[redacted]
[redacted]
[redacted] **MI** [redacted]

Date Mailed: February 21, 2019
MAHS Docket No.: 18-012774
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250. After due notice, a telephone hearing was held on January 9, 2019, from Detroit, Michigan. The Petitioner was represented by himself. The Department of Health and Human Services (Department) was represented by Kimberly Williams, Eligibility Specialist and Medical Contact Worker.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. An MRI of brain and two MRI's of the cervical spine (patient testing) were received and marked into evidence as Exhibit B; Treatment records from Harper Neurology Clinic were received and marked into evidence as Exhibit C; Hospital admission treatment records for [redacted] 2018, through [redacted] 2018, **were NOT received.** The record closed on January 9, 2019; and the matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

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

FINDINGS OF FACT

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

1. On May 14, 2018, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On July 26, 2018, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 173-195).

3. On July 30, 2018, the Department sent Petitioner a Notice of Case Action denying the application based on DDS's finding of no disability (Exhibit A, pp. 178-179).

4. On August 15, 2018, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 2-3).

5. Petitioner alleged disabling impairment due to nerve sheath deterioration and right knee arthritis and uses a cane. Balance is off as is equilibrium. With upper and lower extremity weakness and inability to hold things and walking without losing his balance. Severe paresthesia in right arm with pain and loss of strength and muscle spasms. The Petitioner has not alleged any mental impairment.

6. On the date of the hearing, Petitioner was [redacted] years old with a [redacted], birth date; he is [redacted] in height and weighs about [redacted] pounds.

7. Petitioner is a high school graduate.

8. At the time of application, Petitioner was not employed.

9. Petitioner has an employment history of work as a cook and server.

10. Petitioner has a pending disability claim with the Social Security Administration.

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 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.

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (July 2015), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI

disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If an individual is found disabled, or not disabled, at any step in this process, 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).

In general, the individual has the responsibility 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, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. 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, are insufficient to establish disability. 20 CFR 416.927(d).

Step 1

The first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Petitioner was not working during the period for which assistance might be available. Because Petitioner was not engaged in SGA, s/he is not ineligible under Step 1; and the analysis continues to Step 2.

Step 2

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration

requirement for SDA means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the *de minimis* standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs v Bowen*, 880 F2d 860, 862-863 (CA 6, 1988), citing *Farris v Sec of Health and Human Services*, 773 F2d 85, 90 n.1 (CA 6, 1985). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28. If such a finding is not clearly established by medical evidence or if the effect of an impairment or combination of impairments on the individual's ability to do basic work activities cannot be clearly determined, adjudication m*ust continue through the sequential evaluation process. Id.; SSR 96-3p.*

The medical evidence presented at the hearing, *and* in response to the interim order*,* was reviewed and is summarized below.

The Petitioner was seen at [redacted] Neurology Clinic on [redacted] 2018, due to paresthesia in bilateral upper and right lower extremity with extensive longitudinal lesion on cervical spine. The Petitioner was referred to the clinic for evaluation of persistent paresthesia, numbness and tingling in bilateral upper extremities, torso, abdomen and right lower extremity. Patient reported that he slipped and fell on the ice in [redacted] 2017, and symptoms started right after the fall. Prior studies showed EMG of upper extremities performed showed ulnar neuropathy in bilateral upper extremities as well as very mild right carpal tunnel syndrome. MRI of Cervical spine in June 2018 revealed longitudinally extensive lesion from C2-C6. Follow-up MRI in October 2018

revealed progression of this lesion now extending from C2 through C7, as well as an area of contrast enhancement at the C3-C4 level. MRI of brain in [redacted] 2018 revealed nonsignificant T2 signal abnormalities. The Patient was sent to hospital to be admitted under neurology for treatment with IV steroids. After receiving five doses of IV solution Medrol, patient reported slight improvement in symptoms. He was advised to undergo five sessions of plasmapheresis. However, patient was not agreeable and wanted to be discharged to home. He was once again referred for further evaluation. On the day of the visit, Petitioner complained of decreased sensation, numbness and tingling in the bilateral upper extremities; worse on the right side. He reports he is unable to use his right arm as he cannot feel anything for the most part. He tends to drop objects that he is holding in his hand unless he is holding the object with both hands and looking at it directly. He has similar sensations in his right leg, which has impaired his balance and ambulation, requiring him to use a cane for ambulation. He also reports similar sensation over his chest and abdomen without any spared areas. He reports that these sensations are constant and intermittently has spasms in his back. Petitioner denied any lightheadedness, dizziness, changes in his vision or hearing, nausea, vomiting, changes in his bowel or bladder function, chest pain or shortness of breath.

A neurological exam was conducted which noted motor was slow and hesitant, with gait slightly wide-based. Petitioner was unstable on tandem gait as well as walking on the toes and heels. Strength is 5/5 in all muscle groups. Bilateral pronator drift more notable on right. Finger to nose past pointing significantly noted on the left. Sensation testing noted significantly decreased light touch and pinprick discrimination in the bilateral upper extremities, torso, abdomen, his back as well as the right lower extremity. Slightly better sensation noted on the left lower extremity. No specific spinal level was determined. There is no sparing of the abnormal sensation. Reflexes were +3 symmetric throughout. Toes were downgoing to plantar stimulation bilaterally.

The assessment was abnormal longitudinally extending lesion in the cervical spinal cord concerning for possible demyelinating disease. Symptoms are less likely to be due to a central cord lesion such as syrinx or a glioma. It is also less likely to be due to the traumatic that he had in [redacted] 2017 since this lesion has started to have an enhancing center at the level of C3-C4. Differential diagnosis at this point includes neuromyelitis optica, sarcoidosis, other demyelinating diseases. Will be sent for workup and will follow up once studies are completed. A series of labs were to be obtained and a CT of chest to evaluate for sarcoidosis. To return to clinic in [redacted] 2018.

An MRI of cervical spine was performed on [redacted] 2018. The Findings were that there has been interval progression since the previous exam with a long segment of T2 signal abnormality in the cervical spinal cord extending from about mid C2 down to about mid C7 associated with cord swelling. There is a focal abnormal enhancement of the cord opposite C3-C4. There is no definite mass lesion or syrinx. At C3-C4 there is a central posterior disc extrusion compressing the spinal cord. There is asymmetric arthropathy with patent neural foramina. At C4-C5 there is a small central disc protrusion effacing the ventral aspect of the cord. There is asymmetric arthropathy

resulting in moderate to severe bilateral foraminal stenosis. At C5-C6, there is a small central posterior disc protrusion effacing the ventral aspect of the cord. There is asymmetric arthropathy and mild bilateral foraminal stenosis more on the left. At C6-C7 there is a central posterior disc protrusion without cord compression the neural foramina are patent.

The impression was (1) interval progression of the spinal cord T2 signal abnormality and cord swelling from mid C2 to Mid C7. There is focal abnormal enhancement at the maximum cord compression site at the C3-C4. The spinal cord findings could result from primary demyelinating process such as neuromyelitis optica, (Devic's disease), vasculitis/connective tissue disorder such as systemic lupus erythematosus, chronic inflammatory conditions such as sarcoidosis. The Disc herniation at C3-C4 accentuates the cord compression at this level with associated abnormal enhancement of the spinal cord that may represent ischemia of the cord on top of the inflammatory background condition. (2) Disc protrusions effacing the ventral aspect of the cord at multiple levels as described. Asymmetric arthropathy and foraminal stenosis of varying severity for C3-C4 through C5-C6.

An earlier MRI of the cervical spine was also performed on [redacted] 2018. The findings at C3-C4 note right paracentral disc osteophyte complex indents the thecal sac and flattens the ventral spinal cord there is also alteration of the dorsal spinal cord contour. Bilateral facet and uncovertebral joint arthropathy results in severe left and moderate right foraminal stenosis. With respect to this finding the Impression was C3-C4 disc complex indents the thecal sac altering both ventral and dorsal margins of the spinal cord contour. There is abnormal intramedullary signal within the cervical spinal cord at this level which does extend superiorly to C2-C3 and inferiorly to C6. If there was recent trauma, this may represent injury to the cord with associate Wallerian degeneration. This may also be due to mechanical compression of the cervical spinal cord. Additional considerations include demyelinating process, connective tissue disorder or other inflammatory etiology. Contrast study may be of benefit. Also noted was multilevel spondylitic foraminal narrowing and altering spinal cord contour at C4-C5.

On [redacted] 2018, an MRI of the brain was performed. The Impression was no acute intracranial process identified. Foci of T2/FLAIR hyperintensity predominantly involving the supratentorial subcortical white matter as well as the undersurface of the corpus callosum demonstrate no enhancement and are nonspecific in appearance and distribution and may be seen in the setting of demyelinating process, vasculopathy or less likely chronic ischemic small vessel disease. Paranasal sinus disease, right greater than left with suggestion of obstruction of the right ostiomeatal complex. Further evaluation with dedicated MRI orbits with and without contrast is recommended.

The Petitioner was seen for evaluation at the Rehabilitation Institute of Michigan on [redacted], 2018, with report of uncontrolled movement on right side after a slip and fall on the ice. Whole right side shut down and had to call an ambulance. Main complaint was numbness/tingling and stiffness in right arm with weakness and

heaviness, and sharp pain with stretching. Pain with lifting 70-8 out of 10, with a range of 6-10. On evaluation sensation on palpation was decreased except along 5th digit and bicep region. The spinal assessment noted flexibility was decreased (b) trap/levator noted severe. The Petitioner self-reported severe pain and limitation for dressing/grooming; cooking/cleaning; reaching/lifting unable without increased pain. Petitioner reported right-sided neck pain into right arm. Thereafter, Petitioner attended physical therapy. Therapy records note no significant improvement of pain and numbness in his right hand but had improved neck and shoulder pain and steroid injections in his right shoulder and was given a wrist splint. EMG noted right ulnar mononeuropathy. Therapy was completed on [redacted] 2018. Notes indicate that patient is to follow up with physician re: upper extremity pain which is not alleviated and is constant. The April 2018 visit noted balance deficits reported and continued high pain levels. Patient reports difficultly with fasteners including zippers and buttons, difficulty lifting and carrying with right hand and tying shoes.

An EMG study in [redacted] 2018 was abnormal noting electrodiagnostic evidence of an old right ulnar mononeuropathy at or above the flexor carpi ulnaris. There is evidence of complete and mature motor reinnervation, but ongoing ulnar axonal sensory loss. Mild carpal tunnel on the right with no evidence of denervation or reinnervation. The findings are consistent with some of the patient's clinical complaints in the distal median and ulnar distribution in the right arm but do not adequately account for the entirety of the subacute clinical complaints of right arm pain and sensation changes on the peripheral nerve or muscle. Additional imaging might be helpful.

On [redacted], 2018, Petitioner received a corticosteroid injection/hydrodissection of the median nerve under ultrasound guidance.

In [redacted] 2018, the Petitioner followed up with his sports medicine doctor, who after examination ordered an MRI of cervical spine due to paresthesia of right upper extremity right cervical radiculopathy and osteoarthritis of the cervical spine. The Patient was also started on Lyrica and Robaxin for muscle spasm.

In [redacted] 2017, the Petitioner was seen at the ER due to a slip-and-fall with complaints of shoulder pain, worse with extension, and relieved with flexion and abduction with shooting pain when arm is extended at 45 degrees causing shoulder to lock up. After x-ray, patient was advised to follow up with orthopedic surgery.

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner has satisfied the requirements under Step 2; and the analysis will proceed to Step 3.

Step 3

Step 3 of the sequential analysis of a disability claim requires a determination if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920(a)(4)(iii). If an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

Based on the medical evidence and the two MRI's showing progression and deterioration of the cervical spine as well as progression of a lesion and compression and compromise of the spinal cord of the cervical spine, due to spinal stenosis with limitation of motion in the spine, motor loss in the right arm and weakness in right lower extremities presented in this case, listings 1.04 disorders of the spine was considered.

Prior studies showed EMG of upper extremities performed showed ulnar neuropathy in bilateral upper extremities as well as very mild right carpal tunnel syndrome. MRI of cervical spine in [redacted] 2018 revealed longitudinally extensive lesion from C2-C6. Follow up MRI in [redacted] 2018 revealed progression of this lesion now extending from C2 through C7, as well as an area of contrast enhancement at the C3-C4 level. MRI of brain in [redacted] 2018 revealed nonsignificant T2 signal abnormalities.

The [redacted], 2018, MRI of cervical spine findings were that there has been interval progression since the previous exam with a long segment of T2 signal abnormality in the cervical spinal cord extending from about mid C2 down to about mid C7 associated with cord swelling. There is a focal abnormal enhancement of the cord opposite C3-C4. There is no definite mass lesion or syrinx. At C3-C4, there is a central posterior disc extrusion compressing the spinal cord. There is asymmetric arthropathy with patent neural foramina. At C4-C5, there is a small central disc protrusion effacing the ventral aspect of the cord. There is asymmetric arthropathy resulting in moderate to severe bilateral foraminal stenosis. At C5-C6, there is a small central posterior disc protrusion effacing the ventral aspect of the cord. There is asymmetric arthropathy and mild bilateral foraminal stenosis more on the left. At C6-C7, there is a central posterior disc protrusion without cord compression the neural foramina are patent.

The impression was (1) interval progression of the spinal cord T2 signal abnormality and cord swelling from mid C2 to Mid C7. There is focal abnormal enhancement at the maximum cord compression site at the C3-C4. The spinal cord findings could result from primary demyelinating process such as neuromyelitis optica, (Devic's disease), vasculitis/connective tissue disorder such as systemic lupus erythematosus, chronic inflammatory conditions such as sarcoidosis. The Disc herniation at C3-C4 accentuates the cord compression at this level with associated abnormal enhancement of the spinal cord that may represent ischemia of the cord on top of the inflammatory background condition. (2) Disc protrusions effacing the ventral aspect of the cord at multiple levels as described. Asymmetric arthropathy and foraminal stenosis of varying severity for C3-C4 through C5-C6.

Therefore, the medical evidence shows that Petitioner's impairment *of* abnormal longitudinally extending lesion in the cervical spinal cord concerning for possible demyelinating disease with a differential diagnosis which includes neuromyelitis optica, sarcoidosis, other demyelinating diseases meets or is equal in severity to the criteria in Appendix 1 of the Guidelines to be considered as disabled. Accordingly, Petitioner **is disabled;** and no further analysis is required.

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

DECISION AND ORDER

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

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

1. Reregister and process Petitioner's May 14, 2018, SDA application to determine if all the other non-medical criteria are satisfied and notify Petitioner of its determination;

2. Supplement Petitioner for lost benefits, if any, that Petitioner was entitled to receive if otherwise eligible and qualified;

3. Review Petitioner's continued eligibility in February 2020.

LMF/jaf

Lynn M. Ferris
Administrative Law Judge
for Robert Gordon, 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) 763-0155; 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

Keisha Koger-Roper
MDHHS-Wayne-55-Hearings

Petitioner

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