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: [redacted]
MAHS Docket No.: 16-003586
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned administrative law judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10; and Mich Admin Code, R 792.11002. After due notice, an in-person hearing was held on [redacted], from [redacted] Michigan. Petitioner appeared and was represented by [redacted]. 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 2, pp. 4-10).
4. On [redacted], 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 2, pp. 2-3).

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

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

8. Petitioner alleged disability based on restrictions related to back pain.

CONCLUSIONS OF LAW

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

Petitioner's hearing request checked a dispute concerning Family Independence Program (FIP) benefits. Petitioner testified a dispute of cash assistance based on disability (i.e. SDA) was intended. MDHHS was not confused by Petitioner's error and prepared for an SDA dispute. MDHHS agreed to defend the denial of SDA benefits and the hearing was conducted accordingly.

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 ([redacted]), 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 ([redacted]), 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. It was not disputed that Petitioner's only basis for SDA was based on a claim of disability.

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 in 2005, he was plowing snow when his vehicle ran into the side of a handicap ramp. Petitioner testified the incident caused a compression fracture in his neck and an unspecified injury to his lower back. Medical records indicated Petitioner reported undergoing a cervical laminectomy which led to taking "large amounts" of pain medication (see Exhibit 1, p. 10). Medical records also noted Petitioner lost his right big toe (Petitioner testified he lost it in a previous motorcycle accident). Petitioner also reported he had many side effects from the pain medication.

A 1994 letter from a psychiatry office was presented. It was noted Petitioner was scheduled for an evaluation.

A lower extremity EMG report (Exhibit 1, p. 48) dated [redacted] was presented. An impression of a normal study was noted.

An upper extremity EMG report (Exhibit 1, p. 49) dated [redacted], was presented. An impression of occasional spontaneous activity in the cervical paraspinal muscles, possibly secondary to osteoarthritis, was noted.

A physician letter (Exhibit A, p. 12) dated [redacted], was presented. A diagnosis of C5-C6 disc bulges with cord compression was noted. A diagnosis of L3-L4 disc protrusion was noted. The physician concluded Petitioner could not work because he was unable to sit, walk, or bend for long periods.

Physician office visit notes (Exhibit 1, p. 11-13) dated May 21, 2014, were presented. Petitioner complained of ongoing neck and lumbar pain (7/10). Rest was reported to be the only relief for pain. Physical examination findings including mid-cervical spine tenderness, painful lumbar motion, and sluggish reflexes. A recommendation of pursuing [redacted] for pain relief was noted. A lumbar spine x-ray report (Exhibit 1, p. 15) indicated no fractures or dislocation.

Physician office visit notes (Exhibit 1, p. 34-35) dated [redacted], were presented. Ongoing lumbar pain was reported.

Neurologist office visit notes (Exhibit 1, p. 41-46) dated [redacted], were presented. Ongoing lumbar pain (8/10) was reported. Radiology was ordered.

A lumbar radiology report (Exhibit 1, p. 50) dated [redacted], was presented. An impression of mild L3-L4 disc space narrowing and mild retrolisthesis was noted.

A lumbar MRI report (Exhibit 1, pp. 51-52) dated [redacted], was presented. Moderate bilateral foraminal narrowing was noted at L4-L5. Mild-to-moderate foraminal narrowing was noted at L3-L4.

Physician office visit notes (Exhibit 1, p. 10) dated [redacted], were presented. Petitioner complained of ongoing back pain, ranging from 3-10/10. A 2007 MRI was noted to be consistent with disc disease and herniation. Petitioner stated he did not want narcotic medication. [redacted] was prescribed.

Neurologist office visit notes (Exhibit 1, p. 36-40) dated [redacted], were presented. Ongoing lumbar pain was reported. An assessment of degenerative disc disease was noted.

Physical therapy (PT) office visit documents (Exhibit 1, pp. 88-94, 249-255) and a plan of care (Exhibit 1, pp. 57-58) dated [redacted], was presented. Functional deficits included limited sitting, standing, and walking. A plan of 12 PT appointment across 4 weeks was noted. Treatments were noted to include stretching, therapeutic exercises, joint mobilization/stabilization, and electric stimulation.

Pain management physician office visit documents (Exhibit 1, pp. 53-55) dated [redacted], were presented. Assessments of lumbar disk disease and facet mediated lumbar pain were noted. A plan to continue PT and pursue injections was noted.

Hospital outpatient treatment documents (Exhibit 1, pp. 208-219) dated [redacted], were presented. It was noted Petitioner presented with complaints of lumbar pain. It was noted Petitioner underwent left-sided L2, L3, and L4 medial branch block injections. Diagnoses of lumbar spondylosis, lumbar facet arthropathy, and lumbar DDD were noted.

Various spinal PT documents from [redacted] and [redacted] (Exhibit 1, pp. 95-136, 256-296) were presented. On [redacted], it was noted Petitioner could tolerate standing for 5 minutes, walking for 10-15 minutes, and sitting for 2-3 hours; 30% improvement was reported by Petitioner. It was also noted on [redacted], that Petitioner underwent left-sided L2, L3, and L4 medial branch block injections. (see Exhibit 1, pp. 220-227). On [redacted], Petitioner reported a pain level of 3/10.

PT discharge documents (Exhibit 1, pp. 137-140, 297-301) dated [redacted], were presented. Petitioner reported a 5/10 pain level. Standing was noted to be tolerated for 4 minutes (on concrete), sitting for 1.5 hours, and walking for 30-40 minutes.

Hospital outpatient treatment documents (Exhibit 1, pp. 208-219) dated [redacted], were presented. It was noted Petitioner underwent an [redacted].

Handwritten pain management physician noted (Exhibit 1, p. 28) dated [redacted], were presented. "Significant pain relief" for 2 days after last [redacted] was noted; pain was reported to have slowly returned. [redacted] was prescribed. PT was recommended.

Handwritten pain management physician noted (Exhibit 1, p. 27) dated [redacted], were presented. "Good relief" with last [redacted] was noted. PT and increased [redacted] was planned.

PT office visit documents and a plan of care (Exhibit 1, pp. 141-147, 302-308) dated [redacted] were presented. Petitioner reported recurring falls (twice per month) due to loss of balance or dragging left foot. Petitioner reported using a cane for walking long distances. Clinical impressions of decreased strength, decreased flexibility, and pain were noted. Petitioner was as noted capable of tolerating walking for 20 minutes, sitting for 15-20 minutes, and standing for 10 minutes. A 6 week plan of PT (18 appointments) was noted.

Physician office visit notes (Exhibit 1, p. 9) dated [redacted], were presented. Petitioner complained of ongoing back pain, ranging from 3-10.

Hospital outpatient treatment documents (Exhibit 1, pp. 238-248) dated [redacted], were presented. It was noted Petitioner underwent an [redacted].

Various PT documents (Exhibit 1, pp. 148-200, 309-361) from [redacted] and [redacted] were presented. On [redacted], Petitioner reported a pain level of 3-4/10. On [redacted], Petitioner reported his legs are still numb. On [redacted] Petitioner reported 5/10 pain level and continued leg numbness. On [redacted], Petitioner reported 4/10 mid-back pain. On [redacted], Petitioner reported 5/10 lumbar pain and continued leg numbness. On [redacted], Petitioner reported a near fall which may have injured his right rotator cuff. On [redacted], Petitioner reported 4/10 left low back pain. On [redacted],

Petitioner reported 4-5/10 levels of left lower back pain. On [redacted], Petitioner reported 5-6/10 pain levels, but increased ease with putting on shoes.

PT discharge documents (Exhibit 1, pp. 201-207, 362-368) dated [redacted], were presented. Back pain levels of 4-5/10 were reported across mid-lower back. It was noted Petitioner ambulated with cane 50% of the time on flat surface. Petitioner's dynamic standing ability was assessed to be fair-poor.

Neuropsychiatry consultation documents (Exhibit A, pp. 8-9) dated [redacted], were presented. Complaints of memory problems, anxiety disorder, and panic attacks were noted. A brain MRI and EMG were planned.

An EEG report (Exhibit 1, p. 22) dated [redacted], was presented. An impression of a normal study was noted.

A brain MRI report (Exhibit 1, p. 23) dated [redacted], was presented. A normal MRI was noted.

An upper extremity EMG report (Exhibit A, p. 15) dated [redacted], was presented. Evidence of bilateral median mononeuropathy at the wrist (i.e. CTS) was noted.

A lower extremity EMG report (Exhibit 1, p. 21, A p. 16) dated [redacted], was presented. An impression of occasional spontaneous activity in the lumbosacral paraspinal muscles, possibly secondary to osteoarthritis was noted.

Physician office visit notes (Exhibit 1, pp. 5-7, A pp. 10-11) dated [redacted], were presented. Complaints of burning and throbbing back and neck pain were noted. Standing and sitting were reported to be painful. It was noted pain clinic referral, [redacted], and PT did not reduce pain. It was noted Petitioner used a cane to be stabilized when ambulating. It was noted an MRI and EMG were suggestive of neuropathic pain coming from a herniated spinal disc. [redacted] was continued. An x-ray report (Exhibit 1, p. 14) of Petitioner's lumbar indicated degenerative disc disease and s/p spinal fusion; L4-L5 and L5-S1 disc narrowing was also noted. It was noted that physical examination demonstrated "severe spasm" of a neck muscle; paraspinal lumbar spasms were also noted. Range of lumbar motion were noted to be restricted due to pain.

Physician office visit notes (Exhibit 1, p. 4) dated [redacted], were presented. Complaints of back, neck, hand, and abdominal pain were noted. [redacted] and [redacted] were prescribed.

Physician office visit notes (Exhibit 1, p. 3) dated [redacted], were presented. Complaints of back pain and spasms were noted. It was noted Petitioner sought [redacted] to reduce pain.

Physician office visit notes (Exhibit 1, p. 2) dated [redacted], were presented. It was noted that Petitioner complained of a rash on his hand. Complaints of neck and back pain were noted. Back and neck motion ranges were noted to be restricted. [redacted] was prescribed.

Handwritten optical testing documents (Exhibit A, pp. 6-7) dated [redacted], were presented. Unaided distance visual acuity was noted to be 20/20 for Petitioner's right eye and 20/40 for Petitioner's left eye.

A prescription (Exhibit A, p. 30) dated [redacted], was presented. A [redacted] unit "for lifetime use" was prescribed.

Petitioner alleged impairments, in part, due to ADD and/or ADHD. Petitioner testified he was diagnosed with an attention deficit at a young age. Petitioner testified he stopped taking medications in 2004. Petitioner and AHR testimony suggested Petitioner may have concentration difficulties, in part to the diagnosis. Insufficient medical evidence was presented to suggest any impairments based on ADD and/or ADHD.

Petitioner testified his past employment caused a loss of hearing. Petitioner testified he has difficulty hearing women and children due to the high-pitched nature of their voices. Petitioner conceded the problem could be resolved by use of a hearing aid. Zero hearing treatment records were presented. Petitioner failed to establish any hearing impairments.

Petitioner testified he has ongoing limits due to lumbar pain, neck pain, and CTS. Petitioner testified he has restrictions in sitting, standing, walking, and dexterity. Presented medical records were consistent with Petitioner's testimony.

It is found Petitioner established work-related impairments which have lasted longer than 90 days. Accordingly, it is found that Petitioner established having a severe impairment and the disability analysis may proceed to Step 3.

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

A listing for spinal disorders (Listing 1.04) was considered based on Petitioner's cervical spine and lumbar complaints. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root, loss of strength, and/or an inability to ambulate effectively (as defined by SSA).

A listing for visual acuity (Listing 2.02) was considered based on a brief history of optical treatment. This listing was rejected due to a failure to establish a corrected eyesight of worse than 20/200 in Petitioner's best eye.

A listing for peripheral neuropathies (Listing 11.14) was factored based on a diagnosis of CTS. The listing was rejected due to a failure to establish significant and persistent disorganization of motor function in two extremities.

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 his only employment in the prior 15 years was as a carpenter. Petitioner testified he last worked in 2006 or 2007. Petitioner testified he had a full-time job for 3 weeks, before he quit to accept a higher paying temporary job. Petitioner testified he was hurt on the job and has not worked since.

Petitioner testified his carpentry duties included working with concrete. Petitioner testimony implied a mostly standing job with extensive bending and lifting/carrying.

Petitioner testimony indicated spinal pain would prevent the performance of past employment. Petitioner testified he could not even hold tools. Petitioner's testimony was generally consistent with presented records. It is found Petitioner is unable to perform past employment and 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 he is limited in walking to 600-800 feet before needing to sit due to back pain. Petitioner testified he could only stand for 10 minutes (at most). Petitioner testified sitting was restricted to 10-30 minutes before he would have to stand and stretch. Petitioner testified his surgeon restricted his lifting/carrying to 10 pounds. Petitioner testified he utilizes a cane when he leaves his home. Petitioner testified he has recurring falls (he estimated they occur twice per month). Petitioner testified he is unable to bend, kneel, or stoop.

Petitioner testified he can shower independently, but he utilizes bars and a shower chair. Petitioner testified he can perform light dusting and cooking; he testified he is unable to vacuum or perform other chores requiring pushing/pulling. Petitioner testified he can do laundry but only has to do 1-2 loads per week. Petitioner testified he can shop by himself, but only on short trips. Petitioner testified he does not drive due to medication side effects.

Petitioner also testified that bilateral CTS is very restrictive. He testified his fingers have diminished sensation causing difficulty with buttoning clothes and tying shoes. He testified he cannot snap his left fingers. Petitioner testified he struggles carrying glassware unless it has a handle.

Petitioner's testimony was indicative of an inability to perform any employment due to limited standing and sitting abilities. Petitioner's testimony will be considered against presented medical documents.

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

In a letter dated [redacted], Petitioner's physician included an assessment of Petitioner's capabilities (see Exhibit 1, pp. 5-7). Petitioner was restricted from any overhead reaching due to neck and back disc disease. Petitioner was deemed "hardly" capable of lifting 10 pounds. A walking restriction of 1-2 blocks was noted. Lifting, pushing, pulling, holding objects were "out of the question." Bending, squatting, and kneeling were "impossible." Petitioner was deemed capable of performing daily activities, except cooking. A poor prognosis was noted. The physician also stated Petitioner could only perform employment that allowed him to lie down when the pain was severe.

Physician-stated restrictions were consistent with Petitioner's testimony and treatment history. Physician-stated restrictions were consistent with Petitioner's capabilities at PT discharge.

Presented records verified two series of PT appointments. Petitioner testified PT helped him stop dragging his left foot, but other positive effects have dissipated.

Multiple [redacted] treatments were verified. Petitioner testified he's had 4-5 lumbar [redacted] over a 2 year period. Petitioner testified the first injection reduced his pain for 6 months. Petitioner testified subsequent injections were gradually less effective.

Petitioner testified he underwent a cervical discectomy in 2006. Petitioner testified the surgery addressed a C5-C6 neck ablation. Petitioner testified the surgery likely resulted in arthritis.

Petitioner testified he also attempted a laser blast therapy. Petitioner testified the therapy did not produce any significant pain reduction.

Petitioner testified he primarily smokes marijuana to treat pain. Petitioner testified he is leery of using pain medication because of previous gastrointestinal bleeding problems.

It is appreciated that Petitioner pursued different types of treatment. Medical records sufficiently verified Petitioner pursued several medical treatments yet maintains a poor prognosis.

Based on presented evidence, Petitioner's combined cervical spine pain, lumbar pain, and CTS likely preclude Petitioner from the performance of any employment. Accordingly, Petitioner is a disabled individual and it is found MDHHS improperly denied Petitioner's SDA application.

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 [redacted]; 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]

Authorized Hearing Rep. [redacted]

Petitioner [redacted]