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: May 11, 2016
MAHS Docket No.: 16-002723
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

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; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on April 18, 2016, from Detroit, Michigan. Petitioner appeared and represented himself. The Department of Health and Human Services (Department) was represented by [redacted], Medical Contact Worker.

ISSUE

Did the Department properly determine that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit program?

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 October 20, 2015, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On March 1, 2016, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 2-8).

3. On March 8, 2016, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit A, pp. 361-362).

4. On March 8, 2016, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 363-364).

5. Petitioner alleged disabling impairment due to chronic pain, shattered foot, torn rotator cuff, bipolar disorder, anxiety and depression.

6. On the date of the hearing, Petitioner was [redacted] years old with a [redacted] birth date; he is [redacted] in height and weighs about [redacted] pounds.

7. Petitioner is GED recipient.

8. At the time of application, Petitioner was not employed.

9. Petitioner has an employment history of work as handrail installer, monitor at transitional housing facility, and maintenance worker.

10. Petitioner has a pending disability claim with the Social Security Administration.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Health and Human Services Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180.

A disabled person is eligible for SDA. BEM 261 (July 2015), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If an individual is found disabled, or not disabled, at any step in this process, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR

416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In general, the individual has the responsibility 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, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. 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). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

Step One

The first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Petitioner has not engaged in SGA activity during the period for which assistance might be available. Therefore, Petitioner is not ineligible under Step 1 and the analysis continues to Step 2.

Step Two

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for SDA means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence

shows that the individual's impairments, when considered in combination, do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

In the present case, Petitioner alleges disabling impairment due to chronic pain, shattered foot, torn rotator cuff, bipolar disorder, anxiety and depression. The medical evidence presented at the hearing was reviewed and is summarized below.

In May 2014, Petitioner slipped in the shower and injured his left foot. An examination revealed a swollen and painful foot and possible stress fracture. Petitioner was put in ambulatory cast with a walking boot and prescribed Norco for pain. In an August 26, 2014 follow up visit, Petitioner reported less pain and slow improvement. The doctor informed him that the bone had healed fine, but he might have hurt the nerves when he injured his foot. (Exhibit A, pp. 300-312, 342-355.)

On June 29, 2014, Petitioner went to the emergency department complaining of pain in his testicles. He was diagnosed with epididymitis and treated with antibiotics; his urinary symptoms improved and his pain was reduced. (Exhibit A, pp. 315-339.)

Petitioner's medical records included progress notes and evaluations from his mental health provider from January 2015 through December 2015. (Exhibit A, pp. 32-246.) In a July 29, 2015 annual assessment, Petitioner was diagnosed with bipolar I disorder, most recent episode depressed, moderate. It was noted he had nondependent alcohol abuse episodic drinking behavior. He was assessed with a global assessment functioning (GAF) score of 48. Petitioner reported weekly mood cycles even with medication, worsening paranoia, struggling anxiety and depression, low self-esteem, feeling on edge, trouble concentrating, and fits of rage. He also reported trouble sleeping, trouble focusing, feelings of worthlessness, thoughts of death (when drinking only), irritability, racing thoughts, excessive involvement in drinking, decreased need for sleep (two hours when unmedicated), grandiosity at times, chest pains in the middle of the night, butterflies in the stomach, shakes and jitters unrelated to alcohol, and unwillingness to leave the house. (Exhibit A, pp. 45-57.) In a July 28, 2015 evaluation, Petitioner was observed to have average grooming, cooperative attitude, normal mood, normal affect, good memory, normal cycle motor activity, normal speech, no hallucinations, goal-directed thought process, normal thought content, normal attention/concentration, adequate impulse control, adequate judgment, no hallucinations, and orientation to person, place, and time. He was prescribed Celexa, Seroquel, and trazodone. (Exhibit A, pp. 59-66.)

In a December 18, 2015 evaluation by the mental health provider, Petitioner reported that he was compliant with medication without side effects and that his anxiety was well-controlled and he had no thought of harming himself or others. It was observed that he had average grooming; aloof attitude; anxious mood; normal affect; good memory; normal cycle motor activity; normal speech; no hallucinations; goal-directed thought process; normal thought content and attention/concentration; adequate impulse control;

adequate judgment; no suicidal, homicidal, or assault ideations; and proper orientation to person, place, and time. His GAF score was increased to 56. (Exhibit A, pp. 120-127.) In a January 25, 2016 letter, Petitioner's mental health provider stated that Petitioner was actively receiving mental health services (Exhibit A, p. 9).

On February 9, 2016, Petitioner was examined at the Department's request by an independent medical examiner who prepared a full mental status report. The doctor noted that Petitioner's speech was clear and communication was within normal limits, his gait and posture was within normal limits, his grooming hygiene and dress were appropriate, and he rode a bike six blocks to timely arrive at his appointment. Petitioner reported difficulty walking, but it was observed that he did not use any assistive devices. He also reported performing activities of daily living independently: housekeeping, shopping, completing errands, cooking simple meals, riding a bike, visiting with friends and family, and doing laundry. Petitioner reported alcohol use from age 5 or 6 to December 2015 with heaviest use between 2000 and 2004, inpatient treatment in 1997, and current attendance at Alcoholics Anonymous meetings. He also reported a history of left foot surgery in March 2014 and surgery to reattach his fingers on his right hand at 12 years old.

The doctor observed that Petitioner responded well to instructions and positive criticism; required no special assistance to complete the examination process; was cooperative, motivated, and verbally responsive; attempted all tasks; worked diligently; had good eye contact; had logical, organized, simple and concrete thoughts; was goal directed; had a euthymic mood; had good confidence level in his own abilities; had responses within normal limits, logical and organized; had good contact with reality; and had appropriate thought content. The doctor noted that Petitioner reported feeling stable and was presenting as stable with respect to his bipolar disorder, with no mania or depression. The doctor concluded that Petitioner had bipolar disorder, with the most recent episode being mild depression in December 2015 and found he had no apparent mood disorder at examination and was doing well with current medications and treatment. He found that Petitioner was able to comprehend and carry out simple directions and perform repetitive, routine simple tasks without difficulty. He also found that Petitioner was able to comprehend complex tasks without difficulty. (Exhibit A, pp. 247-251.)

Petitioner's record included notes from office visits with his family doctor from September 2015 to December 2015 showing diagnoses of generalized anxiety disorder depression, abdominal pains, elevated liver enzymes, and left ankle and foot pain. It was noted that the tips of Petitioner's 2 middle fingers were missing; Petitioner explained that he cut his fingers off when he was ■ years old. The doctor recommended an x-ray of Petitioner's hand to determine whether there was tenosynovitis. (Exhibit A, pp. 261-299.) An October 9, 2015 abdominal ultrasound was negative (Exhibit A, p. 255.)

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner

suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner has satisfied the Step 2 threshold, and the analysis will proceed to Step 3.

Step Three

Step 3 of the sequential analysis of a disability claim requires a determination if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920(a)(4)(iii). If an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

Based on the medical evidence presented in this case, listings 1.02 (major dysfunction of a joint), 1.04 (disorders of the spine), 1.06 (fracture of the femur, tibia, pelvis or one or more of the tarsal bones), 12.04 (affective disorders), and 12.06 (anxiety-related disorders) were considered. The medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Steps 4 and 5, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s), including those that are not severe, and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4); 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional

limitations. 20 CFR 416.969a(b). The exertional requirements, or physical demands, of work in the national economy are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a). Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools and occasionally walking and standing. 20 CFR 416.967(a). Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the 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. 20 CFR 416.967(b). 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). 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). Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. 20 CFR 416.967(e).

In this case, Petitioner alleges both exertional and nonexertional limitations due to his medical condition. Petitioner testified that he could walk two blocks before his foot would start to ache, stand up to an hour as long as he limited the weight on his left foot, and sit for not more than 45 minutes. He had numbness in both hands, on the left because of his shoulder pain and on the right because of his loss of fingers. He testified that he could bend and squat and take stairs and lift between 30 and 40 pounds but not on a repetitive basis. He lived alone and admitted he was able to take care of his personal hygiene, dress himself, do household chores, and shop.

The medical evidence supports Petitioner's testimony that he had injured his foot in 2014 and that he had missing fingers in his right hand from an injury when he was 12 years old. Notes from Petitioner's family doctor, who Petitioner began seeing on September 24, 2015, show that Petitioner complained of numbness in his hands for over ten years at his initial visit and left wrist and left foot and ankle pain in October 2015. He was referred for x-rays of the left wrist, foot, and ankle and a hand x-ray to determine whether there was tenosynovitis but no results are included in the medical file. An October 9, 2015 abdominal ultrasound showed no abnormality.

The medical evidence presented does not support the intensity, persistence and physical limiting effects alleged by Petitioner. The fact that there was a year gap between the time Petitioner finished his follow-up visits with the podiatrist in August 2014 following his May 2014 foot injury and the time Petitioner established a primary care physician relationship in September 2015 indicates that Petitioner was able to manage with his foot pain as well as issues with numbness in his hands. Petitioner's testimony that he could perform many of the activities of daily living and could lift up to 30 pounds, though not on a repetitive basis, indicate that Petitioner's testimony concerning the limiting effects of his impairments is only partially credible.

With respect to Petitioner's exertional limitations, it is found based on a review of the entire record that Petitioner maintains the physical capacity to perform light work as defined by 20 CFR 416.967(b).

Petitioner also alleged nonexertional limitations due to his mental condition. If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions 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 (i.e., unable to 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). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). In addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of mental functional limitation. 20 CFR 416.920a(c)(3). The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. Id. The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. Id.

At the hearing, Petitioner testified he experienced panic attacks daily when he had to leave his home. He had problems with his concentration and memory, finding it difficult to stay focused. He had a temper. He participated in therapy and took medication, both which he testified helped him.

Petitioner's record showed that he had been engaged in mental health treatment beginning January 2015. In July 29, 2015, he was diagnosed with bipolar disorder, most recent episode depressed, moderate, and assigned a GAF score of 48. He reported weekly mood swings, worsening paranoia, anxiety and depression, low self-esteem, feeling on edge, trouble concentrating, fits of rage, trouble sleeping, trouble focusing, feelings of worthlessness, thoughts of death, irritability, racing thoughts, excessive involvement in drinking, decreased need for sleep when unmedicated, grandiosity at times, chest pains in the middle of the night, shakes and jitters unrelated to alcohol, and unwillingness to leave the house. However, he was observed to have a cooperative attitude, normal mood, normal affect, good memory, normal speech, no hallucinations, goal-directed thought process, normal thought content and

attention/concentration, adequate impulse control, adequate judgment, and orientation to person, place, and time. In a December 2015 evaluation, Petitioner reported he was compliant with medication without side effects and that his anxiety was well-controlled and he had no thought of harming himself or others. His GAF score was increased to 56. In the February 9, 2016 mental status examination by the independent medical examiner, the doctor observed that Petitioner responded well to instructions and positive criticism; required no special assistance to complete the examination process; was cooperative, motivated, and verbally responsive; worked diligently; and had logical, organized, simple and concrete thoughts. The doctor concluded that Petitioner had bipolar disorder, with the most recent episode being mild depression in December 2015, but had no apparent mood disorder at examination and was doing well with current medications and treatment. The doctor found that Petitioner was able to carry out simple directions and perform repetitive, routine tests without difficulty and could comprehend complex tasks without difficulty.

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild limitations on his activities of daily living; mild to moderate limitations on his social functioning; and mild limitations on his concentration, persistence or pace to perform simple work. No episodes of decompensation were identified on the record. Petitioner's RFC is considered at both Steps 4 and 5. 20 CFR 416.920(a)(4), (f) and (g).

Step Four

Step 4 in analyzing a disability claim requires an assessment of Petitioner's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner's work history in the 15 years prior to the application consists of work as a handrail installer, monitor at a transitional housing facility, and maintenance worker. All his prior employment required standing at least half of the day. As a handrail installer, Petitioner regularly lifted up to 10 pounds and sometimes 50 pounds, making the job one requiring medium exertion. The monitor position required no lifting, but because of the standing requirements it is properly categorized as requiring light exertion. The maintenance worker position required lifting up to 20 pounds and is also properly categorized as requiring light exertion.

Based on the RFC analysis above, Petitioner is limited to no more than light work activities. Based on his exertional RFC, Petitioner would be capable of performing his past relevant work as a monitor and maintenance worker. Petitioner's mental RFC, which that places mild limitations on his activities of daily living; mild to moderate

limitations on his social functioning; and mild limitations on his concentration, persistence or pace to perform simple work, would not preclude Petitioner in engaging in this prior work. Because Petitioner is able to perform past relevant work, he is not disabled at Step 4 and the assessment ends.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner **not disabled** for purposes of the SDA benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is **AFFIRMED.**

ACE/tlf

Alice C. Elkin
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

[redacted]

[redacted]

[redacted]