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

IN THE MATTER OF:

Reg No.: 2012-64183
Issue No.: 2009
Case No.:
Hearing Date: October 22, 2012
Macomb County DHS (36)

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 Claimant's request for a hearing. After due notice, a hearing was held in Sterling Heights, Michigan on Monday, March 26, 2012. Claimant appeared, along with , and testified. Claimant was represented by of , Inc. Participating on behalf of the Department of Human Services ("Department") was and .

During the hearing, 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. The SHRT determination found Claimant not disabled. This matter is now before the undersigned for a final decision.

ISSUE

Whether the Department properly determined that 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. Claimant submitted an application for public assistance seeking MA-P benefits on March 30, 2012, retroactive to December 2011.

2. On April 30, 2012, the Medical Review Team ("MRT") found Claimant not disabled. (Exhibit 2, pp. 1, 2)

3. The Department notified Claimant of the MRT determination on May 8, 2012.

4. On July 10, 2012, the Department received the Claimant's timely written request for hearing. (Exhibit 1)

5. On August 27, 2012 and February 1, 2013, the SHRT found the Claimant not disabled.

6. Claimant alleged physical disabling impairments due to low back pain with radiculopathy, degenerative disc disease, neck pain, knee pain, knee tumor, chronic obstructive pulmonary disease ("COPD"), and arthritis.

7. Claimant alleged mental disabling impairment(s) due to depression and anxiety.

8. At the time of hearing, Claimant was 55 years old with an [redacted], birth date; was 5'3" in height; and weighed approximately 150 pounds.

9. Claimant has a limited education and is unable to read/write in English with an employment history as a translator.

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-relate activities or ability to reason and make

appropriate mental adjustments, if a mental disability is alleged. 20 CFR 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.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicants takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (i.e. age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4) If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from step three to step four. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both steps four and five. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

As outlined above, the first step looks at the individual's current work activity. In this case, Claimant is not engaged 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 916.920(a)(4)(ii); 20 CFR 916.920(b). An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b). Examples include:

1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

5. Responding appropriately to supervision, co-workers and usual work situations; and

6. Dealing with changes in a routine work setting.

Id.

The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). An impairment qualifies as non-severe only if, regardless of a claimant's age, education, or work experience, the impairment would not affect the claimant's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985).

In the present case, the Claimant alleges disability due to low back pain with radiculopathy, degenerative disc disease, neck pain, knee pain, knee tumor, chronic obstructive pulmonary disease ("COPD"), arthritis, anxiety, and depression.

As a preliminary matter, the evidence shows that in 2009, Claimant was involved in a motor vehicle accident where she fractured her spine. At that point, the attending physician's report indicated Claimant was permanently disabled.

On May 15, 2011, a MRI of the left knee was suggestive of enchondroma within the distal femur; indistinct low grade chondrosarcoma and enchondromas; and osteoarthritis.

On June 13, 2011, a body scan revealed patter of radiotracer in the left lower ribs anteriorly (likely related to traumatic fractures); evidence of bone reaction in the interbody fusion grafts within the lower thoracic and upper lumbar spine region; arthritis at L2-3 facet on the right; arthritis at the patella bilaterally, shoulders, right hip joint, left knee, and right big toe; and left distal femur was compatible with a diagnosis of enchondroma.

On October 12, 2011, an EKG revealed ST abnormality.

On December 15, 2011, Claimant was admitted to the hospital overnight for treatment for pneumonia.

On December 19, 2011, Claimant was treated for/diagnosed with pneumonia, chronic low back pain, and GERD. Protective measures against deep vein thrombosis were taken.

On July 6, 2012, Claimant presented to the hospital with complaints of back pain, dizziness, and left arm pain. The EKG was normal. An MRI and CT of the head/brain found no acute intracranial process of significant interval change compared to the October 2011 images. Claimant was treated and discharged with the diagnosis of fatigue.

On July 12, 2012, an MRI of the cervical spine revealed three level midline disc herniations from C3 to C5-6 level with cord compression at C5-6; minimal disc herniations in the neural foramina; and straightening and mild reversal of the normal cervical lordosis.

On this same date, a MRI of the thoracic spine revealed status post fusion extending from T10 to L2 for surgical treatment of compression fraction of T12 vertebral body and normal alignment and no evidence of encroachment of thecal sac.

On the same date, a MRI of the lumbar spine was unremarkable.

On July 17, 2012, imaging study of the cervical spine revealed straightening of normal cervical lordosis with limited range of excursion during flexion and extension and

discogenic disease at C4-5 and C5-6 level with moderate narrowing of disc space height.

On this same date, imaging study of the thoracic spine was unremarkable with the exception of noting the prior spinal fusion from T10 to L2. Imaging study of the lumbar spine revealed mild rotary scoliosis with the concavity on the right and was suggestive of mild osteopenia, particularly at L3.

On August 2, 2012, a vide ENG testing found no evidence of peripheral vestibular dysfunction. An Electromyography study notes possible neuropathic symptoms.

On August 7, 2012, Claimant underwent back surgery with included discectomy with removal of extruded disc with cord compression, cage placement, allograft, and anterior plating without complication. The post-operative diagnosis was C5-6 disc herniation with cord compression. Claimant was discharged the following day.

On August 30, 2012, a disability status form was completed on behalf of Claimant noting she was totally disabled from August 7th through October 7, 2012.

On September 4, 2012, an EMG of the cervical spine was normal.

On September 6, 2012, imaging studies of the cervical spine revealed interval anterior cervical fusions at C5-6 and cervical degenerative changes with some restriction of flexion and extension.

On this same date, a MRI of the cervical spine revealed post-operative findings at C5-6, cervical degenerative disc disease and uncovertebral joint changes, and straightening of the normal cervical lordosis.

In October, Claimant was referred for physical therapy.

On November 7, 2012, a mental status examination was performed. The Medical source statement provided that there was no current psychiatric symptoms; cognitive impairments; or problems with memory, concentration that would affect her ability to do work related activities at a sustained pace. The diagnosis was adjustment disorder managed with medication. The Global Assessment Functioning ("GAF") was 60. The Mental Residual Functional Capacity Assessment found Claimant not significantly limited in any of the 20 factors.

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 she does have some physical limitations on her ability to perform basic work activities. There was

no evidence of any significant or serious mental limitation. As such, Claimant's claim of disability based on any mental impairment is non-severe and thus does meet the *de minimis* standard and is not further considered. The medical evidence has established that the Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, the Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The evidence confirms treatment/diagnoses of osteoarthritis of the left knee; cysts (left knee); traumatic fractures (healed); arthritis at the patella bilaterally, shoulders, right hip joint, and right big toe; pneumonia; chronic low back pain, GERD; deep vein thrombosis; disc herniation with cord compression (July 2012); discogenic disease with moderate narrowing of disc space height; mild osteopenia; and cervical degenerative changes. The evidence further shows that Claimant underwent back surgery which included discectomy with removal of extruded disc with cord compression, cage placement, allograft, and anterior plating without complication.

Listing 1.00 defines musculoskeletal system impairments. Disorders of the musculoskeletal system may result from hereditary, congenital, or acquired pathologic processes. 1.00A. Regardless of the cause(s) of a musculoskeletal impairment, functional loss for purposes of these listings is defined as the inability to ambulate effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment, or the inability to perform fine and gross movements effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment. Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. 1.00B2b(1). Ineffective ambulation is defined generally as having insufficient lower extremity function to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities. (Listing 1.05C is an exception to this general definition because the individual has the use of only one upper extremity due to amputation of a hand.) *Id.* To ambulate effectively, individuals must be capable of sustaining a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living. 1.00B2b(2). They must have the ability to travel without companion assistance to and from a place of employment or school. . . . *Id.* When an individual's impairment involves a lower extremity uses a hand-held assistive device, such as a cane, crutch or walker, the medical basis for use of the device should be documented. 1.00J4. The requirement to use a hand-held assistive device may also impact an individual's functional capacity by virtue of the fact that one or both upper extremities are not available for such activities as lifting, carrying,

pushing, and pulling. *Id.* The inability to perform fine and gross movements effectively means an extreme loss of function of both upper extremities. 1.00 B2c. 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 a defined in 1.00B2c

* * *

1.04 Disorders of the spine (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the cauda equine) or spinal cord. With:

A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine); or

B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate

medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours; or

C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b. (see above definition)

In this case, the evidence confirms fractures (heeled) and disc herniations with nerve root impingement resulting in difficulties ambulating and performing fine and gross motor skills. The Evidence further shows limitation of the spine and muscle weakness. As noted above, Claimant was involved in a motor vehicle accident in 2009. At that time, treating physicians found Claimant permanently disabled. Since then, Claimant underwent at least two back surgeries, with the most recent being in August 2012. Another physician statement provides that Claimant was disabled through October 2012; the time of hearing. As such, at least through October 2012, Claimant's impairments meet, or are the medical equivalent of a Listed impairment within Listing 1.00. Accordingly, Claimant is found disabled at Step 3. Since the hearing date, there is insufficient evidence to make a determination of whether Claimant continues to meet 1.04A. In consideration the foregoing, a shorter review date is imposed.

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.

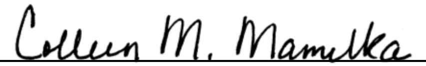
Accordingly, It is ORDERED:

1. The Department's determination is REVERSED.

2. The Department shall initiate processing of the March 30, 2012 application, retroactive to December 2011, and notify the Claimant and her Authorized Hearing Representative 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 eligiblity in October 2013, in accordance with department policy.



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

Date Signed: June 17, 2013

Date Mailed: June 17, 2013

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

CMM/tm

cc: