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 17, 2017
MAHS Docket No.: 17-000476
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.

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

3. On [redacted], the Disability determination Service determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 5-11).

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 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. Spinal dysfunction renders Petitioner unable to perform past employment or sedentary 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 checked a dispute concerning Family Independence Program (FIP) benefits. Petitioner testified a dispute of cash assistance based on disability (i.e. SDA) was intended. MDHHS was not confused by Petitioner's error and prepared for an SDA dispute. MDHHS had no objections to proceeding with a SDA dispute and the hearing was conducted accordingly.

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. 218-219) 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.

Petitioner testified she was in a motor vehicle in [redacted] when another vehicle "t-boned" her vehicle. Petitioner testified the accident caused injuries to her head, neck, right shoulder, left hip, back, and hand. Petitioner testified a second car accident on [redacted], aggravated her injuries. The testimony was consistent with various statements to physicians.

Neurosurgeon office visit notes (Exhibit 1, pp. 145-146) dated [redacted], were presented. It was noted that Petitioner complained of ongoing neck pain which radiated to her arms. Diagnoses included cervical radiculopathy, lumbar radiculopathy, headache, and shoulder dysfunction. A plan of physical therapy (PT) was noted.

Neurosurgeon office visit notes (Exhibit 1, p. 147) dated [redacted], were presented. It was noted that Petitioner complained of ongoing neck pain which radiated to her

arms. A physical examination noted back tenderness and spasms. A plan of PT and pain medication was noted. A referral to an orthopedist was noted.

Neurosurgeon office visit notes (Exhibit 1, p. 148) dated [redacted], were presented. It was noted that Petitioner complained of no improvement in radiating neck pain. A plan of continuing PT and pain meds was noted.

Neurosurgeon office visit notes (Exhibit 1, p. 149) dated [redacted] were presented. It was noted that Petitioner complained of no improvement in radiating neck pain. C4-C5 fusion surgery was planned.

Nerve studies (Exhibit A, pp. 1-2) dated [redacted] were presented. An impression of bilateral CTS caused by motor vehicle accident was noted.

Physician office visit notes (Exhibit 1, pp. 196-200) dated [redacted], were presented. Petitioner reported as a new patient complaining of lumbar, neck, bilateral wrist, bilateral shoulder, and head pains. Severe tender points were noted on bilateral trapezius muscles. Arm elevation was noted to be difficult for Petitioner. A cervical spine MRI was noted to show disc herniations and lordosis straightening, though no stenosis. A lumbar MRI was noted to show disc space narrowing from L5-S1. PT and various medications were ordered.

Neurosurgeon office visit notes (Exhibit 1, p. 150) dated [redacted], were presented. It was noted that Petitioner complained of no improvement in radiating neck pain. An x-ray was noted to demonstrate reverse neck lordosis and a labral tear in right shoulder.

Neurologist office visit notes (Exhibit 1, p. 36-38) dated [redacted], were presented. Petitioner complained of lower extremity paresthesia and headache. Complaints of memory impairments, moodiness, irritability, anxiety, concentration difficulty, and depression were also noted. Normal back curvature was noted. Balance errors were noted on unipedal stance testing. Tandem gait difficulty was noted. A plan of an EEG and brain MRI was noted. PT was recommended.

Neurologist office visit notes (Exhibit 1, p. 35) dated [redacted] were presented. It was noted that Petitioner underwent a one hour awake and asleep qEEG. A normal impression was noted.

Physician office visit notes (Exhibit 1, pp. 194-195) dated [redacted], were presented. Petitioner reported bilateral shoulder, lumbar, head, and bilateral wrist pain. Petitioner reported frustration with managing pain. Petitioner reported she may undergo lumbar surgery.

Hospital notes (Exhibit 1, pp. 40-46, 57-85, 95-116) from an admission dated [redacted] were presented. It was noted Petitioner underwent spinal fusion of C4-C5

surgery. It was noted Petitioner required follow-up surgery to repair a spinal fluid leak on [redacted]. A discharge date of [redacted] was noted.

Neurologist office visit notes (Exhibit 1, pp. 33-34) dated [redacted], were presented. It was noted that Petitioner presented for qEEG and MRI results. Significant improvements in executive function were noted. PT was ordered.

Physician office visit notes (Exhibit 1, pp. 191-193) dated [redacted], were presented. Petitioner reported bilateral wrist, neck, and head pains. Long-term opioids was recommended but declined by insurance. Various medications were continued.

Neurosurgeon office visit notes (Exhibit 1, p. 152) dated [redacted], were presented. The visit was noted to be a routine follow-up following surgery. Petitioner was noted to be “doing well.”

Neurosurgeon office visit notes (Exhibit 1, p. 151) dated [redacted], were presented. Surgical wound treatment was noted.

Physician office visit notes (Exhibit 1, pp. 189-190) dated [redacted], were presented. Petitioner reported 10/10 pain after not receiving pain meds due to insurance obstacles. Morphine-sulfate was prescribed.

Physician office visit notes (Exhibit 1, pp. 186-188) dated [redacted], were presented. It was noted Petitioner reported reduction in pain due to medications. Cervical range of motion was improved. Bilateral arm strength was improved. Bilateral shoulder range of motion was improved. PT and various medications were continued.

Physician office visit notes (Exhibit 1, pp. 183-185) dated [redacted], were presented. It was noted Petitioner reported resurgent back pain, in part, due to insurance not covering PT. Pain was reported to be 10/10 due to absence of pain medication. PT and various medications were continued.

Hospital notes (Exhibit 1, pp. 50-53, 89-92) dated [redacted], were presented. Ongoing treatment for right shoulder pain was noted. It was noted that [redacted]previous pain injections had failed.

Physician office visit notes (Exhibit 1, pp. 180-182) dated [redacted], were presented. It was noted Petitioner appeared in distress after difficulty filling pain medication prescription and not being able to participate in PT. Left hip pain was noted to be 7/10. PT and various medications were continued.

Physician office visit notes (Exhibit 1, pp. 177-179) dated [redacted] were presented. It was noted Petitioner complained of various pains, primarily in the right hip (6/10 pain level at rest). Physical examination assessments included markedly

decreased right shoulder motion, behavior consistent with pain, and restricted range of motion due to left lumbar muscle pain. PT and various medications were continued.

A qEEG report (Exhibit A, pp. 18-30, 33-35) dated [redacted], was presented. Results were noted to be “highly suggestive” of diffuse cerebral dysfunction and a traumatic brain injury. Results were noted to be consistent with diminished functionality. Symptoms potentially consistent with findings included mood swings, aphasia, diminished logic, short-term memory loss, vertigo, and low energy.

Neurosurgeon office visit notes (Exhibit 1, p. 153) dated [redacted], were presented. Petitioner reported improved neck and arm pain. Improved neck range of motion was noted. Lumbar range of motion was noted to be decreased. It was noted Petitioner walked with a cane. A referral to an orthopedist was planned to address Petitioner’s complaints of lower back pain.

Neurologist office visit notes (Exhibit 1, pp. 30-31) dated [redacted] were presented. It was noted that Petitioner complained of ongoing severe headaches with pain level 10/10, occurring three times per week. Other reported problems included bilateral hip pain (10/10) causing painful ambulation, bilateral knee pain including swelling, poor sleep pattern, poor appetite, visual disturbance, depression, anxiety, and poor memory. Physical examination assessments included fidgety hands, bobbing feet, left head tilt, straightening of cervical spine, severe hypertonicity with spasms in right sternocleidomastoid muscle, significantly reduced cervical spine flexion and rotation, apraxia of speech, delayed responsive speech, and poorly sustained attention. A broad-based gait was noted. Impressions included post-concussive syndrome, executive function deficit with memory impairments, cervicogenic migraine disorder, chronic pain, balance disorder, organic mood disorder, and medication side effects. A plan included a change of medications, continuing PT and chiropractor visits and neuropsychological evaluation.

Physician office visit notes (Exhibit 1, pp. 172-175) dated [redacted], were presented. It was noted Petitioner complained of lumbar pain worsening after a recent fall. Ongoing intractable neck pain was reported. Pain in various ranges of motion were noted. A positive FABER sign in hips was noted. It was noted Petitioner ambulated with a cane. Petitioner underwent a left hip steroid injection. PT and various medications were continued.

Neurologist office visit notes (Exhibit 1, p. 29) dated [redacted] were presented. It was noted that Petitioner complained of ongoing severe headaches. It was noted Petitioner requested approval for Adderall instead of morphine.

Physician office visit notes (Exhibit 1, pp. 168-171) dated [redacted], were presented. It was noted Petitioner complained of ongoing neck, lumbar, left hip, and right shoulder pain. A steroid injection in hip during last visit was reported to be relieving for [redacted] weeks. An MRI was noted to demonstrate a rotator cuff tear in right shoulder. It

was noted insurance problems precluded surgical intervention. Petitioner reported back pain causes leg weakness and unsteady gait. Petitioner reported she was undergoing psychiatric care for depression. Paraspinal tenderness and spasms were noted. Pain was noted in ambulation and arising from seated position. Right upper extremity weakness was noted. A left hip steroid injection was performed. PT and pain medication were continued.

Hospital emergency room documents (Exhibit 1, pp. 117-126) dated [redacted] were presented. It was noted that Petitioner presented with neck pain following a motor vehicle accident. Complaints of neck pain (10/10), headaches and radiating back pain was noted. A cervical spine CT report noted no evidence of abnormality, though it was noted an angiography could be more insightful. Follow-up with a neurosurgeon to ensure proper hardware placement was recommended. It was noted Petitioner ambulated with a cane. A small aneurysm was noted following brain radiology. Pain medication was prescribed.

Neurosurgeon office visit notes (Exhibit 1, p. 154) dated [redacted], were presented. Radiology noted surgical hardware was in place. Ongoing assessments of cervical spine pain, lumbar pain, headaches, and shoulder pain were noted. PT was planned.

Hospital emergency room documents (Exhibit 1, pp. 127-134) dated [redacted], were presented. It was noted that Petitioner complained of dizziness, ongoing since [redacted] worse in the last [redacted] days. Photophobia and eye pain was also noted. It was noted Petitioner's symptoms improved with Adderall, though she had not taken any the last 2-3 months due to insurance problems. An EKG showed no acute process. Chronic anemia was noted. An absence of neurological deficits was noted. Vertigo was noted to be likely caused by unspecified neurological dysfunction. Vyvanse and Adderall were prescribed.

Physician office visit notes (Exhibit 1, pp. 164-167) dated [redacted], were presented. Complaints of intractable back and left hip pain were noted. Petitioner reported losing [redacted] pounds since starting PT. Petitioner reported pain affects her ADLs, social relationships, physical activity, and sleep. It was noted Petitioner received disability certification for transportation services. A loss of lower extremity strength was noted. Petitioner was noted to ambulate with a cane. PT, pain medications, and other medications were continued. It was noted Petitioner would be referred to a pain specialist if pain did not lessen.

Hospital emergency room documents (Exhibit 1, pp. 135-138) dated [redacted], were presented. It was noted complained of neck and left shoulder pain. It was noted Petitioner had not followed-up with her neurosurgeon as recommended. Normal neck and left shoulder range of motion was noted. No neurological deficits were noted. Pain medication was prescribed.

Physician office visit notes (Exhibit 1, pp. 160-163) dated [redacted], were presented. Complaints of worsening hip and neck pain were noted. A bilateral hip MRI noted a subchondral cyst (see Exhibit A, pp. 31-32. Lumbar paraspinal tenderness and spasms were noted. Straight-leg raising weakness consistent with hip pain was noted. It was noted Petitioner underwent a steroid hip injection. Assessments included trochanteric left hip bursitis, chronic post-traumatic headache (intractable), post-laminectomy syndrome, cervicalgia, and lumbar pain. PT for Petitioner's back pain was ordered.

A cervical spine MRI report (Exhibit A, pp. 3-8) dated [redacted], was presented. Cervical lordosis straightening was noted. Thecal sac compressions due to disc bulges and/or retrolisthesis at C2-C3, C3-C4, C5-C6, C6-C7, and C7-T1 were noted.

A brain MRI report (Exhibit A, pp. 8-10) dated [redacted] was presented. A recommendation of close clinical correlation and 6-month follow-up were noted.

Petitioner testified she is reliant on a cane. Petitioner testified she is vulnerable to falls without a cane. Petitioner testified she has used a cane since[redacted].

Petitioner testified she recurrently (20-30 times per day) experiences shooting pains down her arms and legs. Petitioner testified she takes medication 3-4 times per day to minimize the pain.

Petitioner testified she has recurring back spasms in her middle and lower back. Petitioner also testified she has left hip pain due to a cyst and arthritis.

Petitioner testified the fusion surgery she underwent improved her neck pain, though not completely. Petitioner testified the surgery only addressed the pain caused by C4-C5 disc dysfunction, but not other cervical spine problems. Petitioner testified she still has muscle spasms and numbness. Petitioner testified she underwent a second surgery to repair leaking spinal fluid shortly after fusion surgery. Petitioner testified she underwent a third neck surgery to repair surgical hardware knocked loose in a separate motor vehicle accident. Petitioner testified she experienced no improvement of pain following the surgery.

Petitioner testified she attends massage therapy twice per week. Petitioner testified she currently attends physical therapy for her neck, back, and arms three times per week. Petitioner testified she also attends occupational therapy once per week; reported occupational therapy tasks include picking up coins and brain teasers to help with her memory. Petitioner testified that she suspected a closed-head injury causes recurrent memory difficulties. Petitioner also testified she is often sleepy, in part, due to having to take 12 medications.

Petitioner testified she underwent surgery in [redacted] to repair right-sided rotator cuff and bicep tears. Petitioner testified her arm is still in a sling.

Petitioner testified she regularly saw a psychiatrist until [redacted] when some problem occurred with her medical coverage. Psychiatric treatment records were not presented.

Petitioner testified she has various degrees of standing, ambulation, siting, lifting/carrying, fatigue, and memory restrictions. Presented medical records generally verified a medical treatment history consistent with general statements 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 hip and shoulder pain. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively or that Petitioner is unable to perform fine and gross movements with 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 organic mental disorders (Listing 12.02) was considered based on a diagnosis of closed-head injury. This listing was rejected due to a failure to establish marked psychological restrictions or a mental disorder of 2 years duration that imposes more than a minimal limitation on Petitioner's ability to perform basic work activities.

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 has previously worked as a machine operator and spot welder. Petitioner testified her duties required regular lifting of at least 10 pounds. Petitioner testified she is not capable of performing the required lifting of this past employment.

Petitioner testified she also held various supervisory/manager positions with fast food restaurants. Petitioner testified her employment required extended periods of standing. Petitioner testified she could not perform the required standing of this past employment.

Petitioner's testimony that she is unable to perform past, relevant employment from the past 15 years was credible and consistent with presented records. It is found Petitioner cannot perform past employment and the 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 estimated she can walk for 10 minutes with a cane before leg weakness and/or shaking prevents further ambulation. Petitioner testimony estimated she is capable of standing for only 5 minutes before her legs get weak. Petitioner testified walking stairs increases dyspnea.

Petitioner testified she has been limited to lifting/carrying 5 pounds since [redacted] Petitioner testified she experiences hand cramps which sometimes affects her ability to open medication bottles.

Petitioner testimony estimated she could sit 4 hours in an 8 hour workday. Petitioner suspects that sitting longer would cause leg and lumbar pain.

Petitioner testified she can independently bathe and dress herself, though she does these activities slowly. Petitioner testified she can sweep her house, but she does no other chores. Petitioner testified she shops, but relies on a scooter. Petitioner testified she has not driven since [redacted] because of restricted neck motion and right shoulder pain.

Petitioner's testimony of restrictions was somewhat indicative of an inability to perform sedentary employment. The testimony will be evaluated against presented physician statements of restriction.

A Physical Residual Functional Capacity Assessment (Exhibit 1, pp. 12-19) dated [redacted], was presented. The authoring physician appeared to complete the assessment based on medical documents submitted as part of Petitioner's SSA claim. Petitioner was deemed capable of occasional lifting/carrying of 20 pounds. Petitioner was deemed capable of standing/walking about 6 hours in an 8 hour workday. Petitioner was deemed capable of walking without a cane for "reasonable" distances, though it was stated she should use a cane for "long" distances. Petitioner was deemed capable of sitting about 6 hours in an 8 hour workday. Petitioner was deemed capable of unlimited pushing/pulling. Petitioner was deemed capable of occasional crawling, crouching, kneeling, stooping, and climbing. No limitations were placed on Petitioner's hand manipulation or communication. Stated justification for the assessments included an absence of cervical spine stenosis, normal ranges of neck motion, normal neurology, and full muscle strength. Petitioner was deemed capable of performing light employment.

The stated assessments were highly indicative of an ability to perform sedentary employment. The assessments appeared to substantially overstate Petitioner's abilities.

To support the assessments, hospital records dated [redacted], were cited. The hospital records were surrounded by numerous treatment records regularly noting range of motion restrictions to Petitioner's neck and arms. The cited hospital records appeared to be a poor representations of Petitioner's abilities.

The assessing physician cited a normal CT of the neck and head as support for the restrictions. The assessing physician did not acknowledge the cervical spine straightening noted in radiology, both before and after the [redacted] CT report.

Cervical spine straightening (i.e. lordosis) is indicative of dysfunction causing neck and head pain.

It is also not understood how the assessor found Petitioner was capable of standing 6-8 hours in a workday when hip dysfunction, ambulation with a cane, and a loss of leg strength was verified.

Presented assessments were not found credible. Other assessments were not presented. Petitioner's capabilities can be inferred based on presented evidence.

Presented evidence verified multiple neck disc bulges, cervical spine lordosis, some loss of leg strength, and hip pain due to bursitis. The sum of Petitioner's problems was highly indicative of an inability to perform any employment other than sedentary employment.

It was notable that a neurologist observed many obstacles indicative of severe pain and dysfunction in [redacted]. "Severe" hypertonicity and "significantly" reduced range of cervical spine motion are consistent with high pain levels and severe cervical spine dysfunction. Apraxia of speech and a delay in speech are also indicative of high pain creating non-exertional obstacles to performing any activity. The possibility of performing sedentary employment is even more remote given additional treatment history of headaches, memory impairment, and vertigo.

It is appreciated that Petitioner has attempted numerous treatments (PT, occupational therapy, injections) but found little improvement in symptoms. It is further appreciated that Petitioner's reported work history is indicative of someone not malingering.

It is found Petitioner is not capable of performing any level of employment due to combined exertional and non-exertional impairments. 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]

**Petitioner**

[redacted]