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: March 6, 2017
MAHS Docket No.: 16-019320
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 [redacted], from [redacted] 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. 7-13).

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

5. [redacted], Petitioner requested a hearing disputing the denial of SDA benefits.

6. As of the date of the administrative hearing, Petitioner was a [redacted]-year-old female.

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

8. Petitioner has a history of past and relevant employment from the last 15 years that she is unable to perform.

9. Petitioner's highest education year completed was the [redacted] grade.

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

11. Petitioner has various impairment and restrictions preventing her from performing light (or more exertional) employment.

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 (January 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, p. 207) dated [redacted] The notice did not include a page stating the basis for denial but it was not disputed that the basis for application denial was a MDHHS determination that Petitioner was not disabled.

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 a summary of presented medical documentation.

A CT cervical spine report (Exhibit 1, p. 197) dated [redacted], was presented. Radiology was performed in response to complaints of dizziness, headache, and neck pain. Stenosis was noted to be absent. Degenerative disc disease was noted.

A cervical spine MRI report (Exhibit 1, p. 199-200) dated [redacted], was presented. Multiple ostephyte complexes causing indents on the thecal sac were noted. Spinal cord contour alteration was noted.

A brain MRI report (Exhibit 1, p. 203) dated [redacted], was presented. An abnormally long TR signal was noted. No evidence of acute process was also noted.
Various otolaryngologist office visit notes and hearing testing results (Exhibit 1, p. 88-101) from 2015 were presented. Normal right-side hearing was noted. Mild-to-profound left-sided hearing loss was noted.

Hospital physician office visit notes (Exhibit 1, p. 103) dated [redacted], were presented. It was noted that Petitioner underwent a septoplasty due to difficult left nostril breathing.

Hospital physician office visit notes (Exhibit 1, p. 102) dated [redacted], were presented. Post-septoplasty treatment was noted.

A lumbar spine MRI report (Exhibit 1, pp. 200-201) dated [redacted], was presented. The radiology was noted as performed in response to complaints of right leg pain and numbness. Mild facet arthropathy at L3-L4 and L4-L5 were noted.

Pain specialist physician office visit notes (Exhibit 1, pp. 114-119, 135-139, 153-162; Exhibit A, pp. 3-6) dated [redacted], were presented. It was noted Petitioner was a new patient reporting worsening neck, lumbar, ankle, hip, and knee pain. It was noted Petitioner completed physical therapy (PT) for her ankle and neck in [redacted]. Pain was reported to be 8/10, at its worst. Aggravating factors included activity. Pain medication and reduced activity were noted to reduce pain. Decreased right-sided sensation was noted. Cervical spine strength was noted to be reduced, along with reduced ranges of motion. Various lumbar spine ranges of motions were noted as reduced. Right-sided rotator cuff strength was noted to be 4/5. Diagnoses included lumbar spine spondylosis without myelopathy or radiculopathy, cervical spine spondylosis without myelopathy or radiculopathy, bilateral sciatica, and osteoarthritis. Norco and Tramadol were prescribed. A body scan was planned.

Pain specialist physician office visit notes (Exhibit 1, pp. 108-113) dated [redacted] were presented. “Significant” ongoing neck and lumbar pain (8/10) was reported. Medication was noted to reduce pain to 3-4/10. Petitioner reported “significant drowsiness” when taking medication. Poor sleep and activity was reported. Norco and Tramadol were noted as current medications. Various reductions in cervical and lumbar spine ranges of motion were noted. Reduced strength and sensation of the right upper extremity was noted. It was noted Petitioner underwent a right shoulder lidocaine injection. It was noted Petitioner would likely need lumbar injections in the future.

Pain specialist physician office visit notes (Exhibit 1, pp. 105-107, 132) dated [redacted] were presented. It was noted that decreased lumbar pain was reported. Sleep and quality of life were noted as improved. An approximate 75% right shoulder pain relief was noted since last injection. PT for lumbar spine was noted as pending insurance approval. Tramadol was continued.

Pain specialist physician office visit notes (Exhibit 1, pp. 128-131) dated [redacted] were presented. Generic discharge instructions for various injections were noted.

Primary care physician office visit notes (Exhibit 1, p. 29) dated [redacted] were presented. It was noted that Petitioner reported right-side pain, knee pain, and congestion. Treatment details were not documented.

Hospital emergency room documents (Exhibit 1, pp. 48-59) dated [redacted] were presented. It was noted that Petitioner presented after she was assaulted and knocked backwards causing her to lose consciousness. Petitioner reported a headache, back pain, and neck pain. Right-side weakness was noted in a neurological examination. A brain CT was noted to be normal. A cervical spine CT report indicated mild degenerative changes and cervical spine straightening. A follow-up in 3 days was recommended.

Pain specialist physician office visit notes (Exhibit 1, pp. 79-81, 126-127) dated [redacted], were presented. It was noted that Petitioner underwent medial block branch injections to address lumbar pain. A next day follow-up noted Petitioner reported her pain was “still gone” (see Exhibit 1, p. 78)

Primary care physician office visit notes (Exhibit 1, p. 28) dated [redacted], were presented. Petitioner reported stomach pain. Diagnoses of acute diverticulitis and anxiety. Medication was prescribed.

Otolaryngologist treatment documents (Exhibit 1, p. 87) dated [redacted], were presented. Assessments included hearing loss. Treatment for allergies was noted. It was noted Petitioner had not gotten a hearing aid due to insurance problems.

A left breast mammogram report (Exhibit 1, p. 30) dated [redacted], was presented. An impression of a simple left breast cyst was noted.

A hip x-ray report (Exhibit 1, pp. 201-202) [redacted], was presented. No abnormalities were noted.

Handwritten physician office visit notes (Exhibit 1, p. 184) dated [redacted], were presented. It was noted that Petitioner had an unsteady gait and relied on a cane. Ongoing diagnoses included asthma, high blood pressure, DM, and arthritis. Various medications were continued.

Pain specialist physician office visit notes (Exhibit 1, pp. 74-76) dated [redacted] were presented. It was noted that Petitioner reported ongoing back pain (8/10). Improved sleep and quality of life was noted since last visit. Various lumbar range of motion restrictions were noted. Straight-leg-raising testing was negative. Right shoulder range of motion and strength (4/5 to 4+/5) was reduced. A plan of medial block injections was noted. Norco and Tramadol were continued.

Pain specialist physician office visit notes (Exhibit 1, pp. 70-73) dated [redacted] were presented. It was noted that Petitioner reported a pain level of 7/10. Current

medications included Norco and Tramadol. Various lumbar range of motion restrictions were noted. Straight-leg-raising testing was negative. Right shoulder range of motion and strength was reduced. A follow-up in a month was planned.

Handwritten physician office visit notes (Exhibit 1, p. 181) dated [redacted], were presented. It was noted that Petitioner had an unsteady gait. Ongoing diagnoses included asthma, high blood pressure, DM, and arthritis. Various medications were continued. An operative report (Exhibit 1, p. 181) of the same date noted Petitioner underwent a right index finger injection block.

Handwritten physician office visit notes (Exhibit 1, p. 180) dated [redacted] were presented. It was noted that Petitioner relied on a cane. Diagnoses included asthma, high blood pressure, and diabetes mellitus (DM).

Pain specialist physician office visit notes (Exhibit 1, pp. 68-69) dated [redacted], were presented. It was noted that Petitioner received medial branch block injections. A pre-procedure pain level of 7/10 was noted. Petitioner's pain level post-procedure was 3/10.

Neurologist office visit notes (Exhibit 1, pp. 204-205) dated [redacted] were presented. Head, lumbar, right leg, right shoulder, pain and numbness were reported. Tinel's test was positive bilaterally. Patrick's test was positive for right hip pain. Gait testing was noted to be slow and cautious. Fibromyalgia was noted to be the most likely diagnosis.

A psychiatric intake assessment (Exhibit 1, pp. 33-36) dated [redacted], was presented. It was noted Petitioner lost [redacted]sons in the past. It was noted that Petitioner lost her job in [redacted] after sleeping on the job due to medications. Petitioner reported an increase in depression since losing employment. Symptoms of poor appetite and low energy were reported. Petitioner reported increased anxiety since a robbery and/or assault. Petitioner also reported increased stress due to an incarcerated child. Zoloft was prescribed. A plan of continued therapy was noted. Activity was encouraged. Diagnoses included anxiety disorder, PTSD, and depression (recurrent and moderate).

Primary care physician office visit notes (Exhibit 1, p. 25) dated [redacted], were presented. Only a diagnosis for "BEH" was noted.

Handwritten physician office visit notes (Exhibit 1, p. 179) dated [redacted], were presented. It was noted that Petitioner had an unsteady gait and relied on a cane. Prescribed medications included Lasix, gabapentin, Lisinopril, and Zocor.

Psychiatric medication review notes (Exhibit 1, pp. 37-38) dated [redacted] were presented. Petitioner reported ongoing depression, though feeling better. Zoloft dosage was doubled.

Neurologist office visit notes (Exhibit 1, pp. 206-207) dated [redacted], were presented. Petitioner reported ongoing body pains (8/10) since last visit. Right grip and right lower extremity strength was noted to be 4/5. It was noted Petitioner relied on a cane, though she could walk without one.

Pain specialist physician office visit notes (Exhibit 1, pp. 65-67) dated [redacted] were presented. It was noted that Petitioner reported ongoing pain (7/10). Petitioner reported the last injection helped for approximately 2 weeks before pain returned. A strength of 5-/5 was noted in left quadriceps, right ankle dorsiflexion, and right foot. Range of motion was restricted in lumbar and right shoulder. A nerve block injection was planned.

Otolaryngologist treatment documents (Exhibit 1, p. 86) dated [redacted], were presented. Assessments included hearing loss. Treatment for allergies was noted. A plan of a hearing aid was noted.

PT documents (Exhibit 1, pp. 141-148) dated [redacted] were presented. A pain level of 7/10 was noted. Complaints of headaches, sleep difficulty, lack of activity, concentration difficulty due to moderate pain was noted. The following restrictions were reported by Petitioner: sitting for more than an hour, standing longer than 30 minutes, walking without a cane/walker, and a limited social life. Reduced strength in hip, ankle, and knee were noted. Petitioner was noted to be at risk for falling.

Primary care physician office visit notes (Exhibit 1, p. 24) dated [redacted] were presented. Only assessments for CHF and BEH were noted.

Psychiatric medication review notes (Exhibit 1, pp. 39-40) dated [redacted] were presented. Petitioner reported ongoing poor sleep, low appetite, and low energy. Petitioner's Zoloft dosage was doubled.

A social worker letter (Exhibit A, p. 7) dated [redacted], was presented. It was noted that Petitioner was diagnosed with major depressive disorder (severe with psychotic symptoms), PTSD, and anxiety disorder. Medications included sertraline and aripiprazole.

A physician letter (Exhibit A, pp. 1-2) dated [redacted], was presented. The authoring physician stated Petitioner was treated for CHF, coronary artery disease, right-sided weakness, HTN, asthma, chest pain, osteoarthrosis, GERD, obesity, and chronic pain syndrome. Current medications included Norco, Tramadol, Zocor, Singular, Lisinopril, and Coreg.

Petitioner's testimony did not allege any impairments related to psychological conditions. A limited amount of psychological/psychiatric treatment was established. The treatment history was sufficient to establish some degree of impairment to

concentration and social interactions. The majority of Petitioner's stated impairments concerned physical problems.

Petitioner testified she has ongoing right-sided pain and/or weakness. Medical records noted Petitioner reported a stroke in [redacted] causing right-sided weakness (see Exhibit 1, p. 114).

Petitioner testified she has ongoing spinal pain. Medical records indicated Petitioner first experienced cervical pain in [redacted] following a car accident (see Exhibit 1, p. 114). Medical records indicated Petitioner a fall at work contributed to back pain (see Exhibit 1, p. 114).

Petitioner reported ankle pain. Medical records referenced an unspecified ankle surgery in [redacted] (see Exhibit 1, p. 114).

Petitioner testified she attended PT from [redacted] to [redacted] Petitioner testified PT did not relieve her body pain.

Petitioner testified she was recently given a TENS unit to help relieve pain. Petitioner testified she feels pain relief for a couple of days after using the TENS unit.

Petitioner testified she has undergone multiple pain relief injections. Petitioner testified the injections help for about a month before her pain returns.

Petitioner reported ongoing problems with drowsiness. Petitioner testified she has fallen asleep twice while standing, the last time she caught herself from falling. Petitioner thinks her medications cause her drowsiness.

Petitioner testified she experiences daily fibromyalgia flare-ups. Petitioner testified the flare-ups typically last 2-3 hours. Petitioner testified she takes Gabapentin when a flare-up occurs.

Presented medical records generally verified a medical treatment history consistent with Petitioner's allegations of restrictions. The treatment history was established to have lasted at least 90 days and at least since Petitioner's date of SDA application. Accordingly, it is found that Petitioner established having a severe impairment and the disability analysis may proceed to Step 3.

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

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 perform fine and gross movements with both upper extremities.

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 hearing loss (Listing 2.10) was considered. The listing was rejected due to auditory testing results not meeting listing requirements.

A listing for chronic pulmonary insufficiency (Listing 3.02) was considered based on a diagnosis for asthma. The listing was rejected due to a lack of respiratory testing evidence.

Cardiac-related listings (Listing 4.00) were considered based on references to CHF treatment. Petitioner failed to meet any cardiac listings.

A listing based on central nervous system vascular accidents (Listing 11.05) was considered based on Petitioner's reported stroke history. The listing was rejected due to a failure to establish motor function disorganization in two extremities or ineffective speech or communication.

A listing for inflammatory arthritis (Listing 14.09) was considered based on Petitioner's complaints of arthritis. The presented medical records were insufficient to establish that Petitioner has an inability to ambulate effectively, perform fine and gross movements, or suffers inflammation or deformities with a diagnosis of ankylosing spondylitis or other spondyloarthropathies, or suffers repeated manifestations of inflammatory arthritis.

It is found that Petitioner failed to establish meeting (or equaling) 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 performed employment as a building attendant. Petitioner testified included stripping floors, cleaning offices, and cleaning restrooms. Petitioner credibly testified that she would be unable to operate the heavy machinery (e.g. buffing machines), mopping, lifting/carrying, and/or bending required of the employment.

Petitioner testified she worked for several years in a telephone call center for a city water department. Petitioner testified her employer required employees to handle [redacted] calls per day, with a 5 minute minimum call duration. Petitioner testimony implied her entire day involved sitting and talking on the telephone.

Petitioner testified she might be able to work 3-4 hour shifts at the call center, but she would eventually need to take medications to relieve pain caused by extended sitting. Presented medical records were suggestive that Petitioner could perform the sedentary duties of her past employment. Petitioner identified multiple non-exertional obstacles in perform her past employment.

Petitioner testified that hearing loss would make performance of her past employment problematic. Hearing loss was verified in Petitioner's left ear. Medical records also suggested that a hearing aid, which was not verified as obtained, would increase Petitioner's hearing.

The degree of left-sided hearing loss was not verified. A mild-to-severe hearing loss was stated. The wide range of possible hearing loss provides little insight into whether employment involving telephone customer service is realistic. Petitioner testified she had "not a lot" of hearing loss, which is not particularly indicative of an inability to perform past employment.

Petitioner testified that recurring drowsiness would be an obstacle to performing past employment. Presented records were suggestive that drowsiness could be a recurring problem, though not necessarily to the extent of finding that Petitioner could not perform past employment. Petitioner testimony provided insight with a story from her employment.

Petitioner testified she was written-up at work for falling asleep during a telephone call with a customer. Petitioner also testified she also often failed to adequately document her telephone calls; Petitioner testimony implied a reduced concentration level due to medication side effects and/or diagnoses were to blame. Petitioner testified that she ultimately quit her job to avoid from being fired. Petitioner testified that an involuntary termination would have voided her right to a pension. Petitioner's testimony was consistent with what she reported to her physician (see Exhibit 1, p. 114). Petitioner's story was poignant and credible.

Petitioner might be able to perform her past employment for a very accommodating and forgiving employer. Such an employer is not known to be available for Petitioner.

It is found Petitioner is not capable of performing past employment. Accordingly, the disability 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 light employment. Social Security Rule 83-10 states that the full range of light work requires standing or walking, off and on, for a total of approximately 6 hours of an 8-hour workday.

Petitioner testified she relied on a cane to ambulate. Petitioner testimony estimated she cannot walk more than a block, due to lumbar pain. Petitioner testified back pain limits her standing to 1 hour. Petitioner testified her sitting is restricted to 1-2 hour periods. Petitioner estimated she cannot lift more than 15 pounds. Petitioner testified her grip is weak and that she often drops items.

Petitioner testified she can independently bathe/shower, but needs to hold onto bars. Petitioner testified she can dress herself other than needing someone to zip her boots, because her hands are not strong enough to do it. Petitioner testified she is very limited in housework, though she washes dishes. Petitioner testified she avoids going into her basement and cannot carry clothes so does no do laundry. Petitioner testified she cannot shop alone and that she relies on a scooter to get around the store. Petitioner testified she can drive, but not for long periods of time.

Generally, Petitioner's testimony was indicative of an inability to perform light employment. The testimony will be compared to presented records.

Physician statements of Petitioner restrictions were not presented. Restrictions can be inferred based on presented documents.

Petitioner's gait was regularly noted as unsteady. A need for a cane was not verified, though use of a cane was regularly documented. The reliance on a cane was highly indicative of an inability to perform the standing, lifting/carrying, and/or ambulation required of light employment.

Neurologist and pain specialist records regularly noted various musculoskeletal restrictions. Cervical spine, lumbar spine, and right upper extremity range of motion were regularly noted. Loss of right-sided strength was regularly noted. Right-sided neurology was noted to be reduced. Presented evidence was highly suggestive of restrictions that would prevent the standing and ambulation needed for light employment.

Without even factoring Petitioner's difficulty in concentrating due to pain and/or drowsiness, it was established that Petitioner could not perform light employment. It is found that Petitioner is restricted to sedentary employment, at most.

Based on Petitioner's exertional work level (sedentary), age (approaching advanced age), education (high school with no direct entry into skilled work), employment history (unskilled), Medical-Vocational Rule 201.12 is found to apply. This rule dictates a finding that Petitioner is disabled. Accordingly, it is found that MDHHS improperly found Petitioner to be not disabled for purposes of SDA benefits.

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/

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]