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

IN THE MATTER OF:

[redacted]

MAHS Reg. No.: 15-019689
Issue No.: 4009
Agency Case No.: [redacted]
Hearing Date: January 19, 2016
County: Wayne (18)

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 19, 2016, from Detroit, Michigan. Petitioner appeared and was unrepresented. [redacted] Petitioner's friend and caregiver, testified on behalf of Petitioner. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted]-[redacted] 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 [redacted], Petitioner applied for SDA benefits.

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

3. On [redacted], the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibits 1, p. 2-8).

4. On [redacted], MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action (Exhibit 1, pp. 75-77) informing Petitioner of the denial.

5. On [redacted], Petitioner requested a hearing disputing the denial of SDA benefits.

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

7. Petitioner has a history of secretarial employment.

8. Petitioner alleged disability based on restrictions related to spinal pain, carpal-tunnel syndrome (CTS), and knee 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.

An MRI report of Petitioner's thoracic spine (Exhibit A, p. 6) dated [redacted], was presented. Disc dessication at T6-T7 through T9-T10 was noted. An impression of old wedging deformity of T6 with multilevel spondylosis was noted. An absence of stenosis and foraminal narrowing was noted.

An x-ray report of Petitioner's left knee (Exhibit A, p. 4) dated [redacted], was presented. A slight lucency at the patella indicative of a chondral defect was noted. A 20 millimeter osteochrondrama was noted to be projecting.

Orthopedist office visit notes (Exhibit 1, pp. 69-71) dated [redacted], were presented. It was noted that Petitioner presented with left knee pain. It was noted the pain began after Petitioner heard a pop in her knee when she stepped up and into a van. It was noted Petitioner used crutches and could not bend her knee. An antalgic gait was noted. Knee x-rays were noted to reveal mild degenerative joint disease in both knees. A left knee MRI was recommended.

An MRI report of Petitioner's left knee (Exhibit 1, p. 74; Exhibit A p. 5) dated [redacted], was presented. An impression of degenerative changes, particularly the medial facet of the patella, was noted.

Orthopedist office visit notes (Exhibit 1, pp. 72-73) dated [redacted] were presented. It was noted that Petitioner presented for MRI results of left knee. A full range of motion was noted in Petitioner's left knee, though swelling (+1), tenderness, and crepitus were also noted. Imaging noted osteoarthritis with questionable loose joint body. Diagnoses of chondromalacia patella and osteoarthritis were noted. A plan of arthroscopic removal of loose joint body was noted.

A CT report of Petitioner's left ankle (Exhibit A, p. 9) dated [redacted], was presented. An impression of mild arthritic changes with no evidence of fracture or dislocation was noted.

A CT report of Petitioner's right ankle (Exhibit A, p. 10) dated [redacted], was presented. An impression of osteochondral defect was noted.

An Adult Health Assessment (Exhibit 1, pp. 48-55) from a treating mental health agency was presented. The initial assessment was performed on [redacted], and completed by a registered nurse. It was noted Petitioner reported ongoing ankle pain (8/10). A history of cancer (from 2011) was noted. It was noted Petitioner also reported problems with "major depression", a right ankle bone defect, and osteoarthritic pain. It was noted Petitioner was given body mass index information.

A Psychiatric Evaluation (Exhibit 1, pp. 56-60) dated [redacted] was presented. It was noted Petitioner reported feeling depressed for the previous year. It was noted Petitioner reported frustration at not getting job offers in her field of work. It was noted Petitioner thought she was not getting hired because of her age. Mental examination observations of Petitioner included the following: unremarkable speech, anxious mood, constricted affect, unremarkable perception, fair insight, fair judgment, orientation x3, unremarkable memory, and unremarkable thought process. The examining psychiatrist noted suspecting Petitioner had mild depression since childhood though Petitioner had not previously sought treatment. An Axis I diagnosis of major depressive disorder (single episode) was noted. A GAF of 65 was noted. It was noted Petitioner was prescribed Brintellix, though Petitioner expressed trepidation about taking medication.

An MRI report of Petitioner's lumbar spine (Exhibit A, p. 7) dated [redacted], was presented. Degenerative facet changes and ligamentum flavum hypertrophy were noted at L5-S1. Diffuse disc bulging was noted at L3-L4 and L4-L5.

Physician office visit notes (Exhibit A, p. 8) dated [redacted], were presented. It was noted Petitioner underwent a fluoroscopic guided right tibiotalar joint lidocaine injection of the right ankle.

An Operative Report (Exhibit A, pp. 1-3) dated [redacted], was presented. Pre-operative and post-operative diagnoses of right ankle osteochondritis and bone cyst tallus were noted. It was noted Petitioner had an 18 month history of a painful OCD

lesion. It was noted Petitioner underwent ankle arthroscopy and extensive debridement and excision of osteochondritis dissecans. Complications were not noted.

Presented documents verified a period of brief treatment for depression. Petitioner's GAF of 65 is indicative of mild functional restrictions. Petitioner's testimony did not note depression as an obstacle to employment. Based on Petitioner's limited treatment history, mild restrictions, and lack of testimonial support, it is found Petitioner failed to establish a severe impairment related to depression.

Petitioner testified she has ongoing problems with CTS. Petitioner testified her medical history includes left wrist surgery in 2012. Petitioner testified she underwent range of motion therapy after her surgery. Petitioner testified she wears braces on both of her wrists. Petitioner testified she is unable to repetitively type, even with an ergonomic keyboard; Petitioner testimony conceded she can do some typing, though she estimated she could only work 10 hours per week as a secretary.

References to CTS in Petitioner's medical history were noted (see Exhibit 1, p. 72). Treatment documents were not presented. A history of CTS, by itself, is insufficient to justify an inference that Petitioner is impaired due to CTS.

Petitioner testified she has ongoing back pain. Petitioner testified she tried epidurals which did little to alleviate her pain. Petitioner testified physical therapy helped, but only temporarily (approximately one month). Petitioner testified she tried to return to secretarial work after PT, however, other physical problems kept her from maintaining employment.

Petitioner presented mid and lower back radiology which verified some degree of abnormality. Spondylosis was noted in Petitioner's mid-back; this is indicative of abnormalities that would reasonably cause some degree of discomfort and/or pain. Discomfort and/or pain could also be reasonably construed from disc bulges and degenerative changes in Petitioner's lumbar spine. Some degree of an ongoing lifting/carrying restriction can be inferred from the radiology.

Petitioner testified she has ongoing medical problems with her ankles. Petitioner testified she has right ankle osteochroniditis and PTTD. Petitioner testified she had a lesion removed from her ankle on [redacted]. Petitioner testified her doctor restricted her from driving since the surgery. Petitioner testified she does not expect her doctor to clear her for driving until the ankle cartilage regenerates.

Petitioner testified she also has bilateral knee problems. Petitioner testified she has osteoarthritis in both of her knees. Petitioner testified her left knee is additionally impaired because of a misaligned kneecap which she blames on patella femoral syndrome.

On the day Petitioner applied for SDA benefits, she received a pain medication injection in her right ankle. Petitioner's presented records included radiology, surgery, and treatment records which would reasonably restrict Petitioner's ambulation, standing, sitting, and lifting/carrying. Evidence was supportive of severe impairments since the date of SDA application.

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.

Petitioner's primary claim of disability was bilateral knee and ankle problems. Disability by joint degeneration is established by the following SSA listing:

> **1.02** ***Major dysfunction of a joint(s) (due to any cause)***: Characterized by gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankylosis, instability) and chronic joint pain and stiffness with signs of limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With:
>
> A. Involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in inability to ambulate effectively, as defined in 1.00B2b;
>
> OR
>
> B. Involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively, as defined in 1.00B2c.

Petitioner testified she is reliant on crutches or a wheelchair since undergoing right ankle surgery in October 2015. Petitioner testified she has no timetable for ambulation without a walking assistance device. Petitioner's testimony was credible, however, it was also unverified. Treatment documents since the surgery were not presented. Inferences of Petitioner's ambulation can be made based on presented documentation.

It was verified Petitioner underwent arthroscopic surgery in November 2015. Generally, arthroscopic surgery is relatively not invasive. Arthroscopic surgery is indicative of a timetable of less than 90 days of recovery.

Petitioner mentioned other problems with her knees and ankle. It was verified Petitioner had left knee treatment in 2014. Crepitus was verified; this is indicative of some abnormality; swelling and tenderness was noted. It was also noted Petitioner had a full range of motion which is not indicative of restrictive pain or a significant abnormality. An impression of mild arthritic changes was noted in Petitioner's left ankle; the diagnosis, is not indicative of ineffective ambulation. It is found Petitioner does not meet the listing for joint dysfunction.

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 affective disorder (Listing 12.04) was considered based on diagnoses of depression. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Petitioner required a highly supportive living arrangement, suffered repeated episodes of decompensation or that the residual disease process resulted in a marginal adjustment so that even a slight increase in mental demands would cause decompensation.

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's held approximately five different secretarial jobs since 2000. Petitioner testified one of her more recent jobs was a full-time legal secretary. Petitioner testified that her back and CTS would prevent her from performing the employment.

Petitioner testified she can only walk a few feet due to various problems. Petitioner testified, if she stands, she must do so on one leg (presumably her left leg). Petitioner testified her only relief from pain is lying down and applying heat. Petitioner testified she requires a caretaker for cleaning and laundry. Petitioner testified she does not go

shopping (presumably due to the stress on her ankles). Petitioner testified she dresses and grooms herself, though she takes a long time. Petitioner's testimony was highly indicative of impairments that would likely prevent the performance of any employment. Petitioner's testimony was generally credible, but not well verified.

As noted in the second step analysis, a history of CTS was verified. Treatment and current status of CTS was not verified.

Petitioner's back condition does not appear to be a significant restriction on the performance of secretarial employment. Thoracic and lumbar radiology noted abnormalities, however, stenosis and foraminal narrowing was a notably absent diagnosis. Spondylosis in Petitioner's thoracic spine could cause discomfort; the diagnosis, by itself, is insufficient to justify an inference that Petitioner could not perform a sedentary type of employment such as legal secretary. The same inference can be made concerning bulging discs and degenerative changes in Petitioner's lumbar. It is also notable that Petitioner did not appear to undergo any kind of spinal treatment following radiology. Based on presented evidence, Petitioner would not be precluded from performing secretarial employment due to CTS or back problems.

Petitioner's right ankle problem is more concerning. It was established Petitioner required surgical intervention to remove a lesion on her ankle. Other problems with Petitioner's ankles and left knee were also verified. Unfortunately, no physician statements of restriction were presented. Post-surgical treatment documents were not presented. A reference to use of crutches was noted, but that was shortly after Petitioner injured her left knee back in November 2014; a need for a walking-assistance device was not verified at any point in Petitioner's history.

Petitioner testimony noted her ankle surgery did not address PTTD or Achilles tendonitis. Though Petitioner's testimony is accurate, the lesion on her ankle appeared to be the primary cause for her pain and walking difficulty. It is not clear why Petitioner would be unable to perform legal secretary employment at this stage in her post-surgey recovery.

Petitioner's diagnoses and treatment history tend to verify some degree of ambulation restriction. The evidence was insufficient to justify an inference that Petitioner's problems preclude her performance of secretarial employment.

It is found Petitioner is capable of performing past employment resulting in SGA. Accordingly, Petitioner is not disabled and it is found MDHHS properly denied Petitioner's SDA application.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that MDHHS properly denied Petitioner's SDA benefit application dated [redacted], based on a determination that Petitioner is not disabled. The actions taken by MDHHS are **AFFIRMED**.

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

Date Signed: **2/9/2016**

Date Mailed: **2/9/2016**

CG / hw

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: [redacted]