STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

Date Mailed: February 1, 2018
MAHS Docket No.: 17-016032
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 January 17, 2018, from Detroit, Michigan. Petitioner appeared and was unrepresented. [redacted], Petitioner's friend, testified on behalf of Petitioner. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted] supervisor, and [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 July 24, 2017, Petitioner applied for SDA benefits (see Exhibit A, pp. 24-1).

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

3. On October 25, 2017, the Disability Determination Service determined that Petitioner was not a disabled individual (see Exhibit A, pp. 257-251).

4. On November 27, 2017, MDHHS denied Petitioner's application for SDA benefits.

5. On December 7, 2017, Petitioner requested a hearing disputing the denial of SDA benefits (see Exhibit A, p. 263)

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 ██-year-old female.

8. Petitioner's highest education year completed was the 10th grade.

9. Petitioner has no past and relevant employment from the past 15 years.

10. Petitioner has restrictions which allow the performance of sufficiently available non-complex sedentary and 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 (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.

MDHHS presented a Notice of Case Action (Exhibit 1, pp. 262-259) dated November 27, 2017, verifying Petitioner's application was denied based on a determination that Petitioner was not disabled. Petitioner's only alleged basis for SDA was an inability to work for 90 days due to mental and/or physical disabilities.

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.

Generally, state agencies must use the same definition of disability as used for Supplemental Security Income (SSI) (see 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. The remainder of the analysis considers the specific disability evaluation set forth by federal SSI regulations.

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 $

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.

A Medical Examination Report (Exhibit A, pp. 39-37) dated ██████████ was presented. The form was completed by a family practice physician with an approximate eight month history of treating Petitioner. Restrictions to memory concentration, and social interaction were noted; the restrictions were noted to be indefinite. The assessment was not factored due to its age, other than establishing Petitioner's history of mental health problems.

A Mental Residual Functional Capacity Assessment (Exhibit A, pp. 111-110) dated ██████████ was presented. The assessment was signed by a social worker. Marked restrictions to various work activities were noted. It was noted Petitioner demonstrated "severe" anxiety. The assessment was not factored due to its age, other than establishing Petitioner's history of mental health problems.

A lumbar spine radiology report (Exhibit A, p. 79) dated ██████████, was presented. Minimal hypertrophic changes to Petitioner's lumbar spine were noted.

Various treatment records from 2012 and older (Exhibit A, pp. 71-58, 43-40) were presented. Petitioner's complaints of acute sinusitis, constipation, congestion, back pain, anxiety, and sore throat were noted.

Medical center treatment records (Exhibit A, pp. 76-72) dated ██████, were presented. Treatment for bruises as a result of an assault by Petitioner's boyfriend was noted.

Various primary care physician (PCP) office visit notes (Exhibit A, pp. 150-124) from ██████ were presented. Ongoing treatment for back pain, depression, anxiety, and COPD was noted.

Primary care physician office visit notes (Exhibit A, pp. 153-151) dated ██████ were presented. Ongoing PTSD, anxiety, COPD, insomnia, nausea, and lumbar treatment was noted. COPD symptoms included cough upon exertion; Ventolin, Qvar, and Symbicort were continued. Ultram and Naproxen were continued for back pain. It was noted that Petitioner reported increased anger after running out of medications for the past two weeks; Xanax was continued. Seroquel was continued for affective disorder. Promethazine was prescribed for nausea.

Primary care physician office visit notes (Exhibit A, pp. 157-154) dated ██████ were presented. Ongoing PTSD, anxiety, and lumbar treatment was noted. Anxiety was noted to be moderate in severity, but improving. Lumbar pain was noted to be moderate, and unchanged. All extremities had normal range of motion and strength. Straight-leg-raising testing was negative. Lumbar tenderness and a spasm was noted. Ultram, and naproxen were continued for back pain. Latuda was continued for PTSD. Xanax was continued for anxiety.

A Psychosocial Assessment (Exhibit 1, pp. 1-20) dated ██████, was presented. The assessment was signed by a social worker from a mental health treating agency. Petitioner reported depression and social anxiety symptoms. Other symptoms included racing thoughts, feeling overwhelmed, nightmares, and difficulty keeping appointments. Petitioner reported crying on the way to the appointment because of difficulty leaving her home. Petitioner's anxiety was assessed as chronic and severe. Petitioner reported recent weight loss due to depression. Petitioner reported having conversations with people from her past. Daily panic attacks were noted. A history of involvement in abusive relationships was noted. It was noted that Petitioner reported smoking 1-2 packs of cigarettes per day. Assessments included normal thought process, tearful behavior, depressed and anxious affect, normal judgment, and decreased energy. A primary diagnosis of MDD (recurrent and severe) was noted. Other diagnoses included PTSD and social anxiety disorder, mild alcohol use disorder, and moderate cannabis use disorder. Petitioner's GAF was 40 as of June 11, 2014.

Mental health treatment documents (Exhibit A, pp. 218-211) dated ██████. A plan of ongoing therapy of 3-4 times per week was noted.

Nurse practitioner office visit notes (Exhibit A, pp. 210-207) dated ██████, were presented. Exam assessments included normal gait, no abnormal psychomotor activity, bright affect, fair judgment, and fair insight.

Physician assistant office visit notes (Exhibit A, pp. 224-219) dated ██████████, were presented. Normal gait and station were noted. MDD and PTSD were noted to be unstable. Mental health assessments included sad mood, semi-bright affect, no delusions or paranoia, linear thought process, intact memory, questionable impulse control, and fair insight. Medications were updated. Follow-up in four weeks was planned. It was noted Petitioner has never attempted suicide. No psychosis was noted.

A Physical Residual Functional Capacity Assessment (Exhibit A, pp. 167-160) dated ████ ██ ███, 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 of an 8-hour workday, and unlimited pushing/pulling. Comments noted Petitioner had not seen a physician for back pain and that she used bronchodilators for COPD.

Mental health treatment documents (Exhibit 1, pp. 21-28) dated ███████████, was presented. A plan to attend weekly appointments to address depression was noted.

Petitioner alleged walking, sitting, and standing impairments, in part, due to lumbar pain. Petitioner testified she's been treated for lumbar pain for the past 5-6 years. Petitioner testified the only treatments she has attempted were pain medication and a back brace. Petitioner testified she will be attending physical therapy soon. Petitioner testified her current doctor (who treated Petitioner since March 2017) stopped prescribing pain medication.

Petitioner alleged exertional restrictions due to COPD. Petitioner testified she smokes a pack of cigarettes per day. Petitioner testified she experiences dyspnea upon exertion.

Petitioner alleged concentration and social restrictions due to PTSD, depression, and anxiety disorder. Petitioner testified it is difficult for her to be around people, to keep appointments, and to leave her residence. Petitioner testified she has been receiving medications from a nurse practitioner for the past four months and has seen a counselor on a weekly basis for the past year. Before the past few months, Petitioner testified she received her mental health medications from a walk-in clinic.

Presented medical records generally verified a medical treatment history consistent with degrees of exertional restrictions due to COPD and back pain. Presented records also generally verified degrees of concentration and social interaction restrictions due to PTSD, anxiety, and depression. 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, we also consider the medical severity of your impairment(s). 20 C.F.R. § 416.920 (4)(iii). If you have an impairment(s) that meets or equal one of our listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, we will find that you are disabled. *Id*. If you have an impairment(s) which meets the duration requirement and is listed in appendix 1 or is equal to a listed impairment(s), we will find you disabled without considering your age, education, and work experience. *Id*. 20 C.F.R. § 416.920 (d).

Diagnoses for PTSD, anxiety, and depression were noted. Most notably, a recent diagnosis for "severe" depression was noted. The SSA listing for depressive-related disorders justifies a finding of disability based on the following:

12.04 Depressive, bipolar and related disorders (see 12.00B3), satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1 or 2:
   1. Depressive disorder, characterized by <u>five</u> or more of the following:
      a. Depressed mood;
      b. Diminished interest in almost all activities;
      c. Appetite disturbance with change in weight;
      d. Sleep disturbance;
      e. Observable psychomotor agitation or retardation;
      f. Decreased energy;
      g. Feelings of guilt or worthlessness;
      h. Difficulty concentrating or thinking; or
      i. Thoughts of death or suicide.
   2. Bipolar disorder, characterized by <u>three</u> or more of the following:
      a. Pressured speech;
      b. Flight of ideas;
      c. Inflated self-esteem;
      d. Decreased need for sleep;
      e. Distractibility;
      f. Involvement in activities that have a high probability of painful consequences that are not recognized; or
      g. Increase in goal-directed activity or psychomotor agitation.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):
   1. Understand, remember, or apply information (see 12.00E1).
   2. Interact with others (see 12.00E2).
   3. Concentrate, persist, or maintain pace (see 12.00E3).
   4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is "serious and persistent;" that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and
2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

Presented medical records documented reported symptoms including depressed mood, insomnia, decreased energy, concentration difficulty, and diminished interest in activities. It is found that Petitioner meets Part A of the listing for depressive disorders.

Consideration of whether Petitioner meets Part B requires assessing the degree of Petitioner's restrictions. A presented assessment from a SSA consultative examiner was provided.

A Psychiatric Review Technique (Exhibit A, pp. 186-172) dated ██████████, was presented. The document was signed by a licensed psychologist as part of Petitioner's Social Security Administration (SSA) claim of disability. Mild restrictions to understanding, interaction, and adaptation were noted. A moderate restriction to concentration/persistence was noted. Consideration for Petitioner meeting affective disorder and anxiety listings was noted; it was concluded Petitioner did not meet considered listings. A medical examination report was cited ass support for the assessment. The assessment was indicative that Petitioner does not have marked or extreme restrictions.

Petitioner's most recent GAF was noted to be 40. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF of 31-40 is described as "some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood." Petitioner's GAF is highly indicative of marked and/or extreme restrictions which meet listing requirements for disability.

It is notable that Petitioner's GAF was last assessed in ████ The age of Petitioner's GAF does not necessarily preclude accepting the GAF as current, but little evidence would justify doing so.

No records from 2014 justifying Petitioner's GAF were presented. The absence of a context for the GAF is not supportive in accepting Petitioner's GAF as 40.

Petitioner testified she hears a deceased boyfriend talking to her. Petitioner's alleged audio hallucinations could be consistent with marked and/or extreme restrictions. The symptom was documented, but there was not an indication that the hallucination involved psychosis or a loss of reality. Evidence was indicative that reported hallucinations did not significantly affect Petitioner's functioning level.

Petitioner has no history of psychiatric hospitalizations. Petitioner's absence of hospitalizations, despite an alleged recent suicide attempt is not consistent with meeting SSA listings.

Generally, a person's insight and/or judgment closely correspond to their functioning ability. Petitioner's judgment and insight were assessed to be "fair". A fair insight and judgment are not indicative of marked or extreme restrictions.

It is concerning that Petitioner was diagnosed with "severe" depression on ████ ████ The diagnosis becomes less concerning when factoring that Petitioner had not treated with a mental health agency in the prior months. The degree of Petitioner's symptoms would be more insightful after attempts at treatment by the mental health agency.

Consideration was given to an ████ record stating that Petitioner's diagnosis were unstable, which is indicative of a lack of improvement. The statement was not accompanied with any explanation for how Petitioner's symptoms and/or diagnoses were unstable, though Petitioner's impulse control was noted to be questionable.

If Petitioner's psychological symptoms were as severe and long running as stated by Petitioner, it would be expected that Petitioner have consistent and long running attendance at therapy. Presented records documented "poor" engagement by Petitioner with mental health services (see Exhibit 1, p. 221).

Presented records verified better than "poor" engagement, though few mental health treatment records were presented. Presented records verified a physician prescribing medications for several months, verification of a mental health assessment from ████ ████ a general statement that symptoms were unstable in ████, and a counseling session from December 2017; the records were not particularly consistent with marked restrictions.

Based on presented evidence, it is found that Petitioner does not have any marked restrictions. Insufficient evidence of meeting Part C was not presented. it is found Petitioner does not meet the listing for affective disorders.

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 a diagnosis for COPD. The listing was rejected due to a lack of respiratory testing evidence.

Listings for anxiety disorders (Listing 12.06), and stressor disorders (Listing 12.15) were considered based on Petitioner's mental health 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 disability analysis may proceed.

If your impairment(s) does not meet or equal a listed impairment, we 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). We use our residual functional capacity assessment at the fourth step of the sequential evaluation process to determine if you can do your past relevant work… 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 … *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).

For purposes of this decision, a fully developed RFC assessment will not be undertaken at this point. Instead an RFC assessment will be performed, as necessary, in the final steps of analysis.

At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. 20 C.F.R. § 416.920(a)(4)(iv). If you can still do your past relevant work, we will find that you are not disabled. *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). We will not consider your vocational factors of age, education, and work experience or whether your past relevant work exists in significant numbers in the national economy. 20 C.F.R. § 416.960(b)(3).

Petitioner testified she has no work history from the past 15 years. Without any work history from the past 15 years, it must be found that Petitioner cannot return to

performing past and relevant employment from the past 15 years. Accordingly, the disability analysis may proceed to the final step.

If we find that your residual functional capacity does not enable you to do any of your past relevant work or if we use the procedures in § 416.920(h), we will use the same residual functional capacity assessment when we decide if you can adjust to any other work. We will look at your ability to adjust to other work by considering your residual functional capacity and the vocational factors of age, education, and work experience, as appropriate in your case. (*See* § 416.920(h) for an exception to this rule.) Any other work (jobs) that you can adjust to must exist in significant numbers in the national economy (either in the region where you live or in several regions in the country).

At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. 20 C.F.R. § 416.920(a)(4)(v). If you can make an adjustment to other work, we will find that you are not disabled. *Id*. If you cannot make an adjustment to other work, we will find that you are disabled. *Id*.

Your impairment(s) and related symptoms, such as pain, may cause limitations of function or restrictions which limit your ability to meet certain demands of jobs. 20 C.F.R. § 416.969a(a). These limitations may be exertional, nonexertional, or a combination of both. *Id*.

When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect only your ability to meet the strength demands of jobs (sitting, standing, walking, lifting, carrying, pushing, and pulling), we consider that you have only exertional limitations. 20 C.F.R. § 416.969a(b). When your impairment(s) and related symptoms only impose exertional limitations and your specific vocational profile is listed in a rule contained in appendix 2, we will directly apply that rule to decide whether you are disabled. *Id*.

When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect only your ability to meet the demands of jobs other than the strength demands, we consider that you have only nonexertional limitations or restrictions. 20 C.F.R. § 416.969a(c)(1). Some examples of nonexertional limitations or restrictions include the following … nervousness, anxiousness, depression, attention or concentration deficits, difficulty remembering instructions, vision loss, hearing loss, difficulty with environment (e.g. fumes), hand manipulation, bending, crouching, kneeling, or other body maneuvers (see *Id*.).

If your impairment(s) and related symptoms, such as pain, only affect your ability to perform the nonexertional aspects of work-related activities, the rules in appendix 2 do not direct factual conclusions of disabled or not disabled. 20 C.F.R. § 416.969a(c)(2)

Limitations are classified as exertional if they affect your ability to meet the strength demands of jobs. *Id*. To determine the physical exertion requirements of work in the national economy, we classify jobs as *sedentary, light, medium, heavy,* and *very heavy.* 20 C.F.R. § 416.967.

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

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. 20 C.F.R. § 416.967(b). Even though the 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, you must have the ability to do substantially all of these activities. *Id*. If someone can do light work, we determine that he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id*.

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 C.F.R. § 416.967(c). If someone can do medium work, we determine that he or she can also do sedentary and light work. *Id*.

Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 C.F.R. § 416.967(d). If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work. *Id*.

Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. 20 C.F.R. § 416.967(e). If someone can do very heavy work, we determine that he or she can also do heavy, medium, light, and sedentary work. *Id*.

Given Petitioner's age, education and employment history a determination of disability is dependent on Petitioner's ability to perform sedentary employment; for purposes of this decision, an evaluation of light and sedentary employment will be undertaken. 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.

A work history can be sometimes insightful for assessing a client's capabilities. Petitioner testified her last employment was in ████ as a cashier for a dollar store.

Petitioner's lack of recent work history provides no assistance for determining Petitioner's current capabilities.

Petitioner testified she does not use a walk-assistance device to ambulate. Petitioner testified that she is limited to walking two blocks due to back pain and dyspnea. Petitioner testified she is limited to standing or sitting for periods of an hour. Petitioner was not certain how many hours she could sit or stand out of 8 hours.

Petitioner testified she has no difficulties with bathing, dressing, or grooming. Petitioner testified she needs someone to cook for her if her back pain is bad. Petitioner testified she can do housework but needs a break after an hour. Petitioner testified she can do laundry, though her back hurts if she does too much. Petitioner testified she does not drive and that she recently began using public transportation. Petitioner testified she needs someone to go shopping with her and that she has to take anti-anxiety medications before going.

Petitioner testified she sleeps 4-5 hours per night with the assistance of medication. Petitioner testified she attempted suicide a few months ago and reported the incident to her counselor. Petitioner testified all of her days are bad, but they are better when she can see her grandkids; Petitioner testified despite her love of her grandkids, she can only withstand the stress for an hour. Petitioner's friend testified to comparable restrictions for Petitioner.

Petitioner's stated restrictions could be reasonably interpreted to preclude Petitioner's performance of all light and/or sedentary employment. Petitioner's testimony will be evaluated based on presented medical records.

The only presented lumbar radiology verified minor hypertrophic changes. Minor hypertrophic changes are not indicative of exertional restrictions precluding the performance of light or sedentary employment.

Petitioner testified she had a lumbar MRI done a few years ago. Petitioner verified no lumbar radiology since 2012. The absence of lumbar radiology since 2012 is not indicative of exertional restrictions.

Petitioner's only verified back treatment was pain medication, which Petitioner testified she no longer takes. Petitioner testified she used a back brace, but this was not apparent in presented records. The absence of physical therapy, chiropractor treatments, and current absence of pain medication all support finding that Petitioner is capable of performing light or sedentary employment.

Restricted ranges of motion can be consistent with lumbar pain that precludes the performance of light or sedentary employment. No indication of restricted motion ranges were verified.

Presented medical records verified ongoing lumbar pain complaints, a spasm, and lumbar tenderness. At most, the records verified Petitioner is precluded from performing medium employment.

Presented medical records verified complaints of dyspnea and a diagnosis of COPD. No respiratory testing was verified. Without respiratory testing, little inference can be made concerning Petitioner's exertional restrictions due to COPD. Whatever inference is made must also be weighed with Petitioner's admitted smoking habits of a pack per day.

Based on presented evidence, it is found that Petitioner is exertionally capable of sedentary and light employment. The analysis will proceed to consider Petitioner's non-exertional restrictions.

A Mental Residual Functional Capacity Assessment (Exhibit A, pp. 171-169) dated [redacted], was presented. The document was signed by a licensed psychologist as part of Petitioner's SSA claim of disability. Moderate restrictions to the following Petitioner abilities were noted: understanding and remembering detailed instructions, carrying-out detailed instructions, maintaining attention for extended periods, and interacting with the general public. An unstated examination report was cited as support for the assessment. MDHHS did not present an examination report to verify the basis for which the assessment was made.

Given Petitioner's absence of hospitalizations and relatively sparse treatment history, moderate restrictions to concentration and social interactions appear to be accurately assessed. Such restrictions would reasonably limit Petitioner to performance of non-complex employment involving limited face-to-face interaction.

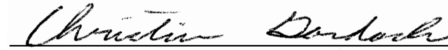
Jobs within the Dictionary of Occupational Titles that are appropriate for Petitioner would include telemarketing, light assembly, data entry, customer service telephone representative, light stockperson, cook, and others. MDHHS did not present vocational evidence of jobs available to Petitioner, however, such jobs are presumed to be sufficiently available that vocational evidence is not needed. It is found that sufficiently available light and sedentary employment exists for Petitioner.

Based on Petitioner's exertional work level (light), age (younger individual), education (limited but capable of reading and writing English), and employment history (none), Medical-Vocational Rule 202.17 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

July 24, 2017, based on a determination that Petitioner is not disabled. The actions taken by MDHHS are **AFFIRMED**.



CG/

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

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

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

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

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

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

DHHS

Petitioner