

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

[REDACTED]

Reg No.: 2012-10259
Issue No.: 2009
Case No.: [REDACTED]
Hearing Date: February 27, 2012
Oakland County DHS (02)

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 held in Madison Heights, Michigan on Monday, February 27, 2012. The Claimant appeared, along with [REDACTED], and testified. The Claimant was represented by [REDACTED] appeared on behalf of the Department of Human Services ("Department").

During the hearing, the Claimant waived the time period for the issuance of this decision, in order to allow for the submission of additional medical records. The evidence was received, reviewed, and forwarded to the State Hearing Review Team ("SHRT") for consideration. On May 4, 2011, this office received the SHRT determination which found the Claimant not disabled. This matter is now before the undersigned for a final decision.

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of the Medical Assistance ("MA-P") benefit 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 MA-P benefits on May 12, 2011.

2012-10259/CMM

2. On September 20, 2011, the Medical Review Team (“MRT”) found the Claimant not disabled. (Exhibit 1, pp. 1, 2)
3. The Department notified the Claimant of the MRT determination.
4. On November 3, 2011, the Department received the Claimant’s timely written request for hearing.
5. On January 5th, and May 1, 2012, the SHRT found the Claimant not disabled. (Exhibit 4)
6. The Claimant alleged physical disabling impairments due to neck and back pain with radiculopathy, degenerative disc disease, right foot swelling, high blood pressure, acid reflux, and neuropathy.
7. The Claimant alleged mental disabling impairments due to anxiety and depression.
8. At the time of hearing, the Claimant was [REDACTED] years old with a [REDACTED] birth date; was 5’2” in height; and weighed 140 pounds.
9. The Claimant is a high school graduate with some college and vocational training and an employment history of work as a coordinator/dispatcher and customer service contractor/specialist.
10. The Claimant’s impairments have lasted, or are expected to last, continuously for a period of 12 months or longer.

CONCLUSIONS OF LAW

The Medical Assistance 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, formerly known as the Family Independence Agency, pursuant to MCL 400.10 *et seq.* and MCL 400.105. Department policies are found in the Bridges Administrative Manual (“BAM”), the Bridges Eligibility Manual (“BEM”), and the Bridges Reference Tables (“RFT”).

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-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

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 applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

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 416.945(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 is made. 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. In the record presented, the Claimant is not involved in substantial gainful activity and, therefore, is not ineligible for disability benefits 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 416.920(a)(4)(ii); 20 CFR 416.920(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 416.920(a)(4)(ii); 20 CFR 416.920(c).

Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921(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 neck and back pain with radiculopathy, degenerative disc disease, right foot swelling, high blood pressure, acid reflux, neuropathy, anxiety, and depression.

In support of her claim, medical records were submitted from [REDACTED] through [REDACTED] which show treatment for neck/back pain, loss of bowels, urinary incontinence, drug dependence, shoulder pain, hip pain, leg pain, feet pain, hand stiffness, and reduced range of motion. In [REDACTED] the Claimant underwent anterior fixation and fusion at C4 through C6.

On [REDACTED] an MRI of the cervical spine revealed small focus of central cord T2 hyperintensity at the C6-7 level and moderate to severe degenerative changes at C3-4 and C6-7.

2012-10259/CMM

On [REDACTED] x-rays of the cervical spine revealed post-operative changes of anterior fusion at the C4 through C6 vertebra with near complete fusion at the C4-5 and C5-6 discs. The Neurologist diagnosed the Claimant with cervical spondylotic myelopathy with junctional syndrome at the C3-4 and C6-7. Surgical intervention was needed to prevent progressive myelopathy.

On [REDACTED] the Claimant's treating physician wrote a letter confirming treatment for right upper and lower extremity pain. Due to the severity of her symptoms, the Claimant was referred to a pain clinic and to a neurosurgeon. The diagnosis was cervical spondylotic myelopathy secondary to junctional syndrome at C3-4 and C6-7 with evidence of cord concussion. Surgical intervention was needed.

On [REDACTED] the Claimant presented to the emergency room with complaints of neck pain after a recent fall. The MRI showed cord signals suggestive of spinal cord compression.

On [REDACTED] the Claimant attended a follow-up appointment for her neck pain. Symptoms included neck pain, numbness of bilateral hands, walking difficulty, and bladder incontinence. The diagnoses were cervical spondylotic myelopathy and junctional syndrome. Surgery was needed.

On [REDACTED] the Claimant attended a follow-up appointment for her neck pain. Review of the MRI showed a herniated disc at C3-4 and C6-7 with significant compression of the spinal cord anteriorly with myelomalacia. Surgical intervention was scheduled.

On [REDACTED] the Claimant attended a follow-up appointment after being scheduled for anterior cervical discectomy and fusion; however, the surgery was cancelled due to the lack of insurance. The Claimant's cervical myelopathy is a slow steady deterioration of neurological function with progressive difficulty ambulating, numbness of the hands, loss of dexterity of the hands, and eventually quadriparesis.

On [REDACTED] a Medical Examination Report was completed on behalf of the Claimant. The current diagnoses were spondylotic cervical myelopathy with reduced range of motion, pain, numbness, and urinary incontinence. The Claimant's condition was deteriorating and she required assistance with basic home care, dressing, showering, grooming, chores, etc.

On [REDACTED] the Claimant attended a follow-up appointment. The impression was progressive cervical myelopathy from stenosis and cervical pain. A C3-7 laminectomy and fusion was recommended.

2012-10259/CMM

On [REDACTED] the Claimant attended a follow-up appointment. The diagnoses were history of C4 through C7 anterior cervical discectomy and fusion with disc protrusions above and below the level of fusion as well as core signal changes at C6-7 level; back and lower limb pain; right foot pain and weakness; probable substance addiction; and myofascial neck and shoulder pain.

On [REDACTED] the Claimant's treating physician wrote a letter confirming continued pain and the discussion of surgical intervention which would not resolve all of her pain. Surgery was to prevent further spinal cord damage from the stenosis.

On [REDACTED] the Claimant presented to the hospital with complaints of continued neck pain and burning sensation down both arms. The Claimant underwent a laminectomy from C3-7 with fusion and C4 foraminotomy. The Claimant was transferred to inpatient rehabilitation program on [REDACTED]. The Claimant was discharged on [REDACTED].

On [REDACTED] the Claimant attended a follow-up appointment status post surgery. The physical examination noted pain in the shoulder area, especially on the left, with tenderness to palpation of soft tissues in the left superior and anterosuperior shoulder area. The impressions were persistent pain following the recent cervical decompression and fusion.

On [REDACTED] the Claimant attended a follow-up appointment for her persistent neck and shoulder pain.

On [REDACTED] the Claimant was admitted to the hospital with complaints of a seizure-like spell. The Claimant had numbness and weakness in her extremities. The Claimant was discharged the following day with the diagnosis of xanax withdrawal.

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 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 minimus* 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 to neck and back pain with radiculopathy,

degenerative disc disease, right foot swelling, high blood pressure, acid reflux, neuropathy, anxiety, and depression.

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. 1.00B2a. The inability to perform fine and gross movements effectively means an extreme loss of function of both upper extremities. 1.00B2c. In other words, an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. 1.00B2c To use the upper extremities effectively, an individual must be capable of sustaining such functions as reaching, pushing, pulling, grasping, and fingering to be able to carry out activities of daily living. 1.00B2c. Examples include the inability to prepare a simple meal, feed oneself, take care of personal hygiene, sort/handle papers/files, or place items in a cabinet at or about the waist level. 1.00B2c. Pain or other symptoms are also considered. 1.00B2d

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 as 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 evidence confirms disc herniation at C3-4 and C6-7 with significant compression of the spinal cord. The Claimant underwent a C3-7 laminectomy and fusion and left C4 foraminotomy without success in relieving her pain. The purpose of the surgery was to prevent further spinal cord damage from the stenosis. As a result, the Claimant has limited mobility, incontinence, and experiences severe pain. The treating physician noted that the Claimant's condition was deteriorating requiring assistance with activities of daily living both before and after the surgery. Ultimately, it is found that the Claimant's impairment(s) meet, or are the medical 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.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law finds the Claimant disabled for purposes of the MA-P benefit program.

Accordingly, It is ORDERED:

1. The Department's determination is REVERSED.

2. The Department shall initiate review of the May 12, 2011 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 lost benefits (if any) 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 June 2013 in accordance with department policy.

Colleen M. Mamelka

Colleen M. Mamelka
Administrative Law Judge
For Maura Corrigan, Director
Department of Human Services

Date Signed: May 11, 2012

Date Mailed: May 11, 2012

NOTICE: Michigan Administrative Hearing System (MAHS) 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. MAHS 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. (60 days for FAP cases)

The Claimant may appeal the Decision and Order to Circuit Court 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 receipt date of the rehearing decision.

Claimant may request a rehearing or reconsideration for the following reasons:

- A rehearing **MAY** be granted if there is newly discovered evidence that could affect the outcome of the original hearing decision.
- A reconsideration **MAY** be granted for any of the following reasons:
 - misapplication of manual policy or law in the hearing decision,
 - typographical errors, mathematical error, or other obvious errors in the hearing decision that effect the substantial rights of the claimant:
 - the failure of the ALJ to address other relevant issues in the hearing decision.

2012-10259/CMM

Request must be submitted through the local DHS office or directly to MAHS by mail at

Michigan Administrative Hearings
Re consideration/Rehearing Request
P. O. Box 30639
Lansing, Michigan 48909-07322

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cc:

