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.: 15-023133
Issue No.: 4009
Agency Case No.: [redacted]
Hearing Date: February 8, 2016
County: Charlevoix

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 February 8, 2016, from Detroit, Michigan. Petitioner appeared and was unrepresented. [redacted] Petitioner's mother, testified on behalf of Petitioner. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted] hearing liaison.

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 Exhibit 1, pp. 27-12).

4. On [redacted], MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action (Exhibit 1, pp. 11-7) informing Petitioner of the denial.

5. On [redacted], Petitioner requested a hearing disputing the denial of SDA benefits (see Exhibit 1, p. 317).

6. As of the date of the administrative hearing, Petitioner was a 26-year-old female.

7. As of the date of the administrative hearing, Petitioner did not have employment earnings amounting to substantial gainful activity.

8. Petitioner's highest education year completed was the 12th grade (with approximately 3 years of college).

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

10. Petitioner alleged disability based on restrictions related to various mental health problems, carpal-tunnel syndrome (CTS), and leg 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. Accordingly, the disability analysis may proceed to the second step.

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.

Medical center visit notes (Exhibit 1, pp. 155-150) dated [redacted], were presented. It was noted that weight loss and anxiety were topics of discussion. Improved anxiety and sleeping difficulties were reported by Petitioner. Celexa was noted as prescribed.

Medical center visit notes (Exhibit 1, pp. 149-146) dated [redacted], were presented. Celexa was noted as refilled.

Medical center visit notes (Exhibit 1, pp. 145-143) dated [redacted], were presented. Exercise, increasing fiber intake, and snacking on vegetables was recommended.

Medical center visit notes (Exhibit 1, pp. 142-140) dated [redacted], were presented. Exercise and nutrition were discussed.

Medical center visit notes (Exhibit 1, pp. 139-137) dated [redacted], were presented. Exercise and nutrition were discussed.

Medical center visit notes (Exhibit 1, pp. 136-133) dated [redacted], were presented. A complaint of right forearm and hand tingling was noted. Petitioner's grip strength was noted to be normal. A diagnosis of "likely CTS" was noted.

Medical center visit notes (Exhibit 1, pp. 132-131) dated [redacted], were presented. Exercise and nutrition were discussed.

Medical center visit notes (Exhibit 1, pp. 130-129) dated [redacted], were presented. Exercise and nutrition were discussed. It was noted Petitioner lost 33.4 pounds.

Medical center visit notes (Exhibit 1, pp. 128-126) dated [redacted], were presented. Assessments of obesity, chronic foot and back pain, and anxiety/depression were noted.

Medical center visit notes (Exhibit 1, pp. 125-121) dated [redacted], were presented. It was noted Petitioner reported increasing depression. A recent break-up was noted. It was noted Petitioner lost 80 pounds since last April.

Physical medicine physician notes (Exhibit 1, pp. 80-79) dated [redacted], was presented. Sensory testing results were presented. An impression of mild-moderate right-sided CTS and mild left-sided CTS was noted. It was noted there was no evidence of cervical radiculopathy, myopathy, neuropathy, or ulnar nerve injury.

Hospital emergency room documents (Exhibit 1, pp. 78-76) dated [redacted], were presented. It was noted that Petitioner presented with complaints of headache. It was noted Petitioner reported feeling stressed. Petitioner was observed to be resting comfortably and laughing and interacting with her friend. A CT report of Petitioner's head (see Exhibit 1, p. 172) was negative.

Medical center visit notes (Exhibit 1, pp. 120-117) dated [redacted], were presented. It was noted Petitioner reported increased home stress. It was noted Petitioner had never seen a counselor. A medication switch to Lexapro was noted.

Medical center visit notes (Exhibit 1, pp. 116-113) dated [redacted], were presented. It was noted Petitioner felt increasing work stress and reduced her hours. It was noted Petitioner was not taking prescribed medications. It was noted Petitioner needed to call a psychologist.

Medical center visit notes (Exhibit 1, pp. 112-109) dated [redacted], were presented. It was noted Petitioner reported ongoing headaches and wanted a work excuse note. A normal gait was noted.

Medical center visit notes (Exhibit 1, pp. 108-106) dated [redacted], were presented. It was noted Petitioner reported ongoing headaches.

Medical center visit notes (Exhibit 1, pp. 105-101) dated [redacted], were presented. Complaints of headaches and forgetfulness were noted. Topamax and Imitrex were discontinued. It was noted Petitioner was waiting for a neurology referral.

Medical center visit notes (Exhibit 1, pp. 100-97) dated [redacted], were presented. A complaint of dyspnea was noted. Albuterol was prescribed.

Hospital emergency room documents (Exhibit 1, pp. 38-36) dated [redacted], were presented. It was noted that Petitioner presented with complaints of headache (pain level 10/10). Petitioner's weight was noted to be 220 pounds. The examining physician suspected the headache was an exacerbation of Petitioner's chronic headaches.

A letter from a treating neurologist (Exhibit 1, p. 170) dated [redacted], was presented. It was noted Petitioner reported a complaint of headaches (ongoing since November 2014). Associated symptoms included blurry vision, fainting, and vomiting. It was noted a neurological examination was within normal limits. An MR Venogram (MRV) was noted as planned. A suspicion of analgesic rebound was noted. A recommendation of no analgesics for 8 days was noted and a 6 week follow-up was planned.

An MRV report of Petitioner's head dated [redacted], was presented. The MRV was noted to have been completed in response to a diagnosis of sinus thrombosis. An unremarkable MRV was noted.

Medical center visit notes (Exhibit 1, pp. 96-93) dated [redacted], were presented. It was noted Petitioner reporting shaky hands (with grip difficulties), recurrent falling, ringing in ears, and difficulty staying on feet at work. A medical history of plantar fasciitis was noted. Petitioner was referred for a neurological examination.

Hospital emergency room documents (Exhibit 1, pp. 66-62) dated [redacted], were presented. It was noted that Petitioner presented with complaints of vomiting and diarrhea. An abdominal ultrasound was unremarkable. It was noted that Petitioner received fluids and medication. A discharge diagnosis of gastroenteritis was noted.

Medical center visit notes (Exhibit 1, pp. 92-89) dated [redacted], were presented. It was noted Petitioner reported a stool frequency of "only" once per day. Tenderness to palpation was noted in all quadrants. Stool results were negative. Medications were adjusted.

Hospital documents (Exhibit 1, pp. 261-258, 167-160, 73-69, 61-47) dated from an admission starting [redacted], were presented. It was noted that Petitioner presented

with complaints of “persistent depression.” A history of depression since the age of 13 was noted. Associated symptoms included hopelessness, photophobia, and fleeting suicidal ideation. Petitioner’s GAF was 35 at admission. A plan of offering supportive care, redirection, and milieu therapy was noted. A plan of prescribing duloxetine and topiramate was noted. A discharge date of [redacted] was noted. Noted discharge diagnoses included binge-eating disorder (moderate), depression (major recurrent and in partial remission), and panic disorder with agoraphobia. Petitioner’s current medications included albuterol, ciprofloxacin, Duloxetine, hydroxyzine, medoxyprogesterone, meloxicam, omeprazole, onedanestron, topiramate, and trazadone. At discharge, Petitioner’s GAF was 60.

An internal medicine examination report (Exhibit 1, pp.198-192) dated [redacted] was presented. The report was noted as completed by a consultative physician. Petitioner reported complaints of obesity, eating disorder, back pain, and ankle injuries. A history of ankle strains (9-10 on right and 3 on left) was noted. Petitioner’s height was noted to be 5’2’ and her weight was noted to be 285 pounds. A full range of motion was noted. Views of Petitioner’s lumbar spine noted an acute or remote distal sacral fracture.

A mental status examination report (Exhibit 1, pp. 190-184) dated [redacted], was presented. The report was noted as completed by a consultative licensed psychologist. It was noted Petitioner reported difficulties being around people. Petitioner reported she will cry, hyperventilate, pace and get fidgety whenever she leaves her home. A history of a 24 hour treatment related to suicidal ideation (from July 2015) and 2 psychiatric visits (in September 2015) were noted. A history of paternal abuse was noted. Other reported symptoms included: forgetfulness, difficulty with focus, helplessness, suicidal ideation, daily feelings of panic, and irritability. It was noted Petitioner had difficulty with odd numbers (e.g. Petitioner ate French fries in twos). The examiner noted Petitioner had minimally productive and non-spontaneous speech. Diagnoses of social anxiety disorder, depressive disorder, binge-eating disorder, and personality disorder. A fair prognosis was noted.

A discharge document (Exhibit A, p. 1) from an unspecified facility were presented. The document noted an admission and discharge date of November 25, 2015. Diagnoses of borderline personality disorder, persistent depressive disorder, and anxiety disorder were stated.

An operative report (Exhibit A, pp. 4-5) dated [redacted], was presented. A pre-operative and post-operative diagnosis of right-sided CTS was noted. It was noted Petitioner underwent right endoscopic carpal-tunnel release surgery. No complications were noted.

Orthopedic office visit notes (Exhibit A, p. 2) dated [redacted], were presented. Medications included Cymbalta, Hydroxyzine, Naproxen, Norco, Ompeprazole, Promethazine, Topiramate, and Trazadone.

Petitioner and her mother testified Petitioner has recurring panic attacks. Petitioner testified they began around the time of Petitioner's 20th birthday. Petitioner testified medication helps to reduce symptoms, but panic attacks still persist. Petitioner testified she felt like she might have a panic attack during the hearing. Petitioner testified her anxiety, in part, is based on mistrust of others. Petitioner testified she is scared that other people will hurt her.

Petitioner testified her anxiety has worsened over the last 2 years. Petitioner testified she began seeing a psychiatrist in November 2015. Petitioner testified attending therapy helps to reduce symptoms.

Petitioner testified she is 5'2" and weighs 295 pounds. Petitioner testified she has been obese for most of her life. Petitioner testified her weight did not significantly fluctuate in 2015, though Petitioner testified she went from 320 to 240 pounds in 2014.

Petitioner testified she was psychiatrically hospitalized only one time (in July 2015). Petitioner testified she voluntarily admitted herself after feeling suicidal. Petitioner testified she thinks about suicide daily. Petitioner testified she has people she can contact if and/or when she feel suicidal.

Petitioner testified her days typically involve watching television and cooking. Petitioner testified she does not leave the house alone "unless she absolutely has to" leave. Petitioner testified it had been a couple weeks since she went shopping by herself.

Petitioner testified she has various physical pains. Petitioner testified her back and feet hurt. Petitioner testified she is physically capable of performing all activities of daily living.

Petitioner's presented records established a history of anxiety and depression which would reasonably limit Petitioner's ability to perform employment heavily reliant on dealing with the public. Petitioner's depression could also be construed to restrict Petitioner from performing work requiring extended periods of high concentration. Presented records further established some degree of lumbar and foot pain which would restrict Petitioner's ability to lift/carry, stand, and ambulate.

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 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.

A listing for anxiety-related disorders (Listing 12.06) was considered based on Petitioner's treating physician's diagnosis of an anxiety disorder. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Petitioner had a complete inability to function outside of the home.

It is found that Petitioner 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 had various part-time jobs as a cashier and as a stockperson. Petitioner testified she never had a full-time job and never earned more than $1,000/month in gross employment income. Petitioner's testimony was credible and will be accepted.

Because Petitioner never had earnings amounting to SGA, it must be found that Petitioner cannot return to work which amounted to SGA earnings. 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.

Physician statements of Petitioner restrictions were not presented. Restrictions can be inferred based on presented documents.

Petitioner testified she is capable of walking for 30 minutes on a bad day. Petitioner testified on a good day she might be able to stand for 60 minutes. Petitioner testified that standing for longer than 30 minutes causes shooting pains. Petitioner testified she cannot perform heavy lifting (she estimated a 50 pound maximum). Petitioner's stated lifting restriction was indicative of an ability to perform sedentary employment. Petitioner's testimony concerning walking and standing was debatably indicative of an ability to perform sedentary employment.

The bulk of Petitioner's presented documentation verified treatment for obesity and/or psychological problems. Diagnoses for plantar fasciitis, CTS, and lumbar pain were indicated.

Petitioner's CTS was described as mild (left hand) and mild-to-moderate (right hand) which was not highly indicative of any restrictions. Petitioner's grip strength was noted to be normal.

It was verified Petitioner underwent right endoscopic carpal-tunnel release surgery in January 2016. Petitioner's CTS history is suggestive of restrictions from heavy lifting (50 pounds or more) and possible even medium (20 pounds or more). Petitioner's treatment history is not suggestive of restrictions precluding the performance of light or sedentary employment.

Lumbar pain was indicated in presented treatment records. Spinal treatments (e.g. physical therapy, chiropractor appointments, epidurals…) were not verified. Radiology indicated an old fracture but did not indicate any ongoing problems. Petitioner had a full range of motion at a consultative examination. The evidence was insufficient to infer that Petitioner cannot perform sedentary employment.

A diagnosis of plantar fasciitis was verified; treatment beyond pain medication was not verified. Petitioner's weight likely exacerbates Petitioner's symptoms. Even factoring Petitioner's obesity, presented evidence was not indicative that Petitioner is physically incapable of performing sedentary employment.

Petitioner's non-exertional restrictions were better established. A brief psychiatric-related hospitalization was verified. At that point, Petitioner's functional level was 35. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF of 31-40 is described as "some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood." During this period of low function, Petitioner could not be expected to perform any employment.

As it happened, Petitioner's function level increased 1-2 days later. At discharge, Petitioner's GAF was 60. A GAF within the range of 51-60 is representative of someone with moderate symptoms or any moderate difficulty in social, occupational, or school functioning. The GAF is indicative of borderline mild functional problems. This GAF is presumed to be more indicative of Petitioner's functioning level. One basis for this presumption is that Petitioner did not undergo counseling, therapy, or psychiatric care until recently; records from the recent treatment were not presented.

It is likely that Petitioner would encounter difficulties in employment involving high-stress employment. Petitioner would also not likely perform well in employment heavily reliant on face-to-face interactions. Petitioner testimony conceded she is more capable of handling telephone interactions instead of in-person interactions. These types of employment would reduce Petitioner's potential sedentary employment base. Types of employment still available to Petitioner would include most office jobs (e.g. data entry, telemarketing, office assistant, office management…). The availability of such jobs were not presented, but they are presumed to be sufficiently available to Petitioner. It is found Petitioner is capable of sedentary employment.

Based on Petitioner's exertional work level (sedentary), age (younger individual aged 18-44), education (high school graduate with 3 years of college), employment history (unskilled), Medical-Vocational Rule 201.27 is found to apply. This rule dictates a finding that Petitioner is not disabled. Accordingly, it is found that MDHHS properly 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 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

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

Date Signed: **FEBRUARY 25, 2016**

Date Mailed: **FEBRUARY 25, 2016**

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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]