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

**IN THE MATTER OF:**

[redacted]

Reg. No.: 201246782
Issue No.: 2009
Case No.: [redacted]
Hearing Date: July 25, 2012
County: Wayne DHS (19)

**ADMINISTRATIVE LAW JUDGE:** Christian Gardocki

## HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 following Claimant's request for a hearing. After due notice, a telephone hearing was held on July 25, 2012 from Detroit, Michigan. Participants included the above named claimant. Participants on behalf of Department of Human Services (DHS) included [redacted], Specialist.

## ISSUE

The issue is whether DHS properly denied Claimant's application for Medical Assistance (MA) on the basis that Claimant is not a disabled individual.

## FINDINGS OF FACT

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

1. On 1/3/12, Claimant applied for MA benefits including a request for retroactive MA benefits from 10/2011-12/2011.

2. Claimant's only basis for MA benefits was as a disabled individual.

3. On 3/30/12, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 4-5).

4. On 4/3/12, DHS denied Claimant's application for MA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On 4/16/12, Claimant requested a hearing disputing the denial of MA benefits.

6. On 6/30/12, the State Hearing Review Team (SHRT) determined that Claimant was not a disabled individual (see Exhibits 85-86), in part, by finding that Claimant retained the capacity to perform past relevant work.

7. As of the date of the administrative hearing, Claimant was a [redacted] year old female with a height of 5'3'' and weight of 133 pounds.

8. As of the date of the administrative hearing, Claimant was a half pack per day smoker with no known relevant history of alcohol or substance abuse.

9. Claimant's highest education year completed was the 12th grade (via general equivalency degree).

10. As of the date of the administrative hearing, Claimant had no ongoing health coverage and had not received coverage for approximately seven years.

11. Claimant alleged that she is disabled based on impairments and issues including: scoliosis and other back problems, numbness in arms, shooting pains from her hip to her foot, constant headaches, constant shoulder pain and thyroid disease.

12. Claimant also requested a hearing concerning a Food Assistance Program (FAP) dispute, which she now states is resolved.

## 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). DHS (formerly known as the Family Independence Agency) administers the MA program 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 Reference Tables Manual (RFT).

MA provides medical assistance to individuals and families who meet financial and nonfinancial eligibility factors. The goal of the MA program is to ensure that essential health care services are made available to those who otherwise would not have financial resources to purchase them.

The Medicaid program is comprised of several sub-programs which fall under one of two categories; one category is FIP-related and the second category is SSI-related. BEM 105 at 1. To receive MA under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled. *Id*. Families with dependent children, caretaker relatives of dependent children, persons under age 21 and pregnant, or recently pregnant, women receive MA under FIP-related categories. *Id*. AMP is an MA program available to persons not eligible for Medicaid

through the SSI-related or FIP-related categories though DHS does always offer the program to applicants. It was not disputed that Claimant's only potential category for Medicaid eligibility would be as a disabled individual.

Disability for purposes of MA benefits is established if one of the following circumstances applies (see BEM 260 at 1-2):

- by death (for the month of death);
- the applicant receives Supplemental Security Income (SSI) benefits;
- SSI benefits were recently terminated due to financial factors;
- the applicant receives Retirement Survivors and Disability Insurance (RSDI) on the basis of being disabled; or
- RSDI eligibility is established following denial of the MA benefit application (under certain circumstances).

There was no evidence that any of the above circumstances apply to Claimant. Accordingly, Claimant may not be considered for Medicaid eligibility without undergoing a medical review process which determines whether Claimant is a disabled individual. *Id*. at 2.

Generally, state agencies such as DHS must use the same definition of SSI disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally defined as the inability to do any substantial gainful activity (SGA) 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 functionally identical definition of disability is found under DHS regulations. BEM 260 at 8.

Substantial gainful activity means a person does the following:

- Performs significant duties, and
- Does them for a reasonable length of time, and
- Does a job normally done for pay or profit. *Id*. at 9.

Significant duties are duties used to do a job or run a business. *Id*. They must also have a degree of economic value. *Id*. The ability to run a household or take care of oneself does not, on its own, constitute substantial gainful activity. *Id*.

The person claiming a physical or mental disability has the burden to establish a disability 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 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).

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled. 20 CFR 416.920. If there is no finding of disability or lack of disability at each step, the process moves to the next step. 20 CFR 416.920 (a)(4).

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person is statutorily blind or not. The 2011 monthly income limit considered SGA for non-blind individuals is $1,000.

In the present case, Claimant denied having any employment since the date of the MA application; no evidence was submitted to contradict Claimant's testimony. Without ongoing employment, it can only be concluded that Claimant is not performing SGA. It is found that Claimant is not performing SGA; accordingly, the disability analysis may proceed to step two.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the 12 month duration requirement. 20 CFR 416.920 (a)(4)(ii). The impairments may be combined to meet the severity requirement. If a severe impairment is not found, then a person is deemed not disabled. *Id*.

The impairments must significantly limit a person's basic work activities. 20 CFR 416.920 (a)(5)(c). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. *Id.* Examples of basic work activities include:

- physical functions (e.g. walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling)
- capacities for seeing, hearing, and speaking, understanding; carrying out, and remembering simple instructions
- use of judgment
- responding appropriately to supervision, co-workers and usual work situations; and/or
- dealing with changes in a routine work setting.

Generally, federal courts have imposed a de minimus standard upon claimants to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v Bowen,* 880 F2d 860, 862 (6th Cir. 1988). Similarly, Social Security Ruling 85-28 has been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirement is intended "to do no more than screen out groundless claims."

*McDonald v. Secretary of Health and Human Servs.*, 795 F.2d 1118, 1124 (1st Cir. 1986).

SSA specifically notes that age, education, and work experience are not considered at the second step of the disability analysis. 20 CFR 416.920 (5)(c). In determining whether Claimant's impairments amount to a severe impairment, all other relevant evidence may be considered. The analysis will begin with the submitted medical documentation. Some documents were admitted as exhibits but were not necessarily relevant to the disability analysis; thus, there may be gaps in exhibits numbers.

A Social Summary (Exhibits 6-7) dated [redacted] was presented. A Social Summary is a standard DHS form which notes alleged impairments and various other items of information; the Social Summary was completed by a DHS specialist. It was noted that Claimant alleged disability based on physical and psychological problems.

A Medical Social Questionnaire (Exhibits 8-10) completed by Claimant and dated [redacted] was presented. The form allows for reporting of claimed impairments, treating physicians, previous hospitalizations, prescriptions, medical test history, education and work history. Claimant noted impairments of insomnia, depression, cervical spondylosis, radiculopathy and a goiter. Claimant noted that the impairments cause her constant pain, memory loss, excessive crying, right side numbness, a lack of coordination and limited sleep. Claimant noted a hospitalization from 10/2011 related to a fall and two hospitalizations from 12/2011 related to the fall and a numbness on her right side.

A physical examination report (Exhibits 13-19) dated [redacted] was presented. It was noted that Claimant reported conditions including: carpal-tunnel syndrome, herniated disc, broken tailbone and a dysfunctional thyroid. Claimant reported ongoing back pain for approximately seven years. Claimant's gait was noted as slightly wobbly. The following impressions were given: scoliosis, lumbosacral stenosis, right cervical radiculopathy, early arthritis of right knee, past diagnosis of carpal-tunnel syndrome, suspected vascular disease, history of thyroid dysfunction and probable depression. Claimant's ranges were noted as limited in all cervical spine and lumbar spine motions. It was noted that the Claimant could sit and stand. It was noted that Claimant would benefit from use of a cane for long distance walking or walking on uneven ground. It was noted that Claimant was capable of fine and gross dexterity.

A psychological examination report (Exhibits 20-22) dated [redacted] was presented. It was noted that Claimant was depressed due to severe pain. It was noted that Claimant had difficulty sleeping and experienced a loss of appetite resulting in a 30 pound weight loss. The examiner provided a diagnosis based on Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV). An Axis I diagnoses of dysthymic disorder was provided; it was also noted that Claimant had a history of opiate and alcohol dependence. Claimant's GAF was 55. A GAF within the range of 51-60 is representative of someone with moderate symptoms or any moderate difficulty in social, occupational, or school functioning. Claimant's prognosis was guarded.

An MRI Report (Exhibit 43) dated [redacted] of Claimant's cervical spine was presented. Impressions were given that Claimant had mild-moderate spondylosis and disc degenerative changes. Moderate cervical facet hypertrophy was also noted.

An MRI Report (Exhibit 44) dated [redacted] of Claimant's lumbar spine was presented. Impressions were given of no significant spinal stenosis, though degenerative changes were noted at L4-L5 and L5-S1; at these vertebrae, it was noted that Claimant had moderate spinal stenosis related to disc protrusion and facet arthropathy.

A Final Report (Exhibits 38-40) from a consultation dated [redacted] was presented. It was noted that Claimant was admitted to the hospital on [redacted] to report chronic back pain due to scoliosis. It was noted that image review showed multilevel disc disease with small disc bulges from C3-C7. It was reiterated that there was no appreciable degree of central canal stenosis, foraminal stenosis or frank disc herniation. It was recommended that Claimant consult a physician concerning pain management.

A physical examination report (Exhibits 24-27) dated [redacted] was presented. It was noted that Claimant fell down approximately one month earlier and hurt her right knee. It was noted that an x-ray of Claimant's knee was negative. It was noted that Claimant went to the ER on [redacted] due to right shoulder pain, which Claimant described as 10/10 intensity. It was noted that Claimant was a tobacco and marijuana user. Assessments of neck pain, shoulder pain and depression were provided.

Medical records and prescription copies (Exhibits 49-79) from various 2011 dates were presented. The records were not particularly notable other than remaining consistent with other records. It was noted that Claimant injured her knee while riding a dirt bike on [redacted]. Claimant testified that she was injured on [redacted] when she fell down after nearly being hit by someone else. Prescriptions for Vicodin, Soma, Motrin, Neurontin, Suboxone, Flexeril and Levothyroxine were each verified.

A letter (Exhibit 47) dated [redacted] to the Michigan Pain Institute was presented. The letter was noted as being written by a physician that treated Claimant in the hospital in 12/2011 for back and neck pain. It was noted that Claimant's neck range of motion was significantly limited on flexion, but was capable of forward flexion.

A Medical Examination Report (Exhibits 11-12) dated [redacted] was completed by Claimant's treating physician. It was noted that the physician first treated Claimant on [redacted] and last examined Claimant on [redacted]. The physician provided diagnoses of moderate cervical stenosis and moderate lumbar stenosis. An impression was given that Claimant's condition was stable. It was noted that Claimant can meet household needs.

Toxicology records (Exhibits 28-36) from 1/2012 were presented. The documents noted that Claimant tested positive for cannabis use. Claimant testified that she did not use marijuana and did not mention a previous habit. It was also noted that Claimant was at risk for thyroid disease. It should be noted that drug screening documents dated [redacted]

and [redacted] (Exhibit 59 and 69 respectively) showed Claimant was negative for all tested substances.

Claimant completed an Activities of Daily Living (Exhibits 80-84) dated [redacted]; this is a questionnaire designed for clients to provide information about their abilities to perform various day-to-day activities. Claimant noted that she slept only 4-5 hours because of intense pain. Claimant noted needing help with cooking and washing her hair because her right arm is not strong enough. Claimant noted that she dusts, washes clothes and dishes, sweeps, makes bed and feeds animals; Claimant noted she did the cleaning with her left arm. Claimant noted that she sees family and friends every other day.

Claimant did not allege that she is disabled due to psychological impairments, though a psychological examination report was presented. There was no verification of ongoing psychological treatment or a need for psychological examinations. There was a hint of a medical opinion that Claimant was depressed but no significant medical evidence of psychological impairments that would significantly impair Claimant's ability to perform basic work activities.

Claimant's primary complaint was pain. Claimant complained of neck pain, lower back pain, headaches shooting pains in her arms and leg and numbness in her hand. Some of Claimant's testimony was completely unverified. There was little to no evidence that Claimant regularly suffered headaches. Claimant's other pains were diagnosed and verified.

It was well established that Claimant had cervical and lumbar problems including moderate stenosis at two vertebrae. It was established that Claimant had other disc problems including mild-moderate spondylosis in the cervical spine. It was verified that Claimant had limited ranges of motion in her neck and lumbar spine. The need for a cane for long distances and uneven ground verified an ambulation restriction. The totality of Claimant's restrictions due to back problems was sufficient to establish a significant impairment to the performance of basic work activities.

The evidence tended to establish that Claimant's cervical and lumbar problems began no later than 1/2011, the date of the first medical record concerning Claimant's complaints. It is not clear that Claimant's condition was as severe in 1/2011 as Claimant complains today, but it tends to establish an impairment that has lasted 12 months. Also, Claimant's condition was considered stable (see Exhibit 12); this is somewhat persuasive that Claimant's condition will likely last 12 months or longer because the physician did not note that Claimant's condition was improving. The hospital trip in 12/2011 also tended to establish a deterioration of Claimant's condition rather than an improvement. Based on the presented evidence, it is found that satisfied the durational requirements of a severe impairment.

As it was found that Claimant established significant impairment to basic work activities for a period longer than 12 months, it is found that Claimant established having a severe impairment. Accordingly, the disability analysis may move to step three.

The third step of the sequential analysis requires a determination whether the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920 (a)(4)(iii). If Claimant's impairments are listed and deemed to meet the 12 month requirement, then the claimant is deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step.

Claimant's primary impairment involved back pain. Musculoskeletal issues are covered by Listing 1.00. Back problems are covered by SSA Listing 1.04 which reads:

> **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 equina) 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 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.

Claimant's back problems were well documented. It was verified that Claimant had moderate stenosis in her lumbar spine and mild-moderate cervical spondylosis. These diagnoses would qualify as examples of spinal disorders.

It was less clear whether a spinal cord nerve root was compromised. Symptoms of nerve root compression would include muscle weakness, diminished reflexes or loss of bladder and/or bowel function; these symptoms were not supported by medical records.

Claimant's cervical spine MRI verified that "moderate cervical facet hypertrophy contributes to significant bilateral neural foraminal stenosis". The reference to neural is persuasive evidence that Claimant has neuro-anatomic distribution of pain but not necessarily nerve root compression.

A diagnoses of moderate stenosis is by itself evidence of nerve root compression. Claimant's wobbly gait and need for a cane is evidence of nerve root compression as

well as Claimant's complaints of radiating pains. It is found that Claimant satisfied the introduction for the listing for spinal disorders.

Looking at Part A, nerve root compression can be presumed by the diagnosis of significant bilateral neural foraminal stenosis. Claimant's complaints of pain were well document, even resulting in a letter from Claimant's hospital physician to a pain clinic this tended to establish neuro-anatomic distribution of pain. Claimant's limited range of motion of her neck was also verified by the consultative examiner (see Exhibit 16). The examiner also noted abnormal reflexes in Claimant's lower extremities (see Exhibit 18) and a limitation in performing straight leg raising due to pain. Based on the presented evidence, it is found that Claimant established meeting the listing for 1.04. Accordingly, it is found that Claimant is a disabled individual.

## DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that DHS improperly denied Claimant's application for MA benefits. It is ordered that DHS:

(1) reinstate Claimant's MA benefit application dated 1/3/12 including Claimant's request for retroactive MA benefits from 10/2011-12/2011;
(2) evaluate Claimant's eligibility for MA benefits on the basis that Claimant is a disabled individual;
(3) supplement Claimant for any benefits not received as a result of the improper denial; and
(4) schedule a review of benefits in one year from the date of this administrative decision, if Claimant is found eligible for future MA benefits.

The actions taken by DHS are REVERSED.

Christian Gardocki
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: July 31, 2012

Date Mailed: July 31, 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.

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

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

CG/hw

cc: [redacted]