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: February 8, 2017
MAHS Docket No.: 16-017445
Agency No.: [redacted]
Petitioner: [redacted]

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; and Mich Admin Code, R 792.11002. After due notice, a telephone hearing was held on January 9, 2017, 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 [redacted], Petitioner applied for SDA benefits.

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

3. On [redacted] the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 6-10).

4. On [redacted], MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action informing Petitioner of the denial.

5. On [redacted], Petitioner requested a hearing disputing the denial of SDA benefits.

6. On [redacted], an administrative hearing was held.

7. During the hearing, Petitioner and MDHHS waived the right to receive a timely hearing decision.

8. During the hearing, the record was extended 3 days to allow Petitioner to submit additional medical records.

9. On [redacted], Petitioner presented additional medical records

10. Petitioner is unable to ambulate effectively due to various problems including post-laminectomy syndrome.

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).

It should be noted that the record was extended 3 days to allow Petitioner to submit chiropractor and hand surgeon records from the previous 3 months. Typically, an Interim Order Extending the Record is subsequently mailed. In the present case, Petitioner submitted medical documents on the date of the hearing and before a written order was issued. Due to Petitioner's submission on the hearing date, an Interim Order Extending the Records was not issued as Petitioner had already submitted all requested documents.

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (July 2015), 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 (January 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.

Petitioner requested a hearing to dispute the denial of a SDA application. Petitioner claimed an inability to work for 90 days due to mental and/or physical disabilities.

MDHHS presented a Notice of Case Action (Exhibit 1, pp. 4-5) dated [redacted] verifying Petitioner's application was denied based on a determination that Petitioner was not disabled.

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 [90 days for SDA eligibility]. 20 CFR 416.905.

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. The 2016 monthly income limit considered SGA for non-blind individuals is $1,130.00.

Petitioner credibly denied performing current employment; no evidence was submitted to contradict Petitioner's testimony. Based on the presented evidence, it is found that Petitioner is not performing SGA. Accordingly, the disability analysis may proceed to the second step.

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.

Petitioner's history was documented in presented documents (see Exhibit 1, p. 17). Petitioner reportedly fell down approximately 15 stairs an unspecified number of years earlier. Petitioner had not been surgically treated. Petitioner reported ongoing right knee pain from her fall.

An MRI lumbar report (Exhibit 1, pp. 153-154) dated [redacted], was presented. Disc bulging was noted at L4-S1. A disc herniation and bulge were noted at L5-S1. Possible nerve root impingement was noted at L5-S1. Stenosis was not noted.

Primary care physician office visit notes (Exhibit 1, pp. 32-36) dated [redacted], were presented. It was noted that Petitioner was scheduled for back surgery to address intractable back pain. Blood pressure was noted as “better controlled recently” though it was noted to worsen with increases in pain.

Neurosurgery office visit notes (Exhibit 1, pp. 46-47) dated [redacted], were presented. It was noted that Petitioner was scheduled for a L4-S1 transforaminal lumbar fusion surgery the following day. An EMG noted loss of sensory action potentials in lower extremities; mild distal sensory neuropathy was also noted.

An Operative Report (Exhibit 1, pp. 72-74) dated [redacted], was presented. It was noted Petitioner underwent L4-L5 and L5-S1 fusions. Post-operative diagnoses of lumbar degenerative disc disease and lumbar foraminal stenosis were noted. Post-surgery documents (Exhibit 1, pp. 75-84) noted mild cardiomegaly and ongoing lumbar pain complaints by Petitioner.

Neurosurgery office visit notes (Exhibit 1, pp. 48-49) dated [redacted], were presented. It was noted that Petitioner reported ongoing lumbar pain, controlled with medications.

Neurosurgery office visit notes (Exhibit 1, pp. 50-51) dated [redacted], were presented. It was noted Petitioner presented in a wheelchair and appeared lethargic. It was noted that Petitioner reported improving lumbar pain, but increased shooting right leg pain. An increase in activity was recommended. A weight lifting limit of 5 pounds (for an unspecified period of time) was noted.

Neurosurgery office visit notes (Exhibit 1, pp. 52-53) dated [redacted], were presented. It was noted that Petitioner reported ongoing pain. Pain medications were reduced due to concerns of overuse.

A lumbar radiology report (Exhibit 1, p. 39, 85-86) dated [redacted], was presented. No spinal stenosis or other abnormalities were noted.

Neurosurgery office visit notes (Exhibit 1, pp. 54-55) dated [redacted], were presented. It was noted that Petitioner complained of worsening pain following back surgery. A CT myelogram was noted to show no stenosis or hardware displacement. A plan of referral to a pain management physician was noted. A follow-up was planned in 1 year.

Primary care physician office visit notes (Exhibit 1, pp. 28-32) dated [redacted], were presented. It was noted Petitioner was hospitalized for 6 days after back surgery, before undergoing a 45 day rehabilitation residency. Petitioner reported she was unable to lie-down due to back pain; difficulty with sitting was also reported. A pain specialist was recommended. A physical examination noted hand joint swelling and unstated

range of motion limitations. A normal gait was noted. A history of fibromyalgia was noted.

Pain specialist physician office visit notes (Exhibit 1, pp. 56-57) dated [redacted], were presented. It was noted that Petitioner reported back and leg pain which limits activities. Diagnoses of lumbar post-laminectomy syndrome and lumbosacral radiculopathy were noted. Percocet was increased and Flexeril was started.

A lumbar x-ray report (Exhibit 1, p. 40) dated [redacted] was presented. Mild multilevel degenerative changes were noted.

A left foot x-ray report (Exhibit 1, p. 38) dated [redacted], was presented. No abnormalities were noted.

An Operative Report (Exhibit 1, pp. 113-115, 150) dated [redacted], was presented. It was noted Petitioner underwent tenolysis surgery for multiple left fingers. A cyst excision of left middle finger was also noted. Post-surgery documents (Exhibit 1, pp. 108-110) noted a short-arm cast and soft dressings were applied.

Hand surgeon office visit notes (Exhibit 1, pp. 105-107) dated [redacted], were presented. It was noted a cortisone injection in left middle finger provided “some” relief. Swelling and tenderness was noted in left fingers. An x-ray was noted to show mild degenerative changes in left wrist and hand. It was noted Petitioner wanted further surgery.

Primary care physician office visit notes (Exhibit 1, pp. 25-28) dated [redacted], were presented. It was noted that Petitioner complained of intractable occipital headaches; Floricet was prescribed. Blood pressure was noted to be well controlled. Petitioner reported ongoing back pain.

Hand surgeon office visit notes (Exhibit 1, pp. 102-104) dated [redacted] were presented. It was noted Petitioner was fitted for a fiberglass cast (expected to be worn for a week). A plan of physical therapy was noted.

Pain specialist physician office visit notes (Exhibit 1, pp. 59-61) dated [redacted], were presented. It was noted that Petitioner reported a recent fall causing multiple tendon ruptures in her left hand. Reported back pain was 7/10. Frequent falls and neck pain were also reported. A diagnosis of cervical spondylosis was noted. Flexeril and Pamelor were increased. A MRI of cervical spine was planned. Strength was noted to be limited by pain (5-/5).

Hand surgeon office visit notes (Exhibit 1, pp. 99-101) dated [redacted], were presented. Hand scar tenderness and swelling was reported. A plan to continue therapy was noted.

Pain specialist physician office visit notes (Exhibit 1, pp. 62-64) dated [redacted], were presented. It was noted that Petitioner reported ongoing back pain (8/10) since surgery. Medications were noted to provide “some” relief. Pain medications were continued.

Primary care physician office visit notes (Exhibit 1, pp. 22-25) dated [redacted], were presented. Complaints of pain control, some depression, and uncontrolled insomnia were noted. Petitioner’s physician noted Petitioner “must have an underlying fibromyalgia.” A follow-up was scheduled for July 2016.

Hand surgeon office visit notes (Exhibit 1, pp. 96-98) dated [redacted], were presented. Ongoing moderate-to-severe pain in right shoulder, right wrist, right hand, right fingers, and scar tenderness were noted. “Good” finger range of motion was noted. A plan of continuing therapy was noted.

A lumbar x-ray report (Exhibit 1, p. 37) dated [redacted], was presented. An impression of minimal degenerative spurring was noted.

Pain specialist physician office visit notes (Exhibit 1, pp. 65-67) dated [redacted], were presented. It was noted that Petitioner reported right-sided weakness and multiple falls due to right-leg weakness. Pain medications were continued.

Neurosurgeon physician office visit notes (Exhibit 1, pp. 68-70) dated [redacted], were presented. Petitioner’s pain was noted to possibly be neuropathic pain caused by pre-existing foraminal stenosis. A plan of steroid shots and PT was noted.

Hand surgeon office visit notes (Exhibit 1, pp. 93-95) dated [redacted], were presented. It was noted that Petitioner reported ongoing moderate-to-severe pain in right shoulder, right wrist, right hand, right fingers, left wrist, and left fingers. Diagnoses of bilateral CTS, trigger finger in left fingers, and left-sided synovitis were noted. A follow-up in 3 months was noted.

Primary care physician office visit notes (Exhibit 1, pp. 19-22) dated [redacted], were presented. It was noted that Petitioner reported frustration with ongoing medical problems. Petitioner reported an increase in falls and significant knee swelling and pain. It was noted a series of Synvisc injections provided little pain relief. Petitioner reported ongoing back pain despite laminectomy surgery. Wellbutrin would be prescribed for reported depression. A follow-up was scheduled in 2 months.

Pain specialist physician office visit notes (Exhibit 1, pp. 71-72) dated [redacted], were presented. Ongoing lumbar pain (7/10) was noted. A recurrence of back spasms was noted. Right knee pain was also noted. It was noted Petitioner was scheduled for meniscus tear repair.

An Operative Report (Exhibit 1, pp. 17-18) dated [redacted], was presented. Pre-operative diagnoses of degenerative arthritis and synovitis of the right knee were noted. Significant degenerative arthrosis was noted. It was noted Petitioner underwent diagnostic arthroscopy, meniscectomy, osteophyte excision, tricompartmental chondromalacia, and synovectomy. Post-operative diagnoses included torn medial meniscus, synovitis, chondromalacia, and osteophyte of the right knee.

Primary care physician office visit notes (Exhibit A, pp. 1-4) dated [redacted], were presented. It was noted that Petitioner reported a recent hospital visit for pneumonia and sepsis treatment; sepsis was noted to be resolved. Ongoing pain in multiple body areas was noted. Diagnoses included chronic pain syndrome, fibromyalgia, and anxiety.

Petitioner submitted an internist letter (Exhibit 1, p. 3) dated [redacted]. The letter stated Petitioner has a history of multiple problems and surgeries. The physician went on to state Petitioner is permanently disabled.

Chiropractor documents (Exhibit A, pp. 5-14) dated [redacted], were presented. Petitioner reported severe lumbar pain, moderate right extremity pain and weakness, bilateral hip pain, left knee pain, moderate left foot pain, moderate right hand pain, moderate left wrist and hand pain, cervical spine pain, thoracic spine pain. Reported overall pain was 7/10. Subluxation and misalignment was noted. Various adjustments were performed.

Petitioner testified she has persistent and debilitating pain. Petitioner testified her pain is caused by multiple problems.

Petitioner testified she has fibromyalgia flare-ups of 4-7 times per week. Petitioner testified the flare-ups are never separated by more than 1½ days. Petitioner testified the flare-ups can last for “hours at a time.” Petitioner testified pain medications only “somewhat” help.

Petitioner testified her right knee routinely “gives-out.” Petitioner testified a 2016 surgery in the summer to repair a meniscus tear and remove a cyst helped, but she still has weakness and pain.

Petitioner testified she has ongoing lumbar pain. Petitioner testified a laminectomy performed in September 2015 worsened her pain. Petitioner testified chiropractor adjustments are but a temporary help.

Petitioner testified she has bilateral hand arthritis. Petitioner testified she experiences tingling and numbness in left hand after surgery. Petitioner testified her right hand is in need of surgery.

Petitioner testified she needs help with washing her lower body when showering. Petitioner testified she also needs help with dressing her lower body. Petitioner testified she tries to help with housework but is unable to do much other than some washing of dishes.

Presented medical records generally verified a medical treatment history consistent with Petitioner's allegations of restrictions. The treatment history was established to have lasted at least 90 days and at least since Petitioner's date of SDA application. 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 caused by unstated neurological problems and post-laminectomy syndrome. 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 she has used a walker for the last 6 years. Petitioner testified she is unable to even walk a block with a walker due to back and/or knee pain. Petitioner testimony estimated she fell more than 100 times in 2016.

Petitioner testified she can stand 15 minutes without her walker before back and/or knee pain prevent further standing. Petitioner testified her right side and legs restrict her to sitting for 20 minute periods (Petitioner testified she stood 3 times over the first 49 minutes of hearing). Petitioner testified she needs assistance ascending stairs.

Petitioner's testimony was highly indicative of an inability to ambulate effectively. Petitioner's testimony was somewhat consistent with presented documents.

If Petitioner relied on a walker for 6 years, it would be expected that treatment records documented such a need. It was noted Petitioner relied on a wheelchair shortly after lumbar surgery. There were no other apparent records for the need for a walking assistance device within presented records. As of March 2016, Respondent's gait, toe walking, and heel walking were each noted to be normal (see Exhibit 1, p. 60). A normal gait was again noted in April 2016 (see Exhibit 1, p. 63). These considerations are indicative that Petitioner can ambulate effectively.

It is notable that Petitioner reported ongoing falls to her physicians throughout 2016. This is indicative of an inability ambulate effectively.

A diagnosis of post-laminectomy syndrome was noted. The diagnosis is theoretically consistent with ongoing ambulation difficulty.

It is notable that Petitioner verified multiple problems which could adversely affect ambulation. Fibromyalgia could cause an increase in body pain making any activity difficult. Bilateral knee problems were documented. Complaints of pain throughout Petitioner's spine were documented. It was also regularly documented that surgeries, PT, and pain medications provided little relief of pain.

Presented evidence sufficiently verified Petitioner is unable to ambulate effectively due to spinal dysfunction, knee dysfunction, and exacerbating conditions such as fibromyalgia. Presented evidence was sufficient to establish Petitioner meets the equivalent of Listing 1.04 (c). Accordingly, Petitioner is disabled and it is found that MDHHS improperly denied Petitioner'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 Petitioner's application for SDA benefits. It is ordered that MDHHS begin to perform the following actions within 10 days of the date of mailing of this decision:

(1) reinstate Petitioner's SDA benefit application dated [redacted];
(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**.

CG/hw

Christian Gardocki
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]