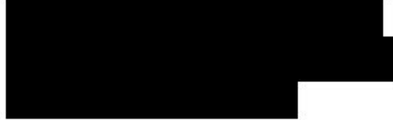
STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

IN THE MATTER OF:



MAHS Reg. No.: 15-020614
Issue No.: 4009
Agency Case No.:
Hearing Date: January 6, 2016
County: Wayne (57)

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 6, 2016, from Detroit, 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 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 31, 2015, Petitioner applied for SDA benefits.

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

3. On May 29, 2015, the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 5-7).

4. On June 1, 2015, MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action informing Petitioner of the denial.

5. On July 9, 2015, Petitioner requested a hearing disputing the denial of SDA benefits (see Exhibit 1, p. 2).

6. As of the date of the administrative hearing, Petitioner was a 53-year-old female.

7. Petitioner does not currently perform substantial gainful activity.

8. Petitioner has a history of secretarial employment, with no transferrable job skills.

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

10. Petitioner alleged disability based on restrictions related to lumbar pain and cardiac 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 (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 documents (Exhibit 1, pp. 15, 17-27) from an admission dated August 4, 2013, were presented. It was noted that Petitioner presented with complaints of chest pain. It was noted an EKG revealed left atrial abnormality poor R-wave in V1 and V2, and possible myocardial ischemia. Further testing was shown to reveal 90% mid-left anterior descending artery stenosis and 80% mid-coronary artery stenosis. It was noted Petitioner underwent cardiac stenting. A discharge date of August 6, 2013, was noted.

Orthopedic specialist notes (Exhibit 1, p. 52) dated May 7, 2014, were presented. It was noted Petitioner had spondylolisthesis and stenosis at L3-L4 and L4-L5.

Cardiology office visit notes (Exhibit 1, pp. 56-58) and echocardiogram test results (Exhibit 1, pp. 61-64) dated June 12, 2014, were presented. It was noted Petitioner reported recurring chest burning sensations. A recommendation of quitting smoking was noted. Echocardiogram results indicated normal left ventricular function and mild left ventricular diastolic dysfunction.

Orthopedic specialist notes (Exhibit 1, p. 51) dated June 18, 2014, were presented. It was noted Petitioner was trying to go back to work but her back pain made it "very difficult."

Orthopedic specialist notes (Exhibit 1, p. 50) dated July 30, 2014, were presented. It was noted that being off from work was helping Petitioner.

Orthopedic specialist notes (Exhibit 1, p. 48) dated August 27, 2014, were presented. Ongoing back pain treatment was noted. It was noted Petitioner had an antalgic gait.

Cardiology office visit notes (Exhibit 1, pp. 53-55) dated September 22, 2014, were presented. It was noted that Petitioner reported recurring chest tightness and dyspnea with exertion. It was noted Petitioner was a smoker. Stress test results (Exhibit 1, pp. 59-60) indicated no evidence of myocardial infarction and normal left ventricular chamber volume and systolic function.

Orthopedic specialist notes (Exhibit 1, p. 48) dated October 1, 2014, were presented. It was noted an MRI showed spondylolisthesis at L3-L4 and L4-L5. It was noted Petitioner's orthopedist disagreed with the MRI report's description of "mild" stenosis. Petitioner's orthopedist noted the stenosis was described as "moderate" in 2012 and that "obviously these things do not correct themselves."

Orthopedic specialist notes (Exhibit 1, p. 47) dated October 22, 2014, were presented. It was noted Petitioner reported difficulty with walking and standing "for any length" of time.

Orthopedic specialist notes (Exhibit 1, p. 46) dated November 5, 2014, were presented. It was noted Petitioner could not receive injections due to Petitioner's use of anticoagulation medication.

Orthopedic specialist notes (Exhibit 1, pp. 44-45) dated November 18, 2014, were presented. It was noted Petitioner reported lumbar pain (6/10). It was noted Petitioner could not take NSAIDs because of "extensive" cardiac history. A history of injections with little pain relief was noted. Lumbar paraspinal muscle tenderness upon palpation was noted. A refill of Norco was noted.

Physician office visit notes (Exhibit 1, pp. 8-9) dated December 4, 2014, were presented. It was noted that Petitioner presented for back pain treatment. A complaint of anxiety was noted. Prescriptions for Accupril, Metoprolol, Aspirin, Plavix, and Norco were noted as continued. Xanax was noted to be prescribed.

Orthopedic specialist notes (Exhibit 1, p. 43) dated December 16, 2014, were presented. It was noted Petitioner reported her back pain is worse with exertion.

Physician office visit notes (Exhibit 1, p. 10) dated January 5, 2015, were presented. It was noted Petitioner complained of a toothache and anxiety.

An orthopedic specialist letter (Exhibit 1, p. 42) dated January 15, 2015, were presented. It was noted the author had treated Petitioner for "several years." It was noted physical examination findings were consistent with stenosis. It was noted that radiology demonstrated spondylolisthesis and advanced lumbar stenosis. It was noted most treatment options were considered risky because of Petitioner's recent stent placement and ongoing use of blood thinners.

Orthopedic specialist notes (Exhibit 1, p. 41) dated January 16, 2015, were presented. It was noted Petitioner reported neck and back pain (9/10). Lumbar tenderness was noted. A negative straight-leg-raising test was noted. Full strength was noted. Norco was noted as refilled.

Physician office visit notes (Exhibit 1, p. 14) dated February 5, 2015, were presented. Complaints of ongoing back pain and financial anxiety were noted.

Orthopedic specialist notes (Exhibit 1, p. 40) dated February 11, 2015, were presented. It was noted Petitioner reported ongoing back pain (8/10). Norco was noted as refilled.

Physician office visit notes (Exhibit 1, p. 12, 16) dated March 1, 2015, were presented. The notes appeared to be incomplete as objective and subjective findings were not presented. Various prescriptions were noted as prescribed.

Physician office visit notes (Exhibit 1, p. 28) dated March 5, 2015, were presented. The notes appeared to be incomplete as objective and subjective findings were not presented. Various prescriptions were noted as prescribed.

Orthopedic office visit notes (Exhibit 1 p. 39 and A p. 11) dated March 11, 2015, were presented. It was noted Petitioner reported ongoing lumbar pain radiating through her buttocks to her knees. It was noted Petitioner reported past physical therapy worsened her pain. Petitioner reported taking 5-6 Norco pills per day to alleviate her pain. Independent ambulation was noted. A positive straight-leg-raising test was noted. An impression of lumbar stenosis was noted.

Physician office visit notes (Exhibit 1, pp. 29-30) dated April 1, 2015, were presented. Ongoing complaints of back pain and anxiety were noted. Various prescriptions were noted as continued.

Orthopedic office visit notes (Exhibit 1 p. 38) and A; p. 10 dated April 15, 2015, were presented. It was noted an imaging study showed "a little bit of" spondylolisthesis and stenosis at L4-L5. The stenosis was described as moderate. A plan of conservative treatment was noted.

Physician office visit notes (Exhibit 1, pp. 31-32) dated April 29, 2015, were presented. Ongoing complaints of back pain and anxiety were noted. Urination frequency and drinking fluids was noted as reported by Petitioner. A diagnosis of DM was noted, possibly based on lab results from April 3, 2015 (Exhibit 1, pp. 33-37).

Orthopedic specialist notes (Exhibit A; p. 9) dated May 15, 2015, were presented. It was noted recent physical therapy flared Petitioner's symptoms.

Orthopedic specialist notes (Exhibit A; p. 8) dated June 12, 2015, were presented. Lumbar back pain of 5/10 was reported by Petitioner.

Orthopedic specialist notes (Exhibit A; pp. 6-7) dated August 12, 2015, were presented. Lumbar spine x-rays were noted to be taken. Lumbar disc spaces were shown to be well maintained.

Orthopedic specialist notes (Exhibit A; p. 5) dated September 11, 2015, were presented. Petitioner reported her current pain as 5/10. Norco was noted to be refilled.

Orthopedic specialist notes (Exhibit A; p. 4) dated October 9, 2015, were presented. It was noted Petitioner was considering surgical options. An updated MRI was recommended.

Orthopedic specialist notes (Exhibit A; pp. 2-3) dated November 6, 2015, were presented. Petitioner reported a decrease in pain (4-5/10) though it was noted to be 9-10/10 a few days earlier.). A Medrol pack was given for future flare-ups of pain. A recent diabetes diagnosis was noted.

Orthopedic specialist notes (Exhibit A; pp. 1-2) dated December 2, 2015, were presented. It was noted Petitioner presented earlier than expected for medication refills.

Petitioner primarily alleged disability based on lumbar pain. Petitioner testified she experiences radiating lower back pain which affects her legs and feet. Petitioner testified she tries to be active because of her cardiac history, however, Petitioner also testified her lumbar pain restricts her ambulation and standing.

Medical records established a multi-year history for lumbar pain. Though radiology reports were not presented, MRIs and x-rays were referenced by Petitioner's orthopedist. Diagnoses of lumbar stenosis and spondylolisthesis were consistently documented and were presumably consistent with cited radiology. A need for narcotic pain medication was also consistently noted.

Petitioner testified she has carpal-tunnel syndrome in both of her wrists. Treatment for CTS was not verified. Due to the absence of treatment records, CTS is not considered to be a severe impairment.

Petitioner testified she has diabetes and a history of cardiac problems. Neither problem, by themselves, was shown to affect Petitioner's performance of basic work abilities. Petitioner testified her cardiologist told her that her heart was fine, though she takes 6 pills per day to maintain her cardiac health.

Petitioner's cardiac treatment was shown to limit Petitioner's lumbar treatment. As noted by Petitioner's orthopedist, Petitioner's lumbar treatment options were limited to surgery, physical therapy (PT), and medication. PT was shown to worsen Petitioner's condition. Lumbar surgery is understood to be an undesirable option. Narcotic pain medication was shown to help but not eliminate Petitioner's restrictions.

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 spinal disorders (Listing 1.04) was considered. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root.

Cardiac-related listings (Listing 4.00) were considered based on Petitioner's cardiac treatment history. Petitioner failed to meet any cardiac listings.

A listing for anxiety-related disorders (Listing 12.06) was considered based on Petitioner's recurring complaints of anxiety. Most notably, Petitioner failed to verify any treatment from a psychiatrist or therapist. Some treatment from Petitioner's primary care physician was verified. 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 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 her only employment from the last 15 years was as a hospital receptionist. Petitioner testified she held the job for 25 years, until she was essentially fired in July 2015 for missing too much work. Petitioner's testimony indicated her absences were caused by lumbar pain. Petitioner also testified her physician advised her that she was not able to work.

Secretarial employment is typically sedentary in nature. Petitioner indicated her employment required more exertion than most secretarial jobs. Petitioner testified she spent half of her day standing and/or walking between her work station and the station of hospital nurses and doctors. Petitioner testified she was expected to lift 40 pound boxes of copy paper, as one of her main duties was copying medical documents. Petitioner testified other duties included faxing and answering phones.

It is appreciated that Petitioner has a 25 year history of employment. Petitioner's stable employment history is indicative that she would not have stopped her employment unless medically unable to do so. This conclusion is speculative, but it was consistent with physician statements.

In a January 2015 letter (see (Exhibit 1, p. 42), Petitioner's orthopedist stated Petitioner should remain off from work. The physician opined that it was unlikely Petitioner could ever return to her previous employment.

Based on presented evidence, it is found Petitioner is not capable of returning to past employment. Accordingly, the disability 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.

Petitioner testified her legs ache "like a toothache." Petitioner testified she is restricted in ambulation of 15-30 minutes, depending on if it's a good or bad day. Petitioner testified her standing abilities are comparable. Petitioner indicated her lumbar pain worsens with exertion. Petitioner testified that "most of the time" she uses a cane to help her ambulate. Petitioner testified she has difficulty with tying shoes and bending her legs due to lumbar pain. Petitioner testified she cleans only when she is physically capable. Petitioner testified she does her own shopping, but she limits trips to 20-30 minutes. Petitioner testified her physician imposed a 10 pound restriction. Petitioner's testimony was indicative of an inability to perform light employment.

It must be determined if Petitioner's testimony was consistent with presented evidence. Physician statements of Petitioner restrictions were not presented. Restrictions can be inferred based on presented documents.

It was not verified that Petitioner required or used a cane. A need for a walking-assistance device was not apparent within Petitioner's medical records.

Radiology records were not presented but were referenced. It was noted Petitioner had "mild" stenosis, though Petitioner's orthopedist stated on multiple occasions that Petitioner's condition was more severe than mild stenosis. The thought process was consistent with Petitioner's reported high pain levels and continued prescription for narcotic medication.

It is also notable that Petitioner's pain level may be higher because of limited treatment options. As noted by Petitioner's orthopedist, Petitioner is unable to undergo injections or take NSAIDs due to cardiac problems.

Much weight was given to the statement of Petitioner's orthopedist. The orthopedist had a verified minimum 1½ year history of treating Petitioner. Presented orthopedist records consistently indicated Petitioner's reported difficulties were consistent with medical findings. The orthopedist also noted surprise at the denial of Petitioner's SSA disability claim (see Exhibit 1, p. 46).

Petitioner consistently reported difficulty with standing and ambulation. Given Petitioner's medical history, it is improbable that could perform the six hours of standing and/or ambulation required of light employment. Based on the presented evidence, it is found that Petitioner is precluded from performing light employment. For purposes of this decision, it will be presumed that Petitioner can perform sedentary employment.

Based on Petitioner's exertional work level (sedentary), age (closely approaching advanced age), education (high school equivalency with no direct entry into skilled work), employment history (semi-skilled with no known transferrable skills), Medical-Vocational Rule 201.14 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 perform the following actions within 10 days of the date of mailing of this decision:

(1) reinstate Petitioner's SDA benefit application dated March 31, 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: **1/13/2016**

Date Mailed: **1/13/2016**

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: