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

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

, MI

Date Mailed: August 6, 2020
MOAHR Docket No.: 20-002771
Agency No.:
Petitioner:

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 three-way telephone hearing was held on June 4, 2020, from Clawson, Michigan. The Petitioner was represented by herself. The Department of Health and Human Services (Department) was represented by Aundrea Jones, 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. The 6 months of medical treatment letters and a DHS 49 from Dr. . were not received. The DHS 49D (psychiatric exam) and DHS 49E (mental residual functional capacity assessment) were not received. The record closed on July 6, 2020, and the matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

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

FINDINGS OF FACT

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

1. On , 2019, Petitioner submitted an application seeking cash assistance on the basis of a disability. Exhibit A, p.2

2. On February 7, 2020, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 11-17, Part 1.)

3. On February 12, 2020, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit A, pp. 22-28, Part 1.

4. On April 13, 2020, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 7, Part 1).

5. Petitioner alleged disabling impairment due to lower back pain and neck pain due to osteoarthritis with pinched nerve in lower back. Diagnosis is cervical myelopathy with radiculopathy. Petitioner also had a cervical fusion (ACDF anterior cervical discectomy and fusion) in May of 2019 with 4 pins and a plate placed which continues to be painful and affecting range of motion in neck and left upper extremity. Petitioner also alleges nerve root injury in both shoulder's bilaterally. Petitioner also alleges loose bladder and loss of bladder control necessitating wearing of a diaper. Petitioner also alleges migraines and environmental allergies. The Petitioner also alleges mental impairments due to depression and anxiety.

6. On the date of the hearing, Petitioner was ██ years old with a ████████, 1973 birth date; she is ██" in height and weighs about ███ pounds.

7. Petitioner is a high school graduate and completed a CDA for early child care education for preschool.

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

9. Petitioner has an employment history of work and last worked in December 2018 as a night janitor in a school. She also worked for Kindercare as a teaching tutor before and after school. The Petitioner was also a preschool teacher for Kindercare.

10. Petitioner also received Home Help services to assist with cleaning and meals.

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

CONCLUSIONS OF LAW

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

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

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (July 2015), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If an individual is found disabled, or not disabled, at any step in this process, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In general, the individual has the responsibility to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

Step 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 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, *and in response* to the interim order, was reviewed and is summarized below.

The Petitioner had a consultative examination arranged for by the DDS on December 4, 2019. Notes indicate that Petitioner was observed walking with a cane and has some loss of balance and sensory and motor loss in the right lower extremity (RLE) and weakness in right lower extremity at the thigh and leg. The strength was 4/5in RLE with sensory loss in thigh and lower leg. In the upper extremity dullness exhibited in left

arm, grip strength 20kg/sq cm on right and 9kg/sq cm on left. Also noted was intrinsic weakness in left hand and dullness of sensation and sensory loss in left arm. Exam of the lumbar spine shows tenderness with obliteration of lumbar lordosis and muscle spasm in lower back. Range of motion in cervical spine is reduced 30 degrees extension and flexion. In the lumbar spine flexion is 65 degrees with extension 15 with straight leg raising 30 and thus straight leg raising was positive. The Petitioner could not heel toe walk or tandem walk and demonstrates an ataxic gait that requires a cane for balance. The Notes indicate some imbalance requiring use of the cane. Sensory and motor functions are reduced for the right lower extremity rated 4/5. The sensory loss are also shown for the thigh and lower leg. There is also dullness and sensory loss to the left arm with dexterity intact but strength reduced for the left hand. There was lumbar tenderness to palpation and spasms present. Range of motion also reduced in the lumbar spine and shoulders. The examiner also noted obesity as a contributing factor. Diagnosis/Assessment was pain and stiffness in cervical spine, lower back pain with sensory and motor loss in right lower extremity with loss of balance. Also cervical spine problems, mental depression, loss of bladder and bowel control, stiffness in bilateral shoulder and lumbar spine problems. The examining doctor noted that Petitioner was limited and could not carry things, could not full squat and was limited as to climbing stairs, he also noted Petitioner would fall without aid of a cane which he found clinically required.

The Petitioner attended a Consultative Psych Examination on December 2, 2019. The notes of the examination indicate that the Petitioner was cooperative, motivated, verbally responsive and attempted all tasks. The Petitioner used a cane to ambulate. Thoughts were logical, organized, simple and concrete. Mood is moderately depressed. Suicidal and homicidal ideations are denied. With regard to mental capacity the Petitioner was oriented to date and time, her date of birth, and could remember five of seven numbers forward and three of seven backward. She could recall her second grade teacher's name and could repeat three words after a three minute break. Petitioner was aware of the current president but did not know the name of the governor of the State of Michigan. At the conclusion of the hearing the diagnosis was depression recurrent and panic disorder without agoraphobia. A note attached to the exam indicated a 2000 Fenner-Williams IQ test noting mild mental retardation, schizoid personality disorder, headaches, delusional disorder and nightmare disorder. At the time of the exam the Petitioner was treating every 3 months at [redacted]. Petitioner was prescribed Xanax and Cymbalta. Overall, the Summary noted Petitioner is sullen and verbal and presents as moderately depressed. Her behavior at the assessment was sullen and tearful with fair motivation, social skills, and insight. Prognosis was Guarded and noted Petitioner did not seem a candidate for work based upon her medical conditions and mental health.

With respect to her activities of daily living the Petitioner noted on July 23, 2019 in her Medical Social statement to DHS that she needed reminders for personal needs/grooming and medications. The Petitioner expressed that she gets along well with others but isolates herself from others. She can maintain attention for roughly 5 minutes and does not do well with following written and spoken instructions. She

expressed she does not handle stress well and she does not cook and does only very light limited housekeeping.

On July 14, 2019, the Petitioner's MRI of the C spine was reviewed by her surgeon which notes no fracture, with degenerative and postsurgical changes of the C spine with interval decrease in prevertebral fluid. On July 2, 2019, the Petitioner's surgeon noted decreased Range of motion in lumbar and Cervical spine, no joint effusion and that Petitioner can ambulate without a can and no gross gait ataxia. Straight leg raising was negative, with sagittal balance and ambulation. Diagnosis was cervical and lumbar spine pain post cervical spine fusion.

Petitioner was seen on June 10, 2019 and requested home help assistance with cooking and cleaning with complaints post-surgery in May 2019 cervical fusion. Petitioner complained of continued neck pain with left arm radiculopathy and difficulty performing home ADLs. Petitioner also reported difficulty with coordination including balance and walking. Also reported an incident of incontinence of bladder and bowel.

Petitioner had cervical fusion surgery on May 15, 2019 at C5-C6 resulting in satisfactory anatomical alignment. Prior to the surgery Petitioner has steroid injections on February 5, 2019 and March 6, 2019 in the C spine at C4-C5, C5-C6 and C6-C7. Diagnosis was cervical myelopathy with cervical radiculopathy.

Petitioner had an MRI of Cervical Spine on September 11, 2018 that showed degenerative and discogenic changes a c5-C6 resulting in mild spinal canal stenosis and bilateral neural foraminal narrowing a C5-C6 and C6-C7.

Petitioner had an MRI of the right knee on November 30, 2017 which noted chondrosis with all 3 joint compartments and tiny radial tear involving the central body of lateral meniscus as well as suggestion of vertical longitudinal tear involving anterior horn of lateral meniscus and grade 2 horizontal linear degenerative signal in the body and posterior horn of the medial meniscus.

Post cervical fusion, Petitioner has radicular pain in neck and weakness in the upper extremities and reduced range of motion.

The Petitioner was allergy tested in June 2018 and was allergic to an extensive list of trees ragweed mold, dog care, dust mites, plant mold, soil mold and cat hair. Exhibit a, part one, page 63.

The Petitioner completed a Function Report for these Social Security administration dated July 23, 2019. The Petitioner reported osteoarthritis of the spine and constant pain in the cervical area rated as a 5/10 due to neck surgery and noted numbness and weakness going into the arm affecting grip and ability to squeeze. Petitioner also noted loss of bladder control due to pinched nerve in her back. Petitioner indicated she could not prepare food due to weakness in her hands arm and noted her inability to do

anything but minimal housework such as wiping off the table in front of her while sitting. The Petitioner indicate that she has daily help with ADLs such as getting out of bed, washing up and dressing and meal preparation. The Petitioner indicates due to her cervical issues she can no longer comb, brush or wash her hair, drive or do laundry and has difficulty wiping herself after a bowel movement. The Petitioner also noted difficulty sleeping through the night due to pain which causes her to wake up. Petitioner also reported difficulty due to numbness and weakness feeding herself and reaching her mouth,.. The Petitioner also reported driving as a safety hazard as she cannot look over her shoulder when changing lanes. The Petitioner noted that she only leaves the house for doctor appointments. The Petitioner reported she is able to handle her finances. The petitioner reported no social activities regarding spending time with others on the phone or by computer. The Petitioner also noted that she isolates and prefers to be left alone and does not talk to family friends or neighbors unless absolutely necessary. The petitioner indicated she could not stand longer than five minutes due to back spasms and can walk only short distances and must have a pull up bar to assist her when sitting to standing. Also noted was difficulty paying attention. The Petitioner also noted using a cane, lumbar brace and bath seat. The Petitioner also reports migraine headaches sometimes lasting 3+ days with relief only after reporting to ER and receiving a migraine cocktail.

The Petitioner was seen on November 11, 2019 with complaints of tingling bilateral shoulder and interscapular pain with no radiological new testing. The physical exam noted decreased range of motion in the cervical and lumbar spine with no effusion or gross deformity of the joints. The Petitioner reported capabilities four standing for five minutes, sitting for approximately 15 to 20 minutes and walking up to 100 feet. Lifting a gallon of milk hurt and she uses a cane in public but not at home. The Petitioner also reported she had not driven for more than one year. She further reported needing assistance getting in and out of the tub and has fallen two times. The Petitioner was able to ambulate without the use of an assistive device. There was no gross gait ataxia. Straight leg raising was negative by laterally for radiculopathy or back pain. Petitioner appeared to have a positive sagittal balance and was ambulating with a mild decreased range of motion in the lumbar spine. There was some tenderness to palpation in the lumbar sacral region mainly. The Assessment was cervical spine pain, lumbar spine pain with a referral to physical medicine and rehabilitation a prescription for an MRI of the cervical spine and lumbar spine. Hardware failure which appears to be intact. At the conclusion of the examination the doctor prescribed a cervical collar for one month.

As part of the November 11, 2019 examination and visit the petitioner was given a neuropsychological functioning test as well. The Petitioner was awake, alert and oriented to person place and time. mood and affect were within normal limits. Poor spelling backward and forward was poor and repetition of five digits forward and backward were good however recall was poor. The Petitioner exhibited normal ability to express and understand as well as an adequate vocabulary and grammar. The Assessment was chronic neck pain, chronic low back pain with cervical radiculopathy e with left arm weakness and lumbar radiculopathy.

The x-rays were completed on November 22, 2019 of both the lumbar and cervical spine the findings were with respect to the lumbar spine and noted that both vertebral body height and alignment were normal in appearance for both flexion and extension. There was no evidence of abnormal laxity of motor or abnormal restriction of motion. There was no spondylolisthesis. There was moderately severe chronic facet osteoarthropathy at L4-L5 and L5-S1. There was chronic moderate osteoarthropathy at level L3-L4. Films of the cervical spine also noted minimal loss of normal disk facing at the C T1 level and minimal uncontrovertibly of joint and facet joint arthropathy. There was no abnormal motion or alignment on flexion, extension or neutral positioning. There was minimal loss of disc spacing at the C7 level suggesting minimal chronic degenerative disc change. There was subtle chronic degenerative endplate changes at the C4-C5 level with normal maintenance of disc spacing. The stabilizing hardware appears appropriate in positioning and mechanically intact. There was no evidence of abnormal change in alignment of the surgically stabilized region on flexion, neutral or extension positioning. Exhibit A, part one,p. 236. An earlier MRI taken in 2015 noted broad base disc osteophyte complex of basing the anterior thecal sac with moderate bilateral neural foraminal narrowing at C4-C5 and C5-C6.

Note 1st migraine record September 10, 2016 at ER. Also seen on October 25, 2017. And given an injection. November 17, 2017

On July 14, 2019 an MRI of the lumbar spine was performed. The impression was no evidence of fracture, discogenic and degenerative change of the lumbosacral spine as described above. Heterogeneity of the bone marrow may be due to obesity or smoking. More specifically there was a mild posterior circumferential disc bulge without evidence of central canal stenosis or neural foraminal compromise. At L3-4 there was mild posterior circumferential disc bulge with fact joint hypertrophy causing mild central canal stenosis. There was mild to moderate bilateral neural foraminal compromise. At L4-S1 there is a mild to moderate posterior circumferential disc bulge present abutting the descending bilateral L4 Nerve roots with mild central canal stenosis. There is bilateral facet joint hypertrophy with moderate to severe left and moderate right neural foraminal compromise. At T12-L1 through L3 there was no evidence of disc bulge, central canal stenosis or neural foraminal compromise.

An MRI of the cervical spine was also performed on July 14, 2019. The findings noted there is a kyphosis of the spine from C3 through C5. The remainder of the vertebral body heights, interspacing and alignment appear normal. Prevertebral fluid is seen from C2 through C4 which appear decreased from prior exam and a small amount of fluid posterior to the C2-C3 vertebral bodies. The cervical spinal cord is normal in course, caliber and signal. Specific findings note at C3-4 there is a mild posterior circumferential disc bulge cause mild central canal stenosis without evidence of neural foraminal compromise. At C4-5 there is mild posterior circumferential disc bulge cause mild central canal stenosis without evidence of neural foraminal compromise. At C2-3 and C6 there is no evidence of disc bulge or central canal stenosis ro neural foraminal compromise. At C6-7 there is mild posterior circumferential disc bulge with facet joint

hypertrophy causing mild to moderate right and moderate to severe left neural foraminal compromise. There is mild central canal stenosis.

On October 31, 2018 the Petitioner was seen in the ER for migraine headache with vomiting and photophobia with a pain level of 10/10. Petitioner described the occurrence as recurrent. The Petitioner was given pain medications to treat the migraine.

The Petitioner was seen on November 6, 2018 by a brain and spine specialist for a recheck of her osteoarthritis of the spine with radiculopathy and received a cervical steroid injection.

On January 15, 2019 the Petitioner had a hysterectomy due to ongoing abdominal pain and embedded Essure IUD. The Petitioner tolerated the procedure well and it was successful petitioner was discharged after a several day hospital stay.

On January 28. 2019 the Petitioner was seen for a consult at Vascular and Interventional Radiology and an injection in her neck due to neck pain. The Petitioner complained of right sided neck pain which radiates to her shoulder and axilla with numbness and weakness of the right arm. Prior symptom were on the left side and underwent a nerve root block which worked to help her symptoms. He surgeon requested a C4-C5, C5-C6 and C6-C7 selective nerve root block. The nerve block was administered and the diagnosis was osteoarthritis of spine with radiculopathy in cervical region.

On February 5, 2019 Petitioner had a CT guided multiple right sided steroid injections, TF ESI in her neck.

Petitioner was seen on February 12, 2019 for follow up due to abnormal vaginal bleeding post hysterectomy. The results of the visit were not posted and Petitioner was to follow up in 5 months.

The Petitioner was seen on March 6, 2019 for neck pain and hair loss. She received an injection for cervical myelopathy. Petitioner was referred to dermatology regarding hair loss.

Petitioner was seen for acute neck pain on April 10, 2019 by her surgeon who considered her pain complaints after two rounds of injections with the first injection in November 2018. At the end of the meeting based on a CT and failure of conservative treatment the Petitioner decided to undergo an anterior cervical discectomy and fusion of cervical C5 through C7 for decompression. The diagnosis was cervical stenosis of the spinal canal and cervical myelopathy.

The Petitioner after surgery May 15, 2019 for cervical fusion (anterior cervical discectomy and fusion of C5-6 and C6-7) was seen by a Rehabilitation Consult who recommended Physical Therapy, In Patient for 11 to 14 days with therapy for mobility,

gait transfers, strengthening, range of motion and conditioning 5 days per week. The Petitioner's insurance denied the in-patient physical therapy Doctor's recommendation. The Petitioner had a 2 day hospital stay as a result of the surgery. A CT at the time of the surgery noted mild facet hypertrophy present at every level of the spine.

The Petitioner was seen on May 19, 2019 due to post op problem for neck pain and severe and sudden left arm pain. On physical exam the range of motion of the left arm was decreased. A CT of the cervical spine was performed and there was increased prevertebral fluid and edema when compared to prior study a C2-C4 levels. The hardware was intact. At the time of the visit the Petitioner had fallen into a wall and had numbness and tingling in the left upper extremity into the fingers. Neck pain was 10/10 and Petitioner was unable to care for herself due to pain and was unable to complete ADLs. The physical exam notes indicated positive for neck pain and paresthesia's radiating from neck to left upper extremity and fingers. Petitioner's cervical range of motion was limited due to pain, with pain with palpations to surrounding cervical paravertebral musculature. The Petitioner was referred for ongoing pain management. Petitioner was seen again on May 23, 2019 for neck pain and left arm paresthesia's and administered pain meds in the ER and given a pain management follow up.

Petitioner was seen again in the ER for post op problem and neck pain on May 23, 2019. At the time of the visit the chief complaint was noted as neck pain and infection, vulvar discomfort. Petitioner was prescribed medications for nausea and vomiting. The Notes indicate that Petitioner fell post-operatively into a wall while walking. Petitioner also reported radiculopathy of the left upper extremity with numbness and tingling into the fingers. At the time, the neck pain was 10/10 and that due to pain she was unable to care for herself and complete her activities of daily living. The physical exam notes indicate that she was positive for neck pain a paresthesias and that Petitioner had limited cervical range of motion due to pain with pain on palpation and pain with range of motion of the left upper extremity. The Petitioner was neurologically intact. The reviewing doctor recommended follow up for pain management as her CT of cervical spine two days prior revealed post-op hardware without fracture, pervertebral fluid and edema at C2-4 C6-7 resulting in some mild left sided neural foraminal stenosis. Muscle relaxers were prescribed. The attending surgeon was consulted and reviewed the CT and felt that there is an amount of expected post-operative swelling. After a valium injection, Toradol Injection and Oxycodone tablet pain level improved. The notes indicate that the anterior cervical discectomy is surgery to remove one or more cervical discs from the neck which is the material that cushions and separates the vertebrae of the neck. The discs help support the head and protect the spine from being damaged when moving. Petitioner was prescribed additional pain medications. Petitioner was seen again in the ER for pain.

On June 19, 2019 the Petitioner's primary care doctor certified that due to her post-op condition, the Petitioner required home care and help with her ADLs to be provided until she recovers from her surgery. A skilled nurse was also assigned to review Petitioner's needs with her caregiver as well. The supporting documentation was multiple ER visits, recent surgery, history of falls and currently taking 5 or more medications. Exhibit A

part 5, p. 1090. Petitioner was seen on June 10, 2019 for chronic lower back pain. Petitioner reported back pain of 10/10 described as stabbing with pins and needles sensation and tingling, and also weakness and also bladder incontinence and headaches. After the visit, Petitioner was prescribed Gabapentin and Flexeril and referred to physical medicine rehabilitation.

The Petitioner had a follow up visit with her spine surgeon on July 2, 2019 and was prescribed an MRI of the lumbar spine and cervical spine due to continuing pain and was referred to physical medicine for rehabilitation and given active range of motion exercises.

Notes indicate lumbar pain with right leg cramps and lumbar spasm and upper back spasm with cervical spine pain. Petitioner also reported that she had shooting pain the previous evening into the left upper extremity with numbness and tingling.

A CT of the Cervical spine taken post-surgery was positive for mild facet hypertrophy present at virtually every level, with mild arthritic changes of the atlantoaxial interval with no bony encroachment of the central canal and noted the above condition as post cervical changes.

Petitioner was seen on September 25, 2019 for post-surgical neck stiffness and decreased neck rotation, post cervical neck fusion and chronic pain. The notes also indicate two falls since July 3, 2019. Her original surgeon who performed her surgery had left the U. S. When seen on July 3, 2019 she reported paresthesia and some loss of bladder control, the assessment was radiculopathy in the cervical region, and cervicalgia. At the exam, Petitioner was using a single prong cane. The exam notes indicate decreased range of rotation in the neck to the left and back pain. The doctor prescribed physical therapy for range of motion in the neck and gait training. When seen previously on July 31, 2019, the Petitioner reported difficulty sleeping at night and was weaned off Norco. Petitioner BMI was 37 and she was started on trazadone. When Petitioner for a pain consult in June 2019, she was placed on pain relief until her cervical collar could be removed to begin long term treatment of chronic pain. Pain was exacerbated with movement, sleeping and when in the car, with some relief with application of ice.

On December 12, 2019 a CT of the sinus was performed and noted Haller cells in the maxillary sinuses. The sinuses were clear with a diagnosis of allergic rhinitis. The Petitioner was seen for a video strobe which showed sever acid reflux (laryngeal reflux) and a nodule on her vocal cord. The treating allergist started her on allergy injections after testing. On follow up on July 25, 2019 the Petitioner reported that she is doing better with weekly shots and Singular daily, however she also reported having recurrent hives daily. She was prescribed an epi pen.

Petitioner was seen again for neck pain post op with a primary diagnosis of cervical spondylosis with myelopathy, cervical spinal fusion with left cervical radiculopathy. The physical exam noted no gross abnormality and decreased range of motion in lumbar

and cervical spine described as mild. No joint effusion or gross deformity noted. Petitioner was able to ambulate without use of assistive device with no gross gait ataxia. There was no atrophy or fasciculation of the musculature. Straight leg raise was negative bilaterally for radiculopathy and back pain. Some mild decreased ROM in lumbar spine with tenderness to palpation. The CT of cervical spine was reviewed and hardware was intact, there was some neuroforaminal stenosis. The Petitioner had no begun physical therapy due to insurance problems. Petitioner was still wearing a cervical collar and was to be weaned off it in one month.

By way of history, an MRI of the right knee was performed on November 17, 2017 after the Petitioner fell on a sloped sidewalk. The Impression was focal areas of chondrosis within all three joint compartments. Tiny radial tear involving free edge margin of the central body of lateral meniscus as well as suggestion of possible vertical longitudinal tear involving the anterior horn of the lateral meniscus with a grade 2 horizontal linear degenerative signal in the body and posterior horn of the medial meniscus. There was no updated medical evidence regarding this condition.

By way of history, a note in February 2017 indicated that Petitioner was moderately depressed after completing a preventative mental exam and physical exam at Beaumont Hospital where she completed a form on which she indicated depression. Petitioner reported headaches note indicated patient was nervous/anxious and prescribed Cymbalta.

Petitioner was also seen for chronic headaches on October 25, 2017 (by way of history) and that the problem had been in existence for a year with history significant for migraine headaches. Pain was in the frontal region and moderate with symptoms aggravated by bright light. She was seen again for migraine headache on November 17, 2017 described as chronic without aura and without status migrainous, not intractable and also had injured her right knee with tenderness found and positive McMurray signal with abnormal meniscus without swelling and sent for an MRI. She was referred to Neurology for consult for migraines. The MRI dated November 30, 2017 noted Impression was tiny radial tear involving fee edge margin of the central body of lateral meniscus and possible vertical longitudinal tear of anterior horn of lateral meniscus. Grade 2 horizontal linear degenerative signal in the body and posterior horm of medial meniscus.

In December 2017 by way of history, Petitioner reported worsening neck pain, back pain and pain in both arms. The Petitioner was seen due to an at home fall where she hurt her hand in April 20, 2018. The physical exam noted limited range of motion with edema and tenderness. She was referred for a hand surgery consult.

As regards her claim of mental impairment for depression and anxiety no current treatment records were provided. The Consultative exam in December 2019 requested by the DDS, is summarized above and concluded at the time of the exam, the Petitioner was treating every 3 months at Beaumont Health. Petitioner was prescribed Xanax and Cymbalta. Overall, the Summary noted Petitioner is sullen and verbal and presents as

moderately depressed. Her behavior at the assessment was sullen and tearful with fair motivation, social skills, and insight. Prognosis was Guarded and noted Petitioner did not seem as a candidate for work based upon her medical conditions and mental health. In addition, a note attached to the exam indicated a 2000 Fenner-Williams IQ test noting mild mental retardation, schizoid personality disorder, headaches, delusional disorder and nightmare disorder. No update to the IQ testing was requested by the DDS and it is determined the previous exam is to old to be considered as current or valid from an assessment standpoint to be applied to Petitioner's current condition. In addition, there is an opposing reevaluation done by another professional group which disputes some of the test findings.

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, listing 1.04 Disorders of the Spine was considered. The medical evidence presented clearly demonstrates, based upon the medical records presented and the MRI results that Petitioner's impairments meet or equal the required level of severity of the listing 1.04 in Appendix 1 and is considered as disabling without further consideration, Therefore, the medical evidence shows that Petitioner's impairment of and conditions and testing demonstrated in the cervical and lumbar spine meets or is equal in severity to the criteria in Appendix 1 of the Guidelines to be considered as disabled. Accordingly, Petitioner **is disabled** and no further analysis is required.

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

DECISION AND ORDER

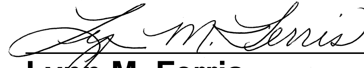
Accordingly, the Department's determination is REVERSED.

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

1. Reregister and process Petitioner's [redacted], 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;

3. Review Petitioner's continued eligibility in August 2021.



LMF/tlf

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

Via Email:

MDHHS-Wayne-19-Hearings
BSC4 Hearing Decisions
L. Karadsheh
MOAHR

Petitioner – Via First-Class Mail:

, MI