STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

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Date Mailed: September 5, 2019
MOAHR Docket No.: 19-006085
Agency No.:
Petitioner:

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 telephone hearing was held on July 10, 2019 from Michigan. Petitioner appeared for the hearing and represented herself. The Department of Health and Human Services (Department) was represented by Jessica Kirchmeier, Hearings Coordinator.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Petitioner submitted additional records which were received, marked and admitted into evidence as Exhibit 1. The record was subsequently closed on August 9, 2019 and the matter is now before the undersigned for a final determination on the evidence presented.

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 April 2, 2018, Petitioner submitted an application for cash assistance on the basis of a disability. (Exhibit A, pp. 6-17)

2. On or around April 10, 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. 1156-1162, 1163-1190)

3. On April 22, 2019, the Department sent Petitioner a Notice of Case Action denying her SDA application based on DDS' finding that she was not disabled. (Exhibit A, pp. 41-44)

4. On June 11, 2019, Petitioner submitted a written Request for Hearing disputing the Department's denial of her SDA application.

5. Petitioner alleged physically and mentally disabling impairments due to back, neck, shoulder, leg, and knee pain; carpal tunnel syndrome (CTS), type I diabetes, thyroid disease, kidney disease, arthritis, history of cervical cancer, and depression. (Exhibit A, pp. 26-29, 45-48)

6. As of the hearing date, Petitioner was ██ years old with a ████████████ date of birth; she was ███ and weighed ███ pounds.

7. Petitioner obtained a GED and has reported employment history of work as a child day care provider and a nursing assistant/aide. Petitioner has not been employed since 2016.

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, she is not ineligible at 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 and in response to the interim order was thoroughly reviewed and is briefly summarized below:

On [redacted] 2019, Petitioner participated in a consultative physical examination, during which she reported that her chief complaint was diabetes, thyroid disease, CTS, back, neck, shoulder and leg pain. Petitioner reported symptoms of diabetes including weakness, dizziness, weight loss, numbness, and tingling in her bilateral hands. She has experienced low blood sugars and keeps glucose tablets with her and has been told that she is starting to have some issues with her kidney function dropping. She requires the use of insulin in the morning and in the evening and reported that her last A1c level was 10. She regularly sees an endocrinologist and checks her blood sugar levels 3 to 4 times daily. Petitioner reported that she has pain in her lower back, for which she was told she has scoliosis. She stated she also has pain in her neck and with respect to her right shoulder, a rotator cuff tear resulting in difficulty moving her shoulder, as well as weakness and tingling from her neck to her hand on the left side of her body. Regarding her CTS, Petitioner reported that she had testing on her right hand and indicated that her symptoms are worsened during colder temperatures. A review of Petitioner's records indicated that an x-ray was completed of her cervical spine in [redacted] 2018 which showed mild cervical lordosis and C5–C6, disc space narrowing and C5–C6 and C6–C7, as well as degenerative changes with limited range of motion and C5–C6 and C6–C7. Notes from February 2019 visits with her nephrologist indicated that Petitioner's

hypertension was poorly controlled and required the use of daily medications. Her HbA1c was also poorly controlled and her creatinine was elevated to 1.3. Petitioner was observed to walk without a limp and without the use of an assistive device. Her neurologic exam was normal, she was able to walk with a normal gait, able to tandem walk, walk on her toes and back on her heels, and had negative straight leg raising test in the seated and supine positions and the right and left leg. She had positive Phalen's and Tinsel's sign in the right wrist. She was able to sit, stand, bend, stoop, carry, push, pull, button clothes, tie shoes, dress and undress, dial a telephone, open the door, make a fist, pick up a coin and pencil and write. Orthopedic examination showed that Petitioner had positive paraspinal muscle spasms in the lumbar spine area although range of motion was normal. Decreased range of motion to the cervical spine was noted. (Exhibit A, pp. 90-95)

Petitioner presented results of a [redacted] 2019 MRI of her cervical spine which showed degenerative changes including disc space narrowing, disc bulging, disc osteophyte ridging, mild canal stenosis without cord compression at the C3-C4 and disc space narrowing with diffuse disc bulging and disc osteophyte ridging as well as moderate canal stenosis and mild cord compression, minimal bilateral arthropathy, bilateral spurring, and bilateral a narrowing of the neural foreman at the C5-C6. At the C6-C7 level, disc space narrowing with diffuse bulging and disc osteophyte ridging was noted, as was mild canal stenosis with effacement of the cord but no frank cord compression. Mild bilateral spurring of the unclean uncovertebral joints and bilateral narrowing worst to the left of the neural foreman at C5-C6. The vertebral bone marrow was noted to have mild reversal of cervical lordosis. Compared to the previous study, findings of degenerative changes have progressed. (Exhibit 1)

Petitioner underwent a cervical facet block on July 23, 2019 for her diagnosis of cervicalgia spondylosis of the cervical region. (Exhibit 1)

Petitioner presented records from her [redacted] 2019 EMG testing at [redacted] [redacted]. Records indicate that she presented to the clinic for an outpatient EMG regarding a chief complaint of left arm pain. She described her pain as aching, pins and needles, sharp and shooting. She indicated that pain can radiate from the neck down to her left arm and stated that the symptoms started in 2018. She reported numbness and tingling in the left hand, in addition to left arm pain and stated that symptoms of numbness and tingling can occur in all five fingers on the left hand as well as all five fingers on the right hand. It was noted that she had a prior diagnosis of right CTS after EMG testing in 2009. She reported that her symptoms are worse on the left side when compared to the right and stated that she is currently in physical therapy for her symptoms and complaints. Physical examination showed a slight decrease in the cervical lordosis noted, as well as palpation of the cervical spine and paraspinal musculature revealing some hypertonicity and tenderness to palpation without any significant muscle atrophy noted. The upper trapezius muscles were also hypertonic and tender to palpation bilaterally. Range of motion testing of the cervical spine was overall decreased on active flexion, extension, rotation and side bending. Facet loading by rotation on extension of the cervical spine to the right and left cause pain and

tenderness of the paraspinal muscles bilaterally. Range of motion testing to the shoulders was somewhat decreased, particularly with shoulder abduction. She appeared to have about 160° of shoulder abduction bilaterally. Electrodiagnostic testing was completed and findings indicated abnormal left median sensory nerve conduction studies (NCS) compared to radial ulnar. The impression was that it was an abnormal study and there were electrodiagnostic findings suggestive of left mild severity CTS without axon loss. Because of Petitioner's intolerance during the procedure, left cervical radiculopathy was not completely worked up. Clinically, most of her symptoms were consistent with a left cervical radiculopathy, however it could not be documented as Petitioner cannot tolerate the testing. (Exhibit 1)

Petitioner presented an after visit summary from her appointment with her nephrologist on [redacted] 2019, which showed that she was receiving treatment for diagnosis of chronic kidney disease stage III due to type I diabetes, nephrolithiasis, nephropathy due to nonsteroidal anti-inflammatory drug, pre-renal acute renal failure, persistent proteinuria, elevated hemoglobin A1c, diabetic poly nephropathy associated with type I diabetes, hyperkalemia, iron deficiency anemia secondary to an adequate dietary iron intake, and systolic murmur. (Exhibit 1)

Results of a [redacted] 2018 echocardiogram showed that Petitioner's left ventricle was normal in size, that the left ventricle ejection fraction appeared to be 55% to 60%, and that a small pericardial effusion was seen. (Exhibit A, pp. 124-125).

Petitioner was evaluated for upper extremity pain by [redacted] with [redacted] on [redacted] 2019. Petitioner reported having neck pain that comes on suddenly on the left side. She has CTS in her right hand, left arm weakness, and is having an EMG next week. She also reported having right pointer finger twitching and a torn rotator cuff in the right shoulder, weakness and numbness in her bilateral hands. During the patient review of systems, Petitioner reported weight loss, appetite changes, changes in daily activities, sleep difficulties, headaches, irregular heartbeat, dizziness, lightheadedness, diarrhea, constipation, postmenopausal aches, pains, stiffness, numbness or tingling, leg cramps, unstable walking pattern, decreased concentration and depressed mood. Physical examination showed decreased bilateral cervical, shoulder, elbow, and wrist range of motion. Sensory was intact in the bilateral shoulder, arm, forearm, hand and finger. Her strength was 4/5 in the left shoulder, elbow, wrist, and finger reflexes were 1/4 bilaterally for biceps, brachioradialis, and triceps. Phalen's testing was positive at the right and left, and scalene stretch was positive on the left, thumbs down Tinsel's on the left was also positive. Petitioner was diagnosed with cervical pain, cervical radiculopathy, left knee pain and chronic back pain to the lumbar region. An MRI of Petitioner's lumbar spine performed on April 2017 showed mild to moderate facet degenerative changes in the L4 and L5, and mild facet degenerative changes in the L5-S1. (Exhibit A, pp. 96-107).

Records from Petitioner's 2018 to 2019 visits with her endocrinologist at [redacted] show that she was receiving treatment for, among other conditions, thyroid nodules, hypothyroidism, type I diabetes, hypoglycemia, neck

pain, cervical radiculopathy, thoracic spine pain, and rotator cuff syndrome. Treatment notes from [redacted] 2019 indicate that Petitioner had been diagnosed with type I diabetes at age [redacted] with diabetic ketoacidosis, and that her diabetes was currently uncontrolled. During this appointment, she reported frequent episodes of hypoglycemia, fluctuating blood sugars, and experiencing numbness and weakness in her legs. She further reported palpitations, chest pain on exertion, arm pain on exertion, shortness of breath when walking, having an unknown heart murmur and lightheadedness on standing. Cough, shortness of breath, and sleep apnea were reported, as were muscle aches and weakness, joint pain, and back pain. She reported weakness, numbness, dizziness, tremor, frequent or severe headaches and restless legs. Depression, anxiety, sleep disturbances, restless sleep and suicidal thoughts were also noted. Records show that an ultrasound of her thyroid indicated enlargement and a markedly heterogeneous gland giving a pseudo morular appearance as well as numerous nodules. She had microvascular complications including neuropathy, nephropathy, a GFR score of 43, Cr of 1.5. In [redacted] 2019 her A1c was 11.6% and her random glucose testing was 345. (Exhibit A, pp. 166-219)

Office Visit notes from Petitioner's treatment with [redacted] indicate that she was referred for treatment of joint pain, fatigue, and elevated sed rate. It was noted that she had been seeing a nephrologist for a year, has had iron infusions, has been diabetic for 35 years, has history of kidney stones, for which she was receiving steroid treatment, and that she suffers from thyroid disease. Joint stiffness in the hands, knees, ankles, and feet were noted, and records showed that she had CTS bilaterally based on EMG testing and wears wrist braces as needed. Physical examination in [redacted] 2018 showed tenderness in the joints of her right hand, and positive Phalen's signs in the right wrist and left wrist. Slight weakness of the left foot dorsiflexion and gluteus as compared to the right were noted. Her gait was observed to be normal. In [redacted] 2018, Petitioner reported continuing pain in her arms, thighs, and calves as well as frequent headaches and fatigue, activity intolerance, and difficulty sleeping. Previous EMG results were reviewed and show sensory polyneuropathy for which Petitioner was advised to follow up with her PCP for sleep study, treatment of the low B6, chronic pain management an MRI of the C-spine to determine if surgical consult was needed or just physical therapy. (Exhibit A, pp. 138 – 161).

Records from Petitioner's 2018 to 2019 treatment with her nephrologist were presented and reviewed. (Exhibit A, pp. 442 – 500). Progress notes from her [redacted] 2019 visit indicate that she has poorly controlled hypertension; hyperkalemia, likely from chronic kidney disease stage III B/stage III; iron deficiency anemia, also related to chronic disease for which she had been treated with IV iron; poorly controlled diabetes and micro albuminemia. Her creatinine levels were elevated to 1.3 and her potassium was elevated in the fives range. Petitioner reported ongoing weight loss of about 10 pounds in the last six months, shortness of breath, back pain, joint pain and myalgias. She reported dizziness, tingling, weakness, and headaches as well as signs of depression.

Petitioner's records from her 2018 to 2019 visits with her primary care physician (PCP) were presented and reviewed. Visit summary notes from [REDACTED] 2019 indicate that Petitioner was receiving treatment for several conditions some of which are identified in the above medical summary. She reported worsened pain in her left leg and there was a discussion of a referral to hand surgery if her bilateral CTS worsened. Left arm numbness was reported for which a MRI to the cervical spine was ordered and a referral to physical medicine and rehabilitation specialist due to possible C-spine stenosis. Per the rheumatologist, Petitioner likely suffered from osteoarthritis. She presented for an eight-week follow-up after physical therapy and reported that the CTS in her left wrist was worse. She reported pain in her calves, leg, back and noted that her left upper arm is feeling pain and weakness all of the time. No edema was exhibited in the musculoskeletal physical examination, however, there was tenderness to touch on the upper left arm and wrists bilaterally. In [REDACTED] 2018, Petitioner had decreased mobility and endurance with chronic midline low back pain without sciatica. Tenderness in the knee quad to palpation was noted and physical therapy was recommended. She reported left leg pain that is made worse by walking and standing. She reported having fallen a few times since her prior appointment and noted that her back and leg start hurting with standing. She reported an ability to stand for only 5 to 7 minutes and that she had to stop and take a break between the car and the door to the doctor's office after one or two minutes of walking. There was some discussion of the use of a walker to assist with ambulation. Physical examination in [REDACTED] 2018 showed right trapezius spasm, no activation of vastus medialis of the left side, full range of motion to the knee with mild crepitus with motion of patella laterally and tight quadriceps. In August 2018, Petitioner was diagnosed with polymyalgia rheumatica, and inflammatory disorder causing aching and stiffness in muscles and joints. Records indicate that Petitioner's type I diabetes remained uncontrolled and chronic and was accompanied by tingling in the toes, tingling in the thigh and calf, fatigue dizziness, weakness, headaches, and tremors. (Exhibit A, pp.506 – 686). Medical Group

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 1.02 (major dysfunction of a joint(s) (due to any cause) , 1.04 (disorders of the spine), 6.05 (chronic kidney disease with impairment of kidney function), 6.06 (nephrotic syndrome), 9.00

(endocrine disorders), and 12.04 (depressive, bipolar and related disorders), were considered.

The medical evidence presented does not show that Petitioner's mental impairment of depression meets or equals the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. However, upon thorough review, and in consideration of the above referenced medical documentation including: the F█████ 2019 MRI of Petitioner's cervical spine which showed degenerative changes including disc space narrowing, disc bulging, disc osteophyte ridging at multiple levels, as well as moderate canal stenosis with cord compression and bilateral narrowing of the neural foreman at the C5-C6: Petitioner's treatment records for her chronic kidney disease stage III; her uncontrolled type 1 diabetes; her diabetic neuropathy; and her bilateral CTS were sufficient to establish that, when combined, the impairments are equal to the required level in severity to the criteria in Appendix 1 of the Guidelines to be considered as disabled. 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

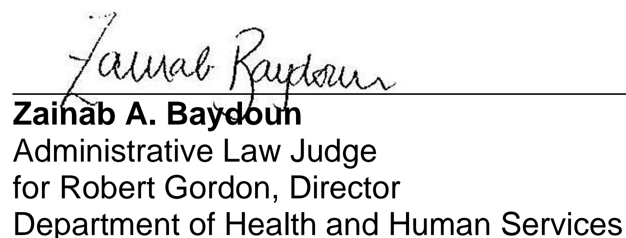
Accordingly, the Department's determination is **REVERSED.**

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 April 2, 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; and

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



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:

MDHHS-Eaton-Hearings
BSC2 Hearing Decisions
Policy-FIP-SDA-RAP
MOAHR

Petitioner – Via First-Class Mail:

MI