RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

Date Mailed: June 8, 2016
MAHS Docket No.: 15-025167
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; and 45 CFR 205.10. After due notice, an in-person hearing was held on , from Sandusky, Michigan. The Petitioner was represented by herself and a witness, , also appeared on Petitioner's behalf. The Department of Health and Human Services (Department) was represented by , Eligibility Specialist.

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the Medical Assistance (MA) and/or 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. The Petitioner applied for SDA on .

2. The Medical Review Team (MRT) denied the Petitioner's request on . The Department sent a Notice of Case Action on , denying the Petitioner's application for SDA.

3. The Petitioner requested a timely hearing on .

4. The Petitioner alleges mental disabling disability which includes bipolar disorder, anxiety and depression as well as adjustment disorders.

5. The Petitioner alleges physical disabling impairments, which include migraine headaches, breathing difficulties and asthma, diabetes, arthritic knees and neuropathy in her feet as well as degenerative disc disease in lumbar and cervical spine.

6. At the time of the hearing, the Petitioner was 5'7" tall and weighed 250 pounds. The Petitioner at the time of the hearing was ██ years of age with a birth date of ████████████.

7. The Petitioner completed a high school education and has difficulty with handwriting as well as simple long division.

8. The Petitioner last worked in 2001 at a factory performing press work lifting 40-pound barrels and parts. The Petitioner worked for this employer for ██ years.

9. The Petitioner's impairments have lasted or are expected to last 12 months duration or more.

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 Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Department of Human Services) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

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. 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.

Pursuant to Federal Rule 42 CFR 435.540, the Department uses the Federal Supplemental Security Income (SSI) policy in determining eligibility for disability under MA-P. Under SSI, disability is defined as:

> ...the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment

> which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.... 20 CFR 416.905.

A set order is used to determine disability. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience are reviewed. If there is a finding that an individual is disabled or not disabled at any point in the review, there will be no further evaluation. 20 CFR 416.920.

Medical evidence may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of the impairment(s), including symptoms, diagnosis and prognosis, what an individual can do despite impairment(s), and the physical or mental restrictions. 20 CFR 416.927(a)(2).

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability. 20 CFR 416.927(e).

For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph (B) of the listings for mental disorders (descriptions of restrictions of activities of daily living, social functioning; concentration, persistence or pace; and ability to tolerate increased mental demands associated with competitive work). 20 CFR, Part 404, Subpart P, Appendix 1, 12.00(C).

The residual functional capacity is what an individual can do despite limitations. All impairments will be considered in addition to ability to meet certain demands of jobs in the national economy. Physical demands, mental demands, sensory requirements and other functions will be evaluated. 20 CFR 416.945(a).

To determine the physical demands (exertional requirements) of work in the national economy, we classify jobs as sedentary, light, medium and heavy. These terms have the same meaning as they have in the Dictionary of Occupational Titles, published by the Department of Labor. 20 CFR 416.967.

Pursuant to 20 CFR 416.920, a five-step sequential evaluation process is used to determine disability. An individual's current work activity, the severity of the impairment, the residual functional capacity, past work, age, education and work experience are evaluated. If an individual is found disabled or not disabled at any point, no further review is made. When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the

applicant has received to relieve pain; and, (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (e.g., age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a) (4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, 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). If impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3 to Step 4. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

The first step is to determine if an individual is working and if that work is "substantial gainful activity" (SGA). If the work is SGA, an individual is not considered disabled regardless of medical condition, age or other vocational factors. 20 CFR 416.920(b).

Secondly, the individual must have a medically determinable impairment that is "severe" or a combination of impairments that is "severe." 20 CFR 404.1520(c). An impairment or combination of impairments is "severe" within the meaning of regulations if it significantly limits an individual's ability to perform basic work activities. An impairment or combination of impairments is "not severe" when medical and other evidence establish only a slight abnormality or a combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work. 20 CFR 404.1521; Social Security Rulings (SSRs) 85-28, 96-3p, and 96-4p. If the Petitioner does not have

a severe medically determinable impairment or combination of impairments, he/she is not disabled. If the Petitioner has a severe impairment or combination of impairments, the analysis proceeds to the third step.

The third step in the process is to assess whether the impairment or combination of impairments meets a Social Security listing. If the impairment or combination of impairments meets or is the medically equivalent of a listed impairment as set forth in Appendix 1 and meets the durational requirements of 20 CFR 404.1509, the individual is considered disabled. If it does not, the analysis proceeds to the next step.

Before considering step four of the sequential evaluation process, the trier must determine the Petitioner's residual functional capacity. 20 CFR 404.1520(e). An individual's residual functional capacity is his/her ability to do physical and mental work activities on a sustained basis despite limitations from his/her impairments. In making this finding, the trier must consider all of the Petitioner's impairments, including impairments that are not severe. 20 CFR 404.1520(e) and 404.1545; SSR 96-8p.

The fourth step of the process is whether the Petitioner has the residual functional capacity to perform the requirements of his/her past relevant work. 20 CFR 404.1520(f). The term past relevant work means work performed (either as the Petitioner actually performed it or as is it generally performed in the national economy) within the last 15 years or 15 years prior to the date that disability must be established. If the Petitioner has the residual functional capacity to do his/her past relevant work, then the Petitioner is not disabled. If the Petitioner is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth step.

In the fifth step, an individual's residual functional capacity is considered in determining whether disability exists. An individual's age, education, work experience and skills are used to evaluate whether an individual has the residual functional capacity to perform work despite limitations. 20 CFR 416.920(e).

Here, Petitioner has satisfied requirements as set forth in steps one and two of the sequential evaluation. The Petitioner is not currently engaging in substantial gainful activity and is not employed; thus, is not disqualified at Step 1. The Petitioner's medical evidence referenced below also satisfies the requirement of severity of his impairment, thus, satisfying Step 2 of the required analysis.

The Petitioner alleges mental disabling disability, which includes bipolar disorder, anxiety and depression as well as adjustment disorders.

The Petitioner alleges physical disabling impairments which include migraine headaches, breathing difficulties and asthma, diabetes, arthritic knees and neuropathy in her feet as well as degenerative disc disease in lumbar and cervical spine.

A summary of the Petitioner's medical evidence follows.

The Petitioner's family practice treating doctor, completed an evaluation of her general health on [redacted]; at which time, he gave an opinion that the Petitioner was unable to work in any capacity secondary to her medical conditions which included, bipolar disorder, depressed, generalized anxiety due disorder and adjustment disorder with anxiety, obstructive sleep apnea hypopnea, obesity, asthma, paroxysmal atrial fibrillation, planter fasciitis, migraine headaches and degenerative disc disease cervical spine.

A Medical Examination Report dated [redacted], was completed by the Petitioner's neurologist who has seen her since [redacted]. At the time of the report, the diagnosis was low back pain and weakness in legs, lumbar disc bulge, cervical disc bulge and diabetic neuropathy. At the time of the examination, the Petitioner weighed 244 pounds. The neurologist noted that the Petitioner walks with a cane and imposed limitations. The Petitioner could occasionally lift carry up to 26 pounds. The Petitioner could stand and/or walk at least two hours in a six-hour workday and sit six hours. The Petitioner could not push or pull, or fine manipulate with either hand or arm, but could perform simple grasping and reaching. The Petitioner could not operate foot controls with either foot; the Doctor further opined that the Petitioner could meet her needs in the home.

The Petitioner is currently in treatment for her mental health conditions at a community mental health facility. A medication review was conducted on [redacted], [redacted] by the Petitioner's psychiatrist. The Petitioner's current diagnosis was bipolar disorder 1, generalized anxiety and adjustment disorders with anxiety. The report also noted chronic pain syndrome and associated insomnia. The physician notes indicate psychomotor retardation with abnormal involuntary movements. At the time, mood was noted as depressed with restricted affect, without suicidal or homicidal ideation. Insight and judgment were adequate. The GAF score was 50. The report also noted insomnia associated with chronic pain syndrome and circadian rhythm disruption due to recent time change.

At a periodic review completed [redacted] the report notes that Petitioner had medication changes with Amitriptyline and a Lamictal increase due to sleep concerns and mood fluctuations. Continued mood fluctuations and anger increasing without suicidal or homicidal indication thoughts at this time. A review note indicated moderate symptoms or moderate difficulties with daily living and the Petitioner is residing independently in her own house.

On [redacted], the Petitioner was seen for a medication review by her mental health care treating doctor. At the time, depression was not noted. The Petitioner was cognitively stable and insight and judgment were fair; the diagnosis remained the same as did the GAF score with no medication changes.

On [redacted], Petitioner met with her psychotherapist to discuss her sleep patterns and self-care. Petitioner reported she continues to have times where she sleeps all day and stays up all night and vice versa. At the time, the Petitioner reported that she was medication compliant; however, it often did not work adequately for her to sleep.

On [redacted], the Petitioner had an annual review by her mental health care provider. At the time of the review, the Petitioner was diagnosed with a primary diagnosis of bipolar 1 disorder, most recent episode depressed, generalized anxiety disorder, and adjustment disorders with anxiety. The GAF score was 50. The report notes, in addition to the diagnoses, the Petitioner displayed significant functional disability and serious mental illness of sufficient duration to be eligible for continued mental health services. In addition, the report noted substantial disability with regard to personal hygiene and self-care, activities of daily living, social transactions and interpersonal relationships. The report also notes that the Petitioner can complete the majority of her activities of daily living independently, but often neglects these when she is having a depressed episode. The evaluation also notes that Petitioner has ongoing problems with anger management and medication concerns. At the meeting, the Petitioner noted that she sometimes forgets or misses medications; but they are helping her when she remembers. At the time of the evaluation, the Petitioner presented with an edgy mood and noted psycho motor activity with difficulty due to back pain, injured ribs and foot pain. Judgment was appropriate. Thought process was noted as ruminating ongoing. Current symptoms included poor sleep, anxious mood irritability, depressed mood, inability to focus, psychomotor agitation, rapid speech, mood instability, crying, and lack of motivation for self-care. No substance abuse was noted. The Petitioner was informed of the risks of not taking medications as prescribed. The report noted Petitioner continues to not take her medications as often as she is prescribed. The Report further notes that the Petitioner has a significant functional disability, which is of sufficient duration with a serious mental illness qualifying her for continuing treatment eligibility.

On [redacted], the Petitioner was seen by her Psychotherapist. The Petitioner reported that she had been up for three days in a row straight canning quarts of tomatoes and corn. She reported physically struggling with pain. She has been taking the medications prescribed by her psychiatrist. The Petitioner was given her psychiatrist's phone number and changes in her medication were required.

On [redacted]015, the Petitioner exhibited manic symptoms while meeting with her therapist about her physical health situation. On [redacted], her therapist met with the Petitioner in her home regarding concern that she reported falling. Report notes Petitioner fell three times over the weekend. The Petitioner went for an appointment with her primary care physician after meeting with her therapist. On the same date a medication review was conducted, the notes indicate that the Petitioner ambulated with a somewhat wide-based gait, very slowly and had trouble getting in and out of the chair. Mild psychomotor retardation is noted. No abnormal involuntary movements appreciated. Mood is reported as anxious. Her affect is superficially bright pleasant and mildly anxious. Denial of any suicidal or homicidal ideation. No gross psychotic features are noted. Thought processes are relevant. Cognitively, she's alert. She's oriented to self, place and time; otherwise intact insight and judgment are adequate.

On [redacted], the Petitioner had an in-service periodic review by her mental health provider. The report noted that at the time, the Petitioner had serious symptoms or serious impairment in daily living. At the time, the Petitioner reported there were no significant changes in her mental health status.

In a meeting with her psychiatrist for medication review conducted on [redacted], the notes indicate slow ambulation with a wide-based gait with trouble getting in and out of the chair. Mild psychomotor retardation is noted. Judgment and insight were adequate mood anxious and stressed.

At an individual plan of service meeting in [redacted], it was noted that current symptoms included poor sleep, anxious mood irritability, depressed mood, inability to focus, psychomotor agitation, rapid speech, mood instability crying, and lack of motivation to care for self. The report notes that when depressed, the Petitioner neglects the activities of daily living. In addition, an individual progress note made [redacted], notes that the Petitioner had been up for three days. She was struggling with physical pain and had been taking her medications as prescribed. Her medications were immediately reviewed by the psychiatrist and adjusted.

The Petitioner attended a psychological consultative medical examination on [redacted] The examiner noted that the Petitioner had a slow gait and used a cane. Report notes Petitioner having feelings of worthlessness and suicidal ideations. The examiner also noted that Petitioner had weakness in her legs arms and hands and noted sleep problems with waking up 5 to 6 times nightly. The Petitioner presented with depressed and sad affect and cried throughout the evaluation. The Diagnosis was bipolar disorder current most recent episode depressed moderate and generalized anxiety disorder. Petitioner was deemed capable of managing her finances. The prognosis was that improved psychological and adaptive functioning is guarded. She presented depressed with sad affect the evaluation documents in the chart supported the diagnosis. She demonstrated adequate ability to understand simple and complex instructions and adequate with interaction appropriately with others.

The Petitioner underwent an MRI of the cervical spine on [redacted]. There was a comparison with the MRI of the cervical spine dated [redacted]. Impression was: stable mild central canal stenosis with approximation of the underlying cord due to small left paracentral disc protrusion at C5–C6 was stable mild bilateral neural foraminal narrowing unchanged. Stable central canal stenosis at C4–C5 with stable moderate right neural foraminal narrowing and left foraminal narrowing. No cord signal abnormality or syrinx.

An MRI of the brain was conducted on [redacted]. The findings noted normal appearing ventricular system without evidence of subdural fluid collection, mass effect or shift in the interhemispheric structures across the midline. No discrete abnormal areas of increased or decreased signal intensity are noted intra-axially. No areas of restricted diffusion to suggest acute ischemia. No discrete enhancing masses were identified. The Impression was unremarkable MRI exam of the brain without contrast.

Noted sinus disease with mucosal thickening involving the bilateral maxillary, ethmoid and sphenoid sinuses.

An MRI of the lumbar spine was performed on [REDACTED] with comparison to a prior MRI in [REDACTED]. There was a slight grade anterollsthesis of L5-S1 with slight disc desiccation at level L5-S1 level. There are no abnormal or worrisome areas of signal intensity throughout, the visualized vertebral bodies, paraspinal soft tissue or within the visualized court at L5-S1; there is a mild diffuse disc bulge with a central annular tear. There is very minimal posterior disc degenerative bridging. No central canal stenosis. No neural foraminal narrowing.

A nuclear whole body scan was conducted on [REDACTED], when the Petitioner was admitted to the hospital. The impression of the examination noted pattern of radio tracer activity with arthrosis in shoulders, in both knees. There appears to be bilateral genu varus deformities. The Petitioner also underwent a stress test on [REDACTED], with the impression that negative stress test by EKG criteria result with normal myocardial perfusion and function with normal LV function with an ejection fraction 70 percent.

The Petitioner was seen by a pain management doctor on [REDACTED] due to lumbago and chronic pain syndrome based on an MRI result. The Petitioner was referred to a doctor for obstructive sleep apnea due to noted intolerance of CPAP.

The Petitioner underwent an endoscopic sinus surgery and polypectomy on [REDACTED], [REDACTED] for chronic sinus issues and polyps. Surgery removed polyps for reestablishing nasal sinus openings.

The Petitioner underwent a fluoroscopy examination due to back pain. The impression was fluoroscopic guidance was necessary during pain relief procedure.

On [REDACTED], the Petitioner underwent an EMG which found mild axonal demyelinating neuropathy with no denervation and bilateral S1 radiculopathy mild, no denervation. The recommendation noted neural changes are due to axonal demyelinating neuropathy with lumbar radiculopathy, which are all mild in severity and without membrane instability. These are neuromuscular junction changes that would in part explain the pain issues patient is having. The Patient's pain and weakness is due to and axonal demyelinating neuropathy of which the bone and joints are involved and in this case the issue of an early vascular apathy with systemic arthropathy may have to be considered due to musculoskeletal disorder being part of her complex of pain issues.

On [REDACTED], the Petitioner was seen at the emergency room for sudden persistent chest pain with pressure, pain was described as sharp. At the time, the Petitioner had pain with breathing. The finding was acute chest pain with medium priority, dyspnea, anxiety neurosis and rib pain. The Petitioner was seen by a cardiologist. The Petitioner was discharged home after a full workup.

The Petitioner was admitted to the emergency department on , after being seen the previous day with rib pain. She was re-treated for pain with a diagnosis of Tietze's Disease. At the time of admission, Petitioner complained of acute chest pain, anxiety, neurosis, dypsnea and rib pain. The Patient was diagnosed with costochondritis, which is inflammation of the rib cartilage. The Petitioner was give pain medications and discharged home. The previous day, the Petitioner had an epidural injection for back pain.

In , the Petitioner reported to the emergency room with sharp pain over precordial area shooting to left arm and left side of the face with tingling sensations. The incident was accompanied by sweating and feeling shortness of breath with pain shooting to the left arm and face. The pain was ongoing and not exaggerated by anything. Chest pain was not related to exercise. The Petitioner was placed on a chest pain protocol and monitor, given four baby aspirins and one nitroglycerin causing patient's pain to disappear completely. The Petitioner was discharged with a prescription for cardiologist follow-up. The Petitioner was also seen for costochronditus. The Petitioner was discharged home after pain medication (morphine) was administered.

The Petitioner was admitted to the hospital on , for a one-day stay. At that time, the Petitioner presented with chest pain, shortness of breath, and back pain. Upon examination, the findings were acute chest pain, anxiety, neurosis and dypsnea. After a cardiac workup, the results were noted as good; the Petitioner was discharged home with pain relief. The Petitioner had a cardiac consultation while admitted to the hospital; all of the diagnostic testing was negative. The assessment was atypical chest pain syndrome. The EKG did not reveal new ischemic changes. All cardiac enzymes were negative.

In the Petitioner underwent physical therapy as prescribed by her primary care physician for four weeks, three times a week. The diagnosis was degenerative lumbar/lumbosacral disc, and cervicalgia.

The Petitioner also credibly testified to the following physical impairments. Petitioner could sit for 20 minutes and then had to walk around. Petitioner is subject to falling due to problems with her knees and has fallen five times in the last eight months. Petitioner can walk a short distance and bend slightly forward at the waist. Petitioner could shower and dress herself. The Petitioner does not tie her shoes or touch her toes. Petitioner currently takes Norco four times a day for pain and other medications for her mental impairments including Xanax several times daily. During the hearing, it is noted that the undersigned observed Petitioner was required to alternate standing and sitting at the hearing due to too much sitting causing back pain. Her legs and feet are affected by neuropathy caused by her diabetes. Petitioner credibly testified she could reliably carry 3 to 4 pounds. Petitioner does not drive due to her anxiety although she does have a driver's license. Petitioner does not cook anything other than simple meals because of the requirement that she stand too long and concern about her inability to

pay attention due to her mental impairments. The Petitioner does go grocery shopping; however, she does require assistance to do so. The Petitioner also needs assistance with her laundry. The Petitioner further testified credibly that she often refrains from contact with others due to her anxiety and fear, as well as mood swings. Petitioner testified credibly to crying every day, continues to have explosive anger issues, and ongoing sleep problems which are somewhat addressed by her prescribed medications.

As previously noted, the Petitioner bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the Petitioner has presented objective medical evidence establishing that she does have some physical limitations on her ability to perform basic work activities. Accordingly, the Petitioner has an impairment, or combination thereof, that has more than a *de minimis* effect on the Petitioner's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, the Petitioner is not disqualified from receipt of SDA benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Petitioner's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. As the Petitioner has alleged mental disabling impairments with a diagnosis of bipolar disorder, type1, with both manic and depressive symptoms, anxiety disorder and adjustment disorders, and has received ongoing treatment, Listing 12.04, Affective Disorders was considered and examined.

Listing 12.04 was examined in light of Petitioner's lifelong and ongoing bipolar disorder and anxiety related impairments. The Listing provides:

12.04 *Affective disorders*: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

   1. Depressive syndrome characterized by at least four of the following:
      a. Anhedonia or pervasive loss of interest in almost all activities; or
      b. Appetite disturbance with change in weight; or
      c. Sleep disturbance; or
      d. Psychomotor agitation or retardation; or
      e. Decreased energy; or
      f. Feelings of guilt or worthlessness; or
      g. Difficulty concentrating or thinking; or
      h. Thoughts of suicide; or

i. Hallucinations, delusions, or paranoid thinking; or

2. Manic syndrome characterized by at least three of the following:

    a. Hyperactivity; or
    b. Pressure of speech; or
    c. Flight of ideas; or
    d. Inflated self-esteem; or
    e. Decreased need for sleep; or
    f. Easy distractibility; or
    g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
    h. Hallucinations, delusions or paranoid thinking; or

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration;

Based upon a review of the treating psychiatrist's evaluation and the Consultative Exam, which found improvement guarded and which also included confirmation of the Petitioner's depression characterized by at least sleep disturbance, difficulty concentrating or thinking, easy distractibility, as well as satisfying the requirements of the listing for bipolar syndrome which results in marked restrictions of activities of daily living, difficulties in maintaining social functioning and difficulties in maintaining concentration, persistence or pace, it is determined that the Petitioner has satisfied the requirements or its medical equivalent of listing 12.04 B for bipolar disorder and, therefore, is found disabled at Step 3 of the analysis.

Additionally, based upon the objective medical evidence, it is clear, based upon the Petitioner's treating physician's evaluation and the documented deteriorating nature of the Petitioner's health as documented in the medical examination, her chronic pain which is also supported by the MRI evidence, as well as the mental status evaluation evaluating the Petitioner with an ongoing GAF of 50; Petitioner would also be found disabled at Step 5 as well. Based upon her age of ██ years and the fact that she has been evaluated as sedentary by her treating family practice physician, the Petitioner would be found disabled at Step 5 as well.

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

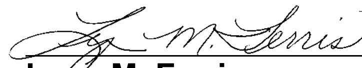
Accordingly, the Department's determination is **AFFIRMED**.

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. The Department is ORDERED to initiate a review of the application dated [redacted] [redacted] if not done previously, to determine Petitioner's non-medical eligibility.

2. The Department shall issue an SDA supplement to the Petitioner for SDA benefits she is entitled to receive in accordance with Department policy.

3. A review of this case shall be set for [redacted].



LMF/jaf

Lynn M. Ferris
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

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

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

DHHS

Petitioner

cc: