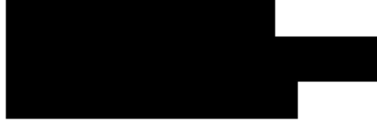
STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

IN THE MATTER OF:



MAHS Reg. No.: 15-019830
Issue No.: 4009
Agency Case No.:
Hearing Date: December 21, 2015
County: Wayne (19)

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; and Mich Admin Code, R 792.11002. After due notice, an in-person hearing was held on December 21, 2015, from Inkster, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by medical contact worker.

ISSUE

The issue is whether MDHHS properly terminated 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. Petitioner was an ongoing SDA recipient.

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

3. MDHHS never certified Petitioner to be disabled or otherwise eligible for SDA benefits.

4. On October 13, 2015, the Medical Review Team (MRT) determined that Petitioner was not a disabled individual for purposes of SDA eligibility (see Exhibits 129-134).

5. On October 20, 2015, MDHHS terminated Petitioner's eligibility for SDA benefits, effective December 2015, and mailed a Notice of Case Action (Exhibits 135-138) informing Petitioner of the termination.

6. On October 26, 2015, Petitioner requested a hearing disputing the termination of SDA benefits (see Exhibits 2-4).

7. As of the date of the administrative hearing, Petitioner was a 56-year-old female.

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

9. Petitioner's highest education year completed was the 11th grade.

10. Petitioner has no history of employment with SGA earnings.

11. Petitioner alleged disability based on restrictions related to knee pain, lumbar pain, shoulder pain, and various mental health problems.

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 (7/2014), 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.

Generally, state agencies such as MDDHS 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. The definition of SDA disability is identical except that only a three month period of disability is required.

Substantial gainful activity 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. BEM 260 (7/2014), p. 10. 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 substantial gainful activity. *Id*.

Once an individual has been found disabled for purposes of disability-related benefits, continued entitlement is periodically reviewed in order to make a current determination or decision as to whether disability remains in accordance with the medical improvement review standard. 20 CFR 416.993(a); 20 CFR 416.994.

It was not disputed that Petitioner was an ongoing SDA recipient. At Petitioner's most recent SDA benefit redetermination, MDDHS determined that Petitioner was not disabled.

In evaluating a claim for ongoing disability benefits, federal regulations require a sequential evaluation process be utilized. 20 CFR 416.994(b)(5). The review may cease and benefits continued if sufficient evidence supports a finding that an individual is still unable to engage in substantial gainful activity. *Id.* Prior to deciding if an individual's disability has ended, the department will develop, along with the petitioner's cooperation, a complete medical history covering at least the 12 months preceding the date the individual signed a request seeking continuing disability benefits. 20 CFR 416.993(b). The department may order a consultative examination to determine whether or not the disability continues. 20 CFR 416.993(c).

The below-described evaluation process is applicable for clients that have not worked during a period of disability benefit eligibility. There was no evidence suggesting that Petitioner received any wages since receiving disability benefits; thus, the analysis may commence.

The first step in the analysis in determining the status of a petitioner's disability requires the trier of fact to consider the severity of the impairment(s) and whether it meets or equals a listed impairment in Appendix 1 of subpart P of part 404 of Chapter 20. 20 CFR 416.994(b)(5)(i). If a listing is met, an individual's disability is found to continue and no further analysis is required. This consideration requires a summary and analysis of presented medical documents.

Medical center visit notes (Exhibit 57) dated May 15, 2014, were presented. A diagnosis of chronic pain was noted.

Medical center visit notes (Exhibit 56) dated July 17, 2014, were presented. It was noted that Petitioner complained of gum swelling and tooth pain.

Psychiatric progress notes (Exhibits 83-84) dated August 1, 2014, were presented. Petitioner reported she had problems with her neighbors, slept well, and ate well. It was

noted Petitioner wanted to be a foster parent though a judge denied her request. An Axis I diagnosis of generalized anxiety disorder and GAF of 46 from October 3, 2013, were noted.

A letter from a treating medical center (Exhibit 58) dated August 17, 2014, were presented. It was noted that Petitioner was pharmacy shopping after she signed a narcotic contract with the medical center. It was noted Petitioner failed to follow-up on referrals to pain management specialist and a psychologist.

Psychiatric progress notes (Exhibits 85-86) dated September 2, 2014, were presented. It was noted Petitioner denied hallucinations, suicidal ideation or drug abuse. It was noted Petitioner had not been taking Celexa or Saphris due to a lack of money.

Medical center visit notes (Exhibit 55) dated September 15, 2014, were presented. It was noted that Petitioner complained of a headache (ongoing for 2 months), back pain (ongoing for one month), and right arm pain. It was noted Petitioner was advised she could not receive narcotics for her complaints.

Psychiatric progress notes (Exhibits 87-88) dated October 1, 2014, were presented. It was noted Petitioner reported feeling paranoid about people stealing her car.

Psychiatric progress notes (Exhibits 89-90) dated October 31, 2014, were presented. It was noted Petitioner felt paranoid all the time. It was noted Petitioner reported problems with her grandson.

Physician office visit notes (Exhibits 61-69) dated December 4, 2014, were presented. It was noted that Petitioner presented with a chief complaint of noncompliance with HTN medication. It was noted Petitioner had not taken prescribed HTN medication for 5 months. A complaint of chronic back pain was noted. Atenolol was prescribed for HTN and Norco was prescribed for back pain.

Psychiatric progress notes (Exhibits 91-92) dated December 15, 2014, were presented. It was noted Petitioner reported concerns about her adopted son who was now in a foster home.

A Treatment Meeting Plan (Exhibits 70-80) dated December 15, 2014, was presented. The plan was signed by Petitioner and a limited licensed professional counselor from Petitioner's treating mental agency. It was noted Petitioner would have regular meetings with a therapist, psychiatrist, and case manager

Psychiatric progress notes (Exhibits 93-94) dated January 22, 2015, were presented. It was noted Petitioner was doing fine with her medications, with no side effects and no distress.

Physician progress notes (Exhibits 109-111) dated February 17, 2015, were presented. It was noted Petitioner complained of pain in her right shoulder, right arm, right knee, and lumber spine. Various medications were noted to be prescribed.

Psychiatric progress notes (Exhibits 95-96) dated February 23, 2015, were presented. It was noted Petitioner denied both paranoia and hallucinations.

Physician progress notes (Exhibit 109) dated March 30, 2015, were presented. It was noted Petitioner reported ongoing right shoulder pain. It was noted Petitioner was denied a request for Norco and Tylenol #3.

Psychiatric progress notes (Exhibits 97-98) dated April 7, 2015, were presented. It was noted Petitioner reported worries about people breaking into her residence. It was noted petitioner reported Saphris (one of her medications) bothers her stomach.

Physician progress notes (Exhibits 107-109) dated April 15, 2015, were presented. It was noted Petitioner presented for a blood pressure follow-up. Blood pressure of 145/69 was noted. Limited right shoulder range of motion was noted. Assessments of lumbago and right shoulder pain were noted. An x-ray of Petitioner's knees was ordered.

Psychiatric progress notes (Exhibits 99-101) dated May 5, 2015, were presented. It was noted Petitioner did not regularly take Seroquel.

Physician progress notes (Exhibits 106-107) dated May 7, 2015, were presented. It was noted Petitioner did not regularly take prescribed blood pressure medication. It was noted Petitioner was a daily smoker. An assessment of stable HTN was noted. Petitioner's blood pressure was noted to be 119/71. A referral for an unspecified vision problem was noted.

A Medication Log Summary (Exhibit 81) dated May 12, 2015, was presented. Medications for Celexa, Xanax, Seroquel, and Atenolol were noted.

A Medical Examination Report (Exhibits 51-53) dated May 15, 2015, was presented. The form was completed by an internal medicine physician with an approximate 3-month history of treating Petitioner. Petitioner's physician listed diagnoses of visual disturbance, HTN, back pain, knee pain, anxiety, and depression. visual acuity was noted to be 20/25 in each eye. Limited range of motion was noted in Petitioner's right shoulder. A difficulty for Petitioner to stay focused and pay attention was noted. An impression was given that Petitioner's condition was stable. It was noted that Petitioner can meet household needs.

An internal medicine examination report (Exhibits 113-115) dated July 16, 2015, was presented. The report was noted as completed by a consultative physician. Petitioner reported complaints of HTN, emphysema, occasional dizziness, and various psychiatric problems. It was noted Petitioner smoked. Lumbar movement was noted to be restricted

to 70-75% of normal. A recommendation of bilateral knee and lumbar spine x-rays were noted. A fair prognosis was noted.

A mental status examination report (Exhibits 116-119) dated July 19, 2015, was presented. The report was noted as completed by a consultative licensed psychologist. Petitioner reported back pain of 10/10. It was noted Petitioner was sexually abused by a babysitter as a child. Noted observations of Petitioner made by the consultative examiner include the following: orientation x3, alert, blunted affect, eurythmic mood, spontaneous speech, and goal-directed speech. It was noted Petitioner was unable to recall three items over a period of 3 minutes. The examiner concluded Petitioner could care for herself, follow simple directions, and manage her own funds. A diagnostic analysis of adjustment disorder (mild) was noted.

A listing for joint dysfunction (Listing 1.02) was considered based on Petitioner's complaints of knee pain. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively. The listing was also considered for Petitioner's complaints of right shoulder pain; the listing was also rejected because it was not established that Petitioner was unable to perform fine and gross movements.

A listing for spinal disorders (Listing 1.04) was considered based on Petitioner'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 visual acuity (Listing 2.02) was considered based on references to vision complaints. 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 chronic pulmonary insufficiency (Listing 3.02) was considered based on various references to breathing problems. The listing was rejected due to a lack of respiratory testing evidence.

A listing for anxiety-related disorders (Listing 12.06) was considered based on Petitioner'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 Petitioner had a complete inability to function outside of the home.

It is found that Petitioner does not meet a SSA listing. Accordingly, the analysis proceeds to the second step.

The second step of the analysis considers whether medical improvement occurred. CFR 416.994(b)(5)(ii). Medical improvement is defined as any decrease in the medical severity of the impairment(s) which was present at the time of the most favorable medical decision that the individual was disabled or continues to be disabled. 20 CFR 416.994(b)(1)(i).

A second step analysis typically begins with a summary of documents that supported the original finding of disability. MDHHS presented no such documents. Without such documents, it can only be found that Petitioner has not had medical improvement and the analysis proceeds directly to the fourth step.

Step 4 of the analysis considers whether any exceptions apply to a previous finding that no medical improvement occurred or that the improvement did not relate to an increase in RFC. 20 CFR 416.994(b)(5)(iv). If medical improvement related to the ability to work has not occurred and no exception applies, then benefits will continue. CFR 416.994(b). Step 4 of the disability analysis lists two sets of exceptions.

The first group of exceptions allows a finding that a petitioner is not disabled even when medical improvement had not occurred. The exceptions are:

(i) Substantial evidence shows that the individual is the beneficiary of advances in medical or vocational therapy or technology (related to the ability to work;
(ii) Substantial evidence shows that the individual has undergone vocational therapy related to the ability to work;
(iii) Substantial evidence shows that based on new or improved diagnostic or evaluative techniques the impairment(s) is not as disabling as previously determined at the time of the most recent favorable decision;
(iv) Substantial evidence demonstrates that any prior disability decision was in error.
20 CFR 416.994(b)(4)

If an exception from the first group of exception applies, then the petitioner is deemed not disabled if it is established that the claimant can engage is substantial gainful activity. If no exception applies, then the petitioner's disability is established.

The second group of exceptions allows a finding that a petitioner is not disabled irrespective of whether medical improvement occurred. The exceptions are:

(i) A prior determination was fraudulently obtained;
(ii) The individual failed to cooperate;
(iii) The individual cannot be located;
(iv) The prescribed treatment that was expected to restore the individual's ability to engage in substantial gainful activity was not followed.
20 CFR 416.994(b)(4)

MDHHS testimony indicated that a previous determination of disability was either never completed or denied. MDHHS testimony further indicated their computer system (Bridges) erroneously approved Petitioner for disability-related benefits. Petitioner's testimony did not present any evidence to rebut the credible MDHHS testimony.

Based on the presented evidence, it is found that Petitioner was erroneously approved for disability-related benefits. Thus, the analysis proceeds so it may be determined if Petitioner is disabled.

Step five of the analysis considers whether all the current impairments in combination are severe. 20 CFR 416.994(b)(5)(v). When the evidence shows that all current impairments in combination do not significantly limit physical or mental abilities to do basic work activities, these impairments will not be considered severe and the claimant will not be considered disabled. *Id.* If the impairments are considered severe, the analysis moves to step six. *Id.*

The impairments must significantly limit a person's basic work activities. 20 CFR 416.921 (a). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921 (b). 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. (*Id.*)

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 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).

Petitioner testified she needs new dentures. Petitioner pulled them out during the hearing as a method of verifying her testimony. It is not known how a need for new dentures equates to a restriction on performing employment. Ongoing treatment for tooth problems was not verified other than one complaint of tooth pain. Petitioner failed to establish a severe impairment related to her teeth.

Petitioner testified she has bilateral knee pain from falling on her porch. Petitioner's testimony estimated this occurred 3 years earlier. Petitioner testified she injured her right shoulder when pulling a dog over a fence. Presented medical documents

established some degree of lumbar, shoulder, and knee pain. The restrictions could reasonably be inferred to restrict Petitioner's ongoing ambulation, standing, and lifting/carrying abilities to some degree.

Petitioner testified she has various mental problems. Petitioner reported a flashback in 2013 from a stillborn child she carried in 1991. Petitioner testified her family members all have mental problems. Petitioner testified she feels stressed and depressed, in part due to neighborhood kids who come in her backyard. Petitioner testified she lost her best friend in 2013 and that she worries more now because her friend kept away her enemies. Petitioner testified she worries about her adopted son who no longer lives with her. Petitioner testified that she has seen a therapist and psychiatrist for the past 2 years.

Petitioner's documentation established some degree of mental problems. Recurring complaints of paranoia and anxiety were documented for at least a 90 day period.

It is found that Petitioner has severe impairments. Accordingly, the disability analysis may proceed to the next step.

The sixth step in analyzing a disability claim requires an assessment of the Petitioner's RFC and past relevant employment. 20 CFR 416.994(b)(5)(vi). 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 been fired from many jobs in her life though she has never had a full-time job. Petitioner testified she was fired from the postal service because she could not do her job fast enough. Petitioner testified she worked at a department store as a cashier, though her job was seasonal. Petitioner testified she was a cook for a fast food restaurant but she was let go because she was not needed.

Petitioner indicated that part of her lack of employment history can be explained by motherhood, though she stated she last supported a child in 2003. MDHHS presented no evidence to rebut Petitioner's testimony. Without any full-time employment history, it is presumed that Petitioner's earnings never exceeded SGA levels. Accordingly, it can only be found that Petitioner cannot return to perform SGA employment and the analysis may proceed to the final step.

In the seventh and final 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. The definitions for each are listed below.

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 nonexertional. 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 (i.e. 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 medium 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. Medium employment requires comparable standing and walking standards, but with a heavier lifting requirement than light employment.

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 physician indicated various restrictions on a Medical Examination Report dated May 14, 2015. The limitation(s) were noted to be expected to last more than 90 days. The physician opined that Petitioner was restricted as follows over an eight-hour workday, about 2 hours of standing and/or walking (due to right knee pain), and less than 6 hours of sitting (due to back pain). Petitioner was restricted to occasional lifting/carrying of 10 pounds, never 20 pounds or more. Petitioner's physician opined that Petitioner was restricted from performing the following repetitive actions: right-sided reaching, right-sided pushing/pulling, and operating leg controls with either foot (due to knee pain). In response to a question asking for the stated basis for restrictions, Petitioner's physician cited right shoulder pain and HTN.

HTN might restrict a client who has repeated exacerbations of HTN. No hospitalizations related to HTN were presented. No evidence of HTN difficulties were established, at least none when Petitioner was medically compliant.

Petitioner testified she needs an x-ray for her right shoulder. It is not known how Petitioner's physician could drastically restrict Petitioner's ambulation and lifting/carrying without radiological support. Documentation also noted no treatment from a specialist, though it was noted Petitioner was referred to a pain specialist.

The restrictions as provided by Petitioner's physician were not supported by presented medical records. Accordingly, they will be rejected.

Presented documents only established Petitioner needs medication for HTN. Complaints of right shoulder pain were referenced, however, the pain was not diagnosed nor even x-rayed. Restrictions in shoulder and lumbar motion were noted. Treatment from a specialist was not documented. Complaints of knee pain were documented, though not x-rayed or treated by a specialist. Presented evidence was insufficient to justify an inference that Petitioner cannot perform medium employment.

Petitioner's physician also stated Petitioner was restricted in comprehension, memory, sustaining concentration, following simple directions, and social interactions. The basis for restrictions was a lack of concentration, anxiety, and history of depression.

Petitioner testified she is not motivated to clean herself. Petitioner testified that she has not gone to the store by herself in over a month due to paranoia. Petitioner testified she has a history of panic attacks in her past. Petitioner also testified that she is not capable of mailing a simple letter.

Petitioner's testimony and her physician's statements were indicative of very restrictive mental health symptoms. Neither's statements were well supported.

An internal medicine physician is not a preferable source for mental restrictions. For an internal physician statement of restrictions to be credible, more is expected that a simple statement of symptoms and/or diagnoses. Again, Petitioner's internal medicine physician's statements of restriction are rejected.

Psychiatric treatment records established Petitioner had a GAF of 46. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF within the range of 41-50 is representative of a person with "serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g. no friends, unable to keep a job)." Generally, a GAF of 48 is consistent with numerous mental health restrictions.

In the present case, Petitioner's GAF was assessed in October 2013- over 2 years before the hearing. An updated GAF was not provided. Ongoing psychiatric records noted several Petitioner complaints about external problems (worry about her adopted

child and neighbors) though very little mention was made of symptoms. Paranoia was occasionally referenced, though an absence of paranoia was mentioned more. Generally, the documents established nothing more than reasonable worries by Petitioner, but nothing that would limit Petitioner from performing non-complex employment. This conclusion is consistent with the conclusions of a consultative psychologist who diagnosed Petitioner with mild anxiety disorder.

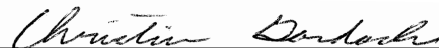
Petitioner testified she is capable of driving. An ability to drive is not typically consistent with significant anxiety and/or paranoia restrictions.

A restriction to non-complex employment does not significantly erode Petitioner's employment base. Examples of non-complex jobs that Petitioner could perform include security guard, cashier, assembler, and/or janitorial-related. MDHHS did not present evidence of the availability of such jobs, but it is presumed they are available in sufficient quantities. It is found that Petitioner can perform non-complex medium-level employment.

Based on Claimant's exertional work level (medium), age (advanced age), education (high school), employment history (none), Medical-Vocational Rule 203.14 is found to apply. This rule dictates a finding that Claimant is not disabled. Accordingly, it is found that MDHHS properly terminated Petitioner's SDA eligibility.

DECISION AND ORDER

The administrative law judge, based upon the above findings of fact and conclusions of law, finds that MDHHS properly terminated Petitioner's SDA eligibility, effective December 2015. The actions taken by MDHHS are **AFFIRMED**.



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

Date Signed: **12/30/2015**

Date Mailed: **12/30/2015**

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 copy of the claim or application for appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Hearing Decision from 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: