[redacted]

Date Mailed: July 17, 2019
MOAHR Docket No.: 19-005088
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Zainab A. Baydoun

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 three-way telephone hearing was held on June 19, 2019, from Detroit, Michigan. Petitioner appeared for the hearing with his Authorized Hearing Representative (AHR) [redacted]. The Department of Health and Human Services (Department) was represented by [redacted], Eligibility Specialist.

ISSUE

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

FINDINGS OF FACT

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

1. On or around January 23, 2019, Petitioner submitted an application for cash assistance on the basis of a disability. (Exhibit A, pp. 9-16)

2. On or around April 24, 2019, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. The DDS determined that Petitioner was capable of performing other work. (Exhibit A, pp. 36-69)

3. On May 3, 2019, the Department sent Petitioner a Notice of Case Action denying his SDA application based on DDS' finding that he was not disabled. (Exhibit A, pp. 4-7)

4. On May 10, 2019, Petitioner submitted a written Request for Hearing disputing the Department's denial of his SDA application.

5. Petitioner alleged physical and mental disabling impairments due to back and leg pain; headaches; post-traumatic stress disorder (PTSD); depression; and anxiety.

6. As of the hearing date, Petitioner was [redacted] years old with a May 18, [redacted] date of birth; he was [redacted] and weighed [redacted] pounds.

7. Petitioner's highest level of education is [redacted] grade. He did not obtain a high school diploma or GED. Petitioner has reported employment history of work as: an overnight stock manager, a cashier, a pizza cook, and crew/management at a fast food restaurant. Petitioner has not been employed since June 2018.

8. Petitioner has a pending disability claim with the Social Security Administration (SSA).

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Health and Human Services Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180.

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (April 2017), 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 One

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, he is not ineligible under Step 1, and the analysis continues to Step 2.

Step Two

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 must continue through the sequential evaluation process. Id.; SSR 96-3p.

The medical evidence presented at the hearing was thoroughly reviewed and is briefly summarized below:

A March 20, 2019 MRI of Petitioner's head showed no intracranial process identified, no evidence of recent hemorrhage or infarct, no intracranial mass or abnormally enhancing intracranial lesions, and prominent fluid was identified within the left-sided mastoid air cells which appear to be similar on the CT examination dated February 21, 2019. (Exhibit A, pp. 81-83; 194-195)

A March 20, 2019 MRI of Petitioner's thoracic spine showed no significant central canal or neural foraminal stenosis identified, mild effacement of the right posterior-lateral thecal sac at the level of T9 – T10 which appears to be secondary to synovial cyst arising off of the right facet joint. An MRI of Petitioner's lumbar spine performed on the same date showed an approximately 8mm of anterolisthesis of the L5 on S1 with resulting uncovering of the disc. A broad-based disc extrusion with minimal superior migration and prominent facet joint degenerative changes was found as was severe bilateral neural foraminal narrowing at L5 – S1. Bilateral L5 pars defects are suspected, which could be confirmed with CT imaging. Mild disc bulge without resulting central canal or neural foraminal stenosis was seen at L4 – L5. (Exhibit A, pp. 84-86)

A Medical Needs form completed by Petitioner's surgeon [redacted] on May 17, 2019 indicates that Petitioner was diagnosed with spondylolisthesis of the lumbosacral region and was scheduled to have a lumbar laminectomy surgery on June 14, 2019, after which he would require additional medical treatment for up to six weeks. The doctor indicated that Petitioner had a medical need for assistance with personal care activities and that he will be unable to work for at least six weeks after surgery. (Exhibit 1)

The Operative Report from Petitioner's June 14, 2019 lumbar laminectomy L5 with posterolateral fusion L5 – S1 reflected a preoperative and postoperative diagnosis of

spondylolisthesis L5-S1 with significant nerve root compression. The report indicates that Petitioner has rather significant back and leg pain, especially on the right side with no response to conservative measures. MRI scanning and imaging studies revealed evidence of spondylolisthesis at the L5-S1 level with significant foraminal stenosis, especially on the right side, with compression of the L5 nerve roots in the foramen. This was confirmed during the procedure, as the report indicates the L5 nerve root was noted to be significantly compressed and required decompression. (Exhibit 2)

Petitioner presented a Medical Needs form completed by his physical therapist on or around May 30, 2019 which indicates that he was receiving treatment for low back pain with degenerative disc disease. The form indicates that this was an ongoing illness which will require medical treatment for the duration of Petitioner's life. The form also indicates that Petitioner would require the use of a higher car or van for special transportation and that his caregiver would need to accompany him to medical appointments. The physical therapist indicated that Petitioner has a medical need that requires assistance with bathing, mobility, meal preparation, shopping, laundry, and housework. It was also indicated that Petitioner is unable to work at any job. (Exhibit 1)

Petitioner presented a visit note from [redacted] documenting his Person-Centered Recovery Plan from May 14, 2019 to May 13, 2020, and which indicates that he is receiving treatment for a diagnosis of major depressive disorder, recurrent severe without psychotic features. (Exhibit 1)

Petitioner provided results from a June 11, 2019 EMG evaluation which showed that he presented with weakness in his legs, and indicated his legs buckled and give out. The nerve conduction study showed normal sural, peroneal and tibial motor responses; normal velocities and normal amplitudes. H – reflexes were small and unreliable bilaterally and symmetrically. Needle examination of both legs identified abnormalities in the quadriceps at 2 to 3+ positive sharp waves and fibrillations in the gastrocnemius, 2 to 3+/4 positive sharp waves with reduced recruitment and polyphasic potentials. Lumbar paraspinals were abnormal as well at the lowest lumbar regions and then again at the L4 level. It was concluded that there was electrodiagnostic evidence of bilateral L4 and bilateral S1 radiculopathies. (Exhibit 2)

Records from Petitioner's visits at [redacted] indicate that he was being treated for diagnoses of migraines, gastroesophageal reflux disease, other complicated headache syndrome, severe episode of recurrent major depressive disorder without psychotic features, degenerative disc disease of the lumbar spine, arthralgia of both lower legs, and bilateral sciatica. In February 2019, Petitioner reported pain in his lower back which radiates to his bilateral knees and lower legs and that the pain is worse with standing. Decreased range of motion, tenderness, and pain were noted upon physical exam of Petitioner's lumbar spine. He indicated that he has pounding headaches on the right side which last 6 to 8 hours, and are exacerbated by light, heat, cold, and sound. (Exhibit A, pp. 92 – 101).

Petitioner's records from [redacted] indicate that she was receiving continued treatment for migraines (without aura), esophageal reflux disease, hypertension, generalized anxiety disorder, primary insomnia with sleep apnea, and hyperlipidemia. (Exhibit A, pp. 126 – 159)

A March 7, 2019 Psychological Evaluation indicates that Petitioner was diagnosed with major depressive disorder, recurrent, unspecified and anxiety disorder. He had a GAF score of 60. Additional diagnosis of PTSD was noted due to history of physical and emotional abuse since he was a child. Petitioner was observed to walk with the assistance of a cane. He denied auditory or visual hallucinations and denied delusions. He had no suicidal or homicidal ideations and reported decreased sleep, decreased energy, decreased interest, and decreased concentration. He reported having panic attacks whenever he is around other people, with the last one being two days prior and consisting of symptoms including shortness of breath and chest pain. He also has agoraphobia. It was noted that Petitioner has never been psychiatrically hospitalized. The examining doctor indicated that Petitioner's attitude was friendly and cooperative, and that his speech was spontaneous and goal directed with normal rate and normal reaction time. His mood was euthymic and his affect full and appropriate his insight and judgment were fair and his mental trend was positive for depression and anxiety. He was alert and oriented times three, his memory intact to recent, remote, and immediate and calculations and general knowledge were normal. (Exhibit A, pp. 160 – 185).

Petitioner presented to the emergency department at [redacted] on February 26, 2019 with complaints of chronic bilateral leg and lower back pain that has been intermittent over the past year and constant for the past month. He reported that his pain is from his bilateral knees to his lower back and that he has tingling in his upper and lower extremities. He reported that he was recently prescribed a walker by his primary care physician as he has had trouble walking secondary to pain and has fallen multiple times. Examination showed mild lower extremity weakness with straight leg raise, and bilateral lumbar paraspinal muscle tenderness. Although no red flags were noted for neuromotor compromise, Petitioner was admitted for observation and further evaluation, as well as for a neurology consult. (Exhibit A, pp.191 – 232)

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 Three

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 presented in this case, listings 1.04 (disorders of the spine), 12.04 (depressive, bipolar and related disorders), 12.06 (anxiety and obsessive-compulsive disorders), 12.15 (trauma and stressor related disorders) were considered. Upon review, at the time of application and continuing through the time of hearing, Petitioner's spine impairment resulted in his inability to ambulate effectively. As referenced above, the March 2019 MRI of Petitioner's lumbar spine showed an approximately 8mm of anterolisthesis of the L5 on S1 with resulting uncovering of the disc. A broad-based disc extrusion with minimal superior migration and prominent facet joint degenerative changes was found, as was severe bilateral neural foraminal narrowing at L5 – S1. Petitioner underwent lumbar laminectomy L5 with posterolateral fusion at L5 – S1 in June 2019, during which spondylolisthesis at the L5 – S1 level with significant foraminal stenosis was confirmed, as was significant compression of the L5 nerve root, according to the operative report. This supports Petitioner's testimony that he has chronic pain and requires the use of a walker to assist with ambulation.

Although it is likely that Petitioner's condition may improve after he completes his recovery from his back surgery, the medical evidence reviewed shows that Petitioner's impairments presently meet or are equal in severity to the criteria in Appendix 1 of the Guidelines to be considered disabling without further consideration. Accordingly, Petitioner **is disabled** at Step 3 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 January 23, 2019 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; and

3. Review Petitioner's continued eligibility in December 2019.

ZB/tlf

Zainab A. Baydoun
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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

Via Email: [redacted]

Authorized Hearing Rep. - Via USPS: [redacted]

Petitioner – Via USPS: [redacted]