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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-013514
Issue No.: 4009
Case No.: [redacted]
Hearing Date: September 14, 2015
County: Oakland (4)

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 September 14, 2015, from Detroit, Michigan. Participants included the above-named Claimant. Donna Kemp-House, Claimant's sister, and [redacted] testified on behalf of Claimant. Participants on behalf of the Michigan Department of Health and Human Services (MDHHS) included [redacted], specialist.

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 November 10, 2014, Claimant applied for SDA benefits.

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

3. On May 5, 2015, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 45-47).

4. On May 8, 2015, MDHHS denied Claimant's application for SDA benefits and mailed a Notice of Case Action (Exhibits 48-49) informing Claimant of the denial.

5. On July 22, 2015, Claimant requested a hearing disputing the denial of SDA benefits.

6. As of the date of the administrative hearing, Claimant was a 51-year-old female

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

8. Claimant's highest education year completed was the 12th grade.

9. Claimant has a history of semi-skilled employment, with no known transferrable job skills.

10. Claimant alleged disability based on restrictions related to back pain, knee pain, chest pain, urination frequency, and mental health issues.

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).

Claimant brought a hearing representative to the hearing. The representative was not recognized as an authorized hearing representative because written documentation for representation within a State of Michigan administrative hearing was not presented.

Claimant's hearing request noted a dispute of Family Independence Program (FIP) (cash) benefits (see Exhibit 11). FIP is a MDHHS program available to caretakers of minor children and pregnant women. Claimant testified that she only intended to dispute a denial of SDA benefits. MDHHS was not confused by Claimant's hearing request and was prepared to defend a denial of Claimant's SDA application denial. It is found that Claimant intended to dispute her SDA eligibility and the hearing was conducted accordingly.

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. SDA differs in that a 90 day period is required to establish 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 CFR 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. 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 durational 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 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 requirements are 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 background information from Claimant's testimony and a summary of presented medical documentation.

Claimant testified she hurt her back while working as a certified nursing assistant in May 2011. Claimant testified she felt a snap in her back after trying to catch a falling patient. Claimant testified she also has a bad knee after slipping in the bathroom. During the hearing, Claimant was asked which knee she hurt; after a long pause, she said, "I want to say it's my right knee." Claimant testified that both her legs swell due to arthritis.

An undated letter from Claimant (Exhibit A8) was presented. A Patient Information Questionnaire (Exhibits A39-A49) dated January 20, 2015, was also presented. The documents were disregarded as hearsay.

One page of a hospital discharge document (Exhibit 10) was presented. The document was from 2009 and provided no treatment information other than a discharge medication of Vicodin.

A physician letter (Exhibit 17) dated August 17, 2010, was presented. It was noted that Claimant was being evaluated for lupus. It was noted that Claimant displayed all the symptoms for lupus and that Claimant needed insurance so that work-up could be performed.

A Referral Information form (Exhibit 21) dated September 15, 2014, was presented. A physician comment of internal derangement of right knee with normal x-rays was noted.

Physician office visit notes (Exhibits 22-23) dated October 8, 2014, were presented. An injection of Toradol was noted. Active medications included Baclofen, Hydrocodone-Acetaminophen, Meloxicam, Ventolin, and Xanax.

Physical therapy notes (Exhibits A28) dated October 9, 2014, were presented. Reduced right knee motion (3+/5) was noted. It was noted Claimant tolerated the therapy poorly due to acute pain symptoms.

Physical therapy discharge documents (Exhibits A29-A30) dated October 23, 2014, were presented. It was noted Claimant appeared for 3 appointments. It was noted that Claimant displayed severe limping with a cane. Claimant's range of motion was noted as unchanged since initial evaluation. Claimant was discharged due to an inability to tolerate therapy.

Physician office visit notes (Exhibit 18) dated November 10, 2014, were presented. Diagnoses of degenerative lumbar/lumbosacral disc disease and spondylosis with lumbar myelopathy were noted.

A Medical Examination Report (Exhibits 7-9) dated November 26, 2014, was presented. The form was completed by a family practice physician with an approximate 26-year history of treating Claimant. Claimant's physician listed diagnoses of degenerative lumbar disc disease and depression. An impression was given that Claimant's condition was deteriorating. Physical examination notes included a need for a cane, slow ambulation, positive right-side straight-leg-raising test at 90 degrees, and right leg weakness. It was noted that Claimant can meet household needs.
Orthopedic specialist documents (Exhibits A14-A15) dated December 19, 2014, were presented. It was noted that Claimant was seen ambulating with a cane. Claimant reported throbbing moderate-to-severe right knee pain. It was noted that a right knee x-ray indicated mild degenerative joint disease with medial joint space narrowing. An MRI of Claimant's right knee indicated no internal derangement and moderate joint effusion (see Exhibits A17-A18). An x-ray of Claimant's lumbar indicated decreased lumbar lordosis. An MRI of Claimant's lumbar indicated disc bulges with facet degenerative changes and mild foraminal narrowing at L2-L3 and L4-L5 (see Exhibits A33-A34). Diagnoses of radiculopathy and right knee pain were noted. It was noted that Claimant

declined an offer of physical therapy because it was too painful when she previously tried it. It was noted that Clamant declined an unspecified injection (presumed to be an epidural lumbar steroid injection).

Physician office visit notes (Exhibits 33-36) dated January 6, 2015, were presented. It was noted that Claimant reported chronic back pain radiating to her right leg. Other complaints included anxiety, and right knee osteoarthritis. Claimant's physician stated that Claimant ambulated without assistance. A normal gait without ataxia was noted. A plan of regular physical exercise in short intervals with flexibility training was noted. Ventolin was noted as prescribed.

A mental status examination report (Exhibits 27-32) dated January 9, 2015, was presented. The report was noted as completed by a consultative licensed psychologist. Claimant reported pain difficulties and depression. It was noted that Claimant appeared uncomfortable throughout the examination. A suicide attempt from 2011 was reported. Noted observations of Claimant made by the consultative examiner included the following: appropriately dressed, no indication of social inappropriateness nor impulsive behavior, spontaneous, orientation x3, good immediate memory, poor remote memory, and anxious with full affect. An Axis I diagnosis of pain disorder with psychological issues was noted. A GAF of 60 was noted. A moderate impairment to withstanding stress was noted. The examiner deemed Claimant to be capable of relating to others, remembering and carrying-out instructions, working independently, and maintaining attention and concentration.

Urologist office visit notes (Exhibits A21-A22) dated January 15, 2015, were presented. It was noted that Claimant complained of urinary incontinence, ongoing for several years.

Physician office visit notes (Exhibits A35-A37) dated January 21, 2015, were presented. An ongoing complaint of back pain was noted. It was noted that Claimant's health insurance denied her request for surgery. Full muscle strength was noted in all areas.

Urologist office visit notes (Exhibits A23-A24) dated January 22, 2015, were presented. It was noted that the bladder showed no abnormalities. A prescription for Flomax was prescribed. A follow-up in 1 month was planned.

Urologist office visit notes (Exhibits A25-A26) dated February 19, 2015, were presented. It was noted that Claimant showed improved PVR testing though no reported symptom improvement.

Physician office visit notes (Exhibit A9), Claimant's statements (Exhibits A10-A11), and physician statements (Exhibits A12-A13), each dated March 6, 2015, were presented. Treatment details were not provided. It was noted that Claimant wanted to increase physical activity. Claimant's physician stated that Claimant had a serious medical condition which precluded Claimant from addressing unhealthy behaviors.

Physician office visit notes (Exhibits A5-A7) dated July 28, 2015, were presented. It was noted that Claimant's chest was doing better. Various active medications included ProAir, Baclofen, Xanax, Remeron, Hydrocodone, Abilify, Neurontin, Nitroglycerin, and Gabapentin. Claimant was noted to be a daily smoker.

Claimant testified she is being evaluated for lupus. It was odd that a possible lupus diagnosis was indicated in 2010, yet Claimant has still not been fully evaluated 5 years later. As no diagnosis and no medical evidence since 2010 was presented, a severe impairment based on lupus symptoms will not be found.

Claimant testified that she has ongoing difficulties holding her urination. Claimant's testimony estimated she has to use the bathroom 10-15 times during day and 5 times during the night. Only 3 physician visits over an approximate 1 month period were documented. Claimant's last treatment verified some degree of improvement (in PVR testing) though Claimant reported no improvement in her symptoms. Bladder radiology provided no indication of ongoing problems. Presented evidence is found to be insufficient to infer that Claimant has ongoing urination symptoms which affect her ability to work.

Claimant's testimony implied restrictions based on mental health. Claimant testified she has seen a psychiatrist for the last year. Claimant testified that she has seen a therapist twice a month for the last year. Despite Claimant's frequent therapist visits, she was unable to state the name of her therapist. Claimant presented no treatment documents though some mental health medications (e.g. Xanax and Remeron) were verified. Overall, the evidence was insufficient to infer that Claimant has mental health restrictions.

Some treatment for COPD was presented. Claimant's testimony mentioned little about COPD, though she conceded she was a daily tobacco smoker. Pulmonary function testing was not presented. Presented evidence is found to be insufficient to infer restrictions in performing basic work activities due to COPD.

Claimant testified she has constant lumbar pain. Claimant testified that pain sometimes radiates to her toes. Claimant also testified that pain radiates to her buttocks and shoulders. Claimant testified that she's had 10 different shots in her back. Claimant testified physical therapy only made her pain worse. Claimant testified that her pain limits her sitting, standing, and carrying abilities. Claimant's testimony was generally consistent with and/or verified by presented treatment documents.

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 determining whether the Claimant's impairment, or combination of impairments, is listed in 20 CFR Part 404, Subpart P, appendix 1. 20 CFR 416.920 (a)(4)(iii). If a claimant's impairments are listed and

deemed to meet the durational requirement, then the claimant is deemed disabled. If the impairment is unlisted or impairments do not meet listing level requirements, then the analysis proceeds to the next step.

A listing for joint dysfunction (Listing 1.02) was considered based on Claimant's complaints of knee pain. 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 Claimant's lumbar complaints. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root.

A listing for chronic pulmonary insufficiency (Listing 3.02) was considered based on a diagnosis for COPD. The listing was rejected due to a lack of respiratory testing evidence.

Cardiac-related listings (Listing 4.00) were considered based on some treatment history for chest pain. Claimant failed to meet any cardiac listings.

A listing for affective disorder (Listing 12.04) was considered based on a diagnosis of depression. 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 required a highly supportive living arrangement, suffered repeated episodes of decompensation or that the residual disease process resulted in a marginal adjustment so that even a slight increase in mental demands would cause decompensation.

A listing for anxiety-related disorders (Listing 12.06) was considered based on Claimant's treating physician's diagnosis of an anxiety disorder. 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.

A listing for inflammatory arthritis (Listing 14.09) was considered based on a diagnosis. The presented medical records were insufficient to establish that Claimant has an inability to ambulate effectively, perform fine and gross movements, or suffers inflammation or deformities with a diagnosis of ankylosing spondylitis or other spondyloarthropathies, or suffers repeated manifestations of inflammatory arthritis.

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 the bulk of her employment from the last 15 years was as a certified nursing assistant (CNA). Claimant did not describe her duties though it is presumed they included typical CNA duties such as the following: assisting patients with ambulation, feeding patients, bathing patients, turning over patients in bed, and light cleaning.

Claimant testified she also worked approximately 6 months as an activity leader. Claimant testified that her job was to wheel patients into the activities room and to perform various activities (e.g. cooking, piano) and exercises with patients.

Claimant's testimony implied that both of her jobs required lifting/carrying which she is no longer capable of performing. Claimant's testimony was credible and consistent with presented evidence. It is found that Claimant cannot perform past employment and the analysis may proceed to the final step.

In the fifth step in the process, the individual's RFC in conjunction with his or her age, education, and work experience, are considered to determine whether the individual can engage in any other substantial gainful work which exists in the national economy. SSR 83-10. 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). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, 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). To determine the physical demands (i.e. exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967.

Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b) Even though weight lifted may be very little, a job is in this 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. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additionally limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.*

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). An individual capable of performing medium work is also capable of light and sedentary work. *Id.*

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). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.*

Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands are considered non-exertional. 20 CFR 416.969a(a). Examples of non-exertional limitations 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 (e.g. can't 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) 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)

The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.* In using the rules of Appendix 2, an individual's circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, is compared to the pertinent rule(s).

Given Claimant's age, education and employment history a determination of disability is dependent on Claimant's ability to perform light employment. Social Security Rule 83-10 states that the full range of light work requires standing or walking, off and on, for a total of approximately 6 hours of an 8-hour workday.

Physician statements of restrictions were provided. SSR 96-2p states that if a treating source's medical opinion is well-supported and not inconsistent with the other substantial evidence in the case record, it must be given controlling weight (i.e. it must be adopted). Treating source opinions cannot be discounted unless the Administrative Law Judge provides good reasons for discounting the opinion. *Rogers v. Commissioner,* 486 F. 3d 234 (6th Cir. 2007)*; Bowen v Commissioner.*

An undated physical capacity functional assessment (Exhibits A1-A4) from Claimant's physician was presented. A diagnosis of lumbosacral disc disease, panic attacks, and COPD were noted. Symptoms were noted as lasting more than 12 months. Symptoms included dyspnea and back pain. An MRI and pulmonary function testing were noted to justify restrictions. Claimant's physician stated Claimant was rarely capable of stooping, crouching/squatting, climbing ladders, or climbing stairs. Claimant was deemed capable of sitting or standing/walking less than 2 hours per 8 hour workday. It was noted that Claimant's pain increased with standing. It was noted that Claimant would need 30 minute breaks every 30 minutes. Claimant was deemed capable of occasional lifting/carrying of less than 10 pounds, never 10 pounds or more. Claimant was deemed incapable of even "low stress: employment due to anxiety. A 1 block walking restriction was noted. Claimant was deemed capable of sitting 15-20 minutes and standing for 15-20 minutes.

The undated physical capacity assessment provides very little insight into Claimant's problems primarily because it is not known when Claimant was assessed. It is known that Claimant's physician treated Claimant since 2002, so it is plausible that the presented assessment is 13 years old. If Claimant was assessed several years ago, it is reasonably possible that Claimant's condition improved. The assessment was given little weight due to Claimant's physician's failure to state a date of assessment.

A Physical Capacities Evaluation (Exhibits 13-16) dated July 31, 2013, was presented. The form was completed by a physician with an approximate 11-year history (see Exhibit 17) of treating Claimant. It was noted that Claimant was capable of sitting 20 minutes before needing to lie-down for 1-2 hours. Claimant was found capable of walking 1/8th of a mile and standing for a 15-minute period. Over an 8 hour workday, Claimant was found capable of the following: 2 hours of standing, 2 hours of sitting, and 1 hour of walking. Claimant was deemed capable of occasional lifting of up to 20 pounds, never more than 20 pounds. Claimant's physician opined a 20 minute rest per hour was insufficient as Claimant needed complete freedom to frequently rest without restriction. Claimant was found to reach maximum medical improvement. It was noted that Claimant's functioning level had been ongoing for 3 years. The basis for restrictions was "see attached."

In a Medical Examination Report dated November 26, 2014, Claimant's physician provided various restrictions. It was noted that Claimant's limitation(s) was expected to last 90 days. Claimant's physician opined that Claimant was restricted as follows over an eight-hour workday, less than 2 hours of standing and/or walking, and less than 6 hours of sitting. Claimant was restricted to occasional lifting/carrying of 10 pounds,

never 20 pounds or more. Claimant's physician restricted Claimant from repetitive right-leg foot control operation. A restriction of sustaining concentration was noted; the basis was marked anxiety. In response to a question asking for the stated basis for restrictions, Claimant's physician responded "see other pages."

Claimant testified she does not get into the shower because she fell in her shower twice in the last year. Claimant testified she does not shower without her sister's presence. Claimant testified she uses a stick to help pull up her pants and to put on socks. Claimant testified her sisters and her niece take turns helping to clean her residence. Claimant testified she washes dishes when she is physically able. Claimant testified she can drive but is usually transported to her medical appointments by a family member. Claimant testified she cannot go down her stairs to do laundry; she said she fell down her stairs previously.

Claimant testified she uses a cane. Claimant testified she can walk no further than a block, even with her cane. Claimant testified she can sit only approximately 15-20 minutes at a time. Claimant testified that she stood up about 7 times throughout the administrative hearing. Claimant testified she takes 3-4 naps during day due to fatigue from medication. Claimant testified that her only relief from pain is lying on her side.

Claimant's testimony and physician statements concerning Claimant's standing, ambulation, sitting, and lifting/carrying restrictions were each consistent with an inability to perform light employment. The stated restrictions were consistent with a treatment history included chronic complaints of back pain, a need for narcotic medication, and an inability to complete physical therapy due to pain. The restrictions appeared to be more than would be expected for radiology verifying mild foraminal stenosis at 2 lumbar discs and knee osteoarthritis with no internal derangement. Radiology was generally consistent with sufficient ambulation and lifting/carrying restrictions so that light employment is an unrealistic expectation.

It is found that Claimant is incapable of performing light employment. For purposes of this decision, it will be found that Claimant is capable of performing sedentary employment.

Based on Claimant's exertional work level (sedentary), age (approaching advanced age), education (high school with no direct entry into skilled employment), employment history (semi-skilled with no known transferrable job duties), Medical-Vocational Rule 201.12 is found to apply. This rule dictates a finding that Claimant is disabled. Accordingly, it is found that MDHHS improperly found Claimant to be not disabled for purposes of SDA benefits.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that MDHHS improperly denied Claimant's application for SDA benefits. It is ordered that MDHHS:

(1) reinstate Claimant's SDA benefit application dated November 10, 2014;
(2) evaluate Claimant's eligibility subject to the finding that Claimant is a disabled individual;
(3) initiate a supplement for any benefits not issued as a result of the improper application denial; and
(4) schedule a review of benefits in one year from the date of this administrative decision, if Claimant is found eligible for future benefits.

The actions taken by MDHHS are **REVERSED**.

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

Date Signed: **9/16/2015**

Date Mailed: **9/16/2015**

GC/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]