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

IN THE MATTER OF:

[redacted]

Reg. No: 2011-36667
Issue No: 2009/4031
Case No: [redacted]
Hearing Date:
October 4, 2011
Jackson County DHS

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 February 8, 2011. After due notice, an in-person hearing was held on October 4, 2011. Claimant and Claimant's representative, [redacted] 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 October 1, 2010, Claimant applied for MA-P, Retro-MA and SDA.

(2) On October 25, 2010, the Medical Review Team (MRT) denied Claimant's MA application stating Claimant's impairments lack duration of 12 months pursuant to 20 CFR 416.909. (Department Exhibit A, pages 27-28).

(3) On November 10, 2010, the department caseworker sent Claimant notice that his application was denied.

(4) On February 8, 2011, Claimant filed a request for a hearing to contest the department's negative action.

(5) On July 5, 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 light work. (Department Exhibit B, pages 1-2).

(7) On October 4, 2011, Claimant requested the record remain open in order to submit additional medical documentation for consideration.

(8) On October 6, 2011, Claimant's medical documentation was forwarded to SHRT.

(9) On November 30, 2011, SHRT upheld the denial of MA-P, Retro-MA and SDA benefits stating Claimant retains the capacity to perform sedentary work. (Department Exhibit C, page 1).

(10) Claimant has a history of deep vein thrombosis, pulmonary embolism, chronic lymphedema, shortness of breath, obstructive sleep apnea, diabetes, anxiety and depression.

(11) On October 23, 2009, Claimant saw his doctor for follow-up after his emergency room visit. He had dyspnea and a cough. All tests, labs, EKG, CT chest, and dopple US lower extremities from the ER were negative. Claimant was prescribed Xanax and Albuterol and an echocardiogram was scheduled. (Claimant Exhibit A, pages 2-3).

(12) On September 14, 2010, Claimant presented to the emergency room with a complaint of chest discomfort. He has a history of chronic DVT left lower extremity, not on any Coumadin, but on full-strength aspirin. He denied any history of pulmonary embous, but after being evaluated in the ER he was found to have an extensive pulmonary embolism on the right with pulmonary infarct. Regarding chest pain, he was found to have significant extensive pulmonary embolism both on the right as well as the left so he was placed on Heparin and Coumadin and subsequently admitted. An examination of his extremities revealed his left leg to be greater than right leg with nonpitting edema. An echocardiogram showed left ventricular ejection fraction greater than 55%. His chest x-ray showed shallow breathing, linear atelectasis in the basal lung fields, otherwise, negative chest. The CT angiogram chest was done which showed large filling defects involving the distal right main pulmonary artery involving the segmental subsegmental branches of right upper lobe, middle lobe, and lower lobe as well as subsegmental branches involving the left lower lobe pulmonary artery branches. Hazy wedge-shaped ground-glass opacity within the lateral right lower lobe, suspicious for pulmonary infarct. Small right pleural effusion. Ultrasound duplex of lower extremities was done which shows a stable chronic thrombus of the left mid to distal, left femoral and popliteal veins. No evidence of acute left lower extremity deep venous thrombosis. Claimant was discharged on September 20, 2010 with a diagnosis of (1) extensive acute right upper and middle lower lobe

as well as left lower lobe pulmonary embolism; (2) pleuritic chest pain; (3) possible pulmonary infract; (4) mild transient hemoptysis at the time of admission, resolved; (5) chronic left lower extremity deep venous thrombosis, currently not on any Coumadin; (6) tobacco abuse; and (7) morbid obesity with body mass index greater than 40. (Department Exhibit A, pages 35-53).

(13) On January 2, 2011, Claimant went to the emergency room with chest pain occurring at rest. Past medical history of extensive right upper and middle lower lobe and left lower lobe pulmonary embolism in September 2010 when he presented with the similar type of chest pan and also had hemoptysis and pulmonary infarct. He has a history of chronic deep venous thrombosis in the left leg for the last seven years and takes Coumadin intermittently. He was on Coumadin regularly since September 2010, but ran out a week ago and has been experiencing intermittent chest pain, radiating to both arms that was worse with activity and walking. Claimant was admitted to the hospital. Claimant underwent a stress test that was negative for ischemia, negative for infarction with an ejection fraction of 60%. An ultrasound duplex of the left lower extremity showed stable, chronic changes of the mid to distal left femoral vein, no evidence for acute deep vein thrombosis of the left lower extremity from the hip to the knee, suboptimal visualization of the calf veins secondary to body habitus and edema. CT was done of the chest that showed (1) faint, linear filling defect in segmental branch left lower lobe. Pulmonary artery representing tiny residual chronic thrombus. Remainder of right and left pulmonary emboli seen on prior study have resolved. No evidence of acute pulmonary embolism. (2) no acute infiltrate, mass or pleural effusion. Minimal scarring atelectasis right lower lobe. He also had a chest x-ray that showed no acute cardiopulmonary process. His labs on discharge revealed an INR of 1.15. He needs a sleep study to rule out obstructive sleep apnea per recommendations of cardiology. His diagnosis at discharge on January 5, 2011 was (1) chest pain, atypical, which is resolved; (2) chronic pulmonary embolism diagnosed in September 2010; (3) chronic left deep vein thrombosis; (4) morbid obesity; and (5) tobacco abuse. (Department Exhibit A, pages 14-24, 58-66).

(14) On January 11, 2011, Claimant saw his doctor for follow-up after his hospitalization for blood clots in his lungs. A physical exam noted chronic lymphedema of his left leg. Coumadin was increased to 9mg daily. Claimant underwent a Live-Watch Holter Monitor which showed he had a predominantly normal sinus rhythm without higher grade arrhythmia. Few episodes of sinus tachycardia not correlating with the patient's symptoms of palpitations and dizziness. (Claimant Exhibit A, pages 21-24).

(15) On February 10, 2011, Claimant underwent testing at the Sleep Health Center. Positive edema was noted in the left lower extremities, but

otherwise standard. Impressions: (1) sleep disorder, probable sleep apnea; (2) BMI greater than 40; (3) excessive daytime sleepiness; (4) recent atypical chest pain, unclear etiology; (5) history of depression and anxiety. A sleep study has been ordered and he is in agreement with CPAP treatment option if he were to be diagnosed with sleep apnea. (Claimant Exhibit A, pages 25-27).

(16) On February 13, 2011, Claimant spent the night at the Sleep Health Center for a Polysomnogram. Major findings: this study shows he had mild obstructive sleep apnea overall, but moderate obstructive sleep apnea when he is supine. Stage REM was reduced, possibly due to respiratory events precluding stage REM. (Claimant Exhibit A, pages 28-29).

(17) On February 23, 2011, Claimant spent the night at the Sleep Health Center for Polysomnogram Interpretation. Major Findings: CPAP pressures ranged from 5-8 cm. He did well at both 6 cm and 8 cm of pressure. At 6 cm of CPAP he had an apnea-hypopnea index of 1 while supine and 2 while non-supine. Oxygen saturation did not drop below 93%. Snoring was not heard. He had a few leg movements late in the night. The periodic limb movement index overall was 16 per hour. Recommendations: CPAP at 6 cm of pressure with C-Flex mode and heated humidification is recommended. (Claimant Exhibit A, pages 30-32).

(18) On February 24, 2011, a cursory medical examination report on behalf of the department showed Claimant has a history of general anxiety, and was currently diagnosed with obstructive sleep apnea, pulmonary embolism and lymphedema. The doctor noted Claimant had left leg lymphedema and snored. (Department Exhibit A, pages 56-57).

(19) On February 25, 2011, Claimant saw his doctor for follow-up on his lab results. He presented with generalized anxiety. He was noted to have left leg swelling and diagnosed with obstructive sleep apnea. Based on his chronic pulmonary embolism, his dosage of Coumadin was increased. (Department Exhibit A, pages 80-82; Claimant Exhibit A, pages 18-20).

(20) On March 4, 2011, a cursory medical examination report on behalf of the department showed Claimant has a history of general anxiety, and was currently diagnosed with obstructive sleep apnea, chronic pulmonary embolism and left leg deep vein thrombosis. The doctor noted Claimant was obese and his left leg was swollen. (Department Exhibit A, pages 25-26).

(21) On March 8, 2011, Claimant saw his doctor complaining of left leg pain and numbness in both hands. An electrophysiological test was ordered.

Since no increase in swelling and chronic suspected postphelebic he was continued to be treated with Ultram. Because of his chronic pulmonary embolism, his dosage of Coumadin was increased. (Department Exhibit A, pages 77-79; Claimant Exhibit A, pages 15-17).

(22) On March 11, 2011, Claimant was referred for an electrophysiological study due to upper extremity tingling and numbness off and on for the past two weeks. The electrophysiological study of both upper extremities found normal duration, amplitude and recruitment of motor unit action potentials. The NCV study of right and left median motor with F wave distal latency was normal with normal NCV. Right and left median sensory with first and second digits and mid palm stimulation and radial sensory distal latency was also normal. The right and left ulnar motor with F wave and sensory and mid palm stimulation distal latency was also normal. (Department Exhibit A, page 76; Claimant Exhibit A, pages 14, 33-34).

(23) On April 7, 2011, Claimant reported back to the Sleep Health Center for follow-up. Impressions: (1) mild obstructive sleep apnea, more significant in supine position; 92) obesity, BMI greater than 40; (3) history of depression; (4) issues with mask fit. (Claimant Exhibit A, pages 35-36).

(24) On April 12, 2011, Claimant saw his doctor for hand pain. There was no injury but his hand was aching. The pain is aggravated by lifting and pushing. There are no relieving factors. Associated symptoms include tingling in the arms, tenderness and weakness. There is a change in skin color of his left ankle. The skin around ankle is darkened without turgor, no open wounds. (Claimant Exhibit A, pages 11-13).

(25) On April 13, 2011, Claimant's Ultrasound Doppler Venous Left Lower Extremity showed no evidence of acute deep venous thrombosis in the left lower extremity and stable chronic wall thickening of the mid to distal left femoral vein. (Claimant Exhibit A, page 10).

(26) On April 14, 2011, Claimant saw his doctor regarding pain and discoloration in his left foot. He has had issues with blood clots for the past 7 years. States he has never been tested for clotting disorder. His left leg has been swollen and he had an ultrasound which showed no clots. He was referred to lymphedemia clinic. His leg has been discolored "black" and he has not been tried on a water pill. He was started on Coumadin at 15mg a day. (Claimant Exhibit A, pages 7-9).

(27) On April 20, 2011, Claimant had a MR Angio Aorta and Bilateral Lower Extremity. Impression: (1) normal abdominal aorta and (2) bilateral lower extremity arteriogram does not show evidence of any significant narrowing or occlusion. (Claimant Exhibit A, pages 6, 40-41).

(28) On July 26, 2011, a Examination for Disability Determination Service listed Claimant's chief complaint as (1) status post deep vein thrombosis affecting the left leg seven years ago with recurrence on September 15, 2010, leaving persistent swelling in the left leg; (2) pain in the left heel radiating to the left calf; and (3) obesity lifelong. An examination of his lower extremities found the right is normal and the left leg has diffuse swelling. The circumferential measurement of his left leg at the calf 15 cm below the infrapatellar line is 51 cm versus the right leg 42 cm. This is nonpitting swelling. Peripheral pulses are not identified on the left leg but the right leg dorsalis pedis and posterior tibial are well felt. Circulation is intact. A review of his musculoskeletal system, shows his left knee has flexion of about 75 degrees. The left ankle dorsiflexion is 25 degrees and plantar flexion 20-25 degrees. He does not move his toes very well. His quadriceps are tight. He limps on the left leg and the use of a cane would be helpful to take the pressure off his left leg. He can partly squat only. He cannot do heel-toe walking. Assessment: Status post left leg deep vein thrombosis which is chronic. He has chronic persistent swelling which is venous and some lymphedema is a possibility. He is having severe pain in the left calf which is starting from his Achilles tendon to the midcalf. He has recently had a pulmonary embolism with pulmonary infarction in September 2010. He has been on Coumadin although recently his INR was low. The etiology of this recurrent deep venous thrombosis affecting his left leg needs to be evaluated. He also has sleep apnea. He states he has been on CPAP and is using it. Recently there has been detection of borderline blood sugar elevation six months ago, although now it is within normal range. He is only on diet control. He thinks Lasix does not help him with reducing the swelling and it should be discontinued. He should go for regular follow up for diabetes. He does not have a glucometer. He is an ex-smoker and states he has quit drinking also. (Department Exhibit C, pages 3-5).

(29) Claimant is a 30 year old man whose birthday is [redacted]. Claimant is 6'1" tall and weighs 334 lbs. Claimant completed high school. Claimant last worked in June 2010.

(30) 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 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 Reference Tables Manual (RFT).

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 Reference Tables Manual (RFT).

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, that being a five-step sequential evaluation process for determining whether an individual is disabled. (20 CFR 404.1520(a) and 416.920(a)). The steps are followed in order. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience is reviewed. If it is determined that the claimant is or is not disabled at a step of the evaluation process, the evaluation will not go on to the next step.

At step one, the Administrative Law Judge must determine whether the claimant is engaging in substantial gainful activity. (20 CFR 404.1520(b) and 416.920(b)). Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. "Substantial work activity" is work activity that involves doing significant physical or mental activities. (20 CFR 404.1572(a) and 416.972(a)). "Gainful work activity" is work that is usually done for pay or profit, whether or not a profit is realized. (20 CFR 404.1572(b) and 416.972(b)). Generally, if an individual has earnings from employment or self-employment above a specific level set out in the regulations, it is presumed that he/she has demonstrated the ability to engage in SGA. (20 CFR 404.1574, 404.1575, 416.974, and 416.975). If an individual engages in SGA, he/she is not disabled regardless of how severe his/her physical or mental impairments are and regardless of his/her age, education, and work experience. If the individual is not engaging in SGA, the analysis proceeds to the second step.

At step two, the Administrative Law Judge must determine whether the claimant has a medically determinable impairment that is "severe" or a combination of impairments that is "severe." (20 CFR 404.1520(c) and 416.920(c)). An impairment or combination of impairments is "severe" within the meaning of the regulations if it significantly limits an individual's ability to perform basic work activities. An impairment or combination of impairments is "not severe" when medical and other evidence establish only a slight abnormality or a combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work. (20 CFR 404.1521 and 416.921; Social

Security Rulings (SSRs) 85-28, 96-3p, and 96-4p). If the claimant does not have a severe medically determinable impairment or combination of impairments, he/she is not disabled. If the claimant has a severe impairment or combination of impairments, the analysis proceeds to the third step.

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). 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).

At step three, the Administrative Law Judge must determine whether the claimant's impairment or combination of impairments meets or medically equals the criteria of an impairment listed in 20 CFR Part 404, Subpart P, Appendix 1. (20 CFR 404.1520(d), 404.1525, 404.1526, 416.920(d), 416.925, and 416.926). If the claimant's impairment or combination of impairments meets or medically equals the criteria of a listing and meets the duration requirement, (20 CFR 404.1509 and 416.909), the claimant is disabled. If it does not, the analysis proceeds to the next step.

Before considering step four of the sequential evaluation process, the Administrative Law Judge must first determine the claimant's residual functional capacity. (20 CFR 404.1520(e) and 416.920(e)). An individual's residual functional capacity is his/her ability to do physical and mental work activities on a sustained basis despite limitations from his/her impairments. In making this finding, all of the claimant's impairments, including impairments that are not severe, must be considered. (20 CFR 404.1520(e), 404.1545, 416.920(e), and 416.945; SSR 96-8p).

Next, the Administrative Law Judge must determine at step four whether the claimant has the residual functional capacity to perform the requirements of his/her past relevant work. (20 CFR 404.1520(f) and 416.920(f)). The term past relevant work means work performed (either as the claimant actually performed it or as it is generally performed in the national economy) within the last 15 years or 15 years prior to the date that disability must be established. In addition, the work must have lasted long enough for the claimant to learn to do the job and have been SGA. (20 CFR 404.1560(b), 404.1565, 416.960(b), and 416.965). If the claimant has the residual functional capacity to do his/her past relevant work, the claimant is not disabled. If the claimant is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth and last step.

At the last step of the sequential evaluation process (20 CFR 404.1520(g) and 416.920(g)), the Administrative Law Judge must determine whether the claimant is able

to do any other work considering his/her residual functional capacity, age, education, and work experience. If the claimant is able to do other work, he/she is not disabled. If the claimant is not able to do other work and meets the duration requirements, he/she is disabled.

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).

At Step 1, Claimant is not engaged in substantial gainful activity and testified that he has not worked since June, 2010. Therefore, Claimant is not disqualified from receiving disability at Step 1.

At Step 2, in considering Claimant's symptoms, whether there is an underlying medically determinable physical or mental impairment(s)-i.e., an impairment(s) that can be shown by medically acceptable clinical and laboratory diagnostic techniques-that could reasonably be expected to produce Claimant's pain or other symptoms must be determined. Once an underlying physical or mental impairment(s) has been shown, the Administrative Law Judge must evaluate the intensity, persistence, and limiting effects of Claimant's symptoms to determine the extent to which they limit Claimant's ability to do basic work activities. For this purpose, whenever statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not substantiated by objective medical evidence, a finding on the credibility of the statements based on a consideration of the entire case record must be made.

At Step 2, the objective medical evidence of record shows Claimant was diagnosed with depression, anxiety, deep vein thrombosis, chronic lymphedema, pulmonary embolism, shortness of breath, obstructive sleep apnea and diabetes. The finding of a severe impairment at Step 2 is a *de minimus* standard. This Administrative Law Judge finds that Claimant established that at all times relevant to this matter Claimant had circulatory problems which would affect his ability to do substantial gainful activity. Therefore, the analysis will continue to Step 3.

At Step 3 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 Claimant's medical record will not support a finding that Claimant's impairment(s) is a "listed impairment" or equal to a listed impairment. Accordingly, Claimant cannot be found to be disabled based upon medical evidence alone. 20 CFR 416.920(d).

At Step 4, Claimant's past relevant employment was working providing direct care in a group home for the last 12 years. At Step 4, the objective medical evidence of record is not sufficient to establish that Claimant has severe impairments that have lasted or are expected to last 12 months or more and prevent him from performing the duties

required from his past relevant employment for 12 months or more. Accordingly, Claimant is disqualified from receiving disability 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 other jobs.

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).

Medium work. Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work. 20 CFR 416.967(c).

Heavy work. Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work. 20 CFR 416.967(d).

At Step 5, the burden of proof shifts to the department to establish that Claimant has the residual functional capacity to do substantial gainful activity. 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. See discussion at Step 2 above. Findings of Fact 10-29.

At Step 5, the objective medical evidence of record is sufficient to establish that Claimant is capable of performing at least sedentary work duties. Claimant alleges he suffers from a history of blood clots in his leg for the past 7 years and his left leg is

constantly swollen. Claimant stated he has chest pain periodically and he has muscle spasms and pain in his hands and fingers.

Claimant's ultrasound in September 2010, of his lower extremities showed a stable chronic thrombus of the left mid to distal, left femoral and popliteal veins. There was no evidence of an acute left lower extremity deep venous thrombosis. A second ultrasound in January 2011, of his left lower extremity showed stable, chronic changes of the mid to distal left femoral vein, and no evidence of acute deep vein thrombosis of the left lower extremity from the hip to the knee, suboptimal visualization of the calf veins secondary to body habitus and edema.

Furthermore, there was no evidence of acute pulmonary embolism in January 2011, and no acute infiltrate, mass or pleural effusion. There was minimal scarring atelectasis of the right lower lobe. He also had a chest x-ray that showed no acute cardiopulmonary process.

In March 2011, Claimant had an electrophysiological study due to upper extremity tingling and numbness off and on for the past two weeks. The study of both extremities found normal duration, amplitude and recruitment of motor unit action potentials.

In April 2011, Claimant was diagnosed with mild obstructive sleep apnea, more significant in the supine position. Claimant was prescribed a CPAP mask. Claimant stated that he does feel a difference and he feels his sleep is more restored. Overall he was happy with the current treatment of his sleep apnea with the CPAP mask.

In July 2011, Claimant informed the doctor performing the medical examination, that he had recently been diagnosed with diabetes, but was controlling it with diet and was not on any medication. His blood pressure was well controlled. An examination of the lower extremities showed persistent swelling in the left leg with no pitting edema. Peripheral pulses were not identified in the left leg, but circulation was intact.

Therefore, this Administrative Law Judge finds that the objective medical evidence on the record does establish that Claimant has the residual functional capacity to perform other work. As a result, Claimant is disqualified from receiving disability at Step 5 based upon the fact that the objective medical evidence on the record shows he can perform sedentary work. Under the Medical-Vocational guidelines, a younger individual age 18 - 49 (Claimant is 30 years of age), with a high school and an unskilled work history is not considered disabled pursuant to Medical-Vocational Rule 201.27. Accordingly, Claimant is not disabled for the purposes of the Medical Assistance disability (MA-P) program.

Claimant has not presented the required competent, material, and substantial evidence which would support a finding that Claimant has an impairment or combination of impairments which would significantly limit the physical or mental ability to do basic work activities. 20 CFR 416.920(c). Although Claimant has cited medical problems, the clinical documentation submitted by Claimant is not sufficient to establish a finding that

Claimant is disabled. There is no objective medical evidence to substantiate Claimant's claim that the alleged impairment(s) are severe enough to reach the criteria and definition of disabled. Accordingly, Claimant is not disabled for the purposes of the Medical Assistance disability (MA-P) program.

The department's Bridges 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 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, Claimant does not meet the disability criteria for State Disability Assistance benefits either.

The Department has established by the necessary competent, material and substantial evidence on the record that it was acting in compliance with department policy when it determined that Claimant was not eligible to receive MA, Retro-MA or SDA.

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 MA, Retro-MA and SDA benefits.

Accordingly, the department's decision is AFFIRMED.

It is SO ORDERED.

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

Date Signed: 12/13/11

Date Mailed: 12/13/11

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