STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF: [redacted]

Claimant

Reg. No.: 2009-22183
Issue No.: 2009
Case No.: [redacted]
Load No.: [redacted]
Hearing Date:
July 2, 2009
St. Clair County DHS

ADMINISTRATIVE LAW JUDGE: Colleen M. Mamelka

## HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Claimant's request for a hearing. After due notice, a hearing was conducted from Port Huron, Michigan on July 2, 2009. The Claimant appeared and testified, along with [redacted]. The Claimant was represented by [redacted] of [redacted]. [redacted] appeared on behalf of the Department. At the Claimant's request, the record was extended to allow for the submission of additional medical records.

## ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of Medical Assistance ("MA-P") 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. The Claimant submitted an application for public assistance seeking Medical Assistance ("MA-P") and State Disability Assistance ("SDA") benefits on or about August 30, 2007. (See - Exhibit 1, pp. 1 – 169)
2. On October 17, 2007, the Medical Review Team ("MRT") determined the Claimant was not disabled. (Exhibit 1, p. 42)
3. The Claimant filed a timely appeal.
4. The Claimant submitted an application for public assistance seeking Medical Assistance ("MA-P") and State Disability Assistance ("SDA") benefits on January 17, 2008.
5. On April 25, 2008 and June 4, 2008, the MRT found the Claimant not disabled. (Exhibit 1, pp. 163 -169)
6. On May 20, 2008, a hearing was held however as of this date, a decision has not issued.
7. The Claimant submitted an application for public assistance seeking Medical Assistance ("MA-P") and State Disability Assistance ("SDA") benefits on December 4, 2008.
8. On February 11, 2009, the Medical Review Team ("MRT") determined the Claimant was not disabled for purposes of the MA-P and SDA benefit programs. (Exhibit 1, pp. 213-14)
9. On February 18, 2009, the Department sent an Eligibility Notice to the Claimant informing her that she was found not disabled.
10. On March 11, 2009, the Department received the Claimant's written Request for Hearing.
11. On May 21, 2009, the State Hearing Review Team ("SHRT") determined the Claimant was not disabled. (Exhibit 2)

12. The Claimant's alleged physical disabling impairment(s) are due to chronic back, knee, and hip pain, degenerative disc disease with herniation, scoliosis, neuropathy, and neurological deficits.

13. The Claimant's alleged mental impairments are due to anxiety and depression.

14. At the time of hearing, the Claimant was 42 years old with a [redacted] birth date; was 5'11" in height; and weighed 200 pounds.

15. The Claimant is a high school graduate with some college and vocational training with a work history as a certified pharmacy technician, assistant supervisor of a group home, direct care provider, and bartender.

16. The Claimant's impairment(s) have lasted, or are expected to last, continuously for a period of 12-months or longer.

## CONCLUSIONS OF LAW

The Medical Assistance ("MA") program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department of Human Services ("DHS"), formally known as the Family Independence Agency, pursuant to MCL 400.10 *et seq* and MCL 400.105. Department policies are found in the Program Administrative Manual ("PAM"), the Program Eligibility Manual ("PEM"), and the Program Reference Manual ("PRM").

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a) The person claiming a physical or mental disability has the burden to establish it 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-relate activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913 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, is insufficient to establish disability. 20 CFR 416.929(a)

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicants 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)

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1) The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (i.e. age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need 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) If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from step three to step four. 20 CFR 416.920(a)(4); 20 CFR 416.945 Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1) An individual's residual functional capacity assessment is evaluated at both steps four and five. 20 CFR 416.920(a)(4) In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv) In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a) An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a) The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6)

In addition to the above, when evaluating mental impairments, a special technique is utilized. 20 CFR 416.920a(a) First, an individual's pertinent symptoms, signs, and laboratory findings are evaluated to determine whether a medically determinable mental impairment exists. 20 CFR 416.920a(b)(1) When a medically determinable mental impairment is established, the symptoms, signs and laboratory findings that substantiate the impairment are documented to include the individual's significant history, laboratory findings, and functional limitations. 20

CFR 416.920a(e)(2) 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 is considered. 20 CFR 416.920a(c)(1) In addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of 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.*

After the degree of functional limitation is determined, the severity of the mental impairment is determined. 20 CFR 416.920a(d) If severe, a determination of whether the impairment meets or is the equivalent of a listed mental disorder. 20 CFR 416.920a(d)(2) If the severe mental impairment does not meet (or equal) a listed impairment, an individual's residual functional capacity is assessed. 20 CFR 416.920a(d)(3)

As outlined above, the first step looks at the individual's current work activity. An individual is not disabled regardless of the medical condition, age, education, and work experience, if the individual is working and the work is a substantial, gainful activity. 20 CFR 416.920(a)(4)(i) In the record presented, the Claimant is not involved in substantial gainful activity therefore is not ineligible for disability under Step 1.

The severity of the Claimant's alleged impairment(s) is considered under Step 2. The Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b) An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c) Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b) Examples include:

1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

5. Responding appropriately to supervision, co-workers and usual work situations; and

6. Dealing with changes in a routine work setting.

*Id.* The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen*, 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services*, 773 F2d 85, 90 n.1 (CA 6, 1985) An impairment qualifies as severe only if, regardless of a claimant's age, education, or work experience, the impairment would not affect the claimant's ability to work. *Salmi v Sec of Health and Human Services*, 774 F2d 685, 692 (CA 6, 1985)

In the present case, the Claimant alleges disability chronic back, knee, and hip pain, degenerative disc disease with herniation, scoliosis, neuropathy, neurological deficits, depression, and anxiety. In support of her claim, some older medical records from 2003 and forward were submitted which document in part, osteoarthritis of the lumbar spine; depression, obesity, depression, degenerative disc disease, hypothyroidism, personality disorder, dizziness, and pyelonephritis. As noted in the findings of fact, a hearing was held regarding the Claimant's earlier application. Accordingly, this hearing addresses only the December 4, 2008 application.

On [redacted], x-rays of the lumbar spine found early degenerative changes with spur formation and incomplete bony union of the posterior remnant of the first sacral segment indicative of spinal bifida.

The [redacted] x-rays revealed mild spondylosis.

On [redacted], an EMG and nerve conduction study was performed on the Claimant which found neurophysiologic finding indicative of peripheral neuropathy.

The [redacted] x-rays found moderate degenerative disc disease centered at the thoracolumbar junction.

On [redacted], a Medical Examination Report was completed on behalf of the Claimant. The current diagnoses were hypertension, degenerative disc disease, GERD, peripheral neuropathy, intermittent bladder dysfunction, iron deficiency, hypothyroidism, gait dysfunction, and torn rotator cuff. The Claimant was able to occasionally lift/carry less than 10 pounds; stand and/or walk less than 2 hours during an 8 hour workday with sitting at less than 6 hours during this same time frame. The Claimant's need for a cane, walker, and occasionally a wheelchair was noted and she was unable to perform repetitive actions with any extremity. The Claimant's memory was listed as a mental limitation.

On [redacted], the Claimant was admitted to the hospital with complaints of shortness of breath, cough, sputum, and laryngitis. The Claimant was treated with antibiotics and given bronchodilators. She was discharged on [redacted] with the diagnoses of acute severe laryngotracheobronchitis with reactive bronchospasm; history of papillary thyroid cancer; diabetes mellitus type 2, hypothyroidsm, and depression.

On [redacted], the Claimant was evaluated at an urogynecology clinic. An EMG report was reviewed which documented body-wide muscle atrophy. The physician opined that the Claimant had fibromyalgia.

On [redacted], the Claimant was evaluated for her management of her bladder and bowel dysfunction. The Claimant was found to have multiple medical problems to include bowel and bladder dysfunction.

On [redacted] a multichannel urodynamics which revealed an abnormal bladder sensation and stress incontinence with the uretha hypermobility.

On [redacted], the Claimant's treating therapist authored a letter stating that the Claimant has been treated for severe depression since [redacted].

On [redacted], the Claimant attended a neurological evaluation. The Claimant was diagnosed with headaches, memory loss, vertigo, cervical/lumbar pain, multiple myalgias and arthralgias, multiple sclerosis, tremor, neck strain, muscle spasms, chronic wide-spread pain, chronic fibromyalgia, peripheral neuropathy, cervical/lumbar spondylosis, sleep disorder/insomnia, bruxism, and obesity.

On [redacted], a MRI of the lumbar spine revealed significant disc bulging with some mild progression of the lower lumbar spine disc desiccation.

On [redacted], a MRI of the brain was performed which revealed a solitary 5 mm lesion and tine mm lesions.

On [redacted], MRIs of the cervical and thoracic spine were performed which revealed some foraminal encroachment at the C6-7 level; disc herniation causing anterolateral mass effect on the thecal sac and extending to cause foraminal encroachment at C4-5; mild foraminal encroachment due to uncovertebral joint hypertrophy and facet arthropathy change; possible underlying scoliosis in the thoracic spine; multilevel spondylosis in the cervical spine; possible underlying dextroscoliosis centered at the upper to midthoracic spine; multilevel spondylosis at the lower thoracic spine; and minute disc protrusions at multiple levels.

On [redacted], a Medical Examination Report was completed on behalf of the Claimant. The current diagnoses were listed as peripheral neuropathy, brain lesions, gait dysfunction, bladder and bowel dysfunction, degenerative disc disease, hypothyroidism, thyroid cancer, headaches, heartburn, fibromyalgia, depression, chronic pain syndrome, left knee pain, and insomnia. The Claimant's condition was deteriorating. The Claimant was able to occasionally lift/carry less than 10 pounds; stand and/or walk less than 2 hours in an 8-hour workday with sitting at less than 6 hours during this same time period; and was unable to perform repetitive action with any extremity. The need for a cane, walker, and occasionally a wheelchair was documented. Mental limitations related to the Claimant's decreased memory.

On [redacted], the Claimant attended a psychological evaluation which found the Claimant with major depressive disorder, recurrent, severe. The Claimant's Global Assessment Function ("GAF") was 35 and her prognosis was guarded. In addition, a Mental Residual Functional Capacity Assessment was completed on behalf of the Claimant. The Claimant was found markedly limited in 9 of the 20 factors.

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the Claimant has presented some medical evidence establishing that she does have some physical and mental limitations on her ability to perform basic work activities. The medical evidence has established that the Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months, therefore, the Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The Claimant has alleged physical and mental disabling impairments due chronic back, knee, and hip pain, degenerative disc disease with herniation, scoliosis, neuropathy, neurological deficits, depression, and anxiety.

Listing 1.00 defines musculoskeletal system impairments. Disorders of the musculoskeletal system may result from hereditary, congenital, or acquired pathologic processes. 1.00A Impairments may result from infectious, inflammatory, or degenerative processes, traumatic or developmental events, or neoplastic, vascular, or toxic/metabolic diseases. 1.00A Regardless of the cause(s) of a musculoskeletal impairment, functional loss for purposes of these listings is defined as the inability to ambulate effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment, or the inability to perform fine and gross movements effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment. Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very

seriously with the individual's ability to independently initiate, sustain, or complete activities. 1.00B2b(1) Ineffective ambulation is defined generally as having insufficient lower extremity function to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities. (Listing 1.05C is an exception to this general definition because the individual has the use of only one upper extremity due to amputation of a hand.) *Id.* To ambulate effectively, individuals must be capable of sustaining a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living. 1.00B2b(2) They must have the ability to travel without companion assistance to and from a place of employment or school. . . . *Id.* When an individual's impairment involves a lower extremity uses a hand-held assistive device, such as a cane, crutch or walker, the medical basis for use of the device should be documented. 1.00J4 The requirement to use a hand-held assistive device may also impact an individual's functional capacity by virtue of the fact that one or both upper extremities are not available for such activities as lifting, carrying, pushing, and pulling. *Id.*

Categories of Musculoskeletal include:

1.02 Major dysfunction of a joint(s) due to any cause: Characterized by gross anatomical deformity (e.g. subluxation, contracture, bony or fibrous ankylosis, instability) and chronic joint pain and stiffness with signs of limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With:

A. Involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in inability to ambulate effectively as defined in 1.00B2b; or

B. Involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, wrist, hand), resulting in inability to perform fine and gross movements effectively a defined in 1.00B2c

* * *

1.04 Disorders of the spine (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, and vertebral fracture), resulting in compromise of a nerve root (including the cauda equine) or spinal cord. With:

A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine); or

B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours; or

C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b. (see above definition)

In order to meet a musculoskeletal listing, the impairment must present a major dysfunction resulting in the inability to ambulate effectively. The objective medical documentation (EMGs, x-rays, MRIs) establish that the Claimant has degenerative disc disease with foraminal encroachment, spinal stenosis, as well as muscle atrophy. The need for assistive device for ambulation is documented as well as the Claimant's peripheral neuropathy. In addition, the objective findings note bladder and bowel dysfunction which may be associated with the Claimant's multiple musculoskeletal impairments which include fibromyalgia. The Claimant's condition is listed as deteriorating and the restrictions imposed are consistent with less than sedentary limitations. Ultimately, it is found that the Claimant's impairments meet, or is the

medical equivalent thereof, a listed impairment within 1.00, specifically, 1.04. Accordingly, the Claimant is found disabled at Step 3 with no further analysis required.

## DECISION AND ORDER

The Administrative Law Judge, based upon the findings of fact and conclusions of law, finds the Claimant disabled for purposes of the Medical Assistance program and the State Disability Assistance program.

It is ORDERED:

1. The Department's February 18, 2009 determination is REVERSED.

2. The Department shall initiate review of the December 4, 2008 application to determine if all other non-medical criteria are met and inform the Claimant and her authorized representative of the determination.

3. The Department shall supplement for any lost benefits that the Claimant was entitled to receive if otherwise eligible and qualified in accordance with department policy.

4. The Department shall review the Claimant's continued eligibility in January of 2011 in accordance with department policy.

Colleen M. Mamelka

Colleen M. Mamelka
Administrative Law Judge
For Ishmael Ahmed, Director
Department of Human Services

Date Signed: __12/17/09_____

Date Mailed: __12/17/09_____

**NOTICE:** Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

The Claimant may appeal the Decision and Order to the Circuit within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the recip date of the rehearing decision.

CMM/jlg

cc: [redacted]