STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: June 9, 2017
MAHS Docket No.: 17-004677
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 May 10, 2017, from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], specialist, and [redacted], manager.

## 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. 774-796).

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.

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

7. As of the date of the administrative hearing, Petitioner was a 41-year-old female.

8. Petitioner's highest education year completed was the 12th grade.

9. Petitioner has no past relevant employment amounting to SGA.

10. Petitioner has restrictions which allow the performance of non-complex light employment outside of the medical and restaurant fields.

## 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 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. 16-19) dated [redacted], verifying Petitioner's application was denied based on a determination that Petitioner was not disabled.

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*.

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.

Physician office visit notes (Exhibit 1, pp. 708-715) dated [redacted], were presented. Petitioner reported bilateral knee pain (7/10 pain level). Petitioner reported improving epigastric pain related to GERD. Petitioner reported chronic knee, neck, and thumb pain. Petitioner reported wanting to attend a new pain clinic because she refused injections at her last clinic. A referral to a new pain clinic was noted. It was noted Petitioner recently lost 45 pounds while on a walking program.

Hospital emergency room documents (Exhibit 1, pp. 740-743, 753-754) dated [redacted], were presented. Petitioner reported upper abdominal pain and nausea with vomiting. It was noted Petitioner requested and was denied narcotic medication multiple times. Petitioner left against medical advice.

Hospital emergency room documents (Exhibit 1, pp. 638-642, 736-739) dated [redacted], were presented. Petitioner reported a recent fall down stairs. Left-sided second finger and left third toe pain was reported. Finger and toe x-rays were noted to be unremarkable. Sexually transmitted disease (STD) treatment was noted.

Hospital emergency room documents (Exhibit 1, pp. 626-633) dated [redacted], were presented. A recent diagnosis for gonorrhea was noted. STD treatment was noted.

Hospital emergency room documents (Exhibit 1, pp. 603-605) dated [redacted], were presented. Discharge diagnoses of acute pharyngitis and candida vaginitis were noted.

Hospital emergency room documents (Exhibit 1, pp. 621-625, 705-707) dated [redacted] were presented. Complaints of cough, wheezing, and asthma flare-ups were noted. Chest radiology was negative. A diagnosis of moderate asthma with acute exacerbation was noted. Petitioner received STD treatment.

Social worker counseling notes (Exhibit 1, pp. 701-704) dated [redacted], were presented. Petitioner presented with cuts and bruises on her arm. Petitioner reported she was assaulted by her niece. Concern over Petitioner's homelessness was noted.

Physician office visit notes (Exhibit 1, pp. 690-700) dated [redacted], were presented. Treatment for vaginal itch, thrush, depression, and asthma was noted; various medications were prescribed. A referral to a pain management specialist for treatment of spinal stenosis was noted.

Physician office visit notes (Exhibit 1, pp. 685-689) dated [redacted], were presented. A diagnosis of bacterial vaginosis was noted.

Hospital emergency room documents (Exhibit 1, pp. 616-620) dated [redacted], were presented. Treatment for trichomonas was noted.

Hospital documents dated [redacted] through [redacted] (Exhibit 1, pp. 161-162, 180-272, 572-597) were presented. It was noted Petitioner presented with suicidal ideation, ongoing for 2 weeks. It was noted Petitioner's niece recently struck her in the back of the head; neck pain (level 8/10 at admission) was reported. Petitioner reported the following recent stressors: loss of subsidized housing, loss of custody of children, arrest for prostitution, HIV diagnosis, and death of mother. Panic attacks and insomnia were reported. Various medications were prescribed, including Celexa Motrin, Albuterol, and Zofran. It was noted Petitioner denied drug use though drug testing was positive for cocaine. Cervical spine x-rays noted a history of spinal fusion with mild reversal of lordosis. A plan of placement in a psychiatric facility was noted.

Hospital documents (Exhibit 1, pp. 163-179, 273-330) from an admission dated [redacted] were presented. Behavioral health progress notes dated [redacted], indicated Petitioner's complaints of back pain (8/10). Behavioral health progress notes dated July 26, 2016, indicated Petitioner missed multiple group therapy appointments. Behavioral health progress notes dated [redacted], indicated Petitioner's planned to attend group therapy. A discharge date of [redacted], was noted.

A Crisis Residential Discharge Summary (Exhibit 1, pp. 744-750) dated [redacted], was presented. It was noted Petitioner reported no suicidal ideation, though lability and

anxiety were ongoing. It was noted Petitioner had not used crack cocaine in the last month and that she hoped to remain sober.

Hospital emergency room documents (Exhibit 1, pp. 383-387, 504-507, 724-728) dated [redacted], were presented. Petitioner presented with a complaint of face sores, ongoing for 1 week. A diagnosis of facial cellulitis was noted. Petitioner was advised to use warm compresses. Medications were prescribed.

Hospital emergency room documents (Exhibit 1, pp. 606-612, 677-680) dated [redacted], were presented. Petitioner complained of a chin abscess, ongoing for 5 days. Bactrim and Keflex were prescribed. STD treatment was noted.

Social worker counseling notes (Exhibit 1, pp. 668-676) dated [redacted], were presented. Petitioner reported hopelessness over her life. Petitioner reported a recent loss of child custody, expected homelessness, and recent HIV diagnosis. Petitioner reported “everyone I know uses crack cocaine.” Petitioner’s PHQ score was 16; Petitioner’s depression was scored as moderately severe.

Physician office visit notes (Exhibit 1, pp. 494-496, 658-667) dated [redacted], were presented. It was noted Petitioner presented with a depressed mood, though suicidal ideation was denied. Diagnosis for depression (unspecified type) and anxiety were noted.

Hospital emergency room documents (Exhibit 1, pp. 566-571, 716-717) dated [redacted], were presented. Petitioner reported she was assaulted a month earlier and has ongoing back pain. Hip and chest radiology were negative for abnormalities. A diagnosis of body pain was noted.

Optical physician encounter notes (Exhibit 1, pp. 523-525) dated [redacted], were presented. Astigmatism was diagnosed. A script for new glasses was provided.

Social worker counseling notes (Exhibit 1, pp. 653-657) dated [redacted], were presented. Mental health exam assessments included euthymic mood, clear speech, normal cognition, normal judgment, and normal insight. Two previous suicide attempts were noted; both were noted to have occurred before Petitioner began outpatient therapy.

Hospital emergency room documents (Exhibit 1, pp. 388-392, 462-464, 718-723) dated [redacted], were presented. Petitioner presented with a complaint of cough congestion, ongoing for 2-3 days. Ongoing right-sided lumbar pain, ongoing that day, was also reported. Prednisone was prescribed medication to assist with breathing. Tylenol was prescribed for pain.

Hospital emergency room documents (Exhibit 1, pp. 559-565, 729-735) dated [redacted], were presented. Petitioner presented with complaints of sore throat

and cough, ongoing for a week. Chest radiology was negative. Treatment for an upper respiratory infection was noted.

Hospital emergency room documents (Exhibit 1, pp. 393-398, 458—462) dated [redacted], were presented. Treatment for an upper respiratory infection was noted.

Physician office visit notes (Exhibit 1, pp. 338-341) dated [redacted], were presented. It was noted Petitioner presented to obtain Ensure supplements.

Hospital emergency room documents (Exhibit 1, pp. 399-405, 408--411) dated [redacted], were presented. Complaints of abdominal cramping, upper neck pain, and bilateral shoulder pain were noted. Dicyclomine, Bentyl, and starter Norco were prescribed.

Physician office visit notes (Exhibit 1, pp. 335-337) dated [redacted], were presented. It was noted that Petitioner presented for immunization treatment. Prescribed medications included Symbicort, Prevacid, triumeq, Ventolin, gabapentin, Neurontin, and albuterol.

Hospital documents (Exhibit 1, pp. 143-155) from an admission dated [redacted] were presented. It was noted that Petitioner presented with complaints of increased suicidal ideation. It was noted Petitioner overdosed on Neurontin. Petitioner was positive for cocaine; Petitioner reported cocaine use of 1-2 times per month. Various medications, including Celexa, gabapentin, and trazadone were administered throughout hospitalization. Improved mood and reduced suicidal ideation were noted. A discharge date of [redacted], was noted. Noted discharge diagnoses included depression, anxiety, and substance use disorders. It was noted Petitioner would be attending a treatment center for at least 14 days following discharge. A good long-term prognosis was noted, if Petitioner was committed to treatment and abstaining from drug use.

An internal medicine examination report (Exhibit 1, pp. 128-137) dated [redacted], was presented. The report was noted as completed by a consultative physician. Petitioner reported cervical spine pain, non-radiating lumbar pain, bilateral hand pain, body pain, fatigue, and headaches. Petitioner cried when discussing HIV status. Notable physical examination findings included positive right Tinel's sign, positive left-sided Phalen's, and muscle strength of 5/5 in all extremities (though left lower extremity weakness and paresthesia was separately noted). Reductions in all cervical spine and lumbar spine range of motion were noted. 8/18 positive fibromyalgia trigger points were noted. Petitioner's tandem walk, toe walk, and heel walk were noted to be normal. A 20-pound lifting/carrying restriction was noted. Restrictions included no squatting, limited sitting, limited standing, and limited bending. The examiner checked a line between "yes" and "no" in response to whether Petitioner had standing restrictions. The examiner stated that clinical evidence did not support a need for a cane.

A mental status examination report (Exhibit 1, pp. 118-123) dated [redacted], was presented. The report was noted as completed by a consultative licensed psychologist. Petitioner reported having her face broken by a former boyfriend in 2011. Petitioner reported losing custody of children in 2016 because she was incarcerated. Psychiatric treatment ongoing for 3 months was reported. Petitioner reported being afraid of men, flashbacks of sexual abuse, and nightmares, mood fluctuation, depression episodes lasting 3-4 weeks followed by energetic episodes, daily crying episodes, hygiene abandonment, suicidal ideation, audio hallucinations, and visual hallucinations. Mental health exam assessments included apprehensive attitude, no appearance of responding to internal stimuli, anxious mood, and intact hygiene. Diagnoses included bipolar disorder I (with psychotic features), PTSD, alcohol use disorder, and substance use disorder. A fair prognosis was noted. Petitioner was deemed unable to manage funds due to a concern of substance abuse.

Petitioner was diagnosed with HIV in April 2016 (see Exhibit 1, p. 148). Petitioner testified her condition is stable. Presented HIV treatment records (Exhibit 1, pp. 334-374) were consistent with Petitioner's testimony.

Petitioner alleged restrictions, in part, due to lumbar pain. Petitioner testified she has a history of physical therapy and cervical spine fusion surgery in 2011. Petitioner testified she cannot currently receive epidural injections due to her pregnancy.

Petitioner presented a physician letter (Exhibit A, p. 1) dated [redacted]. The letter stated Petitioner had a high risk pregnancy and that it would beneficial if she had safe housing. Pregnancy, by itself, is not indicative of restrictions. A "high risk" pregnancy may be indicative of restrictions.

Petitioner testified she was hospitalized for 2 weeks in February 2017 due to a suicide attempt by drug overdose. Corresponding medical records were not provided.

Petitioner alleged restrictions, in part, due to PTSD, depression and anxiety. Petitioner testified she spends most of her days in bed. Petitioner testified she has anxiety around other people. Petitioner testified she experiences flashbacks and crying spells on a daily basis. Petitioner testified psychological medications include Abilify, Celexa, and Neurontin.

Petitioner testified her family does not allow her to shop by herself. Petitioner testified she used public transportation to get to the hearing.

Presented medical records generally verified some degree of knee and back pain which likely restricts Petitioner's ability to ambulate, lift/carry, and stand. Presented medical records also verified a psychiatric treatment history indicative of restrictions to concentration and social interaction. Petitioner's 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 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 complaints of lumbar pain. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root.

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

Listings for affective disorders (Listing 12.04, anxiety disorders (Listing 12.06), and stressor disorders (Listing 12.15) were considered based on Petitioner's treatment history. The listings were rejected due to a failure to establish an extreme restriction or multiple marked restrictions to understanding or applying information, interacting with others, concentration or persistence, and/or adaptation. It was also not established that Petitioner had minimal capacity to adapt to changes in environment or to demands that are not already part of daily life.

A listing for HIV (Listing 14.08) was considered. Petitioner did not establish listing requirements for bacterial infections, fungal infections, viral infections, malignant neoplasms, skin conditions, HIV wasting syndrome, HIV encephalopathy, diarrhea resistant to treatment, or other listing requirements.

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 no work from the last 15 years amounting to SGA. Petitioner's testimony was credible and unrebutted. Without past relevant employment amounting to SGA, it must be found that Petitioner cannot perform past relevant 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).

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. Medium employment requires comparable standing and walking standards, but with a heavier lifting requirement than light employment.

Petitioner testified she previously used a walker for ambulation, but she no longer has one after she lost her home. Petitioner testified she is restricted to walking 3 blocks. Petitioner testified standing is limited to 10 minutes due to sciatic nerve pain in her leg. Petitioner testified her sitting is restricted to 30 minutes due to back pain. Petitioner testified a pain doctor in 2014 limited her lifting/carrying to 2 pounds.

Petitioner's testimony was indicative of an inability to perform light employment, and a debatable inability to perform sedentary employment. The testimony was partially consistent with presented records.

Petitioner presented zero radiology verifying any lumbar, cervical spine, knee, or hip problems. No loss of motor strength was documented by a treating physician. Petitioner was able to perform all requested walking tests without noted difficulty at a consultative

examination in January 2017. The consultative physician noted restrictions, in part, based on positive testing results for irritated nerves and restricted ranges of motion. The examiner reasonably concluded Petitioner had the ability to perform the lifting required of light employment. It is found Petitioner has some unstated degree of standing restrictions but none that would preclude Petitioner's performance of light employment.

Petitioner verified a "high risk" pregnancy. A high risk pregnancy, without supporting information, is not deemed to preclude the performance of light employment.

Presented records verified previous carpal-tunnel syndrome (CTS) release surgery. Recent Phalen's testing was indicative of ongoing problems with CTS. CTS treatment was not highly detailed. The history was indicative of restrictions that would only preclude performance of employment highly reliant on hand dexterity; the restrictions is not deemed to notably reduce Petitioner's employment opportunities.

It is found Petitioner is capable of performing light and sedentary employment not highly reliant on hand dexterity. The analysis will proceed to consider Petitioner's non-exertional restrictions to performing employment.

Petitioner reported ongoing pain. A diagnosis of fibromyalgia was referenced in Petitioner's treatment history; trigger point testing was also consistent with the diagnoses. Petitioner's medical treatment records were not indicative of flare-ups. Medical records were not indicative of an inability to perform ADLs. It is reasonable to infer that Petitioner's pain level might interfere with the concentration necessary to perform complicated and/or detailed employment. It is also reasonable to infer that medical records do justify inferences that Petitioner cannot perform non-complex employment.

Multiple psychiatric hospital admissions in 2016 were verified. Both admissions verified cocaine use by Petitioner shortly before admission. Petitioner's substance abuse renders both episodes of decompensation to be of little insight into Petitioner's psychological condition when sober.

When clients have extensive work histories followed by periods of unemployment related to psychological conditions, an inference can be made that recent psychological dysfunction was a contributor to unemployment. As Petitioner has no work history from the past 15 years, no such inference can be made.

It is also problematic for Petitioner that very little psychiatric treatment was verified. There was no evidence that Petitioner spent more than a few weeks attending counseling and/or psychiatric appointments.

Given Petitioner's limited treatment history and substance abuse, restrictions unrelated to substance abuse cannot be inferred. It is found Petitioner has no psychological obstacles to performing non-complex sedentary or light employment.

Presented evidence verified multiple treatments for STD and an HIV diagnosis. Petitioner's conditions would likely prevent Petitioner from working many jobs in the medical and/or food preparation fields.

Employment within Petitioner's abilities would include telemarketing, telephone customer service, security guard, light assembly, stock, retail sales, and others. MDHHS did not present any evidence of vocational opportunities for Petitioner. Petitioner's employment opportunities are not deemed to be so restricted that evidence of vocational opportunities was necessary. It is found Petitioner has adequate light and sedentary employment opportunities. The

Based on Petitioner's exertional work level (light), age (younger individual under 45), education (high school graduate), employment history (none), Medical-Vocational Rule 202.20 is found to apply. This rule dictates a finding that Petitioner is not disabled. Accordingly, it is found that MDHHS properly 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 properly denied Petitioner's SDA benefit application dated [redacted], based on a determination that Petitioner is not disabled. The actions taken by MDHHS are **AFFIRMED**.

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]