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: April 28, 2017
MAHS Docket No.: 17-002221
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. 20-26).

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 was a 52-year-old female.

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

8. Petitioner's highest education year completed was the 9th grade.

9. Petitioner has a history of unskilled light employment, with no known transferrable job skills.

10. Spinal stenosis, osteoporosis, colon cancer, bilateral shoulder dysfunction, COPD, and thrombosis combine to preclude Petitioner's performance of light 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).

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (July 2015), p. 4. The goal of the SDA program is to provide financial assistance to meet a disabled person's basic personal and shelter needs. *Id*. To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older. BEM 261 (January 2012), p. 1. A person is disabled for SDA purposes if he/she:

- receives other specified disability-related benefits or services, see Other Benefits or Services below, or
- resides in a qualified Special Living Arrangement facility, or
- is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability; or
- is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS).

Id.

Petitioner requested a hearing to dispute the denial of 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. 5-8) dated [redacted], verifying Petitioner's application was denied based on a determination that Petitioner was not disabled.

Generally, state agencies such as MDHHS must use the same definition of SSI disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally defined as the inability to do any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months [90 days for SDA eligibility]. 20 CFR 416.905.

SGA means a person does the following: performs significant duties, does them for a reasonable length of time, and does a job normally done for pay or profit. *Id*., p. 9. Significant duties are duties used to do a job or run a business. *Id*. They must also have a degree of economic value. *Id*. The ability to run a household or take care of oneself does not, on its own, constitute SGA. *Id*.

The person claiming a physical or mental disability has the burden to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CFR 413.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a).

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled. 20 CFR 416.920. If there is no finding of disability or lack of disability at each step, the process moves to the next step. 20 CFR 416.920 (a)(4).

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person is statutorily blind or not. The 2016 monthly income limit considered SGA for non-blind individuals is [redacted].

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.

Various treatment documents for a pelvic mass from 2015 (Exhibit 1, pp. 81-107, 208-229, 368-409) were presented. On [redacted], it was noted that Petitioner had a large pelvic mass causing abdominal pain (see Exhibit 1, pp. 98-100). On [redacted] Petitioner underwent a hysterectomy (see Exhibit 1, p. 92). On [redacted], Petitioner was returned to "full activity" by her physician (see Exhibit 1, p. 84). It was noted Petitioner had kidney damage as a result of the tumor compression (see Exhibit 1, p. 112).

Various physician office visit and testing documents from 2015 (Exhibit 1, pp. 166-201) were presented. Left shoulder radiology from [redacted] was normal. Complaints of left ear pain, urinary tract infection, and back pain were noted.

Hospital documents (Exhibit 1, pp. 241-249, 416-427, 435-436) dated [redacted], were presented. A complaint of left calf pain was noted. Venous lower duplex reports

(Exhibit 1, pp. 230-231, 239-240, 410-411) indicated no evidence of DVT. A pelvis CT report (Exhibit 1, pp. 232-233) noted calcifications without aneurysm were noted; all other impressions were unremarkable. A discharge diagnosis of superficial thrombophlebitis was noted.

Physician office visit notes (Exhibit 1, pp. 162-165) dated [redacted], were presented. It was noted that Petitioner presented for follow-up of a blood clot in her left leg. Petitioner reported compression stockings caused a burning sensation. Testing was planned.

Left and right leg venous duplex reports (Exhibit 1, p. 160-161, 412-413, 440--441) dated [redacted], were presented. An impression of no DVT was noted. Superficial vein thrombosis was noted.

Physician office visit notes (Exhibit 1, pp. 156-159) dated [redacted], were presented. It was noted that Petitioner presented for follow-up of blood clots. Left ear problems were reported. A complaint of abdominal tenderness in place of surgery was noted. Petitioner requested a referral to a specialist to have a leg vein removed. Diagnoses included left ear otalgia, lower extremity phlebitis and thrombophlebitis, and leg cellulitis. A referral to a vascular surgeon was noted.

An ultrasound report (Exhibit 1, p. 153, 442) dated [redacted], was presented. An impression of right kidney parenchymal thinning was noted.

Physician office visit notes (Exhibit 1, pp. 149-152) dated [redacted], were presented. It was noted that Petitioner presented to have insurance documents completed. Medications were continued.

A bone densitometry report (Exhibit 1, pp. 147-148, 445-446) dated [redacted], was presented. Abnormal spinal bone density with a T score of -1.5 was noted. It was noted the possibility of a major spinal fracture within 10 years was 6.4%

A gynecologist letter (Exhibit 1, p. 76) dated [redacted], was presented. It was noted Petitioner was doing well, though complaints of right lower quadrant pain were noted. A plan of a chest CT was noted.

Physician office visit notes (Exhibit 1, pp. 144-146) dated [redacted], were presented. It was noted that Petitioner presented to discuss bone density test results. A diagnosis of osteoporosis was noted. Fosamax was started.

A cytologic interpretation report (Exhibit 1, p. 77) dated [redacted] was presented. An impression of no malignancy was noted.

An abdomen CT report (Exhibit 1, pp. 79-80) dated [redacted] was presented. No evidence of metastasis was noted.

Physician office visit notes (Exhibit 1, pp. 140-143) dated [redacted], were presented. It was noted that Petitioner complained of worsening back pain. Difficulty with ambulation was noted. Physical examination assessments included a full range of motion, negative straight-leg-raising test, and no tenderness.

A thoracic spine radiology report (Exhibit 1, p. 139) dated [redacted], was presented. Mild degenerative changes were noted throughout Petitioner's thoracic spine.

A lumbar radiology report (Exhibit 1, p. 138, 455) dated [redacted] was presented. Mild degenerative changes at L3-L4 were noted.

Physician office visit notes (Exhibit 1, pp. 134-37) dated [redacted] were presented. It was noted that Petitioner complained of right-leg swelling. Petitioner reported pain of 8/10 when walking, 4/10 at rest. A plan of pain management was noted.

Physician office visit notes (Exhibit 1, pp. 130-133) dated [redacted], were presented. It was noted that Petitioner complained of a right leg blood clot. A recent broken left pinky toe and back pain complaints were also noted. An inability to stand for long periods of time was noted. Full ranges of motion were noted though spinal tenderness was noted. Xaralto was added to ongoing medications.

A venous duplex reports (Exhibit 1, p.414-415) dated [redacted], was presented. An impression of no DVT was noted. Acute superficial vein thrombosis was noted.

Physician office visit notes (Exhibit 1, pp. 126-129) dated [redacted] were presented. It was noted that Petitioner complained of ongoing lumbar and abdominal pains. Normal lumbar range of motion was noted and full muscle strength were noted. A lumbar MRI was planned. Various medications were continued.

A lumbar spine MRI report (Exhibit 1, pp. 124-125, 356-357) dated [redacted], was presented. A disc protrusion and ligamentum flavum was noted to cause mild-to moderate canal stenosis and moderate right-sided foraminal narrowing at L3-L4. Mild foraminal narrowing at L4-L5 was noted.

Physician office visit notes (Exhibit 1, pp. 120-123) dated [redacted], were presented. It was noted that Petitioner received ear drops for ear discharge. Monthly breast exams were planned. The lumbar MRI was discussed, though treatment was not apparent.

Venous surgery discharge instructions (Exhibit 1, p. 206) dated [redacted], were presented. A return-to-work date in 1-2 weeks was noted.

Petitioner-completed documents related to chiropractor treatment (Exhibit 1, pp. 354-355) dated [redacted], were presented. A complaint of back pain was reported.

Physician office visit notes (Exhibit 1, pp. 116-119) dated [redacted], were presented. It was noted that Petitioner complained of an abdominal lump, increasing over 2 months. A complaint of cold and cough was also noted. Leg tenderness from a vein surgery was noted. A breathing treatment was performed. Diagnoses included COPD and generalized abdominal pain. A plan of a follow-up in 2 months on the mass was noted.

Physician office visit notes (Exhibit 1, pp. 112-115) dated [redacted], were presented. It was noted that Petitioner presented for follow-up of a lump in her stomach. Petitioner also reported abdominal pain, and limited motion of her left shoulder; a physical examination noted limited shoulder motion. Lumbar range of motion was unlimited. Monthly breast exams were planned.

Pain management physician office visit notes (Exhibit 1, pp. 358-361) dated [redacted], were presented. It was noted that Petitioner complained of back pain. An antalgic gait and spinal tenderness was noted. Restricted spinal range of motion was noted. A plan of PT was noted.

Pain management office visit documents (Exhibit 1, pp. 322-329; Exhibit A, p. 2) dated [redacted], were presented. Petitioner complained of ongoing lumbar pain (6/10) which radiated to the left buttocks. Petitioner reported recently completed PT had no lasting benefit. Use of a TENS unit was noted to be helpful. An antalgic gait and diffuse spinal tenderness were noted. Moderate restrictions to lumbar flexion and extension were noted. Petitioner declined injections. Massage and yoga were discussed. Prescribed medications included Percocet and hydrochlorothiazide.

Physician office visit notes (Exhibit 1, pp. 336-339) dated [redacted], were presented. It was noted that Petitioner complained of “unbearable” bilateral shoulder pain. It was noted Percocet was helping but was stopped because a recent drug test found no evidence of Percocet in her system. A left-shoulder MRI from [redacted] was noted to demonstrate bursitis and rotator cuff tendonitis and a tear. A right-shoulder MRI from [redacted] was noted to demonstrate a rotator cuff tear. Naproxen was prescribed. An assessment of left shoulder impingement syndrome was noted.

After-visit hospital documents (Exhibit A, pp. 3-9) from an admission dated [redacted] were presented. A primary diagnosis of “not on File” was noted. A secondary diagnosis of colon polyp was noted. Various medications were prescribed and continued. A discharge date of [redacted].

Procedure visit documents (Exhibit B, p. 5-8) dated [redacted], were presented. Pelvic pain was noted. Instructions for a future surgery were noted.

Petitioner testimony alleged impairment, in part, due to knee problems. Petitioner testified she has right knee arthritis. Petitioner testified her left knee will sometimes “pop-out” and has to be popped back into place. Petitioner testified her right knee is

achy and swells. Notable treatment for knee arthritis or complaints of “popping” was not apparent. It is found Petitioner failed to verify a severe impairment related to knee pain.

COPD and breathing treatments were documented. Spirometry testing was not apparent. Thus, minimal inferences can be made concerning the severity of Petitioner’s breathing difficulties.

Petitioner testimony alleged impairment, in part, due to hip arthritis. Petitioner testified standing causes her to repeatedly shift her weight. Treatment for hip arthritis was not apparent. It is found Petitioner failed to verify a severe impairment related to hip pain.

Petitioner testified she has a history of ovarian cancer. Petitioner testified she follows-up with a physician every 3 months for check-ups.

Petitioner testified she was recently diagnosed with colon cancer. Petitioner testified she underwent related surgery 14 days earlier. Petitioner testified she is expected to recover from surgery in 4-8 weeks. Petitioner testified she has used a cane since undergoing surgery. The surgery was not verified, though presented documents were consistent with Petitioner’s testimony as a surgery was scheduled shortly after a colon polyp was discovered.

Petitioner testified she deals with recurrent leg blood clots. Petitioner testified a vein was removed on her left leg in [redacted], though she has developed 3 clots since surgery. Petitioner testified the clots are painful. Petitioner testified she undergoes daily shots and blood thinner because of the clots and/or DVT history. The testimony was consistent with presented treatment history.

Petitioner testified she has pain in both of her shoulders and back. Petitioner testified arthritis affects each. The testimony was consistent with presented treatment history.

Petitioner testified she used pain medications in the past, but stopped because they made her feel constipated. Petitioner testified she relies on marijuana to treat pain. Petitioner testified that lying down also helps to relieve pain.

Presented medical records verified diagnoses and treatment for recurrent blood clots, lumbar stenosis, osteoporosis, and bilateral shoulder problems. A more recent treatment for colon cancer was also sufficiently verified. Presented records were generally consistent with degrees of ambulation, standing, and lifting/carrying restrictions. The treatment history was established to have lasted at least 90 days (other than colon cancer treatment) 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 and shoulder pain. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively or perform fine and gross movements with both upper extremities.

A listing for spinal disorders (Listing 1.04) was considered based on Petitioner's lumbar complaints. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root.

A listing for chronic pulmonary insufficiency (Listing 3.02) was considered based on Petitioner's complaints of dyspnea. The listing was rejected due to a lack of respiratory testing evidence.

A listing for cancer of the large intestines (Listing 13.18) was considered based on apparent colon cancer treatment. The listing was rejected due to a failure to establish the cancer was inoperable, was with metastases, or involved small-cell carcinoma.

It is found that Petitioner failed to establish meeting (or equaling) a SSA listing. Accordingly, the analysis moves to the fourth step.

The fourth step in analyzing a disability claim requires an assessment of the Petitioner's residual functional capacity (RFC) and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if it is determined that a petitioner can perform past relevant work. *Id*.

Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

Petitioner testified her only past relevant work was as a cashier/stocker/manager for a convenience store. Petitioner testified her duties included ordering stock, stocking shelves, and cashiering. Petitioner testified her job involved mostly standing. Petitioner's testimony implied stocking shelves required frequent lifting and carrying.

Petitioner testimony implied she is not capable of performing the standing or lifting/carrying required of her former employment. Petitioner's testimony is consistent

with treatment of blood clots, bilateral shoulder dysfunction, osteoporosis, and lumbar pain.

It is found Petitioner is not capable of performing past employment. 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 CFR 416.967.

Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b) Even though weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additionally limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.*

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.*

Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.*

Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands are considered non-exertional. 20 CFR 416.969a(a). Examples of non-exertional limitations include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (e.g. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i)-(vi) If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2)

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

Given Petitioner's age, education and employment history a determination of disability is dependent on Petitioner's ability to perform light employment. Social Security Rule 83-10 states that the full range of light work requires standing or walking, off and on, for a total of approximately 6 hours of an 8-hour workday.

Petitioner testified back, leg, and hip pain restrict her ambulation to 1 block and standing to periods of 20 minutes. Petitioner testimony estimated she can sit for 45 minutes before needing to stand. Petitioner testified her lifting/carrying is limited to 5 pounds. Petitioner testified her gripping/grasping is restricted due to hand cramping.

Petitioner testified she uses a stool when showering. Petitioner testified she has to sit when putting on pants; Petitioner testified she is unable to put on a bra due to shoulder pain. Petitioner testified she does housework, but takes many breaks. Petitioner testified she cannot go into her basement to do laundry. Petitioner testified she uses a scooter when shopping. Petitioner testified she drives, but never for longer than an hour.

Petitioner's testimony was indicative of an inability to perform light employment. The analysis will proceed to compare Petitioner's statements to presented medical records.

An internal medicine examination report (Exhibit 1, pp. 344-350) dated [redacted], was presented. The report was noted as completed by a consultative physician. Petitioner reported ongoing complaints of hip, bilateral shoulder, back, and knee pains.

It was noted Petitioner ambulated without walking assistance. Notable physical examination findings included the following: bilateral shoulder tenderness, left knee tenderness, negative straight-leg-raising tests, unimpaired dexterity, and no difficulty getting on-and-off examination table. Reduced ranges of motion were noted in Petitioner's lumbar flexion (80°- normal 90°) and flexion (20°- normal 25°). Bilateral shoulder motions were unrestricted. Bilateral knee flexion was limited (left- 130°, right- 140, normal 25°). A stable gait was noted. An impression of post-surgical scarring was noted concerning abdominal pain complaints. Petitioner was deemed capable of sitting, standing, and bending- each without stated restriction.

The consultative physician's absence of stated restrictions to standing, lifting/carrying, and ambulation was indicative of an ability to perform light employment. The absence of stated restrictions was not particularly consistent with treatment records.

Petitioner's physician documented a need for a TENS unit and an antalgic gait just a few days before Petitioner's consultative examiner. This consideration is indicative of ambulation restrictions which would likely preclude the performance of light employment.

The consultative examiner noted decreased lumbar range of motion and spinal tenderness. Bilateral knee ranges of motion were also verified. Some degree of restriction could be inferred based on the findings.

Petitioner's treatment history documented recurrent problems with blood clots of the legs. Despite treatment, the problem appears to cause some degree of leg impairments.

Lumbar radiology verified mild-to-moderate canal stenosis and moderate foraminal stenosis. Generally, any level of stenosis is indicative of pain. Mild-to-moderate stenosis is indicative of pain that could inhibit long periods of standing. Presented records were not particularly indicative of improvement of pain over time as a TENS unit had to be prescribed in 2017.

Petitioner's treatment records also documented bursitis and a torn rotator cuff. The injuries could reasonably preclude Petitioner's performance of the lifting/carrying required of light employment.

Based on presented evidence, it is found Petitioner is not capable of performing light employment. For purposes of this decision, it will be found that Petitioner is capable of performing sedentary employment.

Based on Petitioner's exertional work level (sedentary), age (approaching advanced age), education (less than high school), employment history (unskilled), Medical-Vocational Rule 201.09 is found to apply. This rule dictates a finding that Petitioner is disabled. Accordingly, it is found that MDHHS improperly 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 improperly denied Petitioner's application for SDA benefits. It is ordered that MDHHS begin to perform the following actions within 10 days of the date of mailing of this decision:

(1) reinstate Petitioner's SDA benefit application dated September 27, 2016;
(2) evaluate Petitioner's eligibility subject to the finding that Petitioner is a disabled individual;
(3) initiate a supplement for any benefits not issued as a result of the improper application denial; and
(4) schedule a review of benefits in one year from the date of this administrative decision, if Petitioner is found eligible for future benefits.

The actions taken by MDHHS are **REVERSED**.

CG/hw

Christian Gardocki
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

DHHS

[redacted]

Petitioner

[redacted]