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: August 4, 2017
MAHS Docket No.: [redacted] 17-006774
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned administrative law judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10; and Mich Admin Code, R 792.11002. After due notice, a telephone hearing was held on [redacted] from 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. 5-11).

4. On an unspecified date, MDHHS denied Petitioner's application for SDA benefits.

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 44-year-old female.

8. Petitioner's employment from the past 15 years amounting to substantial gainful activity includes employment as a telemarketer.

9. Petitioner has various restrictions which allow the performance of telemarketing 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 did not present a Notice of Case Action though it was not disputed that MDHHS denied Petitioner's SDA application 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 (April 2017), p. 5. 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 (April 2017), p. 1. A person is disabled for SDA purposes if he or she meets any of the following criteria:

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

Id., pp. 1-2.

When the person does not meet one of the [above] criteria, [MDHHS is to] follow the instructions in BAM 815, Medical Determination and Disability Determination Service (DDS), Steps for Medical Determination Applications. *Id*., p. 4. The DDS will gather and

review the medical evidence and either certify or deny the disability claim based on the medical evidence. *Id*. The review of medical evidence is primarily outlined by federal law.

[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).

MDHHS adopted a functionally identical definition of disability (see BEM 260 (July 2015), p. 10). The same definition applies to SDA, though SDA eligibility factors 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 us 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 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 2017 monthly income limit considered SGA for non-blind individuals is $1,170.00.

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*.

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.

At the second step, we consider the medical severity of your impairment(s). 20 C.F.R. §416.920 (a)(4)(ii). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 416.909, or a combination

of impairments that is severe and meets the duration requirement, we will find that you are not disabled. *Id*.

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, SSR 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).

If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. 20 C.F.R. § 416.920 (5)(c). We will not consider your age, education, and work experience. *Id*. The second step analysis will begin with a summary of presented medical documentation and Petitioner's testimony.

Electrodiagnostic physician office visit notes (Exhibit 1, pp. 202-206) dated [redacted], were presented. Petitioner complained of right leg weakness. EMG test results indicated evidence of right superficial peroneal sensory neuropathy.

Various medical treatment documents from 2015 (Exhibit 1, pp. 154-162, 191-201, 210-228) were presented. Treatment for hip pain, dyspnea, back pain, gynecological issues, and various acute problems were noted.

A right-hip radiology report (Exhibit 1, p. 233) dated [redacted], was presented. Mild spurring without joint space narrowing was noted.

A right-hip radiology report (Exhibit 1, p. 231) dated [redacted], was presented. A normal examination was noted.

A lumbar spine MRI report (Exhibit 1, pp. 189-190, 229-230) dated [redacted] was presented. A disc bulge causing mild bilateral narrowing was noted. No central canal narrowing or nerve root compression was noted.

Physician office visit notes (Exhibit 1, pp. 207-209, 414-417) dated [redacted] were presented. Ongoing complaints of back pain and leg weakness were noted. Petitioner reported being unable to walk long distances or stairs. Assessments included

lumbar spondylosis without radiculopathy and nicotine dependence. Robaxin was continued. A neurosurgeon appointment was noted as scheduled.

Pain management physician office visit notes (Exhibit 1, pp. 167-173) dated [redacted], were presented. Petitioner underwent a sacroiliac (SI) joint injection. An antalgic gait was noted. Lumbar and priformis tenderness was noted. Reduced leg strength was noted. Petitioner's complaints of pain scored as a "severe" disability on the Oswestry Disability Index.

Various pain management physician office visit notes (Exhibit 1, pp. 175-187) from [redacted] were presented. Various lumbar injections were documented.

Various social worker office visit notes (Exhibit 1, pp. 234-245, 322-350, 388-395) from [redacted] were presented. Regular complaints of physical pain were noted. An assessment of adjustment disorder (with mixed anxiety and depressed mood) was regularly noted.

Neurologist office visit notes (Exhibit 1, pp. 95-104) dated [redacted], were presented. Petitioner reported "short-lived" pain relief following medial branch blocks and no improvement after SI joint injections. Petitioner reported numbness, and tingling in legs. Reported pain levels ranged from 4/10 to 10/10, including interference with ADLs. Diagnoses of bilateral lumber pain with right-sided sciatica, piriformis syndrome of right side, and myofascial pain were noted. Trigger point injections were performed. Petitioner was referred to physical therapy.

An initial evaluation for physical therapy (PT) (Exhibit 1, pp. 105-107) dated [redacted] was presented. Petitioner reported lumbar pain, ongoing for several years; worse in the last 4 years. Various PT goals of decreasing pain and increasing lumbar motion were noted.

Various physical therapy documents (Exhibit 1, pp. 108-120, 420-431, 456-586) from [redacted] through [redacted] were presented. On [redacted], mild improvements to pain and motion were noted.

Physician office visit notes (Exhibit 1, pp. 410-413) dated [redacted], were presented. Petitioner reported ongoing lumbar pain. It was recommended Petitioner find employment with a sit/stand option. An emphasis on quitting smoking was noted.

Neurologist office visit notes (Exhibit 1, pp. 121-128) dated [redacted], were presented. Petitioner reported that PT did not reduce back pain. It was noted Petitioner reported that Neurontin worsened her leg pain. Gabapentin was prescribed. Petitioner was referred to a pain management clinic.

Neurologist office visit notes (Exhibit 1, pp. 129-136) dated [redacted], were presented. It was noted that Petitioner reported leg pain due to Gabapentin.

Neurologist office visit notes (Exhibit 1, pp. 137-146) dated [redacted], were presented. Petitioner reported ongoing back pain interfering with ADLs. It was noted Petitioner might have chronic pain syndrome.

A mental status examination report (Exhibit 1, pp. 147-151) dated [redacted], was presented. The report was noted as completed by a consultative licensed psychologist. Petitioner reported physical pain, crying “a lot”, fluctuating mood, and wanting to lay in bed all the time. Assessments and observations of Petitioner included normal speech, average intelligence, no psychotic intrusion, friendly, depressed, and orientation x3. Diagnoses included depression and panic disorder. A fair-to-good prognosis was noted. Petitioner’s symptoms were not deemed to interfere with employment.

Emergency room documents (Exhibit 1, pp. 448-455) dated [redacted], were presented. Petitioner complained of right foot and ankle pain, ongoing for 2 days. Radiology was negative. A sprain was diagnosed.

Physician office visit notes (Exhibit 1, pp. 406-409) dated [redacted], were presented. Petitioner reported worsening lumbar pain. Petitioner reported PT, injections and Neurontin worsened her pain. A prescription for a TENS unit was noted.

Emergency room documents (Exhibit 1, pp. 440-444) dated [redacted], were presented. Treatment for lumbar pain exacerbation was noted.

Physician office visit notes (Exhibit 1, pp. 403-405) dated [redacted], were presented. Petitioner reported ongoing back pain and increased leg pain. Petitioner also reported both hips “go out.” A physiatrist referral was noted.

Physician office visit notes (Exhibit 1, pp. 400-402) dated [redacted] were presented. Petitioner reported ongoing back pain and foot pain. Petitioner reported difficulty walking. Aquatic therapy was discussed. The physician noted Petitioner appeared to have visible decrease in function.

A lumbar x-ray report (Exhibit 1, p. 309) dated [redacted], was presented. Slight suggestion of L4-L5 interspace with no latent malalignment was noted.

Physician office visit notes (Exhibit 1, pp. 305-307, 365-367) dated [redacted] were presented. Petitioner reported ongoing lumbar pain. Petitioner reported being unable to walk to mailbox due to pain. All previous treatment was reported as unhelpful or aggravating to pain. SI tenderness was noted. Positive straight-leg-raising was positive. Slight lumbar flexion restriction was noted. Fibromyalgia was assessed based on ankle reflex and tender areas. Duloxetine was prescribed.

An Operative Report (Exhibit 1, pp. 303-304) dated [redacted], was presented. Petitioner underwent various spinal injections.

Physician office visit notes (Exhibit 1, pp. 396-399) dated [redacted], were presented. Petitioner reported ongoing chronic pain in all 4 quadrants; it was noted there was “no identifiable cause.” Petitioner reported pain was worsened by standing, walking, and changing position. Petitioner reported no relieving factors. Discussions of nutrition, lifestyle, and sleep were noted. It was noted another physician prescribed Cymbalta despite previous complaints by Petitioner that it did not work. Petitioner reported recent loss of employment of 6 hours per week at a bank, (see p. 403). Prescribed medications included acyclovir, Cymbalta, Ibuprofen (600 mg at bedtime), an inhaler, and Robaxin. It was noted Petitioner walked without assistance.

An Operative Report (Exhibit 1, pp. 287-288. 301-302, 363-364) dated [redacted], was presented. Petitioner underwent various spinal injections.

Physician office visit notes (Exhibit 1, pp. 298-300, 361-362) dated [redacted] were presented. Petitioner reported ongoing pain. A lumbar fact injection was noted to be beneficial. A primary assessment of spondylosis without myelopathy or radiculopathy was noted. Medications were updated and further spinal injections were planned.

Social worker office visit notes (Exhibit 1, pp. 318-321) dated [redacted], were presented. Petitioner reported doing “pretty well.” Legal concerns and coping skills were discussed.

Physician office visit notes (Exhibit 1, pp. 378-387) from [redacted] were presented. Treatment for bronchitis and an earache were noted.

An Operative Report (Exhibit 1, pp. 285-286, 296-297, 359-360) dated [redacted] was presented. Petitioner underwent various spinal injections.

Social worker office visit notes (Exhibit 1, pp. 314-317, 375-378) dated [redacted] were presented. Complaints of depression, physical pain, and low self-esteem (in part related to weight gain) were noted.

Physician office visit notes (Exhibit 1, pp. 294-295, 357-358) dated [redacted], were presented. Petitioner reported left-arm, hand, lumbar, and leg pain. Petitioner reported no improvement after injections. A primary diagnoses of fibromyalgia was noted. Cymbalta was continued. An EMG and lumbar MRI were planned.

A lumbar MRI report (Exhibit 1, pp. 289-290, 435-436) dated [redacted], was presented. Mild disc bulges and bilateral foraminal stenosis was noted at L4-L5 and L5-S1.

Social worker office visit notes (Exhibit 1, pp. 311-312, 372-374) dated [redacted], were presented. It was noted that Petitioner planned on reducing smoking. Pain self-management was noted as discussed. A diagnosis of adjustment disorder was noted.

Orthopedist office visit notes (Exhibit 1, pp. 282-284) dated [redacted], were presented. It was noted Petitioner was a new patient complaining of bilateral leg pain (right greater than left) and back pain. 5/5 strength was noted. A non-antalgic and normal gait was noted. No need for a walking aid was indicated. Petitioner walked on heels and toes without difficulty. Hip motion was unrestricted. Lumbar motion was restricted in all directions. Increased (3+) reflexes were noted in all extremities. Bilateral Hoffman's reflex was noted. Diagnoses of lumbar radiculitis and stenosis were noted. It was noted that Petitioner may have neurological dysfunction, such as a demyelinating condition. An EMG study was recommended. A left-sided L5 injection was recommended if Petitioner's pain worsened.

A mental status examination report (Exhibit 1, pp. 254-257) dated [redacted], was presented. The report was completed by a consultative licensed psychologist. Petitioner reported increased depression with increased physical pain. Assessments and observations of Petitioner included normal speech, average intelligence, no psychotic intrusion, friendly, depressed, and orientation x3. Diagnoses included depression and panic disorder. A fair-to-good prognosis was noted. Petitioner's symptoms were not deemed to interfere with employment.

Petitioner testified she suffers from fibromyalgia and lumbar dysfunction. Petitioner testified she has undergone approximately 50 pain medication injections. Petitioner also testified she tried physical therapy on 5 different occasions, regularly stretches her legs, and is currently attending aqua therapy. Petitioner testified all attempted therapies have essentially failed.

Petitioner testified she takes Amitriptyline, Ibuprofen, Norco, and Cymbalta. Petitioner testified that medications also do little to reduce her pain.

Petitioner testified she sees a behavioral therapist every 2 weeks. Petitioner testified she has attended for the past 2 years. Petitioner testified she has ongoing depression and anxiety. Petitioner testified she attempted suicide in [redacted], but was not hospitalized; the incident was reported to a consultative examiner (see Exhibit 1, p. 255). Petitioner testified that anxiety causes her to uncontrollably shake; Petitioner testified she tries breathing techniques to control her anxiety.

Presented medical records generally verified a medical treatment history consistent with exertional restrictions due to lumbar pain and fibromyalgia. Presented records also generally verified degrees of concentration and social interaction restrictions due to pain and psychological disorders. 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 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 anxiety disorders (Listing 12.06) 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).

Residual functional assessments were provided. The assessments will be evaluated for their weight and credibility

A Physical Residual Functional Capacity Assessment (Exhibit 1, pp. 52-59) dated [redacted], was presented. The assessment was signed by a "single decisionmaker" as part of Petitioner's SSA claim of disability. 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, and unlimited pushing/pulling. Petitioner was restricted to only occasional kneeling, crawling, crouching, and climbing due to back pain. Various medical records including radiology from [redacted] were cited as support for the assessments.

A Psychiatric Review Technique (Exhibit 1, pp. 12-26) dated [redacted]. The document was completed by a single decision-maker as part of Petitioner's claim of disability with SSA. Petitioner was assessed as having mild understanding, interaction, concentration and persistence, and adaptation restrictions. Petitioner was assessed as not meeting any listings. Noted considerations included various medical encounters from 2017 (and a June 2016 encounter).

A Physical Residual Functional Capacity Assessment (Exhibit 1, pp. 27-34) dated [redacted] was presented. The assessment was signed by a "single decisionmaker" as part of Petitioner's SSA claim of disability. 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, and unlimited pushing/pulling. Petitioner was restricted to only occasional kneeling, crawling, crouching, and climbing due to back pain. Various medical records since [redacted] were cited as supportive of the assessments.

Single decision-makers are not acceptable medical sources. Thus, the above-cited assessments are not deemed to be insightful of Petitioner's capabilities.

A Psychiatric Review Technique (Exhibit 1, pp. 60-73) dated [redacted], was presented. The document was completed by a licensed psychologist as part of Petitioner's claim of disability with SSA. Petitioner was assessed as having mild understanding, interaction, and concentration and persistence restrictions. Petitioner was assessed as not meeting any listings. Noted considerations included various medical encounters from [redacted], and a consultative examination form [redacted].

Petitioner's testimony concerning uncontrollable hand shaking was indicative of an anxiety symptom that could significantly limit Petitioner's RFC. Hand shaking did not appear to be documented in treatment records. The complaint was noted in a consultative examination report (see Exhibit 1, p. 255). Petitioner reported weekly panic attacks lasting 5-10 minutes which cause arm and leg shaking. The examiner went on to find that Petitioner was capable of performing employment.

"Mild" restrictions were generally consistent with presented counseling documents and a consultative examination report. "Mild" restrictions to concentration, social interaction, and concentration/persistence are not indicative of restrictions that would reduce Petitioner's employment opportunities. Such restrictions would reasonably only preclude

performance involving complex skills or large amounts of social interaction. The analysis will proceed to consider Petitioner's exertional restrictions.

Petitioner testified her left-hand gripping is restricted due to Raynaud's syndrome. Treatment for Raynaud's was either not apparent or not sufficiently notable to infer restrictions to dexterity.

Petitioner testified she always relies on a cane for ambulation. Petitioner testified she is capable of walking only 5-10 steps before stopping. Petitioner testified she can only stand a "couple minutes" (with or without her cane). Petitioner testified she is restricted to sitting for 20-minute periods due to hip, leg, and lumbar pain. Petitioner testified she is limited to lifting/carrying of 2 pounds.

Petitioner testified she has difficulty showering due to bending restrictions. Petitioner testified putting on shoes or socks is difficult because of bending limitations. Petitioner testified she performs housework and laundry, but only for short periods before a break is needed. Petitioner testified she is unable to shop other than waiting in front of a store while a friend shops for her. Petitioner testified she can drive and that she drove about 5 miles to the hearing.

Petitioner's specialist testified that she has witnessed Petitioner's deterioration. Petitioner's specialist testified that she observed Petitioner's use of a cane. Petitioner's specialist testified that Petitioner has called several times in a crying state. Petitioner's specialist also testified that Petitioner has asked for assistance in carrying documents.

The testimony of Petitioner and her specialist was indicative of excruciating pain that severely limits Petitioner's activities. The evidence supporting the allegations was less than compelling.

Petitioner's lumbar radiology noted disc bulges and stenosis. Radiology from 2017 noted *mild* disc bulges causing stenosis. Mild disc bulges and/or mild stenosis is generally indicative of mild pain that should be controllable through traditional treatments such as physical therapy, injections, or pain medication.

Hip radiology from 2015 was also not indicative of major dysfunction. No joint narrowing was noted after radiology. Based on Petitioner's general lack of complaint of hip pain in 2016, it is assumed that hip pain does not contribute to Petitioner's complaints.

Petitioner did not indicate when her reliance on a cane began. Presented documents did not appear to document Petitioner's use of a cane nor any substantiation for such a need. As recently as [redacted], Petitioner's orthopedist noted Petitioner had a normal gait, full strength, and no need for a cane. It is notable that the orthopedist treatment document was the most recent medical treatment document presented. The consideration implies restrictions far less significant than those alleged by Petitioner.

It is also notable that smoking cessation was recommended to reduce pain. Cessation of smoking was one remedy not attempted by Petitioner, at least throughout her alleged period of disability.

In support of Petitioner, Petitioner's treatment history documented multiple attempts at different therapies. Petitioner's and her physician's efforts into therapy was indicative of pain complaints that were more severe than indicated by radiology.

The diagnosis for fibromyalgia is helpful to Petitioner in closing some gap between Petitioner's pain complaints and dysfunction verified by radiology. Fibromyalgia is a diagnosis which can potentially exacerbate body pains. The disorder is not steeped in objective criteria so that degrees of its effects can be easily be inferred. A reference to chronic pain syndrome and concern about a neurological disorder were also documented in treatment records.

Consideration was given to inferences that can be made concerning a bilateral Hoffman's reflex. A positive sign can be indicative of a nerve injury, though it can also be indicative of anxiety. Without follow-up neurological treatment, Petitioner's positive Hoffman's reflex is not insightful into restrictions.

Given presented evidence, Petitioner is deemed capable of sitting for extended periods (with a sit/stand option) and reduced sitting or ambulation (approximately 2 hours within an 8-hour workday). Petitioner is likely limited in bending due to pain.

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 provided a written list of her work history from the past 15 years (see Exhibit 1, p. 81). Listed employment that likely amounted to SGA included work as a cashier. Petitioner also reported working 40 hours per week at a "call-center for donations." It is assumed that Petitioner's employment for a call center involved telemarketing.

Telemarketing is a job consistent with extended periods of sitting allowing for a sit/stand option. The job is not one that is expected to require lifting/carrying of more than nominal weight or significant bending. It would be expected that such jobs require minimal standing and/or ambulation. Telemarketing employment is consistent with Petitioner's RFC.

It is found that Petitioner is capable of past employment. Accordingly, 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]