RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

MIKE ZIMMER
DIRECTOR

[redacted]

Date Mailed: April 27, 2016
MAHS Docket No.: 16-002859
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned administrative law judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10; and Mich Admin Code, R 792.11002. After due notice, an in-person hearing was held on April 18, 2016, from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], specialist.

ISSUE

The issue is whether MDHHS properly denied Petitioner's State Disability Assistance (SDA) eligibility for the reason that Petitioner is not a disabled individual.

FINDINGS OF FACT

The administrative law judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On [redacted], Petitioner applied for SDA benefits.

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

3. On [redacted], a Disability Determination Explanation (Exhibit 2, pp. 3-17) stated Petitioner was not disabled.

4. On an unspecified date, the Medical Review Team (MRT), in reliance on the Disability Determination Explanation, determined that Petitioner was not a disabled individual (see Exhibit 2, pp 1-2).

5. On [redacted], MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action informing Petitioner of the denial.

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

7. As of the date of the administrative hearing, Petitioner was a 49-year-old male.

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

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

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

11. Petitioner alleged disability based on restrictions related to back 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).

Prior to a substantive analysis of Petitioner's hearing request, it should be noted that Petitioner's noted special arrangements in order to participate in the hearing. Petitioner stated he wanted the opportunity to bring a lawyer to the hearing. Petitioner testified he was unable to procure a lawyer's services and the hearing was conducted accordingly.

Petitioner requested a hearing to dispute the denial of a SDA application. MDHHS testimony credibly indicated Petitioner failed to meet the disability requirement for SDA benefits.

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.

Petitioner alleged SDA eligibility based on a disability lasting longer than 90 days. 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.

Various mental health treatment records (Exhibit 1, pp. 456-535) from 2011 and 2012 were presented. Reported symptoms included the following: depressed mood, decreased energy, lack of motivation, social isolation, hopelessness, worthless, irritability, concentration difficulties, racing thoughts, and anxiety. An Axis I diagnosis of major depressive disorder (recurrent) was noted. Petitioner's GAF was 60 as of August

25, 2011. Various medications were prescribed throughout Petitioner's period of therapy.

A radiological report of Petitioner's right ankle (Exhibit 1, p. 456) dated [redacted] was presented. An impression of degenerative talonavicular joint changes was noted.

A radiological report of Petitioner's right hip (Exhibit 1, p. 457) dated [redacted], was presented. An impression of minimal osteoarthritis was noted.

A consultation report (Exhibit 1, pp. 359-362) was presented. The report was noted as completed by a physician based on an interview with Petitioner on [redacted]. Petitioner reported complaints of neck and lumbar pain from a recent motor vehicle accident. Related symptoms included left leg numbness and right hand finger numbness. The physician cited lumbar and cervical spine MRI reports in the evaluation. Notable physical examination findings included the following: morbid obesity, not exhibiting pain, significant left leg edema, decreased lower leg strength, decreased right upper extremity sensation, antalgic gait (with cane use), decreased cervical spine motion range, decreased hip motion ranges, and no indication of foraminal narrowing. Noted impressions included lumbar disc displacement, lower and upper extremity radiculopathy symptoms, cervical disc displacement, and rotator cuff syndrome. A plan of a left L5 transforaminal steroid injection was noted. A left shoulder MRI was recommended.

Hospital emergency room documents (Exhibit 1, pp. 315-318) dated December 4, 2014, were presented. It was noted that Petitioner presented with a complaint of neck pain after being in a car accident. It was noted a CT of Petitioner's neck showed no abnormalities. A clinical impression of "no serious injury" was noted.

Physician office visit notes (Exhibit 1, pp. 341-342) dated December 15, 2014, were presented. It was noted that Petitioner presented for initial treatment for bilateral knee pain, headaches, shoulder pain related to a recent motor vehicle accident. Various motion ranges were noted to be reduced to pain. Diagnoses included cervicalgia, cephalalgia, radiculopathy, and improving knee pain. A recommendation of physical therapy (PT) was noted.

A radiology report of Petitioner's bilateral knees (Exhibit 1, p. 397) dated December 15, 2014, was presented. An impression of no acute osseous injury was noted.

Physician office visit notes (Exhibit 1, pp. 339-340) dated January 12, 2015, were presented. It was noted Petitioner presented for ongoing treatment of bilateral knee pain, headaches, shoulder pain (left more than right), sleeping difficulty, neck pain, and lumbar pain. Various motion ranges were noted to be reduced to pain. Petitioner reported ongoing PT assisting in reducing knee pain. A recommendation of an 8 pound lifting restriction was noted. Norco, and Motrin were prescribed.

Hospital documents (Exhibit 1, pp. 197-228) from an admission dated [redacted], were presented. It was noted that Petitioner presented with complaints of bilateral foot pain, back pain, and chest pain. Petitioner reported he may have developed frostbite 2 weeks earlier. An assessment of edema with xerosis and neuritis, likely secondary to nerve damage was noted. Views of Petitioner's lumbar spine were negative for fracture and subluxation. A view of Petitioner's chest was negative. Neurontin and AmLactin were prescribed. A discharge date of [redacted], was noted.

A lumbar MRI report (Exhibit 1, pp. 383-384, 394-395) dated [redacted], was presented. A disc herniation mildly encroaching the anterior epidural space at L4-L5 was noted. A disc herniation mildly encroaching anterior epidural space and inferior nerve root recess was also noted.

A cervical spine MRI report (Exhibit 1, pp. 385-386, 393) dated [redacted], was presented. A disc herniation mildly encroaching epidural space was noted at C5-C6.

Hospital documents (Exhibit 1, pp. 229-274) from an admission dated [redacted], [redacted] were presented. It was noted that Petitioner presented with complaints of lower extremity pain (10/10). Petitioner's weight was noted to be 416 pounds. Assessments of cellulitis and sepsis were noted. Petitioner was treated with various medications. It was noted Petitioner's admission was complicated by fever and acute renal failure. Petitioner's blood pressure was noted to be normal. At discharge, cellulitis was noted to show "significant improvement." A discharge date of [redacted], was noted.

Convalescent center documents (Exhibit 1, pp. 423-424) were presented. An admission date of February 25, 2015, was verified. A discharge date was not provided, though convalescent center records dated through a document dated [redacted] indicated a single comment of "resolved."

Motor nerve test results (Exhibit 1, pp. 353-355) dated [redacted], were presented. Mild left L5 radiculopathy was noted. It was noted there was no other evidence of neuropathy.

A Psychiatric Evaluation (Exhibit 1, pp. 145-148) dated [redacted], was presented. It was noted Petitioner was referred for treatment following a hospital admission for cellulitis. It was noted Petitioner expressed frustration at the lack of healing progress and not being able to return to his home. Observations of Petitioner included the following: apparently normal muscle strength, somewhat unstable gait, unremarkable thought content, depressed affect, good concentration, good intermediate memory, and good short-term memory. Axis I diagnoses of adjustment disorder, with mixed anxiety and depression was noted. Petitioner's GAF was 50. A recommendation of psychotherapy with medication was noted.

Pain management physician office visit notes (Exhibit 1, pp. 379-381) dated [redacted], [redacted] were presented. It was noted Petitioner received pulse neurostimulator treatment.

Pain management physician office visit notes (Exhibit 1, pp. 375-378) dated [redacted], [redacted] were presented. A diagnosis of a right rotator cuff tear was noted.

Pain management physician office visit notes (Exhibit 1, pp. 372-374) dated [redacted] were presented. It was noted Petitioner received pulse neurostimulator treatment.

A Physical Therapy Order Form (Exhibit 1, p. 405) dated [redacted], was presented. PT on Petitioner's lumbar and left shoulder was ordered.

Physician office visit notes (Exhibit 1, pp. 356-357) dated [redacted], were presented. It was noted Petitioner underwent a lumbar L5 steroid injection.

Physician office visit notes (Exhibit 1, pp. 290-300) dated [redacted], were presented. Diagnoses of lumbar radicular syndrome treatment and lumbar disc displacement were noted. It was noted Petitioner underwent lumbar transforaminal steroid injection.

Pain management physician office visit notes (Exhibit 1, pp. 369-371) dated [redacted] were presented. It was noted Petitioner received pulse neurostimulator treatment.

Pain management physician office visit notes (Exhibit 1, pp. 364-366) dated [redacted] were presented. It was noted Petitioner received pulse neurostimulator treatment.

Physician office visit notes (Exhibit 1, pp. 278-289) dated [redacted], were presented. It was noted Petitioner underwent a second lumbar transforaminal steroid injection. A previous injection was noted to provide "good relief."

A radiology report of Petitioner's left foot (Exhibit 1, pp. 182-185) dated [redacted], was presented. An impression of early degenerative changes, including a small calcaneal spur and a tiny anterior spur were noted. Soft tissue swelling was also noted.

A radiology report of Petitioner's left foot (Exhibit 1, pp. 186) dated [redacted], was presented. An impression of soft tissue swelling was noted.

Neurologist office visit notes (Exhibit 1, pp. 125-130) dated [redacted], were presented. It was noted that Petitioner had multiple cerebrovascular risk factors of HTN, hyperlipidemia, morbid obesity, and right ganglia abnormality. It was noted Petitioner displayed problem with executive function and memory. A diagnosis of mild cognitive impairment was noted. It was noted Petitioner was a high risk for future dementia. A plan of head radiology was planned.

A CTA report of Petitioner's head (Exhibit 1, pp. 131-134) dated [redacted], was presented. An impression of a normal examination was stated.

A mental status examination report (Exhibit 1, pp. 116-120) dated [redacted], was presented. The report was noted as completed by a consultative licensed psychologist. Petitioner reported a complaint of depression. Petitioner reported he

keeps to himself. Petitioner reported he attended ongoing mental health appointments. A diagnosis of depression (secondary to medical conditions including obesity) was noted. A fair prognosis was noted.

Petitioner testified he developed cellulitis in left leg in 2014. Petitioner testified he ended up spending 5-6 months in a nursing home for treatment. Petitioner testified his left leg still occasionally swells. Presented medical records verified an approximate 9 week period at a convalescent center across February 2015 through April 2015. It is notable that Petitioner applied for SDA benefits several months later. By the time Petitioner applied for SDA, problems of cellulitis and/or sepsis appeared to be resolved.

Petitioner testified he attended PT for his back in 2014 and the end of 2015; Petitioner's testimony was consistent with presented PT records (see Exhibit 1, pp. 408-411). Petitioner testified he had to stop PT attendance after he developed chest pain and his blood pressure increased. Petitioner testified medication does little to control his blood pressure; a history of pain medication was verified (see Exhibit 1, pp. 412-415, 416-417).

Petitioner's treatment records sufficiently verified lumbar, cervical spine, right leg, and right shoulder problems. Some degree of psychological impairment was also verified. Based on presented records, ambulation, standing, lifting/carrying, and concentration difficulties can be inferred. The restrictions were sufficiently verified to have lasted at least 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 joint dysfunction (Listing 1.02) was considered based on Petitioner's complaints of knee pain. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively or perform fine and gross movements with both upper extremities effectively.

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 sleep apnea (Listing 3.10) was considered based on medical document references to the diagnosis. The listing was rejected due to a failure to meet the requirements of Listings 3.09 or 12.02.

A listing for chronic skin infections (Listing 8.04) was considered based on treatment for cellulitis. The listing was rejected due to a failure to establish extensive fungating or extensive ulcerating skin lesions that persist for at least 3 months despite continuing prescribed treatment, at least not since Petitioner's date of SDA application.

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 continues.

The fourth and fifth step of the disability analysis requires an assessment of Petitioner's functional capacity. Physician statements of restriction were provided.

SSR 96-2p states that if a treating source's medical opinion is well-supported and not inconsistent with the other substantial evidence in the case record, it must be given controlling weight (i.e. it must be adopted). Treating source opinions cannot be discounted unless the Administrative Law Judge provides good reasons for discounting the opinion. *Rogers v. Commissioner,* 486 F. 3d 234 (6th Cir. 2007)*; Bowen v Commissioner.*

Various disability certificates (Exhibit 1, pp. 400-404) from a treating physician were provided. The certificates covered the dates from [redacted], through [redacted] The certificate presented closest to Petitioner's SDA application date was dated [redacted] and covered the period from [redacted] through [redacted]. Petitioner's weight bearing ability was restricted to 10 pounds. A need for cleaning assistance was noted.

Traditionally, "weight bearing" refers to placing weight on a leg. Utilizing this traditional interpretation would render Petitioner unable to stand and/or walk, unless his body weight was 10 pounds or less. Other disability certificates listed weight bearing restrictions of 4 and 8 pounds. It is improbable that Petitioner's physician distinguished between such weights in restricting weight bearing. These considerations support rejecting the weight bearing restriction.

Rejecting the restriction is also consistent with not having a standing restriction. On Petitioner's most recent disability certificate, Petitioner's physician did not check a standing restriction for Petitioner.

It is found that physician stated “weight bearing” restrictions are rejected. Based on provided restrictions (4-10) pounds, it is presumed that the restrictions were intended to be lifting/carrying restrictions.

In March 2015, an evaluating psychiatrist determined Petitioner’s GAF was 50. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF within the range of 41-50 is representative of a person with “serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g. no friends, unable to keep a job).” A GAF of 50 could be indicative of marked restrictions (e.g. social or concentration); such an inference will not be made for Petitioner.

The same examining psychiatrist determined Petitioner had good concentration. Good concentration is not consistent with a GAF of 50.

It is notable that Petitioner’s GAF was assessed during a lengthy convalescent center admission. It is expected that Petitioner’s mental functioning would be lower during a period of pain, discomfort, and away from home. Psychological treatment following convalescent center discharge would be a more reliable indicator of mental function.

The same psychiatrist assessing Petitioner’s mental function also noted Petitioner did not wish to participate in services. This statement is consistent with an absence of psychological treatment records since 2012. One recent GAF is not sufficient to infer ongoing psychological restrictions.

A consultative mental examiner found further restrictions in December 2015. The examiner stated Petitioner demonstrated only slight capacity to concentrate due to difficulties performing calculations. It was noted Petitioner displayed difficulties with judgment and impulse control. It was noted Petitioner had slight to moderate strength in memory. The examiner opined Petitioner could engage in simple and repetitive work activities involving a 2-3 step procedure, with no independent judgment required.

For purposes of this decision, the examiner’s assessments will be accepted. The restrictions are consistent with an ability to perform non-complex employment with little decision making obligations. It should be noted that provided restrictions appear to be consistent with mild cognitive dysfunction (as indicated by a treating neurologist).

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 his only full-time job from the last 15 years was a cleaning company supervisor from approximately 2012-2014. Petitioner testified his company was responsible for cleaning the floors of a grocery store chain. Petitioner testified he performed some supervisory duties, though he was routinely expected to perform cleaning floors with brooms, mops, and/or a machine. Petitioner testified he could not perform the standing, ambulation, lifting/carrying of his past employment due to physical problems.

Petitioner's testimony was credible with presented records. It is found Petitioner cannot perform past employment; accordingly, the analysis may proceed to the final step.

In the fifth step in the process, the individual's RFC in conjunction with his or her age, education, and work experience, are considered to determine whether the individual can engage in any other substantial gainful work which exists in the national economy. SSR 83-10. While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). To determine the physical demands (i.e. exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967.

Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b) Even though weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additionally limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.*

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.*

Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.*

Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands are considered non-exertional. 20 CFR 416.969a(a). Examples of non-exertional limitations include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (e.g. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i)-(vi) If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2)

The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.* In using the rules of Appendix 2, an individual's circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, is compared to the pertinent rule(s).

Given Petitioner's age, education and employment history a determination of disability is dependent on Petitioner's ability to perform sedentary employment. For sedentary employment, periods of standing or walking should generally total no more than about 2 hours of an 8-hour workday. Social Security Rule 83-10.

Petitioner brought a cane to the hearing. Petitioner testified his physician recommended a walker, however, Petitioner opted to use a cane because it is easier to use when ambulating. Petitioner testified he could not walk the length of a football field. Petitioner estimated he could only stand for 3-4 minutes. Petitioner testified he can sit for 40 minutes before he would need to change positions. Petitioner testified he can climb 5-10 stairs, though going up stairs is harder than going down; Petitioner testified he has to take his time when climbing stairs.

Petitioner testified he is unable to get into a tub or stand in the shower. Petitioner testified he may have to wash himself outside of a tub. Petitioner testified he has difficulty with dressing his lower half; Petitioner testified he has to spend up to 4 hours (with breaks) when getting dressed. Petitioner testified he performs no housework. Petitioner testified he is unable to help with laundry because it is difficult for him to go into the basement. Petitioner testified other persons shop for him due to his ambulation difficulties.

Petitioner's testimony was highly suggestive of an inability to perform the standing, ambulation, or lifting/carrying of any employment. Presented medical records were less suggestive.

Petitioner's treatment history verified complaints of back pain. Two lumbar disk herniations and a single cervical spine herniation was verified. The diagnoses are not particularly indicative of any restrictions. It is notable that stenosis was not found within Petitioner's cervical or lumbar spine. It is also notable that Petitioner's most recent spinal treatment indicated "good relief" from neuro-stimulation treatment; this is suggestive of improvement of previously reported symptoms. Other radiology was also not highly indicative of an inability to perform the exertional requirements of sedentary employment.

Left foot radiology verified soft tissue swelling and a "tiny" spur. Neither problem is indicative of sitting restrictions an inability to perform the standing and/or ambulation required of sit-down employment.

A right rotator cuff tear was verified in March 2015. Follow-up treatment was not apparent unless neuro-stimulation was performed for the purpose of relieving pain. A statement of restriction was not apparent. The evidence was insufficient to infer right arm restrictions due to the tear.

Petitioner testified he stopped smoking and changed his diet about 1-2 weeks before the hearing. Petitioner testified his physicians recently referred him to a weight loss clinic. Petitioner testified he is "doing everything" he can to improve.

It is not known if Petitioner recently began doing "everything" to improve. Presented records indicated no noncompliance with any treatments. It is known Petitioner testified he weighed 474 pounds. That is an increase of 58 pounds from earlier in the year. It is appreciated Petitioner has some restrictions which limit his ambulation. It is appreciated depression is not a motivating illness. It is appreciated Petitioner's morbid obesity likely exacerbates his back and leg pain. It cannot be appreciated that Petitioner was doing "everything" he can to improve. Weight gain is consistent with poor nutritional choices which Petitioner testimony suggested he makes. Petitioner testified that his HTN is extremely high (though it was not well documented), in part due to his eating choices.

Petitioner's presented history sufficiently verified various physical problems likely exacerbated by obesity. Despite the many problems, presented evidence did not justify an inference that Petitioner is physically incapable of performing sedentary employment.

In assessing Petitioner's RFC, some non-exertional restrictions were accepted. The restrictions would erode Petitioner's potential sedentary employment opportunities.

Mild cognitive impairment would preclude the performance of any complex or highly detailed sedentary employment (e.g. bookkeeper, administrative assistant…). Petitioner was deemed capable of performing repetitive and simple employment. The availability of such employment was not presented. Employment within Petitioner's abilities would include telemarketing, assembly, customer service, and clerical employment. Such employment is presumed to be available to Petitioner in sufficient quantity so that SGA may be achieved.

Based on Petitioner's exertional work level (sedentary), age (younger individual aged 45-49), education (less than high school but capable of communicating in English), employment history (unskilled), Medical-Vocational Rule 201.18 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**.

CG/hw

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

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; 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

DHHS

[redacted]

Petitioner

[redacted]