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GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

Date Mailed: July 21, 2017
MAHS Docket No.: 17-006124
Agency No.:
Petitioner:

**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 June 19, 2017, from Detroit, Michigan. Petitioner appeared and was represented by . The Michigan Department of Health and Human Services (MDHHS) was represented by , supervisor, and , 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 , Petitioner applied for SDA benefits.

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

3. On , the Disability Determination Service determined that Petitioner was not a disabled individual (see Exhibit 2, pp. 2-8).

4. On MDHHS denied Petitioner's application for SDA benefits.

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

6. On [redacted], an administrative hearing was held.

7. During the hearing, Petitioner and MDHHS waived the right to receive a timely hearing decision.

8. During the hearing, the record was extended 14 days to allow Petitioner to submit radiology reports and bloodwork results; an Interim Order Extending the Record was subsequently mailed to both parties.

9. On [redacted], Petitioner submitted a Work Capacity Evaluation (Mental).

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

11. As of the date of the administrative hearing, Petitioner was a 45-year-old female.

12. Petitioner's highest education year completed was the 12th grade (via general equivalency degree).

13. Petitioner has a history of no known past relevant employment amounting to substantial gainful activity.

14. Petitioner has restrictions which allow the performance of sufficiently available 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 hearing to resolve the SDA dispute and the hearing was conducted accordingly.

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. A Notice of Case Action was not presented, however, it was not disputed that 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.

[State agencies] must use the same definition of disability as used under SSI… 42 C.F.R. § 435.540(a). [Federal] law defines disability as the inability to do any substantial gainful activity 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. 20 C.F.R. §416.905(a). Substantial gainful activity means work that… involves doing significant and productive physical or mental duties; and is done (or intended) for pay or profit. 20 C.F.R. §416.910.

MDHHS adopted a functionally identical definition of disability and substantial gainful activity (see BEM 260 (July 2015), p. 10). The same definition applies to SDA, though SDA eligibility requires only a 90-day period of disability.

In general, you have to prove… that you are blind or disabled. 20 C.F.R. § 416.912(a). You must inform [the agency] about or submit all evidence known… that relates to whether or not you are blind or disabled. *Id*. Evidence includes, but is not limited to objective medical evidence e.g. medical signs and laboratory findings), evidence from other medical sources (e.g. medical history and opinions), and non-medical statements about symptoms (e.g. testimony) (see *Id*.).

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled (see 20 20 C.F.R. § 416.920). If there is no finding of disability or lack of disability at each step, the process moves to the next step (see *Id*.)

The first step in the process considers a person's current work activity (see 20 C.F.R. §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

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 C.F.R. §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 C.F.R. §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 C.F.R. § 416.920 (5)(c). In determining whether Petitioner's impairments amount to a severe impairment, all other relevant evidence may be considered.

During the hearing, the record was extended to allow Petitioner to submit additional medical documents. Specifically, Petitioner was allowed to submit recent radiology and bloodwork results for the purposes of verifying neurological dysfunction. Petitioner responded by submitting no such records. Instead, Petitioner submitted an assessment of Petitioner's mental abilities completed by a treating social worker. The document was not admitted as an exhibit because it did not comply with the specific documents

authorized for submission in the Interim Order Extending the Record. Other documents were considered.

A right lower joint MRI report (Exhibit A, p. 13) dated [redacted], was presented. An impression of a meniscus tear and fibrous talocalcaneal coalition was noted.

A lumbar spine MRI report (Exhibit A, pp. 1-2) dated [redacted], was presented. Disc protrusions were noted from L3-S1. Nerve root abutment was noted at S1 left-nerve root. An impression of multilevel degenerative changes without stenosis was noted.

Various hospital documents (Exhibit 1, pp. 94-108) from [redacted] [redacted] were presented. Various treatments for right hand pain were noted.

A radiology report of Petitioner's right hand (Exhibit 1, p. 93) dated [redacted], was presented. An impression of a right hand fifth metacarpal fracture was noted.

Various mental health treatment documents (Exhibit 1, pp. 156-227) dated from [redacted], to [redacted], were presented. Ongoing treatment for depression was noted.

Hospital documents (Exhibit 1, pp. 76-88) from [redacted] and [redacted] [redacted] were presented. Petitioner underwent an open reduction-internal fixation of the fifth metacarpal on Petitioner's right hand.

Orthopedist office visit notes (Exhibit 1, p. 75) dated [redacted], were presented. Petitioner reported "incredible amount of pain" in fifth metacarpal of her right hand. Follow-up in a week was planned.

Orthopedist office visit notes (Exhibit 1, pp. 73-74) dated [redacted], were presented. Petitioner had no complaints about fifth metacarpal of her right hand. Some bone loss was noted.

Orthopedist office visit notes (Exhibit 1, pp. 70-72) dated [redacted], were presented. Petitioner reported ongoing pain in her right hand fifth metacarpal. A bone stimulator was prescribed.

An Interpretive Summary of Assessment Data (Exhibit 1, pp. 148-151) dated [redacted] [redacted], from a supervisor at a mental health agency was presented. Petitioner reported a history of drug abuse from early adulthood. A troubled legal history was indicated. Recommendations included continued psychiatric, nursing, and case management.

Orthopedist office visit notes (Exhibit 1, pp. 67-69) dated [redacted], were presented. Petitioner reported 10/10 pain in her finger despite use of bone stimulator. X-rays noted delayed healing. Continued bone stimulator use was recommended. Use of a splint was discontinued.

Mental health treatment documents from a physician (Exhibit 1, pp. 138-144) dated [redacted] were presented. It was noted Petitioner was last seen on [redacted] Mental health exam assessments included dysphoric mood, normal affect, normal speech, grossly intact memory, adequate concentration, adequate impulse control, and adequate judgment.

Emergency room encounter notes (Exhibit 1, pp. 60-66) dated [redacted], were presented. Petitioner was taken after texting her boyfriend that she did not want to live anymore. Petitioner reported depression, but denied suicidal ideation. Treatment details were not apparent.

Orthopedist office visit notes (Exhibit 1, pp. 58-59) dated [redacted], were presented. Petitioner reported 10/10 pain in her finger despite use of bone stimulator. X-rays noted delayed healing. Follow-up in 4 weeks was planned.

Rheumatologist office visit notes (Exhibit A, pp. 3-11) dated [redacted], were presented. Generic information for hip bursitis was noted.

Physician office visit notes (Exhibit 1, pp. 56-57) dated [redacted], were presented. Petitioner complained of non-radiating back pain (8/10). Petitioner reported her pain was worse at night. Paraspinal tenderness was noted. Gait, muscle strength, and reflexes were normal. Diagnoses included bilateral sacroiliac joint syndrome, lumbar spondylosis, and lumbar herniated nucleous pulposus. A sacroiliac joint injection was planned.

Orthopedist office visit notes (Exhibit 1, pp. 52-54) dated [redacted], were presented. Petitioner reported 7/10 pain in her finger despite use of bone stimulator. Petitioner reported her finger was stiff. Radiology noted a delayed union of fracture. A plan of pain control was noted. Petitioner was given finger exercises and a referral to a hand specialist.

Various social worker notes from [redacted] were presented. Repeated attempts to contact Petitioner were noted.

Social worker home visit notes (Exhibit 1, pp. 126-127) dated [redacted], were presented. Various goals of Petitioner were discussed. It was noted Petitioner was noncompliant with medication due to running-out of meds and failing to attend medication reviews.

Social worker home visit notes (Exhibit 1, pp. 123-125) dated [redacted], were presented. Various goals of Petitioner were discussed. It was noted Petitioner was noncompliant with medication due to running-out of meds and failing to attend medication reviews.

Mental health treatment documents from a nurse practitioner (Exhibit 1, pp. 115-121) dated [redacted], were presented. Petitioner reported being tearful and angry at

the world. Assessments of Petitioner included depressed mood, constricted affect, normal speech, goal-directed thought process, normal thought content, normal concentration, impaired impulse control, and adequate judgment. Effexor and Trazadone were prescribed. A GAF of 50 as of [redacted] was noted.

Physician office visit notes (Exhibit 1, pp. 49-50) dated [redacted], were presented. Petitioner complained of non-radiating back pain. Physical examination assessments included normal reflexes, normal muscle strength, and normal gait. Restricted spine range of motion and spinal tenderness were also noted. Petitioner underwent bilateral sacroiliac joint injection.

A mental status examination report (Exhibit 1, pp. 32-36) dated [redacted] was presented. The report was noted as completed by a consultative licensed psychologist. Petitioner reported trying to isolate herself from others. A history of suicide attempts was also reported. Assessments and observations of Petitioner included slightly sullen attitude, slightly agitated affect (also sullen and depressed), anhedonia, and not overtly anxious. Petitioner's psychotherapy was characterized as characterological. A diagnosis of borderline personality disorder was noted. A fair prognosis was given. The examiner concluded that Petitioner showed no signs of severe mental illness or affect disturbance.

An internal medicine examination report (Exhibit 1, pp. 39-46) dated [redacted], was presented. The report was noted as completed by a consultative physician. Petitioner reported back pain ongoing for 10 years. Petitioner reported a pain level of 9/10, down to 7/10 after taking medication. A normal gait and stance were noted. Mild lumbar tenderness and restricted range of lumbar motions were noted. Knee and hip motion ranges were normal. Intact fine and gross dexterity was noted. A "slight" limitation to extended standing or sitting was noted. The examiner stated that clinical evidence did not support a need for a cane.

Petitioner testified she has torn ligaments and a torn meniscus. Petitioner testified she was diagnosed about 15 years ago. Petitioner testified she has not been treated for knee pain until she recently saw a neurosurgeon. Presented records, which included a radiology report from 2002 and no apparent subsequent knee treatment records, were consistent with Petitioner's testimony. Presented evidence was insufficient to infer that Petitioner had impairments related to knee problems.

Petitioner testified she has flat feet. Petitioner testified her ankles nearly touch the ground. Presented records also failed to verify any notable impairments related to flat feet.

Petitioner testified she broke her right hand in the past. Petitioner testified she is unable to bend her pinky finger. Petitioner testified her right hand is painful and her grip is weak.

Petitioner testified she has restrictions, in part, due to lumbar pain. Petitioner testified epidural injections did little to relieve pain. Petitioner testified she has been to physical therapy 20 times and that she takes pain medications in attempts to control pain.

Petitioner testified she received mental health treatment for 4 years. Petitioner testified she receives weekly hour-long visits from a case manager. Petitioner testified she is unable to attend counseling because of a lack of transportation. Petitioner testified her agency provides services for emergencies. Petitioner testified she had an emergency 3 weeks earlier. Petitioner testified mental health treatment helped her to stop hitting herself.

Petitioner testified she is passive-suicidal. Petitioner described it as wanting to commit suicide, though she does not follow through.

Petitioner testified she has 10 anxiety attacks per day. Petitioner testified the attacks cause her to feel nervous, nauseous, and empty. Petitioner testified the attacks also make her forgetful and confused.

Petitioner testified she spends most of her time alone in her home wishing she would die. Petitioner testified she is not liked because she only talks about her problems. Petitioner testified she feels anxious when around persons.

Petitioner testified she has never been admitted for psychiatric hospitalization. Petitioner testified she once attended a day-treatment program about 3-4 years earlier.

Presented medical records generally verified a medical treatment history consistent with exertional restrictions due to lumbar and finger dysfunction. Presented records also generally verified degrees of concentration and social interaction restrictions due to depression and/or anxiety. 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.

At the third step, [SSA will] also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals… listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, [SSA] will find that you are disabled. 20 C.F.R. § 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 (see 20 C.F.R. § 416.920 (d)). If your impairment(s) does not meet or equal a listed impairment, [SSA] will assess and make a finding about your residual functional capacity based on all the relevant medical and other evidence in your case record…. 20 C.F.R. § 416.920 (e).

A listing for joint dysfunction (Listing 1.02) was considered based on Petitioner’s complaints of finger pain. The listing was rejected due to a failure to establish that Petitioner is unable to effectively perform fine and gross movements.

Listings for affective disorders (Listing 12.04) was considered based on a diagnosis of depression. The listing was 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 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 causing Petitioner to ambulate ineffectively.

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.

It is found Petitioner does not meets any SSA listings. Accordingly, the analysis may proceed to the fourth step.

If your impairment(s) does not meet or equal a listed impairment, [SSA] will assess and make a finding about your residual functional capacity based on all the relevant medical and other evidence in your case record… 20 C.F.R. § 416.920(e). [SSA uses the]… residual functional capacity assessment at the fourth step of the sequential evaluation process to determine if you can do your past relevant work (paragraph (f) of this section) and at the fifth step of the sequential evaluation process (if the evaluation proceeds to this step) to determine if you can adjust to other work (paragraph (g) of this section). *Id*.

Your impairment(s), and any related symptoms, such as pain, may cause physical and mental limitations that affect what you can do in a work setting. 20 C.F.R. § 416.945 (a)(1). Your residual functional capacity is the most you can still do despite your limitations. *Id*. We will assess your residual functional capacity based on all the relevant evidence in your case record. *Id*. We will consider all of your medically determinable impairments of which we are aware, including your medically determinable impairments that are not "severe,"… when we assess your residual functional capacity. 20 C.F.R. § 416.945 (a)(2). We will assess your residual functional capacity based on all of the relevant medical and other evidence. 20 C.F.R. § 416.945(a)(3). We will first use our residual functional capacity assessment at step four of the sequential evaluation process to decide if you can do your past relevant work. 20 C.F.R. § 416.945(a)(5). An RFC assessment will be reserved for later in the analysis.

The fourth step in analyzing a disability claim requires an assessment of the Petitioner's residual functional capacity (RFC) and past relevant employment. 20 C.F.R. § 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 C.F.R. § 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 C.F.R. § 416.960(b)(3).

Petitioner testified her employment history from the past few years consists of part-time employment. Petitioner testified her part-time jobs included making sandwiches for a fast-food restaurant and working for a national pet store chain. Petitioner testified both jobs were for minimum wage.

Petitioner's testimony was consistent with past relevant employment from the last 15 years that did not amount to SGA. Without past employment amounting to SGA, it cannot be found that Petitioner can return to perform past employment which amounted to SGA. Accordingly, 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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 416.969a(c)(2)

The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.* In using the rules of Appendix 2, an individual's circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, is compared to the pertinent rule(s).

Given Petitioner's age, education and employment history a determination of disability is dependent on Petitioner's ability to perform sedentary employment. For sedentary employment, periods of standing or walking should generally total no more than about 2 hours of an 8-hour workday. Social Security Rule 83-10.

Petitioner testified she does not use a cane or walker. Petitioner testified she has not discussed a cane or walker with her physician, though she believes she should use a wheelchair.

Petitioner testified she can only walk a block due to back, hip, knee, and ankle pain. Petitioner testimony estimated she is restricted to less than a minute of standing due to pain. Petitioner testimony initially indicated she could sit without restrictions; Petitioner later testified she can only sit for 30 minute periods. Petitioner testified it is painful to pick up 10 pounds. Petitioner testimony estimated she could walk 0 hours out of an 8-hour workday.

Petitioner testified she uses a chair when showering. Petitioner testified she once fell in the shower and is fearful of falling again. Petitioner testified she dresses herself, though putting on shoes is difficult. Petitioner testified she is unable to perform the repetitive bending required of laundry, mopping, and vacuuming. Petitioner testified she sits while cooking or doing dishes. Petitioner testified she utilizes a scooter when shopping. Petitioner testified she spends most of her days performing Bible study and writing papers.

Petitioner's testimony was highly consistent with exertional restrictions which would prevent the performance of any employment. Petitioner's testimony will be evaluated with presented medical evidence.

Presented evidence verified a period of treatment for her pinky. Petitioner testimony implied that employment regularly requiring writing and/or typing would be impossible. Petitioner's testimony conflicted with her testimony that she spends hours per day writing for her Bible studies.

It was verified through [REDACTED] Petitioner's right pinky healed poorly following a surgery. It is curious that Petitioner was referred to a specialist though specialist documents were not presented. The absence of documents from a specialist was indicative of finger pain that become decreasingly problematic. Further, right pinky pain is not particularly indicative of writing or typing limitations, though Petitioner insisted otherwise.

Generic treatment instructions for hip bursitis were presented. Radiology supporting the diagnosis was not presented. The documentation was not sufficient to justify inferences of restrictions related to hip bursitis.

Presented lumbar spine radiology verified nerve root abutment and degenerative changes. Lumbar injection treatments were also verified. Paraspinal tenderness and decreased range of motion was consistently noted in physical examinations. Despite the treatment history, Petitioner's statements of restrictions were not particularly consistent with presented evidence.

Neither foraminal nor canal stenosis was indicated in radiological records. Though Petitioner claimed a need for a wheelchair, a need for a cane was not even verified. Physical examination assessments regularly noted full muscle strength, normal

neurology, and a normal gait; the assessments are not indicative of severe lumbar problems precluding the performance of sedentary employment.

A Physical Residual Functional Capacity Assessment (Exhibit 2, pp. 28-35) dated [redacted] [redacted], was presented. The assessment was signed by a consultant physician as part of Petitioner's SSA claim of disability. The stated basis for assessments was Petitioner's consultative examination from [redacted]. Stated limitations 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 kneeling, occasional crawling, and occasional crouching. No manipulative restrictions were indicated. The assessment was reasonably consistent with presented medical records and not rebutted by other physician statements. The assessments were consistent with finding that Petitioner can perform sedentary employment.

It is found that Petitioner is capable, at minimum, of performing sedentary employment. The analysis will proceed to consider Petitioner's non-exertional restrictions.

Petitioner testified she will not sleep if she does not take medication. Petitioner testified she typically sleeps 3-4 hours when she takes her medication. Petitioner testified she is too unreliable to perform any employment.

Petitioner's testimony implied her non-exertional impairments would preclude her performance of any employment. Petitioner's testimony will be evaluated with presented evidence.

A GAF is a useful tool to evaluating a client's psychological limitations. A GAF of 50 was verified. The most recent verified GAF was 50. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF within the range of 41-50 is representative of a person with "serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g. no friends, unable to keep a job)."

Petitioner's GAF is somewhat indicative of an inability to perform any employment. Petitioner's most recently verified GAF happened to occur in 2013, presumably before Petitioner received any regular psychiatric treatment. It is reasonable to infer that treatment and counseling improved Petitioner's functioning. Petitioner's GAF is not deemed to be particularly insightful into determining current psychological function.

Presented treatment records regularly noted goal-directed thought process, normal thought content, no hallucinations. Petitioner's most recent assessment from a treater also noted normal concentration and adequate judgment. Previous psychiatric hospitalizations were neither alleged nor documented. Generally, presented evidence from treating sources was indicative that Petitioner can perform simple employment not heavily reliant on face-to-face interaction.

A Psychiatric Review Technique and Mental Residual Functional Capacity Assessment (Exhibit 2, pp. 9-27) dated [redacted], were presented. The documents were signed by a licensed psychologist as part of Petitioner's SSA claim of disability. Mild restrictions to Petitioner's understanding and memory were noted. Moderate restrictions to Petitioner's ability to socially interact and concentrate were noted. Moderate restrictions to the following abilities were noted: carrying out detailed instructions, concentrating for extended periods, interacting appropriately with the public, getting along with coworkers, and adapting to workplace changes. Petitioner was deemed capable of performing simple and rote employment involving little social interaction. The assessments were consistent with presented records.

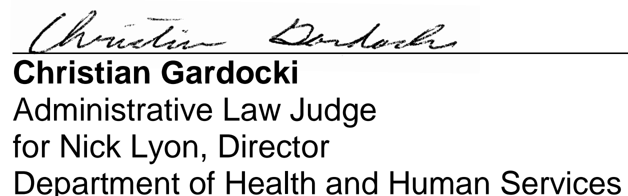
No counseling or therapy records were provided. Presented evidence only verified medication for anti-depressants and/or anxiety. Such evidence does not imply restrictions beyond those stated by SSA's consultative psychologist. Stated restrictions were indicative that Petitioner could not perform very complex work, but is capable of performing non-complex employment.

MDHHS did not present evidence of employment available to Petitioner. Petitioner's available employment is not deemed to be so restrictive that ample opportunities are unlikely to be available. Examples of employment Petitioner could reasonably be expected to perform include the following: telemarketing, telephone customer service, data entry, document preparation, and receptionist. It is found Petitioner is capable of performing sufficiently available sedentary employment.

Based on Petitioner's exertional work level (sedentary), age (younger individual), education (high school equivalency), employment history (none), Medical-Vocational Rule 201.27 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**

**Petitioner**

**Authorized Hearing Rep.**