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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-013288
Issue No.: 4009
Case No.: [redacted]
Hearing Date: September 9, 2015
County: Wayne (15)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

Following Claimant's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10. After due notice, a telephone hearing was held on September 9, 2015, from Detroit, Michigan. Participants included the above-named Claimant. [redacted], Claimant's [redacted] testified on behalf of Claimant. Participants on behalf of the Michigan Department of Health and Human Services (MDHHS) included [redacted], medical contact worker.

ISSUE

The issue is whether MDHHS properly denied Claimant's State Disability Assistance (SDA) eligibility for the reason 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 January 20, 2015, Claimant applied for SDA benefits.

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

3. On April 28, 2015, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 2-13).

4. On May 29, 2015, MDHHS denied Claimant's application for SDA benefits and mailed a Notice of Case Action (Exhibits 156-158) informing Claimant of the denial.

5. On July 10, 2015, Claimant requested a hearing disputing the denial of SDA benefits.

6. As of the date of the administrative hearing, Claimant was a 45-year-old female.

7. Claimant has not earned substantial gainful activity since before the first month of benefits sought.

8. Claimant alleged disability based on restrictions related to knee pain and lumbar pain.

CONCLUSIONS OF LAW

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. MDHHS administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. MDHHS policies for SDA are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (1/2013), p. 4. The goal of the SDA program is to provide financial assistance to meet a disabled person's basic personal and shelter needs. *Id*. To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older. BEM 261 (1/2012), p. 1.A person is disabled for SDA purposes if he/she:

- receives other specified disability-related benefits or services, see Other Benefits or Services below, or
- resides in a qualified Special Living Arrangement facility, or
- is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability; or
- is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS).

Id.

Claimant testified SSA found her to be disabled, but not disabled enough to receive benefits. During the hearing, Claimant read an excerpt from a SSA letter stating that she was not disabled. The evidence only established that SSA found Claimant to be not disabled.

There was no evidence that any of the above circumstances apply to Claimant. Accordingly, Claimant may not be considered for SDA eligibility without undergoing a medical review process (see BAM 815) which determines whether Claimant is a disabled individual. *Id*., p. 3.

Generally, state agencies such as MDHHS 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. SDA differs in that a 90 day period is required to establish disability.

SGA means a person does the following: performs significant duties, does them for a reasonable length of time, and does a job normally done for pay or profit. *Id*., p. 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 SGA. *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 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).

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. "Current" work activity is interpreted to include all time since the date of application. The 2015 monthly income limit considered SGA for non-blind individuals is $1,090.

Claimant denied performing any employment since the date of the SDA application; no evidence was submitted to contradict Claimant's testimony. Based on the presented evidence, it is found that Claimant is not performing SGA and has not performed SGA since the date of application. Accordingly, the disability analysis may proceed to Step 2.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the durational 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 requirements are 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).weakness

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 a summary of presented medical documentation.

Physician office visit notes (Exhibits 95-97) dated May 3, 2012, were presented. It was noted that Claimant presented for treatment of recurring yeast infections, asthma, back pain, and prescription refills. Diagnoses of allergic rhinitis, leiomyoma of uterus, dyspepsia, asthma, ovarian cyst, and sciatica were noted.

Physician office visit notes (Exhibits 98-102) dated June 22, 2012, were presented. It was noted that Claimant presented for prescription refills. Assessments of chronic pain syndrome, chondromalacia of patella, iron deficiency, obesity, and other symptoms involving nervous and musculoskeletal system were noted. A refill of Tylenol/Codeine #4 was noted.

Physician office visit notes (Exhibits 103-105) dated August 29, 2012, were presented. It was noted that Claimant primarily presented for a flu shot. It was noted that Claimant was in too much pain to make follow-up appointment.

Physician office visit notes (Exhibits 106-113) dated May 21, 2014, were presented. It was noted that Claimant primarily presented for increased pain medications. Chronic pain complaints included lumbar pain radiating to right leg, numbness below Claimant's knee, left-side numbness, and right foot dragging. An MRI from 1 year earlier was referenced.

Physician office visit notes (Exhibits 113-117) dated June 25, 2014, were presented. It was noted that Claimant presented primarily for chronic iron deficiency treatment secondary to blood loss. Claimant reported that her son assists her with daily activities due to body pain. A script for Tylenol/Codeine#4 was noted.

Hospital treatment notes (Exhibits 20-54; 60-94) from an admission dated June 28, 2014, were presented. It was noted that Claimant presented with chest pain (pain level of 7/10 and ongoing since morning), nausea, and vomiting. A physical examination noted no abnormalities. Pain was noted to be relieved by nitroglycerin. Lab work was noted to be normal. It was noted that Claimant was admitted so that ACS could be ruled-out as a possibility. Chest radiology was noted to be normal. An impression of atypical chest pain was noted. A discharge date was not apparent though hospital notes through June 29, 2014, were provided.

Physician office visit notes (Exhibits 118-120) dated July 12, 2014, were presented. It was noted that Claimant presented for follow-up of chest pain. Treatment for iron deficiency, dyspepsia, and vitamin D deficiency was noted.

Physician office visit notes (Exhibits 121-123) dated August 14, 2014, were presented. Treatment for lumbar degeneration was noted; an MRI was noted as reviewed. Treatment for dyspepsia and trace edema was noted. Refills for Tylenol/Codeine, prenatal vitamins, diphenhydramine, and ventolin were noted.

Physician office visit notes (Exhibits 124-128) dated November 3, 2014, were presented. It was noted that Claimant complained of nasal discharge; a diagnosis of allergic rhinitis was noted. Ongoing treatment for degenerative osteoarthritis and chronic pain management was also noted.

A Medical Examination Report (Exhibits 148-150) dated November 3, 2014, was presented. The form was completed by a treating physician with an unstated history of treating Claimant; based on presented records, an approximate 4 ½ month history was documented. Claimant's physician listed diagnoses of herniated discs, chronic pain, chondromalacia of patella, gait impairment, and chronic gastritis was noted. An impression was given that Claimant's condition was stable. It was noted that Claimant

could meet household needs. Physical examination findings noted obesity, gait impairment, foot drop, and right foot weakness.

Physician office visit notes (Exhibits 129-133) dated December 1, 2014, were presented. It was noted that Claimant complained of chronic body pain.

Physician office visit notes (Exhibits 134-138) dated February 9, 2015, were presented. It was noted that Claimant presented for headache treatment, med refills, and chronic pain management. Various medications were noted as refilled.

Physician office visit notes (Exhibits 139-143) dated March 17, 2015, were presented. It was noted that Claimant presented for med refills, and chronic pain management. Ongoing assessments of lumbar degeneration and chondromalacia of patella were noted.

A Medical Needs form (Exhibit A1) dated June 9, 2015, was presented. The form was completed by Claimant's treating physician. Diagnoses of chronic pain, lumbar spine degeneration, and meniscus tear were noted. A history of monthly appointments was noted. It was noted that Claimant was ambulatory. It was noted that Claimant required assistance with bathing, grooming, dressing, mobility, taking medication, meal preparation, shopping, laundry, and housework.

A Referral (Exhibits A4-A5) dated July 29, 2015, was presented. The referral was completed by a treating spine specialist. A reason for referral was not stated though a diagnosis of discogenic syndrome was noted.

A Referral Order for neurological treatment (Exhibit A2-A3) dated August 21, 2015, was presented. The basis for the referral was an abnormal gait.

A prescription (Exhibit A6) from Claimant's treating physician dated September 7, 2015, was presented. The script was for hydrocodone.

Claimant testified she was restricted in ambulation, sitting, and lifting/carrying due to chronic lumbar, knee, and body pain. Presented evidence sufficiently verified a history of treatment for lumbar, knee, and body pain since before Claimant's SDA application date.

It is found that Claimant established significant impairment to basic work activities for a period longer than 90 days. Accordingly, it is found that Claimant established having a severe impairment and the disability analysis may proceed to Step 3.

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

the impairment is unlisted or impairments do not meet listing level requirements, then the analysis proceeds to the next step.

Claimant's most prominent impairment appears to be back pain. Spinal disorders are covered by 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.

Looking at Part C, the inability to ambulate effectively is a requirement. SSA defines this as follows:

> 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. Ineffective ambulation is defined generally as having insufficient lower extremity functioning (see 1.00J) to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities.

Claimant testified she is unable to reach her back or lift her feet when bathing; Claimant testified her son assists her with bathing. Claimant testified she gets help from her sister with grooming her hair. Claimant testified her son cooks, washes clothes, helps Claimant out of bed, and helps Claimant with dressing. Claimant testified that she is unable to shop or drive due to pain. Claimant testified that she is financially dependent on her sons. Claimant's son testified consistently with the statements of his mother.

Claimant testified that she can walk 10-15 feet before right leg goes out. Claimant testified her sitting is limited to 10 minute periods. Claimant testified her back pain is

worse on her right-side than left-side. Claimant testified that her back pain is caused by a lack of spinal fluid at L4-L5. Claimant testified she started taking Tylenol 3 to control her pain, but progressed to Norco.

Overall, Claimant's and her son's testimony was highly indicative of an inability to ambulate effectively. There were several obstacles in accepting the testimony.

Obesity is understood to increase lumbar pain. During the hearing, Claimant was asked if a physician ever discussed her weight as a back pain factor. Claimant responded that she'd look like a heroin junkie if she lost weight. Claimant's response was indicative for someone extremely underweight. Claimant testified that she was 5'3" and weighs 185 pounds. Diagnoses of obesity were repeatedly referenced in presented documents (see Exhibits 21, 61…). It is difficult to imagine that weight loss would be harmful to Claimant.

Generally, radiological evidence (e.g. MRI, CT scans, x-rays…) is highly insightful in determining disability. Claimant presented zero radiological evidence.

Claimant testified she was prescribed a cane several years ago by an orthopedic specialist with a 10-year history of treating Claimant. Claimant testified that she still uses a cane for ambulation. A need for a cane was not verified.

Claimant testified she has attended physical therapy since May 2015; Claimant testified therapy helps temporarily (only approximately 1-2 days). No evidence of physical therapy was verified.

Claimant testified that she complained of back pain for the previous 15 years. Claimant testified she has not seen a chiropractor. Claimant testimony conceded that she has still not undergone steroid or cortisone epidural injections. Claimant testified that surgery may be an option if injections fail. It is not appreciated why Claimant has not attempted a fairly common procedure such as epidurals if her back pain has persisted for so long. Claimant's lack of treatment cannot be explained by a lack of access to health insurance as it was not disputed that Claimant received coverage from MDHHS since April 2014.

Though Claimant's presentation of disability had many shortcomings, physician statements of restriction were more supportive of a disability finding. SSR 96-2p states that if a treating source's medical opinion is well-supported and not inconsistent with the other substantial evidence in the case record, it must be given controlling weight (i.e. it must be adopted). Treating source opinions cannot be discounted unless the Administrative Law Judge provides good reasons for discounting the opinion. *Rogers v. Commissioner,* 486 F. 3d 234 (6th Cir. 2007)*; Bowen v Commissioner.*

On November 3, 2014, Claimant's physician noted various restrictions for Claimant (see Exhibit 149). Claimant was restricted to occasional lifting/carrying of less than 10 pounds, never 10 pounds or more. Claimant's physician stated that Claimant was

restricted from performing repetitive bilateral arm pushing/pulling right-sided foot control operation. Claimant's physician contradictorily stated Claimant was capable of standing/walking about 6 hours in an 8 hour workday and also less than 2 hours over an 8 hour workday. In response to a question asking for the stated basis for restrictions, Claimant's physician noted weakness and an MRI. It was noted that Claimant's limitation(s) was expected to last 90 days.

Generally, a restriction to occasional lifting/carrying of less than 10 pounds based on lumbar pain is indicative of severe ambulation difficulties.

The same treating physician also stated that Claimant required assistance with multiple daily activities. Generally, a need for assistance with daily activities is highly indicative of an inability to ambulate effectively.

Though radiology reports were not presented, a physician statement referencing an MRI of Claimant's lumbar was presented. On December 1, 2014, Claimant's physician noted a diagnosis of degenerative disc disease with mild displacement of bilateral S1 nerve; a history of foot drop was also noted. Nerve root displacement and foot drop are indicative of ambulation difficulty.

A history of narcotic pain medication was verified. Generally, a need for narcotic pain medication is indicative of impairments which could cause ineffective ambulation.

Foot drop, abnormal gait, and a torn meniscus were also indicated in Claimant's recent medical history. Each problem is indicative of ineffective ambulation.

Based on presented evidence, it is found that Claimant meets the equivalent of Listing 1.04 (c). Accordingly, Claimant is a disabled individual and it is found that MDHHS improperly denied Claimant's SDA application.

DECISION AND ORDER

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

(1) reinstate Claimant's SDA benefit application dated January 20, 2015;
(2) evaluate Claimant's eligibility subject to the finding that Claimant is a disabled individual;
(3) initiate a supplement for any benefits not issued as a result of the improper application 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 benefits.

The actions taken by MDHHS are **REVERSED**.

Christian Gardocki
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Signed: **9/11/2015**
Date Mailed: **9/11/2015**
GC/tm

NOTICE OF APPEAL: A party may appeal this Hearing Decision in the circuit court in the county in which he/she resides, or the circuit court in Ingham County, within 30 days of the receipt date.

A party may request a rehearing or reconsideration of this Hearing Decision from the Michigan Administrative Hearing System (MAHS) within 30 days of the mailing date of this Hearing Decision, or MAHS may order a rehearing or reconsideration on its own motion.

MAHS may grant a party's Request for Rehearing or Reconsideration when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion;
- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the client;
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The party requesting a rehearing or reconsideration must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date this Hearing Decision is mailed.

A written request may be faxed or mailed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

cc: [redacted]