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

IN THE MATTER OF:

[redacted]

MAHS Reg. No.: 15-016558
Issue No.: 4009
Agency Case No.: [redacted]
Hearing Date: November 2, 2015
County: Wayne (55)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

Following Petitioner'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, an in-person hearing was held on November 2, 2015, from Hamtramck, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted] specialist.

ISSUE

The issue is whether MDHHS properly denied Petitioner's State Disability Assistance (SDA) eligibility for the reason that Petitioner 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 July 17, 2015, Petitioner applied for SDA benefits.

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

3. On August 3, 2015, the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibits 1-2).

4. On August 18, 2015, MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action (Exhibits 2-3) informing Petitioner of the denial.

5. On August 28, 2015, Petitioner requested a hearing disputing the denial of SDA benefits.

6. Petitioner has not earned substantial gainful activity since before the first month of benefits sought.

7. Petitioner alleged disability based on restrictions related to back pain, hand pain, and poor mental health.

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.

There was no evidence that any of the above circumstances apply to Petitioner. Accordingly, Petitioner may not be considered for SDA eligibility without undergoing a medical review process (see BAM 815) which determines whether Petitioner 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 eligibility requires a 90 day period of 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.

Petitioner credibly denied performing any employment since the date of the SDA application; no evidence was submitted to contradict Petitioner's testimony. Based on the presented evidence, it is found that Petitioner 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 Petitioners 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).

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 Petitioner'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.

Orthopedic center visit notes (Exhibits 7-9) dated October 20, 2014, were presented. It was noted that Petitioner reported hip pain (8/10) two weeks after a fall. It was noted that Petitioner ambulated with a cane and walker. It was noted that x-rays of Petitioner's hip and right hand showed no fractures or acute abnormalities. It was noted that Petitioner reported pain relief after a recent right greater trochanter bursa injection (noted elsewhere to have been given on April 22, 2014 (see Exhibit 12)). A physical examination demonstrated 4/5 strength on her right side. Tenderness to light palpation was noted along the trochanter. An assessment of chronic right greater trochanteric bursitis was noted. A prescription for a cane and 6 weeks of physical therapy was given.

Orthopedic center visit notes (Exhibits 10-14) dated December 30, 2014, were presented. It was noted that Petitioner presented with complaints of bilateral hand pain, neck pain, lower back pain (ongoing for several years), and right hip pain. It was noted that Petitioner had a full, but guarded range of motion. Right hip tenderness was noted in the greater trochanter. Degenerative changes were noted in Petitioner's neck. A lumbar spine MRI was noted to show disc bulges, with no significant stenosis. An assessment of chronic right greater trochanteric bursitis, cervical and lumbar disc degeneration, and bilateral hand pain was noted. It was noted that Petitioner experienced mild relief following a greater trochanteric injection that day.

Orthopedic center visit notes (Exhibits 15-16) dated March 9, 2015, were presented. It was noted that Petitioner reported cervical and lumbar pain, ongoing for several years.

Petitioner reported she uses Norco and Valium to help her sleep through pain. An impression of degenerative disc disease was noted. Grip strength of 4/5 was noted. A plan of 4 weeks of physical therapy was noted.

A radiology report of Petitioner's cervical spine (Exhibits 17-18) dated March 9, 2015, was presented. Large anterior spurs were noted from C3-C5, which included calcification of annulus fibrosis. Normal alignment and curvature was noted.

Orthopedic center visit notes (Exhibits 19-21) dated April 27, 2015, were presented. It was noted that Petitioner reported a long recovery following thyroidectomy and hysterectomy which was complicated by cardiac arrest. Petitioner reported Norco and recent physical therapy (PT) helped alleviate her neck and lumbar pain. Petitioner also reported an increase in back pain after her PT ended. It was noted Petitioner had a limp, used a cane in her left hand, and displayed downgoing Babinski Sign. A plan for cervical and lumbar MRIs was noted.

A PT Cervical Evaluation (Exhibit 31) dated June 1, 2015, was presented. It was noted that Petitioner reported continuous discomfort and reduced range of motion. It was noted Petitioner reported improvement with "use of hot/cold."

Various PT progress notes (Exhibits 26-30) were presented. The notes covered 10 therapies starting June 18, 2015, and continuing through July 20, 2015. Generally, reduced overall pain was noted.

A Psychiatric Evaluation (Exhibits 35-42) dated June 17, 2015, was presented. It was noted Petitioner reported difficulties with physical pain. A history of hopelessness, worthlessness, decreased mood, decreased energy, and anxiety was noted. Prescribed medications included Wellbutrin, Trazadone, and Valium. Assessments of Petitioner included the following: orientation x4, alert, intact memory, good judgment, unremarkable thought process, normal stream of mental activity, unremarkable speech, and appropriate affect. An Axis I diagnosis of atypical depressive disorder was noted. Petitioner's GAF was noted to be 48.

Internal physician treatment documents (Exhibits 56-65) dated July 1, 2015, was presented. Assessments of hypertension, diabetes mellitus, thrombocytopenia, degenerative joint disease, glaucoma, depression, and CTS were noted.

Petitioner alleged disability, in part, due to asthma which has progressed to COPD. Presented documents verified COPD as a problem (see Exhibit 65). Presented documents also indicated Petitioner is prescribed medication for breathing. Petitioner testified she has to use a breathing machine every 4-6 hours; Petitioner's testimony was not verified by medical documentation. Pulmonary function testing was not presented. Presented documents sufficiently verified a breathing disorder, but were inadequate for verifying a degree of severity.

Petitioner testified she takes insulin 4 times per day and that her diabetes is worsening. Though DM was verified as a problem and insulin was listed as an active medication (see Exhibit 63), insufficient evidence of DM complications (e.g. retinopathy or neuropathy) were not presented.

Petitioner testified she has been depressed since 2006. Petitioner testified she did not see a psychiatrist right away, in part, because of a lack of health insurance. Petitioner testified she began seeing a psychiatrist in 2009 after a friend encouraged her to seek treatment. Petitioner testified she sees a therapist monthly and a psychiatrist every 3 months. Despite Petitioner's long claim of mental health treatment, documentation from only one psychiatric appointment was presented. Though Petitioner's mental health treatment documentation was not overwhelming, some degree of long-term mental health impairments were verified.

Petitioner testified she has polyps in her throat which affect her voice. Petitioner testified her voice is limited and would prevent her from performing her previous employment as an administrative assistant. Petitioner's testimony was not supportable based on presented documentation.

Petitioner testified she needs back and hand surgery. Petitioner testified she has a low platelet count and needs approval from a hematologist before any type of surgery.

Petitioner testified she has CTS in her right hand and trigger finger (her ring finger does not bend) in her left hand. Petitioner testified that she also needs hematologist approval before procedures such as cortisone injections can be performed.

Petitioner testified that back pain and discomfort inhibit her abilities to sit, stand, and ambulate. Presented documents verified Petitioner uses a cane. Presented treatment and radiology documents supported Petitioner's testimony.

It is found that Petitioner established significant impairment to basic work activities for a period longer than 90 days. Accordingly, it is found that Petitioner 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 Petitioner'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 Petitioner's impairments are listed and deemed to meet the durational requirement, then the Petitioner 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.

Petitioner testified back pain restricts her walking to less than 1 block. Petitioner testified she can only sit 10-15 minutes before needing to move; it should be noted that Petitioner's testimony came as she was sitting into the 33rd minute of the hearing. Petitioner testified she has a housekeeper (paid for by MDHHS) because she is restricted from all lifting/carrying. Petitioner testified she cannot reach her backside in showering or toileting. Petitioner testified she needs help with putting on socks, shoes, and pull-over shirts. Petitioner testified she cannot do laundry, clean, or drive. Petitioner testified she gets around using a service catering to disabled persons.

Petitioner's testimony was highly indicative of being unable to effectively ambulate. Radiology documents were supportive of Petitioner's testimony.

An MRI report of Petitioner's cervical spine (Exhibits 22-23) dated May 16, 2015, was presented. Disc herniations and osteophyte complexes compressing the spinal cord were noted from C3-C4 to C6-C7. Mild stenosis was noted a multiple levels.

An MRI report of Petitioner's lumbar spine (Exhibits 24-25) dated May 16, 2015, was presented. Facet hypertrophic arthropathy causing moderate-to-severe bilateral foraminal stenosis at L5-S1 was noted. Disc bulges, not causing significant canal stenosis, were noted at L3-L4 through L5-S1.

Generally, moderate-to-severe stenosis in the lumbar spine is a borderline disabling condition. Petitioner's lumbar stenosis is further complicated by mild stenosis throughout her cervical spine and hip bursitis. When also factoring Petitioner's hand difficulties and use of a cane, presented evidence was highly suggestive that Petitioner sufficiently meets Listing 1.04 (c).

Consideration was given to finding that PT reduced Petitioner's pain levels to the point where she can ambulate effectively. Petitioner credibly testified that PT reduced her pain levels, but only during the time of therapy. Petitioner testified pain levels returned shortly after she finished a day of therapy. Though PT can reduce back pain, it is not a probable long-term solution to moderate-to-severe lumbar stenosis or mild stenosis throughout the cervical spine. Petitioner's extremely low GAF- indicative of severe functioning difficulties- further supports a finding that petitioner meets the listing for spinal disorders.

It is found that Petitioner meets Listing 1.04. Accordingly, Petitioner is disabled and it is found that MDHHS improperly denied Petitioner's application dated July 17, 2015.

DECISION AND ORDER

The administrative law judge, based upon the above findings of fact and conclusions of law finds that MDHHS improperly denied Petitioner's application for SDA benefits. It is ordered that MDHHS perform the following actions within 10 days of the date of mailing of this decision:

(1) reinstate Petitioner's SDA benefit application dated July 17, 2015;
(2) evaluate Petitioner's eligibility subject to the finding that Petitioner 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 Petitioner 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: **11/4/2015**

Date Mailed: **11/4/2015**

CG/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 copy of the claim or application for appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Hearing Decision from 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]