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

IN THE MATTER OF:

[redacted]

Reg No.: 2012-27313
Issue No.: 2009
Case No.: [redacted]
Hearing Date: December 5, 2012
Wayne County DHS (76)

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 Detroit, Michigan on Wednesday, December 5, 2012. The Claimant appeared and testified. The Claimant was represented by [redacted] of [redacted], Inc. Participating on behalf of the Department of Human Services ("Department") was [redacted].

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 February 4, 2013, this office received the SHRT determination which found the Claimant not disabled. This matter is now before the undersigned for a final determination.

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes of the Medical Assistance ("MA-P") benefit programs?

FINDINGS OF FACT

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

1. The Claimant submitted an application for public assistance seeking MA-P benefits on October 21, 2011, retroactive to September 2011.

2. On November 30, 2011, the Medical Review Team ("MRT") found the Claimant not disabled. (Exhibit 1, pp. 5. 6)

3. On December 13, 2011, the Department notified the Claimant of the MRT determination. (Exhibit 1, p. 2)

4. On January 23, 2012, the Department received the Claimant's timely written request for hearing. (Exhibit 1, p. 1)

5. On September 7, 2012, the State Hearing Review Team ("SHRT") found the Claimant not disabled. (Exhibit 3)

6. The Claimant alleged physical disabling impairments due to back pain/spasms, shoulder pain, shoulder pain, neck pain, and left leg pain/weakness.

7. The Claimant alleged mental disabling impairments due to cognitive problems as a result of a closed head injury, anxiety, and depression.

8. At the time of hearing, the Claimant was 50 years old with a [redacted], birth date; was 5'9½" in height; and weighed approximately 215 pounds.

9. The Claimant is a high school graduate with some college and vocational training with an employment history in home health care and as a nanny.

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 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 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 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 back pain/spasms, shoulder pain, shoulder pain, neck pain, left leg pain/weakness, cognitive issues as a result of a closed head injury, anxiety, and depression.

On June 27, 2011, the Claimant attended a follow-up appointment. The physical examination noted acute distress and pain along with tenderness, spasms, and reduced range of motion. The Claimant's gait was slow with the inability to toe or heel walk. EMG studies of all extremities, MRI of the cervical spine, and MRI of the lumbar spine confirmed neck pain, thoracic pain, low back pain, shoulder pain, bicipital tenosynovitis, cervical sprain/strain, lumbar strain/sprain, muscle spasm, myofascitis, head injury, ataxia, dizziness, tinnitus, and acute pain due to trauma. The Claimant was provided a cervical collar and pain medication and muscle relaxers.

On July 2, 2011, a MRI of the cervical spine revealed posterior annular disc bulging and face hypertrophy and central canal narrowing at C3-4, C4-5, and C6-7. Minimal posterior annular disc bulge/herniation at T2-3 was also documented.

On this same date, a MRI of the lumbar spine showed mild posterior annual bulge, annular tearing, mild to moderate facet arthropthy at L3-4; annual disc bulging, annual tear, and facet arthropathy with bilateral foraminal stenosis at L4-5; and transistional lumbosacral segment with right facet arthropathy at L5-S1.

On June 27th, July 8th, July 13th, July 15th, July 20th, July 22nd, and July 26, 2011, the Claimant attended a follow-up appointment. The physical examination revealed limited range of motion in the cervical, thoracic, and lumbar spine with pain, limited left shoulder range of motion with pain; joint dysfunction in the cervical, thoracic, and lumbar spine with spasm and tenderness. The diagnoses were cervical radiculitis, cervical disc displacement, lumbar lumbar disc displacement, facet arthropathy syndrome, muscle spasms, cervical sprain/strain, lumbar strain/sprain, numbness and tingling, neck pain, thoracic pain, low back pain, dizziness, limb pain, shoulder pain, bicipital tenosynovitis, myofascitis, head injury, ataxia, acute pain due to trauma, closed dislocation of first cervical vertebra, closed dislocation of multiple cervical vertebra, closed dislocation of thoracic vertebra, closed dislocation of lumbar vertebra, closed dislocation of sacrum, and closed dislocation of pelvis.

On July 29, 2011, an EMG confirmed left L5 radiculopathy.

On June 29th, a neuropsychological evaluation was completed. The Claimant full scale IQ was 77 suggesting functioning in the borderline rand of intelligence. The Claimant's auditory memory, visual memory, immediate memory, and delayed memory were extremely low and the Claimant's visual working memory was below average. The Claimant's motor speed was severely decreased bilaterally as was motor problem solving. Test results revealed a significant decline from lifelong functioning. The diagnoses were cognitive disorder due to traumatic brain injury, post-traumatic stress disorder, and mood disorder. The Claimant was found unable to drive and unable to work.

On August 2, 2011, the Claimant attended an appointment at an ear institute with complaints of balance issues. An audiogram was unremarkable and was a CT of the heard. The impressions were status post head injury from motor vehicle accident collision on April 12, 2011 and imbalance.

On August 5, 2011, the Claimant attended a follow-up appointment with complates of bilateral low back pain with radiation down left leg. Epidural injection was performed without complication. The diagnoses were lumbar radiculopathy, lumbar strain/sprain, and low back pain.

On August 8, 2011, x-rays of the left shoulder revealed mild arthritic degenerative changes.

On this same date a MR arthrogram showed fray/tear at the glenoid labrum (superior, anterior, and posterior); supraspin tendinosis with fraying; mild AC joint arthritis; mild anterior subacromial spurring; and mild to moderate atrophy compatible with denervation in anxillary nerve distribution.

On August 3rd and August 19, 2011, the Claimant attended a follow-up appointment for neck and shoulder pain. The diagnoses were neck pain, thoracic pain, low back pain, numbness/tingling, limb pain, shoulder pain, bicipital tenosynovitis, cervical sprain/strain, lumbar strain/sprain, muscle spasms, myofascitis, head injury, ataxia, dizziness, tinnitus, and acute pain due to trauma. An ultrasound and left shoulder injection was performed and pain medication was prescribed.

On September 10, 2011, the Claimant was treated via emergency room for nausea, vomiting and diarrhea. The diagnoses were gastroenteritis and diabetic hyperglycemia.

On September 16, 2011, the Claimant had an injection in her left shoulder and was treated for low back pain.

On August 9th, August 16th, August 18th, August 24th, August 26th, August 29 - 31st, September 2nd, September 6 - 8th, September 29th, October 3rd, October 4th, October 11th, October 17th, October 19th and October 26, 2011, the Claimant attended follow-up appointments for continued musculoskeletal pain, numbness, and dizziness. The physical examination confirmed restricted range of motion and abduction of the shoulder noting pain. The cervical compression test was positive with radiation between shoulder blades along with limited range of motion. Continued joint dysfunction of the thoracic spine was documented along with muscle spasms and restricted range of motion. The Claimant's gait was off with guarding with transitions. Joint dysfunction of the lumbar spine was noted with positive Patrick's sign bilaterally and positive straight leg raising. Braggard's test was positive as was Yeoman's test on the left. The diagnoses were cervical radiculitis, cervical disc displacement, lumbar radiculopathy, lumbar disc displacement, throactic disc displacement, rotator cuff syndrome, frozen shoulder, closed dislocation of sacroiliac joint, muscle spasms, facet arthropathy syndrome, cervical sprain/strain, lumbar strain/sprain, numbness and tingling, neck pain, thoracic pain, low back pain, dizziness, limb pain, shoulder pain, bicipital tenosynovitis, myofascitis, head injury, ataxia, acute pain due to trauma, closed dislocation of first cervical vertebra, closed dislocation of multiple cervical vertebra, closed dislocation of thoracic vertebra, closed dislocation of lumbar vertebra, closed dislocation of sacrum, and closed dislocation of pelvis. Mechanical traction, therapeutic exercise, and chiropractic manipulative therapy were performed.

On July 15th, August 12th, September 9th, September 12th, September 14th, October 5th, October 10th, October 17th and October 26, 2011, the Claimant attended a massage

appointments where she was diagnosed with myofascitis, neck pain, shoulder pain, and thoracic pain.

On November 4, 2011, the Claimant attended a follow-up appointment. The diagnoses were neck pain, thoracic pain, low back pain, numbness and tingling, limb pain, shoulder pain, bicipital tenosynovitis, cervical sprain/strain, lumbar strain/sprain, muscle spasm, myofascitis, head injury, ataxia, dizziness, tinnitus, acute pain due to trauma.

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the Claimant has presented some medical evidence establishing that he does have some physical and mental limitations on his ability to perform basic work activities. The medical evidence has established that the Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted 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 back pain, radiculopathy, left shoulder pain, neck pain, knee pain, CTS, occasional incontinence, diabetes, coronary artery disease, shortness of breath, COPD, diabetes, 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. 1.00 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 confirmed restricted range of motion and abduction of the shoulder noting pain; positive cervical compression test with radiation between shoulder blades along with limited range of motion; continued joint dysfunction of the thoracic spine with muscle spasms and restricted range of motion; slow gait with guarding; joint dysfunction of the lumbar spine with positive Patrick's sign bilaterally and positive straight leg raising; positive Braggard's test, positive Yeoman's test on the left; cervical radiculitis; cervical disc displacement; lumbar radiculopathy; lumbar disc displacement; throactic disc displacement; rotator cuff syndrome; frozen shoulder; closed dislocation of sacroiliac joint; muscle spasms; facet arthropathy syndrome; cervical sprain/strain; lumbar strain/sprain; numbness and tingling; neck pain; thoracic pain; low back pain; dizziness; limb pain; shoulder pain; bicipital tenosynovitis; myofascitis; head injury; ataxia; acute pain due to trauma; closed dislocation of first cervical vertebra; closed dislocation of multiple cervical vertebra; closed dislocation of thoracic vertebra; closed dislocation of lumbar vertebra; closed dislocation of sacrum; and closed dislocation of pelvis. The evidence further shows major joint dysfunction with weakness, nerve impingement, reduced range of motion, and ineffective ambulation. Ultimately, in consideration of the objective medical findings, it is found that the Claimant's multiple impairments 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 processing of the October 21, 2011 application, retroactive to September 2011, to determine if all other non-medical criteria are met and inform the Claimant and her Authorized Hearing Representative of the determination in accordance with Department policy.

3. The Department shall supplement for any lost 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 accordance with Department policy in April 2014.

Colleen M. Mamelka

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

Date Signed: February 28, 2013
Date Mailed: February 28, 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: [redacted]