[redacted]

Date Mailed: June 7, 2019
MOAHR Docket No.: 19-003768
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Jacquelyn A. McClinton

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; and 45 CFR 205.10. After due notice, a telephone hearing was held on May 9, 2019, from Detroit, Michigan. Petitioner appeared at the hearing on her own behalf. Participants on behalf of the Department of Human Services (Department) included [redacted], Assistant Payments Supervisor.

ISSUE

Did the Department properly determine 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 October 30, 2018, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On January 4, 2019, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 4-10).

3. On March 21, 2019, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit A, pp. 1-3).

4. On April 15, 2019, the Department received Petitioner's timely written request for hearing.

5. Petitioner alleged disabling impairment due to nerve damage, wrist pain, plantar fasciitis, depression, and back pain.

6. On the date of the hearing, Petitioner was [redacted] years old with a February 27, [redacted] birth date; she is [redacted] in height and weighs about [redacted] pounds.

7. Petitioner is a high school graduate.

8. At the time of application, Petitioner was not employed.

9. Petitioner has an employment history of work as a paper shredder, painter and housekeeper.

10. Petitioner has a pending disability claim with the Social Security Administration.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Human Services Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180.

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (July 2015), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If an individual is found disabled, or not disabled, at any step in this process, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR

416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In general, the individual has the responsibility 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, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. 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). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

Step One

The first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Petitioner was not working during the period for which assistance might be available. Because Petitioner was not engaged in SGA**,** she is not ineligible under Step 1, and the analysis continues to Step 2.

Step Two

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for SDA means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, do not have

more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the de minimis standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs v Bowen, 880 F2d 860, 862-863 (CA 6, 1988), citing Farris v Sec of Health and Human Services, 773 F2d 85, 90 n.1 (CA 6, 1985).* A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28. If such a finding is not clearly established by medical evidence or if the effect of an impairment or combination of impairments on the individual's ability to do basic work activities cannot be clearly determined, adjudication must continue through the sequential evaluation process. *Id.; SSR 96-3p.*

The medical evidence presented at the hearing, *and in response to the interim order,* was reviewed and is summarized below.

On December 29, 2017, Petitioner was seen at [redacted] regarding case management services. This was Petitioner's first meeting. A treatment plan with objectives was developed. (Exhibit A, pp. 133-134).

Petitioner continued receiving case management services through [redacted] through November 20, 2018. The November 30, 2017 record noted that Petitioner had obtained a part time job doing shredding for [redacted] but was laid off through no fault of her own. (Exhibit A, p. 157).

On March 19, 2018, Petitioner was seen at [redacted] for an MRI of the left wrist. The conclusion indicated that there was a central tear of the lunotriquetral ligament, allowing egress of midcarpal contrast into the radiocarpal joint; central perforating tear of the triangular fibrocartilage; and injected contrast fills a 1.5 cm ganglion cyst along the volar lip of the radial styloid, indicating a tear of the volar radiocarpal ligament, which is not definitely identified. (Exhibit A, pp. 75-76).

On May 22, 2018, Petitioner was seen at [redacted] for right L4-L5 and L5-S1 facet joint RFA. The impression indicated right L4-L5 and L5-S1 facet joint denervation. (Exhibit A, pp. 131-132).

On June 29, 2018, Petitioner was seen at [redacted] with a chief complaint of low back pain. Petitioner reported that she has had no relief since her recent bilateral L5-S1 lumbar radiofrequency ablations that she had in May despite the fact she had apparent diagnostic responses to prior facet blocks. Petitioner indicated that she still had aching

pain across her back. Petitioner stated that her pain physician recommended that she do some physical therapy but that they did not discuss options such as cognitive behavioral therapy. Petitioner admitted that she had not been doing any kind of exercise program. Impression indicated chronic low back pain. (Exhibit A, ppl 127-130).

On August 8, 2018, Petitioner was seen at [redacted] as a new patient for pain management. Petitioner had been treating with [redacted] but had a falling out over medication. She had a drug screen on February 26, 2018 and tested positive for Diazepam which was prescribed. A chart note dated March 26, 2018 indicated that Petitioner was confronted about the positive drug screen. The doctor indicated that he would give her one more Norco prescription but was no longer comfortable prescribing her narcotic which was why Petitioner was not seeking treatment elsewhere. A review of chart note relating to a previous MRI of the lumbar spine in March 2015 reviewed mild discogenic degenerative change at L5-S1 with foraminal osteophyte minimally abutting the left greater than the right L5 nerve root. (Exhibit A, pp. 116-119).

On August 17, 2018, Petitioner was seen at [redacted] with a chief complaint of low back pain. Petitioner reported an inability to lift and impaired ability to perform ADLs. The impression included lumbar spondylosis and chronic pain syndrome. (Exhibit A, pp. 88-89).

On August 20, 2018, Petitioner was seen at [redacted] with a chief complaint of right wrist pain. Petitioner indicated that she has had x-rays of the left wrist completed as well as EMG that were both negative. Petitioner indicated that she had an upcoming appointment relating to her left wrist and that she had been wearing a brace which helped a little. The assessment indicated right wrist pain and a body mass index of 34.0-34.9. (Exhibit A, pp. 112-115).

On August 22, 2018, Petitioner was seen at [redacted] for an x-ray of her left wrist. The conclusion indicated that there was no visible acute bony or joint abnormality bilaterally. (Exhibit A, pp. 77-78).

On August 22, 2018, Petitioner had an x-ray of right wrist. The findings included that there were no visible acute fracture; no visible acute joint abnormality or dislocation; no soft tissue swelling; and no radiopaque foreign bodies. (Exhibit A, p. 126).

On August 30, 2018, Petitioner was seen at [redacted] as a follow up after a radiocarpal injection to the left wrist for chronic wrist pain for the last 20 years. The record noted that Petitioner had an MRI that showed a number of pathologies, none of which at her last exam the ratio was contributing to the pain she had at the time of the visit. X-rays of the right wrist reviewed from August 22, 2018 showed no acute fracture dislocations. The assessment was bilateral chronic wrist pain. (Exhibit A, pp. 124-125).

On September 20, 2018, Petitioner was seen at [redacted] for a recheck of her right wrist pain. Petitioner reported that she has had pain in both wrist for

approximately 21 years but stated that lately the right wrist had been bothering her more. Petitioner noted a sharp shooting pain up her wrist with certain movements such as pulling up her pants. Petitioner indicated that she has tried physical therapy and cortisone injection with little relief. Her doctor indicated that there was nothing more he could do and recommended that she obtain a second opinion. Petitioner complained of numbness in her left and right pinky fingers. The assessment indicated right wrist pain; other chronic pain; bipolar affective disorder; chronic low back pain; and anxiety. (Exhibit A, pp. 102-111).

On October 29, 2018, Petitioner was seen at [redacted] with a chief complaint of low back pain. Petitioner was requesting injection, physical therapy or topical medication. The impression included lumbar spondylosis and chronic pain syndrome. (Exhibit A, pp. 93-94).

On November 27, 2018, Petitioner was seen at [redacted] with a chief complaint of wrist paint. Petitioner indicated that her wrists are bothering her on a daily basis. Petitioner was requesting to stop taking Lyrica as she reported swelling of her hands/feet and weight gain since starting the medication. Petitioner indicated that weight gain makes her anxiety and depression symptoms worse. The assessment indicated gastroesophageal reflux disease; anxiety; bipolar affective disorder; chronic low back pain; and right wrist pain. (Exhibit A, pp. 103-106).

On December 17, 2018, Petitioner was seen at [redacted] for a second opinion for evaluation of her bilateral wrist pain. Petitioner described the pain as sharp and indicated that it was exacerbated with activities. Petitioner indicated that the pain began seven years prior and has worsened. Petitioner brought x-rays of her right wrist which demonstrated no gross scapholunate dissociation, radiocarpal mid carpal or distal radioulnar joint arthrosis, or thumb axis arthrosis or instability. Review of the MRI/report was consistent with some dye leakage through perforation and the lunotriquetral ligament without a complete tear around the margins. Report was that there was no scapholunate widening from her previous records brought into this visit though some possibility of dorsal intercalated segment instability deformity was mentioned. (Exhibit A, pp. 84-87).

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step Three

Step 3 of the sequential analysis of a disability claim requires a determination if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920(a)(4)(iii). If an individual's impairment, or combination of impairments, is of a severity to meet or medically equal

the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

Based on the medical evidence presented in this case, listings 1.02 (major dysfunction of a joint); 12.04 (depressive, bipolar and related disorders); and 12.06 (anxiety and obsessive-compulsive disorders) were considered. The medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Steps 4 and 5, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s), including those that are not severe, and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4); 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. *20 CFR 416.929(c)(3).* The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b).

The exertional requirements, or physical demands, of work in the national economy are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a). 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 and occasionally walking and standing. 20 CFR 416.967(a). Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds; even though the weight lifted may be very little, a job is in the light 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. 20 CFR 416.967(b). 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). 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). 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 CFR 416.967(e).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions 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 (i.e., unable to 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). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). Where the evidence establishes a medically determinable mental impairment, the degree of functional limitation must be rated, taking into consideration chronic mental disorders, structured settings, medication, and other treatment. The effect on the overall degree of functionality is evaluated under four broad functional areas: (i) understand, remember, or apply information; (ii) interact with others; (iii) concentrate, persist, or maintain pace; and (iv) adapt or manage oneself. 20 CFR 416.920a(c)(3). For the first three functional areas, a five-point scale is applied (none, mild, moderate, marked, and extreme). 20 CFR 416.920a(c)(4). The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. 20 CFR 416.920a(c)(4).

In this case, Petitioner alleges both exertional and nonexertional limitations due to her medical condition. Petitioner testified that she could dress/undress herself; bathe/shower herself; use the bathroom unassisted; eat unassisted; complete chores; prepare meals; bend at the waist; reach; kneel; climb stairs; and use her hands. Petitioner indicated that she is unable to squat because she would fall over due to balance issues. She is unable to stand for more than 10-30 minutes. She cannot walk more than one block without experiencing pain. Petitioner indicated that sitting is always painful.

Further, Petitioner indicated that her short-term memory was impacted due to an accident. Petitioner stated that she has always had issues with concentration. Petitioner testified that she could follow simple instructions. Petitioner stated that she

does not work well with others because she doesn't like to take orders and is easily irritated.

Petitioner consistently complains of low back pain and pain in both wrists. Additionally, on September 20, 2018, Jennifer Vance, PA-C, authored a letter indicating that Petitioner was her patient and that due to her chronic back and wrist pain as well as her planter fasciitis, Petitioner was unable to work. (Exhibit A, p. 74). There was no further information provided such as any specific limitation or the objective basis for the opinion. Further, a review of Petitioner's medical records revealed that her objective testing yielded either normal or mild limitations. Petitioner does not have any impending surgeries. Petitioner is currently searching for a primary care physician. Relating to Petitioner's mental health, she is receiving case management services which assist with doctor's appointments, medication reviews and the completion of paperwork, however, the medical documentation provided does not contain any recent psychiatric or psychological evaluations.

A two-step process is applied in evaluating an individual's symptoms: (1) whether the individual has a medically determinable impairment that could reasonably be expected to produce the individual's alleged symptoms and (2) whether the individual's statement about the intensity, persistence and limiting effects of symptoms are consistent with the objective medical evidence and other evidence on the record from the individual, medical sources and nonmedical sources. SSR 16-3p.

With respect to Petitioner's exertional limitations, it is found based on a review of the entire record that Petitioner maintains the physical capacity to perform light work as defined by 20 CFR 416.967(b). Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild limitations on her mental ability to perform basic work activities. Petitioner's RFC is considered at both Steps 4 and 5. 20 CFR 416.920(a)(4), (f) and (g).

Step Four

Step 4 in analyzing a disability claim requires an assessment of Petitioner's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed by Petitioner (as actually performed by Petitioner or as generally performed in the national economy) within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1) and (2). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner's work history in the 15 years prior to the application consists of work as a paper shredder, painter and a housekeeper. Petitioner's work as a paper shredder was primarily sitting in which she lifted up to 30, required light medium exertion.

A review of Petitioner's case management records revealed that Petitioner felt as if the paper shredding job was perfect for her. (Exhibit A, p. 175). Further, the records indicated that Petitioner missed several appointments with the job developer and struggled with following through on job related assignments. (Exhibit A, pp. 187;190). Additionally, on November 20, 2018, Petitioner indicated that she would take a job which had the same responsibilities and hours as her previous one shredding documents at [redacted]. (Exhibit A, p. 215).

Based on the RFC analysis above, Petitioner's exertional RFC limits her to no more than medium work activities. As such, Petitioner is able to perform past relevant work. Accordingly, Petitioner is not disabled at Step 4 and the assessment ends.

DECISION AND ORDER

NOT DISABLED: The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner **not disabled** for purposes of the SDA benefit program.

Accordingly, the Department's determination is **AFFIRMED.**

JAM/tlf

Jacquelyn A. McClinton
Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR 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

Via Email: [redacted]

Petitioner – Via First-Class Mail: [redacted]