RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

Date Mailed: June 15, 2016
MAHS Docket No.: 16-004533
Agency No.:
Petitioner:

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 May 18, 2016, from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by , 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 , Petitioner applied for SDA benefits.

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

3. On , the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 2-8, 16).

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

5. On [redacted], Petitioner requested a hearing disputing the denial of SDA benefits (see Exhibit 1, pp. 178-179).

6. As of the date of the administrative hearing, Petitioner was a 47-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.

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

10. Petitioner alleged disability based on restrictions related to a neck injury.

CONCLUSIONS OF LAW

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

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (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 requested a hearing to dispute the denial of an SDA application. Petitioner claimed an inability to work for 90 days due to mental and/or physical disabilities. MDHHS testimony credibly indicated Petitioner's SDA application was denied following a determination that Petitioner was not disabled.

Before a disability analysis is undertaken, it should be noted Petitioner testified she also wanted a hearing to dispute unpaid medical bills. Petitioner testimony conceded the subject was not part of her hearing request dated [redacted]. As a courtesy,

Petitioner’s Medicaid history was discussed during the hearing, however, Petitioner will have to request a hearing if she wishes to pursue an administrative remedy.

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 [90 days for SDA eligibility]. 20 CFR 416.905.

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 background information from Petitioner's testimony and a summary of presented medical documentation.

Petitioner testified she was in a motor vehicle accident in April 2014. Petitioner testified her vehicle rammed head-on into a utility pole. Petitioner testified her neck suffered a compound fracture and her lumbar and collarbone were injured. Petitioner testified she's experienced numerous difficulties since her accident.

Hospital rehabilitation institute documents (Exhibit 1, pp. 123-167; Exhibit A, p. 1) were presented. Petitioner's physical therapy start date was [redacted]. It was noted Petitioner underwent 44 appointments and was discharged from therapy on [redacted]. It was noted Petitioner showed "significant improvement" in range of motion, strength, and pain reduction. Petitioner testified her pain was not reduced by PT, though it was documented Petitioner's paraspinal and left shoulder pain was reduced from 10/10 to 7/10.

Head and neck institute office visit notes (Exhibit 1, pp. 64-70, 117-119) dated [redacted], were presented. It was noted Petitioner presented for her first visit. Complaints of jaw pain, upper back pain, neck pain, shoulder pain, neck stiffness, neck swelling, eye pain, blurred vision, and ear pain were noted. Physical exertion was noted to worsen pain; rest was reported to alleviate pain. X-rays were noted to show “severe” displacement of condyle at rest and during clenching. Recommendations included an orthotic to reposition lower jaw, monthly evaluations to insure proper jaw positioning, and physical therapy.

Head and neck institute office visit notes (Exhibit 1, pp. 62-63, 112-113, 120) dated [redacted], were presented. Complaints of eye pain, headaches, blurry vision, ulcers, colitis, neck pain, and jaw pain were reported. Joint sound testing was performed (see Exhibit 1, pp. 114-116). A guarded prognosis for TMD (presumed to be Temporomandibular Disorder) was noted.

Head and neck institute office visit notes (Exhibit 1, pp. 61, 108-111) dated [redacted], [redacted] were presented. It was noted Petitioner reported “extreme pain” with a tooth. It was noted Petitioner had ulcers and colitis. Amoxicillian and Norco were prescribed (see Exhibit 1, p. 52).

Various head and neck institute office visit notes (Exhibit 1, pp. 83-107) from June 2015 and July 2015 were presented. Complaints of jaw pain and neck pain were regularly noted.

Head and neck institute office visit notes (Exhibit 1, p. 59-60) dated [redacted], were presented. It was noted Petitioner was fitted for an orthotic. Ongoing eye pain and blurred vision were reported. Magnetic crandiomanduibular scans were performed.

Head and neck institute office visit notes (Exhibit 1, p. 58) dated [redacted], were presented. It was noted Petitioner felt “wonderful” after injections intended to relax muscles and increase blood flow.

Head and neck institute office visit notes (Exhibit 1, p. 57) dated [redacted], were presented. It was noted Petitioner recently started PT. Difficulty with chewing was noted. Ongoing but reduced pain in neck, headaches, and jaw was noted.

A Disability Certificate (Exhibit 1, p. 15) dated [redacted] was presented. Petitioner’s physician stated Petitioner was disabled from [redacted], through [redacted], [redacted] Petitioner was stated to need attendant care every day for 8 hours. Assistance with housework was also indicated as a need. Petitioner was restricted from driving.

Head and neck institute office visit notes (Exhibit 1, p. 56, 84-87) dated [redacted], were presented. Neck pain was noted to decrease “just slightly.” It was noted Petitioner could get better relief by not allowing muscles to get stiff. Petitioner’s prognosis was noted to be complicated by emotional, cognitive, and physical concerns.

A prescription (Exhibit 1, p. 50) dated [redacted], was presented. Flexeril was prescribed by Petitioner’s neck physician.

A Medical Examination Report (Exhibit 1, pp. 9-11, 18-19) dated [redacted], was presented. The form was completed by a physician with an approximate 10 month history of treating Petitioner. Petitioner’s physician listed diagnoses of neck pain including C5-C6 herniation, left shoulder tendinitis, T1 compound fracture, and left-side TMS. Percocet was noted as currently prescribed. It was noted that Petitioner needed assistance with household chores. Neck range of motion was noted to be restricted. A need for a walking-assistance device was not indicated.

Head and neck institute office visit notes (Exhibit 1, pp. 81-82) dated [redacted], were presented. Symptoms of bilateral jaw pain and neck pain were noted. Treatments of hot packs, electrical stimulation, “spray & stretch”” manual therapy, and iontophoresis were noted. Follow-up plan included soft food diet, limit of jaw opening, and daily massaging of masseters. A guarded prognosis was noted.

Head and neck institute office visit notes (Exhibit 1, p. 80) dated [redacted], were presented. Symptoms of bilateral jaw pain, intense right-sided zygo pain, and neck pain were noted. Treatments of hot packs, electrical stimulation, and iontophoresis were noted. Follow-up plan included soft food diet, limit of jaw opening, wearing orthotic, and daily massaging of masseters.

Head and neck institute office visit notes (Exhibit 1, p. 79) dated [redacted], were presented. Symptoms of bilateral jaw pain and neck pain were noted. Treatments of electrical stimulation and iontophoresis were noted. Follow-up plan included soft food diet, limit of jaw opening, and daily massaging of masseters.

Head and neck institute office visit notes (Exhibit 1, p. 78) dated [redacted], were presented. Symptoms of slightly decreased jaw pain and frequent neck pain were noted. Treatments of hot packs, electrical stimulation, and iontophoresis were noted. Follow-up plan included soft food diet, limit of jaw opening, and daily massaging of masseters.

Head and neck institute office visit notes (Exhibit 1, p. 77) dated [redacted], were presented. Symptoms of mild bilateral jaw pain, neck pain, and intense right-sided zygo pain were noted. Treatments of hot packs and iontophoresis were noted. Follow-up plan included soft food diet, limit of jaw opening, wearing of orthotic, and daily massaging of masseters.

Head and neck institute office visit notes (Exhibit 1, p. 55, 73-76) dated [redacted], [redacted] were presented. Petitioner reported “some relief” in neck pain. Continued difficulty with crunching and chewing was noted. Prognosis for Phase I TMD was noted to be good (with compliancy).

Head and neck institute office visit notes (Exhibit 1, p. 72) dated September 9, 2015, were presented. Symptoms of mild right jaw pain, decreased left-side jaw pain, neck pain, and intense right-sided zygo pain were noted. Treatments of hot packs and iontophoresis were noted. A stable condition was noted. Follow-up plan included soft food diet, limit of jaw opening, wearing of orthotic, and daily massaging of masseters.

Head and neck institute office visit notes (Exhibit 1, p. 71) dated September 9, 2015, were presented. Symptoms of mild right jaw pain, neck pain, and bilateral zygo pain were noted. Treatments of hot packs and iontophoresis were noted. A stable condition was noted. Follow-up plan included soft food diet, limit of jaw opening, wearing of orthotic, and daily massaging of masseters.

An internal medicine examination report (Exhibit 1, pp. 170-177) dated December 30, 2015, was presented. The report was noted as completed by a consultative physician. Petitioner reported complaints of back pain, neck pain, left-sided paresthesias, stomach ulcer, daily headaches, and HTN. Tandem walk, toe walk, and heel walk were noted as slowly performed. Reduced ranges of motion were noted in Petitioner's lumbar flexion (75°- normal 90°) and bilateral hip forward flexion (50°- normal 100°). The examiner stated that clinical evidence did not support a need for a cane.

Petitioner testified she has ongoing pain from a previous motor vehicle accident. Petitioner testified her neck pain radiates to the back of head and down her back. Petitioner testified prolonged activity increases pain. Petitioner testified a high-back chair alleviates some pain while sitting. Petitioner testified she attended PT in 2016 until April 2016. Petitioner testified she still has problems eating due to jaw pain related to her neck injuries.

Petitioner testified she experiences pain in her left shoulder. Petitioner testified she needs to find a neurologist but is having difficulty finding one who accepts her insurance.

Petitioner testified she is capable of walking for 2 blocks before radiating neck pain prevents further walking. Petitioner testified she can stand for at least 30 minutes. Petitioner testified she has no restrictions on sitting, though it is painful; she testified she would need to lie down after a while. Petitioner testified she can lift/carry a jug of water (she could not specify a weight limit), but she would have to hold it close to her chest.

Petitioner testified she independently showers though she has difficulty reaching her legs and back. Petitioner testified she can dress herself if her shirt is not too tight-fitting. Petitioner testified she is unable to mop or sweep; she testified she is starting to perform vacuuming. Petitioner testified she sometimes shops, and will use a scooter when in the store. Petitioner testified she can drive, but her seat has to be upwards; Petitioner testified she limits driving to short trips. Petitioner testified she has difficulty checking her blind spots and putting on her seat belt.

Presented medical records generally verified a medical treatment history consistent with Petitioner's allegations of restrictions. The treatment history was established to have lasted at least 90 days and at least since Petitioner's date of SDA application. 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.

Claimant's most prominent impairment appears to be neck pain and related complications. Spinal disorders are covered by Listing 1.04 which reads:

> **1.04 *Disorders of the spine*** (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the cauda equina) or the spinal cord. With:
>
> A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine);
> OR
> B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours;
> OR
> C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b.

Looking at Part C, the inability to ambulate effectively is a requirement. SSA defines this as follows:

> Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. Ineffective ambulation is defined generally as having insufficient lower extremity functioning (see 1.00J) to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities.

Petitioner testified her pride prevents from using a cane, though she stated she might benefit from using one. Non-use of a cane or walker is highly supportive in finding that Petitioner is not unable to ambulate effectively.

Radiology of Petitioner's spine was not presented. The absence is particularly notable because Petitioner's physician stated a cervical spine MRI was performed in April 2014 (see Exhibit 1, p. 18). There was no diagnosis of stenosis, nerve root compression, or other condition stated within the spinal dysfunction listing. Provided diagnoses of shoulder tendonitis, disc herniation, and compound fracture (presumably healed as no evidence indicated otherwise) are not sufficient to meet listing requirements.

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

The fourth and fifth step of the disability analysis requires an assessment of Petitioner's functional capacity.

Various medical 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.*

Physical therapy discharge documents from December 2014 assessed Petitioner's abilities. Dressing, grooming, meal preparation, housework, prolonged sitting, range of motion, and strength were noted as minimally impaired. Driving, lifting/carrying, prolonged standing, sleeping, and overhead reaching were stated to be moderately impaired. Generally, moderate restrictions to lifting/carrying and prolonged standing would restrict Petitioner to sit-down jobs.

On a Medical Examination Report dated ███████████, Petitioner's physician stated Petitioner had various limitation(s) expected to last 90 days. The physician opined that Petitioner was restricted as follows over an eight-hour workday, less than 2 hours of standing and/or walking, and less than 6 hours of sitting. Petitioner was restricted from performing any lifting/carrying. Petitioner's physician opined that Petitioner was restricted from performing the following repetitive actions: left-sided reaching, bilateral pushing/pulling, and bilateral operation of leg/foot controls. Petitioner's diagnoses were the cited basis for imposing restrictions.

Generally, diagnoses, by themselves, are not ideal support for restrictions. In the present case, Petitioner established a substantial history of physical therapy and physician appointments for her spinal pain. It is also notable that Petitioner reported symptoms which are atypical and consistent with a severe injury (e.g. TMJ pain, hearing loss, and blurry vision).

In December 2015, a consultative examiner stated Petitioner was able to perform all 23 listed work-related activities (e.g. sitting, standing, lifting, carrying, stooping, bending, and reaching…) without any stated restriction. The statement of restriction was not consistent with Petitioner's treatment history or physician-provided restrictions. The lack of restrictions also appeared to be inconsistent with other statements from the consultative examiner (e.g. slow ambulation, limited lumbar flexion…). The absence of restrictions by the consultative examiner were not a persuasive consideration.

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 performed previous employment as a certified nursing assistant. Petitioner testified she could no longer perform the lifting or transferring of patients.

Petitioner testified that she had previous employment as a driver. Petitioner testified her shifts were 10 hours long. Petitioner expressed doubts about being able to perform her old job, though she was not specific. Presumably, Petitioner might be capable of performing a sit-down job with a standing option. Standing is not an option while driving. Thus, it is doubtful that Petitioner could perform previous driving employment.

Petitioner testified she had previous employment as a tax preparer. Petitioner testified she could probably perform the job part-time, but expressed doubt in completing a full week of employment.

Petitioner described her tax preparation employment as sedentary employment (see below definition). An analysis of Petitioner's ability to perform sedentary employment will be reserved for the final step. At this point in the analysis, it is found Petitioner is not capable of performing past employment.

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.

At the discharge of physical therapy (in December 2014), Petitioner work/school potential was noted to be "4". A "4" was noted to represent a maximum impairment (i.e. an activity that could not be performed). Presumably, the assessment was based on Petitioner's combined exertional and non-exertional restrictions. The assessment is indicative of not being able to perform any employment.

Petitioner's physician stated Petitioner was not capable of performing a combined 8 hours of standing/walking (less than 2 hours) and sitting (less than 6 hours). Generally, an inability to perform a combination of standing/walking and sitting for 8 hours renders the performance of any job to be unrealistic.

A Disability Certificate (Exhibit A, p. 4) dated [redacted], was presented. Petitioner's physician stated Petitioner was disabled from [redacted], through [redacted]. Petitioner was stated to need attendant care every day for 8 hours. Assistance with housework was also needed. Petitioner was restricted from driving. A need for attendant care and housework assistance is consistent with an inability to perform any employment.

Based on presented evidence, it is found Petitioner is not capable of performing any employment. Accordingly, Petitioner is disabled and it is found that MDHHS improperly denied Petitioner's SDA application.

It should be noted that the finding of disability is not necessarily a permanent one. It is hopeful that Petitioner's conditions sufficiently improve to the point that employment is a plausible expectation.

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

Petitioner