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: April 7, 2017
MAHS Docket No.: 17-001498
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 March 8, 2017, from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], specialist.

ISSUE

The issue is whether MDHHS properly denied Petitioner's State Disability Assistance (SDA) eligibility for the reason that Petitioner is not a disabled individual.

FINDINGS OF FACT

The administrative law judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On August 8, 2016, Petitioner applied for SDA benefits.

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

3. On January 18, 2017, the Disability Determination Service determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 5-10).

4. On January 23, 2017, MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action informing Petitioner of the denial.

5. On February 12, 2017, Petitioner requested a hearing disputing the denial of SDA benefits.

6. Petitioner alleged disability based on restrictions related to spinal dysfunction.

7. Petitioner's spinal dysfunction functionally renders Petitioner to ambulate ineffectively.

CONCLUSIONS OF LAW

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. MDHHS administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. MDHHS policies for SDA are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (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. 144-145) dated January 23, 2017, 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.

A right knee x-ray report (Exhibit 1, p. 37) dated [redacted], was presented. An impression of a small suprapatellar effusion with spurring was noted.

A lumbar spine x-ray report (Exhibit 1, p. 62) dated [redacted], was presented. Degenerative spurring and calcification of the abdominal aorta was noted.

Physician office visit notes (Exhibit 1, pp. 60-61) dated [redacted], were presented. Physical therapy was planned (see Exhibit 1, pp. 72-74. Norco, Xanax, and cyclobenzaprine were continued.

Physical therapy documents (Exhibit 1, pp. 82-83, 86-88) dated [redacted], were presented. Various bilateral reductions in strength and range of motion were noted in Petitioner's trunk and hips. Restrictions to repetitive bending, prolonged standing, and walking more than 15 minutes were noted. 8-24 appointments were planned.

Physical therapy documents (Exhibit 1, pp. 89-91) dated [redacted], were presented. Improvement in sit-to-stand was noted. Petitioner reported soreness.

Physical therapy documents (Exhibit 1, pp. 92-93) dated [redacted], were presented. Petitioner reported ongoing back pain (7.5/10). Ongoing finger numbness was noted.

Physician office visit notes (Exhibit 1, pp. 58-59) dated [redacted], were presented. Petitioner reported minimal improvement with physical therapy. Back pain reportedly went down to calf area. An MRI was planned.

Physical therapy documents (Exhibit 1, pp. 94-95) dated [redacted], were presented. Petitioner reported ongoing back pain (6/10). Petitioner reported use of inversion table increased back pain. Moderate trunk restrictions were noted.

Physical therapy documents (Exhibit 1, pp. 96-97) dated [redacted], were presented. Petitioner reported ongoing back pain (5-6/10) after session.

A lumbar spine MRI report (Exhibit 1, pp. 30-33, 38) dated [redacted], was presented. An impression of moderate bilateral (worse on left) foraminal narrowing effacing the L4 nerve root was noted. Mild central canal stenosis was noted.

Physician office visit notes (Exhibit 1, pp. 56-57) dated [redacted], were presented. It was noted MRI results were reviewed. Medications were continued.

Physical therapy documents (Exhibit 1, pp. 84-85) dated [redacted], were presented. It was noted Petitioner's therapy ended due to lack of attendance.

Neurosurgery office visit notes (Exhibit A, pp. 4-6) dated [redacted], were presented. It was noted Petitioner reported ongoing back pain. Full muscle strength for all tested areas was noted. A Medrol dose pack was prescribed. Weight loss was recommended. A diagnosis of ulnar nerve entrapment was noted.

Physician office visit notes (Exhibit 1, pp. 54-55) dated [redacted], were presented. Ongoing back pain was reported. Norco and Xanax were refilled.

Physician office visit notes (Exhibit 1, pp. 52-53) dated [redacted], were presented. Back pain was reported to be 9/10 and worsening. It was noted Petitioner was awaiting spinal injections.

Physician office visit notes (Exhibit 1, pp. 50-51) dated [redacted], were presented. It was noted Petitioner reported better pain control with morphine but he wanted to gradually reduce pain medications. It was noted Petitioner also wanted to "hold off" injections and surgery. It was noted Petitioner was in physical therapy.

Physician office visit notes (Exhibit 1, pp. 48-49) dated [redacted] were presented. It was noted Petitioner presented for medication refills. Active medications included Norco, Ibuprofen, Xanax, and Cyclobenzaprine.

A cervical spine MRI report (Exhibit 1, pp. 14-15, 28-29, 34, 39) dated [redacted], was presented. Impressions included severe spinal canal stenosis and spinal cord

compression at C5-C6; severe bilateral neural foraminal narrowing was also noted at C5-C6. Mild spinal canal stenosis at C4-C5, C6-C7, and C7-T1 was noted.

Physician office visit notes (Exhibit 1, pp. 46-47) dated [redacted], were presented. It was noted back pain was "under control" while Petitioner attended physical therapy. Various medications were continued.

Physician office visit notes (Exhibit 1, pp. 44-45) dated [redacted], were presented. A complaint of leg pain was noted. It was noted the physician was awaiting MRI results. Various medications were continued.

Physician office visit notes (Exhibit 1, pp. 42-43) dated [redacted], were presented. Ongoing back pain complaints were noted. Various medications were continued.

Physician office visit notes (Exhibit 1, p. 41) dated [redacted], were presented. Various medications were continued.

Physician office visit notes (Exhibit 1, p. 40, 64) dated [redacted], were presented. It was noted Petitioner reported no change in pain and sought refills. It was noted Petitioner did not abuse medications. Active medications included Norco, Ibuprofen, Xanax, Celexa, and Cyclobenzaprine.

Neurosurgery office visit notes (Exhibit A, pp. 1-3) dated [redacted], were presented. It was noted Petitioner reported ongoing back pain radiating to lower right extremity. Lumbar tenderness to palpation was noted. Decreased lumbar flexion and extension was noted. Hoffman's test, Babinski's sign, and clonus were noted as all positive. It was noted Petitioner needed ACDF surgery at C5-C7.Petitioner testified the surgery was scheduled for March 24, 2017. A new MRI was planned.

A cervical spine MRI report (Exhibit A, p. 7) dated [redacted], was provided. An impression of severe spinal canal stenosis at C5-C6, moderate spinal canal stenosis at C6-C7, and severe multilevel neural foraminal narrowing was noted.

Petitioner testified he hurt his back at work in [redacted]. Petitioner testified he and a coworker were lifting a heavy piece of steel when his coworker suddenly and unexpectedly dropped his side. Petitioner testified he continued to work, but with restrictions. Petitioner testified he was "let go" after his employer stopped accommodating his needs. Petitioner testified he has attempted to look for employment but cannot find an employer willing to accommodate needs (e.g. 10 pounds of maximum lifting; no prolonged standing, bending, climbing, walking, sitting…). Petitioner's girlfriend testified Petitioner has to lie down several times (at least 6) per day due to back pain.

Petitioner testified his back pain currently radiates through his right hip, leg and foot. Petitioner testified his right leg sometimes "gives out" due to numbness. Petitioner testified current medications include Norco, Motrin, and Celexa.

Petitioner testified he is limited to climbing 2-3 stairs and ½ a block of walking. Petitioner testified his standing is restricted to 30 minute periods. Petitioner testified sitting for 45 minutes causes his right leg to burn; Petitioner estimated he would have to lie down for 45 minutes before being able to sit another 45 minutes. Petitioner testified his primary care physician restricted his lifting/carrying to 10 pounds or less.

Petitioner testified he has no difficulties with dressing or bathing. Petitioner testified he is unable to vacuum or do dishes. Petitioner testified he is unable to bend in order to remove clothes from his dryer. Petitioner testified he does not attempt to go shopping due to back pain.

Petitioner testified physical therapy somewhat helped his back range of motion. Petitioner testified physical therapy worsened his back pain. Petitioner testified chiropractor adjustments helped to reduce pain, but he had to stop attending after he exhausted the visits covered by insurance. Petitioner also testified his doctor warned him that he could be paralyzed if he further damaged his spine; Petitioner testimony implied that is why "emergency" fusion surgery was scheduled.

Presented medical records generally verified a medical treatment history consistent with general statements 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.

Petitioner testified he does not utilize a walking-assistance device. Generally, non-use of a walking-assistance device is insufficient to meet the SSA listing for spinal disorders. Other evidence was more persuasive.

A Treating Physician Medical Questionnaire (Exhibit 1, pp. 20-23), was presented. The document was signed by an internal medicine physician on [redacted]. A history with Petitioner since February 2015 was noted. Diagnoses of lumbar pain and degenerative disc disease was noted. Stated restrictions included a 30 minute standing limit, standing "only 2 hours" over an 8 hour workday, occasional lifting/carrying of 20 pounds or less, and severe limitations in bending, kneeling, and climbing. Petitioner was projected to be absent more than 6 times/month due to impairments. It was stated Petitioner met the SSA listing for 1.04 (c). The opinion of Petitioner's physician is supportive in finding that Petitioner functionally meets the SSA listing for spinal disorders.

Radiology verified "severe" cervical spine stenosis requiring emergency fusion surgery. Severe stenosis is highly consistent with back dysfunction causing loss of reflexes and strength.

The diagnosis of "severe" cervical spine stenosis was highly consistent with other evidence. Physical exam testing noted positive Hoffman's and Babinski's testing; both are indicative of neurological problems. A diagnosis of ulnar nerve entrapment is also indicative of severe cervical spine dysfunction which can cause permanent atrophy, if not treated.

Lumbar spine radiology was less compelling than cervical spine radiology, though mild stenosis and moderate foraminal narrowing was verified. Petitioner's lumbar problems surely exacerbate pain for Petitioner.

It is found Petitioner functionally meets the SSA listing for spinal disorders. Accordingly, Petitioner is a disabled individual and it is found that MDHHS improperly denied Petitioner's SDA application.

MDHHS has the authority to review Petitioner's ongoing restrictions at redetermination. Petitioner's spinal function may drastically improve following surgery. Petitioner's future SDA eligibility will be contingent upon Petitioner's level of improvement.

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 August 8, 2016;
(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]