STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

IN THE MATTER OF:

[redacted]

Reg. No.: 15-011699
Issue No.: 4009
Case No.: [redacted]
Hearing Date: August 17, 2015
County: Oakland (3)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

Following Claimant's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10. After due notice, a telephone hearing was held on August 17, 2015, from Detroit, Michigan. Participants included the above-named Claimant. Olivia Nicozisis, Claimant's daughter, testified on behalf of Claimant. Participants on behalf of the Michigan Department of Health and Human Services (MDHHS) included [redacted], hearings facilitator.

ISSUE

The issue is whether MDHHS properly denied Claimant's State Disability Assistance (SDA) eligibility for the reason that Claimant is not a disabled individual.

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 January 13, 2015, Claimant applied for SDA benefits.

2. Claimant's only basis for SDA benefits was as a disabled individual.

3. On May 29, 2015, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 9-11).

4. On June 22, 2015, MDHHS denied Claimant's application for SDA benefits and mailed a Notice of Case Action (Exhibits 5-8) informing Claimant of the denial.

5. On June 29, 2015, Claimant requested a hearing disputing the denial of SDA benefits.

6. As of the date of the administrative hearing, Claimant was a 49-year-old female.

7. Claimant has not earned substantial gainful activity since before the first month of benefits sought.

8. Claimant earned a bachelor's degree with a major in intrapersonal and public communication and a minor in marketing.

9. Claimant performed full-time sedentary employment within the past 15 years, which Claimant can currently perform.

10. Claimant alleged disability based on restrictions related to diagnoses of back pain, neck pain, and anxiety.

CONCLUSIONS OF LAW

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. MDHHS administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. MDHHS policies for SDA are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (1/2013), p. 4. The goal of the SDA program is to provide financial assistance to meet a disabled person's basic personal and shelter needs. *Id*. To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older. BEM 261 (1/2012), p. 1.A person is disabled for SDA purposes if he/she:

- receives other specified disability-related benefits or services, see Other Benefits or Services below, or
- resides in a qualified Special Living Arrangement facility, or
- is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability; or
- is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS).
  Id.

There was no evidence that any of the above circumstances apply to Claimant. Accordingly, Claimant may not be considered for SDA eligibility without undergoing a medical review process (see BAM 815) which determines whether Claimant is a disabled individual. *Id*., p. 3.

Generally, state agencies such as MDHHS must use the same definition of SSI disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally defined as the inability to do any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result

in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905. As noted above, SDA eligibility is based on a 90 day period of disability.

SGA means a person does the following: performs significant duties, does them for a reasonable length of time, and does a job normally done for pay or profit. *Id*., p. 9. Significant duties are duties used to do a job or run a business. *Id*. They must also have a degree of economic value. *Id*. The ability to run a household or take care of oneself does not, on its own, constitute SGA. *Id*.

The person claiming a physical or mental disability has the burden 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 ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913. 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).

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled. 20 CFR 416.920. If there is no finding of disability or lack of disability at each step, the process moves to the next step. 20 CFR 416.920 (a)(4).

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person is statutorily blind or not. "Current" work activity is interpreted to include all time since the date of application. The 2015 monthly income limit considered SGA for non-blind individuals is $1,090.

Claimant credibly denied performing any employment since the date of the SDA application; no evidence was submitted to contradict Claimant's testimony. Based on the presented evidence, it is found that Claimant is not performing SGA and has not performed SGA since the date of application. Accordingly, the disability analysis may proceed to Step 2.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the 12 month duration requirement. 20 CFR 416.920 (a)(4)(ii). The impairments may be combined to meet the severity requirement. If a severe impairment is not found, then a person is deemed not disabled. *Id*. The 12 month durational period is applicable to MA benefits; as noted above, SDA eligibility requires only a disability duration of 90 days.

The impairments must significantly limit a person's basic work activities. 20 CFR 416.920 (a)(5)(c). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. *Id.* Examples of basic work activities include:

- physical functions (e.g. walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling)
- capacities for seeing, hearing, and speaking, understanding; carrying out, and remembering simple instructions
- use of judgment
- responding appropriately to supervision, co-workers and usual work situations; and/or
- dealing with changes in a routine work setting.

Generally, federal courts have imposed a de minimus standard upon claimants to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v Bowen,* 880 F2d 860, 862 (6th Cir. 1988). Similarly, Social Security Ruling 85-28 has been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirement is intended "to do no more than screen out groundless claims." *McDonald v. Secretary of Health and Human Servs.*, 795 F.2d 1118, 1124 (1st Cir. 1986).

SSA specifically notes that age, education, and work experience are not considered at the second step of the disability analysis. 20 CFR 416.920 (5)(c). In determining whether Claimant's impairments amount to a severe impairment, all other relevant evidence may be considered. The analysis will begin with a summary of presented medical documentation.

A lumbar spine MRI report (Exhibits 97; 116) dated August 12, 2010, was presented. An impression of a disc protrusion at L5-S1 was noted.

An MRI report of Claimant's lumbar spine (Exhibits 102; 117) dated November 11, 2011, was presented. An impression of mild-to-moderate right paracentral disc protrusion without stenosis was noted.

A lumbar spine MRI report (Exhibit 96) dated November 30, 2012, was presented. An impression of moderate degenerative disc disease at L5-S1 was noted.

Physician office visit notes (Exhibit 98) dated July 22, 2013, were presented. A complaint of lumbar degenerative disc disease was noted. Clonaze and hydrocodone-acetaminophen were noted as prescribed.

A lumbar spine MRI report (Exhibits 95; 118) dated July 10, 2014, was presented. An impression of mild bulging at L5-S1 with degenerative joint disease of the facet joints was noted.

A "return to work" form dated November 18, 2014, (Exhibit 153) completed by Claimant's physician was presented. It was noted that Claimant was restricted to 4-hour work shifts.

Physician office visit notes (Exhibits 100-101) dated December 18, 2014, were presented. A problem list included hip pain, anxiety, GERD, degenerative disc disease, back pain, allergic rhinitis, and dysfunctional uterine bleeding.

A radiology report dated December 29, 2014 (Exhibit 141) of Claimant's bilateral hips was presented. An impression of a normal report was noted.

Various physical therapy notes (Exhibits 45-75 from January 21, 2015 through March 20, 2015, were presented. Claimant reported that back pain began with a motor vehicle accident from 2006 and was exacerbated by a fall from a horse in 2013. It was regularly noted that Claimant underwent laser and exercise therapy for her lumbar.

Physician office visit notes (Exhibits 91-94; 136-138) dated January 12, 2015, were presented. It was noted that Claimant reported for an initial visit seeking lumbar pain treatment. It was noted that Claimant reported pain began following a 2006 motor vehicle accident when she hit someone from behind. It was noted that Claimant had PT in the past.

A radiography report of Claimant's cervical spine (Exhibits 111; 134) dated January 28, 2015, was presented. An impression of moderate degenerative changes at C5-C6 and C6-C7 were noted.

A Medical Examination Report (Exhibits 27-29) dated February 9, 2015, was presented. The form was completed by a family practitioner with an approximate 3 month history of treating Claimant. Claimant's physician listed diagnoses of lower back pain, degenerative joint disease, anxiety, GERD, and allergies. An impression was given that Claimant's condition was stable. It was noted that Claimant can meet household needs.

Physician office visit notes (Exhibits 87-90) dated February 10, 2015, were presented. Claimant reported ongoing neck pain for 5-6 weeks.

Physician office visit notes (Exhibits 80-83) dated March 6, 2015, were presented. It was noted that Norco helped with her lumbar and neck pain.

Physician office visit notes (Exhibits 80-83) dated March 27, 2015, were presented. It was noted that Claimant reported improvement in pain with physical therapy. It was

noted that neck and lumbar pain remains severe. Ongoing diagnoses of lumbosacral spondylosis and lumbar radiculopathy was noted.

Physical therapy notes (Exhibits 40-42) dated April 7, 2015, were presented. Muscle test scores of 3+/5 and 4-/5 were noted for multiple trunk and bilateral hip tests.

Physical therapy notes (Exhibits 38-39) dated April 14, 2015, were presented. It was noted that Claimant reported feeling like she was “falling apart” due to neck and back pain.

An MRI report of Claimant’s cervical spine (Exhibits 105-106) dated April 15, 2015, was presented. An impression of a disc protrusion causing mild canal stenosis at C5 was noted. A minimal disc bulge not causing stenosis was noted at C6-C7 was noted; mild degenerative changes contributing to mild bilateral neural foraminal narrowing was also noted.

Physical therapy notes (Exhibits 36-37) dated April 17, 2015, were presented. It was noted that Claimant reported lumbar stiffness with pain radiating to her left leg. It was noted that therapy temporarily relieves her pain.

An ultrasound report (Exhibits 126-127) dated April 23, 2015, was presented. The ultrasound was completed in response to Claimant’s complaints of pain. An impression of a negative ultrasound with no evidence of obstruction was noted.

Physician office visit notes (Exhibits 76-79) dated April 24, 2015, were presented. It was noted that Claimant reported ongoing lumbar pain, at worst 10/10. Paravertebral tenderness was noted at C2-C6 and L2-L5. Ongoing diagnoses of cervicalgia and cervical spondylosis were noted. A plan of continuing Norco (10 mg-325 mg tablet every 4-6 hours) was noted.

Physical therapy notes (Exhibits 34-35) dated April 28 2015, were presented. It was noted that Claimant reported episodes of lumbar spasms.

Physical therapy notes (Exhibits 32-33) dated May 4, 2015, were presented. It was noted that Claimant reported increased lumbar stiffness when it rains. Lumbar pain was reported to be 5/10.

Physical therapy notes (Exhibits 30-31) dated May 7, 2015, were presented. It was noted that Claimant underwent laser and exercise treatment. Claimant reported “doing ok.” Stiffness with lumbar spine extension was noted.

Physical therapy notes (Exhibits 122-123) dated May 13, 2015, were presented. It was noted that Claimant reported being bothered “a lot” by her neck. Claimant reported tingling into her right arm.

A Health Summary dated June 3, 2015, (Exhibits 124-125) from a treating physician was presented. Claimant's current medications included Oscal, Klonopin, Claratin, fish oil, Motrin, multivitamins, and Zantac.

Physician office visit notes (Exhibits A16-A17) dated June 30, 2015, were presented. It was noted that Claimant reported ongoing back and neck pain (10/10 at its worst).

Physician office visit notes (Exhibits A16-A17) dated July 13, 2015, were presented. It was noted that Claimant presented to seek an injection to assist with neck pain. It was noted that Claimant reported Norco helped with neck and pain, though Claimant had difficulty with daily functioning. Tenderness was noted at L2-L5 and C2-C6.

Physician office visit notes (Exhibits A24-A25) dated July 23, 2015, were presented. It was noted that Claimant was to undergo ulnar nerve testing. Claimant was noted to be an active smoker.

Claimant testified that she typically watches television and/or reads all day long. Claimant testified that she lives off of the goodwill of her daughter and is financially dependent on her daughter. Claimant testified that she tries to help her daughter by performing light cleaning.

Claimant alleged disability, in part, based on anxiety. Medical records noted a diagnosis for anxiety. Medical records also verified anti-anxiety prescriptions (e.g. Klonopin). Claimant testified that she attended a type of group therapy for anxiety on a weekly basis. Psychiatric and psychological records were not presented. Specific complaints of anxiety were not apparent. Presented evidence was insufficient to infer that Claimant has any restrictions based on anxiety.

Claimant alleged disability, in part, based on neck and back pain. Claimant testified that she attended 4 months of physical therapy, two times per week, in 2015. Claimant testified that her therapy included leg pressing, laser therapy, and massage therapy. Claimant testified that she's had two neck injections and that she is considering corrective surgery. Claimant testified that she's had back injections in the past; Claimant testified that her injections reduced her pain level approximately 20%. Claimant testified that she saw a chiropractor several years ago, but the appointments did not alleviate her discomfort.

A multi-year history of back pain treatment was verified. A history of neck pain was verified back to the month of Claimant's SDA application. Ongoing treatment included physical therapy and pain medication. It was also verified that spinal injections were a possible medical treatment.

It is found that Claimant established significant impairment to basic work activities for a period longer than 90 days. Accordingly, it is found that Claimant established having a severe impairment and the disability analysis may proceed to Step 3.

The third step of the sequential analysis requires a determination whether the Claimant'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 Claimant's impairments are listed and deemed to meet the 12 month requirement, then the claimant is deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step.

A listing for joint dysfunction (Listing 1.02) was considered based on a diagnosis for degenerative joint disease. The listing was rejected due to a failure to establish that Claimant is unable to ambulate effectively.

A listing for spinal disorders (Listing 1.04) was considered based on complaints of cervical spine and lumbar spine pain. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root.

A listing for anxiety-related disorders (Listing 12.06) was considered based on Claimant's complaints of anxiety. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Claimant had a complete inability to function outside of the home.

It is found that Claimant failed to establish meeting a SSA listing. Accordingly, the analysis moves to the fourth step.

The fourth step in analyzing a disability claim requires an assessment of the Claimant's residual functional capacity (RFC) and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if it is determined that a claimant can perform past relevant work. *Id*.

Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

Claimant testified that she performed various jobs including work as a cashier and as a department store greeter. The analysis will focus on Claimant's employment as a customer service representative.

Claimant testified that her primary job duty as a CSR was to answer telephone calls from persons with questions concerning State of Michigan and Social Security Administration benefits. Claimant testimony conceded that her employment was of a mostly sitting nature. Claimant testimony also indicated that her old job required little-to-

no lifting/carrying. Claimant testified that she cannot do her old job due to anxiety, back pain, and neck pain.

At the second step, it was found that Claimant failed to establish anxiety restrictions. Thus, anxiety will not be found as a barrier to Claimant performing CSR employment.

On a medical Examination Report dated February 9, 2015, Claimant's physician stated that Claimant had no mental restrictions, including no concentration restriction (see Exhibit 28). This is consistent with an ability to perform past employment.

On the Medical Examination Report, Claimant's physician also opined that Claimant was restricted to less than 2 hours of standing/walking over an eight-hour workday; sitting restrictions were not provided. Claimant was completely restricted from lifting/carrying of 50 pounds and to occasional lifting/carrying of 20-25 pounds. Claimant was restricted from performing repetitive left leg actions. The stated basis for restrictions was left hip and lumbar pain. The restrictions appear to be compatible with Claimant's former employment as there was no indication that being a CSR requires ambulation of even 2 hours per work shift.

Radiology verified, at worst, moderate problems with Claimant's lumbar and cervical spine. Only mild stenosis was verified. Mild stenosis and moderate degeneration is surely indicative of spinal pain and a need for pain medication and/or other treatment. Generally, marked problems are indicative of disabling conditions, moderate degeneration and/or mild stenosis is not. Overall, radiological evidence was supportive in finding that Claimant can perform past employment.

Claimant's physician noted that Claimant had no need for household assistance. Claimant's physician noted that Claimant did not require a walking assistance device. Generally, not needing assistance with household activities and not needing a cane or walker are consistent with an ability to perform sedentary employment such as answering questions on the telephone.

Claimant testimony implied that she could not do the sitting required of her past employment. Claimant initially testified that she could only sit 20 minutes before needing to stand. Claimant also testified that she does very little driving, presumably due to difficulty with sitting. Claimant later testified that she drove, without stopping, 30 minutes to the hearing; Claimant's daughter estimated the drive was closer to an hour. It is not known if Claimant can regularly sit for 60 minute periods, however, the evidence was indicative of an ability to sit for an extended period. The absence of sitting restrictions from Claimant's physician also supports finding that Claimant can perform the sitting required of past employment.

It is found that Claimant can perform her previous employment as a customer service representative. Accordingly, Claimant is not disabled and it is found that MDHHS properly denied Claimant's SDA application. It should be noted, if the analysis

proceeded to the final step, application of Medical-Vocational Rule 201.21 would have directed an identical finding.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that MDHHS properly denied Claimant's SDA benefit application dated January 13, 2015 based on a determination that Claimant is not disabled. The actions taken by MDHHS are **AFFIRMED**.

Christian Gardocki
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Signed: **8/19/2015**
Date Mailed: **8/20/2015**

CG/tm

NOTICE OF APPEAL: A party may appeal this Hearing Decision in the circuit court in the county in which he/she resides, or the circuit court in Ingham County, within 30 days of the receipt date.

A party may request a rehearing or reconsideration of this Hearing Decision from the Michigan Administrative Hearing System (MAHS) within 30 days of the mailing date of this Hearing Decision, or MAHS may order a rehearing or reconsideration on its own motion.

MAHS may grant a party's Request for Rehearing or Reconsideration when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion;
- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the client;
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The party requesting a rehearing or reconsideration must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date this Hearing Decision is mailed.

A written request may be faxed or mailed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

cc: [redacted]