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

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: April 28, 2017
MAHS Docket No.: 17-002306
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] manager.

ISSUE

The issue is whether MDHHS properly denied Petitioner's State Disability Assistance (SDA) eligibility for the reason that Petitioner is not a disabled individual.

FINDINGS OF FACT

The administrative law judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On [redacted], Petitioner applied for SDA benefits.

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

3. On [redacted] the Disability Determination Service determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 25-31).

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 (see Exhibit 1, p. 2) disputing the denial of SDA benefits.

6. As of the date of the administrative hearing, Petitioner was a 49-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 12th grade (via general equivalency degree).

9. Petitioner has no past and relevant employment history amounting to SGA earnings.

10. Sufficiently available sedentary employment exists for Petitioner to perform despite impairments related to cardiac dysfunction, complications related to a skull fracture, right shoulder pain, and psychological problems.

CONCLUSIONS OF LAW

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. MDHHS administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. MDHHS policies for SDA are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

Petitioner requested a hearing to dispute the denial of an SDA application. Petitioner claimed an inability to work for 90 days due to mental and/or physical disabilities. MDHHS presented a Notice of Case Action (Exhibit 1, pp. 493-496) dated [redacted], verifying Petitioner's application was denied based on a determination that Petitioner was not disabled.

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

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

Id.

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

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

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

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

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person is statutorily blind or not. The 2016 monthly income limit considered SGA for non-blind individuals is $1,130.00.

Petitioner credibly denied performing current employment; no evidence was submitted to contradict Petitioner's testimony. Based on the presented evidence, it is found that Petitioner is not performing SGA. Accordingly, the disability analysis may proceed to the second step.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the durational requirement. 20 CFR 416.920 (a)(4)(ii). The impairments may be combined to meet the severity requirement. If a severe impairment is not found, then a person is deemed not disabled. *Id*.

The impairments must significantly limit a person's basic work activities. 20 CFR 416.920 (a)(5)(c). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. *Id.* Examples of basic work activities include:

- physical functions (e.g. walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling)
- capacities for seeing, hearing, and speaking, understanding; carrying out, and remembering simple instructions
- use of judgment
- responding appropriately to supervision, co-workers and usual work situations; and/or
- dealing with changes in a routine work setting.

Generally, federal courts have imposed a de minimus standard upon petitioners to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v Bowen,* 880 F2d 860, 862 (6th Cir. 1988). Similarly, Social Security Ruling 85-28 has been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirements are intended "to do no more than screen out groundless claims." *McDonald v. Secretary of Health and Human Servs.*, 795 F.2d 1118, 1124 (1st Cir. 1986).

SSA specifically notes that age, education, and work experience are not considered at the second step of the disability analysis. 20 CFR 416.920 (5)(c). In determining whether Petitioner's impairments amount to a severe impairment, all other relevant evidence may be considered. The analysis will begin with a summary of presented medical documentation.

Physician office visit notes (Exhibit 1, pp. 166-170) dated [redacted] were presented. It was noted that Petitioner reported severe back pain following a fall from the day before. Ongoing depression was also noted. Norco was prescribed.

Psychotherapy office visit notes (Exhibit 1, pp. 171-175) dated [redacted], were presented. Ongoing treatment for depression was noted. A history of 4 inpatient hospitalizations over 20 years was noted. Reported stressors included financial difficulties, health, bed bugs, and aging parents. Breathing exercises were practiced.

A thoracic spine x-ray report (Exhibit 1, p. 227) dated [redacted], was presented. No abnormalities were noted.

Hospital emergency room documents (Exhibit 1, pp. 476-486) dated [redacted], were presented. It was noted that Petitioner complained of migraine headache. Petitioner reported having 1-2 headaches per year since her skull was fractured in 1997. Petitioner reported the pain was worsened by taking Norco. Medications were prescribed.

Physician office visit notes (Exhibit 1, pp. 175-179) dated [redacted], were presented. Treatment for mid-back pain, tooth pain, and CAD was noted. Completed PT was reported to not reduce back pain. It was noted Petitioner's upper gum was draining. Norco, Nitrostat, Valium, and various other medications were continued.

Physician office visit notes (Exhibit 1, pp. 87-90) dated [redacted], were presented. It was noted that Petitioner reported daily stress-related angina. A history of multiple stent insertion and a 2-vessel bypass was noted. Current meds were continued.

Physician office visit notes (Exhibit 1, pp. 180-184) dated [redacted], were presented. Diagnoses of depression (moderate and recurrent) and HTN were noted. Various medications were continued.

Hospital emergency room documents (Exhibit 1, pp. 486-489) dated [redacted], were presented. Petitioner complained of dental pain. It was noted Petitioner was awaiting dentures, but needed heart clearance. Cephalexin was prescribed.

Physician office visit notes (Exhibit 1, pp. 185-190) dated [redacted], were presented. It was noted Petitioner presented with anxiety symptoms of headache, tearfulness, irritability, and nausea. Prozac was prescribed in response to Petitioner's request. Lexapro was continued.

Mental counseling office visit notes (Exhibit 1, pp. 191-195) dated [redacted], from a treating social worker were presented. Petitioner reported increased stressors. Coping skills were discussed.

Nurse practitioner office visit notes (Exhibit 1, pp. 196-200) dated [redacted] were presented. Ongoing depression treatment was noted. Unspecified symptoms were noted to be poorly controlled.

Mental counseling office visit notes (Exhibit 1, pp. 201-204) dated [redacted], from a treating social worker were presented. Petitioner reported improvement (5/10) with use of breathing techniques. Dental pain and bed bugs were noted as stressors.

A thoracic spine x-ray report (Exhibit 1, p. 490) dated [redacted] were presented. An impression of no abnormalities was noted.

Hospital emergency room documents (Exhibit 1, pp. 305-346) dated [redacted], were presented. It was noted that Petitioner presented with complaints of left-sided

chest pain ongoing for a morning. Petitioner was noted to be a daily smoker. Lab results noted mild cytosis, with low potassium and low magnesium. A chest x-ray was normal, though a density indicative of granuloma was noted. Various medications were administered. Noted discharge diagnoses included hypomagnesemia and hypokalemia. Follow-up with a PCP was recommended.

Hospital emergency room documents (Exhibit 1, pp. 347-362) dated [redacted], were presented. It was noted that Petitioner presented with complaints of rash. It was noted Petitioner had an allergic reaction to taking Lamictal. A steroid shot was administered. Petitioner's request for Norco was denied. Follow-up with a PCP was recommended.

Hospital emergency room documents (Exhibit 1, pp. 363-379) dated [redacted], were presented. It was noted that Petitioner presented with complaints of rash and mouth lesions. It was noted Petitioner was undergoing cardiac testing to have teeth pulled. Various medications were administered.

Cardiac testing results (Exhibit 1, p. 84) dated [redacted], were presented. It was noted Petitioner reached 6.3 METs. An ECG was noted to be normal. An initial trial of medical therapy was recommended due to sub-maximal treadmill exercise. A cardiologist deemed the results to be normal (see Exhibit 1, p. 114).

Nurse practitioner office visit notes (Exhibit 1, pp. 205-208) dated [redacted] were presented. It was noted Petitioner was recently seen in an emergency room for allergic medication reaction; meds were updated. Dental surgery was noted to be pending.

Hospital emergency room documents (Exhibit 1, pp. 380-396) dated [redacted] were presented. It was noted that Petitioner presented with a complaint of an ongoing rash on the back of her hands. Petitioner reported no improvement with recently prescribed cream. Headaches, reported to be secondary to itching, were reported. The rash was noted to be possibly caused by medication, which Petitioner reportedly did not want to stop taking. Petitioner's medication was updated.

Nurse practitioner office visit notes (Exhibit 1, pp. 209-212) dated [redacted] were presented. Routine gynecological examinations were noted. Difficulty with anxiety was reported.

Hospital emergency room documents (Exhibit 1, pp. 397-411) dated [redacted], were presented. It was noted that Petitioner presented with a complaint of a sinus infection. Ibuprofen and a nasal spray were administered.

Hospital emergency room documents (Exhibit 1, pp. 412-450) dated [redacted], were presented. It was noted that Petitioner presented with a complaint of a radiating chest pain, ongoing since that day. Recent cardiac testing was noted to be normal. An EKG and chest radiology were unremarkable for cardiac dysfunction.

Physician office visit notes (Exhibit 1, pp. 80-83) dated [redacted] were presented. It was noted that Petitioner presented for follow-up of chest pain. A plan of continuing medications and stress testing was noted.

Nurse practitioner office visit notes (Exhibit 1, pp. 213) dated [redacted], were presented. Ongoing treatment for worsening of anxiety and depression was noted. Petitioner reported recent audio hallucinations. Medications were continued.

Hospital documents (Exhibit 1, pp. 91-98, 108-110, 116-126, 232-297) from an admission dated [redacted], were presented. It was noted Petitioner presented with a complaint of chest pain. A chest x-ray was negative. EKGs were noted to show sinus brachycardia with negative troponins. It was noted Petitioner underwent catheterization and stent placement, in part, due to extensive history of CAD. It was noted Petitioner ambulated without difficulty at discharge. Various medications were prescribed. A discharge diagnosis of angina (class IV) was noted. A discharge date of [redacted], was noted. A follow-up on [redacted] was planned.

Cardiologist office visit notes (Exhibit 1, pp. 111-115) dated [redacted], were presented. Ongoing chest pain was reported by Petitioner. A history of double-bypass surgery, 6 stents, and angina (class IV), COPD, dyslipidemia, and HTN was noted. An angiogram was recommended.

Hospital emergency room documents (Exhibit 1, pp. 451-464) dated [redacted], were presented. It was noted that Petitioner complained of right shoulder and right elbow pain. Norco was issued.

Physician office visit notes (Exhibit 1, pp. 99-107) dated [redacted], were presented. It was noted that Petitioner complained of chronic right-shoulder pain, and right-elbow pain. Various medications were continued.

Physician office visit notes (Exhibit 1, pp. 218-223) dated [redacted], were presented. Improved right-shoulder pain, with valium, was noted.

Hospital emergency room documents (Exhibit 1, pp. 465-475) dated [redacted], were presented. It was noted that Petitioner complained of right shoulder pain. Petitioner reported overusing her arm the day before. Full strength and range of motion was noted. Tylenol #3 was prescribed.

Physician office visit notes (Exhibit A, pp. 5-8) dated [redacted], were presented. Right rotator-cuff tear treatment was noted. Various medications were prescribed.

A Psychiatric/Psychological Medical Report (Exhibit 1, pp. 73-79) dated [redacted], was presented. The report was noted as completed by a consultative licensed psychologist and a limited-licensed psychologist. Petitioner reported ongoing

depression shortly after her 26-year-old son was born. Petitioner reported a head fracture from 1997 caused by domestic violence. Noted observations of Petitioner made by the consultative examiner include the following: in-contact with reality, focused on symptoms, fatigued appearance, mild dysphoria. Diagnoses included persistent depression and drug/alcohol use disorder. A guarded prognosis was noted.

Physician office visit notes (Exhibit A, pp. 1-4) dated [redacted] were presented. Treatment for back and musculoskeletal pain was noted. Diagnosis of improving acute left lumbar pain, chronic right shoulder pain, and nicotine dependence were noted. Low-dose aspirin, Lamictal, Lexapro, Lisinopril, Metoprolol, Norco (325 mg), Wellbutrin, and other meds were continued.

Petitioner reported restrictions, in part, related to teeth problems. Petitioner testified she only has 15-16 teeth left. Petitioner testified she is unable to have teeth pulled because of blood thinner medication she is taking. Petitioner testified her dental appearance renders her to be unattractive to employers.

It is appreciated Petitioner may feel self-conscious about her teeth. Petitioner's concern may be relevant to self-esteem, which may impact psychological disorders. Petitioner's dental appearance cannot be directly factored as an impairment.

Petitioner's history referenced occasional complaints of dental pain. The records were not recurrent nor recent enough to presume that dental pain is an ongoing impairment.

Petitioner testified she has a history of coronary artery disease. Petitioner testified her history included 8 heart stents and double bypass surgery. Petitioner testified she requires stress testing every 6 months.

Petitioner testified she has ongoing right shoulder pain due to a torn rotator cuff and arthritis. Petitioner testified she is awaiting surgery and will likely have to undergo 6 months of rehabilitation.

Petitioner testified her skull was fractured in 1997. Petitioner testified the injury left her comatose for 5 days. Petitioner testified she was awarded disability benefits and has improved steadily since. Petitioner testified she is still forgetful and has difficulty making decision, in part, due to her skull injury.

Petitioner testified she has psychological disorders. Reported symptoms included audio hallucinations, depressed mood, short temper, moodiness, and irritability.

Petitioner testified she does not have hallucinations if she is medication compliant. The hallucinations will not be considered as an impairment as they appear to not restrict Petitioner, assuming medication compliance.

Petitioner testified she has recurrent headaches, related to her skull fracture. The only documentation of a headache related to skull fracture indicated Petitioner goes to the ER only once or twice per year. The recurrence is not deemed to be enough to be considered an impairment to basic work activities.

Presented medical records were consistent of cardiac, psychological, and right shoulder disorders which reasonably impact Petitioner's lifting/carrying, concentration, and other basic work activities. Petitioner's treatment history was established to have lasted at least 90 days and at least since Petitioner's date of SDA application. Accordingly, it is found that Petitioner established having a severe impairment and the disability analysis may proceed to Step 3.

The third step of the sequential analysis requires determining whether the Petitioner's impairment, or combination of impairments, is listed in 20 CFR Part 404, Subpart P, appendix 1. 20 CFR 416.920 (a)(4)(iii). If a petitioner's impairments are listed and deemed to meet the durational requirement, then the petitioner is deemed disabled. If the impairment is unlisted or impairments do not meet listing level requirements, then the analysis proceeds to the next step.

A listing for joint dysfunction (Listing 1.02) was considered based on Petitioner's functionally comparable problem with her rotator cuff. The listing was rejected due to a failure to establish that Petitioner is unable to perform fine and gross movements with both hands.

Cardiac-related listings (Listing 4.00) were considered based on Petitioner's cardiac treatment history. Petitioner failed to meet any cardiac listings.

A listing for chronic skin infections (Listing 8.04) was considered based on Petitioner's rash treatment. The listing was rejected due to a failure to establish extensive fungating or extensive ulcerating skin lesions that persist for at least 3 months despite continuing prescribed treatment.

A listing for affective disorder (Listing 12.04) was considered based on diagnoses of depression. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Petitioner required a highly supportive living arrangement, suffered repeated episodes of decompensation, or that the residual disease process resulted in a marginal adjustment so that even a slight increase in mental demands would cause decompensation.

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

The fourth step in analyzing a disability claim requires an assessment of the Petitioner's residual functional capacity (RFC) and past relevant employment. 20 CFR

416.920(a)(4)(iv). An individual is not disabled if it is determined that a petitioner can perform past relevant work. *Id*.

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

Petitioner testified she has had zero employment in the 15 years before her date of SDA application. Petitioner's testimony was credible and unrebutted.

Without any past and relevant employment, Petitioner cannot be found capable of returning to the performance of past employment. Accordingly, the disability 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 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 is limited to walking of a block due to leg pain and dyspnea. Petitioner testified she is limited to standing or sitting periods of an hour. Petitioner testified she is unable to state her lifting/carrying abilities. Petitioner testified she had no

problems with gripping or grasping. Petitioner was unable to state if her shoulder would inhibit typing.

Petitioner testified she has difficulty washing and brushing her hair, presumably due to shoulder pain. Petitioner testified she can dress without difficulty. Petitioner testified her shoulder also prevents her from washing dishes, vacuuming, or sweeping. Petitioner did not allege physical obstacles to shopping, though she stated she is indecisive. Petitioner testified she can drive, but it hurts her right arm; Petitioner's boyfriend testified he has witnessed Petitioner have difficulty with driving.

Petitioner testimony was generally consistent with an ability to perform sedentary employment. It is possible that Petitioner's claim of walking could be construed as insufficient to perform sedentary employment.

Treating physician statements of restriction were not provided. Statements of restriction were provided by consultative physicians.

A Physical Residual Functional Capacity Assessment (Exhibit 1, pp. 41-48) dated [redacted], was presented. The assessment was signed by a consultant physician 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, unlimited pushing/pulling, and occasional crawling. Stated considerations included treatment records from [redacted], rotator cuff repair surgery from [redacted], and unspecified history of CAD.

Petitioner's history of heart disease and shoulder dysfunction would likely preclude her from employment requiring lifting/carrying of 10 pounds, long period of standing and/or ambulation, and or most employment involving physical labor. The history was not indicative of restrictions to performance of sedentary employment.

Petitioner testimony conceded no problems with gripping or grasping. There was no evidence that Petitioner's shoulder function affected her hands.

It is found that Petitioner is physically capable of performing a full range of sedentary employment. The analysis will proceed to determine any non-exertional restrictions to sedentary employment.

A Psychiatric Review Technique (Exhibit 1, pp. 134-152) dated [redacted], was presented. The assessment was signed by a licensed psychologist as part of Petitioner's SSA claim of disability. Mild restrictions to understanding, interaction, and independence were noted. A moderate concentration obstacle was noted. It was noted Petitioner reported being socially active. It was noted Petitioner was interviewed and showed no signs of major mental illness. Petitioner was deemed capable of performing unskilled work. Moderate restrictions to maintaining socially apt behavior and

responding to workplace changes were noted. Petitioner was deemed capable of performing simple and unskilled employment.

Petitioner's treatment history was consistent with the restrictions stated by the consultative psychologist. It is found Petitioner is limited to unskilled and simple sedentary employment.

MDHHS did not present vocational evidence of the availability of jobs within Petitioner's abilities. Jobs within the Dictionary of Occupational Titles that are appropriate for Petitioner would include telemarketing, light assembly, data entry, receptionist, customer service telephone representative, and others. Such jobs are not presumed to be insufficiently available that vocation evidence is needed to justify their availability. It is found that sufficiently available sedentary employment exists for Petitioner.

Based on Petitioner's exertional work level (sedentary), age (younger individual aged 45-49), education (high school with no direct entry into skilled work), employment history (no transferrable job skills), Medical-Vocational Rule 201.21 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 October 14, 2016, 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]