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GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

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Date Mailed: May 15, 2018
MAHS Docket No.: 18-000559
Agency No.:
Petitioner:

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned administrative law judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250. After due notice, a telephone hearing was held on April 5, 2018, from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by , manager.

ISSUE

The issue is whether MDHHS properly determined that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit program.

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 February 16, 2017, Petitioner applied for SDA benefits.

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

3. On an unspecified date, the Disability Determination Service (DDS) determined that Petitioner was not a disabled individual.

4. On January 2, 2018, MDHHS denied Petitioner's application for SDA benefits.

5. On January 12, 2018, Petitioner requested a hearing disputing the denial of SDA benefits. (Exhibit A, pp. 2-3)

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 male.

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

9. Petitioner has a history of semi-skilled employment, with no known transferrable job skills.

10. Petitioner has restrictions which allow the performance of light and sedentary employment with restrictions to simple and routine work for which there are significant number of jobs available to Petitioner.

CONCLUSIONS OF LAW

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

Petitioner's hearing request checked a dispute concerning Family Independence Program (FIP) benefits and Food Assistance Program (FAP) benefits. Petitioner testified a dispute of cash assistance based on disability (i.e. SDA) was the only program he intended to dispute. MDHHS was not confused by Petitioner's error and prepared for an SDA dispute. MDHHS had no objections to proceeding with a hearing to resolve the SDA dispute, and the hearing was conducted accordingly.

Petitioner requested a hearing to dispute the denial of an SDA application. Petitioner claimed an inability to work for 90 days due to mental and/or physical disabilities. MDHHS presented a Notice of Case Action (Exhibit A, pp. 1197-1199) dated January 2, 2018, 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 (April 2017), p. 5. The goal of the SDA program is to provide financial assistance to meet a disabled person's basic personal and shelter needs. *Id.*

To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older. BEM 261 (April 2017), p. 1. A person is disabled for SDA purposes if he or she meets any of the following criteria:
- Receives other specified disability-related benefits or services….
- Resides in a qualified Special Living Arrangement (SLA) facility.
- Is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability.

- Is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS)...

Id., pp. 1-2.

When the person does not meet one of the [above] criteria, [MDHHS is to] follow the instructions in BAM 815, Medical Determination and Disability Determination Service (DDS), Steps for Medical Determination Applications. *Id.*, p. 4. The DDS will gather and review the medical evidence and either certify or deny the disability claim based on the medical evidence. *Id*. The review of medical evidence is primarily outlined by federal law.

Petitioner alleged being unable to work for at least 90 days. Petitioner alleged no other basis for SDA eligibility.

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 substantial gainful activity (SGA). The monthly amount depends on whether a person is statutorily blind or not. The 2017 monthly income limit considered SGA for non-blind individuals is $1,170.00.

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

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

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

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

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

On ██████████ 2016, Petitioner presented to a cardiologist with complaints of palpitations and headache. Petitioner also reported fatigue and tiring easily. Follow-up was planned. (Exhibit A, pp. 786-789) Other treatment documents from 2015 and 2016 noted similar complaints (Exhibit A, pp. 801-804, 809-816)

On ████████ 2016, Petitioner was treated for a cough. Chest radiology was normal. Acute bronchitis was diagnosed. (Exhibit A, pp. 246-251, 300-311, 408-412)

On █████ 2016, Petitioner underwent an ILR (implantable loop recorder) implant. No complications were noted. (Exhibit A, pp. 215-216, 252-253, 312-314)

On ██████ 2016, Petitioner was treated for a cough. Chest radiology was normal. Acute bronchitis was diagnosed. (Exhibit A, pp. 254-258, 316-320)

On ███, 2016, Petitioner underwent a cervical spine MRI. Severe foraminal stenosis was noted at C5-C6. Mild right-sided foraminal narrowing was noted at C4-C5. (Exhibit A, pp. 267-268)

On ███, 2016, Petitioner underwent a psychiatric evaluation following initial presentation for ongoing mental health care. Mental health exam assessments included fair judgment, intact memory, able to focus, unremarkable thought content and process, normal stream of mental activity, and appropriate affect. An Axis I diagnosis of mood disorder was noted. Petitioner's GAF was 55. A crack cocaine history including use from two weeks ago was noted. Hospital admissions following crack cocaine usage were also noted. Prescribed medications included Seroquel, Lexapro, Lamictal, Xanax, and Ativan. (Exhibit A, pp. 208-214)

On ███ 2016, Petitioner went to an emergency room for treatment of neck pain radiating to his right hand. Petitioner reported his symptoms began after he was hit by a car three weeks earlier. A CT scan noted mild degenerative disc narrowing at C5-C6 with mild foraminal narrowing. Acute paresthesias was diagnosed. Petitioner was prescribed Valium. (Exhibit A, pp. 259-263, 321-326)

On ███, 2016, Petitioner went to an emergency room for treatment of neck pain and dental pain. Petitioner was given pain medication. (Exhibit A, pp. 264-266, 327-329)

On ███ 2016, Petitioner reported daily heart palpitations to his cardiologist. Metoprolol was prescribed, and a sleep study was recommended. A NYHA FC Grade I classification was noted. Smoking cessation was recommended. (Exhibit A, pp. 220-223)

On ███ 2016, Petitioner saw an orthopedist for neck pain radiating to his left hand causing numbness; pain was ongoing for 1½ months. Reported pain level was 9/10 for which he takes Motrin. A cervical spine examination revealed a normal gait, mild spasm, positive left-sided Spurlings testing, full muscle strength. Decreased sensation was noted at left C6. Past MRIs noted severe foraminal stenosis at C5-C6. Impressions of cervicalgia, radiculopathy, and disc degeneration were noted. "Conservative" treatment of NSAIDs, oral steroids, cervical collar, and physical therapy were planned. (Exhibit A, pp. 114-122)

On ███, 2016, Petitioner underwent a left shoulder MRI in response to complaints of pain, ongoing for three months. Impressions included the following: Hill-Sachs deformity of the humeral head, small glenohumeral joint effusion, rotator cuff tendinosis with a small rim rent tear, and mild subdeltoid bursitis. (Exhibit A, pp. 332-333)

On ███ 2017, Petitioner saw an orthopedist for a follow-up on neck pain. Petitioner reported PT made his neck pain worse. Petitioner also reported no relief from pain with medication. ACDF surgery of C5-C6 was planned. (Exhibit A, pp. 123-128)

On [redacted] 2017, Petitioner saw an orthopedist for follow-up on left shoulder pain. Impressions of left shoulder osteoarthritis, and non-traumatic complete rotator cuff tear were noted. Arthroscopic surgery was planned. A history of two lumbar fusions at L3-L5 was noted. (Exhibit A, pp. 191-192)

On [redacted] 2017, Petitioner reported heart palpitations to his cardiologist. A normal cardiac exam assessment was noted. Treatment details were not presented. (Exhibit A, pp. 217-219, 782-785)

On [redacted] [redacted] 2017, Petitioner underwent arthroscopic left shoulder surgery. Discharge restrictions included no lifting of more than 20 pounds for six weeks. (Exhibit A, pp. 197-199)

On [redacted], 2017, Petitioner was evaluated for neck pain, ongoing for four months and since Petitioner was in a motor vehicle accident. Reflexes were normal. Spurling's test was positive. Gait and tandem gait were normal. Petitioner underwent an epidural injection the following day. (Exhibit A, pp. 146-154, 452-460)

A letter dated [redacted] 2017, from a therapist/case manager from Petitioner's treating social worker was presented. The author stated that Petitioner was a patient since [redacted], 2016, and that he receives ongoing psychiatric and counseling appointments for a diagnosis of mood disorder. The author stated that Petitioner had a disability. (Exhibit A, p. 207)

On [redacted] 2017, Petitioner saw an orthopedist for a follow-up on neck pain. Petitioner reported worse pain following shoulder surgery. An MRI was planned. Neck surgery remained planned. (Exhibit A, pp. 129-134)

A letter from a substance abuse treatment center dated [redacted] 2017, was presented. It was noted Petitioner began a residential substance abuse treatment on [redacted], 2016, and remained a resident within the program. (Exhibit A, p. 193) It was noted that Petitioner completed a 90-day treatment program on [redacted] 2017. (Exhibit A, pp. 237-238)

On [redacted] 2017, Petitioner underwent stress testing. A normal stress test was noted and Petitioner was cleared for upcoming neck fusion surgery. (Exhibit A, pp. 194, 790-793)

On [redacted] 2017, Petitioner underwent testing for possible home use of O2. It was noted Petitioner would have to desaturate below or at 88% at rest or with exertion for O2 to be warranted. O2 testing levels of 98 (at rest) and 97 (at exertion) were noted. (Exhibit A, pp. 334-335)

On [redacted] 2017, Petitioner underwent an anterior cervical discectomy fusion of C5-C6. No complications were noted. (Exhibit A, pp. 135-137)

On ██████ 2017, Petitioner presented to an orthopedist for follow-up of neck surgery. Petitioner reported 0/10 arm pain and 4-5/10 neck pain. Petitioner reported his arm pain was 100% improved and that neck pain 50% improved. A non-antalgic gait was noted. Percocet was prescribed and follow-up in four weeks was planned. (Exhibit A, pp. 851-853)

On ██████ 2017, Petitioner presented to a cardiologist with a complaint of palpitations. Petitioner was referred for a sleep study and to a pulmonologist. (Exhibit A, pp. 794-79)

On ██████ 2017, Petitioner presented to an orthopedist for follow-up. Petitioner reported 0/10 arm pain and 2/10 neck pain. Petitioner called neck pain 95% improved. Restrictions of no more than 20 pounds of lifting and no excessive neck flexion were noted. Home exercises were recommended. (Exhibit A, pp. 854-856)

On ██████ 2017, Petitioner underwent a chest x-ray. An unremarkable chest was noted. An echocardiogram demonstrated EF of 50%-55% and normal diastolic function. (Exhibit A, pp. 434-435, 542-543)

On ██████ 2017, Petitioner attended counseling with a treating social worker. Assessments of Petitioner included euthymic mood, logical speech, and appropriate affect. (Exhibit A, pp. 648-651) Other counseling records from 2017 noted Petitioner received assistance with bus tickets and housing advice. (Exhibit A, pp. 658-661)

On ██████ 2017, Petitioner underwent a mental status examination as part of his Social Security Administration (SSA) claim of disability. Petitioner reported various medical problems. Petitioner also reported a history of 12 psychological hospitalizations (his most recent being from 2016) and past suicidal ideation. Petitioner reported that medication stabilizes his symptoms, but he still has racing thoughts and feels depressed and "always on edge". Assessments of Petitioner included large body scars due to past surgeries, a somewhat restricted affect, slightly guarded mood, logical and goal directed, intact working memory, and capable of performing basic calculations. Diagnoses included the following: mood disorder which is managed with medication, partially resolving adjustment disorder, and early remission of cocaine abuse. The examiner concluded Petitioner could mentally perform, at a minimum, simple and routine work at a sustained pace. (Exhibit A, pp. 86-94, 861-865)

On ██████ 2017, Petitioner was treated for recurrent diarrhea, ongoing for two months. Metamucil was recommended. (Exhibit A, pp. 461-467)

On ██████ 2017, Petitioner attended counseling with a treating social worker. Petitioner was assessed as having mild depression due to situational stressors; a similar assessment was noted on ██████, 2017 (Exhibit A, p. 668). It was noted that Petitioner was "very pleased and happy" after the session. (Exhibit A, pp. 634-635)

On ██████ 2017, Petitioner attended an appointment with a primary treater. Abnormal liver function studies, sleep apnea, and diarrhea treatment were noted. (Exhibit A, pp. 636-641) Recurrent treatment for diarrhea was evident from past 2017 records (see Exhibit A, pp. 653, 663).

On ██████ 2017, Petitioner appeared for ongoing psychiatric treatment with a treating mental health agency. Petitioner reported moodiness, poor sleep, racing thoughts. Medications were adjusted. (Exhibit A, pp. 630-633)

On ██████, 2017, Petitioner presented to a cardiologist with a complaint of palpitations. Petitioner denied fatigue, dizziness, dyspnea, and chest pain. A normal sounding heart was noted during examination. Follow-up in one month was planned. (Exhibit A, pp. 544-547, 805-808)

On ██████ 2017, Petitioner underwent a left total shoulder hemiarthroplasty in response to failed conservative management of shoulder pain. Petitioner was discharged on ██████, 2017. (Exhibit A, pp. 567-588)

On ██████, 2017, Petitioner complained of left shoulder pain after he threw a punch and experienced chest pain. Petitioner reported his punch tore sutures from recent arthroscopic surgery. Petitioner was described as “clearly intoxicated”. Mild shoulder swelling and tenderness was noted. X-rays of the shoulder were negative. Pain medication was provided. Later follow-up for chest pain was planned. (Exhibit A, pp. 162-172, 468-478, 512-522, 560-563)

On ██████ 2017, Petitioner presented to a cardiologist for follow-up of reported palpitations. Episodes of tachycardia during monitoring were noted. Permanent Pacemaker (PPM) placement was planned. (Exhibit A, pp. 548-552)

On ██████ 2017, Petitioner underwent PPM insertion for treatment of arrhythmia and bradycardia. A chest x-ray was negative. PPM insertion occurred without complication. (Exhibit A, pp. 436-444)

On ██████ 2017, Petitioner presented to a cardiologist for follow-up of reported palpitations. Cardiac exam assessments were normal. Follow-up in “a few weeks” was planned. (Exhibit A, pp. 553-557)

On ██████ 2017, Petitioner presented for treatment of a lung nodule. Petitioner reported dyspnea after walking 2 blocks. Petitioner reported ongoing smoking of a pack per day. Normal Spirometry testing was noted. A lung nodule was noted on radiography. Follow-up in 6-8 months was planned. Suspected causes of dyspnea included noncompliance with sleep apnea, smoking, and/or cardiac function. (Exhibit A, pp. 173-189, 479-494)

Presented medical records established a medical treatment history consistent with exertional restrictions due to cardiac dysfunction, lumbar dysfunction, cervical spine dysfunction, left shoulder dysfunction, and respiratory restrictions. Presented records also established degrees of psychological restrictions due to mood disorder. 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).

A listing for joint dysfunction (Listing 1.02) was considered based on Petitioner's treatments for his left shoulder and knee pain. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively or unable to effectively perform fine and gross movements with both upper extremities.

A listing for spinal disorders (Listing 1.04) was considered based on Petitioner's lumbar pain complaints. This listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively or that nerve root compression causes sensory or reflex loss.

A listing for chronic pulmonary insufficiency (Listing 3.02) was considered based on Petitioner's complaints of dyspnea. The listing was rejected because Petitioner's Spirometry test results did not meet listing requirements.

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 affective disorders (Listing 12.04) was considered based on Petitioner's treatment for a mood disorder. The listing was rejected due to a failure to establish an extreme restriction or multiple marked restrictions to understanding or applying information, interacting with others, concentration or persistence, and/or adaptation. It was also not established that Petitioner had marginal adjustment.

It is found Petitioner does not meet any Social Security Administration (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).

Petitioner testified he uses a chair for showers; he also testified he has difficulty with left hand reaching. Petitioner testified that dressing his lower body is difficult. Petitioner testified he is limited to 15 minutes of shopping. Petitioner testified he can sit on a bus for up to 40 minutes, but only if he is sitting.

Petitioner testified he has used a cane for the last 10 years, but it was recently stolen, and he is in need of a new one. Petitioner testified he can walk with a cane about 1-2 blocks before back pain prevents further walking. Petitioner testified he can stand 20 minutes before experiencing radiating back pain and cramps. Petitioner testified he can only sit for 20-25 minute periods. Petitioner estimated he can sit for 2 hours if given a standing option; after two hours he would have to lie down. Petitioner testified he was restricted by his physician in 2008 to 10 pounds of lifting/carrying.

Petitioner's testimony was indicative of restrictions to lifting/carrying, sitting, standing, and ambulation. Petitioner's testimony was only partially supported by presented records.

Petitioner testified he has a history of cardiac dysfunction. He testified that he experiences arrhythmia and will eventually undergo laser surgery for correction. Petitioner testified he cannot undergo any surgeries until six months pass from a pacemaker implantation. Petitioner testified he also experiences a-fib episodes.

Notably, Petitioner's heart was assessed as NYHA Grade I functional classification. The assessment is indicative of cardiac disease with no symptoms and no limitation in ordinary physical activity (specifically no shortness of breath from walking or climbing stairs). An absence of restrictions is consistent with Petitioner's normal ejection fraction testing. A Grade I NYHA functional classification is perhaps indicative of a restriction on

lifting/carrying of heavier weights (e.g. more than 50 pounds) but not of weights of 50 pounds or less.

Petitioner's testimony implied respiratory restrictions. Recent treatment for a benign lung nodule was verified. During the appointment, Petitioner's complaints of dyspnea were suspected to be caused noncompliance with sleep apnea treatment, smoking, and/or cardiac function. Cardiac function can be ruled out based on Petitioner's stable cardiac function (though a need for a pacemaker was documented) leaving two causes of dyspnea that are not related to disability. The evidence was consistent with finding that Petitioner can lift/carry up to 50 pounds and stand, walk, or sit at least six hours out of an eight-hour work shift.

Petitioner testified he has right knee problems which require wearing a knee brace. Petitioner testified he underwent meniscus repair surgery in 2014. Petitioner testified that he has drop foot, which causes him to often trip and place unwelcome pressure on his knee.

Petitioner's gait was normal in examinations from November 2016, January 2017, and April 2017. A normal gait is indicative of no restrictions to ambulation. Though Petitioner testified he relied on a cane for 10 years, multiple orthopedist examinations did not note Petitioner's reliance on a cane. Further, presented records did not establish any notable treatment for knee dysfunction and/or drop foot.

Petitioner testified he is impaired due to left shoulder pain. Petitioner testified that fluid built-up in his shoulder following surgery in April 2017; Petitioner testified this was his 7th shoulder surgery. Petitioner testified he is expected to undergo replacement surgery after he turns ███ Petitioner testified he takes Tylenol3 for his pain. Petitioner testified he is unable to reach his left arm overhead or to his right as a result of shoulder dysfunction.

Restrictions from left hand overhead reaching and to the right were reasonably consistent with Petitioner's treatment history which verified shoulder surgery. Notably, Petitioner's discharge instructions following surgery limited Petitioner to lifting more than 20 pounds for only a six-week period; further restrictions from arthroscopic surgery other than no lifting more than 50 pounds cannot be inferred. It is possible that Petitioner may have reinjured his arm when fighting while intoxicated as indicated by an August 2017 emergency room visit. Restrictions cannot be inferred as shoulder x-rays were negative, and follow-up treatment was not presented.

Petitioner testified he underwent a lumbar laminectomy in 2000 and a lumbar fusion in 2004. Petitioner testified that his fusion surgery failed as did a follow-up surgery. Petitioner testified that bending is painful because hardware from past surgeries move. Petitioner testified that epidural injections and approximately 50 visits to physical therapy have not reduced his pain.

Petitioner testimony acknowledged that he has not recently attempted physical therapy; the absence of recent physical therapy is consistent with minimal restrictions. Petitioner's recurrently documented normal gait is further evidence of minimal lumbar restrictions. Petitioner also did not present any notable recent treatment for lumbar dysfunction, though references to past lumbar fusions were verified in Petitioner's medical history. Petitioner also testified he has ongoing problems following cervical spine fusion surgery in 2014. Petitioner testified his neck gets achy and stiff due to scar tissue.

At the end of May 2017, Petitioner reported that cervical spine fusion surgery resolved 100% of his arm pain and 95% of his neck pain and a pain level of 2/10. The evidence did not establish any worsening of Petitioner's pain level since May 2017. Petitioner's reported improvement is suggestive of a pain that should be treatable through pain medication which imposes no more than mild restrictions to Petitioner's concentration. Given Petitioner's extensive spinal surgical history, it is reasonable to restrict Petitioner from repetitive bending and/or frequent lifting of greater than 20 pounds.

Petitioner testified he attends monthly sessions with a psychiatrist. Petitioner testified that his related symptoms include mood swings, crying spells every other day, anger management difficulties, racing thoughts, and difficulty with people. Petitioner also testified he sees a counselor as needed.

Petitioner testified he has a history of 11-12 hospitalizations (3-4 involved drug use) and that he was hospitalized two years earlier for a seven-day period. Petitioner's hospitalization history is indicative of severe psychological symptoms. Records from Petitioner's past hospitalizations were not presented. Notably, Petitioner has not been hospitalized since completing drug rehabilitation in January 2017. The evidence further established that Petitioner's symptoms appear to have improved since Petitioner completed drug treatment.

Consideration was given to recognizing Petitioner's GAF of 55 from 2016 as evidence of moderate restrictions to concentration. Notably, Petitioner has since undergone drug rehabilitation. Further, an assessment of Petitioner's diagnosis in July 2017 considered Petitioner's depression to be "mild" and based on situational stressors. The assessment of "mild" depression was also consistent with improvement in Petitioner's medical condition and reported happiness at a counseling appointment.

Based on the evidence, Petitioner is deemed capable of walking, standing, and/or sitting for 6 hours per 8 hours and frequent lifting/carrying of 20 pounds. Petitioner is further deemed capable of simple and routine work at a sustained pace (as stated by a consultative psychological examiner in November 2017). Petitioner's lumbar history would further restrict Petitioner from employment involving excessive bending.

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 credibly testified that his only work since 2004 was for approximately one month in 2016 when he worked as a full-time auto mechanic. Petitioner testified that his job did not last longer because he was not physically capable of repetitive bending. Petitioner's physical assessment precludes the performance of this employment due to his bending limitations.

Petitioner testified in 2004, he worked as an assembler which required regular lifting of auto parts weighing up to 30 pounds. Petitioner also testified that the job was mostly standing. Petitioner would be unable to perform the lifting/carrying required of this employment.

Based on the evidence, Petitioner is unable to perform either of his past jobs from the past 15 years. Thus, it is found that Petitioner is unable to perform past relevant employment from the past 15 years and the 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*.

Petitioner's lifting/carrying, standing and sitting restrictions were consistent with Petitioner's ability to perform a full range of light employment. Based on Petitioner's exertional work level (light), age (younger individual), education (high school), and employment history (semi-skilled with no known transferrable skills), Medical-Vocational Rule 202.21 would dictate a finding that Petitioner is not disabled. Petitioner's non-exertional restrictions must also be considered before a determination of disability is finalized.

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). 20 C.F.R. §416.960(c)(1). In order to support a finding that you are not disabled at this fifth step of the sequential evaluation process, we are responsible for providing evidence that demonstrates that other work exists in significant numbers in the national economy that you can do, given your residual functional capacity and vocational factors. 20 C.F.R. §416.960(c)(2).

During the hearing, Petitioner was asked about the possibility of performing employment as a cable repairman. Petitioner testified that he would have difficulty in this employment because he is not a good reader or writer; Petitioner's reason for not performing the employment is not supported by any known cognitive restriction or disability. Petitioner also testified he would need to lie down at some point during the day; Petitioner's stated reason for not being able to perform the employment was not supported by presented medical evidence.

Petitioner's restriction to performing simple and routine work would reduce Petitioner's employment opportunities. MDHHS did not present evidence of opportunities available to Petitioner but the restriction is not deemed to be so significant that it is likely that Petitioner does not have ample employment available to him. Examples of job titles within Petitioner's employment capabilities include data entry, light assembly, telemarketing, light maintenance, retail clerk, and security guard. Significant numbers of available jobs are assumed to exist for Petitioner.

Based on the evidence, it is found that Petitioner can adjust to other work. Thus, Petitioner is not disabled, and it is found that MDHHS properly denied Petitioner's application for 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 February 16, 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

[redacted]
MDHHS-Wayne-17-Hearings

Petitioner

[redacted]
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[redacted] MI [redacted]

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MAHS