STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: October 12, 2016
MAHS Docket No.: 16-011403
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 September 14, 2016, 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 terminated 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. Petitioner was an ongoing SDA benefit recipient.

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

3. On [redacted], the Medical Review Team (MRT) determined that Petitioner was not a disabled individual for purposes of SDA eligibility (see Exhibit 1, pp. 14-27), in part, based on a Disability Determination Explanation (Exhibit 1, pp. 28-59).

4. On an unspecified date, MDHHS terminated Petitioner's eligibility for SDA benefits, effective September 2016, and mailed a Notice of Case Action informing Petitioner of the termination.

5. On [redacted], Petitioner requested a hearing disputing the termination of SDA benefits (see Exhibit 1, pp. 2-3).

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. 5. 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 (July 2015), p. 1. A person is disabled for SDA purposes if he [or she]:

- Receives other specified disability-related benefits or services…, 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., pp. 1-2.

Generally, state agencies such as MDDHS must use the same definition of disability as used under SSI regulations (see 42 CFR 435.540(a)). Disability is federally defined as the inability to do any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905. MDHHS adopted a functionally identical definition of disability (see BEM 260 (July 2015, p. 10)). The definition of SDA disability is identical except that only a 90 day period of disability is required.

Substantial gainful activity 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. BEM 260 (July 2015), p. 10. 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 substantial gainful activity. *Id*.

Once an individual has been found disabled for purposes of disability-related benefits, continued entitlement is periodically reviewed in order to make a current determination or decision as to whether disability remains in accordance with the medical improvement review standard. 20 CFR 416.993(a); 20 CFR 416.994. Petitioner's only allegation was that MDHHS improperly failed to certify her to be a disabled individual.

In evaluating a claim for ongoing disability benefits, federal regulations require a sequential evaluation process be utilized. 20 CFR 416.994(b)(5). The review may cease and benefits continued if sufficient evidence supports a finding that an individual is still unable to engage in substantial gainful activity. *Id.* Prior to deciding if an individual's disability has ended, the department will develop, along with the petitioner's cooperation, a complete medical history covering at least the 12 months preceding the date the individual signed a request seeking continuing disability benefits. 20 CFR 416.993(b). The department may order a consultative examination to determine whether or not the disability continues. 20 CFR 416.993(c).

The below-described evaluation process is applicable for clients that have not worked during a period of disability benefit eligibility. There was no evidence suggesting that Petitioner received any wages since receiving disability benefits.

The first step in the analysis in determining the status of a petitioner's disability requires the trier of fact to consider the severity of the impairment(s) and whether it meets or equals a listed impairment in Appendix 1 of subpart P of part 404 of Chapter 20. 20 CFR 416.994(b)(5)(i). If a listing is met, an individual's disability is found to continue and no further analysis is required. This consideration requires a summary and analysis of presented medical documents and testimony.

Medical clinic documents (Exhibit 1, pp. 257-261) from 2011 and 2012 were presented. It was noted Petitioner complained of poor appetite and difficulty coping with stress. It was noted Petitioner expressed unresolved anger over her father's death. As of October 2011, a GAF of 68 was stated. A diagnosis of PTSD (in remission) was noted.

An MRI report of Petitioner's left knee (Exhibit 1, p. 399-400) dated [redacted] was presented. An impression of arthritis and possible grade 1 chondromalacia patella was indicated.

Physician office visit notes (Exhibit 1, pp. 272-274) dated [redacted], were presented. It was noted that Petitioner complained of asthma; medication was prescribed.

Physician office visit notes (Exhibit 1, pp. 301-303) dated [redacted], were presented. It was noted that Petitioner recently went to the ER for asthma treatment. An ongoing complaint of dyspnea was indicated.

Physician office visit notes (Exhibit 1, pp. 352-354) dated [redacted] were presented. A recent ER treatment for asthma was noted. It was noted Petitioner had an upcoming appointment with a pulmonologist. Petitioner reported knee pain was treated by an orthopedist.

Physician office visit notes (Exhibit 1, pp. 348-350) dated [redacted], were presented. Diagnoses of knee contusion and DM (diabetes mellitus) were noted.

Physician office visit notes (Exhibit 1, pp. 344-346) dated [redacted], were presented. Diagnoses of a knee contusion and asthma were noted; Percocet was prescribed.

Physician office visit notes (Exhibit 1, pp. 337-338) dated [redacted], were presented. It was noted that Petitioner reported a chief complaint of cold. Ongoing knee pain was indicated.

Physician office visit notes (Exhibit 1, pp. 333-335) dated [redacted], were presented. It was noted that Petitioner reported depressed mood, work stressors, sleep disturbances, anhedonia, and sadness. Neither a related diagnosis nor treatment was apparent.

Physician office visit notes (Exhibit 1, pp. 340-342) dated [redacted], were presented. Diagnoses for DM and HTN were noted; various medications were prescribed.

Physician office visit notes (Exhibit 1, pp. 298-299) dated [redacted], were presented. It was noted that Petitioner complained of knee pain. Only diagnoses of DM and HTN were stated.

Physician office visit notes (Exhibit 1, pp. 329-331) dated [redacted], were presented. It was noted that Petitioner complained of epigastric pain.

Physician office visit notes (Exhibit 1, pp. 294-296) dated [redacted], were presented. It was noted that Petitioner complained of left knee swelling. A limp was noted. Only a diagnosis of DM was stated.

Physician office visit notes (Exhibit 1, pp. 325-327) dated [redacted], were presented. It was noted that Petitioner reported cold symptoms. Ongoing knee pain was noted.

Physician office visit notes (Exhibit 1, pp. 290-292) dated [redacted] were presented. It was noted that Petitioner complained of knee pain, though a related diagnosis was not stated.

A physician statement (Exhibit 1, p. 245, 378) dated [redacted], was presented. It was noted Petitioner was scheduled for Achilles reparation surgery on January 25th. It was noted Petitioner was estimated to be off from work for 4 months.

Physician office visit notes (Exhibit 1, pp. 268-270) dated [redacted], were presented. It was noted that Petitioner reported left elbow pain following a recent fall on ice. It was noted Petitioner did not regularly check her blood sugar. A plan of continuing DM meds was noted; Percocet was prescribed.

Physician office visit notes (Exhibit 1, pp. 286-288) dated [redacted], were presented. Primary diagnoses of DM screening and acute laryngitis were indicated. Continued limping was indicated.

Physician office visit notes (Exhibit 1, pp. 282-284) dated [redacted], were presented. It was noted that Petitioner requested for her work a letter stating she had asthma. Petitioner complained of left knee pain (noted to be treated by a specialist). It was noted Petitioner limped while ambulating

Physician office visit notes (Exhibit 1, pp. 279-280) dated [redacted] were presented. Percocet was prescribed for joint pain.

Physician office visit notes (Exhibit 1, pp. 321-323) dated [redacted], were presented. It was noted that Petitioner reported left elbow pain following a fall on ice in her driveway. The fall was noted to have occurred a few days prior.

Physician office visit notes (Exhibit 1, pp. 317-319) dated [redacted], were presented. It was noted that Petitioner complained of chest tightness and congestion. Treatment was not apparent.

Physician office visit notes (Exhibit 1, pp. 314-315) dated [redacted], were presented. It was noted that Petitioner's DM was "in check." Ongoing knee pain and limping was noted.

Physician office visit notes (Exhibit 1, pp. 275-277) dated [redacted], were presented. It was noted that Petitioner reported stress, in part, due to her basement flooding. Assessments of HTN, DM, asthma, and joint pain were stated.

Pain center documents (Exhibit 1, p. 396-398) dated [redacted]. It was noted Petitioner underwent a left knee injection.

Physician office visit notes (Exhibit 1, pp. 265-266) dated [redacted], were presented. It was noted that Petitioner reported neck pain related to a work injury. Assessments of DM and cervical strain were indicated.

An MRI report of Petitioner's cervical spine (Exhibit 1, p. 394-395) dated [redacted] was presented. An impression of multilevel disc osteophyte complexes and protrusions causing "mild mass effect" on the thecal sac were noted. A slight contour alteration at C3-C6 was noted.

An MRI report of Petitioner's right shoulder (Exhibit 1, p. 392-393) dated [redacted], was presented. Assessments included the following: moderate-to-severe infraspinatus tendinosis (with tearing), mild-to-moderate supraspinatus tendinosis, and mild bursitis.

Physician office visit notes (Exhibit 1, pp. 311-313) dated [redacted], were presented. It was noted that Petitioner was off from work after pulling a neck muscle while working. An assessment of cervical strain was stated.

Handwritten hospital physician progress notes (Exhibit 1, p. 410) dated [redacted], were presented. It was noted Petitioner reported ongoing pain (8/10) to right Achilles despite passage of 5 weeks since injury. A diagnosis of right Achilles tendonitis was noted; an MRI was ordered.

Pain center documents (Exhibit 1, p. 380-386) dated [redacted] were presented. It was noted Petitioner underwent a cervical epidural steroid injection.

Handwritten hospital physician progress notes (Exhibit 1, p. 411) dated [redacted] were presented. It was noted Petitioner reported no improvement in right ankle pain. Surgery was noted as scheduled for later in the month.

Pain center documents (Exhibit 1, p. 238-244, 246, 371-377, 379) dated [redacted], were presented. It was noted Petitioner reported 9/10 neck pain. It was noted Petitioner underwent a cervical epidural steroid injection.

Hospital notes (Exhibit 1, pp. 412-416) dated [redacted], were presented. It was noted Petitioner underwent debridement of right Achilles rupture, with repair.

Handwritten hospital physician progress notes (Exhibit 1, p. 417) dated [redacted], were presented. It was noted Petitioner was non-weight bearing following Achilles surgery. A follow-up in a week was noted.

Handwritten hospital physician progress notes (Exhibit 1, p. 418) dated [redacted] were presented. It was noted Petitioner reported swelling at her surgery wound. A follow-up in 3 weeks was noted.

Handwritten hospital physician progress notes (Exhibit 1, p. 419) dated [redacted], were presented. It was noted Petitioner reported she was weight bearing on her right side. Wound treatment was noted.

Physician office visit notes (Exhibit 1, pp. 308-310) dated [redacted], were presented. It was noted that right Achilles healing was complicated by continuance of an open wound. Percocet (among other medications) was prescribed.

Handwritten hospital physician progress notes (Exhibit 1, p. 420) dated [redacted], were presented. It was noted Petitioner reported ongoing Achilles pain (6/10). It was noted Petitioner's daughter reported Petitioner was walking on her leg too much. Decreased activity was recommended.

Physician office visit notes (Exhibit 1, pp. 305-307) dated [redacted], were presented. It was noted that Petitioner complained of left knee pain. Petitioner reported an orthopedic specialist planned surgery, though Petitioner wanted a second opinion. Assessments of knee osteoarthritis and Achilles rupture were noted.

Pain center documents (Exhibit 1, p. 221-229) dated [redacted], were presented. It was noted Petitioner reported 8/10 neck pain. It was noted Petitioner underwent a cervical epidural steroid injection.

A mental status examination report (Exhibit 1, pp. 248-250) dated [redacted], was presented. The report was noted as completed by a consultative licensed psychologist. It was noted Petitioner reported a history of various physical health challenges. Reported mental health symptoms included crying spells and difficulty sleeping. Petitioner's memory was assessed as borderline-to-impaired. Petitioner's fund of general knowledge was assessed to be restricted. It was noted Petitioner was able to deal with simple similarities and differences. A diagnosis of "severe" somatic disorder was noted. A guarded prognosis was stated. Petitioner was deemed incapable of managing her own funds, based on her struggles with arithmetic.

Pain center procedure notes (Exhibit 1, p. 210) dated [redacted], were presented. It was noted Petitioner underwent right-sided cervical facet injections.

Pain center documents (Exhibit 1, pp. 217-218, 220) dated [redacted], were presented. It was noted Petitioner reported neck pain radiating to her right arm and hand. Right grip weakness was noted. A conclusion of low level C6 radiculopathy was noted.

Pain center documents (Exhibit 1, pp. 211-216, 219) dated [redacted], were presented. It was noted Petitioner underwent cervical nerve block injections.

A physical medicine examination report (Exhibit 1, pp. 194-201) dated [redacted], was presented. The report was noted as completed by a consultative physician. Petitioner reported complaints of pain in her right shoulder, right ankle pain, left knee, neck, and back pain. It was noted Petitioner ambulated without an ambulatory device, though she wore a right ankle splint. Notable physical examination findings included the following: even shoulders, normal lordosis, painful and decreased cervical range of

motion, zero range of right ankle motion, 5/5 muscle strength, normal reflexes, and negative straight-leg-raising testing. An impression of “multiple medical comorbidities” was stated.

Hospital discharge summary documents (Exhibit 1, pp. 3, 5-9) from an admission dated [redacted], were presented. A diagnosis for major depressive disorder was stated. A follow-up with a mental health treatment agency was indicated.

Petitioner testified she had surgery on her left knee in March 2014. Petitioner testified she experiences pain upon movement because her knee has no cartilage. Petitioner testified she has recurrent knee stiffness. Petitioner thinks the left knee pain indirectly caused her to over-rely on her right side thereby indirectly causing her right ankle injury.

Petitioner testified she tore her right Achilles in October 2015. Petitioner testified she has not returned to work since injuring her ankle. Petitioner testified she underwent surgery in January 2016, though her wound is healing slowly; Petitioner suspects DM is likely the cause for her slow healing.

Petitioner testified she also sprained her right shoulder in October 2015. Petitioner testified she underwent surgery in August 2016. Petitioner testified she is also affected by neuropathy in her right arm.

Petitioner testified she was psychiatrically hospitalized for a week in August 2016. Petitioner testified she knew she needed to go after she hit her grandchild. Petitioner testified she was diagnosed with depression and she now attends weekly psychiatric sessions. Petitioner testified she takes unspecified medications which make her groggy. Petitioner testified she feels worse since starting therapy. Petitioner testified she could not endure the mental demands of her former employment. Petitioner testified she has a lack of appetite; she testified she lost 17 pounds since June 2016. Petitioner reported audio hallucinations (e.g. hearing her granddaughter cry and thinking people are at her door). Petitioner testified she cries literally “all day long”; Petitioner was asked if she truly cries all day long and was steadfast in stating she did. Petitioner testified other symptoms include anxiety attacks, concentration difficulties, mood swings, anhedonia, forgetfulness, crying spells, and hallucinations.

A listing for joint dysfunction (Listing 1.02) was considered based on Petitioner’s complaints of shoulder, knee, and ankle pain. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively and/or unable to perform fine and gross movements with upper extremities. It should be noted that Petitioner testified she requires a walker (which could support ineffective ambulation), but the requirement was not verified by medical documentation.

A listing for spinal disorders (Listing 1.04) was considered based on Petitioner’s lumbar complaints. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root.

A listing for chronic pulmonary insufficiency (Listing 3.02) was considered based on Petitioner's complaints of dyspnea. The listing was rejected due to a lack of respiratory testing evidence.

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 Petitioner failed to establish meeting any SSA listings. Accordingly, the analysis may proceed to the second step.

The second step of the analysis considers whether medical improvement occurred. CFR 416.994(b)(5)(ii). Medical improvement is defined as any decrease in the medical severity of the impairment(s) which was present at the time of the most favorable medical decision that the individual was disabled or continues to be disabled. 20 CFR 416.994(b)(1)(i).

MRT approved Petitioner for SDA on May 3, 2016 (see Exhibit 1, pp. 14-20). MRT approved Petitioner to provide her time to recover her from Achilles tendon surgery. It was noted Petitioner still had an open wound at her surgery site.

Since the MRT approval of SDA, presented medical documents did not indicate surgery wound treatment. The absence of wound treatment tends to verify sufficient healing of Petitioner's surgical wound.

A consultative physician noted Petitioner was weight bearing as of July 2016. The ambulation improvement is also indicative of medical improvement since the original MRT determination of SDA eligibility.

It is found Petitioner has medically improved since MRT approval. Accordingly, the analysis may proceed to the third step.

The third step of the analysis considers medical improvement and its effect on the ability to perform SGA. Medical improvement is not related to the ability to work if there has been a decrease in the severity of the impairment(s) present at the time of the most recent favorable medical decision, but *no* increase in functional capacity to do basic work activities. 20 CFR 416.994(b)(1)(ii). If there has been any medical improvement, but it is not related to the ability to do work and none of the exceptions applies, benefits will be continued. *Id*. If medical improvement is related to the ability to do work, the process moves to step five.

As noted in the first and second step analysis, Petitioner is currently able to ambulate (though Petitioner testified it is with the assistance of a walker). The ability to ambulate improves Petitioner's functional capacity.

It is found Petitioner's medical improvement is related to her ability to work. Accordingly, the analysis may proceed directly to the fifth step.

The fifth 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 durational requirement for SDA eligibility is 90 days (see BEM 260).

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).

Presented documentation sufficiently verified ongoing ambulation and pain restrictions related to right Achilles and left knee dysfunction.. Unresolved neck pain reasonably causing lifting and/or ambulation restrictions were verified. Increasing psychological dysfunction causing memory and concentration restrictions were verified.

It is found Petitioner has ongoing restrictions which have lasted 90 days or longer. Accordingly, Petitioner has a severe impairment and the analysis may proceed to the sixth step.

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

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

Petitioner testified her work history from the last 15 years consists exclusively of work as a nursing assistant. Petitioner's testimony was consistent with the Disability Determination Explanation of SSA (see Exhibit 1, p. 59). Petitioner testified her work duties included lifting of patients, which she can no longer perform.

Petitioner's testimony that she is unable to perform her past and relevant employment was credible and consistent with presented medical records. It is found that Petitioner cannot perform past relevant employment from the past 15 years and the disability analysis may proceed to the final step.

In the seventh and final 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. The definitions for each are listed below.

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 nonexertional. 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 (i.e. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i)-(vi) If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2)

The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific

case situations in Appendix 2. *Id.* In using the rules of Appendix 2, an individual's circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, is compared to the pertinent rule(s).

Given Petitioner's age, education and employment history a determination of disability is dependent on Petitioner's ability to perform sedentary employment. For sedentary employment, periods of standing or walking should generally total no more than about 2 hours of an 8-hour workday. Social Security Rule 83-10.

Petitioner testified she relies on a walker while in her house. Petitioner testified she switches to a cane when ambulating outside of her house because she may have difficulty controlling the walker. Petitioner estimated she is restricted to walking for 1 block before knee and/or foot pain prevent further ambulation. Petitioner testified right heel pain restrict standing to 10-20 minutes. Petitioner testified she has to elevate her left knee for sitting; Petitioner testified she can only sit for 30-60 minutes. Petitioner testified her foot surgeon restricted her lifting/carrying to 5 pounds or less (until foot pain resolves).

Petitioner testified she relies on a health care aide for performance of daily activities. Petitioner testified she cannot independently get in or out of her bathtub. Petitioner testified she can lift her right arm since undergoing surgery. Petitioner testified she is unable to perform housework or cleaning. Petitioner testified she cannot go down her basement stairs to do laundry. Petitioner testified she can go shopping, but is not able to stand and she needs a ride.

Petitioner's testimony was indicative of an inability to perform any employment due to exertional limits. Petitioner's testimony was not persuasively supported.

Numerous primary care physician office visit documents were presented, however, the documents were not updated well. For example, a June appointment noted a slip and fall on ice from a few days earlier (the slip and fall was first documented during a winter month). Also, many of the notes referenced past injuries as complaints, while not documenting ongoing treatment or diagnoses.

Many of the primary care physician appointment notes also referenced treatment by specialists. For example, it was noted Petitioner saw a pulmonologist for asthma treatment and an orthopedist for knee treatment. Orthopedic and pulmonologist records were not presented.

Petitioner testified she utilizes a walker for ambulation assistance and a health care aide to assist with daily activities. Neither need was verified by presented medical documents.

Petitioner testified she was recently psychiatrically hospitalized for a week. A hospital discharge related to psychological symptoms was verified, however, few details, including the length of the stay, were not verified.

Presented medical documentation failed to verify important allegations of restriction. Despite an absence of records to support many allegations of restrictions, presented records verified some degree of restriction.

In July 2016, a consultative physician noted Petitioner was unable to tandem walk, toe walk, or heel walk. Petitioner's gait was noted to be antalgic, with right-sided limping. Squatting, bending, stooping, pushing/pulling, standing, and walking were each noted to be limited. The statements were generally consistent with Petitioner's history of left knee dysfunction, right ankle surgery, and epidural neck injections. The stated restrictions are consistent with an inability of performing light employment.

The same consultative physician noted Petitioner's ability to sit was unlimited. The absence of restriction was consistent with an ability to perform sedentary employment.

Consideration was given to restricting Petitioner to only certain types of sedentary employment based on verified right shoulder dysfunction. Radiology from November 2015 verified multiple abnormalities which are indicative of chronic tendinitis. The abnormalities were categorized as moderate-to-severe and mild-to-moderate. Subsequent right shoulder treatment was not verified (possibly because Petitioner's focus was on right ankle treatment). The evidence was not sufficient to infer right shoulder restrictions precluding the performance of sedentary employment.

It is found Petitioner is capable of performing the exertional requirements of sedentary employment. The analysis will proceed to determine Petitioner's non-exertional restrictions.

A consultative examiner in May 2016 diagnosed Petitioner with "severe" somatic disorder. Generally, any "severe" psychological disorder is indicative of restrictions allowing only the simplest of employment.

It is also notable that Petitioner's complaints of pain were consistent with presented documents. Abnormalities in Petitioner's cervical spine, right shoulder, left knee, and right ankle were documented. A need for multiple cervical spine injections was verified.

It is also notable that the consultative examiner provided a "guarded" prognosis. Generally, a guarded prognosis is indicative of obstacles to improvement. The prognosis appeared to be justified based on Petitioner's psychological-related hospitalization in August 2016.

Presented evidence was suggestive that Petitioner appears capable of performing relatively simple sedentary employment. One possible job would be as a telemarketer. It

was compelling that Petitioner testified she recently attempted such employment and was told to "get it together" as she had difficulty with memorizing her script and sounding cheerful enough.

MDHHS did not present evidence of jobs that Petitioner could perform or the availability of those jobs. If Petitioner is capable of the simplest sedentary jobs, it is not known what jobs those would be

Based on Petitioner's combined exertional and non-exertional restrictions, it is doubtful that Petitioner can perform employment in the near future. It is found Petitioner is currently incapable of performing any employment and that she a disabled individual. Accordingly, the termination of Petitioner's SDA eligibility was improper.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that MDHHS improperly terminated Petitioner's eligibility 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 eligibility, effective September 2016;
(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 no less than twelve months from the date of this administrative decision, if Petitioner is found eligible for future benefits.

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

CG/hw

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

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

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

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

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

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

DHHS

[redacted]

Petitioner

[redacted]