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: July 22, 2016
MAHS Docket No.: 16-004131
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], specialist.

ISSUE

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

FINDINGS OF FACT

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

1. On [redacted], Petitioner applied for SDA benefits.
2. Petitioner's only basis for SDA benefits was as a disabled individual.
3. On [redacted], the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 5-8).
4. On [redacted], MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action (Exhibit 1, pp. 3-4) informing Petitioner of the denial.

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

6. On [redacted], an administrative hearing was held.

7. During the hearing, Petitioner and MDHHS waived the right to receive a timely hearing decision.

8. During the hearing, the record was extended 37 days for the purpose of ordering MDHHS to request and submit medical records from Petitioner's orthopedist, primary care physician, and pain management physicians.

9. MDHHS did not submit additional medical documents.

10. As of the date of the administrative hearing, Petitioner was a 51-year-old female.

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

12. Petitioner's highest education year completed was the 12th grade.

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

14. Petitioner alleged disability based on restrictions related to various psychological problems, sleep apnea, knee pain, ankle pain, and 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).

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 a SDA application. Petitioner claimed an inability to work for 90 days due to mental and/or physical disabilities. MDHHS presented a Notice of Case Action (Exhibit 1, pp. 3-4) verifying Petitioner's claim of disability was denied.

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.

It should be noted that MDHHS was ordered to present additional treatment records. As it happened, MDHHS presented no additional records. The impetus for ordering MDHHS to request additional records was that it was thought MDHHS possessed additional records which were not presented. This circumstance is known to occur when

MDHHS presents a Disability Determination Explanation (DDE) without providing additional medical records on which the DDE is based. This scenario was thought to occur in the present case; that thought was wrong. A check of Petitioner's case revealed a DDE was not presented; thus no additional documents (other than what MDHHS originally requested) was expected.

An Initial Psychiatric Evaluation (Exhibit 1, pp. 29-31) dated [redacted], was presented. A history of depression since losing her son was noted. Reported symptoms included crying spells, difficulty with concentration, and difficulty sleeping. Normal speech, motor activity, intelligence, and memory were noted. An Axis I primary diagnosis of major depressive disorder (recurrent and moderate) was noted.

A Medical Examination Report (Exhibit 1, pp. 32-34) dated [redacted], was presented. The form was completed by an orthopedic physician with an unstated history of treating Petitioner. Petitioner's physician listed diagnoses of right ankle arthritis and s/p right ankle syndesmotic screw removal. It was noted x-rays showed a healed fracture though narrowing of the tibiotalar joint space was noted. It was noted that Petitioner can meet household needs. It was noted that Petitioner did not need an assistive device for ambulation.

A Mental Residual Functional Capacity Assessment (Exhibit 12-13) dated [redacted] was presented. The assessment was noted as completed by a treating social worker and co-signed by a psychiatrist. This form lists 20 different work-related activities among four areas: understanding and memory, sustained concentration and persistence, social interaction and adaptation. A therapist or physician rates the patient's ability to perform each of the 20 abilities as either "not significantly limited", "moderately limited", "markedly limited" or "no evidence of limitation". Petitioner was found moderately limited in 15/20 listed abilities. It was noted that Petitioner was markedly restricted in the following abilities:

- Maintaining concentration for extended periods
- Working in coordination or proximity to other without being distracting
- Completing a normal workday without psychological symptom interruption
- Accepting instructions and responding appropriately to criticism
- Getting along with others without exhibiting behavioral extremes

A Medical Examination Report (Exhibit 1, pp. 35-37) dated [redacted], was presented. The form was completed by a general medicine physician with an approximate 18 month history of treating Petitioner. Petitioner's physician listed diagnoses of depression, anxiety, HTN, hypothyroidism, allergies, GERD, and chronic lower back pain. An impression was given that Petitioner's condition was deteriorating. A need for a walking-assistance device was not indicated. Bilateral leg edema was noted; Petitioner reported her legs were swollen after a recent pain clinic visit.

An internal medicine examination report (Exhibit 1, pp. 9-16) dated [redacted], was presented. The report was noted as completed by a consultative physician.

Petitioner reported complaints of chronic back pain, insomnia, sleep apnea, urinary incontinence, and hypertension. It was noted Petitioner brought a cane, however, she did not use it during the examination. Tandem walk, toe walk, and heel walk were noted as slowly performed. No reduced ranges of motion were reduced in Petitioner's spine, ankles or knees. It was noted that Petitioner was able to perform all 23 listed work-related activities which included sitting, standing, lifting, carrying, stooping, bending, and reaching; restrictions to performing the activities were not noted. The examiner stated that clinical evidence failed to support a need for a cane. HTN was noted to be under good control. Hyperlipidemia and hyperthyroidism were noted as impressions. Back pain, knee pain, and ankle pain were not noted as impressions.

A mental status examination report (Exhibit 1, pp. 17-21) dated [redacted], was presented. The report was signed by a consultative licensed psychologist and limited licensed psychologist. Petitioner reported struggling with depressions since the deaths of her father and son. Petitioner reported difficulties in crowds. It was noted Petitioner denied any delusions or psychotic symptoms. A history of 5-6 psychiatric-related hospitalizations was noted. Petitioner reported seeing a psychiatrist for the past 1½ years. Notable observations and assessments of Petitioner made by the consultative examiner include the following: Petitioner maneuvered stairs with use of cane, in-touch with reality, minimal effort during examination, constricted affect, logical and goal directed stream of mental activity, and no evidence of psychosis symptoms. Diagnoses of adjustment disorder (with depression and anxiety) managed with medication was noted.

Petitioner testified she lost two close family member in 2007 or 2008 (she was unsure which year). Petitioner testified her son was murdered. Petitioner testified she has since dealt with numerous depression symptoms. Petitioner testified she has a history of psychiatric hospitalizations and suicide attempts, though neither from the past 5 years.

Petitioner testified she stopped attending therapy a few months earlier. Petitioner testified she did not feel that the clinic was providing her enough 1-on-1 therapy. Petitioner testified she hopes to find a new clinic.

Petitioner testified she has recurring nervousness and fears. Petitioner testified she has insomnia. Petitioner testified she does not enjoy going outside.

Petitioner testified she broke her ankle in 2015. Petitioner testified her ankle pain improved, but she thinks the injury caused limping which adversely affected her back and knees. Petitioner testified she uses a cane to relieve some stress to her knees and back. Petitioner testified she is unable to walk long distances due to back and knee pain. Petitioner testified she has knee arthritis and possible back pain due to sciatica. Petitioner testified she performs home exercises to try to help. Petitioner testified she was told by her physician that weight loss would also help to relieve pain.

Petitioner testified she was diagnosed with sleep apnea. Petitioner testified it increases her tiredness, though she did not think it affected her ability to work.

Presented medical records generally verified a medical treatment history 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.

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 back pain complaints. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root.

A listing for affective disorder (Listing 12.04) was considered based on diagnoses of depression. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Petitioner required a highly supportive living arrangement, suffered repeated episodes of decompensation, or that the residual disease process resulted in a marginal adjustment so that even a slight increase in mental demands would cause decompensation.

It is found that Petitioner failed to establish meeting a SSA listing. Accordingly, the analysis 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 she worked in a factory for 1 month. Petitioner testified her job was to assemble car parts. Petitioner testified her job was mostly sit-down and involved "spot-welding." Petitioner stated her job was to stamp parts and shave off the excess by hand. Petitioner testified that her job required bending, which would be too difficult on her back and knees.

Petitioner testified she worked for five years as an office assistant. Petitioner testified her job duties included answering phones, meeting clients, and filing. Petitioner testified her computer skills are poor and that she could not likely perform the job today.

To determine if Petitioner can perform past employment, an analysis of her residual functional capacity (RFC) is necessary. This will be performed by evaluating presented statements of restriction against presented medical evidence.

Petitioner testified that she uses a cane all of the time. Petitioner testified she can walk a mile with her cane, though longer walks increase knee and back pain. Petitioner testified she could stand about 1-1½ hours with her cane. Petitioner testified she has no sitting restrictions. Petitioner testified she is limited to 10 pounds of carrying/lifting due to back pain.

Petitioner testified she can independently bathe and groom herself without problems. Petitioner testified she is unable to perform housework requiring heavy lifting or bending; Petitioner cited vacuuming and scrubbing floors as housework she cannot perform. Petitioner testified she can drive and clean her laundry. Petitioner testified she independently shops, but she sometimes get confused.

Generally, Petitioner's testimony was indicative of an inability to perform light employment. 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.*

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.*

On a Medical Examination Report dated [redacted], Petitioner's orthopedist stated Petitioner had various limitation(s). Petitioner was restricted to occasional lifting/carrying of less than 10 pounds. Petitioner's physician opined that Petitioner was restricted from pushing/pulling and right-sided operation of foot/leg controls. Petitioner's physician cited Petitioner's report of pain as the basis for restrictions. The stated restrictions were not persuasive because they were stated to not last 90 days. It was also factored that the orthopedist stated Petitioner's condition was improving.

On a Medical Examination Report dated [redacted], Petitioner's general medicine physician stated Petitioner had various limitation(s) expected to last 90 days. The physician provided conflicting walking and standing restrictions. Petitioner was deemed capable of sitting 6 hours in an 8 hour workday. Petitioner was restricted from all lifting/carrying, even occasional lifting/carrying of less than 10 pounds. Petitioner was restricted from repetitive leg/foot control operation.

A total lifting/carrying restriction is compelling evidence of disability. The stated restriction was simply not supported by presented evidence. The stated basis for restriction was noted to be Petitioner's reporting of pain. A reporting of pain, by itself, is not persuasive justification of a total/lifting carrying restriction. The restriction was not supported with any radiology. Treatment records other than the Medical Examination Reports were not presented.

Petitioner testified she required a cane for ambulation. A consultative physician stated Petitioner did not require use of a cane. Treating physicians did not reference a need for a cane. The evidence was insufficient to verify Petitioner's need for a cane.

Petitioner's claim of mental disability was similarly not strongly supported. Various marked restrictions were indicated by a psychiatrist. The restrictions were not supported by treatment records. Previous hospitalizations were not verified. A GAF was not indicated. There was not strong correlation between Petitioner's reported symptoms and/or diagnoses to stated marked restrictions.

A consultative examiner not only stated Petitioner had no marked restrictions, it was further stated Petitioner has no cognitive, social, concentration, or memory limitations affecting her ability work. Generally, a treating physician's statements should be given more weight than those of a consultative examiner. In the present case, it cannot be stated that Petitioner's treating physicians had more information to base their opinions than the consultative examiner because few treatment records were not provided.

Presented medical records failed to sufficiently verify restrictions preventing Petitioner's performance of either of her previous jobs. Accordingly, Petitioner is not disabled and it is found MDHHS properly 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 properly denied Petitioner's SDA benefit application dated [redacted], based on a determination that Petitioner is not disabled. The actions taken by MDHHS are **AFFIRMED**.

CG/hw

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

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

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

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

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

DHHS [redacted]

Petitioner [redacted]