STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

[redacted]

Reg. No: 2011-35184
Case No: [redacted]
Issue No: 2009/4031
Hearing Date: October 18, 2011
County: Genesee-06

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

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 received on May 24, 2011. After due notice, an in-person hearing was held on October 18, 2011. Claimant and personally appeared and testified.

ISSUE

Whether the Department of Human Services (the department) properly denied Claimant's application for Medical Assistance (MA-P), Retro-MA 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 December 1, 2010, Claimant applied for MA-P, Retro-MA and SDA.

(2) On May 2, 2011, the Medical Review Team (MRT) denied Claimant's MA application stating Claimant is capable of performing other work pursuant to 20 CFR 416.920(f). (Department Exhibit A, pages 2-3).

(3) On May 11, 2011, the department caseworker sent Claimant notice that his application was denied.

(4) On May 24, 2011, Claimant filed a request for a hearing to contest the department's negative action.

(5) On June 22, 2011, the State Hearing Review Team (SHRT) upheld the denial of MA-P, Retro-MA and SDA benefits stating Claimant retains the capacity to perform a wide range of sedentary work. (Department Exhibit B, page 1).

(6) On October 18, 2011, Claimant requested the record remain open in order to submit additional medical documentation for consideration.

(7) On October 19, 2011, Claimant's medical documentation was forwarded to SHRT.

(8) On December 1, 2011, SHRT upheld the denial of MA-P, Retro-MA and SDA benefits stating Claimant retains the capacity to perform a wide range of sedentary work. (Department Exhibit C, pages 1-2).

(9) Claimant has a history of hypertension, hyperlipidemia, diabetes mellitus, GERD, nonischemic cardiomyopathy, mediastinal lymphadenopathy, systemic sarcoidosis of the lung, severe obstructive sleep apnea, parosysmal nocturnal dyspnea, orthopnea, chronic obstructive pulmonary disease (COPD), pleural effusion on the right, and congestive heart failure (CHF).

(10) On June 7, 2010, Claimant saw his doctor complaining of trouble breathing, coughing and congestion. He was diagnosed with hypertension, back pain and bronchitis. (Department Exhibit A, pages 21-22).

(11) On June 29, 2010, Claimant went to the emergency room for trouble breathing, cough and congestion. Diagnosis: Primary: COPD exacerbation, Additional: Bronchitis (subacute). (Claimant Exhibit A, pages 160-161).

(12) On July 12, 2010, Claimant saw his doctor complaining of a sore throat, ear pain and a rash on his lower back. He was diagnosed with acute bronchitis, eczema and chronic obstructive pulmonary disease (COPD). (Department Exhibit A, pages 19-20).

(13) On July 20, 2010, Claimant saw his doctor complaining of back pain. Claimant was diagnosed with possible sleep apnea and hypertension and prescribed Procardia, Atrovent inhaler, Prednisone, and Keflex. (Department Exhibit A, pages 17-18).

(14) On August 2, 2010, Claimant saw his doctor complaining of trouble breathing. He was diagnosed with hypertension, generalized anxiety disorder and an upper respiratory infection and prescribed Procardia,

Buspar and Phenergan expectorant and advised to return if his symptoms got worse. (Claimant's Exhibit A, pages 119-120).

(15) On August 10, 2010, Claimant saw his pulmonologist complaining of shortness of breath progressively getting worse over the last two months. His pulmonologist reviewed his records from Hurley Medical Center which revealed that he had a recent evaluation about two months ago when he was admitted with abdominal pain. At that time, he did have a chest x-ray performed, which the pulmonologist reviewed, which reveals a mild degree of prominence of vasculature, otherwise, it was reported to be normal. He also described loss of appetite and he continues to have significant trouble with falling asleep related to shortness of breath. He is currently using Albuterol as needed. He smoked one pack a day for 20 years and quit completely about two months ago, secondary to his worsening shortness of breath. He works for the [redacted]. Complete pulmonary function tests revealed no evidence of obstructive or restrictive airway disease. A chest x-ray performed in the pulmonologist's office revealed cariomegaly with diffuse prominence of the bilateral interstitium. These findings are related to congestive heart failure versus possible intersititial lung disease. A pulmonary function test was normal except for increased airway resistance. Compared to previous pulmonary function testing in 2007, there is a significant decline in FEV1 and FVC as well as total lung capacity and diffusion capacity. (Claimant's Exhibit A, pages 105-107, 126-130, 165).

(16) On August 17, 2010, Claimant was having an outpatient echocardiogram which while being performed, he started having significant anterior thoracic as well as right hemithoracic and what appeared to be significant pleuritic chest pain. Due to the severity of his pain, he was sent to the emergency room where he was evaluated for possible angina. He required admission with acute congestive heart failure (CHF), acute chest pain (CP) and COPD. On admission to the hospital he had a creatinine of 1.2 and the creatinine had peaked to a value of 1.4. He has chronic kidney disease stage 2 by definition with a baseline creatinine level of .9 to 1. A chest x-ray showed pulmonary edema. A cat scan of his chest showed no evidence of pulmonary embolism. Moderate cardiomegaly. Multiple prominent to enlarged mediastinal and bilateral hilar lymph nodes, the largest one in the prevascular region measuring 3.1 x 1.7 cm could be related to sarcoidosis. His echocardiogram showed an ejection fraction of less than 40% with questionable cardiomyopathy/congestive heart failure. (Department Exhibit A, pages 23-155; Claimant Exhibit A, pages 163-164).

(17) On August 18, 2010, after Claimant was admitted and found to have a history of left ventricular systolic dysfunction, he was brought in for cardiac catheterization for evaluation and for underlying multivessel coronary

artery disease that may be the symptoms for symptomatic left ventricular systolic dysfunction. A left and right heart catheterization was done in view of symptoms of shortness of breath if there is associated pulmonary hypertension with left ventricular systolic dysfunction. Conclusion: (1) Nonobstructive coronary circulation; (2) elevated left ventricular end-diastolic pressure and elevated pulmonary capillary wedge pressure most likely secondary to nonischemic cardiomyopathy; (3) left ventricular systolic dysfunction, ejection fraction about 35%; (4) moderate pulmonary hypertension with a pulmonary artery pressure of 45/27; (5) exogenous obesity; (6) hypertensive heart disease. (Claimant's Exhibit A, pages 67-69).

(18) On August 23, 2010, an x-ray of Claimant's left upper extremity venous showed a thrombosis of the cephalic vein on the left. A stat report was sent. An ultra sound of the left upper veinous duplex was negative for deep vein thrombosis (DVT). The cephalic vein was noted to be thrombosed from mid forearm to wrist. (Department Exhibit A, pages 108-109, 116).

(19) On August 23, 2010, Claimant's CPXT/Pulmonary Stress Test showed his (1) pulmonary parameters are within normal limits. He does show evidence of some degree of diffusion-type abnormality with decreasing oxygen consumption at the end of the exercising effort and during the recovery period. His pulmonary parameters are otherwise within normal limits. (2) He shows evidence of severe cardiac "pump" limitation to exercise tolerance. His maximum oxygen consumption was 3.8 ml of oxygen per kilogram per minute. (3) He has evidence of progressive increase in dead space to tidal volume ratio with increasing exercise tolerance suggesting the possibility of underlying pulmonary vascular disease. He also shows evidence of no change in end tidal carbon dioxide with increasing effort. Consideration of possible underlying obstructive sleep apnea is also recommended. (4) His test is markedly abnormal with evidence of significant cardiac "pump" limitation to exercise tolerance. (Department Exhibit A, pages 101-102).

(20) On August 26, 2010, Claimant was discharged from the hospital. He had a cardiology consult regarding the congestive heart failure and was found to have left ventricular dysfunction and his ejection fraction was about 37% and he was on Digoxin and Bumex and started on Corge. He had a history of shortness of breath. He was seen by the pulmonary attending was found to have positive hilar densities, possible sarcoidosis and congestive heart failure which contributes to his difficulty breathing. His kidney function started to decrease, creatinine increased to 1.4. Chest pain improved and he did not have any difficulty breathing and was ready to be discharged as stable. Discharge diagnosis: Congestive heart failure,

atypical chest pain, and hypertension. (Department Exhibit A, pages 23-24).

(21) On August 30, 2010, Claimant saw his doctor complaining of chest pain and trouble breathing. He was prescribed Neurontin and is scheduled to see the lung doctor on 9/9/10. (Department Exhibit A, pages 15-16).

(22) On September 9, 2010, Claimant saw his pulmonologist for follow-up in respect to dyspnea. On clinical observation, he was suspected to have underlying cardiomyopathy with congestive heart failure, so he was scheduled for a 2D-echocardiographic evaluation in addition to starting Lasix therapy. A cat scan was also scheduled for possible underlying interstitial lung disease. The echocardiogram was performed, which did confirm a low ejection fraction of 37%. When he presented for the CAT scan, he started having a significant amount of chest pain for which he was admitted and evaluated by a cardiologist. A cardiac catheterization was performed on 8/18/10 which revealed normal coronary arteries. Ejection fraction was decreased to 37%. Cardiac index was 2.7. He has global hypokinesis of the left ventricle and he was diagnosed with nonischemic cardiomyopathy. He had been subsequently started on aggressive medical therapy for congestive heart failure and cardiomyopathy and was discharged home. He described that since his discharge from the hospital, his breathing is significantly better but he still experiences dyspnea with heavy exertion. He still had cough with purulent sputum, however, this is much less in amount than in the past. He was seen by his cardiologist two days ago and he had been given an off work slip until next evaluation with him. Cat scan of his chest performed during the hospitalization revealed no evidence of interstitial lung disease but there is evidence of significant mediastinal lympadenopathy involving subcarinal bilateral hilar and paratracheal aoropulmonary window. The largest lymph node measured 3.1 x 1.7 cm. There was minimal amount of apical subpleural blebs. Last follow-up x-ray performed on 8/24/10 revealed significant primarily congestive heart failure changes compared to previous radiograph from pulmonologist office. He has lost a significant amount of weight since previous evaluation about a month ago, from 284 pounds to a current weight of 267. (Claimant's Exhibit A, pages 102-104).

(23) On September 14, 2010, Claimant saw his doctor due to chest pain, dizziness and inability to stand for a long period of time. He was referred to a lung doctor, and prescribed Naprosyn and Davocet. (Department Exhibit A, pages 11-12).

(24) On September 21, 2010, Claimant was evaluated for a sleep study. Due to severity of sleep apnea, this study was performed as a split night; a diagnostic study initially with CPAP titration after demonstration of severe

sleep apnea. During the diagnostic portion of the study, there was a total of 121 apneas and hypopneas with an apnea/hypopnea index of 55 per hour. With CPAP of 11 cm respiratory events were well controlled. (Claimant Exhibit A, pages 143-146).

(25) On October 10, 2010, the cytology results from the subcarinal lymph node and right hilar lymph node found no malignancy. (Claimant Exhibit A, pages 141-142).

(26) On December 7, 2010, Claimant's chest x-ray showed some bibasilar air-space disease was seen perhaps representing atelectasis. Heart size was within normal limits. There was no overt congestion and no pneumothorax. (Department Exhibit A, page 10).

(27) On December 17, 2010, Claimant underwent a mediastinal lymphadenopathy which was negative for malignancy. (Department Exhibit A, page 8).

(28) On January 18, 2011, Claimant saw his doctor for a follow-up after the mediastinoscopy for lymph node biopsy. He has also been diagnosed with nonischemic cardiomyopathy with ejection fraction decreased to 37%. The biopsy revealed non-caseating granuloma consistent with suspected diagnosis of sarcoidosis. He is also suspected to have significant sleep apnea, for which he underwent a sleep study evaluation on 9/21/10, which revealed severe degree of sleep apnea with apnea/hypopnea index of 55 per hours and he was prescribed CPAP therapy at 11 cm. He continued to suffer from significant amount of symptoms of shortness of breath with activity, even walking from room to room. He has exhibited symptoms of paroxysmal nocturnal dyspnea, orthopnea, as well as cough with frothy sputum. He does have intermittent on and off lower extremity edema. He continues to have intermittent right lower pleuritic chest pain. He did gain a significant amount of weight since last evaluation from 267 pounds to 284 pounds. He uses CPAP therapy regularly of 11 cm. Recommendations: (1) started on prednisone therapy; (2) increased his does of Lasix to improve his congestive heart failure symptoms as evidence by the positional orthopnea, obstructive nocturnal dyspnea and frothy sputum; (3) possible need for AICD placement, as patient has non-ischemic cardiomyopathy with decreased ejection fraction related to systemic sarcoidosis, and he has a high risk of cardiac arrhythmia; (4) advised to do current CPAP therapy for sleep apnea; (5) weight loss measures were discussed and (6) follow-up in re-assessment in one month. (Department Exhibit C, pages 3-6; Claimant Exhibit A, pages 7-8).

(29) On February 21, 2011, Claimant underwent a medical examination for the department. Claimant was diagnosed with sarcoidosis, cardiomyopathy

and sleep apnea. The doctor found Claimant was obese and able to meet his needs in the home. (Department Exhibit A, pages 3-4).

(30) On February 21, 2011, Claimant saw his pulmonologist for a follow-up on his Prednisone therapy. He continues to have symptoms of paroxysmal nocturnal dyspnea with intermittent cough with frothy sputum. He is still having difficulty tolerating CPAP treatment, secondary to significant dryness of the sinuses. He does have a history of severe sleep apnea. He is currently using CPAP at a pressure setting of 11 cm. He also continued to complain of intermittent right-sided pleuritic chest pain. There were also palpable lymph nodes in the right lower neck which were tender to the touch. The pulmonologist deferred further evaluation with respect to possible need for AICD placement to the cariologist as Claimant has had decreased ejection fraction with increased risk of cardiac arrhythmia. (Claimant Exhibit A, pages 5-6, 98-99).

(31) On June 1, 2011, Claimant's chest x-ray was compared to his 12/8/10 x-ray and showed right-sided pleural effusion with underlying lung changes probably related to atelectasis. Follow-up was recommended to ensure resolution. (Claimant Exhibit A, page 124-125).

(32) On July 1, 2011, Claimant's chest x-ray with contrast was compared to his 8/21/10 chest x-ray and revealed new right-sided pleural effusion present. There are changes of scarring and atelectasis in the right lung. The lymphadenopathy has improved from previous exam. (Claimant Exhibit A, pages 122-123).

(33) On July 14, 2011, Claimant saw his doctor complaining of right flank pain. Hypertension stable, obstructive sleep apnea on CPAP, and CHF stable. Cat scan of his chest done 6/30/11 showed right sided pleural effusion which the doctor explained could be contributing to his pain. (Claimant Exhibit A, pages 15-17).

(34) On July 22, 2011, Clamant saw his doctor for back pain. The pain is present in the lumbar spine. The quality of the pain is described as burning, aching, and shooting. The pain radiates to the right thigh and right foot. The pain is moderate. The symptoms are aggravated by position (lifting). The pain is worse during the night. Stiffness is present in the morning. Associated symptoms include leg pain and numbness. He was also depressed and experiencing shortness of breath. (Claimant Exhibit A, pages 14-15).

(35) On August 1, 2011, Claimant was unable to perform complete pulmonary test secondary to chest pain. FVC was 4.35 L, 96% of predicted – normal. FEV1 was 1.362 L, 101% of predicted – normal. FEV1/FVC ratio was

83% - normal. His chest x-ray showed a small right pleural effusion. (Claimant Exhibit A, pages 4, 74-78).

(36) On September 7, 2011, Claimant saw his doctor for right sided lower chest and upper abdominal pain. He has been having right sided lower chest pain and upper abdominal pain for over a year now. He describes the pain as sharp, stabbing in quality, the scale of 10/10 on a severity scale when the pain comes on. There is no radiation of pain anywhere. Pain is relieved with Vicodin which he has to take in excess of prescribed amount to control the pain. He also occasionally feels dizziness when pain comes on. He has shortness of breath. Chest tenderness over the right side. Plan is to continue him on his current medications and get a chest x-ray and a digoxin level and review the chest x-ray to see if the pleural effusion has resolved and to see if any specific measures need to be taken for it. (Claimant Exhibit A, pages 11-14).

(37) On October 12, 2011, Claimant saw his pulmonologist for follow-up on sarcoidosis. He has been treated for sarcoidosis with likely cardiac involvement. On last visit he was advised to slowly taper down Prednisone to 10 mg/day, but it was increased by his primary physician for chest pain and increasing shortness of breath. He completed a pulmonary function test spirometry which was normal. The cat scan of his chest from 6/1/11 was reviewed. There was improvement in mediastinal lymphadenopathy compared to previous CAT scan. New small right pleural effusion was present. Chest x-ray today revealed small right pleural effusion. (Claimant Exhibit A, pages 2-3).

(38) On October 14, 2011, Claimant saw his doctor for right sided chest pain with pleural effusion. The chest x-ray from his last visit shows right sided pleural effusion which has improved since examination of the previous x-ray before that. However he continues to be in pain. An appointment was made with his pulmonologist for a possible flare up of his sarcoidosis. (Claimant Exhibit A, page 10).

(39) Claimant is a 47 year old man whose birthday is [redacted]. Claimant is 6'0" tall and weighs 250 lbs. Claimant completed high school and worked as a machinist. Claimant last worked in August 2010.

(40) Claimant was appealing the denial of Social Security disability at the time of the hearing.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by the 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 (formerly known as the Family Independence

Agency) 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 Reference Tables Manual (RFT).

Under the Medicaid (MA) program:

> "Disability" is:
>
> ...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.

When determining disability, the federal regulations require several factors to be considered, including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitations in light of the objective medical evidence presented. 20 CFR 416.929(c)(94).

> In determining whether you are disabled, we will consider all of your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with objective medical evidence, and other evidence. 20 CFR 416.929(a).
>
> Pain or other symptoms may cause a limitation of function beyond that which can be determined on the basis of the anatomical, physiological or psychological abnormalities considered alone. 20 CFR 416.945(e).
>
> In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings and statements about how your symptoms affect you. We will then determine the extent to which your alleged functional limitations or restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work. 20 CFR 416.929(a).

> Since symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you may submit about your symptoms. 20 CFR 416.929(c)(3).
>
> Because symptoms such as pain, are subjective and difficult to quantify, any symptom-related functional limitations and restrictions which you, your treating or examining physician or psychologist, or other persons report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account in reaching a conclusion as to whether you are disabled. 20 CFR 416.929(c)(3).
>
> We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your treating, examining or consulting physician or psychologist, and observations by our employees and other persons. 20 CFR 416.929(c)(3).
>
> Your symptoms, including pain, will be determined to diminish your capacity for basic work activities to the extent that your alleged functional limitations and restrictions due to symptoms, such as pain, can reasonably be accepted as consistent with the objective medical evidence and other evidence. 20 CFR 416.929(c)(4).

In Claimant's case, the ongoing chest pain, the newly diagnosed right side pleural effusion and atelectasis, and other non-exertional symptoms he describes are consistent with the objective medical evidence presented. Consequently, great weight and credibility must be given to his testimony in this regard.

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 <u>not</u> 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).

Claimant has not been employed since August 2010; consequently, the analysis must move to Step 2.

In this case, Claimant has presented the required medical data and evidence necessary to support a finding that claimant has significant physical limitations upon his ability to perform basic work activities.

Medical evidence has clearly established that Claimant has an impairment (or combination of impairments) that has more than a minimal effect on Claimant's work activities. See Social Security Rulings 85-28, 88-13, and 82-63.

In the third step of the sequential consideration of a disability claim, the trier of fact must determine if the claimant's impairment (or combination of impairments) is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. This Administrative Law Judge finds that the claimant's medical record will not support a finding that claimant's impairment(s) is a "listed impairment" or equal to a listed impairment. See Appendix 1 of Subpart P of 20 CFR, Part 404, Part A. Accordingly, Claimant cannot be found to be disabled based upon medical evidence alone. 20 CFR 416.920(d).

In the fourth step of the sequential consideration of a disability claim, the trier of fact must determine if the claimant's impairment(s) prevents claimant from doing past relevant work. 20 CFR 416.920(e). It is the finding of this Administrative Law Judge, based upon the medical evidence and objective physical findings, that Claimant cannot return to his past relevant work because the rigors of working as a machinist are completely outside the scope of his physical abilities given the medical evidence presented.

In the fifth step of the sequential consideration of a disability claim, the trier of fact must determine if the claimant's impairment(s) prevents claimant from doing other work. 20 CFR 416.920(f). This determination is based upon the claimant's:

(1) residual functional capacity defined simply as "what can you still do despite you limitations?" 20 CFR 416.945;

(2) age, education, and work experience, 20 CFR 416.963-.965; and

(3) the kinds of work which exist in significant numbers in the national economy which the claimant could perform despite his/her limitations. 20 CFR 416.966.

See *Felton v DSS* 161 Mich. App 690, 696 (1987). Once claimant reaches Step 5 in the sequential review process, Claimant has already established a *prima facie* case of disability. *Richardson v Secretary of Health and Human Services,* 735 F2d 962 (6th Cir, 1984). At that point, the burden of proof is on the state to prove by substantial evidence that the claimant has the residual functional capacity for substantial gainful activity.

After careful review of Claimant's extensive medical record and the Administrative Law Judge's personal interaction with Claimant at the hearing, this Administrative Law Judge finds that Claimant's exertional and non-exertional impairments render Claimant unable to engage in a full range of even sedentary work activities on a regular and continuing basis. 20 CFR 404, Subpart P. Appendix 11, Section 201.00(h). See Social Security Ruling 83-10; *Wilson v Heckler*, 743 F2d 216 (1986). The department has failed to provide vocational evidence which establishes that Claimant has the residual functional capacity for substantial gainful activity and that, given Claimant's age, education, and work experience, there are a significant numbers of jobs in the national economy which the Claimant could perform despite Claimant's limitations. Accordingly, this Administrative Law Judge concludes that Claimant is disabled for purposes of the MA program. Consequently, the department's denial of his December 1, 2011 MA/retro-MA and SDA application cannot be upheld.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides the department erred in determining Claimant is not currently disabled for MA/retro-MA and SDA eligibility purposes.

Accordingly, the department's decision is REVERSED, and it is Ordered that:

1. The department shall process Claimant's December 1, 2011 MA/retro-MA and SDA application, and shall award him all the benefits he may be

entitled to receive, as long as he meets the remaining financial and non-financial eligibility factors.

2. The department shall review Claimant's medical condition for improvement in December 2013, unless his Social Security Administration disability status is approved by that time.

3. The department shall obtain updated medical evidence from Claimant's treating physicians, physical therapists, pain clinic notes, etc. regarding his continued treatment, progress and prognosis at review.

/S/
Vicki L. Armstrong
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: 12/19/11

Date Mailed: 12/19/11

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.

VLA/ds