[redacted]
[redacted], MI [redacted]

Date Mailed: July 1, 2020
MOAHR Docket No.: 20-000558
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

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 three-way hearing was held on May 20, 2020, from Clawson, Michigan. The Petitioner was represented by himself. The Department of Health and Human Services (Department) was represented by Jessica Klein, Assistance Payments Worker.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. The requested documents were NOT received**.** The record closed on June 22, 2020, and the matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit programs?

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], 2019, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On January 2, 2020, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 690- 695).

3. On January 6, 2020, the Department sent Petitioner a Notice of Case Action denying the application based on DDS' finding of no disability (Exhibit A, pp.723-725).

4. On January 17, 2020, the Department received Petitioner's timely written request for hearing (Exhibit A, pp.721-722).

5. Petitioner alleged disabling impairment due to sleep issues (hypersomnia) including narcolepsy and insomnia, severe recurrent migraines, lower back pain and hip pain on the left, neck pain, fractured right hand with 3 bone fusion, fibromyalgia and chronic pain syndrome. The Petitioner also has had difficulty with his left knee giving out. The Petitioner also alleges mental impairments of depression and anxiety.

6. On the date of the hearing, Petitioner was [redacted] years old with a [redacted], 1987 birth date; he 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 line worker packaging and shipping and receiving for [redacted].

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, s/he 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 was reviewed and is summarized below.

On June 28, 2019, the Petitioner had an x-ray of the right hand which noted no acute radiographic abnormality of the hand is seen and notes right wrist surgery. The x-ray was taken due to an unspecified injury of right wrist, hand and finger(s). Findings were no fracture dislocation nor osseous erosion of hand is seen. Since previous wrist radiographs of February 12, 2018 the patient has undergone partial resection of the scaphoid bone and partial resection of the capitate bone with a small proximal scaphoid remnant of what appears to be a small distal capitate remnant. The findings also noted as additional: fusion of the lunate capitate remnant and lunate and hamate.

The Petitioner had an MRI of the lumbar spine on December 6, 2018. Findings were mild spondylotic changes of the cervical spine. Small posterior disc osteophyte complexes at the levels of C5-C6 and C6-C7. No significant central stenosis or foraminal narrowing identified. Remainder of cervical spine of normal appearance.

The MRI of thoracic spine was normal.

The MRI of lumbar spine showed straightening of normal lumbar lordosis. Vertebral bodies are of normal height. Mild modic type changes of the L5-S1 endplates. Mild loss of intervertebral disc space height at L5-S1. No findings of lumbar fracture or listhesis. Remaining intervertebral disc spaces are maintained. Conus and cauda

equina of normal appearance. No acute paraspinal abnormality. Examination through L1-L2 through L4-L5 intervertebral levels without central stenosis or foraminal narrowing. Examination through L5-S1 intervertebral level revealing a central disc protrusion. The disc material measuring approximately 4mm in its anterior posterior dimension. No significant associated central stenosis or foraminal narrowing. The Impression was there was mild loss of intervertebral disc space height at L5-S1. Small posterior disc protrusion.

On September 4, 2018 three x-rays of Petitioner's left knee were taken. The notes indicate that there was a complaint of left knee pain medial and lateral to the patella since 2005, and that left knee gave out recently. The x-ray review noted no fracture, dislocation, bony defect or joint space abnormality were seen. No soft tissue abnormality is seen and no joint effusion. The Impression was normal left knee.

In August 2018 the Petitioner was prescribed Adderall 30 mg 3 times daily for his sleep problems and narcolepsy.

The Petitioner was first evaluated for his right wrist pain on March 27, 2018. The notes indicate that he had an injury to the wrist in 2016 requiring surgery for a scaphoid fracture. At the time of the evaluation, he reported worsening pain and pain with motion, a wrist brace was also worn. X-rays were reviewed and noted moderate to severe osteoarthritic changes of lunocapitate region with subchondral sclerosis and cystic changes. The Petitioner was seen April 2, 2018 for follow up visit after CT of the right wrist was taken. At the time of the visit the diagnosis was lunocapitate advanced osteoarthritic changes, lunocapitate osteoarthritis, perilunate injury. The CT performed on April 2, 2018 indicated severe osteoarthrosis of the lunocapitate and lunamate articulations with bone on bone articulation and prominent subchondral cysts. There was fragmentation of the volar ulnar aspect of the lunate with several small intra-articular bodies with a 5mm volar scapholunate intra-articular body in the images. There were similar smaller intra-articular bodies noted. There is moderate radiocarpal osteoarthrosis.

Petitioner was seen on April 10, 2018 for pain in his right wrist. The examination showed point tenderness present throughout the carpal and metacarpals with limited range of motion with 20 degrees extension and 45 degrees flexion, radial and ulnar. Range of motion was limited due to pain. Hand and fingers were fine without tenderness to palpation with full range of motion. The history notes that in January 2016 patient had a scaphoid fracture peri-lunate dislocation and a screw was placed. After the surgery there was a complete midcarpal collapse which developed with a VC deformity. Notes indicate that the wrist is completely arthritic from between his lunate and capitate and triquetrum in his hamate. Notes indicate the Petitioner is limited by this condition due to daily disabling pain. The doctor proposed a partial scaphoid excision with a 3 bone fusion and excision of the triquetrum bone and removal of the existing scaphoid screw. The Petitioner wanted to proceed with the surgery.

Petitioner had a right wrist surgery on May 16, 2018, for post scaphoid excision and mid carpal 3 bone fusion for posttraumatic midcarpal osteoarthritis. The procedure was to remove a deep implant/excise interdigital neuroma. The Petitioner was seen for follow-up post-surgery on July 26, 2018 at his surgeon's office. The progress note indicates Petitioner had a fall off his bike 3 weeks prior and had slight pain increase since then. Petitioner was wearing a fracture brace when he had the accident. The exam found some localized wrist tenderness with about 20% of range of motion which was limited secondary to pain. No joint instability on provocative testing. The diagnosis was right wrist pain aftercare status post fusion of the wrist. A CT of upper right extremity was ordered to assess status of the wrist fusion. Plan noted status post scaphoid excision, midcarpal fusion with concerns prior to this about nonunion and staples backing out. Notes indicate doctor concerns about nonunion and hardware backing out and more concern since patient fall. The doctor notes if the wrist fusion was solid, the staple could be removed. If fusion not solid, a possible total wrist fusion might be called for. Petitioner also was seen on June 19, 2020, six weeks after the surgery (prior to bike fall). The exam noted that range of motion was 20 degrees active flexion and extension. There was no wrist tenderness or swelling and no joint instability. The Tinel's sign was negative over the carpal tunnel. The notes indicate that clinically the wrist looked well, in good posture, gentle range of motion was painless, without crepitus with mild dorsal tenderness and full digital (fingers) range of motion. Some concern was noted for hardware backing out, but had not worsened from prior x-ray and concern was expressed regarding collapse of the fusion site. The Plan was for Petitioner to phase out of splint over the next 6 weeks. The diagnosis was wrist arthritis.

The Petitioner was seen for post-surgery follow up on July 25, 2018 at which time the Petitioner had sustained a fall and the surgeon expressed concern about the staples backing out and noted that one of the staples was backing out and a CT was ordered. The Petitioner was seen by his wrist surgeon on August 17, 2018 for follow up post-surgery. Notes indicate that since the May 2018 surgery, the Petitioner has had a peri-lunate injury that was treated with a simple scaphoid fixation. Also reported were a couple of injuries since his fusion and patient was followed for non-union. A CAT scan was ordered. Post CAT scan review was ordered. The exam noted mild swelling of wrist without focal tenderness palmarly with a Tinel's sign over the carpal tunnel and a tenderness point dorsally. Pain with range of motion limited to 20 degrees on flexion and extension. Based upon the CAT scan it appears the bone is fusing, but with some collapse, but wrist is forming bridging bone. A dorsal staple was noted as possibly causing pain and symptomatic. Also noted a large volar bony projection that may be irritating the median nerve. The Petitioner was sent for an electromyogram nerve conduction testing.

The Petitioner had an electromyogram on September 18, 2018 at which time the Impression was right wrist and hand pain with intermittent sensory disturbance with otherwise normal electrodiagnostic testing. The note indicates that there is no electrodiagnostic evidence for significant right median or ulnar neuropathy and the testing would not suggest a significant right cervical radiculopathy or plexopathy. The doctor interpreting the test opined that he did not have a definitive electrodiagnostic

explanation for the right upper extremity symptoms at least as it relates to underlying nerve function.

The Petitioner was seen on October 3, 2018 and reported that his wrist is improving with no recent injury. Petitioner continued to wear his splint. The exam of the wrist showed no swelling or tenderness, no joint instability and no Tinel's sign over carpal tunnel. Range of motion was full and painless. The Petitioner was to be rechecked in 3 months. In December 2018 the Petitioner was seen for right wrist follow up and reported he was doing relatively well. No progression of the migrating hardware was occurring and swelling was down. Petitioner reported pain if he excessively loads his wrist. Range of motion was 45 degrees flexion and extension without pain. Notes indicate that Petitioner is accommodating his limitations in the wrist well. Petitioner was shown some stretching and strengthening exercises.

The Petitioner completed a Function Report for the Social Security Administration on or about August 23, 2019. With regard to information about his illness Petitioner advised that he had daily in pain due to headaches, migraines, neck pain from disc degeneration radiating down both arms, lower back pain from a herniated disc radiating down left leg and difficulty using his right hand without pain and swelling due to having a bone fusion and removal of a bone with 20° of range of motion. He also reported fatigue and exhaustion. On days when he is able to get up, he performs light housework in small short periods at a time. He reports losing interest in his hobbies and is up at night so he does not have a social life. Before his illness, Petitioner reported playing video games, fixing computers, bicycle rides and visiting with friends. Also reported was a sleeping disorder. With regard to his personal care he indicated difficulty with dressing, bathing with the shower chair and makes only frozen dinners or leftovers. The Petitioner indicated he was able to do his laundry, and clean his room and bathroom and indicated that it takes sometimes hours as he can only work for 15 to 20 minutes at a time. The Petitioner indicated that he is able to drive and he does shop in stores or by computer. The Petitioner's social contacts were his mother and nephew who he lives with. The Petitioner reported difficulty lifting, squatting, bending, standing, walking, kneeling and using his hands and understanding. The Petitioner did not have difficulty sitting. He noted he could lift approximately 30 pounds although not repeatedly and could walk a mile if he was lucky. Squatting and kneeling causes pain in his low back, left leg and knee and bending also causes sharp pain. He indicated he could stand for 1 to 2 hours. His right-hand use could only be for light use due to his surgery. Reaching repeatedly causes weakness, tingling and numbness in the hand and wrist. The notes also indicate that he is photosensitive due to his headaches. When he has a migraine he has difficulty with his short-term memory, concentration and difficulty understanding things. He also reports being occasionally awake 72 to 96 hours due to his sleep problems. The Petitioner indicated he gets along with authority figures and treats them with the same rate suspect he is shown by them. He also notes he does not have a routine due to his body physically cannot keep a continuous sleep cycle. He also reported using braces for his hands and wrists.

The Petitioner attended physical therapy from July 17, 2019 to August 28, 2019 for a total of four visits with zero cancellations or missed appointments. The therapy was for bilateral low back pain with bilateral sciatica. The Petitioner reported current pain level usually 6/10 the Petitioner's range of motion for flexion and extension was 50º and 30° respectively, with 20° for side bending right and left. At the time the disability index score was 42/100 with a functional impairment score of 38/100 at evaluation. Functional deficits included bending, lifting and sleeping with the goal of bending over with no pain. At the time of the August 28, 2019 evaluation the assessment was that the Petitioner had made improvement and was in an ongoing home exercise program. The Petitioner was discharged from therapy due to noncompliance with attendance as of September 12, 2019. The notes indicate that past treatment included physical therapy and injections. At the time of the therapy Petitioner was experiencing severe migraines due to his inability to get injections for the migraines due to insurance issues. The physical therapy was resumed in October 2019. Petitioner reports his back condition had worsened due to the starter for his car requiring replacement after dying in the parking lot at physical therapy. The Petitioner advised that his back was extremely tight due to struggling with the starter and wrist limitations holding the starter in place so he could make the repair.

On July 18, 2018 Petitioner was seen for evaluation of migraine headaches and headaches as a new patient. Petitioner reported daily headaches and migraines lasting up to 72 hours. Typical symptoms include nausea, vomiting, photophobia, phonophobia, and vision "tracers". Pain level for severe migraines are 10 of 10. Migraines began when Petitioner was 13 years old. The Petitioner reports a family history of migraines on both maternal and paternal sides of his family, including his mother who is on preventative medications. Petitioner also reported sleep disorder and advised his primary care physician believes this to be the cause of his migraines. Petitioner also noted that Wellbutrin makes him perspire a lot and causes him to dehydrate which can bring on migraines. All prior CAT scans of the head have been normal and unremarkable since 2006 and prior. At the time Petitioner was going to a pain clinic in Ionia, Michigan. The Notes indicate that the Petitioner is on a number of medications both abortive and preventative including Depakote and Topiramate. Petitioner has migraines considered severe between two and four times a month with prolonged vomiting. Also reports occasional visual aura. The physical examination indicated neurologically the Petitioner was alert and oriented to person, place and time. Normal strength was displayed with no tremors. There were no cranial nerve deficits or sensory deficit. Normal muscle tone was exhibited with coordination and gait normal. The Petitioner was prescribed a new medication and notes indicate he was being followed in the sleep disorder center.

The Petitioner was seen again at the neurology department on August 9, 2018 notes indicate a lifelong problem with very irregular sleep schedule with prior sleep evaluations without clear diagnosis. Notes indicate Petitioner has been on a high dose of Adderall for the past seven years with some benefit. Problem list indicates insomnia, narcolepsy without cataplexy and anxiety associated with depression with chronic low back pain without sciatica and chronic wrist pain. At the time of the visit, notes indicate Petitioner noted greater than 15+ migraine/headaches days per month. Migraines have

been associated with nausea, vomiting and photophobia. Triggers appear to be dehydration and poor sleep. His pain clinic had attempted to get Botox injections approved but was denied. Notes further indicate the newly prescribed migraine medication was denied by insurance. The Petitioner has tried a series of medications to control migraines and thus notes indicate Botox approval will be tried again. The physical examination was essentially normal. At the visit the Petitioner received bi-lateral occipital nerve blocks for his migraines.

On August 31, 2018 the Petitioner received an injection of Botox for his migraines. The Petitioner received Botox in 31 injection sites and was advised to report any worsening headaches. The Petitioner was seen on December 3, 2018 for another series of Botox injections for migraine headache. Notes indicate the first eight weeks after the original Botox injections in August 2018 were very effective and he was headache free for eight weeks. During December his migraines did reoccur and appear somewhat less intense. Petitioner was very happy with the reduction. He was also attending Jayvery Pain Clinic now for general pain control. The Petitioner had another Botox injection on March 4, 2019. At a Botox injection on March 4, 2019 the Petitioner reported no migraine for 8 weeks and then experienced 2 to 3 migraines a week for the last 3-4 weeks before the next injection.

Petitioner was seen on August 24, 2018 with complaints of left knee pain with the knee giving out several times causing him to fall. X-rays of the knee taken September 4, 2018 showed normal left knee. The examination at the office visit showed decreased range of motion, with no effusion and normal patellar mobility and meniscus. Tenderness was noted in medial joint line and lateral joint line. Physical therapy was prescribed for the left knee. The Petitioner attended physical therapy (PT) on September 4, 2018 and noted that symptoms are aggravated by running up and down stairs, walking for long periods and pain fluctuates with activity and weather. Pain was sharp and piercing under the knee cap. Petitioner had decreased knee extension in ambulation and strength deficits. Current activity noted walking over 5,000 steps a day. Functional deficits included walking and pain when rising from a seated position to standing. Petitioner was evaluated as 40% impaired. The goal was to have his knee support him when he stands up. Petitioner was to be seen one or two times a week for 3-4 weeks to improve pain level, range of motion, stretching and strengthening to improve functional stability and ongoing home exercise program. Petitioner was seen on September 12, 17, 19, 24, 2018. At the conclusion of therapy Petitioner reported that his knee had gotten a little bit better, but due to sleep problems he is not able to heal properly because he cannot be active. Since therapy the knee has not given out, however he reported that he continues to have pain with stairs. Petitioner said stretching before activity and before sitting down seems to alleviate pain. Stretching eases symptoms. The highest pain level was 7/10 when Petitioner was carrying things up and down stairs with sharp pain under the knee cap. Many of the goals for therapy were not met, but level of functional impairment with mobility, walking and moving around will be reduced to at least 20% but less than 40% impaired. The Assessment was that Petitioner made fair improvement, and admits not compliant in ongoing home exercise program, short and long term goals have been partially met. Petitioner

acknowledged that he knows what he needs to do, but is unable at times due to not being able to manage his systemic pain well. He would like to consult with his doctor and resume therapy in one month after improved pain management with pain clinic.

Petitioner was seen on October 2, 2018 for follow up with knee pain and pain management. Petitioner was no longer going to the pain clinic because he did not show up for med count within 24 hour window. Petitioner would like to continue PT of left knee, but needs pain management for the rest of his symptoms. A referral to pain management for ongoing recommendations on managing chronic pain, including knee was made by his primary care doctor.

Petitioner was seen on November 2, 2018 for back pain which started one week previously in the gluteal and lumbar spine with aching, shooting and stabbing pain and radiates to the left gluteal buttocks and left hamstring. Pain is moderate and is aggravated by bending and twisting with stiffness. Petitioner recently moved and may have strained himself. The physical exam notes indicate decreased range of motion, tenderness, pain and spasm and Piriformis syndrome of left side. The Plan was to continue medications and exercises with PT on chronic left knee to resume one time per week for 4-6 weeks. Petitioner resumed PT November 13, 2018 and was reevaluated and was found to have left knee pain, with left IT band, patellar tracking dysfunction, decreased ROM and strength with increased left foot pronation. Current pain level was a 4/10, worst pain level 8/10. Symptoms are irritated with by being stationary and getting out of the car. A home exercise program was also assigned to improve functional potential. Petitioner continued therapy through December 12, 2018

On September 7, 2019 the Petitioner was seen for his typical migraine. The migraine had persisted for over 10 days and was scheduled to have Botox injection but could not complete due to insurance issues. The Petitioner reported having photophobia and nausea with this headache. Based on a physical examination a lumbar puncture or CAT scan was not warranted. The doctor prescribed Dilaudid and Phenergan.

On March 20, 2019 the Petitioner was seen for medication change as Adderall medication is not working well as he took the medication and still fell asleep after taking it. Petitioner wanted to explore other options. Adderall was taken for Narcolepsy. Notes indicated that Petitioner needed another sleep study. Petitioner reported depression was worse than it has been. The plan was to try alternate medications to Adderall.

Petitioner was seen on June 28, 2019 due to a fall with injury to right hand with pain described as aching and sharp. In addition, the Petitioner reported pain in right knee, right upper leg, right hip, left upper leg, left knee and hip. The leg pain was a recurrent problem without history of extremity problem. Pain is described as aching and burning. Petitioner has experienced pain, numbness and tingling in right leg which started in February, and when he put weight on it, the leg gave out causing a fall. When he fell, his right hand hit the countertop. A physical exam was conducted and noted decreased range of motion in back, lumbar area with pain and spasm. Right hand exhibits

decrease range of motion, tenderness, and swelling with decreased strength with wrist extension difficulty. An x-ray of right hand was taken and prescription for PT was made to address lower back pain and left extremity radiculopathy. The wrist hardware appeared stable based on the x-ray and was confirmed by radiology with no acute radiographic abnormality of the hand seen.

On July 17, 2019 the Petitioner began PT for his lower back with a diagnosis of lumbago and sciatica left side. Pain was described as constant waning pain with intermittent sharp shooting pain. Pain was rated 5/10 at the time of the visit. Pain is exacerbated with bending over. No ADL limitations were identified. The Petitioner did not report current level of activity being restricted due to his symptoms. On testing Petitioner had diminished back strength on the right side. Petitioner's disability score was 38/100. The plan for therapy was to improve exercise tolerance and functional activity and joint mobility, ongoing home exercise program and ROM stretching/strengthening. Petitioner attended additional PT sessions on July 29, 2019, and August 5, 2019.

The Petitioner was referred by his primary care physician to Javery Pain Institute PC on November 16, 2018 for back and left leg pain, left knee pain and right wrist pain. At the time of the visit the back pain was 4/10 in severity and described as aching, burning and throbbing with an electrical quality and radiates into the left buttocks. Pain is intermittent and is aggravated by bending, climbing stairs, lifting, standing for long periods of time and walking. Pain is alleviated by rest, heat, pain medications and ice. Previous treatment has been physical therapy, epidural steroids and chiropractic management. The PT was effective in relieving pain. Epidural steroids were effective as were chiropractic treatment. The physical exam noted paraspinal musculature is painful to palpation throughout the majority of the cervical spine. Range of motion is reduced in most active and passive planes tested and muscle strength was normal. The lumbosacral spine exam noted pain to palpation over the mid and lower lumbosacral paraspinal anatomy. Spine range of motion is reduced throughout the majority of the lumbosacral spine, all planes tested were reduced, active and passive range of motion testing, including flexion, extension as well as rotation and side bending were all reduced relative to normal values. The mid and lower paraspinal musculature noted to be hypertonic. Straight leg raising was positive for the left lower extremity, with no clonus. The exam of the left knee demonstrated tenderness to palpation over the knee joint line with decrease in flexion and extension with pain on motion. The motor examination noted normal strength and muscle tone throughout. No assistive devices were needed. The doctor order an MRI of lumbar spine without contrast due to chronic worsening bilateral low back pain radiating into the posterior left lower extremity. MRI of cervical and thoracic spine was also ordered.

The Petitioner was seen at the pain clinic again on December 12, 2018 for increased neck pain with throbbing, aching and burning pain radiating into the bilateral upper extremities with 6/10 severity. Petitioner also had low back pain described as dull, throbbing, aching and burning radiating to left leg. The MRI's were also reviewed. Musculoskeletal exam noted decreased range of motion in both cervical and

lumbosacral spine with straight leg raise positive in the left lower extremity. Pain on palpations to both cervical and lumbar spine. The Assessment noted chronic worsening neck pain, chronic worsening right C5-C6 radiculitis and cervical degenerative disc disease. Chronic worsening bilateral low back pain with sciatica, chronic worsening bilateral L5 radiculitis and lumbar disc herniation. Notes indicate that radiculitis is inflammation of the spinal nerve on its path of travel. Notes indicate that the radicular symptoms potentially emanating from the mild degenerative changes in the cervical spine may have overlap with chronic pain in the right wrist. Cervical epidural steroid injection was administered and a bilateral left L5-S1 transforaminal epidural steroid injection of the lumbar spine to treat symptoms and improve pain and function. The Petitioner received a second round of injections for cervical and lumbar on January 3, 2019. Back pain was 5/10.

The Petitioner was seen on January 23, 2019 with reports of neck pain 3/10 in severity, sharp, stabbing and burning radiating into bilateral shoulders. Noted 60% reduction in pain for about 10 days. Low back pain was also present with pain of 4/10. The Petitioner reports the pain is worse than prior to injections. The lumbar and cervical physical exam noted decreased range of motion in both cervical and lumbosacral spine with straight leg raise positive in the left lower extremity. Pain was exhibited on palpations to both cervical and lumbar spine. The was a positive straight leg raise bilaterally in the lumbar spine. Based upon the pain relief for 10 days the doctor recommended repeat injections for both cervical and lumbar spine. Notes indicate while injections last, patient reports 60-75% pain relief for 10 days with functional improvements making day to day improvements in activities. Petitioner received bilateral trigger point injections with lidocaine.

The Petitioner was seen on February 19, 2019 Petitioner received epidural injections in the lumbar and cervical spine. At the time the pain level was 6/10. The Petitioner noted some relief due to the prior trigger point injections. On March 18, 2019, Petitioner reported worsening neck pain 8/10 in severity and is sharp, throbbing, aching, and burning and radiates into the bilateral shoulders. The Petitioner reported that his lower back pain was better than previous visit 4/10 with radiation to the left leg. Petitioner presented as exhausted having been observed sleeping in the lobby. Petitioner reported that his current dose of Adderall is not controlling his narcolepsy and was to see his neurologist the following day. He reports that the injections, although wearing off were providing some meaningful improvement compared to how he was feeling at the prior to receiving injections. Based upon some improvement continued cervical and lumbar epidural interventions will be continued at regular intervals. The injections did taper off after 10 days. Petitioner also received repeat injections in the cervical and lumbar areas. The pain at the time of the injections was 6/10. Petitioner was seen on June 21, 2019 and reported pain worse than previous visit on May 14, 2019. The prior cervical injection did not give meaningful pain relief. Lower back pain was 5/10 and again noted he did not have meaningful relief of daily activities after last injection. Petitioner reported fatigue and sleeping problems with limitation of motion, back pain, stiffness, neck pain, shoulder(s) pain and leg(s) pain. The lumbar and cervical physical exam noted decreased range of motion in both cervical and lumbosacral spine with

straight leg raise positive in the left lower extremity. Pain on palpations to both cervical and lumbar spine. Positive straight leg raise bilaterally in the lumbar spine. Continuing injections were ordered and lidocaine prilocaine cream was prescribed in the interim as it was too early to receive the next series of injections.

On April 19, 2018 Petitioner was seen by a PA-C due to having a migraine for 3 days with severe pain 9 of 10. Multiple medications had been tried without success and had been seen in the ER when symptoms began without any improvement. Patient was described as in pain, tearful and distressed. Petitioner was given Zofran and advised to report to the ER. Diagnosis was intractable migraine, with nausea and vomiting.

Petitioner's lab results in August 2018 demonstrated a marker CRP for inflammation of 7.9 with a reference range of less than 5.0. Exhibit A, p. 230.

Petitioner was seen as a new patient on Michigan Behavioral Consultants on December 20, 2018 and was evaluated. During the interview he reported sleep disorder with 3 sleep studies, wrist injury with two surgeries, hypersomnia sleeps 20 hours or has hours of no sleep, frequent migraines, depression and anxiety. Notes indicate that he uses alcohol sometimes to deal with stress. Notes indicate Petitioner had a chaotic childhood with his parents divorcing when he was eight years old and numerous custody battles which his parents used to get back at each other. He has not seen his brother in three years and his father no longer talks to him. The notes indicate Petitioner was to be taught management techniques to control stress, pain and anxiety. The Petitioner was seen again on January 24, 2019 and had received trigger point injections for his migraines the week prior. He displayed an energy level which was extremely low and reported sleeplessness at night. Major deterrent to sleep involves memories, intrusive thoughts and dreams he has about past relationships he cannot let go of. He describes waking in a panic attack and sweat. Petitioner is having difficulty moving past this problem. The Petitioner was diagnosed with major depressive disorder by the examining psychiatrist.

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(s), 1.04 Disorders of the spine, 12.04 Depressive, bipolar and related disorders, 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)*. In addition, four broad functional areas (understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself) are considered when determining an individual's degree of mental functional limitation. 20 CFR 416.920a(c)(3). The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. *20 CFR 416.920a(c)(4).* A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. Id*. The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. Id.*

In this case, Petitioner alleges both exertional and nonexertional limitations due to his medical condition. Petitioner testified that he could stand for 45 minutes to an hour, sit for several hours on a soft seat, could walk ½ mile with pain increase in the left lower back and hip, he can squat only with difficulty due to his lower back pain , he can bend at the waist but has restrictions because he does not have full range of motion. Petitioner is right handed and has had several surgeries and reinjuries of his right wrist and has severe osteoarthritis in the wrist resulting in a 3 bone fusion surgery. Petitioner testified that he experiences pain and swelling in his wrist with use, and can lift/carry no more than 5 pounds with his right hand and approximately 14 pounds with his left hand. He can shower and dress himself and can microwave food. Petitioner can write with his right hand but not for extended periods of time. He can do some laundry but experiences pain with repetitive lifting. He drives, but only as necessary to the doctors or for groceries. Petitioner was also recently treated at St. Mary's pain clinic and is awaiting a full mental status evaluation which was not available at the time of the hearing. Petitioner also credibly testified to a long history of migraine treatments that are temporarily relieved with Botox injections which wear off near the end of the treatment period leaving him with resumed headaches which can last up to 72 hours

with nausea and pain. Petitioner also has limitations due to pain in his back, neck and hip with activity. He has undergone several rounds of multiple injections in his back and neck with only temporary relief. Due to this pain his activities with climbing stair, squatting and bending are reduced due to pain and range of motion limitations.

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 only less than sedentary work.

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has moderate limitations on his mental ability to perform basic work activities and there was insufficient evidence of medical records to support the diagnosis and has not consistently treated with a therapist for depression and anxiety. Petitioner also has ongoing sleep disorder problems which include narcolepsy, hyper insomnia with an irregular sleeping schedule.

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 in a shipping and receiving department for a fabricator of granite and laminate counter tops shipping products and lifting between 60 and 90 pounds and occasionally operating an edge banding machine and using a hi lo to move products. In this position Petitioner was on his feet most of the day. The work involved light physical exertional demands. Petitioner worked intermittently for an industrial services temporary employment company performing unskilled labor, standing much of the day and performing minimal skill tasks such as packaging items with lifting and carry between 5 and 40 pounds.

This work as well required the capability to perform work requiring light physical exertional demands. Petitioner last worked in 2010.

Based on the RFC analysis above, Petitioner's exertional RFC limits him to less than sedentary activities. As such, Petitioner is incapable of performing past relevant work. Petitioner also has pain limitations arising from migraines and neck and back pain affecting his capacity to perform basic work activities. In light of the entire record, it is found that Petitioner's nonexertional RFC prohibits him from performing past relevant work.

Because Petitioner is unable to perform past relevant work, Petitioner cannot be found disabled, or not disabled, at Step 4, and the assessment continues to Step 5.

Step 5

If an individual is incapable of performing past relevant work, Step 5 requires an assessment of the individual's RFC and age, education, and work experience to determine whether an adjustment to other work can be made. 20 CFR 416.920(a)(4)(v); 20 CFR 416.920(c). If the individual can adjust to other work, then there is no disability; if the individual cannot adjust to other work, then there is a disability. 20 CFR 416.920(a)(4)(v).

At this point in the analysis, the burden shifts from Petitioner to the Department to present proof that Petitioner has the RFC to obtain and maintain substantial gainful employment. 20 CFR 416.960(c)(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden*. O'Banner v Sec of Health and Human Services, 587 F2d 321, 323 (CA 6, 1978).*

When a person has a combination of exertional and nonexertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination **unless** there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969a(d).

In this case, Petitioner was 32 years old at the time of application and 33 years old at the time of hearing, and, thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. He is a high school graduate with a history of work experience performing unskilled work and performing and requiring light physical exertion. As discussed above, Petitioner maintains the exertional RFC to perform at a less than sedentary level. The Petitioner also has nonexertional impediments due to pain, including severe migraines, and hand, back and neck pain which have required ongoing injections without any lasting relief.

In this case, the Medical-Vocational Guidelines, Appendix 2 do not support a finding that Petitioner is not disabled based on his exertional limitations. The Department has failed to counter with evidence of significant numbers of jobs in the national economy which

Petitioner could perform despite his limitations. Therefore, the Department has failed to establish that, based on his RFC and age, education, and work experience, Petitioner can adjust to other work. Therefore, Petitioner is disabled at Step 5.

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 disabled for purposes of the SDA benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is REVERSED.

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE THE ORDER WAS ISSUED:

1. Reregister and process Petitioner's October 7, 2019 SDA application to determine if all the other non-medical criteria are satisfied and notify Petitioner of its determination;

2. Supplement Petitioner for lost benefits, if any, that Petitioner was entitled to receive if otherwise eligible and qualified;

3. Review Petitioner's continued eligibility in July 2021.

LF/

Lynn M. Ferris
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-Kent- Hearings
BSC3 Hearing Decisions
L. Karadsheh
MOAHR

Petitioner – Via First-Class Mail:

[redacted], MI [redacted]