RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

Date Mailed: February 17, 2017
MAHS Docket No.: 16-018613
Agency No.:
Petitioner:

**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 17, 2017, from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by , medical contact worker.

## 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 , Petitioner applied for SDA benefits.

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

3. On , the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibit 3, pp. 1-14).

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

5. On [redacted] requested a hearing disputing the denial of SDA benefits (see Exhibit 2, pp. 1-3).

6. Petitioner has spinal dysfunction causing an inability to ambulate effectively.

**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).

Petitioner's hearing request checked a dispute concerning Family Independence Program (FIP) benefits. Petitioner testified a dispute of cash assistance based on disability (i.e. SDA) was intended. MDHHS was not confused by Petitioner's error and prepared for a dispute concerning a denial of SDA benefits. MDHHS agreed to defend the denial of SDA benefits and the hearing was conducted accordingly.

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 an 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 3, pp. 15-18) dated [redacted], [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.

Neurosurgeon office visit notes (Exhibit 1, pp. 225-233) dated [redacted] were presented. Left-sided lower paraspinal pain and tenderness was noted. Diagnoses of sciatica and HTN were noted. Various prescriptions were refilled.

Neurosurgeon physician office visit notes (Exhibit 1, pp. 233-238) dated [redacted], were presented. Petitioner reported lumbar pain radiating to left leg. Positive straight-leg raising on the left was noted. Nerve root compression was noted to be probable. Multiple MRIs were planned.

A lumbar spine MRI report (Exhibit 1, p. 23-24, 203-205, 252) dated [redacted] 2015, was presented. Moderate left foraminal stenosis and moderate facet degeneration were noted at T9-T10. Moderate foraminal stenosis was noted at T11-T12. Moderate-to-severe bilateral facet degenerative changes were noted at L3-L4. Moderate-to-severe foraminal narrowing with bilateral nerve root compression was noted at L3-L4 and L4-L5. Mild nerve root compression and moderate facet degeneration was noted at L5-S1.

Hospital emergency room documents (Exhibit 1, pp. 209-213) dated [redacted], were presented. It was noted that Petitioner presented with complaints of increasing back and right knee pain since a vehicle accident. Mild L4-L5 stenosis was noted.

Petitioner was noted to be ambulating without difficulty. NSAIDs were provided. Norco, Flexeril, and naproxen were refilled.

Physician office visit notes (Exhibit 1, pp. 308-309) dated [redacted], were presented. It was noted Petitioner complained of "significant worsening" of lumbar pain since a motor vehicle accident from earlier in the month. Recurrent headaches were also reported. It was noted Petitioner could slowly perform heel-to-toe, though it required three steps before Petitioner could balance himself. Anti-inflammatory pain cream and a cervical traction device were prescribed to treat headaches. Nerve blocks were planned for Petitioner's lumbar pain.

A cervical spine MRI report (Exhibit 1, p. 15, 196) dated [redacted], was presented. Mild stenosis related to C2-C3 disc herniation was noted. Straightening of normal cervical spine alignment was noted.

A right knee MRI report (Exhibit 1, p. 14, 195) dated [redacted], was presented. Moderate patellofemoral joint chondramalacia with large joint effusion was noted.

Pain specialist physician office visit notes (Exhibit 1, p. 280-281) dated [redacted], [redacted] were presented. Petitioner reported he was in an auto accident on [redacted] when a moving vehicle hit his stationary vehicle. Lumbar and right knee pain were reported. Physical therapy was recommended for Petitioner's right knee. Injection therapy was recommended for spinal pain.

Hospital emergency room documents (Exhibit 1, pp. 214-218) dated [redacted] were presented. It was noted that Petitioner presented with complaints of dysuria, ongoing for 4 days. Urinary testing was negative for infection. A plan to follow-up with primary care physician was noted.

Hospital physician office visit notes (Exhibit 1, pp. 239-240) dated [redacted], were presented. A complaint of snoring and sleeping difficulty was noted. Petitioner was noted to be a smoker. A BMI of 36 was noted. A sleep study was planned.

Hospital physician office visit notes (Exhibit 1, pp. 241-248) dated [redacted], were presented. Petitioner complaints of back pain, right knee pain, and left leg pain were noted. A 9/10 pain level was reported. A TENS unit and Lyrica were prescribed.

Pain specialist physician office visit notes (Exhibit 1, p. 274-275) dated [redacted] were presented. Mild straight-leg raising was noted on the left. Xanax and Norco were refilled.

Motor nerve conduction testing results (Exhibit 1, pp. 20-22, 200-202) dated [redacted] were presented. A conclusion of L4-L5 radiculopathy was noted.

Sleep study test results (Exhibit 1, pp. 249-251) dated , were presented. An impression of obstructive sleep apnea was noted.

Pain specialist physician office visit notes (Exhibit 1, pp. 164-171, 177) dated , were presented. It was noted Petitioner underwent left-sided nerve root block injections.

Hospital emergency room documents (Exhibit 1, pp. 219-223) dated , were presented. It was noted that Petitioner presented with complaints of cough, ongoing for 3 days. Antibiotics were provided. A diagnosis of bronchitis was noted.

Pain specialist physician office visit notes (Exhibit 1, pp. 124, 157-163) dated , were presented. It was noted Petitioner underwent bilateral facet injections at L3-L5.

Pain specialist physician office visit notes (Exhibit 1, pp. 123, 149-156) dated , were presented. It was noted Petitioner underwent bilateral facet injections at L3-L5.

Pain specialist physician office visit notes (Exhibit 1, pp. 123, 140-148) dated were presented. It was noted Petitioner underwent left-sided lumbar facet rhizotomy at L3-L5.

Pain specialist physician office visit notes (Exhibit 1, pp. 123, 132-139) dated , were presented. It was noted Petitioner underwent right-sided lumbar facet rhizotomy at L3-L5. The treating physician signed a certificate (Exhibit 1, p. 189) stating Petitioner was disabled from work from .

A Disability Certificate (Exhibit 1, p. 188) dated , was presented. Respondent was deemed disabled from , through .

Pain specialist physician office visit notes (Exhibit 1, pp. 123, 125-131, 180) dated , were presented. It was noted Petitioner underwent a L5-S1 nerve root block epidural. The treating physician signed a certificate stating Petitioner was disabled from work from , through

Petitioner presented a script for Oxycodone dated 16. A diagnosis for multi-generative disc disease was noted.

Petitioner testified he is hampered by social anxiety. Petitioner conceded he has not seen a psychiatrist, though he plans on getting a referral. Petitioner presented no psychiatric treatment documents. No indication of restrictions related to social anxiety were documented. Presented evidence was insufficient to establish a severe impairment related to anxiety.

Petitioner testified he was shot in the back in 1997. Petitioner testified his pain "wasn't that bad" initially, but it worsened over time. Petitioner testified his back pain "exploded" after a vehicle accident in August 2015. Petitioner testified he has since experienced severe pain affecting his abilities to stand, sit, walk, and lift/carry.

Petitioner testified he experiences lumbar and left leg pain. Petitioner testified he tried physical therapy for 4 months in 2016 and experienced no pain relief. Petitioner testified he spoke to a chiropractor who advised Petitioner that adjustments could cause further damage. Petitioner testified he considered surgery but was advised that it might worsen his pain. Petitioner testified ongoing pain injections are helpful, but he needs them more often than he can receive them. Petitioner testified an at-home TENS unit relieves pain only during the time of its use. Petitioner testified he tried wearing a back brace, but that it only worsened his pain. Petitioner testified he was told by a physician that his back problems will never improve.

Petitioner testified he has a history of telemarketing employment. Petitioner testified back pain would prevent him from perform any past employment.

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.

Petitioner's most prominent impairment appears to be back pain due to multiple spinal problems. 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 he switches between use of a cane and a walker, depending on his pain level. Petitioner testified he can only walk 15-20 feet distances before stopping. Petitioner testified that standing is limited to 5-10 minutes and sitting is restricted to 20-60 minutes. Petitioner testified he can lift a gallon of milk, though his testimony implied he could not lift/carry heavier weight.

Petitioner testified he is able to dress himself. Petitioner testified he is unable to vacuum, wash dishes, though he stated he can wipe off a table. Petitioner testified he can do laundry but struggles with carrying clothes into his basement. Petitioner testified he relies on a scooter when he shops. Petitioner testified he can drive, but not for long distances. Petitioner also testified his abilities vary from day-to-day, depending on his pain level.

Petitioner testified he spends most of his days resting and watching television. Petitioner testified he occasionally sees friends.

Petitioner’s testimony was indicative of an inability to ambulate effectively. Presented records, particularly radiological records, were highly supportive of Petitioner’s testimony.

A lumbar spine MRI report (Exhibit 1, p. 16-17, 197-198) dated [redacted], was presented. Severe spinal canal stenosis and moderate bilateral neural foraminal stenosis was noted at L4-L5. Severe bilateral neural foraminal narrowing was noted at L5-S1. A disc bulge at L3-L4 was noted to cause moderate left-sided and mild right-sided neural foraminal narrowing.

“Severe” stenosis at multiple disc spaces, by itself, is exceptionally indicative of back pain causing ineffective ambulation. Presented records verified Petitioner’s attempts to treat his problems, all with little success. When factored with Petitioner’s cervical spine and right knee dysfunction, ineffective ambulation is well established.

It is found Petitioner meets SSA Listing 1.04 (c), and therefore, is a disabled individual. Accordingly, 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**

**Petitioner**