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

IN THE MATTER OF:

MAHS Reg. No.:	15-013599
Issue No.:	4009
Agency Case No.:	
Hearing Date:	November 2, 2015
County:	Wayne (55)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

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; 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, an in-person hearing was held on November 2, 2015, from Hamtramck, Michigan. Petitioner appeared and was represented by of . The Michigan Department of Health and Human Services (MDHHS) was represented by , specialist.

ISSUE

The issue is whether MDHHS properly denied Petitioner's State Disability Assistance (SDA) eligibility for the reason that Petitioner 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 March 23, 2015, Petitioner applied for SDA benefits.

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

3. On July 24, 2015, the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibits 10-12).

4. On July 24, 2015, MDHHS denied Petitioner's application for SDA benefits and mailed a Medical program Eligibility Notice (Exhibits 8-9) informing Petitioner of the denial.

5. On August 3, 2015, Petitioner requested a hearing disputing the denial of SDA benefits (see Exhibits 2-3).

6. On November 2, 2015, an administrative hearing was held.

7. During the hearing, Petitioner and MDHHS waived the right to receive a timely hearing decision.

8. During the hearing, the record was extended 30 days to allow Petitioner to submit various medical records; an Interim Order Extending the Record was subsequently mailed to both parties and MDHHS waived the right to object to subsequently submitted documents.

9. On November 16, 2014, the Michigan Administrative Hearing System received Petitioner's additional documents (Exhibits C1-C503; D1-D106; E1-E130).

10. As of the date of the administrative hearing, Petitioner was a 51-year-old female.

11. Petitioner has not earned substantial gainful activity since before the first month of benefits sought.

12. Petitioner's highest education year completed was the 12th grade, with no direct entry into skilled employment.

13. Petitioner has a history of unskilled employment, with no transferrable job skills.

14. Petitioner alleged disability based on restrictions related to asthma, joint pain, rheumatoid arthritis (RA), lupus, bilateral foot pain, and depression.

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).

It was not disputed that Petitioner applied for SDA benefits on July 17, 2015. Petitioner's hearing request dated August 28, 2015, clearly disputed the denial of SDA eligibility. During the hearing, Petitioner's attorney suggested Petitioner might have submitted an earlier hearing request to dispute the termination of SDA benefits.

During the hearing, Petitioner testified she could not recall if she submitted a hearing request to dispute the SDA termination. Petitioner testified she recalled having to submit paperwork by a deadline; this testimony was irrelevant to whether Petitioner submitted a hearing request to dispute a termination of SDA benefits. MDHHS testimony indicated there was no record of a previous hearing request by Petitioner.

It is found that Petitioner did not submit a hearing request to dispute a termination of SDA benefits from December 2014. The analysis will proceed to evaluate the denial of Petitioner's SDA application dated July 17, 2015.

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 Petitioner. Accordingly, Petitioner may not be considered for SDA eligibility without undergoing a medical review process (see BAM 815) which determines whether Petitioner 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. "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.

Petitioner credibly denied performing any employment since the date of the SDA application; no evidence was submitted to contradict Petitioner's testimony. Based on the presented evidence, it is found that Petitioner 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 Petitioners 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 Petitioner's impairments amount to a severe impairment, all other relevant evidence may be considered. The analysis will begin with a summary of presented medical evidence.

Petitioner testified she was working hard to achieve independence before she was diagnosed with lupus in 2013. Petitioner testified her health has severely diminished since the diagnosis.

Various medication descriptions and prescription history (Exhibits A17-A77) were presented. The documents were not notable other than being consistent with other documents.

A dermatopathology report (Exhibit 78) dated July 5, 2013, was presented. It was noted that tissue findings were consistent with a diagnosis of discod lupus erythematosus.

Hospital physician office visit notes (Exhibits C1-C3) from August 2013 were presented. It was noted that Petitioner presented with a rash which spread from her face to her arms and back. An assessment of discoid lupus was noted. It was noted that lupus was likely limited to the skin and there was only a 5% chance of the lupus becoming systemic.

Various hospital physician office visit notes (Exhibits C6-C19) from May 2014 were presented. It was noted that Petitioner complained of asthma, right heel pain, and allergies. Diagnoses of asthma, plantar fasciitis, and rhinoconjunctivitis were noted.

Handwritten physician office notes (Exhibit A4) dated April 24, 2014, were presented. Most notes were not legible though ongoing treatment for DLE (discoid lupus erythematosus) was clearly noted.

Various hospital physician office visit notes (Exhibits C28-C37; C48-C63) from May 2014 were presented. Ongoing treatment for discoid lupus, conjunctivitis, and plantar fasciitis were noted.

Hospital emergency room documents (Exhibits C20-C27) dated May 7, 2014, were presented. It was noted that Petitioner presented with complaints of excessive urination

frequency. A plan of caffeine cessation and use of Oxytrol was noted. A plan of physical therapy for Petitioner's pelvic floor was noted.

Hospital emergency room documents (Exhibits C38-C47) dated May 20, 2014, were presented. It was noted that Petitioner presented with complaints of excessive urination frequency. A referral for PT and bladder retraining information was noted.

Hospital physician office visit notes (Exhibits C64-C66) from June 2014 were presented. Assessments of myopia and discoid lupus were noted. It was also noted Petitioner was doing well on current asthma treatment.

Handwritten physician office notes (Exhibit A5) dated June 16, 2014, were presented. Most notes were not legible though ongoing treatment for DLE and a cyst was clearly noted.

A dermatopathology report (Exhibit A6) dated June 19, 2014, was presented. A cyst on Petitioner's back was noted to be consisted with a finding of DLE.

Handwritten physician office notes (Exhibit A7) dated June 30, 2014, were presented. Most notes were not legible though ongoing treatment for DLE and a cyst was clearly noted.

Various hospital physician office visit notes (Exhibits C67-C77) from July 2015. On July 7, 2014, it was noted Petitioner's foot pain reduced to 4/10 seven weeks after a Celestone injection. On July 17, 2014, Petitioner reported recurrent infections and poor allergy control. On July 23, 2014, Petitioner reported a worsening of asthma and urinary frequency. On July 29, 2014, Petitioner reported decreased urinary leakage.

Handwritten physician office notes (Exhibit A8) dated August 14, 2014, were presented. Most notes were not legible though ongoing treatment for DLE and a cyst was clearly noted.

A dermatopathology report (Exhibit A9) dated August 19, 2014, was presented. A cyst on Petitioner's leg was noted to be consisted with a finding of DLE.

Handwritten physician office notes (Exhibit A10) dated September 4, 2014, were presented. Most notes were not legible though ongoing treatment for DLE and a cyst was clearly noted.

Hospital physician office visit notes (Exhibits C81) dated September 8, 2014, were presented. An assessment of right foot hallux limitus with osteoarthritis and improving mild plantar fasciitis were noted.

Handwritten physician office notes (Exhibit A11) dated September 4, 2014, were presented. Most notes were not legible though ongoing treatment for DLE was clearly noted.

Hospital emergency room documents (Exhibits C82-C86) dated September 18, 2014, were presented. It was noted that Petitioner presented with right foot pain. An impression of a moderate sized plantar spur and osteoarthritis of the first metatarsophelangeal joint were noted.

Hospital emergency room documents (Exhibits C87-92) dated September 20, 2014, were presented. It was noted that Petitioner presented with complaints of a cough with dyspnea, ongoing for a week. It was noted Petitioner did not wish to be evaluated and that she would see her cardiologist on an outpatient basis.

Various hospital documents (Exhibits C93-C128) from October 2014 were presented. On October 3, 2014, Petitioner complained of chest pain, uterine bleeding, and malaise; an electrocardiogram was ordered. On October 7, 2014, Petitioner complained of ongoing right foot pain (4/10). On October 20, 2014, Petitioner reported an absence of menses, ongoing for 8 months; a normal GYN patient impression was noted. On October 30, 2014, it was noted Petitioner presented to the emergency room for uncontrolled asthma.

Handwritten physician office notes (Exhibit A12) dated October 16, 2014, were presented. Most notes were not legible though ongoing treatment for DLE was clearly noted.

Various hospital documents (Exhibits C129-C155) from November 2015 were presented. On November 4, 2014, Petitioner was given predisone to treat complaints of dyspnea. On November 12, 2014, Petitioner was evaluated for recurrent infections, typically 3-4 weeks in duration; Petitioner was found to have fibroids following an ultrasound. On November 13, 2014, Petitioner complained of 4/10 right foot pain, a 30 year history of headaches, and urination frequency; a standing capability of more than 10 minutes was noted. On November 20, 2014, several functional improvements were noted (e.g. lower extremity strength (4/5), balance, and gait). On November 21, 2014, Petitioner complained of right foot heel pain (3/10); an assessment of resolved plantar fasciitis and discomforting right foot hallux limitus was noted. On November 24, 2014, it was noted Petitioner sought evaluations for fibromyalgia and rheumatoid arthritis.

Various hospital documents (Exhibits C156-C187) from December 2014 were presented. On December 2, 2014, Petitioner reported better controlled asthma since a 10 day course of steroids. On December 4, 2014, physical therapy documents noted improvements in gait, balance, and muscle strength. On December 8, 2014, it was noted there was serological evidence of rheumatoid arthritis. On December 30, 2014, Petitioner reported hand and arm pain during PT.

An MRI report of Petitioner’s brain and cervical spine (Exhibits 89-94) dated December 1, 2014, was presented. The report was performed in response to a history of complaints of upper extremity weakness and hyperreflexia. An unremarkable MRI of the brain was noted. Minimal cervical spine degenerative changes were noted.

An EMG with nerve conduction report (Exhibits 95-97) dated December 9, 2014, was presented. An impression of early and mild polyneuropathy was noted.

A neurologist letter (Exhibit 6) dated December 28, 2014, was presented. It was stated that an MRI of petitioner’s brain was normal. An MRI of Petitioner’s cervical spine was noted to be not significantly abnormal, though degenerative disc disease was noted. It was noted that an EKG demonstrated early axonal sensorimotor neuropathy, possibly related to a diagnosis of lupus. A plan to start Plaquenil was noted.

A referral for physical therapy (Exhibits B1-B2) dated December 29, 2014, were presented. Associated diagnoses of fibromyalgia and RA were noted.

Various hospital documents (Exhibits C188-C222) from January 2015 were presented. Petitioner reported ongoing headaches, depression, leg cramps, and burning sensation in her legs. Pain medication for joint pain was prescribed. A diagnosis of RA was noted on January 8, 2015. It was noted Petitioner fell on January 22, 2015, and felt an increase in pain; prescriptions for Neurontin, robaxin, and naproxen were noted. It was noted Petitioner reported body pain throughout the month.

A Medical Examination Report (Exhibits 60-65) dated January 2, 2015, was presented. The form was completed by a family practice physician with an approximate 2 year history of treating Petitioner. An impression was given that Petitioner’s condition was stable. It was noted that Petitioner can meet household needs.

Physician office visit notes (Exhibit 79) dated January 5, 2015, were presented. Petitioner’s listed problems included lupus, hypertension, obesity, asthma, edema, bunion, urinary frequency, rheumatoid arthritis, and cervical disc disorder with myelopathy.

Handwritten physician office notes (Exhibit A13) dated January 30, 2015, were presented. Most notes were not legible though ongoing treatment for DLE was clearly noted.

Various hospital documents (Exhibits C93-C128) from February 2015 were presented. Treatment for oral thrush, joint pain, RA, and discoid lupus was noted. Petitioner was instructed to continue B12 injections to combat RA.

A Psychiatric/Psychological Examination Report (Exhibits 55-57) dated February 11, 2015, was presented. The form was completed by a treating psychologist with no

previous history of treating Petitioner. Most of the report was illegible though a diagnosis of adjustment disorder was noted. Petitioner's GAF was noted to be 55.

A Mental Residual Functional Capacity Assessment (Exhibits 58-59) dated February 11, 2015 was presented. The assessment was noted as completed by a psychologist with no previous history of treating Petitioner. It was noted that Petitioner showed "no evidence of limitation" in 18 of 20 listed work abilities. Petitioner was found to be moderately restricted in the ability to complete a normal workday without psychological interruption. Petitioner was found to be markedly restricted in her ability to perform activities within a schedule while maintaining punctuality and attendance.

Various hospital documents (Exhibits C93-C128) from March 2015 were presented. On March 11, 2001, an Axis I diagnosis of mood disorder due to medical condition was noted; Petitioner's GAF was noted to be 60. On March 31, 2015, dyspnea was reported to be stable. Ongoing PT and lupus treatment was noted.

Handwritten physician office notes (Exhibit A14) dated March 13, 2015, were presented. Most notes were not legible though ongoing treatment for DLE was clearly noted.

Various hospital documents (Exhibits C267-C286) from April 2015 were presented. Ongoing psychiatric, RA, foot pain, and lupus treatment was noted.

Various hospital documents (Exhibits C287-C303) from May 2015 were presented. A CT scan of Petitioner's lungs was noted to be unremarkable. On May 14, 2015, Petitioner's GAF was noted to be 50; a poor prognosis was noted. Ongoing RA, foot pain, and lupus treatment was noted.

Various hospital documents (Exhibits C304-C340) from June 2015 were presented. On June 3, 2015, an Axis I diagnosis of pain disorder with psychological and physical factors was noted by a treating psychologist. A neuro-opthamologist noted severe impairment of macular core photoreceptor function. On June 18, 2014, an assessment of myofascial pain syndrome was noted. On June 24, 2015, an assessment of axonal sensorimotor peripheral neuropathy was noted.

Handwritten physician office notes (Exhibit A15) dated June 12, 2015, were presented. Most notes were not legible though ongoing treatment for DLE was clearly noted.

A mental status examination report (Exhibits 15-18) dated June 22, 2015, was presented. The report was noted as completed by a consultative psychiatrist. It was noted that Petitioner reported various medical problems and crying spells. Petitioner reported depression since her teens- worse since a lupus diagnosis. Noted observations of Petitioner made by the consultative examiner include the following: crying spells, good contact with reality, and talkative. A diagnosis of major depressive disorder was noted. A guarded prognosis was noted. It was further noted that Petitioner

needed therapy and supportive services. The examiner opined that Petitioner was not able to function on a fully sustained basis.

A neurologist treatment document (Exhibit 7) dated June 24, 2015, was presented. Petitioner's problem list included the following: discoid lupus, chronic hyposmia, long-term use of Plaquenil, unspecified chest pain, right shoulder pain, chronic neck pain, and RA.

An internal medicine examination report (Exhibits 20-47; including report duplicates) dated June 22, 2015, was presented. The report was noted as completed by a consultative physician. Petitioner reported complaints of asthma, arthritis, HTN, lupus, and sinus allergies. Petitioner reported being seen by 8 or more physicians. It was noted that Petitioner did not use a cane. Squatting and recovery was noted as restricted to 70%. Bending was noted as restricted to 80%. It was noted Petitioner performed tandem walk. For unspecified reasons, Petitioner refused to perform heel walk and toe walk. No abnormal physical examination findings were noted. It was noted that Petitioner was able to perform all 23 listed work-related activities which included sitting, standing, lifting, carrying, stooping, bending, and reaching, though most were performed with pain. The examining physician stated that clinical evidence did not support a need for a cane. Assessments of asthma, HTN, arthritis, sinus allergies, and lupus were noted.

Various hospital documents (Exhibits C341-C355) from July 2015 were presented. An MRI of Petitioner's brain was noted to be unremarkable. Ongoing PT and psychiatric treatment were noted.

Various hospital documents (Exhibits C356-C381) from August 2015 were presented. Ongoing PT and other chronic pain treatment were noted.

Various hospital documents (Exhibits C382-C416) from September 2015 were presented. It was noted Petitioner underwent IV lidocaine infusion to treat joint pain.

A letter from a psychologist (Exhibit A16) dated September 28, 2015, was presented. It was noted Petitioner attended pain management psychotherapy.

A Medical Examination Report (Exhibits A1-A2; D76-D77) dated October 2, 2015, was presented. The form was completed by an internal medicine physician with an approximate 4 month history of treating Petitioner. Petitioner's physician listed diagnoses of HTN, systemic lupus erythematosus, fibromyalgia, RA, major depression, bronchial asthma, degenerative spinal arthritis, chronic allergies, and chronic pain syndrome. An impression was given that Petitioner's condition was stable, though Petitioner's symptoms were noted to have worsened. It was noted that Petitioner needed a chore provider for cooking, cleaning, and laundry. Medications included the following: Norco, Singulair, Lisinopril, Methotrexate, Ventolin, Zyrtec, and others. Petitioner's physician stated Petitioner also had restrictions to her concentration,

comprehension, and memory. A diagnosis of major depression was stated as the basis for restrictions.

A Clinical Assessment of Pain form (Exhibit A3) dated September 15, 2015, was presented. The form was completed by Petitioner's treating physician. Petitioner's physician stated that pain distracted Petitioner from adequately performing daily activities. Pain was also stated to either distract Petitioner from task completion or cause abandonment of task completion. Petitioner's drug side effects were noted to be severe.

Petitioner presented hundreds of other documents (Exhibits C417-C503; D1-D106; E1-E130). The documents were notable for being duplicative or consistent with noted documents.

Petitioner testified she is restricted to a half block of ambulation before back and leg pain prevents further ambulation. Petitioner testified she is limited to 20-30 minutes of standing for the same reasons.

Petitioner testified she takes two hour long naps each day to deal with fatigue. Petitioner testified she has daily headaches, sometimes lasting the entire day. Petitioner testified she has severe body pain (9/10) though it decreases (6-7/10) after taking her pain medications which include Tylenol-#3 (every 4-6 hours), valium, and tramadol (2-3 times/day). Petitioner's testimony was indicative of restrictions which might prevent the performance of light employment.

Petitioner testified she also struggles with daily activities. She testified she has difficulty washing her back when bathing. She testified she also has difficulties combing her hair. Petitioner testified she cleans but takes breaks. Petitioner also testified she uses a buggy to do her laundry.

Petitioner testified she is very sad because of body pain. She testified she often has crying spells and does not know why; Petitioner had multiple crying spells during the hearing. Diagnoses for depression and low functioning levels were verified. Petitioner established psychological impairments.

Medical document verified ongoing treatment for asthma. Petitioner testified she uses a breathing machine. Petitioner testimony conceded she has not needed the machine in the past month and she could not remember when she used it last. Petitioner stated she primarily relies on an inhaler whenever she has breathing difficulties. Petitioner's testimony was consistent with presented evidence which verified ongoing asthma treatment and breathing medications.

Petitioner testified she sees several doctors including a primary care physician, rheumatologist, neurologist, podiatrist, pulmonary physician, and a spinal specialist. Petitioner testified she has ongoing problems with lupus, asthma, and body pain.

Petitioner testified she is restricted in ambulation, standing, and lifting/carrying due to her various ailments.

Petitioner testified she is hoping to have surgery on her feet. She testified her toes spasm on her left foot. Petitioner testified her right foot big toe has a loss of cartilage causing painful bon-on-bone friction.

Petitioner testified RA, fibromyalgia, and/or neuropathy cause her tremendous body pain. She testified it affects her arms, hands, and legs. Petitioner testified she also has back pain. Petitioner testified she still regularly attends PT appointments. Petitioner testified she does not use a cane or walker.

Petitioner's testimony concerning impairments was credible and generally consistent with the medical evidence. It is found that Petitioner established significant impairment to basic work activities for a period longer than 90 days. Accordingly, it is found that Petitioner 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 Petitioner'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 Petitioner's impairments are listed and deemed to meet the durational requirement, then the Petitioner 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 Petitioner's complaints of various joint pains. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively or that Petitioner is unable to perform fine and gross movements.

A listing for visual acuity (Listing 2.02) was considered based on eye testing. Petitioner testified her vision was affected by use of Plaquenil. Petitioner's testimony implied her vision is not a permanent problem. This listing was rejected due to a failure to establish a corrected eyesight of worse than 20/200 in Petitioner's best eye.

A listing for asthma (Listing 3.03) was considered based on Petitioner's asthma treatment history. The listing was rejected due to a lack of respiratory testing evidence, or chronic asthma attacks in spite of following prescribed treatment.

Various skin disorder listings (Listings 4.00) were considered based on Petitioner's treatment for discoid lupus. The listings were rejected due to a failure to establish extensive lesions (or other qualifying skin problems) lasting 3 months despite following prescribed treatment.

A listing for peripheral neuropathies (Listing 11.14) was factored based on a documented diagnosis. The listing was rejected due to a failure to establish significant and persistent disorganization of motor function in two extremities.

A listing for affective disorder (Listing 12.04) was considered based on diagnoses 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 Petitioner 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 lupus (Listing 14.02) was considered based on Petitioner's treatment history. The listing was rejected due to a failure to establish a diagnosis for systemic lupus erythematosus treatment (as opposed to discoid lupus).

A listing for inflammatory arthritis (Listing 14.09) was considered based on Petitioner's complaints of arthritis The presented medical records were insufficient to establish that Petitioner 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 Petitioner 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 Petitioner'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 Petitioner 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.

Petitioner testified she has only earned SGA for less than 12 months over the last 15 years. Petitioner testified she spent many years as a caregiver, however, her earning amounted to approximately $400/month- significantly less than SGA requirements.

Petitioner testified she worked for a few months as a shelf stocker for a dollar store. Petitioner testified the job did not require much lifting though she was on her feet for

most of her shifts. Petitioner testimony indicated she can no longer perform the standing required of this employment.

Petitioner also testified she also packaged small automotive parts (e.g. screws, bolts, nuts). Petitioner testified she could choose between sitting or standing. Petitioner testified her duties included regular lifting/carrying of 15 pounds. Petitioner testified she quit her job due to poor health. Petitioner testimony implied she could not perform this job because of an inability to lift/carry.

Petitioner's testimony that she is unable to perform past employment was credible and consistent with presented documents. It is found that Petitioner is unable to 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 Petitioner's age, education and employment history, a determination of disability is dependent on Petitioner'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.*

Petitioner’s family practice physician noted various restrictions on a Medical Examination Report dated January 2, 2015 (see Exhibits 60-65). Petitioner’s physician opined that Petitioner was restricted as follows over an eight-hour workday, less than 2 hours of standing and/or walking. It was noted that Petitioner could sit approximately 6 hours per 8 hour workday. Petitioner was restricted to occasional lifting/carrying of less than 10 pounds, never 10 pounds or more. Petitioner’s physician opined that Petitioner was restricted from performing the following repetitive actions: simple grasping, fine manipulating, and operating leg/foot controls. It was noted that Petitioner did not need an assistive device for ambulation. It was noted that Petitioner’s limitation(s) was expected to last 90 days. Petitioner’s physician stated rheumatoid arthritis justified all stated restrictions. Stated lifting/carrying and standing restrictions were consistent with an inability to perform light employment. The statements were also consistent with presented medical history.

Petitioner’s internal medicine physician listed various restrictions on a Medical Examination Report dated October 2, 2015 (see Exhibits A2; D77). The physician opined that Petitioner was restricted as follows over an eight-hour workday, less than 2 hours of standing and/or walking, and less than 2 hours of sitting. Petitioner was totally restricted from lifting/carrying. Petitioner’s physician opined that Petitioner was restricted from performing the following repetitive actions: reaching, pushing/pulling, operating leg/foot controls, and simple grasping if Petitioner was in pain. In response to a question asking for the stated basis for restrictions, Petitioner’s physician noted decreased ranges of spinal motions and body pain. It was noted that Petitioner did not need an assistive device for ambulation. It was noted that Petitioner’s limitation(s) was expected to last 90 days.

Physician-stated restrictions appeared to increase over the course of 2015. The increase in restrictions is consistent with newly found diagnoses of RA and a possible worsening of lupus.

Consideration was given to disregarding the restrictions stated by her internal medicine physician because systemic lupus erythematous was not a documented diagnosis (only discoid lupus was) elsewhere in the medical packet. The consideration was rejected because Petitioner established multiple other problems including RA and possibly fibromyalgia which could justify stated restrictions.

At the very least, physician-provided restrictions established that Petitioner is incapable of performing light employment. A restriction from performing light employment is fully-supported by Petitioner’s treatment history.

It is found that Petitioner is restricted from performing light employment. For purposes of this decision, it will be found that Petitioner can perform a full range of sedentary employment.

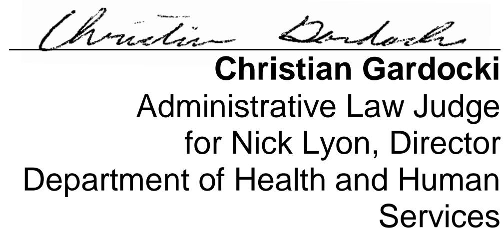
Based on Petitioner's exertional work level (sedentary), age (approaching advanced age), education (high school with no direct entry into skilled employment), employment history (unskilled), Medical-Vocational Rule 201.12 is found to apply. This rule dictates a finding that Petitioner is disabled. Accordingly, it is found that MDHHS improperly found Petitioner 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 Petitioner's application for SDA benefits. It is ordered that MDHHS:

(1) reinstate Petitioner's SDA benefit application dated March 23, 2015;
(2) evaluate Petitioner's eligibility subject to the finding that Petitioner 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 Petitioner 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: **11/20/2015**

Date Mailed: **11/20/2015**

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: