STATE OF MICHIGAN
RICK SNYDER
GOVERNOR
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: February 1, 2018
MAHS Docket No.: 17-014279
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

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; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10; and Mich Admin Code, R 792.11002. After due notice, an in-person hearing was held on January 2, 2018, from Monroe, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], specialist.

ISSUE

The issue is whether MDHHS properly denied Petitioner's State Disability Assistance (SDA) eligibility for the reason that Petitioner is not a disabled individual.

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 May 8, 2017, Petitioner applied for SDA benefits.

2. Petitioner's only basis for SDA benefits was as a disabled individual.

3. On October 12, 2017, the Disability Determination Service determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 14-50).

4. On October 13, 2017, MDHHS denied Petitioner's application for SDA benefits.

5. On October 26, 2017, Petitioner requested a hearing disputing the denial of SDA benefits (see Exhibit 1, pp. 2-3)

6. As of the date of the administrative hearing, Petitioner did not have employment earnings amounting to substantial gainful activity.

7. As of the date of the administrative hearing, Petitioner was a [redacted]-year-old female.

8. Petitioner's highest education year completed was the 12th grade (via general equivalency degree).

9. Petitioner has a history of unskilled employment, with no known transferrable job skills.

10. Petitioner has multiple symptoms and marked understanding and concentration restrictions dye to various to psychological disorders.

CONCLUSIONS OF LAW

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. MDHHS administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. MDHHS policies for SDA are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (April 2017), p. 5. The goal of the SDA program is to provide financial assistance to meet a disabled person's basic personal and shelter needs. *Id*.

It was not disputed that Petitioner actually receives ongoing SDA benefits for a reason other than disability (see Exhibit 1, pp. 5-8). It was also not disputed that Petitioner's ongoing basis for SDA eligibility resulted in a smaller benefit amount than Petitioner would receive if MDHHS determined that Petitioner was disabled. Because the denial of Petitioner's claim of disability affects Petitioner's benefit eligibility, Petitioner is entitled to administrative hearing review.

Petitioner claimed an inability to work for 90 days due to mental and/or physical disabilities. MDHHS presented a Notice of Case Action (Exhibit 1, pp. 9-12) dated October 13, 2017, verifying Petitioner's application was denied based on a determination that Petitioner was not disabled.

To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older. BEM 261 (April 2017), p. 1. A person is disabled for SDA purposes if he or she meets any of the following criteria:

- Receives other specified disability-related benefits or services….

- Resides in a qualified Special Living Arrangement (SLA) facility.
- Is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability.
- Is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS)...

Id., pp. 1-2.

When the person does not meet one of the [above] criteria, [MDHHS is to] follow the instructions in BAM 815, Medical Determination and Disability Determination Service (DDS), Steps for Medical Determination Applications. *Id*., p. 4. The DDS will gather and review the medical evidence and either certify or deny the disability claim based on the medical evidence. *Id*. The review of medical evidence is primarily outlined by federal law.

[State agencies] must use the same definition of disability as used under SSI … 42 C.F.R. § 435.540(a). [Federal] law defines disability 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 C.F.R. § 416.905(a).

MDHHS adopted a functionally identical definition of disability (see BEM 260 (July 2015), p. 10). The same definition applies to SDA, though SDA eligibility factors only a 90-day period of disability. The remainder of the analysis considers the specific disability evaluation set forth by federal regulations.

In general, you have to prove … that you are blind or disabled. 20 C.F.R. § 416.912(a). You must inform us about or submit all evidence known … that relates to whether or not you are blind or disabled. *Id*. Evidence includes, but is not limited to objective medical evidence (e.g., medical signs and laboratory findings), evidence from other medical sources (e.g., medical history and opinions), and non-medical statements about symptoms (e.g., testimony) (see *Id*.).

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled (see 20 C.F.R. § 416.920). If there is no finding of disability or lack of disability at each step, the process moves to the next step (see *Id*.)

The first step in the process considers a person's current work activity (see 20 C.F.R. § 416.920 (a)(4)(i)). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person is statutorily blind or not. The 2017 monthly income limit considered SGA for non-blind individuals is $1,170.00.

SGA means a person does the following: performs significant duties, does them for a reasonable length of time, and does a job normally done for pay or profit. *Id*., p. 9. Significant duties are duties used to do a job or run a business. *Id*. They must also have

a degree of economic value. *Id*. The ability to run a household or take care of oneself does not, on its own, constitute SGA. *Id*.

Petitioner credibly denied performing current employment; no evidence was submitted to contradict Petitioner's testimony. Based on the presented evidence, it is found that Petitioner is not performing SGA. Accordingly, the disability analysis may proceed to the second step.

At the second step, we consider the medical severity of your impairment(s). 20 C.F.R. §416.920 (a)(4)(ii). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 416.909, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. *Id*.

Generally, federal courts have imposed a de minimus standard upon petitioners to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v Bowen,* 880 F2d 860, 862 (6th Cir. 1988). Similarly, SSR 85-28 has been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirements are intended "to do no more than screen out groundless claims." *McDonald v. Secretary of Health and Human Servs.*, 795 F.2d 1118, 1124 (1st Cir. 1986).

If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. 20 C.F.R. § 416.920 (5)(c). We will not consider your age, education, and work experience. *Id*. The second step analysis will begin with a summary of presented medical documentation and Petitioner's testimony.

Hospital documents (Exhibit 1, pp. 239-250) from an admission dated [redacted], were presented. It was noted that Petitioner presented with complaints of depression. A history of bipolar disorder and polysubstance abuse was also noted. It was noted that Petitioner was homeless for 25 days (since an argument with a boyfriend). It was noted Petitioner was supposed to be taking medications, but was not. It was noted that Petitioner was also recently assaulted by two men. At admission, Petitioner's GAF was assessed to be 40. Petitioner was admitted for psychiatric treatment. During admission, it was noted Petitioner experienced cocaine withdrawal and PTSD flashbacks. Discharge medications included Lithobid, Lexapro, Lamictal, Risperdal, Trazodone, Albuterol, Cogentin, and Seroquel for anxiety. Petitioner's GAF at discharge was 45-50. A 12-step program was recommended. A discharge date of [redacted], was noted.

Hospital documents (Exhibit 1, pp. 451-456) from an admission dated [redacted], were presented. It was noted that Petitioner was brought by a friend. A complaint of drug use possibly laced with something was noted. Petitioner was admitted based on reports of suicidal ideation. A discharge date of April 16, 2016 was noted.

An MRI report of Petitioner's cervical spine and brain (Exhibit 1, pp. 448-450) dated [redacted], was presented. A moderate disc protrusion at C5-C6 was noted. A disc herniation possible causing mild cord compression was noted at T2-T3. Stenosis was noted to be absent. An impression of a signal consistent with acute mastoiditis was noted in a brain MRI report.

Hospital documents (Exhibit 1, pp. 294-343, 379-385, 410-412) from an admission dated [redacted], were presented. It was noted that Petitioner presented following a motor vehicle accident. It was noted Petitioner reported she was the passenger in a vehicle that was t-boned and pushed into a tree. Neck pain and a headache were reported. A thoracic spine fracture at T11-T12 was diagnosed. Discharge instructions advised no pushing/pulling, no bending, no lifting more than 10 pounds, and frequent walking. A back brace was prescribed to assist in bone fusion. A discharge date of [redacted], was noted.

Hospital emergency room documents (Exhibit 1, pp. 344-351, 413-414) from an admission dated [redacted], were presented. It was noted that Petitioner presented with a change in mental status. It was noted Petitioner was positive for cocaine and cannabis.

Various hospital treatment records (Exhibit 1, pp. 352-377) from [redacted] were presented. Treatments for asthma, bipolar disorder, upper abdominal pain, pregnancy, and a brain cyst were noted.

Hospital documents (Exhibit 1, pp. 259-290) from an admission dated [redacted], were presented. It was noted that Petitioner presented while 8 months pregnant and a complaint of "something wrong with her head". It was noted Petitioner reported homelessness for the past week. Medication noncompliance was suspected. Petitioner received various meds and psychological treatment throughout hospitalization. Noted discharge diagnoses included bipolar disorder and cocaine dependence. Petitioner's GAF at discharge was 40. A discharge date of [redacted], was noted.

Various Michigan Department of Correction (MDOC) medical treatment documents from 2010-2015 (Exhibit 1, pp. 556-1399) were presented. Regular bipolar disorder treatment with medication and group therapy was noted. Petitioner's reported symptoms included flightiness, disorganization, concentration difficulties, fatigue, hopelessness, mood swings. Treatment for Raynaud's syndrome, foot lesions, eye twitching, knee pain, foot swelling, calf pain, breast pain, GERD, hepatitis C, rash, herpes, abdominal pain, back pain, and asthma was noted.

MDOC medical treatment documents (Exhibit 1, pp. 1401-1412) from [redacted] were presented. Treatment for Raynaud's Syndrome with Norvasc was noted; gloves and warmer clothing was recommended to prevent tissue injury. A Proair inhaler was refilled for asthma. Treatment for a rash and constipation was also noted.

MDOC medical treatment documents (Exhibit 1, pp. 1418-1423) dated [redacted], [redacted] were presented. It was noted Petitioner complained of mood swings, irritability and sleep disturbance. Petitioner's GAF was noted to be [redacted] as of [redacted], Axis I diagnoses of mood disorder, ADHD, PTSD, and cocaine dependence were noted. Mental status exam assessments included no sign of psychosis, clear speech, intact memory, fair impulse control, fair judgment, and fair insight. Various medications were adjusted.

MDOC medical treatment documents (Exhibit 1, pp. 1427-1454) from [redacted] were presented. Stabilized asthma symptoms and frequent skin color change due to Raynaud's Syndrome were noted (see Exhibit 1, p. 1438). GERD symptoms were noted to be mild. Mental status assessments were unremarkable (see Exhibit 1, p. 1449). Gynecological and mouth sore treatments was also noted.

MDOC medical treatment documents (Exhibit 1, pp. 1455-1476) from [redacted] were presented. It was noted Petitioner began group treatment with Beyond Violence in anticipation of parole (see Exhibit 1, p. 1456). Treatment for a mouth infection was also noted. On [redacted], Petitioner reported depressed mood, poor concentration, fatigue, loss of energy, and sleep disturbance; Petitioner's medication was adjusted.

MDOC medical treatment documents (Exhibit 1, pp. 1477-1491) from [redacted] were presented. Asthma and gynecological treatment was noted. A complaint of eyes turning yellow was noted.

MDOC medical treatment documents (Exhibit 1, pp. 1488-1510) from [redacted] were presented. Treatments for yellow eyes, body bruising, increased heartburn, mouth ulcers, and left ear bites accompanied by head pain were noted. It was noted Petitioner completed all sessions with Beyond Violence. On [redacted], Petitioner reported impatience, fatigue, fearful thoughts, anxiety, diminished interest, and restlessness. Active medications included melatonin, clonidine, venlafaxine, topiramate, and Strattera.

MDOC medical treatment documents (Exhibit 1, pp. 1511-1520) from [redacted] were presented. Treatment for asthma and mouth ulcers was noted.

MDOC medical treatment documents (Exhibit 1, pp. 1524-1526) dated [redacted], were presented. Complaints of anxiety, fearful thoughts, poor concentration, and indecisiveness were noted. Mental health assessments included euthymic mood, intact memory, fair reasoning, fair impulse control, fair judgment, fair insight, unremarkable

thought content, and intact memory. Active medications included melatonin, clonidine, Trileptal, Effexor, venlafaxine, topiramate, and Strattera.

MDOC medical treatment documents (Exhibit 1, pp. 1529-1544) from [redacted] were presented. Treatment for ear pain, spider bite on arm, and asthma was noted.

MDOC medical treatment documents (Exhibit 1, pp. 1545-1565) from [redacted] were presented. Moderate persistent asthma was noted; normal respiratory effort was noted. Heartburn and skin color changes of digits and toes were noted. Various medications were continued.

MDOC medical treatment documents (Exhibit 1, pp. 1566-1568) dated [redacted] were presented. Unspecified sleeping problems were noted. Mental status examination assessments included loud speech, labile affect, labile mood, fair judgment, fair insight, logical thought content, and intact memory. It was noted Petitioner appeared to be hypomanic. Strattera was discontinued.

MDOC medical treatment documents (Exhibit 1, pp. 1569-1586) from [redacted] GERD symptoms were noted to be relieved by medication and Tums. Cold weather was noted to exacerbate Raynaud's Syndrome symptoms. Asthma treatment was noted.

MDOC medical treatment documents (Exhibit 1, pp. 1587-1605) from [redacted]. Dental treatment and medication refills were noted.

MDOC physician office visit notes (Exhibit 1, pp. 1608-1610) dated [redacted], were presented. Depression follow-up was noted. Petitioner reported anxiety, scattered thoughts, improved sleep, and low depression. Effexor and clonidine were increased

MDOC physician office visit notes (Exhibit 1, pp. 1612-1614) dated [redacted], were presented. Asthma follow-up was noted. Complaints of cough, dyspnea, and wheezing were noted. Excedrin was prescribed for complaints of nausea and light sensitivity. An abdominal rash in skin folds was reported though not seen.

MDOC physician office visit notes (Exhibit 1, pp. 1616-1645) dated [redacted], through [redacted], were presented. Petitioner reported 8/10 abdominal pain. X-rays were negative. It was noted Petitioner had a "big BM" on [redacted] and that symptoms were not resolved. Lab work was negative. On [redacted], pain was reportedly 5/10. On [redacted], Petitioner reported numerous unrelated abdominal complaints.

MDOC physician office visit notes (Exhibit 1, pp. 1646-1648) dated [redacted], were presented. Mental status assessments included fair judgment, fair insight, logical thought process, euthymic mood, and appropriate affect. Medication adjustments were noted.

MDOC physician office visit notes (Exhibit 1, pp. 1650-1652) dated [redacted], was presented. Follow-up for abdominal pain was noted. Petitioner reported ongoing abdominal pain. Evaluation for constipation was noted as needed before an ultrasound could be performed. Reports of Petitioner "cheeking" medication were noted. Low trileptal levels were noted.

An x-ray report (Exhibit 1, p. 1654) dated [redacted], was presented. An impression of constipation was noted.

MDOC physician office visit notes (Exhibit 1, pp. 1658-1660) dated [redacted], were presented. It was noted Petitioner was not taking Topamax due to side effects. Low trileptal levels were attributed to medication noncompliance.

MDOC physician office visit notes (Exhibit 1, p. 1671) dated [redacted] were presented. Treatment for a UTI was noted. A recommendation of drinking liquids was noted.

MDOC physician office visit notes (Exhibit 1, pp. 70-72, 1688-1690, 1753-1755) dated [redacted], were presented. Treatment for blood pressure elevation and urinary tract infection was noted. Various meds were prescribed.

MDOC physician office visit notes (Exhibit 1, pp. 1700-1701) dated [redacted], were presented. A complaint of shooting lumbar pain was noted. Heat application was performed. Petitioner advised to follow-up if pain persists.

MDOC physician office visit notes (Exhibit 1, pp. 1706-1710) dated [redacted], were presented. Asthma was noted to be "good". Naproxen and ibuprofen were prescribed for cervicalgia. Petitioner reported ongoing arm pain on [redacted] (see Exhibit 1, p. 1713).

MDOC physician office visit notes (Exhibit 1, pp. 73-74, 1756-1757) dated [redacted] were presented. Ongoing psych treatment was noted. Observations and assessments included clear speech, appropriate affect, intact memory, euthymic mood, fair impulse control, fair judgment, and fair insight. Axis I diagnoses included mood order, cocaine dependence, and PTSD. Petitioner's GAF was [redacted] as of [redacted] Topamax was prescribed to stabilize mood; Trileptal and venlafaxine were also prescribed. Follow-up in 3 months was planned.

An Initial Bio-Psycho-Social Assessment (Exhibit 1, pp. 491-497) dated [redacted], was presented. It was noted Petitioner was released from prison one week earlier and sought reconnection to mental health services. Reported symptoms included sleep difficulties, and impulsive behavior (e.g. sexual binges, thievery). Substance abuse was noted to be absent for 10+ years. Suicidal ideation was notably absent. Mental health assessments included pressured speech, elevated mood, fair judgment, fair impulse control, and fair-to-good insight. Psychiatric evaluation was planned.

A Psychiatric Evaluation (Exhibit 1, pp. 540-546) dated [redacted], was presented. Assessments included hyper-verbal speech, flight of ideas, euphoric affect, fair-to-good judgment, and fair-to-good insight. Petitioner reported sleeping 6 hours over past 2 weeks since prison discharge. Petitioner denied depression symptoms. Petitioner denied hallucinations. A history of PTSD related to abuse by parent and other sexual abuse was noted. A diagnosis of bipolar disorder (manic without psychotic features) was noted. Topamax was increased to address hypomania. Clonidine was prescribed to help Petitioner sleep. Effexor was continued.

A Mental Residual Functional Capacity Assessment (Exhibit 1, pp. 68-69, 1751-1752) dated [redacted], was presented. The document was signed by a treating nurse practitioner. It was noted that Petitioner was markedly restricted in the following abilities:

- Understanding and remembering 1 or 2-step directions
- Understanding and remembering detailed instructions
- Carrying out simple 1-2 step directions.
- Carrying out detailed instructions
- Maintaining concentration for extended periods
- Performing activities within a schedule and maintaining attendance and punctuality
- Sustaining an ordinary routine without supervision
- Working in coordination or proximity to other without being distracting
- Completing a normal workday without psychological symptom interruption
- Asking simple questions or requesting assistance
- Accepting instructions and responding appropriately to criticism
- Getting along with others without exhibiting behavioral extremes
- Responding appropriately to changes in the work setting
- Being aware of normal hazards and taking appropriate precautions
- Traveling to unfamiliar places including use of public transportation
- Setting realistic goals or making plans independently of others.

Nurse practitioner office visit notes (Exhibit 1, pp. 546-551) dated [redacted], were presented. Treatment for tongue lesions was noted.

A mental health medication review (Exhibit 1, pp. 511-516) dated [redacted], was presented. Improved mood and speech was noted. Sleeping of 5-6 hours per night was noted. It was noted Petitioner can complete a task with redirection and verbal prompts. Assessments included increased speech rhythm, euthymic affect, mildly disorganized thought process, and orientation x3. Active medications included Effexor, and Topamax.

A Personal Health Review (Exhibit 1, pp. 517-521) dated [redacted], was presented. Petitioner reported no pain. Establishing care with a primary care physician was recommended.

Mental health treatment plans (Exhibit 1, pp. 499-505) dated [redacted], were presented. Treatment plans included individualized therapy, medication reviews, and case management.

A mental health medication review (Exhibit 1, pp. 506-510) dated [redacted], was presented. Petitioner reported 5-6 hours per daily sleep. Complaints of lack of focus, loud talking, and scattered thoughts were noted. Assessments included increased speech rhythm, euthymic affect, mildly disorganized thought process, and orientation x3. Diagnoses included bipolar disorder (manic without psychotic features). Medications were continued.

Case management notes (Exhibit 1, pp. 530-539) from [redacted] were presented. Low-income housing and court dates concerning visitation of children were noted as discussed.

Case management notes (Exhibit 1, pp. 522-529) from [redacted] were presented. On [redacted], it was noted that Petitioner had an unspecified relapse and was in a crisis center for 5 days.

Hospital emergency room documents (Exhibit A, pp. 482-484) dated [redacted], were presented. It was noted that Petitioner presented with complaints of leg wounds and a swollen tongue. Petitioner reported her leg wounds were caused after being attacked and thrown into rocks. Bactrim was prescribed. Follow-up in 3-4 days was planned.

Petitioner testified to impairments, in part, due to back pain. Petitioner testified her back pain began with a car accident from about 10 years earlier. Petitioner testified she has not yet attempted physical therapy. Petitioner testified she takes Tylenol and Flexeril to control pain.

Petitioner testimony implied impairments, in part, to breathing restrictions. Petitioner testified she was recently diagnosed with an incurable benign lung nodule. Petitioner testified she has an upcoming medical appointment to have fluid drained. Petitioner testified she smokes but is trying to quit.

Petitioner testified she experiences fatigue. Petitioner testified she believes it to be caused by hepatitis C.

Petitioner testimony implied impairments due to hand and knee joint swelling. Petitioner testified that her joint swelling is caused by arthritis.

Petitioner testified she does not rely on a cane or walker. Petitioner testified she is restricted to 7 stairs before breathing heavily. Petitioner testified that she is limited to walking ¼ mile before back and leg pain prevent further walking. Petitioner testified she

gets fidgety after 20 minutes of standing or an hour of sitting. Petitioner testified she is limited to 20 pounds of lifting.

Petitioner testified she has difficulty reaching her back when showering. Petitioner testified she has difficulty with carrying laundry. Petitioner testified she can take public transportation as she took a bus to attend the hearing.

Petitioner's hearing request alleged an unspecified problem with her ankles. The request alleged that she has recurrent sprained ankles for unspecified reasons.

Petitioner testified she last worked full-time as a waitress in [redacted] Petitioner testified she worked as a porter in prison though she only typically worked 10 minutes per day. Petitioner testified that she might be able to perform a customer service telephone job but does not know how to use a computer.

Presented medical records verified myriad treatments over 15 years. Conditions from 2015 and earlier are presumed to be resolved unless noted in subsequent documents.

Presented medical records generally verified a medical treatment history consistent with exertional restrictions due to asthma and/or lung nodule, back pain, and Raynaud's syndrome. Presented records also generally verified degrees of concentration restrictions due to psychological illness. Petitioner's treatment history was established to have lasted at least 90 days and at least since Petitioner's date of SDA application. Accordingly, it is found that Petitioner established having a severe impairment and the disability analysis may proceed to Step 3.

At the third step, we also consider the medical severity of your impairment(s). 20 C.F.R. § 416.920 (4)(iii). If you have an impairment(s) that meets or equal one of our listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, we will find that you are disabled. *Id*. If you have an impairment(s) which meets the duration requirement and is listed in appendix 1 or is equal to a listed impairment(s), we will find you disabled without considering your age, education, and work experience. *Id*. 20 C.F.R. § 416.920 (d).

Diagnoses for bipolar disorder and PTSD were noted. The SSA listing bipolar disorder justifies a finding of disability based on the following:

12.04 Depressive, bipolar and related disorders (see 12.00B3), satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1 or 2:
    1. Depressive disorder, characterized by <u>five</u> or more of the following:
        a. Depressed mood;
        b. Diminished interest in almost all activities;
        c. Appetite disturbance with change in weight;
        d. Sleep disturbance;

e. Observable psychomotor agitation or retardation;
f. Decreased energy;
g. Feelings of guilt or worthlessness;
h. Difficulty concentrating or thinking; or
i. Thoughts of death or suicide.

2. Bipolar disorder, characterized by three or more of the following:
   a. Pressured speech;
   b. Flight of ideas;
   c. Inflated self-esteem;
   d. Decreased need for sleep;
   e. Distractibility;
   f. Involvement in activities that have a high probability of painful consequences that are not recognized; or
   g. Increase in goal-directed activity or psychomotor agitation.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):
   1. Understand, remember, or apply information (see 12.00E1).
   2. Interact with others (see 12.00E2).
   3. Concentrate, persist, or maintain pace (see 12.00E3).
   4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is "serious and persistent;" that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:
   1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and
   2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

Presented medical records documented reported symptoms including pressured speech, flight of ideas, distractibility, and sleep difficulties. It is found that Petitioner meets Part A of the listing for depressive disorders.

Petitioner testified she was diagnosed with bipolar disorder, severe PTSD, and seasonal affective disorder. Petitioner testified that she is impulsive, has nightmares, and flashbacks (10 times per day). Petitioner testified she has difficulty functioning after having a flashback. Petitioner's hearing request specifically claimed that she is forgetful and lacking in focus. Petitioner testified that she often gets confused and loses her train of thought.

Petitioner's testimony was generally indicative of marked restrictions to understand information and concentration. Petitioner's testimony was generally consistent with presented evidence.

The most compelling evidence of marked restrictions was the assessment from a treating nurse practitioner of work-related abilities. Marked restrictions in understanding 1-2 step directions and carry out 1-2 step directions is highly indicative of marked restrictions to applying information. Marked restrictions in concentrating for extended periods and to performing activities within a schedule are highly indicative of marked restrictions to overall concentration.

The assessments were not accompanied by any comments to justify the restrictions. The absence of stated justification for the assessments supports rejecting the assessments.

It is notable that the nurse practitioner making the assessments had a limited history with Petitioner. Given Petitioner's first appointment with the agency making the assessment occurred less than one month earlier, the assessment appeared to be primarily based on Petitioner's reporting. The limited history with Petitioner also supports finding that Petitioner might improve with treatment; this is less of a consideration as Petitioner established a lengthy treatment history while imprisoned.

Some stated restrictions also appeared to be inconsistent with presented evidence. For example, Petitioner was found markedly restricted in using public transportation. Petitioner testimony conceded she used public transportation to attend the hearing.

Generally, physician statements of restrictions are the most reliable evidence of restrictions; this is particularly true for treating physicians. Treating source opinions cannot be discounted unless the Administrative Law Judge provides good reasons for discounting the opinion. *Rogers v. Commissioner,* 486 F. 3d 234 (6th Cir. 2007)*; Bowen v Commissioner.*

Presented evidence established that Petitioner has a lengthy history of mental health treatment. Other than Petitioner's drug relapse in [redacted], history from the past 10 years appeared to not involve drug abuse. Between regularly documented bipolar and/or PTSD symptoms, the assessments made by a nurse practitioner appear to be reasonable. It is also notable that Petitioner has a history of hypomanic episodes which is further supportive of marked restrictions. Based on the totality of the evidence, deference will be given to the assessments from the Mental Residual Functional Capacity Assessment.

It is found that Petitioner has marked understanding and concentration restrictions and that Petitioner sufficiently meets the listing for bipolar disorders. Thus, it is found that Petitioner is disabled and that MDHHS improperly rejected Petitioner's application for SDA benefits.

DECISION AND ORDER

The administrative law judge, based upon the above findings of fact and conclusions of law finds that MDHHS improperly denied Petitioner's application for SDA benefits. It is ordered that MDHHS begin to perform the following actions within 10 days of the date of mailing of this decision:

(1) reinstate Petitioner's SDA benefit application dated May 8, 2017;
(2) evaluate Petitioner's eligibility subject to the finding that Petitioner is a disabled individual;
(3) initiate a supplement for any benefits not issued as a result of the improper application denial; and
(4) schedule a review of benefits in one year from the date of this administrative decision, if Petitioner is found eligible for future benefits.

The actions taken by MDHHS are **REVERSED**.

CG/

Christian Gardocki
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

[redacted]

Petitioner

[redacted]