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[redacted] **MI** [redacted]

Date Mailed: September 9, 2019
MOAHR Docket No.: 19-006084
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 July 11, 2019, from [redacted] Michigan. The Petitioner was represented by herself. Her son [redacted] also appeared. The Department of Health and Human Services (Department) was represented by Gregory Folsom, Hearing Facilitator.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Exhibit B was received and marked into evidence as were records from the Insight Pain Management Center. The Interim Order also requested the Department obtain DHS-49 Medical Exam Reports for Dr. [redacted] Dr. [redacted] Dr. [redacted] and the last three months of treatment records for [redacted] of [redacted] and [redacted] Counties. The requested documents were NOT received. The record closed on August 10, 2019; and the matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

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

FINDINGS OF FACT

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

1. Petitioner was an ongoing recipient of SDA benefits based on a Hearing Decision MOAHR (formerly MAHS) Docket No. 17-009164 issued October 6, 2017, by Administrative Law Judge (ALJ) Carmen G. Fahie. The Hearing Decision found that Petitioner's condition caused her to be determined disabled based upon her

nonexertional mental impairments. ALJ Fahie ordered that the Department review Petitioner's medical condition and ongoing eligibility for SDA in November 2018, Exhibit A, pp. 48-56.

2. In an SDA medical review of Petitioner's SDA application dated December 8, 2016, the Disability Determination Service (DDS) reviewed Petitioner's medical evidence and concluded that she was not disabled on June 28, 2017. After a hearing of Petitioner's appeal of the DDS denial of her application, the Hearing Decision referred to in paragraph 1 hereof found that Petitioner was eligible for SDA and reversed the DDS June 28, 2019, Decision.

3. The DDS again reviewed Petitioner's SDA case and determined on May 22, 2019, that the Petitioner was not eligible for continued SDA and found her no longer disabled and capable of performing other work. Exhibit A, pp. 9-16.

4. On May 28, 2019, the Department sent the Petitioner a Notice of Case Action notifying her that her case would close, effective July 1, 2019, because she was not disabled. Exhibit A, pp. 719-722.

5. On June 6, 2019, the Department received Petitioner's timely written request for hearing disputing the closure of her SDA case (Exhibit A, pp. 3-4).

6. Since the date of disability determination based on the Hearing Decision issued October 6, 2017, the Petitioner has treated with [redacted] of [redacted] and [redacted] Counties for her mental impairments. Petitioner has received treatment since 2014. Her continuing diagnosis is Major Depressive Disorder, Recurrent episode, with psychotic features as of February 2017. No other medical treatment records were available from this provider for review.

7. The Petitioner had an MRI of the Lumbar spine on March 7, 2018. The conclusion was mild circumferential disc bulge at L3-L4 through L5-S1 with mild central canal stenosis at L4-L5; mild L3-L4, mild to moderate, L4-L5 and L5-S1 foraminal stenosis from interforaminal disc bulge; mild L3-L4 and L4-L5 facet arthropathy. More specifically, the MRI found a Mild Circumferential disc bulge at L3-L4 and L4-L5 with mild facet arthropathy with no central canal stenosis at L3-L4 and mild to moderate Foraminal Stenosis bilaterally at L4-L5. And L5-S1 there was no central canal stenosis and mild to moderate foraminal stenosis bilaterally. Exhibit A, pp. 361-362.

8. A prior MRI taken in February 2016 noted bulging disc with right foraminal herniation probable right paracentral cranial extruded herniation originating from the L4-L5 disc there is right L4 nerve root impingement and broad-based herniation at L5-L6. More specifically, at L5-S1, there is disc dehydration with normal disc space height with a broad based herniation measuring approximate 4.5mm; canal diameter is adequate; there is moderate-to-severe right and moderate left-sided foraminal stenosis. Exhibit A, pp. 237, 238.

9. In connection with a DDS review, DDS determined on May 21, 2019, that Petitioner's condition had significantly improved and that Petitioner was capable of performing other work based upon 20 CFR 416.920(f). The DDS also found that Petitioner's mental impairments of anxiety and adjustment disorder were not disabling. Exhibit A, pp. 9-14.

10. Petitioner has alleged disabling impairment due to degenerative disc disease resulting in back pain in lumbar with radiation down bilateral legs with numbness in left leg, pain cervical spine, joint pain, carpal tunnel syndrome in bilateral hands, lupus, fibromyalgia, major depression (psychotic) and hears voices and sees shapes.

11. At the time of the hearing, Petitioner was [redacted] years old with an [redacted] birth date. Petitioner is now [redacted] years of age; she is [redacted] in height and weighs about [redacted] pounds.

12. Petitioner completed the 11th grade and attended special education classes throughout her schooling. Petitioner can read and write and do basic math but cannot do long division or multiplication.

13. Petitioner has an employment history of work and was last employed at a fast food restaurant, [redacted], as a cashier at the light-work exertional level. She also worked as a packer in a factory and as a prep cook at a medium-exertional work level.

14. Petitioner has a disability claim pending 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 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. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. BEM 261, p. 2. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment lasting, or expected to last, 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).

Once an individual has been found disabled, continued entitlement to benefits based on a disability is periodically reviewed in accordance with the medical improvement review standard in order to make a current determination or decision as to whether disability remains. 20 CFR 416.993(a); 20 CFR 416.994(a). If the individual is not engaged in substantial gainful activity (SGA), the trier of fact must apply an eight-step sequential evaluation in evaluating whether an individual's disability continues. 20 CFR 416.994. The review may cease and benefits may be continued at any point if there is sufficient evidence to find that the individual is still unable to engage in SGA. 20 CFR 416.994(b)(5). In this case, Petitioner has not engaged in SGA at any time since she became eligible for SDA. Therefore, her disability must be assessed to determine whether it continues.

An eight-step evaluation is applied to determine whether an individual has a continuing disability:

> **Step 1.** If the individual has an impairment or combination of impairments which meets or equals the severity of an impairment listed in 20 CFR Appendix 1 of subpart P of part 404, the disability will be found to continue. 20 CFR 416.994(b)(5)(i).
>
> **Step 2.** If a listing is not met or equaled, it must be determined whether there has been medical improvement as defined in paragraph (b)(1)(i) of 20 CFR 416.994 and shown by a decrease in medical severity. If there has been a decrease in medical severity, Step 3 is considered. If there has been no decrease in medical severity, there has been no medical improvement unless an exception in Step 4 applies. 20 CFR 416.994(b)(5)(ii).
>
> **Step 3.** If there has been medical improvement, it must be determined whether this improvement is related to the individual's ability to do work in accordance with 20 CFR 416.994(b)(1)(i) through (b)(1)(iv); *i.e.*, there was an increase in the individual's residual functional capacity (RFC) based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to the individual's ability to do work, the analysis proceeds to Step 4. If medical improvement *is* related to the individual's ability to do work, the analysis proceeds to Step 5. 20 CFR 416.994(b)(5)(iii).
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> **Step 4.** If it was found at Step 2 that there was no medical improvement or at Step 3 that the medical improvement is not related to the individual's ability to work, the exceptions in 20 CFR 416.994(b)(3) and (b)(4) are considered. If none of them apply, the disability will be found to continue. If an exception from the first group of exceptions to medical improvement applies, the analysis proceeds to Step 5. If an exception from the second group of exceptions to medical improvement applies, the disability is found

to have ended. The second group of exceptions to medical improvement may be considered at any point in this process. 20 CFR 416.994(b)(5)(iv).

Step 5. If medical improvement is shown to be related to an individual's ability to do work or if one of the first group of exceptions to medical improvement applies, **all** the individual's current impairments in combination are considered to determine whether they are severe in light of 20 CFR 416.921. This determination considers all the individual's current impairments and the impact of the combination of these impairments on the individual's ability to function. If the RFC assessment in Step 3 shows significant limitation of the individual's ability to do basic work activities, the analysis proceeds to Step 6. When the evidence shows that all the individual's current impairments in combination do not significantly limit the individual's physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature and the individual will no longer be considered to be disabled. 20 CFR 416.994(b)(5)(v).

Step 6. If the individual's impairment(s) is severe, the individual's current ability to do substantial gainful activity is assessed in accordance with 20 CFR 416.960; i.e., the individual's RFC based on all current impairments is assessed to determine whether the individual can still do work done in the past. If so, disability will be found to have ended. 20 CFR 416.994(b)(5)(vi).

Step 7. If the individual is not able to do work done in the past, the individual's ability to do other work given the RFC assessment made under Step 6 and the individual's age, education, and past work experience is assessed (unless an exception in 20 CFR 416.994(b)(5)(viii) applies). If the individual can, the disability has ended. If the individual cannot, the disability continues. 20 CFR 416.994(b)(5)(vii).

Step 8. Step 8 may apply if the evidence in the individual's file is insufficient to make a finding under Step 6 about whether the individual can perform past relevant work. If the individual can adjust to other work based solely on age, education, and RFC, the individual is no longer disabled, and no finding about the individual's capacity to do past relevant work under Step 6 is required. If the individual may be unable to adjust to other work or if 20 CFR 416.962 may apply, the individual's claim is assessed under Step 6 to determine whether the individual can perform past relevant work. 20 CFR 416.994(b)(5)(viii).

Step 1

Step 1 in determining whether an individual's disability has ended requires the trier of fact to consider the severity of the impairment(s) and whether it meets or equals a listed impairment in Appendix 1 of subpart P of part 404 of Chapter 20. 20 CFR

416.994(b)(5)(i). If a listing is met, an individual's disability is found to continue with no further analysis required.

The medical record presented was reviewed and is briefly summarized below.

The Petitioner's therapist made an update note on [redacted] 2017, indicating Petitioner continues to have depression and hopelessness with no suicidal ideation. Client has decreased health and increased pain. She just got out of hospital again and having trouble breathing, with new medication she reports it is helping. Pain reported 9 of 10. Client observed to appear to be in pain. Client has lost 20 pounds, but it has yet to help her mobility. The therapist noted that the Petitioner attends regular counseling sessions. Additional treatment records were requested from Catholic Charities for the last three months of treatment in Interim Order issued on [redacted] 2019, which were not returned.

On [redacted] 2017 the Petitioner had a Medication Review by Dr. Johnson. In the Mental Status notes, it states client had total body pain; and treatments are not helping. Had steroid injection about a week ago; also noted was that it seemed visual distortions may be the result of some of her meds. The updated diagnosis indicates Major depressive disorder, recurrent, with psychotic symptoms. No other changes were noted.

Most of the medical treatment records for Petitioner's depression predate the last approval date, [redacted] 2017; and thus, minimal evidence was available to review from the treating source most records were from 2016 and earlier.

The Petitioner had a consultative Mental Status Examination conducted on behalf of the DDS on [redacted] 2019. She was on time for the examination. There were no mental or medical health records provided to the examiner at the time of the exam and completion of his report. The Petitioner reported anxiety and depression as well as schizophrenic condition hearing noises and light which bothered her. She could not explain or describe her symptoms with regard to schizophrenia. The examiner conducted a thorough exam and a history given by the patient.

At the conclusion of the exam, the diagnostic impressions were adjustment disorder with depressed mood, persistent type and prognosis was guarded.

The Medical Source Statement notes that Petitioner overtly underrepresented her abilities during the exam as well as magnified/exaggerated symptomology. The examiner stated that his observation was that Petitioner was generally verbal in her presentation while describing her limitations and hardships to be reflective of higher abilities than demonstrated here today. She does appear to present with a degree of depression resulting from negative life circumstances/hardships as well as ongoing medical conditions which would likely have some level of impact on her social emotional regulation and general efficiency. Learned helplessness and cluster B personality traits are evident. In summary, the examiner found Petitioner mentally able of understanding, attending to, remembering and carrying out instructions related to at least unskilled work like behaviors.

Pertaining to social/interactional functioning, she would likely experience mild limitations within the workplace setting with regard to social interactions and responding appropriately to coworkers and supervision as well as to adapt to change in stress. Also noted were mild-to-moderate limitations regarding her ability to perform activities within a schedule, at a consistent pace, maintaining regular attendance, being punctual and completing a normal workday without interruptions from psychological symptoms.

The examiner made mention of several examples of his observations of Petitioner's behavior during the examination with respect to concentration and memory noting her recall of three numbers forward, two backward and then presented as being unable to understand the task without multiple examples and that it was his impression she was capable of better performance on the tasks. Questions and answers also sighted, Current President: Obama, Big Cities? "bigger cities; Famous Living People? Janet Jackson and could not think of one more, Current Events? "no response." When asked questions regarding orientation to place and time, she presents as unaware what city or state she may be in. She further indicates she is unsure where she may live. She said the month may be April; and when asked the year, she stated "this year is… this is 1920?"

On [redacted] 2018, due to abdominal pain and concern for pulmonary embolism, the Petitioner had a CT scan of the chest, abdomen and pelvis. The Conclusion was previously noted nodular densities in left lower lobe has resolved. No evidence of pulmonary embolism. No acute abnormality identified with chest, abdomen and pelvis to explain patient's symptomology. X-rays were also taken of the abdomen on the same date. The findings noted non-obstructive bowel gas pattern; no definite evidence of free intraperitoneal air; soft tissue structures were unremarkable, a few phleboliths are seen on the sides; osseous structures are stable. The conclusion was nonobstructive bowel gas pattern. No definite free inter peritoneal air changes were due to mild constipation.

The Petitioner has been seen at the [redacted] for several years.

The Petitioner was seen on [redacted] 2019, for continual vaginal irritation and possible urinary tract infection. Reports nausea and weakness with one episode of vomiting last week. With no abnormal discharge or itching. No sexually-transmitted diseases were indicated based upon the culture taken by the doctor.

The Petitioner was seen for on [redacted] 2018, for vaginal bacterial problem, vaginitis. Patient continued to have discharge and odor and discomfort with urination. The Petitioner was prescribed Diflucan.

On [redacted] 2018, the Petitioner appeared with complaints of both wrists/hands hurting with decreased strength, hard to open bottles or hold a cup. The Petitioner was prescribed new wrist braces as the old one did not feel well. No testing of the Petitioner's wrists or hands was conducted.

On [redacted] 2018; [redacted] 2018; and [redacted] 2018, the Petitioner was seen for vaginal irritation. The Petitioner was prescribed Metronidazole for bacterial vaginosis.

The Petitioner was seen again on [redacted] 2018, with constipation and abdominal pain, cramping and in-frequent bowel movements. Notes indicate a CT of the abdomen dimension was conducted on [redacted] 2018, and noted no acute abnormality. The impression was to increase intake of daily fiber and water and MiraLAX was prescribed for constipation.

On [redacted] 2018, a physical exam was conducted and was normal except for TTP in the lumbar region noted. Petitioner was alert, cooperative, and mood normal and affect normal with normal attention span and concentration. The impression and recommendation at that time was hypertension and new orders were a pain management consult for her lumbar radiculopathy. Systemic lupus erythematosus medications were reviewed and continued. The Petitioner is seen approximately every six weeks. Petitioner was seen for low-back pain and received a caudal injection.

On [redacted] 2019, the Petitioner was seen at an office visit due to vaginal discharge described as mucus, malodorous and copious and noted being sexually active with one partner. The Petitioner had cultures taken.

On [redacted] 2019, the Petitioner was seen for pain in her arm with a pain level of nine and a diagnosis of carpal tunnel syndrome as a problem was added. Cervical disc displacement was also added. No alcohol use was noted. During the exam, Patient was examined for left-arm pain with shooting pain. The pain is noted to be up her entire arm with weakness reported as well, neck pain was denied. The impression was neurosurgeon wanted updated EMG, and an appointment was made for tomorrow. For low-back pain, she was prescribed acetaminophen and Oxycodone acetaminophen as well as Mobic. The Petitioner was also prescribed medications for hypertension. At the time, the problem list noted hypertension, lumbar radiculopathy, chronic pain syndrome, systemic lupus erythematosus, spinal stenosis of lumbar region.

Most of her examinations at the [redacted] include a note indicating the Patient to be alert, cooperative normal mood and affect with normal attention span and concentration.

The Petitioner is also seen at Insight Institute of Neurosurgery and Neuroscience for pain management and treatment. She has been seen for several years since [redacted] 2016. The course of treatment of Petitioner's pain has been prescribed physical therapy, three times weekly for low-back pain and injections as well as chiropractic adjustments and massage. The Petitioner has also had several courses of physical therapy.

The Petitioner was seen on [redacted] 2019, and received a caudal epidural steroid injection with sedation. At the time of the procedure, the assessment was radiculopathy lumbar region, chronic right lower extremity radiating pain. The active problems noted

cervical disc displacement high cervical region and at C4-through C7 level, other intervertebral disc degermation lumbar region , unspecified osteoarthritis, fibromyalgia, myalgia, pain in thoracic spine, pain in left shoulder, spondylosis without myelopathy or radiculopathy, lumbar region, lupus, unspecified. Petitioner was also seen on [redacted] 2019, for low-back pain. Medications were given, and exercises were also given. A repeat caudal injection was recommended.

Petitioner was seen on [redacted] 2019, and received a caudal epidural steroid injection and was assessed as having radiculopathy lumbar region with chronic right-lower-extremity radiating pain.

Petitioner was seen at Insight on [redacted] 2019, with complaints of low-back pain. Pain was 8 out of 10. Pain in left shoulder and right lower extremity. Pain exacerbated with sitting, standing, walking, bending and lifting. Norco was used to treat pain. Current pain outcome was fair pain relief. The bilateral leg pain with numbness and tingling goes all the way to the bilateral feet. Patient was stable on her current medications.

Petitioner was seen on [redacted] 2019, with complaints of low-back pain and left-shoulder pain. She had presented the same complaints at last appointment on [redacted] 2019. At this appointment, pain radiates to cervical, left shoulder, bilateral wrists, lumbar, buttocks and right-lower extremity with a pain level average of 8 out of 10. The assessment was radiculopathy lumbar region, fibromyalgia, and systemic lupus erythematosus unspecified. Petitioner reported being sore from her prior caudal injection and was offered a shoulder injection, which she declined.

Petitioner was seen on [redacted] 2019, at which time she was seen for medication management. The lumber spine had decreased range of motion. The assessment noted discogenic changes at L5-S1.

On [redacted] 2019, the Petitioner was seen by the chiropractor and also on [redacted] 2019, at which time she received adjustments to thoracic spine, and rapid release technology to trigger points on low-back musculature, heat-and-ice therapy and traction. On the following dates, Petitioner received physical therapy in the pool as part of her treatment [redacted] 2019, (difficulty due to pain); [redacted] 2019, (able to perform 80% of activities without using pool edge), [redacted] 2019, (improved tolerance 80%; [redacted] 2019, (improved tolerance 80%); [redacted] 2019, (improved tolerance 80%); [redacted] 2019, fair tolerance very slow and guarded. The Petitioner has consistently received chiropractic treatments, massage and since at least [redacted] 2018 to improve the condition of her spine.

The Petitioner was evaluated for physical therapy on [redacted] 2019; and it was determined that she needed skilled physical therapy due to decreased range of motion, strength, faulty posture, decreased functional activity tolerance, impaired balance, abnormal gait, dependence on assistive device. The evaluator found the Petitioner's current pain score was 76% (Oswestry Disability Index) with a score of 61%-80% range

indicates crippled with back pain which infringes on all aspects of life. Physical therapy recommendation was three times a week for four weeks.

On the following dates, the Petitioner received injections for pain (epidural steroid injection): [redacted] 2018 (shoulder), [redacted] 2019 (caudal lumbar), [redacted] 2018 (caudal lumbar spine), [redacted] 2018 (epidural injection cervical spine), [redacted] 2018 (epidural injection cervical spine), [redacted] 2018 (thoracic spine trigger-point injection), [redacted] 2018 (epidural steroid injection cervical spine) and on [redacted] 2018, received a caudal injection.

The Petitioner was seen on [redacted] 2019, for medication management; aqua therapy was discussed and was too early to tell if there was improvement. Petitioner was to receive caudal steroid injection for end of [redacted] 2019.

The Petitioner was seen by Dr. Eldohiri on [redacted] 2018, for continued medication management as a follow-up appointment. Petitioner presented with complaints of pain which radiates to bilateral shoulders, right-upper extremity and bilateral lower extremities with a 9 out of 10 pain level, noted as severe. The physical exam noted joint pain, muscle spasms, neck pain and back pain. History of procedures notes three epidural steroid injections (cervical spine) in [redacted] 2018 with 30% relief and a caudal with 50% relief on [redacted] 2018. The plan was to reduce symptoms, increase functional capacity and return to normal activities of daily living.

The Petitioner was seen at [redacted] on [redacted] 2018. The visit was for a follow-up for arthritis due to complaints of joint pain with gradual onset. The Petitioner reported symptoms as moderate in severity. Current medications were Plaquenil and Voltaren for hands and knees.

The Petitioner was seen on [redacted] 2018, for low-back pain and neck pain by Dr. [redacted] The appointment was a follow-up appointment based on recommended C6-C7 epidural steroid injection with recommendation for caudal epidural steroid injection three times in the left shoulder as well. Associated symptoms at this appointment indicated numbness, tingling. Factors exacerbating the condition noted sitting, standing, walking, bending, lifting, sleeping and noted fair pain relief. The surgical history noted the following nerve root blocks: a left lumbar transforaminal epidural steroid injection at L4 L5 with 90% relief on [redacted] 2018, as well as left lumbar facet blocks at L3-S1 with sedation with increased pain afterwards on [redacted] 2018, and an injection at C6-C7 with sedation which made the pain worse given on [redacted] 2018. The Petitioner's medications were reviewed including Norco 325 and Trazodone for pain. The Petitioner's medication list was significant. See Exhibit A, p. 442. The assessment was radiculopathy, cervical region, cervicalgia, low-back pain chronic, pain and thoracic spine, pain in left shoulder and fibromyalgia. The plan was to have an MRI of the cervical spine. The Petitioner received a steroid injection in the cervical spine. The Petitioner follows up approximately every four weeks and was seen again on [redacted] 2018, at which time she presented with complaints of low-back pain; notes indicate that her pain radiates to bilateral shoulders and bilateral lower extremities; notes indicate fair pain relief; the notes

indicate three injections of the cervical spine for and epidural steroid injection for the period [redacted] 2018 through [redacted] 2018.

In [redacted] 2018, the Petitioner was seen for Medication management, and the treatment plan recommended procedures at C6-C7 three epidural steroid injections then three caudal epidural steroid injections and one left-shoulder joint injection.

In [redacted] 2018, the Petitioner was seen for follow-up; and notes indicate that her pain complaints are quite stable; and medications would be refilled. The assessment at that time was subluxation of C3/C4 cervical, dislocation of sacroiliac and joint, subluxation of L4/L5 vertebrae, subluxation of T8/T9 and other intervertebral disc degeneration, lumbosacral region, cervical disc degeneration mid-cervical region.

On [redacted] 2018, the Petitioner was seen for a left-sided lumbar facet block at L3-S1 due to lumbar spondylosis. The Petitioner was given another injection on [redacted] 2018, and received a left lumbar transforaminal epidural steroid injection at L4-L5, a steroid injection in cervical spine on [redacted] 2018, and a nerve root block lumbar spine due to chronic lumbar transforaminal epidural steroid injection.

The Petitioner was seen for a surgery assessment and MRI on [redacted] 2018, at which time discogenic changes at L4-L5 and L5-S1 were note as the pain generator. Upper motor neuron symptoms in her lower extremities. Also noted concern with left foot and weakness exhibited. The examiner recommended a follow-up MRI of the thoracic spine, and EMG and Nerve conduction study of her lower extremities. A physical exam was performed with noted pain with flexion and extension, antalgic gait, walks with a cane, with positive right-sided straight leg raise. The recommendations were referral to pain management. The analysis was due to significant changes at L4-L5 and L5-S1 levels with back pain appearing to be worse. Several options were discussed which included spinal fusion, medical cannabis, endoscopic discectomy, all of which were not perfect with fusion likely to have a 50% chance of helping her pain. Medical management with the pain team was the selected option and supported by the doctor.

Petitioner was seen on [redacted] 2017, for medication management ,and her pain was stable on medication and had no new pain complaints. The Assessments noted were radiculopathy lumbar region, chronic right lower extremity, low back pain chronic and long term current use of opiate analgesic.

The medical evidence contains two MRI's of the lumbar spine, which follow.

The Petitioner had an MRI of the Lumbar spine on [redacted] 2018. The conclusion was mild circumferential disc bulge at L3-L4 through L5-S1 with mild central canal stenosis at L4-L5; mild L3-L4, mild to moderate, L4-L5 and L5-S1 foraminal stenosis from interforaminal disc bulge; mild L3-L4 and L4-L5 facet arthropathy. More specifically, the MRI found a Mild Circumferential disc bulge at L3-L4 and L4-L5 with mild facet arthropathy with no central canal stenosis at L3-L4 and Mild to moderate Foraminal

Stenosis bilaterally at L4-L5. And L5-S1 there was no central canal stenosis and mild to moderate foraminal stenosis bilaterally. Exhibit A, pp. 361-362.

A prior MRI taken in [redacted] 2016 noted bulging disc with right foraminal herniation probable right paracentral cranial extruded herniation originating from the L4-L5 disc there is right L4 nerve root impingement and broad-based herniation at L5-L6. More specifically, at L5-S1 there is disc dehydration with normal disc space height with a broad based herniation measuring approximate 4.5mm, canal diameter is adequate, there is moderate to severe right and moderate left-sided foraminal stenosis. Exhibit A, pp. 237, 238.

In light of the medical evidence presented, listings 1.04 disorders of the spine, and 1.02 major dysfunction of a joint(s) due to any cause, 14.02 Systemic Lupus Erythematosus, 12.04 Depressive, bipolar and related disorders, 12.03 Schizophrenia spectrum and other psychotic disorders, 12.06 Anxiety and obsessive compulsive disorders and 12.08 Personality and impulse-control disorders were considered.

Because the medical evidence did not establish that Petitioner was unable to ambulate effectively, as that term is defined in 1.00B2b, the evidence does not support a listing under 1.02 or 1.04. There was no evidence of compromise of a nerve root or spinal cord to support a listing under 1.04. Petitioner's medical record does not reflect marked restrictions of activities of daily living; marked difficulties in maintaining social functioning; marked difficulties in maintaining concentration, persistence, or pace; repeated episodes of decompensation, each of extended duration; a residual disease process where even a minimal increase in mental demands would cause the individual to decompensate; or a current history of one or more years' inability to function outside a highly supportive living arrangement. Therefore, Petitioner's condition does not meet a listing under 12.03,12.04, 12.06, or 12.08.

Because the medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration, a disability is not continuing under Step 1 of the analysis, and the analysis proceeds to Step 2.

Step 2

If the impairment(s) does not meet or equal a Listing under Step 1, then Step 2 requires a determination of whether there has been medical improvement as defined in 20 CFR 416.994(b)(1). 20 CFR 416.994(b)(5)(ii). Medical improvement is defined as any decrease in the medical severity of the impairment(s) which was present at the time of the most favorable medical decision that the individual was disabled or continues to be disabled. 20 CFR 416.994(b)(1)(i). For purposes of determining whether medical improvement has occurred, the current medical severity of the impairment(s) present at the time of the most recent favorable medical decision that found the individual disabled, or continued to be disabled, is compared to the medical severity of that impairment(s) at the time of the favorable decision. 20 CFR 416.994(b)(1)(vii). If there is

medical improvement, the analysis proceeds to Step 3, and if there is no medical improvement, the analysis proceeds to Step 4. 20 CFR 416.994(b)(5)(ii).

The most recent favorable decision finding Petitioner disabled is the Hearing Decision dated October 6, 2017, medical-social eligibility certification finding that Petitioner was disabled as a result of her nonexertional mental impairments (Exhibit A, pp. 48-56). The medical evidence relied on that point included the following: On [redacted] 2017, Petitioner was seen by her treating psychiatrist for a medication review at [redacted] and [redacted] County. There was no evidence of a severe thought disorder or risk factors; she was diagnosed with major depressive disorder, recurrent episode with psychotic features. There were no changes to the treatment plan or medications.

The evidence presented in connection with the May 2019 review does show medical improvement in Petitioner's condition from that presented in the Hearing Decision which is the most recent favorable decision finding Petitioner disabled. This conclusion is based in part on the Consultative Mental Status Exam in which the examiner found Petitioner mentally able of understanding, attending to, remembering and carrying out instructions related to at least unskilled work like behaviors. Pertaining to social/interactional functioning she would likely experience mild limitations within the workplace setting with regard to social interactions and responding appropriately to coworkers and supervision as well as to adapt to change in stress. Also noted were mild to moderate limitations regarding her ability to perform activities within a schedule, at a consistent pace, maintaining regular attendance, being punctual and completing a normal workday without interruptions from psychological symptoms. Because there is medical improvement, the analysis proceeds to Step 3.

Step 3

If there has been medical improvement, it must be determined whether there is an increase in the individual's residual functional capacity (RFC) based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to the individual's ability to do work, the analysis proceeds to Step 4. If medical improvement *is* related to the individual's ability to do work, the analysis proceeds to Step 5. 20 CFR 416.994(b)(5)(iii).

In this case, the Petitioner has mild limitations as regards social interactions in the workplace setting Petitioner has mild limitations. Mild to moderate limitations regarding ability to perform activities within a schedule, at a consistent pace, regular attendance and completing a normal workday without interruptions for psychological symptoms. Thus, Petitioner's medical improvement is related to her ability to do work and as such the analysis proceeds to Step 5. 20 CFR 416.994(b)(5)(iii).

Because Petitioner's medical improvement is related to her ability to do work, the analysis proceeds to Step 5.

Step 5

Where medical improvement is shown to be related to an individual's ability to do work, **all** the individual's current impairments in combination are considered to determine whether they are severe in light of 20 CFR 416.921. An individual's impairments are not severe only if, when considered in combination, they 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.

In this case, the Petitioner's physical impairment regarding her back pain, in both the lumbar and cervical spine and the MRI showing degenerative disc disease at multiple levels, and her multiple spinal injections support a severe impairment.

The evidence presented was sufficient to establish that Petitioner's impairments have more than a minimal effect on her ability to perform basic work activities. Therefore, the impairments are severe, and the analysis proceeds to Step 6.

Step 6

Under Step 6, the individual's RFC based on all current impairments is assessed to determine whether the individual can still do work done in the past. If so, disability will be found to have ended. 20 CFR 416.994(b)(5)(vi).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b). The exertional requirements, or physical demands, of work in the national economy are classified as sedentary (involving lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools and occasionally walking and standing), light (involving lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds, or a good deal of walking or standing, or sitting most of the time with some pushing and pulling of arm or leg controls), medium (involving lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds), heavy (involving lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds), and very heavy (involving lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more). 20 CFR 416.967; 20 CFR 416.969a(a).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or

postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2).

In this case, Petitioner testified that she could stand for short periods of time, 10 to 15 minutes, and then was required to sit. She could sit for 10 to 15 minutes. Petitioner testified that she lies down often due to back pain to relieve the pain. She cannot bend at the waist, and showers and dresses herself with assistance. She cannot touch her toe or tie her shoes. Petitioner is right-handed and has bilateral carpal tunnel syndrome and wears wrists braces. Her feet hurt bilaterally and swell, and she has numbness. Her left arm and left back are painful. The heaviest weight she can carry is a quart of milk, about two pounds. Petitioner can walk a block and uses a cane.

Based on the evidence on the record, including Petitioner's testimony, it is found that the improvement in Petitioner's condition has resulted in an exertional RFC to perform less than sedentary work based upon her exertional limitations due to her spine and back issues as well as chronic pain and degenerative disc disease, an MRI showing degenerative disease at multiple levels and the multiple epidural injections including nerve blocks she has received and continues to receive since the last determination. The nonexertional RFC that allows her to perform simple, unskilled labor on a sustained basis provided she has superficial interactions with coworkers, supervisors and the public.

Petitioner reported past employment as a cashier at [redacted] at the light exertional level, and also was employed as a packer and prep cook at the medium level. Based on her description of the jobs, Petitioner's employment as a cashier, which involved standing substantially all of the day and lifting up to 15 pounds on a regular basis, required light physical exertion, and her past employment as a packer and prep cook, which involved standing substantially all of the day and required lifting between 20 and 35 pounds, respectively, required medium physical exertion. Based on her current exertional RFC, Petitioner is **unable** to do work done in the past. Accordingly, Accordingly, Petitioner **is** disabled at Step 6, and the analysis continues to Step 7.

Step 7

In Step 7, an assessment of an individual's RFC and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.994(5)(B)(vii). If the individual can adjust to other work, then the disability has ended. *Id.* If the individual cannot adjust to other work, then the disability continues. *Id.*

When the impairment(s) and related symptoms, such as pain, only affect the ability to perform the exertional aspects of work-related activities, Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix 2, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981)

cert den 461 US 957 (1983). However, if the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2). When a person has a combination of exertional and nonexertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination **unless** there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969a(d).

In this case, Petitioner was [redacted] years old at the time of review decision; and at the time of hearing, Petitioner is currently [redacted] placing her age within the younger individual (age 44-49) category for purposes of Appendix 2. She completed the 11th grade and stated she has problems with multiplication and long division and was in special education classes throughout her schooling. The skills from her past employment, which was tied to light to medium physical exertion, are **not** transferable. As discussed above, Petitioner maintains the RFC for work activities on a regular and continuing basis to meet the physical demands to perform less than sedentary activities. In this case, the Medical-Vocational Guidelines, Appendix 2, do not support a finding that Petitioner is not disabled based on his exertional limitations. The Department has failed to counter with evidence of significant numbers of jobs in the national economy which Petitioner could perform despite his limitations. Therefore, the Department has failed to establish that, based on his RFC and age, education, and work experience, Petitioner can adjust to other work.

Accordingly, Petitioner's disability is found to continue at Step 7.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Petitioner **has** a continuing disability for purposes of the SDA benefit program. Therefore, Petitioner's SDA eligibility **continues** and the Department **did not act** in accordance with Department policy when it closed her SDA case.

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. Reinstate Petitioner's SDA case effective July 1, 2019;

2. Issue supplements to Petitioner for any lost SDA benefits that she was entitled to receive from July 1, 2019 ongoing if otherwise eligible and qualified in accordance with Department policy;

3. Notify Petitioner of its decision in writing; and

4. Review Petitioner's continued SDA eligibility in September 2020 in accordance with Department policy.

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 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

DHHS (via electronic mail)

Gregory Folsom
MDHHS-Genesee-Clio-Hearings
BSC2
L Karadsheh

Petitioner (via first class mail)

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