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: September 2, 2016
MAHS Docket No.: 16-009191
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on August 15, 2016, from Detroit, Michigan. Petitioner appeared and represented herself. The Department of Health and Human Services (Department) was represented by [redacted], Assistance Payment Supervisor.

ISSUE

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

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On February 4, 2016, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On June 20, 2016, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 1-16).

3. On June 20, 2016, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit B).

4. On July 1, 2016, the Department received Petitioner's timely written request for hearing.

5. Petitioner alleged disabling impairment due to osteoarthritis, osteoporosis, bulging back discs, ankle surgery, balance issues, asthma, depression and anxiety.

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

7. Petitioner is a high school and college graduate.

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

9. Petitioner has an employment history of work as treatment specialist counseling children.

10. Petitioner has a pending disability claim with the Social Security Administration (Exhibit C).

CONCLUSIONS OF LAW

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

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

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

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If

an individual is found disabled, or not disabled, at any step in this process, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In general, the individual has the responsibility to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

Step One

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

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

Step Two

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

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-

workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

The medical evidence presented by the Department at the hearing, which consisted of notes from Petitioner's office visits with her orthopedic surgeon from [redacted] to [redacted] and a [redacted] psychiatric evaluation (Exhibit A, pp. 40-73, 77-82), was reviewed on the record with Petitioner. Petitioner was given the opportunity to provide additional medical documentation at the hearing and to respond to the record presented. The medical evidence presented is summarized below.

An [redacted] CT scan of Petitioner's right ankle showed postsurgical changes of the tibiotalar arthrodesis with adequate osseous bridging. There was also moderate osteoarthrosis of the posterior subtalar joint. (Exhibit A, pp. 38-39).

Petitioner had ankle/foot surgery, a subtalar arthrodesis, of the right foot on [redacted] At her [redacted] office visit, she complained of right foot pain with weight bearing and was using a cane to alleviate the pain. The doctor discussed the possibility of a calcaneal osteotomy on the left foot for residual varus of the hindfoot but wanted to see a complete consolidation of the right subtalar fusion first (Exhibit A, pp. 60-63, 64-67). [redacted] x-rays of the right ankle and foot and left ankle and foot showed incomplete union of the right subtalar arthrodesis and consolidation of the left subtalar arthrodesis. (Exhibit A, p. 69).

Petitioner was diagnosed with osteoarthritis and traumatic arthropathy of the left foot and ankle, and on [redacted] she had ankle/foot surgery, a hindfoot midfoot fusion, calcaneal osteotomy, of the left foot. A [redacted] x-ray of the left foot showed ongoing left hindfoot revision and calcaneal osteotomy. Following the [redacted] surgery, she was placed in a well-padded, well-molded short-leg non-weight-bearing cast (Exhibit A, pp. 48-55, 69). A [redacted] x-ray of the left ankle and foot showed maintenance of position and fixation (Exhibit A, p. 68). [redacted] and [redacted] x-rays of the foot and ankle showed maintenance of position and fixation and interval healing (Exhibit A, p. 68). Because she had mobility issues that impaired her participation in mobility-related activities of daily living, she was prescribed a tall boot and, at the [redacted] visit, she was advised to proceed with WBAT (weight bearing as tolerated) and wean off the boot. Petitioner also complained of intermittent numbness in the toes and the doctor recommended continued observation and an EMG (electromyogram) NCS (nerve conduction studies). (Exhibit A, pp. 44-48.)

A psychiatric assessment of Petitioner was completed by a nurse practitioner on [redacted] and reviewed by a doctor on [redacted]. Petitioner reported crying spells three times weekly, isolating behavior, feeling stressed, experiencing a lot

of anxiety, having panic attacks, fear and paranoia. She also reported auditory hallucinations with derogatory and religious themes. She stated that her symptoms decreased with medications and the hallucinations resolved with an increase in medications. Petitioner reported going to the emergency department several times over the years but no psychiatric hospitalizations. She was diagnosed with major depressive disorder, recurrent, severe with psychotic features. (Exhibit A, pp. 77-82.)

On [redacted], Petitioner's doctor completed a letter indicating that Petitioner was diagnosed with lumbar degenerative disc disease and spondylosis with chronic lumbar radiculopathy and lower extremities weakness, fibromyalgia, bilateral severe primary osteoarthritis of the feet and ankles status post surgeries, hypertension, coronary artery disease, anemia with suspicion of multiple myeloma, anxiety and depression. The doctor indicated that the conditions were chronic, progressive, and affecting her physical and psychological well-being, preventing her from being able to function at a normal level, and debilitating her. The doctor opined that Petitioner was disabled and could not work part-time or full-time in any job for life. (Exhibit 1.) Opinions from a medical source that an individual is disabled may be considered but are not binding in assessing disability. 20 CFR 416.927(d); SSR 96-5p.

On [redacted], Petitioner visited her primary care physician to address her non-alcoholic fatty liver disease, iron deficiency anemia, essential hypertension with goal blood pressure less than 140/90, and fibromyalgia. Her current problem list included hiatal hernia, weakness of both lower extremities, gait instability, idiopathic peripheral neuropathy, chronic lumbar radiculopathy, morbid obesity, gastroesophageal reflux disease, DDD, arteriosclerotic heart disease, history of ankle fusion, iron deficiency anemia, anxiety and depression, chronic headaches, panic attacks, chronic low back pain, cervical radiculopathy, and fibromyalgia. The doctor listed Petitioner's medication list: Zovirax, albuterol, Abilify, Qvar, Zyrtec, Flexeril, Cymbalta, ferrous sulfate, furosemide, hydrochlorothiazide, lidocaine, losartan, meloxicam, Prilosec, Lyrica, Ultram, kenalog, and Ambien. (Exhibit 2).

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step Three

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

In this case, listings 1.02 (major dysfunction of a joint), 1.04 (disorders of the spine), 2.07 (disturbance of labyrinthine-vestibular function), 3.03 (asthma), 12.04 (affective disorders), and 12.06 (anxiety-related disorders) were considered. In this case, Petitioner used a cane and, as such, cannot establish an inability to ambulate effectively, as defined in 1.00B2b. Therefore, the evidence does not support a listing under 1.02. There was insufficient medical evidence to support a listing under the remaining listings.

Because the medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

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

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

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b). The exertional requirements, or physical demands, of work in the national economy are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a). Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools and occasionally walking and standing. 20 CFR 416.967(a). Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds; even though the weight lifted

may be very little, a job is in the light category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. 20 CFR 416.967(b). Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. 20 CFR 416.967(e).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1).

In this case, Petitioner alleges both exertional and nonexertional limitations due to her medical condition. Petitioner testified that she had difficulty with standing, walking and balance and could not walk more than ½ block and back, stand more than 15 minutes, or lift more than two pounds. She testified that she used a cane prescribed by her doctor, and the Department worker confirmed that Petitioner used a cane and had difficulty getting up and walking. Petitioner also testified that her ability to sit was limited by her back pain, which was relieved only if she laid on her bed. She lived with her mother. While Petitioner could care for her personal hygiene and dress herself, her mother did all of the chores in the home and her son did her shopping. She also testified that she suffered from depression and anxiety, resulting in concentration and memory problems, crying spells, isolation, and auditory and visual hallucinations. She testified that she saw a therapist twice monthly and a psychiatrist who prescribed medications.

The medical record shows that Petitioner suffers from significant problems with her feet and ankles that resulted in a subtalar arthrodesis of the right foot on [redacted] and a calcaneal osteotomy of the left foot on [redacted]. Although x-rays showed maintenance of position and fixation and interval healing, Petitioner continued to complain of pain and impaired mobility-related activities of daily living and numbness in the toes. This evidence is sufficient to substantiate the Petitioner's allegations

concerning the intensity, persistence and limiting effects of her foot pain and the resulting significant limitations on her ability to stand and walk. SSR 16-3p.

Petitioner also alleged limitations to her ability to sit. In his [redacted] letter, Petitioner's doctor stated he had treated Petitioner for more than five years and that, in addition to her severe bilateral osteoarthritis of the feet and ankles status post surgeries, she was also diagnosed with lumbar degenerative disc disease and spondylosis with chronic lumbar radiculopathy and lower extremities weakness, fibromyalgia, hypertension, coronary artery disease, and anemia with suspicion of multiple myeloma. He indicated that those conditions were chronic, progressive and preventing her from being able to function at a normal level. Despite the doctor's indication that he had treated Petitioner for over five years, Petitioner did not identify him as a medical source who had treated her within the 12 months of the date she submitted the medical-social questionnaire to the Department identifying her treating sources. (Exhibit A, pp. 17-20.) The doctor, in connection with his letter, did not provide any relevant evidence to support his opinion of Petitioner's limitations, particularly medical signs and laboratory findings. See SSR 06-03p. The absence of such evidence limits the weight given to the doctor's assessment of Petitioner's limitations and it results in the lack of a medically determinable impairment that could reasonably be expected to produce Petitioner's remaining alleged symptoms, particularly those concerning an inability to sit. See SSR 16-3p.

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

With respect to Petitioner's allegations of nonexertional limitations due to her mental condition, the medical evidence is limited to a psychiatric assessment of Petitioner completed by a nurse practitioner on December 10, 2014 and reviewed by a doctor on [redacted] where Petitioner is diagnosed major depressive disorder, recurrent, severe with psychotic features. Petitioner admitted at the hearing that her medications help with her condition. The medical evidence presented shows that Petitioner has mild limitations to her ability to perform basic work activities due to her mental condition. Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild limitations on her nonexertional RFC due to her mental condition.

Petitioner's RFC is considered at both Steps 4 and 5. 20 CFR 416.920(a)(4), (f) and (g).

Step Four

Step 4 in analyzing a disability claim requires an assessment of Petitioner's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). An individual who has the RFC to meet the physical and mental demands of work done in the past is not

disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner's work history in the 15 years prior to the application consists of work as a treatment specialist counseling children. Petitioner's past employment, which required sitting most of the day and minimal lifting, required sedentary physical exertion. Based on the RFC analysis above, Petitioner's exertional RFC limits her to sedentary work activities. Based on her exertional RFC, Petitioner is capable of performing past relevant work. The mild limitations to Petitioner's nonexertional RFC due to her mental condition do not preclude her from engaging in past relevant work. Because Petitioner is able to perform past relevant work, Petitioner is **not** disabled at Step 4 and the assessment ends.

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

DECISION AND ORDER

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

ACE/tlf

Alice C. Elkin
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

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

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

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

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

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

DHHS

[redacted]

Petitioner

[redacted]

Via Electronic Mail:

[redacted]