RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: June 10, 2016
MAHS Docket No.: 16-004062
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, a telephone hearing was held on May 16, 2016, from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], hearing facilitator.

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. 6-12).
4. On [redacted], MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action (Exhibit 1, pp. 2-4, 232-233) informing Petitioner of the denial.

5. On [redacted] Petitioner requested a hearing disputing the denial of SDA benefits (see Exhibit 1, p. 2).

6. As of the date of the administrative hearing, Petitioner was a 36-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 (via general equivalency degree).

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

10. Petitioner alleged disability based on restrictions related to chronic back pain, kidney stones, ankle pain, and various psychological problems.

CONCLUSIONS OF LAW

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. MDHHS administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. MDHHS policies for SDA are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

Petitioner requested a hearing to dispute the denial of a SDA application. MDHHS presented a Notice of Case Action (Exhibit 1, pp. 232-233) verifying Petitioner's application was denied due to a failure to meet disability requirements.

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (July 2015), 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.

Physician office visit notes (Exhibit 1, pp. 104-110) dated [redacted], were presented. Ongoing treatment for kidney stones was noted.

Medication review notes (Exhibit 1, pp. 154-158, 195-199) dated [redacted], from a mental health treatment agency were presented. It was noted Petitioner reported stress from a recent move. Cutting and crying spells were reported. An Axis I diagnosis of bipolar disorder (Type II) was noted. Petitioner's GAF was 43 (as of [redacted]).

Hospital emergency room documents (Exhibit 1, pp. 22-56) dated [redacted], were presented. It was noted that Petitioner appeared highly distressed, suicidal, emotionally overwrought, and overwhelmed. Petitioner was admitted for psychiatric review.

Reported symptoms included difficulty sleeping, up-and-down appetite, crying spells, hopelessness, helplessness, and suicidal ideation. A history of cutting was reported, including an incident from 2 days earlier. Petitioner reported a history of sexual abuse by her stepfather. Petitioner's GAF was 30-35 as of [redacted]; a guarded prognosis at admission was noted. On April 27, 2015, it was noted Petitioner lacked educational history to manage in the vocational world; rapid mood shifts were noted. On [redacted] Petitioner planned on returning home; concern was expressed about her insight and judgment. On [redacted], it was noted Petitioner obviously had deep emotional wounds from being raised by a drug-addicted mother. Petitioner was noted to likely respond to weekly (at a minimum) psychotherapy. It was noted Petitioner had medication and group therapy throughout her hospital stay. An Axis I diagnosis of bipolar disorder (type 1) was noted. A discharge date of [redacted], was noted. Petitioner's GAF at discharge was 50-55.

Hospital emergency room documents (Exhibit 1, pp. 18-21) dated [redacted], were presented. It was noted that Petitioner reported not sleeping and not eating for last 24 hours and feeling shaky. Petitioner reported her roommates were being mean to her and that she was hungry. Petitioner was given food and prescribed Xanax. An impression of anxiety was noted.

Medication review notes (Exhibit 1, pp. 147-153, 188-194) dated [redacted], from a mental health treatment agency were presented. It was noted Petitioner reported inconsistent medication compliance, suicidal thoughts, and cutting. Mental health assessments included orientation x3, depressed mood, organized thought content, fair concentration, fair judgment, and intact knowledge. Recommendations included therapy, AA/NA attendance, and dual diagnosis services.

Physician office visit notes (Exhibit 1, pp. 98-103) dated [redacted], were presented. Ongoing treatment for chronic back pain was noted. Norco was prescribed.

Medication review notes (Exhibit 1, pp. 142-146, 183-187) dated [redacted], from a mental health treatment agency were presented. Ongoing medications included Lamictal, Zoloft, Latuda, and Trazodone.

Physician office visit notes (Exhibit 1, pp. 93-97) dated [redacted], were presented. Ongoing treatment for back pain, and kidney stones was noted. A stent was noted to be recently placed. Medication was prescribed for Petitioner's back pain.

A renal ultrasound report (Exhibit 1, pp. 111-112) dated [redacted], was presented. An impression of an unremarkable ultrasound was noted.

Physician office visit notes (Exhibit 1, pp. 83-92) dated [redacted], were presented. Ongoing treatment for DM, HTN, back pain, and kidney stones was noted. Pain medication was prescribed for back pain. Regular exercise was recommended for HTN. Ongoing medications included Norco, atorvastatin, Lisinopril, metformin, Miralex, cyclobenzaprine, and amlodipine. Petitioner's weight was 261 pounds.

Medication review notes (Exhibit 1, pp. 136-141, 177-182) dated [redacted], from a mental health treatment agency were presented. Ongoing medications included Lamictal, Zoloft, Latuda, and Trazodone.

Medication review notes (Exhibit 1, pp. 127-135, 168-176) dated [redacted], from a mental health treatment agency were presented. Petitioner reported increased leg pain. Reported psychological symptoms included crying spells, mood swings, feeling depressed, and social isolation. Petitioner reported being out of medications. Mental health examination assessments included able focus, fair judgment, limited insight, obsessive and paranoid thought process, unremarkable speech, and “so-so” mood. Current medications included Lamictal, Zoloft, Latuda, and Trazodone.

Medication review notes (Exhibit 1, pp. 118-126) dated [redacted], from a mental health treatment agency were presented. Petitioner reported increased leg pain. Reported psychological symptoms included poor sleeping and erratic appetite. Petitioner reported she had recent uncontrollable shaking. Petitioner’s condition was noted to be improving. Mental status assessments included: fair judgment, able concentration, limited insight, unremarkable thought process, “okay” mood, unremarkable presentation, and unremarkable speech. A follow-up in 2 months was planned.

Physician office visit notes (Exhibit 1, pp. 72-82) dated [redacted], were presented. It was noted that Petitioner reported ongoing back pain, and left ankle joint swelling. Petitioner reported having leg tremors one week earlier, though none occurred since. Petitioner’s physician expressed doubt that seizures caused shaking; anxiety was noted to be a more likely cause of seizures. An ankle sprain was assessed. A recommendation of PT for Petitioner’s back was noted. Petitioner’s weight was noted to be 264 pounds (BMI of 43.93).

Medication review notes (Exhibit 1, pp. 159-167) dated [redacted], from a mental health treatment agency were presented. It was noted Petitioner presented for a comprehensive assessment. Complaints of increased back and leg pain were noted. It was noted Petitioner was to undergo extended PT, but did not due to unstable living situation. Petitioner reported dreams of death, poor sleep, and poor eating (one meal per day). An improving condition was noted.

Physician office visit notes (Exhibit 1, pp. 200-204) dated [redacted] were presented. Complaints of back pain, joint swelling, and shaking were noted. Assessments of DM (type 2), anxiety, chronic back pain, other pain, shaking spells (not seizures), and left ankle sprain were noted. Various medications were continued. A plan of PT for Petitioner’s back was noted. Self-rehab for Petitioner’s ankle was recommended.

Physical therapy documents (Exhibit 1, pp. 58-68) dated [redacted], were presented. Petitioner reported a fall in November 2015 causing an ankle sprain and an

exacerbation of chronic back pain. Petitioner's weight was noted to be 240 pounds. Reduced bilateral hip strength (3+/5) was noted. A recommendation of PT 2-3 times per week for 90 days was noted.

Physical therapy documents (Exhibit 1, p. 68) dated [redacted] were presented. It was noted Petitioner was discharged from PT as she was not seen since initial appointment.

Hospital emergency room documents (Exhibit A, pp. 1-12) dated [redacted] were presented. It was noted that Petitioner presented with complaints of abdominal pain. It was noted an ultrasound of Petitioner's abdomen demonstrated a right renal cystic lesion and renal calculus. Pelvic radiology was noted to be consistent with enteritis/ileus. A right ovarian tumor was found. Follow-up with a gynecologist was scheduled.

Hospital emergency room documents (Exhibit A, pp. 13-16) dated [redacted], were presented. It was noted that Petitioner presented with complaints of knee pain, right ankle pain, and skin inflammation. Treatment was not apparent though generic discharge instructions for folliculitis were provided.

Physician office visit documents (Exhibit A, pp. 25-29) dated [redacted], were presented. Complaints of back pain were noted. Diabetes was noted as currently controlled. Petitioner was referred for PT and pain management for her back. HTN was noted as uncontrolled. A referral for kidney stone treatment was noted. A referral to a gynecologist for ovarian teratoma treatment was noted.

Pain center office visit documents (Exhibit A, pp. 17-20) dated [redacted], were presented. Complaints of back and leg pain were noted. Diagnoses of right-sided sciatica, chronic right knee pain, acute right ankle pain, and central pain syndrome were noted. Various medications were prescribed. A lumbar MRI was ordered.

Gynecologist office visit documents (Exhibit A, pp. 20-24) dated [redacted], were presented. A complaint of abnormal bleeding was noted. No abnormal findings were found during the exam.

Physician office visit documents (Exhibit A, pp. 30-35) dated [redacted], were presented. Diabetes was noted as currently uncontrolled; diet changes and weight loss were recommended. A right ankle fracture was noted to be routinely healing.

Petitioner testified she broke her right knee in 2010. Petitioner testified she has suffered a litany of health problems since. Petitioner testified her right knee swells and sometimes gives-out. For example, Petitioner testified she broke her ankle in March of 2016 after falling down stairs.

Petitioner testified she has recurring kidney stones. She testified she underwent 3 surgeries in 2015 for the problem.

Petitioner testified she has chronic back pain, ongoing for 5 years. Petitioner testified she may need back surgery. She testified she has not yet had an MRI.

Presented evidence sufficiently satisfied various exertional and non-exertional restrictions for a period longer than 90 days. Accordingly, it is found that Petitioner established having a severe impairment and the disability analysis may proceed to Step 3.

The third step of the sequential analysis requires determining whether the Petitioner's impairment, or combination of impairments, is listed in 20 CFR Part 404, Subpart P, appendix 1. 20 CFR 416.920 (a)(4)(iii). If a petitioner's impairments are listed and deemed to meet the durational requirement, then the petitioner is deemed disabled. If the impairment is unlisted or impairments do not meet listing level requirements, then the analysis proceeds to the next step.

Petitioner alleged restrictions, in part, based on bipolar disorder/ Bipolar disorder is an affective disorder covered by Listing 12.04 which reads as follows:

> **12.04** ***Affective disorders***: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation. The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.
>
> A. Medically documented persistence, either continuous or intermittent, of one of the following:
> 1. Depressive syndrome characterized by at least four of the following:
> a. Anhedonia or pervasive loss of interest in almost all activities; or
> b. Appetite disturbance with change in weight; or
> c. Sleep disturbance; or
> d. Psychomotor agitation or retardation; or
> e. Decreased energy; or
> f. Feelings of guilt or worthlessness; or
> g. Difficulty concentrating or thinking; or
> h. Thoughts of suicide; or
> I. Hallucinations, delusions, or paranoid thinking
> OR
> 2. Manic syndrome characterized by at least three of the following:
> a. Hyperactivity; or
> b. Pressure of speech; or
> c. Flight of ideas; or
> d. Inflated self-esteem; or
> e. Decreased need for sleep; or
> f. Easy distractibility; or

g. Involvement in activities that have a high probability of painful consequences which are not recognized; or

h. Hallucinations, delusions or paranoid thinking

OR

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration

OR

C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or

2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or

3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

Petitioner testified she sees psychiatrist every 6 weeks and a therapist and/or case manager twice per month. Petitioner testified she regularly attends group therapy for issues of cutting. Petitioner testified she has reduced the frequency of cutting since last year, though she claimed it is still an ongoing problem.

Petitioner verified a hospitalization and a hospital encounter involving psychological impairments. Only a handful of psychiatric encounters were otherwise presented. A need for psychiatric medication and treatment was verified. Presented records verified some degree of impairment, but was overall lacking in verifying marked restrictions.

On two occasions, Petitioner had an improving mental condition. Improvement is not indicative of marked restrictions.

Petitioner did not present any therapy or counseling records. Though Petitioner testified she regularly attended counseling, this was not verified. Petitioner’s allegation of mental

impairment would have more compelling if details of her counseling sessions were presented.

Petitioner's GAF was verified to be 50-55 at her hospital discharge. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that 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 (assuming it was not at 50) was not indicative of marked restrictions. A GAF of 50 is indicative of marked restrictions. Even if Petitioner's GAF was 50 at hospital discharge, it is presumed Petitioner's functioning improved with the taking of psychiatric medications. Evidence of a GAF since hospital discharge was not presented.

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.

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.

It is found that Petitioner failed to establish meeting a SSA listing. Accordingly, the analysis moves to the fourth step.

The fourth step in analyzing a disability claim requires an assessment of the Petitioner's residual functional capacity (RFC) and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if it is determined that a petitioner can perform past relevant work. *Id*.

Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

Petitioner testified her only employment from the last 15 years was as a certified nursing assistant. Petitioner testified her duties included transferring patients, transporting patients, housecleaning, and cooking.

Petitioner testified she is physically unable to perform her past duties due to knee and back restrictions. Petitioner's testimony was consistent with presented evidence. It is found Petitioner is unable to perform past, relevant employment form the last 15 years. 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 testified she always utilizes a cane for ambulation. Petitioner testified she can walk 1 block before her knee and back cramps. Petitioner testified she can stand approximately 15 minutes before back and leg pain prevent further standing. Petitioner testified she can sit 30 minutes before she has to stop due to leg and back pain; Petitioner estimated she would have to stand 15 minutes before she could sit for another 30 minutes. Petitioner testified her physician restricted her to lifting/carrying to 5 pounds.

Petitioner testified she has to utilize a shower chair when bathing. Petitioner testified she can dress herself, but putting on socks is difficult (presumably due to difficulty in bending her back). Petitioner testified she can sometimes wash dishes, but she is unable to vacuum, sweep, or mop, due to the stress on her knee and back. Petitioner testified she can shop, but needs help from her sister. Petitioner testified she can drive, but not for long periods; she stated she is authorized to park in handicap spaces.

Much of Petitioner's presentation of evidence was underwhelming. For example, Petitioner testified she is currently undergoing her 4th physical therapy for her back, right knee, and right ankle; a reference to Petitioner's failure to attend PT was verified and no PT records were presented. Petitioner alleged significant back pain and an MRI for her back was ordered; an MRI lumbar report was not presented. Petitioner alleged ongoing right ankle pain after a recent fall; presented evidence failed to verify any complications from the broken ankle.

Despite many shortcomings in presented records, it was established Petitioner had a need for PT. It was established that Petitioner required relatively heavy pain medication (e.g. Norco). It was established Petitioner had a need for pain management, which is consistent with spinal and/or joint dysfunction. A diagnosis for central pain syndrome was documented; these considerations are consistent with significant pain from spinal and/or joint dysfunction. Other various problems (recurring kidney stones and an ovarian tumor with no apparent outcome) were also verified.

Presented evidence sufficiently verified pain and restrictions which would likely limit Petitioner to the ambulation, lifting/carrying, and sitting required for sedentary employment. Petitioner's exertional restrictions have to be considered with her non-exertional restrictions.

Petitioner testified she has a very short attention span due to psychological restrictions. Petitioner also testified that she takes a lot of medications (5-6 medications and 16 pills per day) causing her to struggle in ADL completion. Petitioner testified some days she is unable to sleep, eat or even get out of bed. Petitioner testified her mind sometimes races and that she dreams of death. Petitioner testified she is uncomfortable in crowds.

Though Petitioner did not establish marked psychological restrictions to performing employment, moderate restrictions were established. Petitioner's mental health examination findings consistently noted impairments of judgment and insight. Moderate degrees of concentration can be inferred based on Petitioner's numerous medications and psychological diagnoses. Concentration difficulties can also be inferred based on medication side effects and/or physical pain.

Petitioner's psychological treatment history is highly suggestive of social and concentration restrictions that would restrict Petitioner to a relatively stress-free, simple, and non-social type of employment. It is theoretically possible that such employment currently exists, however, MDHHS has the burden to establish that Petitioner has sufficiently available employment opportunities. MDHHS did not meet that burden.

It is found Petitioner has no known available opportunities. Accordingly, Petitioner is disabled and it is found that MDHHS improperly denied Petitioner's SDA application.

Consideration was given to factoring Petitioner's medical noncompliance in the disability determination. Presented records verified Petitioner was discharged form PT due to a failure to attend. Petitioner appears to have difficulties with nutrition as diabetes was noted as uncontrolled and diet recommendations were noted just one month before the hearing. Petitioner testified she lost 50 pounds over the previous year, though obesity appears to be an ongoing problem. Overall, insufficient evidence of noncompliance was established.

It should also be noted that a finding of disability for SDA is not a permanent one. Petitioner's conditions have room for improvement with time and better medical

compliance. If medical improvement is established, Petitioner may be found to be not disabled at a later date.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that MDHHS improperly denied Petitioner's application for SDA benefits. It is ordered that MDHHS begin to perform the following actions within 10 days of the date of mailing of this decision:

(1) reinstate Petitioner's SDA benefit application dated [redacted];
(2) evaluate Petitioner's eligibility subject to the finding that Petitioner is a disabled individual;
(3) initiate a supplement for any benefits not issued as a result of the improper application denial; and
(4) schedule a review of benefits in one year from the date of this administrative decision, if Petitioner is found eligible for future benefits.

The actions taken by MDHHS are **REVERSED**.

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]