RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: July 11, 2016
MAHS Docket No.: 16-003420
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

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; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, an in-person hearing was held on [redacted], from Detroit, Michigan. The Petitioner was represented by herself. The Department of Health and Human Services (Department) was represented by [redacted] Hearing Facilitator.

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) 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 Petitioner applied for SDA on [redacted].
2. The Medical Review Team (MRT) denied the Petitioner's application for SDA on [redacted].
3. The Department issued a Notice of Case Action on [redacted], denying the Petitioner's application for SDA.
4. The Petitioner requested a timely hearing on [redacted].
5. The Petitioner has alleged physical disabling impairments including multiple left foot surgeries due to her Achilles tendon, placement of screws and plate in the foot

and reconstruction of the Achilles tendon. The Petitioner also walks with difficulty and wears a boot on her left foot. The Petitioner has tendonitis in her right foot due to her Achilles tendon. The Petitioner also has alleged bilateral carpal tunnel syndrome in both hands and wrists. The Petitioner has alleged chronic ongoing lower back pain and pain in her left hip. The Petitioner has loss of cartilage in both knees and has had knee repair of the meniscus in both knees. The Petitioner has also undergone shoulder surgery to repair both shoulders for rotator cuff tear and bone spurs. The Petitioner also has alleged sleep apnea and also undergoes pain management treatment.

6. The Petitioner has alleged mental disabling impairments including bipolar disorder, depression and anxiety.

7. At the time of the hearing, the Petitioner was [redacted] years of age with a birthdate of [redacted]. The Petitioner completed high school and two years of college in business administration.

8. The Petitioner last worked in [redacted], at which time she was employed in a produce factory packing, sorting and carrying fruit. The Petitioner also worked as a customer service representative call center for a 3-year period, which required her to sit long periods of time and answer phones and take orders and type. The Petitioner also worked for 10 years as an inside and outside sales representative for a phone company, [redacted], selling cell phone and residential service phones. The Petitioner also worked on an assembly line, assembling parts for [redacted]

9. The Petitioner's impairments have lasted or are expected to last 90 days or more.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Health and Human Services Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

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-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the 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 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 (e.g., 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 to 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 impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3 to Step 4. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do

basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

As outlined above, the first step looks at the individual's current work activity. In the record presented, the Petitioner is not involved in substantial gainful activity and, therefore, is not ineligible for disability benefits under Step 1.

The severity of the Petitioner's alleged impairment(s) is considered under Step 2. The Petitioner bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b). An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b). Examples include:

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

2. Capacities for seeing, hearing, and speaking;

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

4. Use of judgment;

5. Responding appropriately to supervision, co-workers and usual work situations; and 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 Petitioner's age, education, or work experience, the impairment would not affect the Petitioner's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985).

The Petitioner has alleged physical disabling impairments including multiple foot surgeries due to her Achilles tendon, placement of screws and plate in the foot and reconstruction of the Achilles tendon. The Petitioner also walks with difficulty and wears a boot on her left foot. The Petitioner has tendonitis in her right foot due to her Achilles tendon. The Petitioner also has alleged bilateral carpal tunnel syndrome in both hands and wrists. The left foot and Achilles tendon surgeries have caused numbness in the left foot due to nerve complications and inability to bend or move the toes of the foot. The Petitioner has alleged chronic ongoing lower back pain and pain in her left hip. The Petitioner has loss of cartilage in both knees and has had knee repair of meniscus in both knees. The Petitioner has also undergone shoulder surgery to repair both shoulders for rotator cuff tear and bone spurs. The Petitioner also has alleged sleep apnea and also undergoes pain management treatment.

The Petitioner alleges mental disabling impairments including bipolar disorder, depression and anxiety.

A summary of the medical evidence follows.

The Petitioner's treating Doctor completed a Medical Needs Form dated [redacted], [redacted] The diagnosis was left Achilles tendon reconstruction. The Doctor indicated the Petitioner had limitations which were expected to last more than 90 days and indicated Petitioner needed assistance with activities of daily living, which included toileting, bathing, grooming, dressing, transferring, mobility, taking medications, meal preparation, shopping, laundry, and housework.

Another Medical Needs Form was completed [redacted], by the Petitioner's treating family practice Doctor with a diagnosis of calcified Achilles tendon, hypertension, coronary artery disease, post cholesterol's sis, asthma and osteoarthritis in multiple joints. The evaluation indicated chronic ongoing illness estimated number of months for the diagnosis was lifetime. The patient was ambulatory. The Petitioner needed help with toileting, bathing, grooming, dressing, transferring, mobility, taking medications, meal prep, shopping, laundry, and housework the limitations were expected to last for lifetime; and the doctor noted the Petitioner could not work at any job.

The Petitioner's neurologist noted a diagnosis of bilateral carpal tunnel syndrome upper extremities based upon an EMG. The Doctor also noted multiple stiff joints and pain in joint multiple sites and referred the Petitioner to rehabilitation. The referral also noted equinus contracture of the ankle, Achilles tendinitis and right foot pain. The EMG was performed [redacted].

A Medical Needs Form was also completed by the Petitioner's family medicine doctor on [redacted]. At that time the diagnosis was calcific Achilles tendonitis, post reattachment. The doctor also noted osteoarthritis in multiple joints. The doctor indicated that diagnosis was continue for lifetime. The doctor certified that the Petitioner need help with the activities of daily living including toileting, bathing, grooming,

dressing, transferring, mobility, taking medications, meal preparation, shopping, laundry and housework.

The Petitioner underwent a lumbar epidural steroid injection on [redacted].

The Petitioner was referred to the [redacted] and was seen for treatment due to lumbar pain on [redacted]. On examination, the patient was alert and oriented and in pain. The distal lower extremity on the right is four out of five, pain limited on the left is limited to multiple foot surgeries. Reflexes seem to be about +2 in bilateral knees; the patient has intact sensation to touch. The patient has diffuse low back tenderness to palpation. Range of motion of the lumbar spine is limited due to pain. A review of the MRI of the lumbar spine showed no evidence of forminal or canal stenosis. Good lordosis was also noted there is minor arthritis but nothing to significant. The Assessment was low back pain. As far as her lumbar spine, I do not think the patient will need any surgical intervention. I explained to her that because of her left foot and left hip and problems with walking, arthritis may affect posture and cause some myofascial pain. Based upon the examination there was no need for surgical intervention.

The Petitioner was seen at [redacted] for depression on [redacted] A psychiatric evaluation was conducted. The diagnosis was major depressive disorder, recurrent, severe with psychotic symptoms. Generalized anxiety disorder and bipolar 1 disorder most recent episode depressed mood. The Petitioner was initially evaluated in [redacted] having been given a full evaluation at that time. At the time of the evaluation, the Petitioner noted little interest or pleasure in doing things feeling depressed and hopeless, falling asleep was difficult with extreme tiredness and little energy nearly every day. At that time, the depression was noted as severe. The Petitioner had no history of prior suicide attempts. The Petitioner's mental status was that she was oriented to time and place grooming and hygiene were appropriate. The Petitioner was able to focus and judgment was noted as fair with some insight. Her stream of mental activity was normal, and her emotional affect was sad and depressed. The clinical summary follows: the Client is a [redacted]-year-old divorced mother of one. Client has a long history of depression and trauma. Client is currently experiencing severe depression, anxiety and possible psychotic symptoms. Client has no income and lacks a support system; client would benefit from mental health counseling to address core medical care, income development and resources. Client would benefit from individual/group therapy to address past trauma and symptom management. Her prognosis at the time was fair with ongoing treatment. The diagnosis was major depressive disorder, recurrent, severe with psychotic symptoms. Generalized anxiety disorder. Bipolar 1 disorder most recent episode depressed was noted as rule out. The GAF score was 45.

On [redacted], the Petitioner underwent a consultative examination by an internist. At the time of the exam, the Petitioner was using crutches. The Petitioner was noted to have marked difficulty standing up from a chair and getting on and off the examining table. At the time of the exam, her weight was 220 pounds and her height

was 5'11". Respiratory rate was 20 bpm; heart sounds were good quality, regular, no murmurs or gross cardiac enlargement. Blood pressure was 146/96. Lumbosacral spine was in good alignment with moderate tenderness. Range of motion was not done because she cannot stand on her feet. Mild to moderate tenderness in both hips noted as well is both knees without gross swelling. The left foot and ankle were in a cast. Moderate decrease on pinprick and vibratory sensation on the right upper and lower limbs. The Petitioner cannot bear weight on her left lower limb. The Petitioner's mood appeared flat. The diagnosis was recent surgery to reattach the left Achilles tendon. Degenerative disease of both knees and hips. Spondylosis of the cervical and lumbar spine with right-sided radiculopathy at both levels. The current abilities noted the Petitioner could not stand, bend, stoop or carry anything. The Petitioner, at the time, was non-ambulatory and her gait was ataxic. The clinical evidence supported the need for a walking aid to reduce pain. The range of motion in the cervical spine was below normal in all categories. The range of motion in the shoulder for abduction was 20. The range of motion in the hip was significantly limited in all categories. The knee flexion was 10° to 80° and was half of normal. The ankle was casted, and thus, not tested.

Petitioner was prescribed a sleep study on [redacted], due to snoring, nocturnal gasping/choking, fatigue low energy and pulmonary disorders. The prescription was due to onset of sleep apnea.

The Petitioner was seen at the [redacted] on [redacted], with complaints of urinary incontinence and sleep apnea. The Petitioner's history was reviewed by the doctor with the impression to rule out neurogenic bowel/bladder. In addition, foot pain and arthritis were noted with continued prescription of Norco for pain. The patient was also seen on [redacted]5, by the same clinic where a referral to urology for evaluation and follow-up was made. As well as a referral for follow-up regarding neck and back pain with a prescription for an MRI of the cervical spine. A referral was also made to psychiatry for depression.

The Petitioner was seen again at the [redacted] on [redacted], at which time she was seen for shoulder pain, foot pain and hip pain. At that time, the Petitioner was injected with cortisone in her left hip, was given Norco for pain control, and referred to pain management and rehabilitation.

A Medical Exam Report was completed by the Petitioner's doctor who diagnosed her with left foot fracture, torn Achilles tendon in [redacted]. The doctor had treated the Petitioner for six months beginning [redacted]. The exam noted immobility regarding the musculoskeletal system. The Petitioner was noted as deteriorating and limitations were imposed which were expected to last 12 months or more. The Petitioner could occasionally lift less than 10 pounds. The Petitioner could stand/walk less than 2 hours in an 8-hour workday. The Petitioner could grasp only with the left hand and could operate foot leg controls only with the right foot. The Petitioner was also considered as needing assistance to meet her needs in the home. The limitations were also based

upon functional findings and medical findings. The doctor also noted mental limitations regarding comprehension, sustained concentration, social interaction and memory.

On [redacted], an MRI of the left ankle noted prior postsurgical changes at the distal aspect of the Achilles tendon at the calcaneal insertion, with enthesopathic change, bony irregularity and suture anchors. There is moderate thickening of the distal Achilles tendon, liked related to chronic tendinosis and postsurgical change. There is mild thinning and fraying of the articular cartilage at the middle facet of the subtalar joint with very mild spur and subchondral cyst formation.

On [redacted], the Petitioner had an operation regarding her left foot, which included a partial excision of calcaneus, Achilles tendon debridement and reattachment. The flexor halluces longus tendon was transferred to the hind foot. During the operation, it was determined that there was significant degeneration of the central aspect of the distal 4 cm of her Achilles tendon. There was a small spur at the posterior aspect of the insertion at the Achilles tendon with significant scar tissue. The Achilles tendon was 80% degenerated. The surgeon completed a Medical Needs Form on [redacted], (four and a half months post-operative) and indicated that the Petitioner could not work at any job and needed home care for toileting, bathing, grooming, dressing, transferring, mobility, taking medications, meal preparation, shopping, laundry and housework.

The Petitioner was evaluated for further surgery of her left foot and Achilles tendon. An Initial Evaluation was made on [redacted], due to left foot pain and pain in the right foot. The notes indicate three previous surgeries to the left ankle. The Petitioner had pain on dorsiflexion of her ankle whether passive or active. An insertional Achilles tendon spur was noted in left foot and tenderness over the left Achilles tendon. The Assessment was left heel pain due to calcific insertional Achilles tendinitis. Right foot plantar fasciitis of the mid portion. The Plan was Excision of calcific insertional spur and posterosuperior process of calcaneus. Reconstruction of diseased Achilles tendon including FHL tendon transfer. Surgery was proposed.

As previously noted, the Petitioner bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the Petitioner has presented objective medical evidence establishing that she does have some physical limitations on her ability to perform basic work activities. Accordingly, the Petitioner has an impairment, or combination thereof, that has more than a *de minimis* effect on the Petitioner's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, the Petitioner 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 Petitioner's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The Petitioner has alleged physical disabling impairments including several repairs and re-attachment of the Achilles tendon

and four surgeries and placement of screws and plate in the foot and reconstruction of the Achilles tendon. The Petitioner also walks with difficulty and wears a boot on her left foot. The Petitioner has tendonitis in her right foot due to her Achilles tendon. The Petitioner also has alleged bilateral carpal tunnel syndrome in both hands. The Petitioner has alleged chronic ongoing lower back pain and pain in her left hip. The Petitioner has loss of cartilage in both knees and has had knee repair of meniscus in both knees. The Petitioner has also undergone shoulder surgery to repair both shoulders for rotator cuff tear and bone spurs. The Petitioner also has alleged sleep apnea and also undergoes pain management treatment.

As regards these impairments, the following Listings were reviewed.

Listing **1.03** ***Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint***, with inability to ambulate effectively, as defined in 1.00B2b, and return to effective ambulation did not occur, or is not expected to occur, within 12 months of onset.

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

As regards listing 1.04, although the Petitioner's doctor did indicate that the Petitioner's back pain is related to difficulties with her left foot and left hip, it is determined that the medical evidence did not support a finding of nerve root compression and thus the listing is not met.

As regards the listing 1.03, the medical evidence does indicate that the Petitioner has had further surgery on her left foot since being evaluated in [redacted] and [redacted]. The Petitioner also credibly testified to limited capability to walk, less than 20 feet and limited ability to stand, about 5 to 10 minutes at best. Based upon the most current evaluations of her family practice doctor and her foot surgeon, it is established that her gait instability due to multiple ankle and Achilles tendon surgeries will last for 12 months or more, and thus, the listing or its medical equivalent is met. This determination is also based on the evaluation of her doctors who place the [redacted] year-old Petitioner at less than sedentary. The undersigned also gave weight to the Petitioner's treating doctors' evaluations, which included her family practice doctor, surgeon and neurologist. The evaluations of the treating physician under 20 CDF§ 404.1527(d)(2) provides that the medical conclusion of a "treating physician" is "controlling" if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the

case record. Thus, it is determined that the Petitioner is disabled at Step 3 with no further analysis required.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner disabled for purposes of the SDA benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is **REVERSED**.

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE THE ORDER WAS ISSUED:

1. The Department shall process the Petitioner's [redacted], SDA application and determine if all non-medical eligibility requirements are met.

2. A review of this case shall be completed in July 2017.

LMF/jaf

Lynn M. Ferris
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

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

DHHS [redacted]

Petitioner [redacted]

cc: [redacted]