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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ORLENE HAWKS
DIRECTOR

[REDACTED]
[REDACTED]
[REDACTED]

Date Mailed: July 9, 2019
MOAHR Docket No.: 19-004032
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 October 13, 2014, from Detroit, Michigan. Petitioner represented herself. Participants on behalf of the Department of Human Services (Department) included [REDACTED] Family Independence Manager and [REDACTED] Family Independence Specialist.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Records from [REDACTED] and [REDACTED] were received and marked into evidence as Exhibit 1. The record closed on June 19, 2019, and the matter is now before the undersigned for a final determination based on the evidence presented.

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 [REDACTED], 2018, Petitioner submitted an application seeking cash assistance on the basis of a disability.
2. On April 9, 2019, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 19-25).

3. On April 16, 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. 316-318).
4. On April 16, 2019, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 319-320).
5. Petitioner alleged disabling impairment due to scoliosis; bulging discs; osteoarthritis in spine and knees; schizoaffective disorder; and bipolar disorder.
6. On the date of the hearing, Petitioner was [REDACTED] old with an [REDACTED] birth date; she is [REDACTED] in height and weighs about [REDACTED]
7. Petitioner received her GED.
8. At the time of application, Petitioner was not employed.
9. Petitioner has an employment history of work as dietary cook, deli clerk and sky chef.
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 [REDACTED], 2017, Petitioner had an MRI of the lumbar spine without contrast completed at Pure Open MRI. The impression included: scoliosis; lumbar disc bulges without spinal stenosis or nerve root compression; facet osteoarthritis at L4-5 and L5-S1; and a small amount of free pelvic fluid. (Exhibit A, p. 240).

On J [REDACTED] 2018, Petitioner was seen at [REDACTED] emergency department with a chief complaint of flu like symptoms. Petitioner indicated that three days prior to the visit, she began having lower abdominal pain with nausea. Petitioner was diagnosed with acute viral syndrome and discharged home. (Exhibit A, pp. 76-88).

On [REDACTED], 2018, Petitioner was seen at [REDACTED] emergency department with a chief complaint of anger issues. Petitioner indicated that she wanted to snap and wanted to go to a crisis center. Petitioner was prescribed Seroquel (Exhibit A, pp. 120-123). Petitioner was transferred to the [REDACTED] where she indicated that she had been sober from alcohol/crack cocaine for a year and a half. Petitioner believed life to be too overwhelming and indicated that she cannot handle everything on her own. Petitioner further indicated that she was walking by the river contemplating jumping in but because she cannot swim, she decided to go to the emergency room instead. (Exhibit A, p.

131). Petitioner was determined not to be suicidal; she was not violent, and her judgment was listed as good. Petitioner was diagnosed with depression and discharged to a shelter. (Exhibit A, pp. 172-174).

On [REDACTED], 2018, Petitioner underwent a psychiatric evaluation at [REDACTED]. The history indicated that Petitioner began hearing voices on and off at age 6 and that later in 2013, she started having paranoid delusions. Petitioner stating that she has racing thoughts, feels very depressed, and impulsive. Petitioner indicated that she had feelings of hopelessness and worthlessness. She has attempted to commit suicide on two occasions. Following the examination, Petitioner was found to have no impairment to thought process; her attention was distractible; her concentration was adequate; she was able to recall with difficulty; her intellectual functioning was average; and her judgment was adequate. The recommendation was outpatient therapy with prescribed medication. (Exhibit 1, pp. 106-111).

On [REDACTED] 2018, Petitioner was seen at [REDACTED] emergency room with a chief complaint that she was hearing voices. (Exhibit A, p. 176). Petitioner was seen at the [REDACTED]. Petitioner denied current active suicidal or homicidal thoughts, attempt or plan. Petitioner stated that she had been out of her psychiatric medication for five months as she is unable to remember to take her medication. Petitioner stated that she had not slept in two days. It was determined that based upon the continuing assessment, there were no acute physical complaints present and that Petitioner continued to be medically stable. The diagnosis included schizoaffective bipolar and personality disorders. Petitioner was discharged to outpatient and transitional housing. (Exhibit A, pp. 198-231).

Petitioner received outpatient therapy sessions through [REDACTED] from [REDACTED] 2018 through at least [REDACTED] 2019. There were no risk behaviors reported. The [REDACTED] 2018 note indicated that Petitioner processed thoughts and feelings and had awareness and insight. (Exhibit 1, pp. 43-44). The [REDACTED] 2019 note indicated that Petitioner had multiple health issues including knee pain and needing surgery, anemia, GERD, scoliosis in her back, and bronchitis. The note further indicated that all medical conditions were being monitored by her PCP and that she was overall stable with conditions. (Exhibit 1, p. 79).

On [REDACTED], 2018, Petitioner was seen at [REDACTED] to undergo Genicular Nerve Blocks with Fluoroscopy. Petitioner tolerated the procedure well. The assessment included chronic knee pain. (Exhibit 1, pp. 82-83). There is also a note indicating that Petitioner was seen on the same date with a chief complaint of low back pain and right knee pain. Petitioner describe the pain as sharp, dull, aching, burning shooting, stabbing, throbbing, prickling, cramping, tingly and numbing. Radiology reports were reviewed. The Assessment included lumbar spondylosis; knee osteoarthritis and meniscus degeneration. (Exhibit 1, pp. 90-92).

On [REDACTED], 2019, Petitioner underwent Genicular Nerve Blocks with Fluoroscopy (right). The notes indicated that Petitioner tolerated the procedure well. Petitioner was

discharged the same date. The assessment indicated chronic knee pain; and knee osteoarthritis. (Exhibit 1, pp. 94-95).

On [REDACTED], 2019, Petitioner underwent Genicular Nerve Radiofrequency Ablation with Fluoroscopy (right). The notes indicated that Petitioner tolerated the procedure well. The assessment indicated chronic knee pain; and knee osteoarthritis. (Exhibit 1, pp. 96-97).

On [REDACTED], 2019, Petitioner was seen at [REDACTED] for follow up with complaints of right knee pain and occasional low back pain. Petitioner indicated that the right genicular RFA provided her with about 70% relief lasting a couple of weeks. Petitioner stated that since the procedure, she was able to walk without her cane and walk farther distances. Petitioner was attending physical therapy and reported that things were going well. The plan was to titrate her off opiate medication at the next visit. (Exhibit 1, pp. 98-101).

On [REDACTED], 2019, Petitioner was seen at [REDACTED] with complaints of right knee pain and low back pain. Petitioner described the pain as constant aching in her lower back and gluteal region that turns into sharp pains down her legs and into her feet. Petitioner was interested in steroid injections. Petitioner did not want any more RFAs as she stated that the pain during the procedure was severe and not worth the partial relief she experienced after. Petitioner reported that physical therapy was going well. (Exhibit 1, pp. 102-105).

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 1.04 (disorders of the spine); 12.03 (schizophrenia spectrum and other psychotic disorders); and 12.04 (depressive, bipolar and related 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; use the bathroom unassisted, reach, and sit. Petitioner indicated that she uses assistance to bathe/shower because she is a fall risk; cannot squat due to knee issues; and cannot bend at her waist because she is limited due to back pain. Petitioner further stated that she cannot stand for more than 2-3 minutes and cannot walk more than five minutes due to her knees.

Petitioner testified that she was asserting a disability relating to her back, spine and knee issues. While the 2017 MRI noted some disc bulging, it further noted that the lumbar disc bulges was without spinal stenosis or nerve root compression. Petitioner received regular injections until she stated that she no longer wished to receive the injections. The medical evidence indicated that the right genicular RFA provided her with about 70% relief lasting a couple of weeks. On May 16, 2019, Petitioner reported that her physical therapy was going well. Further, there was no objective medical evidence to support Petitioner's testimony that she could not stand for more than 2-3 minutes or walk more than five minutes.

Petitioner also asserted a disability due to her mental health issues. Petitioner had ongoing mental health therapy session from [REDACTED] 2018 through at least [REDACTED] 2019. There were no risk behaviors reported. It was further noted that all medical conditions were being monitored by her PCP and that she was overall stable with conditions.

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(a). Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild to moderate 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 dietary cook, deli clerk and sky chef. Petitioner's work in each of these positions, which required standing and bending and lifting up to 10 pounds regularly, required light physical exertion.

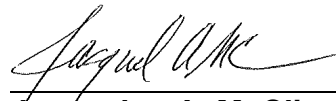
Based on the RFC analysis above, Petitioner's exertional RFC limits her to no more than light work activities. Further, as previously stated, Petitioner also has mild to moderate limitations in her mental capacity to perform basic work activities. In light of the entire record, it is found that Petitioner is able to perform past relevant work. Accordingly, Petitioner is not disabled at Step 4 and the assessment ends.

DECISION AND ORDER

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

Via Email:

MDHHS-Wayne-49-Hearings
BSC4 Hearing Decisions
Policy-FIP-SDA-RAP
MOAHR

Petitioner – Via First-Class Mail:

[REDACTED]
[REDACTED]
[REDACTED]