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

IN THE MATTER OF:

[redacted]

Reg. No.: 2013-2999
Issue No.: 2009
Case No.: [redacted]
Hearing Date: January 23, 2013
County: Branch

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

HEARING DECISION

This matter is before the undersigned Ad ministrative Law Judge upon Claimant's request for a hearing made pursuant to Mi chigan Compiled Laws 400.9 and 400.37, which gov ern the administrative hearing a nd appeal process. After due notice, a telephone hearing was commenced on J anuary 23, 2013, from Lansing , Michigan. Claimant, represented by Attorn ey [redacted] personally appeared and testified. Participants on behalf of the Department of Human Serv ices (Department) included Eligibility Specialist [redacted]

ISSUE

Whether the Department of Human Serv ices (the department) properly denied Claimant's application for Medical Assistance (MA-P) and Retro-MA benefits?

FINDINGS OF FACT

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

(1) On July 31, 2012, Claimant applied for MA and Retro-MA.

(2) On September 7, 2012, the M edical Review T eam (MRT) denied Claimant's MA/Retro-MA applic ation fo r lack of duration. (Department Exhibit A, pp 106-107).

(3) On September 12, 2012, the department caseworker sent Claimant notice that her application was denied.

(4) On October 8, 2012, Cla imant filed a request for a hearing to contest the department's negative action.

(5) On November 26, 2012, the State Hearing Review Team (SHRT) upheld the denial of MA-P and Retro-MA indicating Claimant retains the capacity to perform past work as an administrative assistant. (Department Exhibit B, pp 1-2).

(6) Claimant alleges disability based on a history of osteomyelitis, osteoporosis, discitis, degenerative joint disease, microcrytic anemia, hyperglycemia, and multiple level spondylosis.

(7) On April 17, 2012, the lumbar MRI revealed possible septic arthritis in the right facet joint at L3-L4 with suspected osteomyelitis at the posterior arches of L3 and L4. There was also mild extension of inflammatory tissue into the right lateral and anterolateral epidural space and entrance at the right foramen. It was accompanied by diffuse myositis involving the posterior paraspinal muscles, worse in the left from L2 through S1 levels. There was also mild to moderate acquired central spinal canal stenosis at L4-L5 due to disc pathology, facet arthrosis and ligamentous thickening. In addition, there was also a left-sided intraforaminal protrusion type disc herniation, at L5-S1 about 4-5 mm in diameter, resulting to foraminal stenosis, mild to moderate on the left side, contacting the L5 nerve on the left as well as multiple level degenerative disc disease and spondylosis. Moreover, there was bilateral foraminal stenosis at L4-L5, which was moderate on the left and mild on the right with hypertrophic changes contacting the left L4 nerve. (Department Exhibit A, p 20; Claimant Exhibit A, pp 17-18).

(8) On May 10, 2012, Claimant presented to the emergency department with acute on chronic back pain. She stated she fell in January, 2012, and the pain had been worsening since then and she had been seeing a chiropractor. In April, 2012, an MRI was completed of the lumbar spine which showed findings concerning for septic arthritis involving the L3-L4 facet joint. She was seen at the [redacted] emergency room on 5/9/12 where the physician contacted neurosurgery at [redacted] [redacted] Claimant called neurosurgery this morning and was unable to get a timely appointment and returned to her primary care physician. Her primary care physician, who saw the April, 2012 MRI report, sent her to the emergency department for evaluation. Because her April, 2012 MRI was now outdated, a new MRI was ordered. Provisional diagnosis was acute on chronic lower back pain. (Department Exhibit A, pp 11-12).

(9) On May 11, 2012, the MRI showed at the L3-L4 level right greater than left facet prominent T2 signal abnormality with contrast enhancement and involvement of the surrounding soft tissues extending to the right greater than left neural foramen. This surrounded the right greater than left exiting L3 nerve roots. No central canal stenosis. The differential diagnosis included infectious/inflammatory disease. There were also multilevel

degenerative changes and mild central canal stenosis at L4-L5 level. Based on the MRI, there appeared to be an infection and possible myositis, with possible osteomyelitis. Claimant's case was discussed with neurosurgery who recommended an IV antibiotic, CT-guided biopsy, sed rate and CRP. She was diagnosed with osteomyelitis, lumbar spine, and admitted for further observation, testing and treatment. She then underwent a CT-guided biopsy of the L3-L4 right facet. (Department Exhibit A, pp 6-8, 10).

(10) On May 12, 2012, Claimant's CT of the lumbar spine without contrast revealed the findings were most consistent with septic facet arthritis at L3-L4, right greater than left. The CT appearance was atypical for a neoplastic process. (Department Exhibit A, p 9).

(11) On May 13, 2012, cultures came back and showed it was Staph aureus on the bone culture and sensitivities and final identification of the Staph were pending. The musculoskeletal exam showed definitive tenderness in the lower lumbar area on both sides which was positive for point tenderness. She also underwent a lumbar spine MRI without and with contrast which revealed abnormal signal intensity at L3-L4 facet level extending to the adjacent tissues consistent with infection. Claimant was diagnosed with (1) abnormal signal intensity at L3-L4 facet level consistent with a septic arthritis/osteomyelitis with possible contiguous infection in the soft tissue around the joint; (2) progressive severe intractable low back pain secondary to the septic arthritis/osteomyelitis, associated with increasing weakness in both lower extremities secondary to prolonged immobility due to severe pain; (3) multiple level degenerative disc disease of the lumbar spine as well as moderate to severe herniated discs in multiple levels; (4) multiple level spondylosis in the lumbar spine area; (5) microcrytic anemia; and (6) hypothyroidism secondary to post-total thyroidectomy. (Department Exhibit A, pp 14-20).

(12) On May 15, 2012, Claimant underwent an ultrasound-guided PICC placement of the right upper extremity vein. Claimant then had a transthoracic echocardiogram which showed a normal left ventricular size, regional and global systolic function. The left ventricular ejection fraction was in the range of 60-65%. There appeared to be a catheter/pacemaker lead in the right atrium. The Doppler suggested diastolic dysfunction. (Department Exhibit A, pp 1-2, 5).

(13) On May 31, 2012, Claimant was transported from the hospital by ambulance and transferred to a nursing home with an initial diagnosis of osteoporosis and osteomyelitis of the left lumbar spine. She had a PICC line in her right upper arm and was on an IV antibiotic. (Department Exhibit A, pp 85, 95-100).

(14) On June 26, 2012, Claimant's MRI lumbar spine without and with contrast revealed a stable abnormal signal seen in L4, L5, and S1 with degenerative disc disease changes as well as bulging discs and some central canal stenosis at L4-L5 with neural foraminal compromise. The L1 vertebral body demonstrated slight compression of the superior endplate, which was not on the April, 2012 study. There was also a markedly abnormal appearance of T9 and T10 which was at the very edge of the magnetic field, and suspected of being an acute compression fracture of both T9 and T10 with mild retropulsion of osseous elements into the central canal as well as possibly some disc material. There may also be an element of cord compression. (Claimant Exhibit A, p 13).

(15) On June 28, 2012, while in the nursing home, Claimant reported complaints of back pain. An MRI was completed and the radiologist reported some abnormalities in the thoracic spine and recommended a thoracic spine MRI be done as well, mainly for compression fracture. (Department Exhibit A, p 94).

(16) On July 2, 2012, Claimant's thoracic spine MRI findings at the T9-T10 level were concerning for discitis. There was probable surrounding phlegmon with no definite evidence of abscess or cord compression on the current study. (Claimant Exhibit A, p 12).

(17) On July 10, 2012, Claimant completed her IV antibiotics. She was awaiting a follow-up MRI for evaluation of need for fusion. Claimant was ambulating using a walker. (Department Exhibit A, p 93).

(18) On July 27, 2012, Claimant underwent a neurology consultation. The neurologist diagnosed Claimant with possible discitis at T9-T10 and improved L3-L4 facet infection. Claimant was prescribed a Jewett brace to wear when up out of bed and to follow-up with her infectious disease physician immediately to determine if any other treatment was necessary for T9-T10 findings and whether she would need a PICC line. X-rays of Claimant's thoracic spine showed an age indeterminate moderate compression fracture deformity of T10. Although there was some endplate irregularity at T10-T11, this could be degenerative and with it reported in the setting of trauma likely related to altered biomechanical stresses and degenerative change although discitis- osteomyelitis could cause a similar appearance, further evaluation with an MRI was recommended. X-rays of Claimant's lumbar spine, flexion/extension revealed minimal superior endplate irregularity of L1 which may be related to Schmorl's node formation but is not definitely seen on the prior MRI study from May, 2012, and therefore the possibility of a very mild compression fracture persists. Repeat MRI was suggested. There were also additional multilevel degenerative changes at the line, predominantly

involving the facet joints at L3-L4 and L4-L5. (Claimant Exhibit C, pp 10-11; Department Exhibit A, pp 89-92).

(19) On August 5, 2012, Claimant had a second internal medicine exam for a second opinion. The examining physician found that Claimant was presenting with abnormality that was very suspicious for discitis at T9-T10 disc. There were also some paraspinal inflammatory findings especially along the anterior longitudinal ligament and destruction of the cortical bone, according to the radiologist. The original process at the lumbar level appeared inactive although there was mild residual abnormality, there was no intense update noted at the spot. The physician was concerned about the T9-T10 process and whether it was a staphylococcal infection or a different organism. Claimant was scheduled for new blood cultures and blood tests to determine if the inflammatory parameters had changed. If significant inflammatory paraspinal collection was present, then Claimant would possibly need a drainage procedure. (Department Exhibit A, pp 86-87).

(20) On August 6, 2012, Claimant had a unilateral upper extremity duplex ultrasound to evaluate for a deep vein thrombosis in relation to PICC line sepsis. The ultrasound revealed loosely attached thrombus at the right proximal subclavian vein. The remaining subclavian vein showed non-occlusive thrombus. There was also superficial thrombophlebitis involving the right basilica vein which was also non-occlusive. (Claimant Exhibit C, p 9).

(21) On August 21, 2012, Claimant underwent a venous doppler right lower extremity which showed no evidence of deep vein thrombosis involving the right lower extremity. (Claimant Exhibit C, p 8).

(22) On January 23, 2013, Claimant's treating physician submitted a written letter indicating that Claimant had osteomyelitis of the spine, the treatment of which required a stay of 5 months in a nursing home. Due to the fact that she was sedentary for this span of time, and that she developed sepsis during this time, accompanied by a blood clot in the right subclavian vein, Claimant's stamina and muscle strength have been severely compromised. As such, Claimant's treating physician opined that she did not believe Claimant would be able to work on a regular schedule, as she cannot remain in the same position for any length of time without becoming stiff, then not being able to walk. (Claimant Exhibit C, p 1).

(23) Claimant is a 57 year old woman whose birthday is [redacted]. Claimant is 5'10" tall and weighs 202 lbs. Claimant completed high school.

(24) Claimant had applied for Social Security disability at the time of the hearing.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by the Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (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).

Under the Medicaid (MA) program:

> "Disability" is:
>
> . . . the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905.

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 limitations in light of the objective medical evidence presented. 20 CFR 416.929(c)(94).

In determining whether you are disabled, we will consider all of your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with objective medical evidence, and other evidence. 20 CFR 416.929(a). Pain or other symptoms may cause a limitation of function beyond that which can be determined on the basis of the anatomical, physiological or psychological abnormalities considered alone. 20 CFR 416.945(e).

In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings and statements about how your symptoms affect you. We will then determine the extent to which your alleged functional limitations or restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work. 20 CFR 416.929(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 to make appropriate mental adjustments, if a mental disability is being 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 and 20 CFR 416.929. By the same token, a conclusory statement by a physician or mental health professional that an individual is disabled or blind is not sufficient without supporting medical evidence to establish disability. 20 CFR 416.929.

A set order is used to determine disability. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience is reviewed. If there is a finding that an individual is disabled or not disabled at any point in the review, there will be no further evaluation. 20 CFR 416.920.

If an individual is working and the work is substantial gainful activity, the individual is not disabled regardless of the medical condition, education and work experience. 20 CFR 416.920(c).

If the impairment, or combination of impairments, do not significantly limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. Age, education and work experience will not be considered. 20 CFR 416.920.

Statements about pain or other symptoms do not alone establish disability. There must be medical signs and laboratory findings which demonstrate a medical impairment. 20 CFR 416.929(a).

> Medical reports should include –
>
> (1) Medical history.
>
> (2) Clinical findings (such as the results of physical or mental status examinations);
>
> (3) Laboratory findings (such as blood pressure, X-rays);
>
> (4) Diagnosis (statement of disease or injury based on its signs and symptoms). 20 CFR 416.913(b).

In determining disability under the law, the ability to work is measured. An individual's functional capacity for doing basic work activities is evaluated. If an individual has the ability to perform basic work activities without significant limitations, he or she is not considered disabled. 20 CFR 416.994(b)(1)(iv). Basic work activities are the abilities and aptitudes necessary to do most jobs. Examples of these include –

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

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

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

(6) Dealing with changes in a routine work setting. 20 CFR 416.921(b).

Medical findings must allow a determination of (1) the nature and limiting effects of your impairment(s) for any period in question; (2) the probable duration of the impairment; and (3) the residual functional capacity to do work-related physical and mental activities. 20 CFR 416.913(d).

The residual functional capacity is what an individual can do despite limitations. All impairments will be considered in addition to ability to meet certain demands of jobs in the national economy. Physical demands, mental demands, sensory requirements and other functions will be evaluated. 20 CFR 416.945(a).

To determine the physical demands (exertional requirements) of work in the national economy, we classify jobs as sedentary, light, medium and heavy. These terms have the same meaning as they have in the *Dictionary of Occupational Titles*, published by the Department of Labor. 20 CFR 416.967.

Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. 20 CFR 416.967(a). Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. 20 CFR 416.967(b). Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work. 20 CFR 416.967(c). Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do

heavy work, we determine that he or she can also do medium, light, and sedentary work. 20 CFR 416.967(d).

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability. 20 CFR 416.927(e).

When determining disability, the federal regulations require that several considerations be analyzed in sequential order. If disability can be ruled out at any step, analysis of the next step is not required. These steps are:

1. Does the client perform Substantial Gainful Activity (SGA)? If yes, the client is ineligible for MA. If no, the analysis continues to Step 2. 20 CFR 416.920(b).

2. Does the client have a severe impairment that has lasted or is expected to last 12 months or more or result in death? If no, the client is ineligible for MA. If yes, the analysis continues to Step 3. 20 CFR 416.920(c).

3. Does the impairment appear on a special listing of impairments or are the client's symptoms, signs, and laboratory findings at least equivalent in severity to the set of medical findings specified for the listed impairment? If no, the analysis continues to Step 4. If yes, MA is approved. 20 CFR 416.290(d).

4. Can the client do the former work that he/she performed within the last 15 years? If yes, the client is ineligible for MA. If no, the analysis continues to Step 5. 20 CFR 416.920(e).

5. Does the client have the Residual Functional Capacity (RFC) to perform other work according to the guidelines set forth at 20 CFR 404, Subpart P, Appendix 2, Sections 200.00-204.00? If yes, the analysis ends and the client is ineligible for MA. If no, MA is approved. 20 CFR 416.920(f).

Based on Finding of Fact #6-#23 above this Administrative Law Judge answers:

Step 1: No.

Step 2: Yes.

Step 3: Yes. Claimant has shown, by clear and convincing documentary evidence and credible testimony, his spinal impairments meet or equal Listing 1.04(A) and 1.04(C):

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 the spinal cord. With:

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

AND

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.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides the department erred in determining Claimant is not currently disabled for MA/Retro-MA eligibility purposes.

Accordingly, the department's decision is **REVERSED,** and it is ORDERED that:

1. The department shall process Claimant's July 31, 2012, MA/Retro-MA application, and shall award her all the benefits she may be entitled to receive, as long as she meets the remaining financial and non-financial eligibility factors.

2. The department shall review Claimant's medical condition for improvement in February, 2014, unless her Social Security Administration disability status is approved by that time.

3. The department shall obtain updated medical evidence from Claimant's treating physicians, physical therapists, pain clinic notes, etc. regarding her continued treatment, progress and prognosis at review.

It is SO ORDERED.

/s/

Vicki L. Armstrong
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: January 29, 2013

Date Mailed: January 29, 2013

NOTICE: Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative Hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

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

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

2013-2999/VLA

VLA/las

cc: [redacted]