion posteriorly into the central canal with mild central canal stenosis and mild neural foraminal narrowing. There was no acute fracture or subluxation.

From [redacted] 2015 to [redacted] 2015, records show that Petitioner was admitted to Flower Hospital in Ohio for inpatient psychiatric treatment following reports of depression and suicidal ideations and plans including shooting himself with a gun or overdose.

Petitioner was again admitted to the psychiatric unit for inpatient psychiatric treatment due to suicidal ideations and a suicide attempt by hanging himself in a neighborhood tree using fishing gear. Petitioner was admitted for treatment on [redacted] 2018 and discharged on [redacted], 2018.

Progress notes from Petitioner's [redacted] 2022 office visit with the ProMedica [redacted] Pain Management department indicate that Petitioner's chief complaint was head pain, left arm and left knee extremity pain, and back pain. Petitioner presented for an initial consultation, reporting that he has had this pain for more than six months and

the initiating event was acute trauma after a tree limb fell on Petitioner. A history of traumatic brain injury was noted; however, it was unclear whether the injury was a result of the current or a previous incident. Petitioner reported that the pain is located in his head, left shoulder, neck, lower back, and left knee and that the pain radiates to his left leg and left arm. Petitioner's pain was described as burning, crushing, excruciating, severe, sharp, and stabbing pain that is severe and constant. The pain intensity was rated as a 10 on a scale of 0-10. The pain is rated for on the best day in 10 on the worst day with symptoms interfering with physical activity, work, walking, sleeping, sitting, household cleaning, reaching for shelves and lifting. The pain is exacerbated by sitting, standing, forward flexion, lifting, and walking and alleviated by medications and ice. Petitioner reported participating in physical therapy sessions within the last six months that he did not tolerate. Petitioner reported that he is homeless but built himself a small shack in the woods near a spring in which he swims for therapy and exercise. Petitioner described diffuse weakness since the injury. Range of motion to petitioner's back was limited due to pain, there was pain on palpation of the lumbar spine, reproducible pain with extension, straight leg raising test positive at 30° sitting bilaterally. Tenderness on palpation over the lumbar spine, lumbar facets, and mild lumbar paraspinal muscle tenderness. There was difficulty going from sitting to standing. Sensation was diffusely diminished on the left to light touch and Petitioner's gait was observed to be antalgic. A cervical epidural steroid injection at C7-T1 was recommended to address Petitioner's chronic neck pain and left upper extremity radiculopathy that has not responded to conservative treatment. A lumbar MRI scan was also recommended.

Progress notes from Petitioner's [redacted] 2022, office visit with the ProMedica Physicians Cardiology-[redacted] indicate that Petitioner was referred for chest pain, palpitations, and abnormal EKG. Petitioner reported that he was pretty active, a tree climber, and used to cut wood and lift heavy wooden logs and throw them easily without any concerns. However, about eight months ago a heavy wood log fell from 45 feet, hit Petitioner's left hand, left arm, and left shoulder with head trauma. Petitioner reported brief loss of consciousness, brain contusions, and since then, has gone through a lot of pain and anxiety/panic attacks. Petitioner described his pain is starting from the left scapular region, radiating to his shoulder and left pectoral muscle, down his left arm. He feels that his arm is "not there" and that his pain is worsened with activities. With small exertion, Petitioner reported feeling palpitations, strong and fast heartbeats but has had no syncope since the trauma. While the doctor did not believe Petitioner's symptoms were cardiac in etiology, an echocardiogram was ordered to ensure no complications from the trauma incident. It was also recommended that Petitioner receive a 48 hour Holter monitor to investigate the palpitations.

Multiple records reviewed indicate that Petitioner has trouble remembering appointments, lacks access to transportation, and has been homeless for several years. Drs. indicated there was a potential large mental component to Petitioner symptoms and he was encouraged to continue following up with psychiatry.

Petitioner presented to the emergency department at the University of Michigan hospital on [redacted] 2022, with complaints of back pain since being hit by a log one month

ago and past medical history of recent traumatic brain injury, depression, schizoaffective disorder, and PTSD. Petitioner reported he was helping a friend cut a tree branch when a log fell and hit him in the head. Petitioner reported that he has been declining since that time and reported feeling out of it but denied overt confusion. Petitioner reported significant left-sided back pain since the accident and reported an unsteady gait. Petitioner denied lightheadedness or syncope, but reported episodes where he will pass out from pain when he is lying flat. Petitioner reported episodes of palpitations one walking and intermittent shortness of breath that he describes as shallow breathing. Petitioner reported a second fall down the stairs two weeks ago, after which he went to St. [redacted] emergency department and was discharged. One week ago, Petitioner presented to Flowers Emergency Department for headache and back pain and reported he was diagnosed with "a broken bone in my left upper back." The MyCare Everywhere record was reviewed and while no documentation of a fracture was found, records show an MRI of the cervical spine was performed resulted in degenerative disc changes including mild stenosis at C6-C7. Petitioner was discharged with a muscle relaxant, tramadol, and ibuprofen. Petitioner reported that his chief complaint was back pain and bilateral leg numbness. He reported that his pain waxes and wanes and at times is 6-7/10. He reported that his pain is currently minimal because the numbness is more prominent. He continued to ambulate without issue but reported generalized weakness, there was no focal weakness of the legs and denied bowel or bladder dysfunction. History of prior psychiatric admissions for depression and schizoaffective disorder were noted and Petitioner reported that he may attempt to kill himself if discharged from the hospital. Physical examination showed diffuse left arm tenderness without midline spinal tenderness. Neurological exam showed no deficits and there was no objective sensation loss in the lower extremities. Psychiatry evaluated Petitioner and noted during their evaluation that Petitioner was not suicidal, but more so, frustrated due to concerns of coordination of his long-term care. Petitioner was provided with resources and instructed to connect with them upon his discharge. Upon reevaluation, and based on the reassuring physical exam, negative workup in the emergency department, psychiatry recommendation, and improvement in symptoms, Petitioner was safe to be discharged home. A referral was made for the Fast Back Clinic (PM&R) to address his pain.

Records from the Mercy St. [redacted] emergency department documenting Petitioner's visit on [redacted], 2022, were reviewed. Petitioner presented with chest pain and left shoulder pain that began one month ago, following a log injury. Petitioner reported that the pain in his shoulder is described as bulging and severe with a rating of 7/10. The pain was located primarily in the scapular region of his back, radiating up to his shoulders, and down to his chest. The pain has been constant and he denied taking any medications for the pain. Petitioner reported that since being hit with the log, he suffers from headaches. A chest x-ray was performed and ruled out any fractures or lung masses. An EKG was also performed and showed no ischemic changes. There was no acute abnormality following x-ray of the left shoulder. Petitioner was discharged the same day.

Petitioner presented to the emergency department at Mercy Health on [redacted], 2019, and was discharged on [redacted], 2019, following complaints of suicidal ideations by shooting or hanging. Petitioner reported that prior to this he had been off of his medications for five months and reported constantly feeling agitated, lack of appetite, and quick to anger. A history of trauma was reported as was feeling of isolation and diagnosis of PTSD. Petitioner's affect was dysthymic and poorly reactive. He had suicidal ideations but denies homicidal ideations. His insight and judgment were poor and his psychomotor status was agitated. His mood was depressed. Petitioner was admitted to inpatient psychiatric treatment, participated in supportive therapy with medication management, as well as therapeutic activities and groups. Petitioner was treated and discharged in stable condition and recommended follow-up for outpatient treatment.

Petitioner was admitted to inpatient psychiatric treatment at Mercy Health on [redacted], 2021, and discharged on [redacted], 2021, with complaints of depression and suicidal thoughts, and suicidal plan. The psychiatric assessment indicated that Petitioner was admitted to the psychiatric unit due to a mental disorder causing a major disability in social, interpersonal, occupational, and or educational functioning that is leading to a dangerous or life-threatening functioning and can only be addressed in an acute inpatient setting. A long history of depression and anxiety was reported, with petitioner indicating he first noticed changes in his mood when he was in the sixth grade. Petitioner reported feeling depressed and having thoughts of suicide for quite some time and feeling like giving up. Petitioner reported having ongoing paranoid thoughts and difficulties with his appetite. Anger episodes, daily feelings of hopelessness and worthlessness were reported, as well as housing instability. Petitioner reported feelings of guilt, anhedonia, increased need for sleep, decreased energy and concentration, increased in excessive worry, restlessness, edginess and irritability. Nervousness and occasional panic attacks were also reported. Petitioner indicated that he was previously diagnosed with PTSD due to many years of trauma, noted hypervigilance, frequent nightmares, and flashbacks. As a child, he was physically and verbally abused. He denied auditory or visual hallucinations but reported experiencing periods of elevated mood, impaired judgment, racing thoughts, difficulty sleeping for one or two nights, pacing and restlessness.

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 and the listing criteria applicable at the time of Petitioner's application date, listings 1.15 (disorders of the skeletal spine resulting in compromise of a nerve root), 1.16 (lumbar spinal stenosis resulting in compromise of the cauda equina), 1.18 (abnormality of a major joint(s) in any extremity), 11.18 (traumatic brain injury), 12.03 (schizophrenia spectrum and other psychotic disorders), 12.04 (depressive, bipolar and related disorders), 12.05 (intellectual disorder), 12.06 (anxiety and obsessive-compulsive disorders), 12.11 (neurodevelopmental disorders), and 12.15 (trauma and stressor related disorders). were considered. A thorough review of 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). Where the evidence establishes a medically determinable mental impairment, the degree of functional limitation must be rated, taking into consideration chronic mental disorders, structured settings, medication, and other treatment. The effect on the overall degree of functionality is evaluated under four broad functional areas: (i) understand, remember, or apply information; (ii) interact with others; (iii) concentrate, persist, or maintain pace; and (iv) adapt or manage oneself. 20 CFR 416.920a(c)(3), to which a five-point scale is applied (none, mild, moderate, marked, and extreme). 20 CFR 416.920a(c)(4). The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. 20 CFR 416.920a(c)(4).

In this case, Petitioner alleges exertional and nonexertional limitations due to his impairments. Petitioner testified that in late 2021, he was helping a friend cut a tree and a log fell and hit him in his head, crushing him to the ground. Since that time, Petitioner testified that he has severe back, shoulder, and neck pain. He reported losing all strength in his left side. Petitioner testified that he can walk just a few steps before he is triggered by shortness of breath, pain, and dizziness. He testified that he has issues with both hands but the left hand is disabled and he lost complete control and strength in his left hand due to the incident. He is unable to grip or grasp items and constantly drops everything. Petitioner reported that he is able to sit for only a few minutes before

needing to stand and move around and readjust positions. He is able to stand for 10 minutes and can bend or squat with difficulty. Petitioner is able to lift not more than 10 pounds at a time. Petitioner testified that he has been homeless since he was 18 years old and has been living in the woods. He testified that he prepares his own food by hunting for fish and deer and cooking it over a fire. He testified that he is able to do dishes but cannot stand without his legs and body shaking. He testified that he is able to drive but does not have a mode of transportation. With respect to his mental impairments, Petitioner testified that he has been in mental health treatment for several years since childhood and that he is diagnosed with PTSD, bipolar disorder, schizoaffective disorder, ADHD, anxiety, depression, and that he has a learning disability. He reported suffering from panic/anxiety attacks and that he is in a constant state of fight or flight due to past and current trauma. He suffers from claustrophobia, can only focus for a few seconds at a time because his mind can't concentrate and reported suffering from loss of memory following the incident with the log. Petitioner suffers from crying spells and anger issues, but does not have auditory or visual hallucinations. Petitioner reported that his schizoaffective disorder causes paranoid thoughts. He reported visiting the hospital 10 times in the last 12 months and being admitted for inpatient psychiatric treatment on several occasions since he was 18 years old.

Petitioner's representative and friend testified on his behalf. It was reported that Petitioner is noncompliant with his medications and memory problems. [redacted] who reported knowing Petitioner since high school, testified that Petitioner was in special education classes due to his emotional impairments. He is prone to severe depression, grandeur, and is homeless. It was ported that Petitioner suffered childhood trauma and was raised in an abusive household. Petitioner's schizoaffective disorder has caused him to suffer symptoms of delusions and hallucinations, as well as major depressive mood symptoms. Petitioner's speech is disorganized due to his traumatic brain injury and he is unable to perform activities or function in society. Petitioner's paranoia has resulted in his inability to sustain employment for long periods of time.

A two-step process is applied in evaluating an individual's symptoms: (1) whether the individual has a medically determinable impairment that could reasonably be expected to produce the individual's alleged symptoms and (2) whether the individual's statement about the intensity, persistence and limiting effects of symptoms are consistent with the objective medical evidence and other evidence on the record from the individual, medical sources and nonmedical sources. SSR 16-3p.

The evidence presented is considered to determine the consistency of Petitioner's statements regarding the intensity, persistence and limiting effects of his symptoms. Petitioner's statements are supported by the extensive medical records presented for review and documented impairments. Based on a thorough review of Petitioner's medical record and in consideration of the reports and records presented from Petitioner's treating physicians, 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). However, Petitioner is unable to perform the full range of sedentary

work thus, the occupational base is eroded by his additional limitations or restrictions. SSR 96-9p.

Based on the medical records presented as well as Petitioner's testimony, Petitioner has moderate limitations on his non-exertional ability to perform basic work activities, with respect to performing manipulative or postural functions of some work such as reaching, handling, bending, climbing, crawling, or stooping, as a result of the injury to his brain, the results of the MRI of Petitioner's spine, and evidence of left side weakness. Additionally, records indicate that Petitioner suffers from daily symptoms associated with schizoaffective disorder bipolar type, PTSD, learning disability, depression, anxiety, and bipolar disorder for which Petitioner has been receiving mental health treatment. Petitioner's medical records clearly document symptoms associated with these conditions including depressed mood, sleep disturbance, panic attacks, swings alternating between depression and irritability with disorganization, nightmares, flashbacks, feelings of worthlessness, hopelessness, and thoughts of wishing he were dead. Furthermore, the record clearly shows multiple inpatient psychiatric hospitalizations and suicidal ideations/attempts over the course of several years. Upon review, has moderate to marked limitations in his ability to understand, remember, or apply information; to interact with others; in his ability to concentrate, persist, or maintain pace; and in his ability to adapt or manage oneself. Petitioner's nonexertional RFC is considered at both Steps 4 and 5.

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 limited and sporadic work as a foundation water proofer, a steel cutter, a stocker at a fruit and vegetable market, and an oil change technician, which can be classified as requiring light to medium exertion. (Exhibit A, pp. 15-21, 79). Based on the RFC analysis above, Petitioner's exertional RFC limits him to sedentary work activities, with additional nonexertional limitations. As such, Petitioner is incapable of performing past relevant work. Because Petitioner is unable to perform past relevant work, he cannot be found disabled, or not disabled, at Step 4, and the assessment continues to Step 5.

Step Five

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, 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 a younger individual (age [redacted]) for purposes of Appendix 2. He completed the 11th grade and did not obtain a high school diploma or GED and is limited to unskilled work. 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, however, as referenced above, the occupational base is eroded by additional limitations or restrictions. Thus, based solely on his exertional RFC, the Medical-Vocational Guidelines result in a finding that Petitioner is not disabled.

However, as referenced above, Petitioner also has nonexertional impairments imposing additional limitations. As a result, and based on the evidence presented, Petitioner has a nonexertional RFC imposing moderate limitations on his non-exertional ability to perform basic work activities, with respect to performing manipulative or postural functions of some work such as reaching, handling, bending, climbing, crawling, or stooping, as well as, moderate to marked limitations in his ability to understand, remember, or apply information; to interact with others; in his ability to concentrate, persist, or maintain pace; and in his ability to adapt or manage oneself. The Department has failed to present evidence of a significant number of jobs in the national and local economy that Petitioner has the vocational qualifications to perform in light of his RFC, age, education, and work experience. Therefore, the evidence is insufficient to

establish that Petitioner is able to adjust to other work. Accordingly, Petitioner is found disabled at Step 5 for purposes of the SDA benefit program.

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 SDA 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. Re-register and process Petitioner's [redacted] 2022, 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 from the application date, ongoing; and

3. Review Petitioner's continued SDA eligibility in September 2023.

ZB/ml

Zainab A. Baydoun
Administrative Law Judge

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 Electronic Mail :

DHHS
Pam Farnsworth
Monroe County DHHS
903 Telegraph
Monroe, MI 48161
MDHHS-Monroe-Hearings@michigan.gov

Interested Parties
BSC4
L Karadsheh
MOAHR

Via First Class Mail :

Authorized Hearing Rep.
[redacted]
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Petitioner
[redacted]
MI [redacted]