[redacted]

Date Mailed: February 6, 2020
MOAHR Docket No.: 19-011776
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. After due notice, a telephone hearing was held on December 9, 2019, from Detroit, Michigan. The Petitioner was represented by herself. The Department of Health and Human Services (Department) was represented by Amber Gibson, Hearing Facilitator.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Exhibit B was received from the Department after the hearing and was part of the medical packet prepared by the Department but was not included in the DHS hearing packet. Exhibit C was received and marked into evidence and contains medical treatment records of Petitioner including psychological evaluations. The Interim Order requested a DHS-49-D and DHS-49-E be completed by Petitioner's therapist and a DHS-49 be completed by Petitioner's treating Nurse Practitioner. The requested documents were not received**.** The record closed on January 8, 2020; and the matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

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

FINDINGS OF FACT

1. On [redacted] 2019, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On May 17, 2019, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 9-7).

3. On September 10, 2019, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit A, pp. 4-8).

4. On [redacted] 2019, the Department received Petitioner's timely written request for hearing (Exhibit A, p. 3).

5. Petitioner alleged disabling impairment due to fibromyalgia which she alleged at the time of the hearing had become severe in the last six months, and spinal stenosis, sciatica and history of ruptured and herniated disc in 2010. The Petitioner has not treated for her back since 2010 and exercises to strengthen her back. Petitioner has plantar fasciitis in left foot affecting her walking and standing. The Petitioner also has alleged mental impairments due to major depressive disorder and suicide attempt in November 2019 and another attempt in 1997 when her father died, and as well in high school and in her twenties. The Petitioner's alleged that her mental impairments include Major depression, Anxiety with panic attacks, agoraphobia ADD and OCD, and headaches, PTSD and Borderline Personality Disorder. Petitioner also alleges that shehas tardive dyskinesia from long-term antipsychotic medication use and was observed shaking during the hearing.

6. The Petitioner has alleged that she has physical impairments which include fibromyalgia, and lumbar spinal stenosis but the medical evidence and medical documentation of these conditions do not support signs or symptom, nor were testing records available or other medical documentation giving a longitudinal basis of the alleged condition other than diabetes which is controlled. The record contains a recent examination for fibromyalgia by Petitioner's Nurse Practitioner based on the Petitioner's self-reporting with alleged onset for two years. The Petitioner has not seen a neurologist with respect to her condition, and no evidence of the condition of her spine was available or presented.

7. On the date of the hearing, Petitioner was [redacted] years old with a [redacted], 1965 birth date; she is [redacted] in height and weighs about [redacted] pounds.

8. Petitioner is *a* high school graduate and completed several semesters of community college and completed a Registered Medical Assistant Certificate from [redacted] in [redacted] Michigan.

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

10. Petitioner has an employment history of work as a medical assistant; she last worked in August 2004 and performed charting, calling in prescriptions and

scheduling doctor home visits, consisting of mostly desk and phone work as well as training new medical assistants. The Petitioner had a breakdown and had to quit as she was having fantasies of murdering her boss.

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

CONCLUSIONS OF LAW

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

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

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

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

In general, the individual has the responsibility to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20

CFR 416.912(a); 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

Step 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, s/he 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 was reviewed and is summarized below.

The Petitioner was evaluated face-to-face on [redacted], 2019, in a consultative psychological evaluation and formal mental status examination as requested by the Disability Determination Services. During the examination, the Petitioner described her symptoms to include extreme nervousness, fear, insomnia, G.I. issues, panic attacks, lots of crying and does not like going places or new people because she cannot stand the stress. The Petitioner also reported tremendous fears of abandonment, chronic emptiness, impulse control issues, marked mood lability and other symptoms of borderline personality disorder. The Petitioner also reported binge eating and being addicted to food without purging. At the time of the psychological examination, the Petitioner was in therapy. The Petitioner expressed that she could no longer work due to the stress of it and being told what to do and that negative feedback makes her want to “beat the shit” out of the person or run away from the situation. This stress level then causes her to binge eat. After incidents such as these, the Petitioner described herself as isolating, going to bed and staying there. The Petitioner also reported being on Facebook most of the day. The Petitioner presented as anxious and fidgety, but polite. She was cooperative and exhibited good contact with reality. She was not significantly distracted or inattentive at any time and gross motor activity and gait appeared normal. Adequate insight was exhibited, and there was no effort notice to exaggerate or minimize symptoms. There was no behavioral evidence of ideological, bizarre or circumstantial ideation. No pressured speech or mania was observed and thought processes were largely logical and coherent. No hallucinations, delusions or obsessions were exhibited. No suicidal intent was expressed. The Petitioner did present with a flat affect and appeared anxious and depressed with reports of hopelessness, worthlessness, reduced capacity to experience pleasure, reduced interest, isolation, irritability, impaired sleep and numerous fears and anxiety. During the examination, she reported an anxiety level of 8 on a scale of 0-10 and reported having to take Valium just to leave the house. Panic attacks were also reported, characterized by increased heart rate, sweating, shaking, nausea, vomiting, tunnel vision and feelings of choking. Other symptoms include sometimes throwing up and shaking. The results of the exam evaluation concluded that Petitioner showed a long

history of reported psychological turmoil and agitation was present. During the exam, Petitioner exhibited reduced coping skills for managing distress. The Petitioner's ability to understand, remember, apply information (remember locations, follow simple/complex instructions): was moderately limited with respect to simple instructions and was rated as markedly limited with respect to complex instructions. With respect to concentration/persistence/pace (carry out simple/detailed instructions, sustain routine, make simple work-related decisions, attendance, working a full day without rest periods): the Petitioner exhibited marked limitations. With respect to social interaction with (general public, request assistance, respond to criticism, socially appropriate behavior, asking for help when needed): the Petitioner exhibited marked limitations. With respect to adapting or managing one's self (changes in work setting, travel to unfamiliar places/public transportation, set realistic goals): the Petitioner exhibited marked limitations. The diagnostic impression was post-traumatic stress disorder, borderline personality disorder, major depressive disorder, recurrent, severe, panic disorder and binge eating disorder. The notes indicate the Petitioner is incapable of managing her own funds, and the prognosis was poor.

The Petitioner was seen on [redacted], 2019, for an office visit with her therapist due to anxiety. At this session, the Petitioner presented with anxious fearful thoughts, compulsive thought pattern, depressed mood, difficulty falling asleep, difficulty staying asleep, easily startled, excessive worry, fatigue, feelings of guilt, poor judgment, racing thoughts, restlessness and thought of death or suicide. Aggressive behavior was noted as Petitioner stated if she does not get valium and trazodone increased, she will take all of her pills. Notes indicate the patient has a strong history of personality disorder, manipulative behavior and states that she will take her medicine by the handfuls if she does not get Valium. The therapist explained that controlled substances will not be prescribed because she had broken her contract. In addition, she has reported taking medications that were not prescribed to her, taking medication and doses that have not been prescribed 93 to 20 times the dose per patient. It was further explained how increasing the milligrams of medication would put her at higher risk for overdose. Ultimately, the trazodone was increased and Paxil as well and a 30-day supply was provided with no refills, and Petitioner agreed to return within the week. The suicide risk at the conclusion of the session was rated by the therapist as a medium risk. A safety contract between the therapist and the patient was agreed to by Petitioner. The assessment and plan after the session per borderline personality disorder indicate patient agrees she will take medications as prescribed and not increase the dose. She will be referred to psychiatry; and with regard to anxiety disorder, the trazodone was increased. In addition, notes indicate that the Petitioner, upon leaving the office, was heard screaming inaudibly.

The Petitioner was seen for a therapy session on [redacted], 2019; and the diagnosis at that time was major depressive disorder, recurrent moderate, anxiety disorder unspecified and borderline personality disorder. The Petitioner was being seen due to ongoing support for depressive and anxiety symptoms, management of trauma related anger responses and maintaining daily functioning. During the meeting, the Petitioner

presented with euthymic mood, good memory normal speech with broad affect notes indicate substance use with respect to cannabis was not clinically related to significant distress. Petitioner was advised of substance use disorder services available.

The Petitioner was seen on [redacted], 2019, at [redacted] for a psychiatric diagnostic evaluation with medical services. The notes indicate, at the time of the examination, alcohol was consumed nightly with no taking of Valium on nights she has consumed alcohol. Petitioner reports trying to take one half of Valium per day instead of 1 to 2 per day. Petitioner presented as irate and emotionally labile throughout the interview. The Petitioner also reported that "Weed" is the only thing that helps with her anxiety. Notes indicate that Petitioner expressed that if the examiner did not understand using weed, she just needed to find a different provider and that she should not have told the examiner that she smoked weed and went on to say that the place was terrible. Nonetheless, Petitioner completed the session. Notes further indicate she became quite aggressive and yelled when informed she was in violation of controlled substances contract. The Petitioner was unable to accept personal responsibility on any level of the violation of the contract exhibiting minimal insight, poor coping skills, labile, intense outburst of emotions throughout the interview. The assessment was major depressive disorder recurrent, moderate anxiety disorder, borderline personality disorder and alcohol consumption binge drinking. At the conclusion of the examination, a tapering schedule for Valium was discussed, numerous additional drugs including Topamax and Seroquel for insomnia were considered. At the time of the exam the Petitioner was prescribed 5 mg of Valium, one tablet two times a day as needed. The mental status evaluation noted attitude toward the examiner was hostile, defensive, evasive, anxious, demanding and manipulative. The Petitioner's mood was anxious and irritable with an affect that was labile and included irate yelling after disclosing cannabis use. The Petitioner's speech was rapid, pressured and over productive. Thought process was circumstantial and tangential. Hallucinations were denied and thought content was within normal limits. No delusions were reported and cognition was within normal limits. Average insight was noted as minimal due to difficulty acknowledging presence of substance abuse problems and difficulty acknowledging presence of psychiatric problems. Judgment was impaired with respect to Petitioner's ability to make reasonable decisions.

The Petitioner was seen on [redacted] 2019, at [redacted] for a diabetes check; notes indicate the problem was stable and has been managed with oral medications with negatives including chest pain, weight gain and weight loss. At the conclusion of the examination and visit, the diabetes was rated as under control without complications and that Petitioner should have an annual ophthalmological exam.

The Petitioner was seen at [redacted] on [redacted], 2019, at which time she was evaluated for psychological issues and reports of over eating and will eat every night half a cake and other large portions and has been binging on food nightly. The behavior was related to a relationship ending and feelings of abandonment with chronic feelings of emptiness and use of food, alcohol or drugs to emotionally

numb herself as well as self-harm to relieve stress. During the exam, the Petitioner denied homicide or suicide ideations. The Petitioner appeared unkempt, overweight with rigid posture, average eye contact and was cooperative with the examiner. The mood was depressed with anxiety and irritability, with labile affect. No hallucinations or delusions were reported but impairment of attention and concentration were noted. Insight was noted also as minimal and judgment was impaired as was the ability to make reasonable decisions. At the conclusion of the examination, the assessment was anxiety disorder and major depressive disorder. A safety plan was also put in place should the Petitioner feel at risk of harm to herself or others. Her medications were reviewed and continued.

The Petitioner was seen at the [redacted] beginning in [redacted] 2018 through [redacted] 2019. The Petitioner was seen weekly by her therapist. In summary, the notes indicate that the Petitioner was diagnosed with borderline personality disorder and was upset about the diagnosis. Notes indicate she is self-medicating with marijuana and liquor. At such time, she does not take her medications. Throughout the notes, Petitioner presents with depression, anxiety and thoughts of suicide. Notes further indicate that her ability to cope in the world has worsened significantly since the death of her parents and is a huge factor in her behavioral issues. On weekends, Petitioner is exceedingly depressed, fails to get dressed and stays in bed. The Petitioner has expressed worries about losing her family home and has threatened suicide if that occurs. The suicidal thoughts are made without a plan; however, the Petitioner has a history of attempted suicide years ago. The notes indicate the Petitioner is engaging in destructive behaviors and irrational thoughts. The therapist notes indicate that at this time she is unable to work due to her behaviors as she flies off the handle very easily, especially if reacting to unforeseen situations. The Petitioner also exhibits irrational thoughts and paranoia.

On March 5, 2019, the Petitioner's then-therapist wrote a letter regarding the Petitioner's condition and observations having worked with Petitioner since mid-June 2018. The notes indicate that the therapist has observed that Petitioner cannot handle any sort of change. During the period of treatment, the therapist had to have spinal surgery and was unable to meet with Petitioner. When returning to work, she noted that Petitioner had regressed considerably. The Petitioner further disclosed that she has destructive anger issues and keeps people away by verbally abusing them in fits of rage, including strangers she encounters. The Petitioner also has Agoraphobia in part due to attempting to work around her irrational anger and panic attacks. In the therapist's opinion, the Petitioner could not successfully cope with the changes involved with working outside of her home. The therapist also knows that most of her coping mechanisms used are self-destructive. The notes also further indicate that several of her coping behaviors used in the past, and currently in use in November 2018, included binge eating, hair pulling and angry outbursts to strangers. During this period, the Petitioner was called for jury duty but was excused as a result of a letter from her therapist regarding her mental condition stating she is currently unable to remain calm enough to sit on a jury due to severe anxiety and panic disorder.

In May 2018, the Petitioner transferred therapists as her then-student therapist was leaving the facility. The Petitioner had been in treatment with this student therapist since [redacted] 2018, at which time, the presenting information was panic attack, anxiety and depression all expressed as a lifelong condition. The Petitioner's prior treatments included medication and therapy. Several of the former therapist's notes indicate stable mood with anxiety, but not remarkable, and at other times client's anxiety is reported at high and that client is isolating herself to her home. The student therapist diagnosed generalized anxiety disorder.

The medical records presented by way of history also include treatment for much of 2016 and 2017 for anxiety, panic attacks, depression, PTSD and trichotillomania (repeated and uncontrollable urge to pull out body hair).

The Petitioner was seen also for follow-up on lab work on [redacted] 2019, at [redacted] The Petitioner self-reported the symptoms were moderate, constantly occurring. It is unclear regarding whether the rheumatoid factor was positive. Also reported was fibromyalgia with the two-year prior onset. Pain is constant and is worsening, located in bilateral calves and arms with headache and without radiation. The pain is described as burning and throbbing. Pain is aggravated by bending, climbing and descending stairs, lifting, movement, pushing, sitting, walking and standing. Associated symptoms include joint tenderness, limp, nocturnal pain, tingling in the arms, tingling in the legs and weakness. The Petitioner is prescribed Paxil, Amantadine, Ibuprofen 800 mg, Trazodone, Naltrexone, Valium, Glucophage, Vitamin D and Simvastatin. The notes also indicate the Petitioner is positive for cardio claudication and edema, extremity weakness, tingling in arms and legs and anxiety and depression. Petitioner did have full range of motion, however, reported tenderness with light palpation to back, upper and lower extremities and lower back. The assessment/plan noted fibromyalgia with additional lab testing to be performed the assessment was alcohol use disorder moderate in early remission. This is the first and only reference to allegations of fibromyalgia in the medical records presented. No evidence of the medical condition of Petitioner's spine was presented.

The Petitioner was seen on [redacted] 2019, for bipolar disorder. At the 15-minute session, the Petitioner reported improved mood with some anxiety ongoing. The behavioral health care advocate noted fair insight and working on improving impulse control and presented with a neat appearance and full affect. Notes indicate with respect to body mass index of 35-35.9 that Petitioner lost over 200 pounds four years ago weighing [redacted] pounds and has kept the weight off. During Christmas of 2018, the Petitioner reported that she resumed eating carbs; notes indicate Petitioner's emotions were labile, worsening fatigue and neuropathy. The assessment was major depressive disorder, recurrent, moderate; anxiety disorder, unspecified and borderline personality disorder. The psychosocial stressors were rated as severe and the highest GAF Score was [redacted] as of February 26, 2019. The Petitioner was seen on [redacted], 2019, for a psychotherapy session lasting 30 minutes. During the session, the Petitioner reported improvement in housing situation with an old friend moving in and discuss the plan to

head off potential conflicts as well as distress tolerance. Also discussed was yelling at someone on the phone due to a tax bill and waiting before responding to something that is upsetting. The Petitioner was seen on [redacted] 2019, for an individual psychotherapy's session. The patient reported improved mood since utilities were restored to the house; patient presented with a bright mood, eye contact and motor activity within normal limits and no suicidal ideation.

The Petitioner was seen by her therapist on [redacted] 2019, for a 30-minute session. Notes indicate borderline personality disorder. Petitioner reported mounting stress due to no income and utilities being off at her house. At the session, notes indicate the Petitioner presented with the labile affect, limited insight, poor judgment and considering moved to San Francisco from an invitation on Facebook from a friend. Suicidal ideation was confirmed but no plans. The Petitioner was seen again on [redacted] 2019, for a 30-minute psychotherapy session. The Petitioner discussed ambivalence about her relationships and a sense of grief and loss about her home as she is not able to afford to maintain it. Petitioner reports hopelessness about staying in her home and is not ready to think about leaving. The Petitioner was seen on [redacted], 2019, for a 30-minute therapy session. During the session, the Petitioner expressed passive suicidal ideation and was tearful when discussing negative thought patterns and intense emotional responses as well as deepening depression. Also discussed that drug Paxil is effective, as is going to the gym.

The Petitioner was seen on [redacted] 2019, by the nurse practitioner at [redacted] At that time, the history of present illness indicated fibromyalgia, foot pain and immunizations were also checked. The notes indicate that the nurse practitioner discussed with Petitioner the lack of evidence to support long-term improvement regarding long-term use of benzodiazepines. The Nurse Practitioner indicated she was in agreement with prior providers who strongly encouraged Petitioner to reconsider her decision to resist tapering off of Valium. The Petitioner was also urged to start a keto-type diet. The Petitioner was encouraged to begin exercising and eating less sugars and carbohydrates.

The Petitioner was seen on [redacted] 2019, for an individual psychotherapy session; during the session, the Petitioner presented as tearful with negative thought patterns, noted intense emotional responses and deepening depression. The Petitioner reported Paxil is effective as is going to the gym and being outside. On [redacted], 2019, the notes indicate that Petitioner was seen by her current therapist for the first time based upon a referral with a diagnosis of anxiety, depression and borderline personality disorder. The Petitioner presented with anxious affect and demonstrated fair insight.

The Petitioner was seen previously at [redacted] and [redacted] in 2018. Most of the visits were routine for medication and lab reviews, follow-up on anxiety and blood pressure. The focus of the treatment appeared to be Petitioner's mental conditions.

The Petitioner testified that she has transportation problems as the insurance transportation is always late causing her to miss her appointments.

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.

Based on the medical evidence presented in this case, listings 12.04 depressive, bipolar and related disorders; 12.06 Anxiety and obsessive-compulsive disorders; 12.08 Personality and impulse-control disorders and 12.15 Trauma and stress or related disorders were considered. The medical evidence presented does not show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consid*eration.* Therefore, Petitioner is not disabled under Step 3, and the analysis continues to Step 4.

Residual Functional Capacity

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Steps 4 and 5, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s), including those that are not severe, and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4); 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). *This includes consideration of* (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).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b).

The exertional requirements, or physical demands, of work in the national economy are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a). Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools and occasionally walking and standing. 20 CFR 416.967(a). Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds; even though the weight lifted may be very little, a job is in the light category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. 20 CFR 416.967(b). Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. 20 CFR 416.967(e).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). In addition, four broad functional areas (understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself) are considered when determining an individual's degree of mental functional limitation. 20 CFR 416.920a(c)(3). The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). A four-point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. *Id.* The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. *Id.*

In this case, Petitioner alleges nonexertional limitations due to her mental impairments and diagnosis of major depressive disorder, recurrent, anxiety disorder, unspecified and borderline personality disorder. The Petitioner has alleged that she has physical impairments which include fibromyalgia, but the medical documentation does not support signs or symptom, nor were testing records available or other medical documentation giving a longitudinal basis of the alleged condition other than diabetes which is controlled and recent examination for fibromyalgia by Petitioner's Nurse Practitioner based on the Petitioner's self-reporting with alleged onset for two years. The Petitioner has not seen a neurologist with respect to her condition, and no evidence of the condition of her spine was available. Petitioner testified that she could walk five miles, and stand 5-10 minutes, she lies on the couch rather than sits much of the day; she can squat and bend at the waist a little, shower and dress herself, and can carry 20 pounds. As regards her mental impairments, Petitioner testified that she has difficulty sleeping and sleeps erratically usually arising between 10:00 a.m. and noon. Although she goes to bed at midnight, she does not sleep. Petitioner also described that has tardive dyskinesia, which is shaking due to long-term use of antipsychotic drugs including powerful drugs. The Petitioner who is five feet six inches tall currently weighs 227 pounds as of the hearing date and at one point previously weighed 425 pounds. She described herself as a binge-eater when extremely anxious. The Departmental representative also confirmed that Petitioner was shaking during the hearing and was also observed by the intake worker at the time of her application to be shaking. The medical records, however, do not report or diagnose this condition. In addition, she testified she has wanted to die since she was a little girl. When asked about her current symptoms from depression, she testified that she was sad and wants to die, eats a lot or nothing, has diarrhea and stated several times that she wished she was dead. Petitioner also testified that she recently assaulted a stranger in a [redacted] parking lot during an argument. During the hearing, the Petitioner reacted loudly and with some anger in an outburst when the undersigned attempted to clarify the purpose of her appeal which she described as an appeal to get emergency cash assistance. During an exchange where the undersigned was attempting to explain the nature and purpose of the appeal, Petitioner stated very loudly "well it's an emergency when you have no cash"; "I am having a panic attack OK". A short break was suggested, and Petitioner was able to resume participation in the hearing in less than a minute, once she was allowed to calm down. This event is mentioned solely to describe and indicate that the Petitioner does have outbursts when extremely anxious as exhibited during the above exchange at the hearing. Petitioner also testified that she does frequently have suicidal ideations without a plan. Police were called when she was at [redacted] offices when she had an outburst at the receptionist. She also described how she often, when enraged, wants to punch people and curse at them. Petitioner also described how she went to bed for several years when her mother died in 2009. Petitioner described her behavior as isolating herself except when she attends the gym and relates to people on Facebook. Normally, when in public, she is susceptible to panic attacks except at [redacted] and the gym. Petitioner also described being an empath and being able to communicate with dead people and has a being or "entity" in her basement who is mean.

A two-step process is applied in evaluating an individual's symptoms: (1) whether the individual has a medically determinable impairment that could reasonably be expected to produce the individual's alleged symptoms and (2) whether the individual's statement about the intensity, persistence and limiting effects of symptoms are consistent with the objective medical evidence and other evidence on the record from the individual, medical sources and nonmedical sources. SSR 16-3p.

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has moderate and marked limitations on her mental ability to perform basic work activities in the following areas: understand, remember, or apply information moderate; interact with others, marked limitations; concentrate, persist, or maintain pace; moderate for simple task limited step tasks, and marked if task requires detailed instructions and multiple more complex steps and Petitioner's ability adapt or manage oneself are seriously impaired due to her outbursts, her borderline personality disorder symptoms and anxiety. The record is replete with instances where the Petitioner demonstrated an inability to regulate her emotions and control her behavior and would likely be unable to do so in a work setting.

Petitioner's RFC is considered at both Steps 4 and 5. 20 CFR 416.920(a)(4), (f) and (g).

Step 4

Step 4 in analyzing a disability claim requires an assessment of Petitioner's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed by Petitioner (as actually performed by Petitioner or as generally performed in the national economy) within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1) and (2). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner's work history in the 15 years prior to the application consists of work as Medical Assistant. The Petitioner last worked in 2004. Petitioner's work as a Medical Assistant, which required standing two hours and lifting up to 10 pounds frequently, sitting six hours and minimal kneeling, crouching or climbing. As such, this job required sedentary physical ability. However, the Petitioner has limitations in her mental emotional capacity to perform basic work activities. In her position as a Medical Assistant, the Petitioner was required to schedule doctor visits, contact with the public, contact patient's for scheduling and referrals, calling in prescriptions, interacting with her supervisor and training new medical assistants. In light of the entire record, it is found that Petitioner's nonexertional RFC prohibits her from performing past relevant work.

Because Petitioner is unable to perform past relevant work, Petitioner cannot be found disabled, or not disabled, at Step 4, and the assessment continues to Step 5.

Step 5

If an individual is incapable of performing past relevant work, Step 5 requires an assessment of the individual's RFC and age, education, and work experience to determine whether an adjustment to other work can be made. 20 CFR 416.920(a)(4)(v); 20 CFR 416.920(c). If the individual can adjust to other work, then there is no disability; if the individual cannot adjust to other work, then there is a disability. 20 CFR 416.920(a)(4)(v).

At this point in the analysis, the burden shifts from Petitioner to the Department to present proof that Petitioner has the RFC to obtain and maintain substantial gainful employment. 20 CFR 416.960(c)(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services,* 587 F2d 321, 323 (CA 6, 1978).

In this case, Petitioner was [redacted] years old at the time of application and [redacted] years old at the time of hearing, and turned [redacted] during the hearing month, [redacted] 2019 and thus, is considered to be closely approaching advanced age (age [redacted]) for purposes of Appendix 2. She is a high school graduate and earned a certificate as a Medical Assistant with a history of work experience as a medical assistant.

The Medical-Vocational Guidelines, Appendix 2, do not result in a disability finding based on Petitioner's exertional RFC as her impairments concern non exertional impairments as Petitioner has impairments due to her mental condition. As a result, she has a nonexertional RFC imposing moderate limitations in her activities of daily living; marked limitations in her social functioning; marked limitations in her concentration, persistence or pace and Petitioner's ability adapt or manage oneself are seriously impaired due to her outbursts, her borderline personality disorder symptoms and anxiety.

The Department has failed to present evidence of a significant number of jobs in the national and local economy that Petitioner has the vocational qualifications to perform in light of her nonexertional RFC, age, education, and work experience. Therefore, the evidence is insufficient to establish that Petitioner is able to adjust to other work. Accordingly, Petitioner is found disabled at Step 5 for purposes of the SDA benefit program.

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 [redacted] 2019 SDA application to determine if all the other non-medical criteria are satisfied and notify Petitioner of its determination;

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

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

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 MA and/or the SDA benefit program.

LMF

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

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

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

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

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

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

Via Email:

Amber Gibson
MDHHS-Ingham-Hearings
BSC2
L Karadsheh

Petitioner – Via First-Class mail:

[redacted]