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: June 9, 2017
MAHS Docket No.: 17-004803
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.

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. 10-16).

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 54-year-old male.

8. Petitioner has a history of janitorial employment which amounted to substantial gainful earnings.

9. Petitioner has restrictions which allow the performance of past 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 requested a hearing to dispute the denial of an 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. 2-5) 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 2015), p. 1. A person is disabled for SDA purposes if he/she:

- Receives other specified disability-related benefits or services… or
- Resides in a qualified Special Living Arrangement… facility, or
- Is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability; or
- Is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS)...

Id., pp. 1-2.

Generally, state agencies such as 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.

Psychiatric office visit notes (Exhibit 1, pp. 169-174) dated [redacted], were presented. Petitioner reported improvement in depression, anxiety, and hallucinations because of medication.

Psychiatric office visit notes (Exhibit 1, pp. 163-168) dated [redacted], were presented. Petitioner reported improvement in psyche because of meds. Valium was prescribed with reduced dosage and discouraged because of side-effect concerns. It was noted Petitioner threatened administrative action against the physician if his Valium dose was not increased.

Psychiatric office visit notes (Exhibit 1, pp. 156-162) dated [redacted], were presented. Petitioner reported improvement in psyche because of medication. Valium was discontinued because of side-effect concerns.

Psychiatric office visit notes (Exhibit 1, pp. 150-155) dated [redacted], were presented. Petitioner reported depression following a denial of disability. An ongoing complaint of auditory hallucinations was noted. A request for valium was noted. Mental health exam assessments included normal affect, eurythmic mood, normal thought process, normal concentration, and adequate judgment. Seroquel was continued.

A biopsychosocial assessment (Exhibit 1, pp. 136-149) dated [redacted], was presented. The assessment was completed by a social worker. Petitioner reported a

history of hallucinations, poor concentration, nightmares, depression, and anger. Improvement in symptoms since starting medication was noted. Symptoms were noted to begin after 2011 and shortly after the end of Petitioner's boxing career. Mental health exam assessments included fair judgment, flight of ideas, normal speech, and appropriate affect. An Axis I diagnosis of affective disorder with manic episode (severe with psychotic symptoms). A GAF of 50 was noted.

Psychiatric office visit notes (Exhibit 1, pp. 130-135) dated [redacted], were presented. It was noted that Petitioner reported that an SSA judge told him to use valium. Petitioner's behavior was described as manipulative. Seroquel was continued. Valium did not appear to be prescribed.

Incomplete psychiatric office visit notes (Exhibit 1, pp. 126-129) dated [redacted], were presented. Mental health exam assessments included normal concentration and adequate judgment. Seroquel was continued.

Psychiatric office visit notes (Exhibit 1, pp. 120-125) dated [redacted], were presented. Petitioner reported improvement in psyche and "under control" psychosis. Petitioner reported no side effects from medication. Mental health exam assessments included normal affect, eurythmic mood, normal thought process, normal concentration, and adequate judgment. Seroquel was continued.

Physician office visit notes (Exhibit 1, pp. 87-90) dated [redacted], were presented. It was noted that Petitioner complained of ongoing lumbar pain. Valium was prescribed. Petitioner was referred for a colonoscopy.

Psychiatric office visit notes (Exhibit 1, pp. 114-119) dated [redacted], were presented. Petitioner reported improvement in depression and anxiety. Petitioner reported no side effects from medication. Mental health exam assessments included normal affect, eurythmic mood, normal thought process, slowed psychomotor activity, normal concentration, and adequate judgment. Seroquel was continued.

Physician office visit notes (Exhibit 1, pp. 77-82) dated [redacted], were presented. It was noted that Petitioner complained of ongoing anxiety and lumbar pain. Valium was continued.

Psychiatric office visit notes (Exhibit 1, pp. 108-113) dated [redacted], were presented. Petitioner reported psychosis was under control and "better" depression. Petitioner reported no side effects. Mental health exam assessments included normal affect, eurythmic mood, normal thought process, normal concentration, and adequate judgment. Seroquel was continued.

Physician office visit notes (Exhibit 1, pp. 74-76) dated [redacted], were presented. It was noted that Petitioner complained of anxiety, lumbar pain, and bilateral knee pain. It was noted Petitioner took over-the-counter NSAIDs for pain. Valium was prescribed.

An Operative Report (Exhibit 1, pp. 22-23) dated [redacted], was presented. It was noted Petitioner underwent a colonoscopy. Mild diverticular disease was noted.

Psychiatric office visit notes (Exhibit 1, pp. 102-107) dated [redacted], were presented. Petitioner reported improvement in depression and "good" sleeping. Petitioner reported no side effects. Mental health exam assessments included normal affect, eurythmic mood, normal thought process, normal concentration, and adequate judgment. Seroquel was continued.

Physician office visit notes (Exhibit 1, pp. 66-71) dated [redacted], were presented. It was noted that Petitioner complained of ongoing lumbar pain. Spinal tenderness was noted. It was noted Petitioner was wearing a back brace. Valium was continued.

A letter to Petitioner's PCP dated [redacted] (Exhibit 1, p. 63) was presented. It was noted Petitioner was diagnosed with presbyopia.

Psychiatric office visit notes (Exhibit 1, pp. 96-101) dated [redacted], were presented. Petitioner reported psychosis was "under control" because of medications. Petitioner reported no side effects. Mental health exam assessments included normal affect, eurythmic mood, normal thought process, and adequate judgment. Seroquel was continued.

Physician office visit notes (Exhibit 1, pp. 61-62) dated [redacted], were presented. It was noted that Petitioner complained of lumbar pain and spasms, ongoing since 2015. Petitioner reported he was consulting with a neurosurgeon. Petitioner also reported he was attending PT. Petitioner reported no need for a cane. Valium was continued.

A left-knee x-ray report (Exhibit A, pp. 1-2) dated [redacted], was presented. An impression of small joint effusion and mild degenerative changes were noted.

A right-knee x-ray report (Exhibit A, pp. 3-4) dated [redacted], was presented. An impression of small joint effusion and mild degenerative changes were noted.

A Psychiatric Review Technique and Mental Residual Functional Capacity Assessment (Exhibit 1, pp. 40-54) dated [redacted], were presented. The documents were signed by a licensed psychologist as part of Petitioner's SSA claim of disability. Consideration of meeting the affective disorder listing was noted and declined. Moderate restrictions to understanding and remembering information, social interaction, concentration, and adapting were noted. The stated basis for the assessment was a medical examination report from a treating psychiatrist.

Petitioner testified it takes him 4 hours to leave the home. Petitioner testified before he leaves, he eats and watches church on television.

Petitioner testified he has used a cane since 2005 when he jumped off of a truck and broke one of his heels. Petitioner testified he almost recently fell even though he was using his cane. Petitioner also testified he was struck by a truck in 2015 while he was a pedestrian. Petitioner testimony implied bilateral knee arthritis, lumbar pain, and shoulder pain affect his ability to ambulate and lift/carry.

Petitioner testified he has received psychiatric treatment for the past 6 years. Petitioner testified he was a professional boxer and a head injury in 1998 slows his mental function. Petitioner testified he has ongoing anxiety and depression. Petitioner testified his concentration is limited as he has difficulty watching movies because he cannot follow them. Petitioner testified he spends most of his days napping.

Presented medical records generally verified a medical treatment history consistent with degrees of restrictions to ambulation, lifting/carrying, and concentration. 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 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 establish a spinal disorder resulting in a compromised nerve root.

Listings for affective disorders (Listing 12.04) and organic mental disorders (Listing 12.02) 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.

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 listed his work history on a Medical-Social Questionnaire (Exhibit 1, pp. 179-182). Petitioner indicated he last worked in 2005 as a fast-food restaurant cashier and cook; Petitioner testified he worked for about a year at the job. Petitioner also listed assistant management duties for another fast-food restaurant from November 2002 until August 2003 and work as a cleaner from May 2001 until July 2003; Petitioner testified his cleaning duties included mopping, trash removal, and sweeping. The fourth step analysis will focus on Petitioner's ability to perform janitorial employment.

Petitioner testified he is limited to walking 3-4 short blocks. Petitioner testified standing is limited to 5 minutes before his legs give out. Petitioner testified his right arm is limited to lifting/carrying 8 pounds. Petitioner testified his sitting is restricted to 30 minutes before his legs tingle and he has to stand.

Petitioner testified he is scared of bathing himself. Petitioner testified he is able to dress himself. Petitioner testified his housework duties are limited to dishes. Petitioner testified he can take public transportation as he did so on the date of hearing.

Petitioner's stated restrictions of ambulation, standing, and lifting/carrying were indicative of an inability to perform janitorial employment. The testimony will be evaluated for its consistency with presented medical records.

Presented knee radiology noted *small* joint effusions and *mild* degenerative changes. The radiology was indicative of knee dysfunction, but not to the extent that janitorial employment could not be performed.

Complaints of back pain were documented. Spinal radiology was not presented. Physical therapy documentation was not presented. Medical records also indicated that Petitioner was able to manage pain with over-the counter medication. All these considerations were indicative of an ability to perform all exertional requirements of janitorial employment.

A Physical Residual Functional Capacity Assessment (Exhibit 1, pp. 28-35) was presented. A signature page listing the date and credentials of the assessor was cut-off, but the assessment is assumed to have been completed by a consultant physician as

part of Petitioner's SSA claim of disability. A date near [redacted] (the date of a mental assessment) is also assumed. Stated restrictions included occasional lifting of 20 pounds, frequent ability to lift/carry 10 pounds, standing or sitting about 6 hours in an 8-hour workday, unlimited pushing/pulling, occasional climbing, occasional balancing, occasional stooping, and limited overhead reaching. Cited medical records included office visits from [redacted], and [redacted]. The stated restrictions were consistent with an ability to perform janitorial employment.

It is found Petitioner has no exertional restrictions preventing the performance of past janitorial employment. The analysis will proceed to consider non-exertional restrictions.

Psychiatric treatment records from 2016 consistently noted relatively unremarkable mental health assessments. Petitioner's mood and/or affect were sometimes subnormal though restrictions to concentration, judgment, insight, thought process and/or speech were regularly unremarkable.

A history of hallucinations was noted. Generally, hallucinations are indicative of significant concentration and/or social restrictions. In 2016, no complaint of hallucination was document as it was regularly noted that Seroquel managed Petitioner's symptoms well.

A GAF of 50 was noted in February 2016. Generally, a GAF of 41-50 is indicative of marked non-exertional restrictions. The assessment came from a social worker, not a psychiatrist; generally, statements of restrictions are less persuasive when not from acceptable medical sources (see SSR 06-03p). Further, the functioning assessment was made before Petitioner's SDA application. Subsequent treatments indicated general medical improvement suggesting a higher functioning level for Petitioner.

A Mental Residual Functional Capacity Assessment (Exhibit 1, pp. 36-38) dated [redacted], was presented. The assessment was completed by a licensed psychologist as part of Petitioner's SSA claim of disability. Moderate limitations to understanding and remembering detailed information, carrying out detailed instructions, maintaining attention, interacting appropriately with the public, and responding to workplace changes were noted. Marked restrictions were not noted. Petitioner was deemed capable of performing repetitive 1-2-step tasks.

The statements from the licensed psychologist were consistent with presented treatment records. It is found Petitioner has moderate restrictions to social interaction and concentration. The restrictions would not prevent Petitioner form performance of past employment as a janitor.

It is found Petitioner is capable of performing past employment amounting to SGA. Thus, Petitioner is not disabled and it is found that MDHHS properly 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 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]