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 3, 2017
MAHS Docket No.: 17-000171
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] hearing facilitator.

ISSUE

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

FINDINGS OF FACT

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

1. On [redacted], Petitioner applied for SDA benefits (see Exhibit 1, pp. 4-24).

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. 246-250) based on a Disability Determination Explanation (Exhibit 1, pp. 251-266).

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

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

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

7. Petitioner has a history of unskilled light employment involving cleaning and cooking duties.

8. Petitioner has various restrictions related to fibromyalgia, lupus, knee pain, back pain, and depression that would prevent the performance of any 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).

Petitioner's hearing request noted an authorized hearing representative. Petitioner appeared for the hearing without her AHR. MDHHS also submitted documentation of representation. During the hearing, MDHHS' representative was contacted. On the record, MDHHS waived their right to representation. The hearing proceeded without either side being represented based on the waivers of representation.

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, pp. 571-572) dated [redacted] verifying Petitioner's application was denied based on a 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.

An Initial Psychiatric Evaluation (Exhibit 1, pp. 174-176, 472-474) dated [redacted] was presented. It was noted that Petitioner reported crying spells and hallucinations of her mother. It was noted Petitioner's mother passed away in [redacted] and that Petitioner was close with her. Suicide attempts in [redacted] and [redacted] were noted. Examination assessments included sad affect, orientation x3, and normal speech. An Axis I diagnosis of major depressive disorder (severe with psychotic features) was noted. Petitioner's Global Assessment of Functioning *(*GAF) score was 55.
Mental health treatment plan documents (Exhibit 1, pp. 156-170, 474-480) and outpatient discharge summaries (Exhibit 1, pp. 214-239; 469-471) ranging from [redacted] were presented. Treatment goals included eliminating negativity, eating more nutritionally, and exercising more often. A diagnosis of depression (severe with psychotic features) was regularly noted. Ongoing medication therapy was noted.

Various mental health agency outpatient progress notes (Exhibit 1, pp. 177-209) ranging from [redacted] through [redacted] were presented. It was regularly noted that Petitioner reported ongoing depression and poor sleep.

Physician office visit notes (Exhibit 1, pp. 434-441) dated [redacted], were presented. Treatment for breast abscesses was noted. It was noted Petitioner took Norco for body pains.

Physician office visit notes (Exhibit 1, pp. 429-433) dated [redacted], were presented. It was noted a pap smear was abnormal, in part, based on oozing breast abscesses. It was noted Petitioner used a rolling walker. Gout was stable.

Rheumatologist office visit notes (Exhibit 1, pp. 113-117) dated [redacted], were presented. Ongoing complaints of joint pain was noted. Physical examination findings were unremarkable. Diagnoses of polyarthropathy and lumbago were noted. Various lab work was ordered.

A lumbar spine MRI report (Exhibit 1, pp. 145-146) dated [redacted], was presented. Disc degeneration was noted at multiple levels, each without significant stenosis. Severe foraminal narrowing was noted at L4-L5.

Ophthalmologist office visit notes (Exhibit 1, pp. 127-131) dated [redacted], were presented. It was noted Petitioner needed regular eye testing due to Plaquenil treatment. It was noted Petitioner complained of recurrent blurry vision, ongoing for a year. Eye testing was unremarkable (see Exhibit 1, pp. 137-144).

Physician office visit notes (Exhibit 1, pp. 424-428) dated [redacted], were presented. It was noted Petitioner wanted nicotine gum to try to quit smoking. Petitioner reported chronic back pain and leg pain (6/10). Various medications were refilled.

Rheumatologist office visit notes (Exhibit 1, pp. 109-112) dated [redacted], were presented. Petitioner reported sudden left arm pain, ongoing for 1 month. Petitioner was noted to be tearful when reporting that she could not move her arm. Pain was noted to be likely tissue-related. It was noted that Petitioner was recently started on plaquenil based on low suspicion for lupus. A recommendation of emergency room treatment was noted.

A Psychiatric Evaluation Update (Exhibit 1, pp. 171-173) dated [redacted], was presented. A history of medication noncompliance was indicated. Petitioner's moods were reported as "kind of ok." Poor sleep and concern about medical problems were noted. An ongoing diagnosis of depression was noted. Petitioner's GAF continued to be [redacted] Monthly medication reviews were planned.

Hospital emergency room documents (Exhibit 1, pp. 89-91) dated [redacted], was presented. It was noted that Petitioner complained of left shoulder and left-sided

back pain. Toradol was given and Petitioner's condition improved. A diagnosis of acute musculoskeletal pain, possibly related to fibromyalgia, was noted.

Physician office visit notes (Exhibit 1, pp. 414-419) dated [redacted], were presented. 97% oxygen test results were noted. An assessment of bronchitis/COPD was noted. Chest x-rays were ordered.

Neurologist office visit notes (Exhibit 1, pp. 113-117) dated [redacted], were presented. Middle and lumbar back pain radiating to right leg was noted. Pain management was recommended. Physical examination findings were negative.

Rheumatologist office visit notes (Exhibit 1, pp. 103-108) dated [redacted], were presented. Severe left foraminal narrowing due to a disc protrusion and facet arthropathy was noted in L4-L5. It was noted the L4 spinal nerve was contoured because of the disc protrusion. It was noted Petitioner declined PT and planned to have a pain injection in her lumbar spine. Lyrica was noted to stabilize fibromyalgia.

Ophthalmologist office visit notes (Exhibit 1, pp. 122-124) dated [redacted] were presented. Normal eye test results were noted. A dilated fundus exam (DFE) was planned.

A Physician's Transportation Restriction Form (Exhibit A, p. 2) dated [redacted], was presented. It was noted Petitioner was medically unable to walk ½ mile. It was noted Petitioner used a walker. It was noted pertinent medical conditions included chronic back pain, arthritic knee pain, fibromyalgia, lupus, and dizzy spells.

Physician office visit notes (Exhibit 1, pp. 409-411) dated [redacted], were presented. Diagnoses of HTN, gout, depression, and nicotine dependence were noted. It was noted Petitioner utilized a rolling walker.

Ophthalmologist office visit notes (Exhibit 1, pp. 118-121) dated [redacted], were presented. Normal eye test results were noted following DFE.

An Integrated Biopsychosocial Assessment Form (Exhibit 1, pp. 481-522) dated [redacted] was presented. The assessment was signed by a clinical manger from a mental health treatment agency. It was noted Petitioner's initial treatment began [redacted]. Depression symptoms were noted to be stable. Petitioner denied any history of hallucinations. Mental health assessments included orientation x4, distractible concentration, limited insight, loosely-organized thought process, delayed response, soft speech, guarded presentation, sad affect, and depressed mod. It was noted Petitioner could walk without a walking-assistance device. A primary Axis I diagnosis of major depressive disorder (recurrent and severe) was noted. Petitioner's GAF was 55.

A cervical spine x-ray report (Exhibit 1, pp. 65-66) dated [redacted], was presented. An impression of mild spurring at C4 was noted. Minimal disc narrowing and minimal retrolisthesis was noted at C4-C5 and C5-C6.

Gynecologist treatment records (Exhibit 1, pp. 60, 63, 67-70) dated [redacted], were presented. A complaint of pelvic pain was noted. Petitioner reported having twice per month menstrual cycles. Radiology noted a cyst in both ovaries.

Gynecologist treatment records (Exhibit 1, pp. 71-73) dated [redacted], were presented. normal findings were noted following a hysteroscopy.

Gynecologist office visit notes (Exhibit 1, pp. 52-57) dated [redacted], were presented. It was noted Petitioner presented for a surgical follow-up to polypectomy. A plan for a hysterectomy was noted.

Gynecologist office visit notes (Exhibit 1, pp. 74-80) dated [redacted], were presented. Ongoing complaints of irregular menstrual cycles and pelvic pain were noted. Pain was noted to be relieved by Tylenol. Gynecological examination findings were normal.

Physician office visit notes (Exhibit 1, pp. 400-403) dated [redacted], were presented. It was noted that Petitioner presented for ongoing hypertension (HTN) treatment. A review of systems were all negative. Prescribed medications included Lisinopril, Lasix, potassium, Plaquenil, ranitidine (for gastritis), Claritin (for sinusitis), and Colace (for constipation),

Rheumatologist office visit notes (Exhibit 1, pp. 97-102, 451-465) dated [redacted] were presented. Ongoing treatment for lupus and fibromyalgia was noted. Systemic lupus erythematosus (SLE) symptoms were noted to be mild and stable. Fibromyalgia pain was reported as moderate. Mild osteoarthritic degenerative changes were noted in Petitioner's right knee (see Exhibit 1, pp. 87-88). It was noted that Petitioner underwent bilateral knee Kenalog injections; PT was refused by Petitioner.

Physician office visit notes (Exhibit 1, pp. 395-397, Exhibit A p. 3) dated [redacted] were presented. Ongoing HTN treatment was noted. It was noted that Petitioner's BMI was 38.2.

A mental status examination report (Exhibit 1, pp. 379-387) dated [redacted], was presented. The report was noted as completed by a consultative licensed psychologist. Petitioner reported symptoms of social difficulties, paranoia, hallucinations of her mother, and anhedonia. It was noted Petitioner reported that the television sometimes told her messages, such as not to leave the home or that her situation will be okay. Noted observations of Petitioner made by the consultative examiner included logical and goal-directed speech and adequate contact with reality. The examiner opined that Petitioner displayed a moderate capacity to concentrate. Immediate memory

was noted to be a slight strength. Petitioner was deemed best suited for simple repetitive tasks requiring little independent judgment. A fair prognosis was noted.

Petitioner testified her body “locks-up” 3-4 times per week. Petitioner clarified “locks-up” refers to swelling. Petitioner testified swelling affects her hands, arms, legs, feet, and ankles. Petitioner testified the swelling has been ongoing for [redacted] years. Petitioner testified speculated that fibromyalgia flare-up is the likely cause. Petitioner testified she has received pain shots when flare-ups are unbearable.

Petitioner testified she has ongoing knee pain. Petitioner testified her treatments include knee injections and pain medication. Petitioner testified a gel injection from [redacted] helped relieve pain, but only for 2 weeks.

Petitioner testified she has ongoing back pain, related to sciatica problems. Petitioner testified she takes nerve and muscle relaxer medication to treat the pain. Petitioner testified she’s also tried pain medication injections.

Petitioner testified she has ongoing psychological symptoms. Petitioner testimony estimated she has crying spells three times per week. Petitioner testified other symptoms include isolating herself, and screaming. Petitioner testified she sees a psychiatrist monthly.

Petitioner testified she has one previous psychiatric hospitalization. Petitioner recalled she was hospitalized after she had a knife and was screaming. Petitioner recalled the corresponding hospitalization lasted [redacted] days.

Petitioner testified she has dizzy spells twice per week. Petitioner testified the spells are caused by a “little” tumor in head. Presented evidence was not indicative of any diagnosis or symptoms related to a head tumor.

Petitioner testified she was diagnosed with hidradenitis. Petitioner testified she has a history of multiple surgeries. Though some treatment for breast abscesses were established, ongoing restrictions related to hidradenitis was not established.

Presented medical records generally verified a medical treatment history for fibromyalgia, SLE, knee pain, chronic back pain, and psychiatric problems. Impairments affecting walking, standing, lifting/carrying, sitting, and/or concentration, and anxiety are supported. The treatment history and related restrictions were established to have lasted at least 90 days and at least since Petitioner’s date of SDA application. Accordingly, it is found that Petitioner established having a severe impairment and the disability analysis may proceed to Step 3.

The third step of the sequential analysis requires determining whether the Petitioner’s impairment, or combination of impairments, is listed in 20 CFR Part 404, Subpart P, appendix 1. 20 CFR 416.920 (a)(4)(iii). If a petitioner’s impairments are listed and deemed to meet the durational requirement, then the petitioner is deemed disabled. If

the impairment is unlisted or impairments do not meet listing level requirements, then the analysis proceeds to the next step.

A listing for joint dysfunction (Listing 1.02) was considered based on Petitioner's complaints of knee pain. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively.

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

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

A listing for sleep apnea (Listing 3.10) was considered. The listing was rejected due to a failure to meet the requirements of Listings 3.09 or 12.02.

A listing for chronic skin infections (Listing 8.04) was considered based on treatment for breast abscesses. The listing was rejected due to a failure to establish extensive fungating or extensive ulcerating skin lesions that persist for at least [redacted] months despite continuing prescribed treatment.

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

It is found that Petitioner failed to establish meeting (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 her past full-time employment (from the last 15 years) included work as a supervisor at an adult foster care home. Petitioner testified her duties included janitorial duties such as washing clothes and cooking. Petitioner testified she also monitored 4-8 patients.

Petitioner testified she also worked as a dietary aide. Petitioner testified her duties were to serve food for patients at a nursing home. Petitioner testified her duties included dish washing and cleaning the kitchen.

Petitioner testified she performed employment as a hotel housekeeper. Petitioner testimony was the expected duties of cleaning hotel rooms and common areas.

Petitioner testimony implied that her past full-time jobs required standing and lifting/carrying that she can no longer perform due to her various ailments. Petitioner's testimony was consistent with presented evidence. It is found Petitioner is unable to perform past employment and 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 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 is supposed to use a rolling walker for ambulation, but she currently uses no walking-assistance device. Petitioner testified she is capable of

walking less than a block before she would likely fall from dizziness. Petitioner testimony estimated she can only stand for 15-20 minutes before back pain prevented further standing. Petitioner testified she is restricted to sitting of 15-30 minute periods (this was stated after Petitioner had been sitting for [redacted] minutes during the hearing). Petitioner testified her primary care physician restricted her to 5 pounds of listing/carrying. Petitioner testified she cannot independently ambulate on stairs because of the potential for falling.

Petitioner testified she needs help entering and exiting the bathtub when her body is swollen. Petitioner testified she also needs help with dressing when her body is swollen. Petitioner testified she is unable to perform housework. Petitioner testified she cannot help with laundry because she is unable to go downstairs to where her washer/dryer are. Petitioner testified she cannot perform her own shopping.

Petitioner's testimony was generally indicative of an inability to perform any employment. Petitioner's testimony was somewhat supported by physician statements.

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

A Medical Needs form (Exhibit 1, p. 423) dated [redacted] was presented. The document was signed by Petitioner's primary care physician. Diagnoses of HTN, gout, fibromyalgia, lupus, sciatica, and sleep apnea were noted. It was noted Petitioner required special transportation; no explanation was provided. It was noted Petitioner needed assistance with toileting, bathing, grooming, dressing, transferring, taking medications, meal prep, shopping, laundry, and housework. Petitioner was deemed to be incapable of working for the rest of her life.

The Medical Needs form was supportive of finding that Petitioner is unable to perform sedentary employment. The document was fairly well supported.

Presented radiology verified no canal stenosis, though *severe* foraminal narrowing was verified. A description of "severe" foraminal narrowing is indicative of severe pain from possible nerve root compression. The radiology is indicative very limited standing and ambulation abilities. For good measure, cervical spine radiology also verified disc degeneration contributing to Petitioner's overall pain.

Diagnoses for lupus and fibromyalgia were verified. Petitioner's complaints of fibromyalgia flare-ups and swollen limbs were not well substantiated, however, the diagnoses, by themselves, likely exacerbate Petitioner's overall pain and further restrict Petitioner's abilities.

Consistent psychological impairment were sufficiently verified. Throughout Petitioner's psychological treatment history, Petitioner's GAF was 55. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF within the range of 51-60 is representative of someone with moderate symptoms or any moderate difficulty in social, occupational, or school functioning. The GAF, by itself, is not indicative of psychological impairments preventing employment. The GAF, when combined with Petitioner's other restrictions, is indicative of severe concentration difficulties due to pain.

During the hearing, Petitioner was asked if she could perform sedentary office employment. Petitioner testified her pain levels would be difficult to overcome. Petitioner also testified that she takes so much medication, that she doubted she would be alert enough to perform any employment. Petitioner's testimony was consistent with presented evidence.

Petitioner handwrote her current list of medications (see Exhibit A, p. 1). Petitioner listed 24 medications which included Norco, Lisinopril, Lasix, Lyrica, Lexapro, Seroquel, Buproprion, Lipitor, Plaquenil, Protonix, Symbicort, and Spiriva. The medication list is indicative of side effects that would reasonably contribute to drowsiness.

It is found that Petitioner's combined impairments would prevent the performance of any employment. Accordingly, Petitioner is disabled and it is found that MDHHS improperly denied Petitioner's SDA application.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that MDHHS improperly denied Petitioner's application for SDA benefits. It is ordered that MDHHS begin to perform the following actions within 10 days of the date of mailing of this decision:

(1) reinstate Petitioner's SDA benefit application dated [redacted]
(2) evaluate Petitioner's eligibility subject to the finding that Petitioner is a disabled individual;
(3) initiate a supplement for any benefits not issued as a result of the improper application denial; and
(4) schedule a review of benefits in one year from the date of this administrative decision, if Petitioner is found eligible for future benefits.

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

CG/hw

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

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

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

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (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]

Counsel for Respondent

[redacted]

Counsel for Petitioner

[redacted]

Petitioner

[redacted]