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

Date Mailed: April 30, 2019
MOAHR Docket No.: 19-000861
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on March 4, 2019, from Detroit, Michigan. Participants on behalf of Petitioner included the Petitioner and a witness, [redacted], the Petitioner's mother. Participants on behalf of the Department of Human Services (Department) included Donna Rojas, Family Independence Manager.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. A DHS-49-D and DHS-49-E were received and marked into evidence as Exhibit B; a DHS-49 was received from [redacted] and marked into evidence as Exhibit C; the Medical records from [redacted] were received and marked into evidence as Exhibit D. The record closed on April 3, 2019; and the matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

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

FINDINGS OF FACT

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

1. On September 10, 2018, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On November 16, 2018, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program. Exhibit A, pp. 21-24.

3. On November 19, 2018, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability. Exhibit A, pp. 484-486.

4. On January 28, 2019, the Department received Petitioner's timely written request for hearing. Exhibit A, pp. 484-486.

5. Petitioner alleged disabling impairment due to mental impairment due to Bipolar Disorder, Agoraphobia, Posttraumatic Stress Disorder and Generalized Anxiety Disorder. The Petitioner alleged physical disabling impairments including fibromyalgia, diabetes type II, cervical nerve pain right side, diabetic neuropathy of the bilateral feet and degenerative disc disease.

6. On the date of the hearing, Petitioner was [redacted] years old with an [redacted], birth date; she is [redacted] in height and weighs about [redacted] pounds.

7. Petitioner completed the seventh grade and participated in special education classes from the fourth through the sixth grades.

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

9. Petitioner has no history of gainful employment.

10. 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 90 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 1

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 2

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 Department presented this SDA application denial to the undersigned based upon its Notice of Case Action as denied due to Petitioner being found not disabled. The DDS also noted that forms were not returned by Petitioner in their denial of disability; however, this basis for the denial of the application was not presented at the hearing, and the case was analyzed based upon

the medical evidence presented, as well as additional medical evidence obtained by the Department pursuant to the interim order issued in this case.

The Petitioner receives mental health treatment services from [redacted]. On [redacted] 2019, Petitioner was seen for a psychiatric evaluation to monitor effectiveness and safety of currently prescribed psychotropic treatment regimen.

The assessment included information from multiple sources, including consumer self-reported information, consultation with treatment team, information contained within available collateral records for [redacted] and others. The evaluation indicates that Petitioner was referred by her primary care provider, [redacted], [redacted] through [redacted]. Records indicate that Petitioner has been treating with a therapist prior to the evaluation. The primary care physician noted bipolar disorder with previous episodes of psychosis, mood dysregulation, anger/agitation, depression, misperception, paranoia and severe and incapacitating anxiety. Patient self-reported a worsening of symptoms in 2017 as she was discharged from her former provider and was not on medications. Worsening symptoms included obsessive and intrusive thoughts and severe anxiety. She started working with her primary care office in 2018, and medications were restarted. Symptoms have improved with an addition of several medications, including Seroquel and Cymbalta. Symptoms continue to be problematic and incapacitating, however.

Notes indicate Petitioner has struggled for many years with incapacitating Agoraphobia and anxiety. Patient isolates at home and avoids social contact. Patient rarely leaves home other than to attend critical appointments with the support of her mother. It has been several years since she has gone grocery shopping. Previously, patient was not following up with medical issues due to anxiety and other mental health symptoms; however, this has improved over the past year. Notes indicate anxiety and other mental health symptoms have prevented Petitioner from connecting with friends, prevented her from having age-appropriate romantic attachments, prevented involvement in social activities and inability to hold a job or live independently. Her symptoms worsened in recent months due to severe psychosocial stressors, including the death of her therapy dog recently, recent health stressors and worsening family dynamics as well as dysfunctional interpersonal relationships. Patient reports irritability, panic attacks, mood dysregulation, paranoia and intrusive thoughts. Patient also reports a history of psychosis, including auditory hallucinations, paranoid ideations, delusions and manic episodes associated with her bipolar diagnosis requiring involuntary inpatient hospitalization for stabilization of psychiatric symptoms, previous court-mandated mental health treatment, previous issues with non-adherence to treatment recommendations and limited insight.

Report indicates Petitioner's early years marked with extremely dysfunctional family dynamics, extensive behavioral concerns amongst her siblings, separation from family due to multiple episodes of involvement in residential services, instability and functional limitation in multiple domains. Negative past interactions between Petitioner and

previous providers have contributed to difficulty with obtaining documentation related to extensive past mental health treatment history. Petitioner struggles with trust which limits the amount of information she will initially disclose to providers, leading to initial underreporting of symptoms and functional limitations. Notes further indicate that Petitioner has been in the process of applying for Social Security Disability benefits over an extended period of time with delay in approval likely due to fragmentation of care, difficulty with recollection of extensive details of past treatment in symptoms, and difficulty with appropriate communication and inability to adequately advocate for her needs. Patient reported several periods of over-medication for a number of years and has little or limited recollection of that time. Petitioner has had brief episodes of employment but lost the job shortly after starting due to emotional reactivity, mood dysregulation and anger, impulsivity, and other secretly associated with her mental health symptoms.

Petitioner reported a history of residence at [redacted] for approximately one year at age [redacted] due to mental health issues. Second [redacted] residential placement for four months around age [redacted]. In 2011 an involuntary inpatient placement was made at [redacted] due to psychosis and mood instability. 2012 involuntary placement at [redacted] for approximately eight days due to psychosis and mood instability. Records indicate numerous attempts at various medications. During the exam, the Petitioner appeared dressed appropriately and was cooperative with slowed activity with an anxious mood and restricted affect. The Petitioner reported no suicidal or homicidal ideation. Her associations were circumstantial, and her judgment was noted as impaired as well as insight limited. Both her recent and remote memory did not appear to be intact due to health issues, history of trauma, cognitive secretly of long-standing use of psychotropic medications and multiple psychotic breaks. She was able to concentrate. The diagnosis was bipolar disorder recurrent episode depressed, severe without psychotic features. Agoraphobia, posttraumatic stress disorder, generalized anxiety disorder with other health considerations as noted in the report from her primary care physician. The diagnostic impression was, symptoms and history are consistent with the diagnosis as listed additional verification and coordination with therapist confirm diagnostic agreement. Access to collateral information will help to confirm past diagnosis. Symptoms approved over baseline but continue to cause problematic impairments in multiple domains. The treatment plan was a recommendation that patient continued participation in psychotherapy sessions and engage in all aspects of treatment plan for ongoing mental stability. Notes indicate that Petitioner's BMI was 48.74 on the date of the examination. A list of Petitioner's numerous medications appears in Exhibit B, p. 12 of 27.

A mental residual functional capacity assessment was completed by a board- certified Psychiatric Mental Health Nurse Practitioner on [redacted] 2019.

On [redacted] 2019, Petitioner's mental health provider, Hope Network, through its Certified Psychiatric Mental Health Nurse Practitioner certified the following assessment. Psychiatrist also completed a mental residual functional capacity

assessment, DHS-49-E, regarding Petitioner's mental impairments and how they affected her activities. The assessment concluded that Petitioner had **moderate** limitations regarding Understanding and Memory with regard to her ability to remember locations and work-like procedures, ability to understand and remember one- or two-step instructions and ability to understand, remember detailed instructions.

With respect to Sustained Concentration and Persistence, the Petitioner was evaluated as moderately limited in her ability to carry out simple one- or two-step instructions and ability to make simple work-related decisions, but markedly limited in her ability to carry out detailed instructions and to maintain attention and concentration for extended periods; ability to perform activities within a schedule, maintain regular attendance and be punctual within customary tolerances; ability to sustain an ordinary routine without supervision; ability to work in coordination with or proximity to others without being distracted and ability to complete a normal workday and worksheet without interruptions from psychologically-based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.

The Assessment further indicated the Petitioner was moderately limited with respect to Social Interaction in her ability to ask simple questions or request assistance, however she was evaluated as markedly limited in her ability to interact appropriately with the general public, the ability to accept instructions and respond appropriately to criticism from supervisors, the ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes and the ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness. With respect to Adaptation, the assessment indicated the Petitioner was markedly limited in her ability to respond appropriately to changes in the work setting and her ability to travel in unfamiliar places or use public transportation. She was moderately limited in her ability to set realistic goals or make plans independently of others and not significantly limited in her ability to understand normal hazards and take appropriate precautions.

At the conclusion of the Assessment, the comments noted Petitioner's mental health symptoms are chronic and incapacitating. She has not been able to sustain employment for any significant length of time despite a desire to do so. Agoraphobia, mood dysregulation and emotional reactivity, misperceptions and other mental health issues are present.

The Psychiatric, Psychological Examination Report, DHS-49-D was also received and was completed by a Board Certified Psychiatric Mental Health Nurse Practitioner based upon the Psychiatric Evaluation completed by Petitioner's psychiatrist, [redacted], and referenced above in this section of the Hearing Decision for [redacted] 2019. The Petitioner's weekly psychotherapist was also consulted. The report begins with a general observation that Petitioner was unable to come to the appointment by herself due to her anxiety and paranoia and was brought to the appointment by her mother. Exam Report notes that Petitioner has chronic mental health symptoms since childhood continuing throughout life span with multiple inpatient placements and medication trials

due to instability of symptoms. The current treatment and medications indicate psychotherapy participation weekly and multiple psychotropic medications as noted within the psychiatric evaluation referenced earlier. With respect to daily functioning, the exam report notes severe impairments unable to socialize, go out in public, develop/maintain friendships, live independently, or follow up to full extent needed for complex health issues. The Diagnosis indicates bipolar disorder severe, agoraphobia with panic disorder, posttraumatic stress disorder-chronic and generalized anxiety disorder with a current GAF score of 35.

Petitioner began treating with her current mental health provider in June 2018.

Prior to her current mental health provided Petitioner was seen at [redacted] and was seen for evaluation in February 2017. Petitioner completed a reported course of treatment from 2012 through May 2017 at which time she indicated she was discharged from treatment due to misbehavior. Petitioner appears to have started with the treater in September 2016 and a diagnosis of bipolar disorder and generalized anxiety disorder was made. At the time of the evaluation, the Petitioner reported she was in special education classes beginning in the fourth grade and quit school in the seventh grade as she had comprehension issues that interfered with her learning. At that time, she reported never having a significant relationship or history of dating and basically isolated herself with her dog. She uses her support dog 24 hours a day. Notes also indicate she does not attend church due to her anxiety. Petitioner's two brothers are also diagnosed with mental health problems, including her twin brother who has schizophrenia and another brother who has bipolar one. Petitioner reported she could read and write although comprehension was limited and would not sit down and read a book due to her limitations. Petitioner also reported trauma history including domestic violence, verbal emotional abuse, sexual abuse and molestation. Petitioner described a household where every day violence was present, including a brother who threw ammonia in her mother's eyes and a sister who broke a bottle over her mother's face. She was also sexually abused by a paternal grandfather. At age [redacted], she was institutionalized for one year and reported inpatient psychiatric inpatient stay for at least six times for suicidal and homicidal ideation. At the time of the interview, she was most affected by depression and anxiety characterized by isolation, disrupted sleep patterns and difficulty engaging in treatment. She is highly anxious as well characterized by spending all her time indoors with symptoms of panic when she leaves her home feeling jittery and dizzy when triggered. Notes further indicate she has abstained from medical marijuana so that she can qualify for treatment at a pain clinic. Petitioner also suffers from destructive anger, including breaking a television and picture window. Petitioner also has limited healthy emotional support due to her mother's own untreated mental illness. At the time, the Petitioner was subscribed Cymbalta Depakote and Seroquel as well as Buspirone.

A review of earlier medical treatment records for 2016 indicate that the Petitioner was seen at [redacted] and treated for obesity, fatigue, thoracic spine pain, anxiety, paresthesia's, diabetes, lumbar spine pain, left hip pain, fibromyalgia and chest pain.

The Petitioner was evaluated for bariatric surgery at which time she was super morbidly obese, BMI 50.

The Petitioner was seen at Michigan Pain Consultants for pain treatment due to low back pain radiating to the legs and thighs. The patient also complains of pain throughout her body including right shoulder, left lower back and left knee. At the time, she was on a low dose of Gabapentin and Desipramine. After a physical exam, the assessment was insomnia, fibromyalgia, chronic fatigue syndrome, sacroiliitis, agoraphobia anxiety, alcohol abuse episodic, type II diabetes cannabis use, morbid severe obesity inter-vertebral disc degeneration lumbosacral region and spinal stenosis with lumbar radiculopathy and body mass index of more than 50 during the lumbar examination pain was worse with range of motion and sacroiliac joints are provocative bilaterally. Trigger point tenderness present in the bilateral paralumbar musculature. In the thoracic spine area trigger point tenderness was present in the left parathoracic musculature. After the completion of the exam, Gabapentin dose was increased; and a prescription for Desipramine was written. In addition, the Petitioner received in a transforaminal epidural at L5-S1 and right trapezius trigger point injection. Due to her mental health condition, no opioids were prescribed. Her Neurontin prescription was also increased. The Petitioner also received a sacroiliac joint injection bilaterally in February 2017, the Petitioner continued to receive injections for approximately six months during the period January 2016 through January 2017.

The Petitioner completed a Function Report for the Social Security Administration. With regard to her condition, she stated that she could not sit, stand or move around for more than 15 minutes with low back pain and hip pain as well as right shoulder neck. At the time, she was getting nerve injections which were not helping much. Also noted was pain in lower legs and her big toes. Also noted was depression and Agoraphobia with anxiety with panic attacks. Also was reported that sleep was interrupted, and she awakened at 2 PM daily. At the time of the completion of the form, notes indicate that the mother helped her with laundry because she cannot bend or carry as well as her mother doing most of the chores. Social anxiety was also mentioned as inhibiting the Petitioner's ability to go outside in public. Notes also indicate, spends most of her time in bed, 22 hours daily. Petitioner also reported having no friends and is essentially a loner with a strained relationship with most of her family. Petitioner also stated she could not lift more than 10 pounds.

Petitioner was seen by [redacted] on [redacted] 2018, due to low back pain. In addition, Petitioner had an infected nail bed of her toe. Complaints of low back pain assessed as acute and without sciatica. Hair loss and obesity, BMI 49.5, were also noted; and a referral to endocrinology was made. In June of 2018, the Petitioner was seen again at [redacted] and had neck and lower back pain and was on wait list for pain clinic. Neurontin and Flexeril were prescribed as was an MRI for her back and neck. The Petitioner had a positive straight leg raise on left, negative on right, numbness to digits 4 and 5 bilaterally, negative tinels. Petitioner's affect was flat with

poor insight. Cervicalgia was diagnosed and an MRI of cervical spine and lumber spine were ordered.

An MRI of the cervical spine was conducted on [redacted] 2018. The Impression was no acute fracture or subluxation with central C5-C6 and C6-C7 small central disc protrusions with no central canal or neuroforaminal stenosis demonstrated. An MRI of the lumbar spine was also conducted on August 6, 2018. The Impression was disc abnormalities at L3-4, L4-5 and L5-S1 without suspicion of neural impingement. At L3-4 there is diffuse protrusion with slight right paracentral extrusion into the right sub-articular space with no suspicion of significant compromise of the right sub articular space. Central canal, left sub articular space and bilateral foramina are widely patent. At L4-5, there is diffuse protrusion/borderline extrusion with mild facet hyper trophy present. No significant compromise of the central canal, subarticular space or neural foramina. At L5-S1, small disc protrusion central with ample canal, subarticular space and foramina bilaterally.

The Petitioner was seen at [redacted] on [redacted] 2018, to review her MRIs and Gabapentin dosage which had not been increased since June 2018. At the time, the Petitioner reported spending most of her time in bed due to pain. Notes report that she was discharged from [redacted] due to leaving appointments early and missing appointments. Patient reported symptoms of hypoglycemia, including dizziness, lightheadedness and irritability. Patient is not checking blood sugar daily. Patient was also reported to be on statin therapy. The problems identified were listed as uncontrolled insulin-dependent type 2 diabetes mellitus, neuropathy with fibromyalgia bilateral hip pain, hypertension, hyperlipidemia and circulation disorder of lower extremity and morbid obesity, BMI 48.58.

Petitioner was also seen on [redacted] 2018, by [redacted] with complaints of burning abdominal pain and upper back pain. Complaints also for sharp stabbing pain in her flanks since October, which comes on all of a sudden and then stops after a couple of minutes. Her physical exam noted mild mid-spine tenderness in upper thoracic spine with no edema and was noted as obese. PT recommended for thoracic pain. After a lengthy visit, the Petitioner left the appointment prematurely due to frustration and appears unwilling to attempt physical therapy to improve her functioning.

Petitioner was seen again on [redacted] 2019, at [redacted] and reported chronic fatigue and dizziness on standing or standing for too long. Petitioner also reports chronic anxiety much worse due to therapy dog passing away. Patient reported diffuse polymyalgia bilateral, affecting large and small joints alike without joint swelling or deformity and burning neurologic pain in bilateral feet and in many of patient's joints. The Assessment was Type 2 diabetes with complication, Vitamin D deficiency, Iron deficiency, Polymyalgia, pseudotumor cerebri, Hypertension and Fibromyalgia. Petitioner was recommended to walk around her house 10-15 minutes daily.

Suggested finding a new therapy dog as the last one died. The notes indicate that hair loss is suspected due to increased anxiety.

The Petitioner's primary care physician, [redacted] who has seen her since 2011 but who had not had contact with the patient since [redacted] 2018, completed a Medical Examination Report on April 1, 2019. The Current diagnosis was diabetes mellitus type II, vitamin D deficiency, fibromyalgia, polymyalgia and pseudotumor cerebri. Petitioner is also morbidly obese with a BMI of 48.74. The doctor noted that his clinical impression was that the Petitioner was deteriorating. The following limitations were imposed: the Petitioner could lift/carry up to 50 pounds frequently, could stand and/or walk at least two hours of an eight hour day and sit six hours in an eight hour day. The Petitioner was capable of using both hands and arms with no limitation and could operate foot/leg controls with either foot. The findings supporting the physical limitations were the patient has a sedentary life style, refuses physical therapy and has seen multiple pain clinics. The notes indicate Petitioner cannot meet her needs in the home. The report completed by this doctor is noted to be inconsistent in its answers.

On [redacted] 2018, [redacted] reviewed blood lab results and noted CRP was mildly elevated, otherwise, autoimmune work-up is unimpressive. Patients pain most likely due to deconditioning and previous diagnosis of fibromyalgia. Patient would benefit from exercise therapy and PT referral possibly aqua therapy.

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step 3

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.

In this case, the Petitioner presents with lifelong mental health problems starting a with a year-long institutional placement at age [redacted]. Petitioner did not complete school beyond 6th grade and has ongoing chronic mental health problems outlined above in the medical evidence review above with a current GAF score evaluated at 35. The Petitioner's diagnosis includes Bipolar I disorder with depression, Generalized Anxiety and Agoraphobia. Her current doctor and therapist have also found her to be markedly limited in several important areas of her functioning and demonstrate functional limitation(s) which interferes with a Petitioner's ability to function independently,

appropriately, effectively, and on a sustained basis. See Step II above, Mental Residual Functional Capacity Assessment and Psychiatric Evaluation.

Based on the medical evidence presented in this case, listings 12.04 Depressive, Bipolar and Related Disorders and 12.06 Anxiety and Obsessive-Compulsive Disorders were both considered. The medical evidence presented does demonstrate that the Petitioner's impairments meet or equal the required level of severity of Listing 12.04 of the listings in Appendix 1 to be considered as disabling without further consideration.

Therefore, the medical evidence shows that Petitioner's impairment of Depressive Bipolar Disorder diagnosis 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.

DECISION AND ORDER

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.

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 September 10, 2018, SDA application to determine if all the other non-medical criteria are satisfied and notify Petitioner of its determination;

2. Supplement Petitioner for lost benefits, if any, that Petitioner was entitled to receive if otherwise eligible and qualified;

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

LMF/jaf

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

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

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

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention:
MOAHR Rehearing/Reconsideration Request.

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

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

DHHS

Kimberly Kornoelje
MDHHS-Kent-Hearings

Petitioner

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

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