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.: 201030739
Issue No.: 2009
Case No.: [redacted]
Load No.: [redacted]
Hearing Date:
May 20, 2010
Wayne County DHS

ADMINISTRATIVE LAW JUDGE: Jeanne M. VanderHeide

HEARING DECISION

This matter was conducted pursuant to MCL 400.9 and MCL 400.37 by an in-person hearing held in Wayne County, Michigan on May 20, 2010 upon the Claimant's request for hearing received by the Department on March 25, 2010. At the hearing, the Claimant was present and testified. 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 Medical Assistance ("MA")?

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material and substantial evidence on the whole record, finds as material fact:

1. Claimant applied for SDA and MA as of 9/22/09. Retroactive benefits were requested to August, 2009. Claimant's SDA was approved and a review by

MRT approved MA back to January of 2010. The only benefits at issue are MA benefits from August, 2009 – January, 2010.

2. Claimant is 5’8” tall and weighs 248 pounds.

3. Claimant is left handed.

4. Claimant is 40 years of age.

5. Claimant’s impairments have been medically diagnosed as spinal stenosis, radiculopathy, depression, herniated disc at L4-5 with nerve compression, drop left foot and schizophrenia.

6. Claimant’s physical symptoms are pain in low back (9/10 right now, most times he is in pain), stabbing sensation in stomach, stabbing sensation in legs and thighs as well, numbness and tingling in legs (sometimes just left leg, sometimes to toes and buttocks).

7. Claimant’s mental symptoms are poor memory, poor concentration, panic attacks (rush, flashback mode and thinks of getting shot, doesn’t feel face, fingers start tingling, starts shaking – hates being around noise), anxiety attacks (rage, but also thoughts racing, everything is going fast – like a racing car, no control, may have outburst), some confusion, fear/anger, nervousness, appetite comes and goes – when depressed does not eat, sleep disturbances (keeps waking up due to pain, 4-5 hours total, waking constantly every 40 min to an hour), fatigue, suicidal thoughts (all the time), nervous about being in public (feels like people talking about him or want to jump him), hallucinations (most times hears voices, telling him to do things or kill himself, sees people or images in middle of night – only last 40 seconds), paranoid, and low self esteem.

8. Claimant takes the following prescriptions:
   a) Klonopin (panic attacks)
   b) Celexo – mood disorders
   c) Zyprexa – helps him stay calm
   d) Motrin – pain
   e) Cogentin – helps with voices
   f) Welbutrin
   g) Dicyclomine – stomach pain
   h) Ambien – sleep
   i) NRCO – form of Tylenol and Vicodin (pain) – every day 2x every 3 ½ or 4 hours
   j) Flexeril – muscle relaxer

9. Claimant’s impairments will last or have lasted for a continuous period of not less than 12 months.

10. Claimant has a H.S. education obtained through special education classes. Claimant is certified to drive semi trucks.

11. Claimant is able to read and write some. Claimant testified that he cannot read a newspaper. When he tries to read, his thoughts race and he has a hard time concentrating. Claimant can do some math but admitted that he has difficulty making change at store and tries to have someone with him.

12. Claimant last worked in July, 2009 as a truck driver when he was in a roll over truck accident. Claimant testified that his back pain started right after. Claimant job duties included loading and reloading trucks, changing tires, and lifting between 50 and 125 lbs.

13. Claimant has prior employment experience as construction worker (on feet all day, lifting 100-150 lbs).

14. Claimant testified to the following physical limitations:
    - Sitting: 20 minutes, after that is unbearable
    - Standing: Toes go numb immediately,10-20 minutes total
    - Walking: uses walker or 4 prong cane. Cannot walk further than from car to building.
    - Bend/stoop: Hard to do either, hurts when sneezes, puts shoes on, difficulty putting pants on. Sometimes just sleeps in clothes and leaves shoes loose to slide feet in.
    - Lifting: Claimant can carry a gallon of milk sometimes. Cannot shovel snow or push lawnmower
    - Grip/grasp: No probs

15. Claimant has not washed clothes in months. Claimant does not clean or do any outside maintenance. Claimant stays in his basement because he cannot go anywhere. Claimant has friends who will come and check on him. Claimant is able to make a PB&J or bologna sandwich. Friends often go to store for him although Claimant will go when necessary.

16. The Department found that Claimant was not disabled and denied Claimant's application on January 27, 2010.

17. The Department received Claimant's request for a hearing on March 25, 2010.

18. Medical records examined are as follows, in part:

<u>3/18/10 Internal Medicine Medical Exam Report (Exhibit 3)</u>
DX: L4-L5 herniated disc disorder with nerve compression, lumbar radiculopathy, obesity and left foot drop.

GENERAL EXAM: Unsteady gait due to weakness in left side
MUSCULOSKELETAL: weakness of left lower extremities
MENTAL: Depression, schizophrenia, mood swings
TESTING: CT myelogram of L spine which showed pressure on the L5 nerve from stenosis disc herniation.
PHYSICAL LIMITATIONS: Lifting less than 10 lbs occasionally. Stand/walk less than 2 hours in 8 hour day, sit less than 6 hours in hour day, no pushing/pulling with arms, no operating leg controls with left leg
MENTAL LIMITATIONS: Limited in comprehension, memory, sustained concentration, following simple directions, and social interaction – He has schizophrenia, mood swings and depression.
ASSISTIVE DEVICES: Uses cane, back brace, walker

10/9/09 Psychiatric Evaluation (Exhibit 1, p. 45)
COMPLAINTS: Pt was sexually, emotionally and physically abused as a child and has been experiencing recurrent memories of his abuse. He reported that he experiences irritability, decreased sleep and erratic appetite. He tends to isolate himself because he is easily agitated and angered and he feels as if he will explode if someone bothers him. Chronic back pain from an injury. Currently experiences suicidal ideations without intent or plan. He feels worthless and useless and frustrated.
OBSERVATIONS: Insight – fair, judgment – fair. Pt occasionally moved around related to back pain. Walking with cane. He appeared to be in physical pain. Reported auditory hallucinations and recurrent memories of abuses and recurrent nightmares. His memory was remarkable for being able to remember 3 out of 3 immediately and 0/3 after 2 minutes. His cognition was remarkable for the decreased memory as mentioned.

9/12/09 – 9/17/09 Hospital Admission (Exhibit 2, p. 22)
DX: lumbar radiculopathy, spinal stenosis of lumbar region. Pt advised that he needs neurosurgical intervention, but the pt refused. Pt received steroid epidural injection in L3-L4. Pt provided with Rx for back brace and rolling walker or large based quad cane. CT of lumbar spine revealed diffuse bulging and possible mild stenosis at L4-5 and L5-S1 but no evidence of neuronal compromise. Cannot do MRI due to bullet in kidney

9/16/09 Neurology Consultation (Exhibit 2, pp. 28-29)
Pt will not cooperate to multiple testing of the left leg.

9/16/09 Neurology Consultation (Exhibit 2, p. 31)
Spinal stenosis at L4-5 with left footdrop. Advised that he needs surgery, decompressive laminectomy. Pt has no insurance.

9/15/09 CT Lumbar Spine with Contrast (Exhibit 2, p. 34)
There is evidence of central canal stenosis at L5-S1 and to a lesser extent and L3-4. At L4-5 the is circumferentially bulged.

9/15/09 CT of Head/Brain (Exhibit 2, p. 37)
CT scan of the brain is within normal limits

9/16/09 Medical Exam Report (Exhibit 2, pp. 1-2)
HX: Weakness of left lower extremities
DX: Lumbar spinal stenosis, lumbar radiculitis, R lower extremity weakness
EXAM: Inability to ambulate
MENTAL: Confused on time
TESTING: Myelogram – lumbar spinal stenosis. CT L spine with spinal stenosis at L4-L5, L3-L4
CLINICAL IMPRESSION: Deteriorating
PHYSICAL LIMITATIONS: lifting 10 lbs occasionally, sitting less than 6 hours in 8 hour day. No repetitive actions with right leg or foot due to significant weakness with right lower extremities
MENTAL LIMITATIONS: Limited in comprehension, sustained concentration and somewhat confused.
Cl cannot meet the needs in his home

9/12/09 CT Lumbar Spine without contrast (Exhibit 2, p. 38)
There is presence of bulging discs at L4-L5 and L5-S1 levels compressing the thecal sac more marked at L4-L5 level

8/15/09 – 8/18/09 Hospital Admission (Exhibit 2, p. 3)
COMPLAINTS: Admitted for abdominal pain. Since his accident, he also describes problems with back pain, numbness in the lower extremities as well as some dizziness.
DX: kidney stone, bilateral upper extremity numbness, status post wound gunshot - early 1990s, small reducible incisional hernia.
X-ray: One gunshot pellet in the upper pole of the right kidney. No specific intervention is required with regards to this pellet.

5/14/09 Psychological treatment (Exhibit 2, p. 21)
The pt is anxious and tense and is under severe financial stress and pressure. Pt admits to auditory hallucinations buy denies any harmful content at present. Sleep and appetite are poor.
MENTAL STATUS EXAM: The pt is anxious and tense with increased psychomotor activity and some autistic like rocking that is occurring. Positive auditory hallucinations and occasional visual hallucinations. Some positive paranoid ideation and without delusions.

8/21/08 Psycho-Social Assessment (Exhibit 2, p. 6)
HX: 7/30/08 head trauma in bad car accident. Air lifted to hospital. Complains of depressed feelings, auditory hallucinations, early and middle insomnia, poor appetite, anger, headaches and dizziness. No substance abuse issues. Ran out of psychiatric medications a month ago.
OBSERVATIONS: Mood dysthymic, affect sad, reports hallucinations
DX: Major depressive disorder, recurring, severe with psychosis; dysthymic disorder
SUICIDAL POTENTIAL: Pt has no support system and this appears to be a lifelong issue which with his depression appears to make him vulnerable to suicidality.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the MA program pursuant to MCL 400.1 *et seq*., and MCL 400.105. Department policies are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables (RFT).

Federal regulations require that the department use the same operative definition for "disabled" as used for Supplemental Security Income (SSI) under Title XVI of the Social Security Act. 42 CFR 435.540(a).

"Disability" is:

> . . . 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 CFR416.905

In determining whether an individual is disabled, 20 CFR 416.920 requires the trier of fact to follow a sequential evaluation process by which current work activity; the severity of impairment(s); residual functional capacity, and vocational factors (i.e., age, education, and work experience) are assessed in that order. A determination that an individual is disabled can be made at any step in the sequential evaluation. Then evaluation under a subsequent step is not necessary.

1. Current Substantial Gainful Activity

Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. "Substantial work activity" is work activity that involves doing significant physical or mental activities. 20 CFR 416.972(a). "Gainful work activity" is work that is usually done for pay or profit, whether or not a profit is realized. 20 CFR 416.972(b). Generally if an individual has earnings from employment or self-employment above a specific level set out in the regulations, it is presumed that she has the demonstrated ability to engage in SGA. 20 CFR 416.974 and 416.975. If an individual engages in SGA, he is not disabled regardless of how severe his physical and mental impairments are and regardless of his age, education and work experience. If the individual is not engaging in SGA, the analysis proceeds to the second step. In the subject case, the Claimant has not worked since July of 2009. Therefore, he is not disqualified at the first step.

2. Medically Determinable Impairment – 12 Months

Second, in order to be considered disabled for purposes of MA, a person must have a "severe impairment" 20 CFR 416.920(c). A severe impairment is an impairment which significantly limits an individual's physical or mental ability to perform basic work activities. Basic work activities mean the abilities and aptitudes necessary to do most jobs. 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. 20 CFR 416.921(b)

The purpose of the second step in the sequential evaluation process is to screen out claims lacking in medical merit. The court in *Salmi v Sec'y of Health and Human Servs*, 774 F2d 685 (6th Cir 1985) held that an impairment qualifies as "non-severe" only if it "would not affect the claimant's ability to work," "regardless of the claimant's age, education, or prior work experience." *Id.* At 691-92. Only slight abnormalities that minimally affect a claimant's ability to work can be considered non-severe. *Higgs v Bowen,* 880 F.2d 860, 862 (6th Cir. 1988); *Farris v Sec'y of Health & Human Servs*, 773 F.2d 85, 90 (6th Cir. 1985).

In this case, the Claimant has presented medical evidence of spinal stenosis, possible disc herniation, radiculopathy, depression and schizophrenia. In addition, Claimant's physician has instituted significant physical restrictions due to Claimant's impairments. The medical evidence has established that Claimant has physical and mental impairments that have more than a minimal effect on basic work activities; and Claimant's impairments are expected to last continuously for more than twelve months.

3. **Listed Impairment**

After reviewing the criteria of listing 1.04 *disorders of the spine*, the undersigned finds the Claimant's medical records substantiate that the Claimant's mental impairments meets or is medically equivalent to the listing requirements. 20 CFR 404, subpart P, Appendix A § 1.04 describes Disorders of the Spine as follows:

> *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 the 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 arachoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthisia, 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.

In the subject case, Claimant has a spinal stenosis as evidenced by a CT scan and described by one doctor as a herniated disc along with lumbar radiculopathy. Claimant's treating physician noted that Claimant exhibited weakness of the lower extremities and had difficulty ambulating using a 4 pronged cane or walker to move. At the hearing, Claimant appeared to be in significant pain and had to change positions several times. Claimant was observed to use a walker and ambulated extremely slow.

20 CFR 404, Appendix 1 to Subpart P, § 1.00B2b describes what it means to Ambulate Effectively:

> (2) *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. They must have the ability to travel without companion assistance to and from a place of employment or school. Therefore, examples of ineffective ambulation include, but are not limited to, the inability to walk without the use of a walker, two crutches or two canes, the inability to walk a block at a reasonable pace on rough or uneven surfaces, the inability to use standard public transportation, the inability to carry out routine ambulatory

> activities such as shopping and banking and the inability to climb a few steps at a reasonable pace with the use of a single hand rail. The inability to walk independently about one's home without the use of assistive devices does not, in and of itself, constitute effective ambulation.

Claimant appears to be carrying out his activities of daily living, but barely and not particularly well. Claimant avoids doing anything alone and does not venture out any distance without his walker. The undersigned finds that Claimant would be unable to walk a block at a reasonable pace on rough or uneven surfaces and would have extreme difficulty accomplishing a flight of stairs.

Considering all of the above, the undersigned finds the Claimant's medical records substantiate that the Claimant's physical impairments meets or are medically equivalent to the listing requirements of 1.04(A). In this case, this Administrative Law Judge finds the Claimant is presently disabled at the third step for purposes of the Medical Assistance (MA) program. As claimant is disabled, there is no need to evaluate Claimant with regards to the fourth or fifth steps. Furthermore, the undersigned finds Claimant disabled from August of 2009 as he complained of back pain and lower extremity issues in the August, 2009 hospital visit.

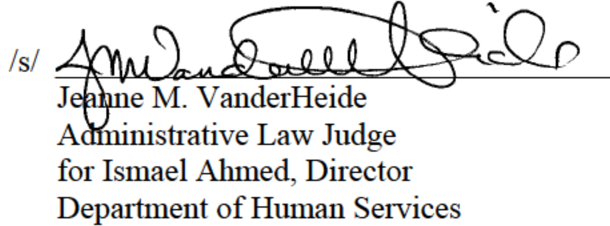
In this case, there is sufficient evidence to support a finding that Claimant's impairment has disabled him under SSI disability standards. This Administrative Law Judge finds the Claimant is "disabled" for purposes of the MA program.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the claimant is medically disabled under the MA program as of August, 2009.

Therefore the department is ordered to initiate a review of the application of September, 2009, if not done previously, to determine claimant's non-medical eligibility. The department

shall inform the claimant of the determination in writing. The case shall be reviewed in June, 2011.

/s/ 
Jeanne M. VanderHeide
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: June 9, 2010

Date Mailed: June 9, 2010

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 Circuit Court within 30 days of the mailing of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt date of the rehearing decision.

JV/htw

cc: