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: October 27, 2016
MAHS Docket No.: 16-008505
[redacted]

ADMINISTRATIVE LAW JUDGE: Vicki Armstrong

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 - 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on September 1, 2016, from Lansing, Michigan. Petitioner personally appeared and testified.

The Department of Health and Human Services (Department) was represented by Eligibility Specialist [redacted] testified on behalf of the Department. The Department submitted 246 exhibits which were admitted into evidence.

The record was extended for 30 days on September 1, 2016, to allow the Department to obtain additional medical records on Petitioner's behalf. On September 26, 2016, the Department submitted an additional 4 exhibits on behalf of Petitioner which were admitted into evidence. The record was closed on receipt of the additional medical evidence.

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit program?

FINDINGS OF FACT

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

1. Petitioner applied for SDA on April 8, 2016. [Hearing Summary].

2. On May 24, 2016, the Medical Review Team denied Petitioner's application for SDA. [Dept. Exh. 228-230].

3. On May 26, 2016, the Department issued Petitioner a Notice of Case Action informing her that her application for SDA had been denied. [Dept. Exh. 1].

4. On June 27, 2016, Petitioner submitted a Request for Hearing regarding her SDA denial. [Dept. Exh. 2-4].

5. Petitioner has been diagnosed with left knee bursitis, ingrown toenails, lumbar back pain, tinea versicolor, uterine fibroids, gastroesophageal reflux disease (GERD), bipolar disorder, chronic bronchitis, bilateral edema of lower extremity, cervicalgia, and cervical and lumbar disc herniation and radiculitis.

6. On April 6, 2015, Petitioner established care with her chiropractor, complaining of neck pain with numbness along her left upper extremity down to her fingers. She also had low back pain. The pain was a result of injuries sustained on February 23, 2014, when she fell while entering a city bus. Petitioner stated that walking for periods of less than five minutes and turning her neck to the left aggravated the pain. She also complained of being unable to sleep through the night without being awakened by neck pain. She stated that nothing relieves her symptoms. During the exam, the physician noted Petitioner had tenderness along C4-C7 and L3-L5 with associated muscle spasms of the lower cervical spine, left upper trapezius and lumbar paraspinal musculature. Petitioner explained that turning her neck to the left would cause numbness down the left upper extremity to her fingers. Also, her low back pain was exacerbated when walking or standing. She was diagnosed with possible cervical disc bulge/herniation. [Dept. Exh. 34-37].

7. On [redacted], Petitioner's MRI of the cervical spine revealed a reversal of the normal lordotic curvature of the cervical spine consistent with muscle spasms. At C3-C4 there was a 3mm broad-based posterior central disc herniation of the protrusion type with effacement of the subarachnoid space ventrally. There was mild left neural foraminal stenosis. C4-C5 also had a 2-3 mm broad-based right paracentral disc herniation of the protrusion type with obliteration of the right ventral subarachnoid space and some compression of the right ventral aspect of the cervical spinal cord. There was also moderately severe right and moderate left-sided neural foraminal stenosis with some desiccation of the intervertebral disc and loss of vertical height and disc space with mild left neural foraminal stenosis. At C5-C6 there was a 2 mm posterior central disc herniation of the protrusion type with effacement of the subarachnoid space ventrally. There was also mild to moderate bilateral neural foraminal stenosis and some loss of vertical height. The lumbar MRI showed a 2 mm broad-based posterior disc herniation of the protrusion type with effacement of the subarachnoid space ventrally and some resultant stenosis of the central spinal canal. There was also a right sided neural foraminal stenosis and minimal left neural foraminal stenosis. There was a grade 1 anterolisthesis of L5 on S1. There was also a 2 mm broad-based posterior disc protrusion as well as biforaminal disc protrusion. There was effacement of the subarachnoid space ventrally adjacent to the origin of the S1

nerve root bilaterally and a moderate amount of bilateral foraminal stenosis. [Dept. Exh. 127].

8. On [redacted], Petitioner underwent an orthopedic consultation. Petitioner complained of cervical spine radiating into bilateral hands, left hand worse than right, along with lumbar spine pain that radiated into both legs. The orthopedic surgeon noted that Petitioner stood with a slightly forward posture. On palpitation, she had moderate to severe tenderness over the cervical region. Active range of motion of the cervical spine revealed a decrease in range of motion secondary to pain. The right straight leg raise was positive. The surgeon opined that Petitioner was a candidate for anterior cervical discectomy and fusion for C3-C4, C4-C5 and C5-C6. Regarding the lumbar spine, the surgeon opined Petitioner should consider a lumbar transforaminal epidural injection at L4-L5 and L5-S1. If the injection failed, the surgeon opined that Petitioner would be a candidate for lumbar decompression at L4-L5 and L5-S1. However, the surgeon wanted to avoid that for the time being because Petitioner already had a grade 1 anterolisthesis at L5-S1 and a posterior decompression would induce more iatrogenic instability which could require surgical stabilization with an interbody fusion at the L5-S1 level. Petitioner elected to remain on conservative treatment for the time being. The surgeon instructed Petitioner to go to the nearest emergency room for bowel or bladder incontinence or saddle anesthesia. Petitioner was also instructed to go the nearest emergency room if she had sudden worsening back pain, bilateral leg pain or weakness. [Dept. Exh. 125-129].

9. On [redacted], Petitioner returned to her orthopedic surgeon complaining of cervical spine pain radiating into bilateral hands, left hand worse than right along with lumbar spine pain that radiated into both of her legs. The surgeon noted that Petitioner stood with a slight forward flexed posture and ambulated with an antalgic gait pattern. Petitioner was in significant pain but told the surgeon that she wanted to avoid surgical intervention for the time being. [Dept. Exh. 130-133].

10. On August 25, 2015, Petitioner underwent a psychological evaluation on behalf of the Department. The psychologist opined that Petitioner had a long history of mood instability, depression and irritability that appeared to be getting worse the older she got, possibly in connection with or exacerbated by approaching menopause. The psychologist noted Petitioner had chronic pain from herniated discs. [Dept. Exh. 214-216].

11. On [redacted], Petitioner saw her chiropractor complaining of intermittent pain and stiffness of her cervical and lumbar spine paraspinal muscles. Petitioner also reported a change in gait due to her low back pain. She explained that the change in her gait was causing bilateral knee pain. [Dept. Exh. 179

12. On [redacted], Petitioner followed up with her orthopedic surgeon complaining of cervical spine pain radiating into bilateral hands, left hand worse than right along with lumbar spine pain that radiated into both of her legs. The surgeon noted that Petitioner had participated in conservative measures which

included Chiropractic treatment/Physical Therapy/Modalities, Activity modification and nonsteroidal anti-inflammatory drugs (NSAIDs). Petitioner opted to undergo surgical intervention for her cervical spine and injections for the lumbar spine as previously discussed. [Dept. Exh. 135-139].

13. On September 16, 2016, Petitioner's primary care physician prescribed Petitioner a cane for her cervical and lumbar disc herniation. [Petitioner Exh. 1-2].

14. Petitioner is a [redacted]-year-old woman born on [redacted]. She is [redacted]" and weighs [redacted] pounds. She is a high school graduate and last worked in 2014.

15. Petitioner was appealing the denial of Social Security disability at the time of the hearing.

16. Petitioner's impairments have lasted, or are expected to last, continuously for a period of 90 days or longer.

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.

Current legislative amendments to the Act delineate eligibility criteria as implemented by department policy set forth in program manuals. 2004 PA 344, Sec. 604, establishes the State Disability Assistance program. It reads in part:

> Sec. 604 (1) The department shall operate a state disability assistance program. Except as provided in subsection (3), persons eligible for this program shall include needy citizens of the United States or aliens exempt from the Supplemental Security Income citizenship requirement who are at least 18 years of age or emancipated minors meeting one or more of the following requirements:
>
> (b) A person with a physical or mental impairment which meets federal SSI disability standards, except that the

> minimum duration of the disability shall be 90 days. Substance abuse alone is not defined as a basis for eligibility.

Specifically, this Act provides minimal cash assistance to individuals with some type of severe, temporary disability which prevents him or her from engaging in substantial gainful work activity for at least ninety (90) days.

A person is disabled for SDA purposes if he or 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.
- Is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS), see Medical Certification of Disability. BEM 261, pp 1-2 (7/1/2015).

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 **or 90 days for the SDA program**. 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 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). 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 an 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).

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).

As outlined above, the first step looks at the individual's current work activity. In the record presented, Petitioner is not involved in substantial gainful activity and testified that she has not worked since 2014 and has never been able to hold a job for one year. Therefore, she is not disqualified from receiving SDA benefits under Step 1.

The severity of the individual's alleged impairment(s) is considered under Step 2. The individual 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

6. Dealing with changes in a routine work setting. *Id.*

The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). An impairment qualifies as non-severe only if, regardless of a 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).

In the present case, Petitioner alleges disability due to left knee bursitis, ingrown toenails, chronic back pain, tinea versicolor, uterine fibroids, gastroesophageal reflux disease (GERD), bipolar disorder, chronic bronchitis, bilateral edema of lower extremities, cervicalgia, and cervical and lumbar disc herniation and radiculitis.

Petitioner credibly testified that she has a very limited tolerance for physical activities and is unable to stand, sit or walk for more than 5 minutes. She reported using a cane. Petitioner stated that she is unable to do housekeeping and despite her pain medication, she is in pain all day every day.

The MRI's of the cervical and lumbar spine dated April 16, 2015, revealed a 2-3 mm broad-based right paracentral disc herniation at the C4-C5 level of the protrusion type with obliteration of the right ventral subarachnoid space and some compression of the right ventral aspect of the cervical spinal cord. There was also a grade 1 anterolisthesis of L5 on S1 and effacement of the subarachnoid space ventrally adjacent to the origin of the S1 nerve root bilaterally and a moderate amount of bilateral foraminal stenosis

As previously noted, Petitioner bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, Petitioner has presented medical evidence establishing that she does have some physical limitations on her ability to perform basic work activities. The medical evidence has established that Petitioner has an impairment, or combination thereof, that has more than a *de minimis* effect on Petitioner's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, Petitioner is not disqualified from receipt of SDA benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. Petitioner has alleged physical disabling impairments due to chronic back pain, cervicalgia, bilateral foraminal stenosis, cervical and lumbar disc herniation and radiculitis.

Listing 1.00 (musculoskeletal system) was considered in light of the objective evidence. Based on the Listing 1.04, Petitioner's impairments are severe, in combination, if not singly, (20 CFR 404.15.20 (c), 416.920(c)), in that Petitioner is significantly affected in her ability to perform basic work activities (20 CFR 404.1521(b) and 416.921(b)(1)).

Listing 1.04 requires a disorder of the spine such as a 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 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 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.

As indicated by Petitioner during her testimony, and supported by the medical evidence in the file, the MRI indicates nerve root compression, resulting in limitation of motion of the spine, motor loss, muscle spasms, radiculopathy and associated muscle weakness displayed by Petitioner's weakness and inability to stand for long periods of time or walk long distances and her prescribed use of a cane. Accordingly, this Administrative Law Judge finds that Petitioner's impairments meet Listing 1.04 and concludes Petitioner is disabled for purposes of the SDA program.

DECISION AND ORDER

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

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 Petitioner's April 8, 2016 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 Petitioner's medical condition for improvement in October, 2017, unless her Social Security Administration disability status is approved by that time.

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

It is SO ORDERED.

[redacted]

Vicki Armstrong
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

[redacted]

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