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.: 2009-29369
Issue No.: 2009
Case No.: [redacted]
Load No.: [redacted]
Hearing Date:
September 16, 2009
Wayne County DHS (19)

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 Inkster, Michigan on Wednesday, September 16, 2009. The Claimant appeared and testified. The Claimant was represented by [redacted] of [redacted]. [redacted] appeared on behalf of the Department.

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of the 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") retroactive from November 2008, on January 29, 2009.

2. On February 24, 2009, the Medical Review Team ("MRT") determined the Claimant was not disabled. (Exhibit 1, pp. 6, 7)

3. On March 4, 2009, the Department sent an Eligibility Notice to the Claimant informing him that he was found not disabled for purposes of the MA-P program. (Exhibit 1, p. 4)

4. On May 18, 2009, the Department received the Claimant's written Request for Hearing.

5. On July 31, 2009, the State Hearing Review Team ("SHRT") determined the Claimant was not disabled. (Exhibit 2)

6. The Claimant's alleged physical disabling impairment(s) are due to chronic back and neck pain with disc herniation and spinal stenosis, severe radiculopathy, vertigo, closed head injury, and sleep apnea.

7. The Claimant has not alleged any mental disabling impairment(s).

8. At the time of hearing, the Claimant was 50 years old with a [redacted] birth date; was 5'10" in height; and weighed 289 pounds.

9. The Claimant completed through the 11th grade and subsequently obtained his GED with an employment history as a truck driver.

10. 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)

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 the Claimant 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 non-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 due to chronic back and neck pain with disc herniation and severe radiculopathy and stenosis; vertigo, closed head injury, and sleep apnea.

By way of background, on [redacted], the Claimant was struck in the back of the head by a truck door resulting in the physical impairments.

On [redacted], the Claimant presented to the neurosurgery clinic for evaluation. The MRI confirmed degenerative disc disease and a recommendation for continued physical therapy was made.

On [redacted], The Claimant attended a follow-up appointment for his cervical spondylosis. A MRI was ordered to further evaluate the need for surgical intervention.

On [redacted], a MRI revealed multilevel degenerative disc changes which contributed to severe spinal stenosis at multiple levels of the mid cervical spine with evidence of spinal cord injury at C5-C6 level.

On [redacted], the Claimant attended a follow-up evaluation regarding his cervical spondylosis. A review of the MRI revealed multilevel cervical spondylosis with severe central canal stenosis, worse at C5 but extending from C3 to C6 with a high abnormal T2 signal within

the C5 region. A long posterior decompression fusion from C3 to C6 with fusion from C3 to T2 was recommended.

On [redacted], a MRI of the brain and lumbar spine without contrast was performed. The brain MRI was abnormal revealing numerous foci of nonspecific white matter with concern of a small arteriovenous malformation or arteriovenous fistula. The MRI of the spine documented multilevel degenerative changes within the cervical spine.

On [redacted], the Claimant presented to the hospital with complaints of severe dizziness. Despite initial treatment, the symptoms continued to include nausea. The CT scan revealed multilevel degenerative disc disease more pronounced at the levels of C3-4 through C5-6.

On [redacted], the Claimant's treating physician authored a letter elaborating on the Claimant's condition. The letter provides that the Claimant as extensive cervical spondylosis and disc protrusion with areas of cord compression. The Claimant also treats for vertiginous episodes with gait dysfunction and pain.

On [redacted], the Claimant attended a follow-up appointment regarding his cervical spondylosis. The Claimant's unsteady gait, weakness, and progressive dizziness were documented as well as a recommendation for posterior decompression and fusion in order to stop progression of the decline and that the procedure would not likely provide significant improvement.

On [redacted], a neurosurgeon informed the Claimant that there was "no realistic chance" that his neck pain would improve and that it would likely worsen after surgery.

On [redacted], a MRI of the brain was performed which revealed numerous punctuate foci of T2 and FLAIR hyperintensisty within the deep and subcortical shite matter of bilateral cerebral hemispheres.

On [redacted], the Claimant attended a follow-up appointment regarding his cervical spondylosis. A MRI of the cervical spine documented multilevel degenerative changes particularly at C4-5 where disc osteophyte complex was noted causing bilateral foraminal stenosis at C4-5 and significant bilateral neural foraminal stenosis at C5-6. Cervical decompression was discussed noting that the surgery may not improve his symptoms. A cervical myelogram study was recommended to determine whether surgical intervention would be warranted.

On [redacted], the Claimant attended a follow-up appointment regarding his cervical spondylosis. Review of a CT cervical myelogram study revealed multilevel degenerative changes throughout the Claimant's cervical spine without spinal cord compression. In addition, a 2-level disc herniation causing "significant nerve compression" was also revealed. As a result, surgical intervention was recommended noting that the procedure would not likely improve his neck pain and/or dizziness.

On [redacted], a Medical Examination Report was completed on behalf of the Claimant. The current diagnoses were listed as persistent neck and low back pain/weakness, unsteady gait, vertigo, cervical and lumbar spondylosis, and central canal stenosis. The Claimant was required a cane for ambulation and was unable to perform repetitive action with any extremity. Mental limitations were noted with memory, sustained concentration, and social interaction. The Claimant was unable to meet his needs in the home.

On [redacted], the Claimant was admitted to the hospital for anterior cervical discectomy and fusion due to his cervical radiculomyelopathy. Disc herniation at C4-5 and C5-6 with nerve root compression was confirmed with a CT scan, MRI, and myelogram study. The surgery was performed without complication and the Claimant was discharged the following day.

On [redacted], the Claimant attended a post-operative examination. Review of the cervical spine films revealed one screw at C6 had "backed out slightly, …" The Claimant was required to wear a cervical collar at all times. Overall, the Claimant was found to be healing well.

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 medical evidence establishing that he does have some physical limitations on his 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 disabling impairments due to chronic and mental disabling impairments due to chronic back and neck pain with disc herniation and spinal stenosis, severe radiculopathy, vertigo, closed head injury, and sleep apnea.

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, 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 this case, the objective medical evidence establishes multiple levels of spinal stenosis with multiple levels of neural foramina compromise and impingement as well as moderate degenerative changes. The Claimant recently underwent surgery, not to provide significant relief, but instead, to prevent further deterioration. The records document pain and weakness which have lasted continuously for 12-months or more despite compliance with prescribed treatment. The Claimant's need for assistive device for effective ambulation is also documented. In light of the foregoing, it is found that the Claimant's impairment(s) meets, or is the equivalent thereof, the intent and severity requirement of a listed impairment within 1.00, specifically, 1.04. Accordingly, the Claimant is found disabled at Step 3 with not 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.

Accordingly, it is ORDERED:

1. The Department's determination is REVERSED.

2. The Department shall initiate review of the January 29, 2009 application to determine if all other non-medical criteria are met and inform the Claimant and his representative of the determination.

3. The Department shall supplement the Claimant any lost benefits he 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 October of 2010 in accordance with department policy.

Colleen M. Mamelka

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

Date Signed: 09/29/09

Date Mailed: 09/29/09

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]