STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF: [redacted]

Claimant

Reg. No: 2010-16638
Issue No: 2009; 4031
Case No: [redacted]
Load No: [redacted]
Hearing Date:
March 2, 2010
Genesee County DHS

ADMINISTRATIVE LAW JUDGE: Landis Y. Lain

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon claimant's request for a hearing. After due notice, an in-person hearing was held on March 2, 2010. Claimant personally appeared and testified. Claimant was represented at the hearing by [redacted] Inc. This hearing will be consolidated with Register No [redacted] Case No. [redacted] Load No. [redacted] as there are two separate applications. One hearing was held for both applications and claimant and the department and claimant's representative agreed to consolidate the applications into one decision.

ISSUE

Did the Department of Human Services (the department) properly deny claimant's application for Medical Assistance (MA-P) and State Disability Assistance (SDA)?

FINDINGS OF FACT

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

(1) On May 18, 2009, claimant filed an application for Medical Assistance and State Disability Assistance benefits alleging disability.

(2) On September 30, 2009, the Medical Review Team denied claimant's application.

(3) On October 14, 2009, the claimant filed a second application for Medical A, State Disability Assistance, and retroactive Medical Assistance benefits alleging disability.

(4) The Medical Review Team denied claimant's application stating that claimant could perform other work.

(5) On December 30, 2009, the department caseworker sent claimant a notice that the application was denied.

(6) On December 30, 2009, claimant filed a request for a hearing to contest the department's negative action.

(7) On January 15, 2010, the State Hearing Review Team denied claimant's application stating in its analysis and recommendation: The evidence supports that the claimant does have limitations but none that meet or equal a Social Security Administration listings. Overall, the claimant's conditions are stable. The claimant retains the physical residual functional capacity to perform light exertional work without psychiatric limitations. The claimant's past work was medium, skilled and light unskilled. Therefore, the claimant retains the capacity to perform his pat relevant work in sales and physical therapy assistance skills are transferrable to similar occupations. MA-P is denied per 20 CFR 416.920(e). Retroactive MA-P was considered in this case and was also denied. State Disability Assistance is denied per PEM 261 due to the capacity to perform past relevant work. Listings 1.02, 1.03, 1.04, 4.02, and 5.01 were considered in this determination.

(8) On February 2, 2010, the State Hearing Review Team again denied claimant's application stating in its analysis and recommendation: The evidence supports that the claimant does have limitations but none that meet or equal the Social Security Administration Listings. Overall, the claimant's conditions are stable. This case was sent back to be reviewed and the determination expedited. There is nothing significantly different than all the previous determinations. The claimant retains the physical residual functional capacity to perform light exertional work without psychiatric limitations. The claimant's past work was medium and light un-skilled work. Therefore, the claimant retains the capacity to perform the past relevant work in sales and as physical therapy assistance skills are transferrable to similar occupations. Medicaid P is denied per 20 CFR 416.920(e). Retroactive Medicaid P was considered in this case and also denied. State Disability Assistance is denied per PEM 261 to for the capacity to perform past relevant work. Listings 1.02, 1.03, 1.04. 4.02 and 5.01 were considered in this determination.

(9) A hearing was heard on March 2, 2010. At the hearing, claimant waived the time period to request additional medical information.

(10) Additional medical information was submitted and sent to the State Hearing Review Team on March 2, 2010.

(11) On March 9, 2010, the State Hearing Review Team again denied claimant's application stating that claimant is capable of performing other work in the form of light work per 20 CFR 416.967(b) and unskilled work (20 CFR 416.968(a) pursuant to Medical Vocational Rule 202.13.

(12) Claimant is a 52-year-old man whose birth date is [redacted] Claimant is 6'3" tall and weighs 240 pounds. Claimant is a high school graduate. Claimant is able to read and write and does have basic math skills.

(10) Claimant last worked August 2009 for two weeks in a bookstore. Claimant also worked in 2007 as a designer for furniture salesperson and at [redacted] as a department manager and as a prep cook in a bakery at [redacted]

(11) Claimant alleges as disabling impairments: congestive heart failure, diverticulitis, pacemaker, lumbar degeneration, lumbar fusion, substance abuse, enlarged heart, degenerative disc disease, atrial fibrillation, hypertension, anxiety and depression.

CONCLUSIONS OF LAW

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

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the MA program pursuant to MCL 400.10, *et seq.*, and MCL 400.105. Department policies are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Program Reference Manual (PRM).

Pursuant to Federal Rule 42 CFR 435.540, the Department of Human Services uses the federal Supplemental Security Income (SSI) policy in determining eligibility for disability under the Medical Assistance program. Under SSI, disability is defined as:

> ...the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.... 20 CFR 416.905

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

If an individual is working and the work is substantial gainful activity, the individual is not disabled regardless of the medical condition, education and work experience. 20 CFR 416.920(c).

If the impairment or combination of impairments do not significantly limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. Age, education and work experience will not be considered. 20 CFR 416.920.

Statements about pain or other symptoms do not alone establish disability. There must be medical signs and laboratory findings which demonstrate a medical impairment.... 20 CFR 416.929(a).

> ...Medical reports should include –
>
> (1) Medical history.
>
> (2) Clinical findings (such as the results of physical or mental status examinations);
>
> (3) Laboratory findings (such as blood pressure, X-rays);
>
> (4) Diagnosis (statement of disease or injury based on its signs and symptoms).... 20 CFR 416.913(b).

In determining disability under the law, the ability to work is measured. An individual's functional capacity for doing basic work activities is evaluated. If an individual has the ability to perform basic work activities without significant limitations, he or she is not considered disabled. 20 CFR 416.994(b)(1)(iv).

Basic work activities are the abilities and aptitudes necessary to do most jobs. Examples of these include --

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting. 20 CFR 416.921(b).

Medical findings must allow a determination of (1) the nature and limiting effects of your impairment(s) for any period in question; (2) the probable duration of the impairment; and (3) the residual functional capacity to do work-related physical and mental activities. 20 CFR 416.913(d).

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

All of the evidence relevant to the claim, including medical opinions, is reviewed and findings are made. 20 CFR 416.927(c).

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

A statement by a medical source finding that an individual is "disabled" or "unable to work" does not mean that disability exists for the purposes of the program. 20 CFR 416.927(e).

When determining disability, the federal regulations require that several considerations be analyzed in sequential order. If disability can be ruled out at any step, analysis of the next step is not required. These steps are:

1. Does the client perform Substantial Gainful Activity (SGA)? If yes, the client is ineligible for MA. If no, the analysis continues to Step 2. 20 CFR 416.920(b).

2. Does the client have a severe impairment that has lasted or is expected to last 12 months or more or result in death? If no, the client is ineligible for MA. If yes, the analysis continues to Step 3. 20 CFR 416.920(c).

3. Does the impairment appear on a special listing of impairments or are the client's symptoms, signs, and laboratory findings at least equivalent in severity to the set of medical findings specified for the listed impairment? If no, the analysis continues to Step 4. If yes, MA is approved. 20 CFR 416.290(d).

4. Can the client do the former work that he/she performed within the last 15 years? If yes, the client is ineligible for MA. If no, the analysis continues to Step 5. 20 CFR 416.920(e).

5. Does the client have the Residual Functional Capacity (RFC) to perform other work according to the guidelines set forth at 20 CFR 404, Subpart P, Appendix 2, Sections 200.00-204.00? If yes, the analysis ends and the client is ineligible for MA. If no, MA is approved. 20 CFR 416.920(f).

At Step 1, claimant is not engaged in substantial gainful activity and has not worked since August 2009. Claimant is not disqualified from receiving disability at Step 1.

The objective medical evidence on the record indicates that on [redacted] medical records indicate that on physical examination, the patient was sitting comfortably in bed and not in any acute distress. The patient had been binge drinking alcohol for about eight days. Vital signs: Pulse: ranging anywhere from 110 and 120. Blood pressure 124/63, no orthostatic changes, saturated 97% to 98% on two liters of oxygen. Temperature 97.8 degrees Fahrenheit. Head, eyes, ears, nose and throat: Head was atraumatic, normal cephalic. Ears: External auditory canal is normal. Tympanic membrane was normal. No jugular venous distention. No carotid bruit. In the cardiovascular system: Apical impulse does not appear to be displaced. Local area of tenderness is present over the chest. S1 and S2 heard. Regular right hand rhythm with no murmur. The respiratory system: Bilateral atrial is adequate. No wheezing or crackles heard. Chest expansion is normal bilaterally. In the abdomen: Soft, nontender, no organomegaly. Bowel sounds normally heard. Inguinal orifice is normal. In the extremities: No pedal edema. Peripheral pulses are normal. Central nervous system: Alert, awake, and oriented. Bilateral upward extremities and lower extremities are normal in strength, power and motor. The patient appears to be anxious at this time. At the time of admission, the EKG showed atrial fibrillation with rapid ventricular weight, T-wave inversion was also found in the B1-B2 lead as there were no ST changes seen. (Page 82.) Claimant was assessed with chest pain, lower gastrointestinal bleeding, and atrial fibrillation with rapid ventricular rate, alcohol intoxication, hypertension and cardiomyopathy. (Page 83.)

A [redacted] reported dated [redacted] indicates that claimant had persistent atrial fibrillation with underlying sick sinus syndrome with permanent pacing in

BBI mood and was brought in for elective cardio version under cover of anticoagulation. The conclusion was transient conversion of persistent atrial fibrillation of normal sinus rhythm (Page B7.) Claimant's Exhibit C and [redacted] report dated [redacted] on physical examination, claimant's blood pressure was 156/81, heart rate was 81, and respiratory rate was 18 and temperature 36.5. The patient was not in any acute distress. Head, ears, eyes, and nose flow was significant. The neck had no jugular venous distension. Lungs were clear to auscultation and percussion (Page C1). The heart S1 and S2 were regular with no murmurs. The abdomen was soft with no distension. There was a mild tenderness and epigastric area. The extremities had no edema. There was a bruise on his left upper thigh. The patient said it was when he slammed his leg on the car door. The neurological: the patient has trauma with upper extremities. Cranial nerves 2 through 12 were grossly intact. No sensation or motor loss. No ataxia. The assessment was atypical chest pain secondary to possibly angina versus gastroesophageal reflux disease and gastritis. He also has assessed an alcohol withdrawal and hypertension (Page B2).

On October 30, 2009, claimant presented at the hospital with dizziness, generalized weakness for two days. In the emergency room, his blood pressure was low at 70/89. Heart rate at respiratory was 70, rate 60. He was not in any acute distress. He was admitted and treated with IV fluids and his home medications and he was found to have severe duodenitis. He was advised to take medication, so no alcohol continues all medications from his primary physician, (Page D3).

On November 29, 2009, claimant was last seen for epidymis and scrotal mass (Page E14). Claimant was diagnosed with epidymis cyst (Page E5). Medical Examination Report dated November 6, 2009, indicates that claimant was 6'2" tall and weighed 239 pounds and his

blood pressure was 110/68. He had an upper GI bleed secondary to Coumadin. Claimant was normal in his examination of cardiovascular where he had a pacemaker and he had a recent GI bleed. (Page F12.) A cardiology report dated November 12, 2009 indicates that the EKG portion of the stress test is nondiagnostic for ischemia secondary to a permanent pacemaker. A myocardial perfusion study reveals no evidence of myocardial perfusion abnormality. A gaited angiogram revealed left ventricular dysfunction with an ejection fraction of 42% secondary to hypertension. The TIV is 1.29. No ischemia was noted. (Page G1 and G2.) An echocardiogram report of October 15, 2009 indicates that claimant had a left ventricular cavity has mildly increased normal left ventricular function. Estimated left ventricular ejection fraction is 45% to 50%. There was mild concentric left ventricular hypertrophy. There was a mildly dilated left atrium. Aortic valve is sclerotic. There is mild pulmonary regurgitation. There was mild tricuspid regurgitation. There was mild mitral valve regurgitation. The inferior vena cava and hepatic vein were normal and stented. The vessels were normal size with respiratory size greater than 50%. (Pages H1 and H2.)

The Medical Examination Report dated November 4, 2009 indicates that claimant is 6'3" tall and weighs 241 pounds and blood pressure is 127/80 and he is right hand dominant. He is normal in all areas of the abdomen where he had some pain and muscularly, he had low back pain. The clinical impression was that claimant was deteriorating but he could never return to work. He could never lift any weight and he could stand or walk less than two hours in an eight-hour workday and sit less than six hours in an eight-hour workday. He could do nothing with effort extremity such as simple grasping, reaching, pushing, pulling and fine manipulating and he could not operate foot nor leg controls. He had no mental limitations. (Pages 37 through 39.)

A September 4, 2009 Medical Report indicates that the clinical impression that claimant's condition was deteriorating and he could never return to work and that he could never lift any weight and could stand and walk less than two hours in an eight-hour workday and could sit less than six hours in an eight-hour day and he could just do simple grasping and reaching without pulling or fine manipulating. He could operate neither feet nor leg controls. Claimant had no mental limitations. (Page 61.) Another Medical Examination Report of June 25, 2009 indicates that the clinical impression of claimant was stable and he could stand or walk at least two hours in an eight-hour day. That he could frequently 20 pounds or less, but with medication 25 or 50 pounds or more. He could do simple grasping, reaching, pushing, pulling, and fine manipulating with both upper extremities and could operate feet and leg controls with both feet and legs. He had no mental limitations and was normal in all areas of examination. (Page 63 through 64.) A cardiology report of June 4, 2009 indicates that on physical examination, claimant was 233 pounds; his blood pressure was 102/76. His heart rate is 69 beats per minute and regular. Height was 62 inches. The patient looked well-nourished and good hygiene. HEENT: Pupils are equal and reactive to light. Range of extraocular muscles is intact. Sclera was white. Thyroid is not palpable. The neck is supple. The jugular vein is distension. The carotid arterial pulses were 2+ with breast abs stroke. No carotids were with. Respiratory and lungs were clear to auscultation, anteriorily and posteriorly. No wheezing. Respiratory rate was normal. In the cardiovascular, the heart rhythm is irregular. S1 and S2 were split, no S3 and S4. No clicks or rubs. 2/6 systolic murmur is noted in the mitral area. The abdomen was soft and bowel sounds were heard. No organomegaly. The abdominal area is not palpable. The musculoskeletal system there were no deformities noted. Muscle strength appears normal. The extremities revealed no evidence of peripheral vascular disease or ischemia or deep venous

thrombosis. Her systolic pedis, femoral and posterior tibial pulses are well felt and 2+ bilaterally. There is no evidence of any varicose veins or ulcers. In the skin, there are no rashes and no arrythmia. In the neurological area, he was alert and oriented. Extremities are mostly intact. Motor sensory systems are grossly intact. The psychiatric patient was oriented to time, place and person. Mental status is good. No lymph nodes were palpable. The current EKG revealed a pace rhythm with third degree AB block with p-waves noted after the QRS. (Page 65 and 66.) The gastroenterology report of December 2, 2009 indicates that the clinical impression is that claimant is stable and he had no physical limitations. He could occasionally lift 25 pounds or less but never lift 25 pounds or more. He could stand or walk two hours in an eight-hour day and sit less than six hours in an eight-hour day. He could use both upper extremities for simple grasping, reaching, pushing, pulling and fine manipulating and could operate foot and leg controls with both feet and legs. He is normal in all areas of examination (Pages 24 and 25.)

Claimant testified on the record that his girlfriend takes care of him but he does have a driver's license and drives about 20 minutes everyday and goes to the drug and grocery store. Claimant does cook with microwave dinners and grocery shops, usually buys a loaf of bread and he does the rest of the shopping. Claimant testified that he does dusting and wipes the counter and his hobby is photography, taking major pictures in spring and summer. He watches television six hours or more per day and reads most of the day. Claimant testified that he could stand for 15 to 20 minutes at a time, sit for 15 to 20 minutes at a time, walk for 200 feet and can do some limited squatting. Claimant testified that he can bend at the waist and shower and dress him, tie his shoes, and touch his toes without difficulty. Claimant testified that he does have some knee pain. Claimant testified that his level of pain on a scale of 1 to 10 without medication is 7 to an 8 and with medication is 4 to 5. Claimant stated that he is left handed and arms and

legs and feet are fine. Claimant testified the heaviest weight he could carry is 13 pounds and that he stopped drinking alcohol in October 2009 when he used to drink about 12 cans of beer per day. Claimant testified that on a typical day, he brushes his teeth and washes up and gets coffee and watches television, reads, has lunch and takes a nap then play cards and does crosswords. Claimant testified that he completed rehabilitation and goes to [redacted] a month. Claimant testified that he basically drank himself into illness. He now has a pacemaker and also has his lower stomach problems and had some bleeding and he stopped drinking after that.

At Step 2, claimant has the burden of proof of establishing that he has a severely restrictive physical or mental impairment that has lasted or is expected to last for the duration of at least 12 months. There is insufficient objective clinical medical evidence in the record that claimant suffers a severely restrictive physical or mental impairment. Claimant has reports of pain in multiple areas of his body; however, there are no sufficient corresponding clinical findings that support the reports of symptoms and limitations made by the claimant. There are some laboratory findings and it is indicated that claimant does have a pacemaker. The clinical impression from the Medical Examination Reports were inconsistent, some of the Medical Examination Report indicated that claimant is deteriorating. Other Medical Examination Reports indicate that claimant's condition is stable. There is no medical finding that claimant has any muscle atrophy or trauma, abnormality or injury that is consistent with a deteriorating condition. In short, claimant has restricted himself from tasks associated with occupational functioning based upon his reports of pain (symptoms) rather than medical findings. Based upon the fact that he does have a pacemaker. Reported symptoms are an insufficient basis upon which a finding that claimant has met the evidentiary burden of proof can be made. This Administrative Law

Judge finds that the medical record is insufficient to establish that claimant has a severely restrictive physical impairment.

Claimant alleges the following disabling mental impairments: depression.

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

There is insufficient objective medical/psychiatric evidence in the record indicating claimant suffers mental limitations resulting from his reportedly depressed state. There is a no mental residual functional capacity assessment in the record. There evidentiary record is insufficient to find that claimant suffers from severely restricted mental impairments. Claimant was oriented to time, person and place during the hearing. Claimant was able to answer all of the questions at the hearing and was responsive to the questions. There is insufficient objective medical/psychiatric evidence contained in the file of depression or a cognitive dysfunction that is so severe that it would prevent claimant from working at any job. In addition, based upon claimant's medical reports, it is documented that he had heavy use of alcohol as well as alcohol withdrawal which would be attributed to his physical and any alleged mental problems. For these reasons, this Administrative Law Judge finds that claimant has failed to meet his burden of proof at Step 2. Claimant must be denied benefits at this step based upon his failure to meet the evidentiary burden.

If claimant had not been denied at Step 2, the analysis would proceed to Step 3 where the medical evidence of claimant's condition does not give rise to a finding that he would meet a statutory listing in the code of federal regulations.

If claimant had not already been denied at Step 2, this Administrative Law Judge would have to deny him again at Step 4 based upon his ability to perform his past relevant work. Claimant's past relevant work is working in a bookstore and at [redacted] as a department manager. There is sufficient objective medical evidence in the file upon which this Administrative Law Judge could base a finding that claimant is unable to perform work in which he has engaged in, in the past. Therefore, if claimant had not already been denied at Step 2, he would be denied again at Step 4.

The Administrative Law Judge will continue to proceed through the sequential evaluation process to determine whether or not claimant has the residual functional capacity to perform some other less strenuous tasks than in his prior jobs.

At Step 5, the burden of proof shifts to the department to establish that claimant does not have residual functional capacity.

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

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

Sedentary work. 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. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. 20 CFR 416.967(a).

Light work. 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 this 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).

Claimant has submitted insufficient objective medical evidence that he lacks the residual functional capacity to perform some other less strenuous tasks than in his prior employment or that he is physically unable to do light or sedentary tasks if demanded of him. Claimant's activities of daily living do not appear to be very limited and he should be able to perform light or sedentary work even with his impairments. Claimant has failed to provide the necessary objective medical evidence to establish that he has a severe impairment or combination of impairments which prevent him from performing any level of work for a period of 12 months. The claimant's testimony as to his limitations indicates that he should be able to perform light or sedentary work.

There is insufficient objective medical/psychiatric evidence contained in the file of depression or a cognitive dysfunction that is so severe that it would prevent claimant from working at any job. Claimant was able to answer all the questions at the hearing and was responsive to the questions. Claimant was oriented to time, person and place during the hearing.

Claimant's complaints of pain, while profound and credible, are out of proportion to the objective medical evidence contained in the file as it relates to claimant's ability to perform work. Claimant did testify that he has received some relief from his pain medication. Therefore, this Administrative Law Judge finds that the objective medical evidence on the record does not establish that claimant has no residual functional capacity. Claimant is disqualified from receiving disability at Step 5 based upon the fact that he has not established by objective medical evidence that he cannot perform light or sedentary work even with his impairments. Under the Medical-Vocational guidelines, a younger individual (age ), with a high school education and an unskilled work history who is limited to light work is not considered disabled.

The Federal Regulations at 20 CFR 404.1535 speak to the determination of whether Drug Addiction and Alcoholism (DAA) is material to a person's disability and when benefits will or will not be approved. The regulations require the disability analysis be completed prior to a determination of whether a person's drug and alcohol use is material. It is only when a person meets the disability criterion, as set forth in the regulations, that the issue of materiality becomes relevant. In such cases, the regulations require a sixth step to determine the materiality of DAA to a person's disability.

When the record contains evidence of DAA, a determination must be made whether or not the person would continue to be disabled if the individual stopped using drugs or alcohol. The trier of fact must determine what, if any, of the physical or mental limitations would remain if the person were to stop the use of the drugs or alcohol and whether any of these remaining limitations would be disabling.

Claimant's testimony and the information indicate that claimant has a history of alcohol abuse. Applicable hearing is the Drug Abuse and Alcohol (DA&A) Legislation, Public Law 104-121, Section 105(b)(1), 110 STAT. 853, 42 USC 423(d)(2)(C), 1382(c)(a)(3)(J) Supplement Five 1999. The law indicates that individuals are not eligible and/or are not disabled where drug addiction or alcoholism is a contributing factor material to the determination of disability. After a careful review of the credible and substantial evidence on the whole record, this Administrative Law Judge finds that claimant does not meet the statutory disability definition under the authority of the DA&A Legislation because his substance abuse is material to his alleged impairment and alleged disability.

The department's Program Eligibility Manual contains the following policy statements and instructions for caseworkers regarding the State Disability Assistance program: to receive State Disability Assistance, a person must be disabled, caring for a disabled person or age 65 or older. BEM, Item 261, p. 1. Because the claimant does not meet the definition of disabled under the MA-P program and because the evidence of record does not establish that claimant is unable to work for a period exceeding 90 days, the claimant does not meet the disability criteria for State Disability Assistance benefits either.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the department has appropriately established on the record that it was acting in compliance with department policy when it denied claimant's application for Medical Assistance, retroactive Medical Assistance and State Disability Assistance benefits. The claimant should be able to perform a wide range of light or sedentary work even with his impairments. The department has established its case by a preponderance of the evidence.

Accordingly, the department's decision is AFFIRMED.

/s/
Landis Y. Lain
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: June 07, 2010

Date Mailed: June 8, 2010

**NOTICE:** Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative Hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the mailing of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt date of the rehearing decision.

LYL/tg

cc: [redacted]