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.: 2010-2060
Issue No.: 2009/4031
Case No.: [redacted]
Load No.: [redacted]
Hearing Date:
December 10, 2009
Oakland County DHS (2)

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 telephone hearing was conducted from Detroit, Michigan on Thursday, December 10, 2009. The Claimant appeared, along with [redacted], and testified. [redacted] appeared on behalf of the Department.

## ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of Medical Assistance ("MA-P") and 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. The Claimant submitted a public assistance application seeking MA-P benefits on April 18, 2008.

2. On May 2, 2008, the Medical Review Team ("MRT") deferred the disability determination requesting the Department schedule an internist examination as well as obtain additoinal medical documentation. (Exhibit 1, p. 25)

3. The Claimant was referred to Michigan Rehabilitative Services on May 6, 2008 and began receiving SDA benefits. (Exhibit 2)

4. On May 27, 2008, the Claimant attended a consultative evaluation. (Exhibit 1, pp. 23, 24)

5. On June 18, 2008, the MRT determined the Claimant was not disabled based on the April 2008 application. (Exhibit 1, p. 21, 22)

6. In error, the Department activated MA-P coverage.

7. On May 1, 2009, the Claimant completed another application for public assistance.

8. On June 4, 2009, the MRT found the Claimant not disabled. (Exhibit 1, pp. 1, 2)

9. On or about June 4th, the Claimant's MA-P case was pended for closure effective June 30, 2009.

10. On September 3, 2009, the Department received the Claimant's timely written request for hearing protesting the proposed termination of MA-P benefits. (Exhibit 3)

11. On October 28, 2009, the State Hearing Review Team ("SHRT") determined the Claimant was not disabled. (Exhibit 4)

12. The Claimant's alleged physical disabling impairments are due to chronic left shoulder, right foot, and back pain, disc herniation with encroachment, asthma, chronic obstructive pulmonary disease ("COPD"), and neurological deficits to include memory loss.

13. The Claimant's alleged mental disabling impairments are due to depression, anxiety, and Schizoaffective disorders.

14. At the time of hearing, the Claimant was 52 years old with a [redacted] birth date; was 5' 11" and weighed 242 pounds.

15. The Claimant completed through the 12th grade with a work history as a general laborer and construction supervisor.

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 416.927 Unless an impairment(s) is expected to result in death, the impairment(s) must have lasted, or must be expected to last, for a continuous period of at least twelve months. 20 CFR 416.909

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) 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) 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 thus 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 asserts physical and mental disabling impairments due chronic shoulder, foot, and back pain, disc herniation with impingement, asthma, COPD, depression, anxiety, and schizoaffective disorder.

On [redacted] a CT of the lumbar spine revealed degenerative disc disease changes at L3-4, L4-5, and L5-S1.

On [redacted], x-rays of the lumbar and cervical spine revealed decreased disc spacing at L4-5 and L5-S1 along with mild degenerative disc disease at L4-S1. The pain was noted as constant, sharp, and radiating. The cervical spine x-ray revealed a decrease in the normal curve. The examination found moderate muscle hypertonicity on the right; moderate muscle tightness of the middle right thoracic spine; severe muscle tightness and spasm of the lumbar spine bilaterally; and subluxation of the C7, T9, L1, L4, L5, and sacrum. An EMG was recommended to confirm the extent of the nerve damage.

On [redacted], a General Medical Examination Report was completed on behalf of the Claimant by a treating physician who listed the current diagnoses of lumbar sacral degenerative and disc disease.

On [redacted], a General Medical Examination Report was completed by the Claimant's different treating physician for MRS. The diagnoses were degenerative/herniated disc disease based upon a CT of the lumbar spine. The Claimant's limiting conditions were permanent and would not be removed with treatment. The Claimant was limited in walking, kneeling, reaching, lifting, pushing, stooping, climbing, and pulling.

On [redacted], the Claimant's strengths and weaknesses relative to performing day to day functions along with an estimation of the level of support need for an individual to be successful in the workplace. The Claimant was found to require extensive support in movement and gross motor skills and strengths. The Claimant was found to be functioning at the 5$^{th}$ grade level with regards to his academic abilities. Ultimately, the Claimant was diagnosed with

schizoaffective disorder, depressed type; borderline cognitive functioning, with a Global Assessment Function ("GAF") of 40. The Claimant's prognosis was guarded.

On [redacted], the Claimant was treated for pain in his feet. X-rays revealed significant 1st MP joint space narrowing; flattening of the 1st MTH and proximal phalangeal base of the hallux; and severe degenerative changes with osteophytosis. Ultimately, the Claimant was found to have foot pain, gait disturbance, hallux rigidus, capsulitis, deformities, onchomycosis, and a history of back pain and acid reflux.

On [redacted], an MRI of the cervical spine revealed multilevel posterior projecting disc osteophyte complexes beginning at levels C2-3 and most significantly at C5-6 which, at this level, approximating and deforming the anterior aspect of the cervical cord. Mild multi-level uncovertebral spondylitic changes were noted as well as multi-level bilateral neural foraminal encroachment, most significant at C5-6.

On this same date, and MRI of the left shoulder found an intact rotator cuff tension with degenerative intrasubstance tendinosis, cystic change in the superolateral humeral head, AC joint degenerative change impinging the anterior aspect of the distal rotator cuff tendon, and a possible ganglion cyst.

On [redacted], after review of the MRI of the lumbar spine, the treating physician documented disc herniation between L5-S1 and posterior protrusion of the discs between L2-3, L3-4, and L4-5. The physician opined that the Claimant was "totally disabled" noting the need for referral to an orthopedic surgeon. The Claimant was restricted from any physical labor to include lifting, pulling, pushing, bending, or twisting. Standing was limited to not more than 30 minutes.

On [redacted] the Claimant was found to have bilateral hallux rigidus with chronic pain. These issues were not resolved with conservative treatment thus the Claimant underwent surgical correction implant arthroplasty on his right foot.

On [redacted], the Claimant attended a neurological consultative examination which documented the Claimant as being confused with wandered speech. The Claimant was found to have shortness of breath, neuropathy, hepatic pain, interstitial lung disease, COPD, chronic pain, hypertension, reflux, depression, and memory loss. The Claimant's exposure to carcinogenic agents was also noted. The Claimant was referred to psychiatry for treatment for his depression.

On [redacted], the Claimant was referred for a pain management consultation which resulted in the diagnoses of lumbar radiculopathy, memory loss, anxiety, panic disorder, schizoaffective disorder, hypercholesterolemia, hypertension, closed head injury, COPD, acid reflux, and hiatal hernia. Lumbar epidural injections were recommended.

An [redacted] EMG studies revealed bilateral L4-5 nerve root irritation.

On [redacted], the Claimant was found to have moderate obstructive sleep apnea syndrome. On [redacted], a CPAP machine was delivered to the Claimant.

On [redacted], a Medical Examination Report was completed on behalf of the Claimant. The current diagnoses were degenerative disc disease of the lumbar spine, bulging disc, learning disability, hypertension, COPD, obstructive sleep apnea, and neuropathy. The Claimant was limited to occasionally lifting/carrying of less than 10 pounds; standing and/or walking less than 2 hours during an 8 hour workday with sitting less than 6 hours during this same time period. The Claimant was unable to perform repetitive actions with any extremity with the exception of simple grasping. The Claimant's memory and sustained concentration was

also limited. The Claimant was unable to meet his needs in the home and required assistance with housework, laundry, shopping, and meal preparation.

On this same date, a Medical Needs form was completed on behalf of the Claimant. The current diagnoses were same as outlined above (Medical Examination Report). The treating physician opined that the Claimant was unable to work at any job.

On [redacted], a pulmonary function study revealed minimal obstructive airways disease and neuromuscular disease.

On [redacted], the Claimant's treating physician listed the Claimant's current diagnoses of back pain, hypertension, depression, gastric esophageal reflux disorder ("GERD"), degenerative joint disease, neck pain, hyperlipidemia, neuropathy, COPD, and sleep apnea.

On [redacted], an occupational/environmental medicine physician referred the Claimant to a toxicology program due to his exposure to DDT.

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 he does have some physical and mental 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, or expected to last, 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 disabling impairments due to

chronic left shoulder, right foot, and back pain, disc herniation with encroachment, asthma, chronic obstructive pulmonary disease ("COPD"), and neurological deficits to include memory loss. The Claimant has mental disabling impairments due to depression, anxiety, and schizoaffective disorder.

Appendix I, Listing of Impairments, discusses the analysis and criteria necessary to support a finding of a listed impairment.

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.*

Major joints refers to the major peripheral joints. 1.00F The ankle and foot are considered separately in evaluating weight bearing. *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

1.03 Reconstructive surgery or surgical arthrodesis of a major weight- bearing joint, with inability to ambulate effectively, as defined in 1.00B2b, and return to effective ambulation did not occur, or is not expected to occur, within 12 months of onset.

1.03 Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint, with inability to ambulate effectively, as defined in 1.00B2b, and return to effective ambulation did not occur, or is not expected to occur, within 12 months of onset.

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 this case, MRIs, x-rays, EMGs, and CTs confirm that the Claimant has degenerative disc disease, severe degenerative changes, radiating pain, decreased normal curve of the cervical spine, severe muscle tightness of the thoracic and lumbar spine, significant 1st MP joint space narrowing (foot), hallux rigidus and deformities (foot), AC joint degenerative change impinging of the anterior aspect of the distal rotator cuff tendon, disc herniation and protrusion at several levels, L4-5 nerve root irritation, degenerative joint disease, neck pain, neuropathy, nerve damage, and foot surgery. The Claimant has participated in conservative treatment (physical therapy and epidural injections) to no avail. The medical evidence documents limitations in walking, kneeling, reaching, lifting, pushing, stooping, climbing, and pulling. (These restrictions equate to the residual functional capacity of less than sedentary.) Ultimately, the records

presented establish that the Claimant has a severe musculoskeletal impairment that meets, or is the equivalent thereof, a listed impairment within Listing 1.00 as detailed above. Accordingly, the Claimant is found disabled at Step 3 with no further analysis required.

The State Disability Assistance ("SDA") program, which provides financial assistance for disabled persons, was established by 2004 PA 344. DHS administers the SDA program purusant to MCL 400.10 et seq. and Michigan Administrative Code ("MAC R") 400.3151 – 400.3180. Department policies are found in PAM, PEM, and PRM. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal SSI disability standards for at least ninety days. Receipt of SSI or RSDI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness (MA-P) automatically qualifies an individual as disabled for purposes of the SDA program.

In this case, the Claimant is found disabled for purposes of the Medical Assistance ("MA-P") program therefore the Claimant's is found disabled for purposes of continued SDA benefits.

## 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 determination is REVERSED.

2. The Department shall initiate review of the May 1, 2009 application to determine if all other non-medical criteria are met and inform the Claimant of the determination in accordance with department policy.

3. The Department shall supplement for any lost benefits 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: 12/22/09

Date Mailed: 12/22/09

**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]