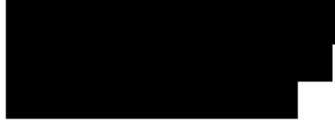
STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

IN THE MATTER OF:



MAHS Reg. No.: 15-020370
Issue No.: 4009
Agency Case No.:
Hearing Date: January 14, 2016
County: Wayne (76)

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, a telephone hearing was held on January 14, 2016, from Detroit, Michigan. Petitioner appeared and was unrepresented. 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 April 20, 20, Petitioner applied for SDA benefits.

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

3. On July 31, 2015, the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 6-12).

4. On August 11, 2015, MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action (Exhibit 1, pp. 4-5) informing Petitioner of the denial.

5. On November 4, 2015, Petitioner requested a hearing disputing the denial of SDA benefits (see Exhibit 1, pp 2-3).

6. As of the date of the administrative hearing, Petitioner was a 42-year-old female.

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

8. Petitioner's highest education year completed was the 12th grade (via general equivalency degree).

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

10. Petitioner alleged disability based on restrictions related to spinal pain.

CONCLUSIONS OF LAW

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

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

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

There was no evidence that any of the above circumstances apply to 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. The 2016 monthly income limit considered SGA for non-blind individuals is $1,130.00.

Petitioner credibly denied performing current employment; 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 documentation.

Hospital discharge instructions (Exhibit 1, pp. 53-54) dated February 14, 2013, were presented. Diagnoses of chronic back pain and SIRS (systemic inflammatory response syndrome) were noted. Treatment details were not provided.

Hospital discharge instructions (Exhibit 1, p. 55) dated February 25, 2013, were presented. A symptom of chronic back pain was noted.

A radiology report (Exhibit 1, pp. 44-45) dated February 4, 2014, was presented. It was noted Petitioner underwent a cervical spine MRI. An impression of a "significant" disc osteophyte complex with central disc protrusion at C5-C6 causing spinal cord compression and abnormal cord signal was noted. Severe left and moderate right neural foraminal narrowing was noted.

A Medical Needs- PATH form (Exhibit 1, pp. 19-20) dated July 8, 2014, was presented. Petitioner's physician stated Petitioner could not work at any job for an unstated time

period. A total lifting/carrying restriction was noted. A restriction from standing and/or walking less than 2 hours in an 8 hour workday was stated. It was stated that Petitioner needed 46 hours of care per day in the home (perhaps this was intended to be a weekly total). Medical needs included the following: bathing, grooming, mobility, shopping, laundry and housework.

A Medical Examination Report (Exhibit 16-18) dated July 8, 2014, was presented. The form was completed by a physician with a stated 15 month history of treating Petitioner. Petitioner's physician listed diagnoses of chronic intractable pain. Percocet and morphine were listed as current medications. An impression was given that Petitioner's condition was deteriorating. It was noted that Petitioner can meet household needs.

Hospital discharge instructions (Exhibit 1, p. 51-52) dated December 4, 2014, were presented. It was noted Petitioner presented with back pain. Treatment details were not provided but a plan to follow-up with a physician in 5-7 days was noted.

Hospital discharge instructions (Exhibit 1, p. 50) dated February 9, 2015, were presented. Generic chronic back pain information was provided.

Hospital discharge instructions (Exhibit 1, p. 48) dated March 12, 2015, were presented. Generic cervical radiculopathy information was provided.

Hospital discharge instructions (Exhibit 1, p. 49) dated March 14, 2015, were presented. Generic cervical radiculopathy information was provided.

Physician office visit notes (Exhibit 1, pp. 59-60) and therapy orders (Exhibit 1, pp. 56-57) dated April 9, 2015, were presented. It was stated Petitioner originally reported left-sided hand weakness. It was noted ulnar neuropathy was suspected and an EMG was ordered. Assessments of a thoracic spine compression fracture, disc displacement, and lymphoma were noted. A referral for 18 PT appointments to relieve pain was noted.

Hospital discharge instructions (Exhibit 1, p. 47) dated April 23, 2015, were presented. It was noted Petitioner presented with back pain. Treatment details were not provided.

A Medical Examination Report (Exhibit 13-15) dated April 27, 2015, was presented. The form was completed by an internal medicine physician with an approximate 3 ½ month history of treating Petitioner. Petitioner's physician listed diagnoses of permanent nerve damage and loss of function in hand. An impression was given that Petitioner's condition was deteriorating. It was noted that Petitioner needed assistance with household needs such as bathing. Prescribed medications included Neurontin, Valium and Lyrica.

A CT report of Petitioner's thoracic spine (Exhibit A, p.1) dated May 16, 2015, was presented. An impression of s/p vertebroplasty was stated. Acute abnormalities and significant stenonsis were noted to be absent.

An x-ray report of Petitioner's cervical spine (Exhibit A, p. 2) dated June 13, 2015, was presented. Limited range of motion and surgical changes were noted.

Hospital discharge instructions (Exhibit A, p. 17-18) dated December 23, 2015, were presented. A diagnosis of cervical pseudoarthrosis was noted. It was noted Petitioner underwent a cervical spinal fusion.

A CT report of Petitioner's cervical spine (Exhibit A, p. 4) dated January 3, 2016, was presented. An impression of a shallow disc protrusion causing mild canal stenosis at C4-C5 was noted. Mild bilateral neural foraminal stenosis was also noted.

A MRA report of Petitioner's cervical spine (Exhibit A, p. 11) dated January 4, 2016, was presented. A "slight" diminish flow related signal was noted.

A MRI report of Petitioner's cervical spine (Exhibit A, p. 13) dated January 4, 2016, was presented. An impression of multilevel spondylitic foraminal narrowing appearing bilaterally and moderately at C5-C6 was noted. Slight flattening of the spinal cord was noted at C4-C5.

A MRI report of Petitioner's lumbar spine (Exhibit A, p. 8-9) dated January 4, 2016, was presented. An impression of multilevel disc bulging contributing to moderate spinal canal stenosis at L4-L5, along with facet arthropathy and ligmentum flavum hypertrophy was noted.

A MRI report of Petitioner's thoracic spine (Exhibit A, p. 6-7) dated January 4, 2016, was presented. Re-demonstration of a compound fracture at T8 was noted. Spinal cord flattening was noted.

Hospital discharge instructions (Exhibit A, p. 19) were presented. An admission date of January 3, 2016, was noted. Treatment details were not provided other than above-listed radiology. A discharge date of January 5, 2016, was noted.

It should be noted that some of Petitioner's exhibits were admitted, but not considered. During the hearing, Petitioner presented a 31 page packet of documents. Immediately after the hearing, the testifying MDHHS specialist made copies of Petitioner's exhibit packet. It was later learned that pages 5, 10, 12, and 15 were omitted from Petitioner's packet, though this was not discovered until later. After the hearing, a request was made for MDHHS to forward the missing pages; the request was unsuccessful.

On an Activities of Daily Living (Exhibit 1, pp. 25-29) dated April 27, 2015, Petitioner stated she has difficulty with sleep and wakes up crying due to pain. Petitioner wrote that she needs help with bathing and dressing. Petitioner wrote her boyfriend helps with meal preparation and her friend and sister help with cleaning and laundry.

Petitioner testified her lumbar pain stems, in part, from 2004- 2008, when Petitioner underwent radiation treatment for non-hodgkin's lymphoma. Petitioner testified that part of her treatment included attending monthly appointments for iron injections and blood transfusions. Petitioner testimony implied that the radiation treatment adversely affects her immune system and permanently damaged part of her spine, her kidneys, and her ureter. Petitioner’s cancer treatment documents were not presented, however, presented medical documents referenced previous cancer treatments and verified ongoing lumbar treatments.

Petitioner testified she underwent neck fusion (C5-C6) surgery in July 2014. Petitioner testified a second fusion had to be done, in December 2015, because of pain and loss of right hand function following the first surgery. Petitioner testified she is still wearing a neck brace as part of her surgery recovery. Petitioner testimony indicated her loss of right hand function was related to her cervical spine problems. Petitioner also testified that her thoracic spine fracture was likely caused by her cervical spine problems.

Petitioner testified she is unable to open a can of soda with her left hand. Petitioner also testified that she often drops things with her left hand. Petitioner testified she is noticing similar problems with her right hand.

Petitioner testified she attempted physical therapy and epidurals before undergoing fusion surgery. Petitioner testified she went forward with surgery after little improvement in her symptoms following non-surgical treatments.
Petitioner testified her various problems cause restrictions to walking, sitting, standing, and lifting/carrying. Not all of Petitioner’s testimony was verified (e.g. cancer treatment details and fusion surgery details), however, multiple ongoing spinal problems across a two year period were sufficiently verified.

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.

Claimant’s most prominent impairment appears to be back pain. Spinal disorders are covered by Listing 1.04 which reads:

> **1.04 *Disorders of the spine*** (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease,

facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the cauda equina) or the spinal cord. With:

A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine);
OR
B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours;
OR
C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b.

Looking at Part C, the inability to ambulate effectively is a requirement. SSA defines this as follows:

> Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. Ineffective ambulation is defined generally as having insufficient lower extremity functioning (see 1.00J) to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities.

Part A of the above listing was rejected due to an absence of verified loss of motor strength. Part B was not applicable as Petitioner was not diagnosed with spinal arachnoiditis. Part C was considered, though ultimately rejected as Petitioner failed to verify a need for a walker.

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 last worked in 2012. Petitioner testified she worked at a deli counter. Petitioner testified she was fired for missing work due to illness. Petitioner testified she had several other part-time jobs since 2000, including assembly and packaging.

Petitioner testimony indicated none of her jobs from the last 15 years amounted to SGA earnings. Petitioner testified she has never had a full-time job; Petitioner's testimony was not rebutted.

Without earnings from the past 15 years amounting to SGA, it can only be found that Petitioner cannot return to employment amounting to SGA. Accordingly, 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 sedentary employment. For sedentary employment, periods of standing or walking should generally total no more than about 2 hours of an 8-hour workday. Social Security Rule 83-10.

Petitioner's testimony conceded her second neck surgery (in December 2015) "somewhat" reduced some of her pain. Petitioner testified that her hand function has not improved since surgery and she still experiences pain that would prevent her from

performing employment. Petitioner testified she might be able to work part-time, however, full-time employment would be an unrealistic expectation.

Petitioner testified she has mostly bad days. She estimated she only has one “good day” each month. Petitioner testified she spends most of her days in bed. Petitioner testified her friends cook for her and do her laundry. As an example of her struggles, Petitioner testified she was not well enough to leave her home on the most recent Thanksgiving or Christmas.

Petitioner’s testimony estimated she is restricted to walking “a few blocks” and standing for less than an hour due to back pain. Petitioner testified sitting is restricted to one hour periods and that she would need to stand for an hour before attempting to sit for another hour. Petitioner testified her neurosurgeon completely restricted her from lifting/carrying.

Petitioner testified she sometimes uses a walker (Petitioner did not use a cane or walker on the date of hearing). Petitioner testified she uses a scooter when she goes shopping. Petitioner testified her boyfriend helps with many activities including the following: entering and exiting vehicles, washing her hair, putting on underwear and shoes, and cleaning.

Generally, Petitioner’s testimony was consistent with an inability to perform any employment. To determine the credibility of Petitioner’s testimony, it will be compared to medical documents and physician statements.

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.*

On a Medical Examination Report dated April 27, 2015, Petitioner internal medicine physician stated Petitioner was restricted in comprehension, sustaining concentration, reading/writing, social interaction, and following simple directions. In response to a question asking for support for restrictions, Petitioner’s physician wrote that neck pain makes it hard for Petitioner to comprehend. Mental restrictions and/or were not documented elsewhere in Petitioner’s records. An isolated statement that Petitioner’s neck pain is debilitating is not sufficient support to justify stated restrictions. The physician-provided mental restrictions are deemed to be unsupported.

On the Medical Examination Report dated July 8, 2014, was presented. Petitioner’s physician stated that Petitioner’s limitation(s) was expected to last 90 days. It was noted that Petitioner did not need an assistive device for ambulation. Standing and sitting restrictions were not stated. Petitioner was restricted from all lifting/carrying, even weight less than 10 pounds. Petitioner’s physician opined that Petitioner was restricted

from performing the following right-sided repetitive actions: simple grasping, reaching, pushing/pulling, and fine manipulating. In response to a question asking for the stated basis for restrictions, Petitioner's physician did not respond.

On a Medical Examination Report dated April 27, 2015, Petitioner internal medicine physician stated Petitioner had limitation(s) expected to last 90 days. Petitioner's physician opined that Petitioner was restricted as follows over an eight-hour workday, less than 2 hours of standing and/or walking; the physician also contradictorily stated Petitioner could stand and/or walk at least 2 hours in an 8 hour workday. Petitioner's physician stated Petitioner could not sit 6 hours in an 8 hour workday. Petitioner was deemed capable of performing repetitive actions with hands and arms. Petitioner was restricted to occasional lifting/carrying of 10 pounds or less, never 20 pounds or more. In response to a question asking for the stated basis for restrictions, Petitioner's physician provided a handwritten response which was difficult to read; it appeared to read "hard to carry, open, assert left and right hand."

The most compelling evidence of restrictions was radiology from January 2016. The radiology reports verified many spinal problems.

In Petitioner's neck, mild canal stenosis and mild bilateral neural foraminal stenosis at C4-C5 was verified. *Mild* stenosis would reasonably cause discomfort, though not likely a debilitating degree of discomfort. *Moderate* foraminal narrowing was noted at C5-C6. *Moderate* foraminal narrowing is more indicative of severe pain.

Radiology also verified a vertebrae fracture in Petitioner's thoracic spine. Most notably, a radiology report from January 2016, stated a fracture was essentially unchanged from a March 2014 examination, which was pre-vertebroplasty surgery (see Exhibit A, p. 8-9). This statement is indicative of a long-term problem which has not improved despite surgical intervention.

Lumbar radiology from January 2016 noted moderate spinal canal stenosis at L4-L5. *Moderate* stenosis is indicative of a relatively high degree of pain, particularly when due to multilevel disc bulging.

Based on Petitioner's combined spinal problems, restrictive lifting/carrying ability, loss of left hand function (though records were contradictory on this issue), it is improbable that Petitioner could sustain any exertional level of employment amounting to SGA. Accordingly, Petitioner is found to be disabled. It is further 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 perform the following actions within 10 days of the date of mailing of this decision:

(1) reinstate Petitioner's SDA benefit application dated April 20, 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: **1/22/2016**

Date Mailed: **1/22/2016**

CG/tm

<u>NOTICE OF APPEAL</u>: 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 **<u>MAY</u>** order a rehearing or reconsideration on its own motion. MAHS **<u>MAY</u>** 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: