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

IN THE MATTER OF:

[redacted]

Reg. No.: 2012-27225
Issue No.: 2009; 4031
Case No.: [redacted]
Hearing Date: March 21, 2012
County: Muskegon County

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

HEARING DECISION

This matter is before the undersigned Administrative Law Judge upon the Claimant's request for a hearing made pursuant to Michigan Compiled Laws 400.9 and 400.37, which govern the administrative hearing and appeal process. After due notice, a telephone hearing was commenced on March 21, 2012, from Lansing, Michigan. Claimant and his sister personally appeared and testified. Participants on behalf of the Department of Human Services (Department) included Family Independence Manager [redacted]

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional medical evidence. The new evidence was forwarded to the State Hearing Review Team ("SHRT") for consideration. On June 6, 2012, the SHRT found Claimant was not disabled. This matter is now before the undersigned for a final decision.

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 February 24, 2011, Claimant applied for MA-P, Retro-MA and SDA benefits.

(2) On December 14, 2011, the Medical Review Team (MRT) denied Claimant's MA application indicating Claimant is capable of performing other work, pursuant to 20 CFR 416.920(f). MRT denied Claimant's SDA application due to lack of duration. (Department Exhibit A, pages 99-100).

(3) On December 19, 2011, the department caseworker sent Claimant notice that his application was denied.

(4) On January 20, 2012, Claimant filed a request for a hearing to contest the department's negative action.

(5) On February 22, 2012, and on June 6, 2012, the State Hearing Review Team (SHRT) upheld the denial of MA-P and Retro-MA benefits indicating Claimant retains the capacity to perform a wide range of medium work. SDA was denied due to lack of duration. (Department Exhibit B, pp 1-2; Department Exhibit C, pp 1-2).

(6) Claimant has a history of migraines, hypertension, sleep apnea, asthma, dyslipidemia, gastroesophageal reflux disease (GERD), hyperlipidemia, morbid obesity and hypokalemia.

(7) Claimant is a 45 year old man whose birthday is [redacted]. Claimant is 5'7" tall and weighs 265 lbs. Claimant completed high school and last worked in January 2011.

(8) 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 Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department, (DHS or department), 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 Mich Admin Code, Rules 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).

Current legislative amendments to the Act delineate eligibility criteria as implemented by department policy set forth in program manuals. 2004 PA 344, Sec. 604, establishes the State Disability Assistance program. It reads in part:

> Sec. 604 (1). The department shall operate a state disability assistance program. Except as provided in subsection (3), persons eligible for this program shall include needy citizens of the United States or aliens exempt from the Supplemental Security Income citizenship requirement who are at least 18 years of age or emancipated minors meeting one or more of the following requirements:
>
> (b) A person with a physical or mental impairment which meets federal SSI disability standards, except that the minimum duration of the disability shall be 90 days. Substance abuse alone is not defined as a basis for eligibility.

Specifically, this Act provides minimal cash assistance to individuals with some type of severe, temporary disability which prevents him or her from engaging in substantial gainful work activity for at least ninety (90) days.

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). The person claiming a physical or mental disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

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 limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed

impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (e.g., age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4). If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3 to Step 4. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

As outlined above, the first step looks at the individual's current work activity. In the record presented, Claimant is not involved in substantial gainful activity and testified that he has not worked since January 2011. Therefore, he is not disqualified from receiving disability benefits under Step 1.

The severity of the individual's alleged impairment(s) is considered under Step 2. The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b). An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b). Examples 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. *Id.*

The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). An impairment qualifies as non-severe only if, regardless of a claimant's age, education, or work experience, the impairment would not affect the claimant's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985).

In the present case, Claimant alleges disability due to migraines, hypertension, sleep apnea, asthma, dyslipidemia, gastroesophageal reflux disease (GERD), morbin obesity, hyperlipidemia and hypokalemia.

On January 13, 2011, Claimant was admitted to the telemetry floor of the hospital after going to the emergency department complaining of chest pain. His admitting diagnoses were: (1) Chest pain, possible acute coronary syndrome; (2) Uncontrolled hypertension with hypertensive urgency; and (3) Noncompliance. Serial cardiac enzymes were obtained, which did not show any elevation of his troponin. He had optimization of his cardiac medications, given his presentation with accelerated hypertension. His chest x-ray on 1/13/11 was negative and his Stress Myoview on 1/14/11 showed no chest pain and no ischemic EKG changes. The Myoview images demonstrated a mildly dilated ventricle with normal perfusion. Gate images demonstrated normal regional contractility with overall low normal systolic function. Ejection fraction was estimated at 52%. His echocardiogram on 1/14/11 showed mild dilation of the left atrium, mild mitral regurgitation, normal left ventricular structure and function, normal diastolic function, and mild concentric left ventricular hypertrophy. Claimant was discharged in stable condition on 1/14/11 with diagnoses of (1) atypical chest pain, possibly secondary to gastroesophageal reflux disease, stress Myoview imaging demonstrated normal perfusion; (2) accelerated hypertension, resolved; (3) dyslipidemia; (4) morbid obesity with a body mass index of 44; and (5) gastroesophageal reflux disease (GERD).

On February 4, 2011, Claimant saw his primary care physician for follow-up after his emergency department evaluation on 1/30/11 where he was seen for a swollen lip. Claimant also complained of a headache. His physician opined that he believed the headache was secondary to the lowering of his blood pressure and had Claimant split the times that he takes his medications by approximately 1-2 hours to see if that helps.

His blood pressure was much better controlled on these medications so there were no changes.

On February 11, 2011, Claimant saw his primary care physician complaining of headaches. Claimant continued to have elevated blood pressures in the office. He was given 0.2 mg of Clonidine with blood pressure going down to 175/115, then he was given another 0.1 mg and rechecked 20 minutes later and his blood pressure was down to 150/105, and he was discharged home with instructions to stop at the lab on his way out to have his blood drawn for sediment rate to rule out temporal arthritis. He was instructed to continue the Diltiazem and Hydralazine (Hctz) and Clonidine was added.

On February 16, 2011, a cat-scan of Claimant's head identified no abnormalities.

On February 25, 2011, Claimant saw his primary care physician for a scheduled follow-up of his hypertension. There had been no associated chest pain, claudication, syncope, paresthesia, fainting or edema. Claimant had been compliant with his medications and there had been no medication side effects. Claimant exercised twice a month. Claimant also complained of acid reflux and headaches. Claimant's blood pressure was better controlled and he was referred to neurology to determine the cause of his headaches.

On April 13, 2011, Claimant had a scheduled evaluation of his hypertension. Claimant had been compliant with his medications and was having headaches as a side effect. He was not following the recommended diet or restrictions to his diet and had not started exercising.

On May 11, 2011, Claimant saw his primary care physician to follow-up on his hypertension. Claimant had been compliant with his medications and had had no medication side effects. Claimant had not followed the recommended diet or restrictions to his diet and was only exercising once a month.

On July 1, 2011, Claimant saw his primary care physician for evaluation of his hypertension. He had been compliant with his medications. There had been no medication side effects. He was following a low sodium diet and was exercising twice a week. Medications for the treatment of hypertension included: Hydrochlorothiazide (Hctz) and Diltiazem. Claimant was instructed to keep his next doctor appointment as his blood pressure was beginning to come down. He was to continue with his current medications and to work on his diet.

On August 17, 2011, Claimant went to the emergency room complaining of headaches. He underwent a cat-scan and when compared with the previous cat-scan of 2/16/11, the ventricular system was within normal limits. There was no evidence of mass effect, midline shift, vasogenic edema, enhancing lesions, intracranial hemorrhage or cortical infarction. His chest x-ray was negative and unchanged from his last examination on 1/13/11.

On August 18, 2011, Claimant saw his primary care physician for a scheduled follow-up on his hypertension. Claimant had been compliant with his medications and has had dizziness as a side effect. A recent CT of the head was negative. He used to get headaches everyday before his blood pressure was under control but now was getting them every other week. He had never been tried on a medication to prevent the headaches. He had an elevated fasting blood sugar per labs in January 2011. He denied any history of diabetes. He is not following recommended diet or restrictions to diet and does not have a formal exercise regimen. Medications used for the treatment of hypertension include Diltiazem, Clonidine and Hctz. Since being on the new medications for his hypertension, his average blood pressures were 130/90's. He is also on Pravastatin and has not had his cholesterol checked since January 2011. He denied any side effect to this medication.

On August 28, 2011, Claimant went to the emergency department complaining of a headache he had had for several weeks. Claimant was initially seen with dizziness on 8/17/11, and had a CT scan of his head which was unremarkable. He saw his family doctor who gave him Ultram for it. It did not seem to be helping. Additional medical records revealed that he did have a normal stress test on 1/14/11 and on 8/17/11 he had a chest x-ray which was also normal. All of his cardiac and other laboratory workup on 8/17/11 was also normal. He appeared to be in no acute distress. Claimant had a normal gait and full range of motion in his neck and extremities. Claimant was started on an IV and given Zofran, Morphine, Toradol and Benadryl which provided good symptomatic relief and he was discharged in stable condition.

On September 23, 2011, Claimant saw his primary care physician for follow-up after his ER visits on 8/17/11 and 8/28/11. He was still getting headaches that went into migraines 3 times a week. His blood pressure had not been controlled in the past. He recently was found to have a potassium level of 2.9 that was treated. His is due for a lab draw to recheck the level. He had been taking Midrin for his headaches with minimal improvement. Claimant was prescribed Depakote 250 mg, 1 tablet twice a day for migraine prevention.

On October 14, 2011, Claimant saw his primary care physician for follow-up of his hypertension. Claimant was not following recommended diet or restrictions to diet and denied any formal exercise program and did not check his blood pressure at home. Claimant had been compliant with his medications but was having headaches as a side effect. Claimant stated that on average he would get two headaches a week, which rapidly became migraines, which occurred four times a week, and lasted 3 hours on average. Since being on Depakote he had not noticed much difference, but he had only been taking 250mg at bedtime and not twice a day as prescribed. He had been taking Imitrex for his acute migraines and he continued to have complications with his blood pressure being elevated.

On November 1, 2011, Claimant saw his primary care physician for evaluation of his hypertension. He had been compliant with medications and was having headaches as a side effect of the medications. He was following a low sodium diet and denied having

a formal exercise regimen. Claimant also had a history of hykpokalemia with continued low levels regardless of supplementation. Claimant denied any heart palpitations, but did occasionally have leg cramps. His last lab draw was 10/14/11 with a potassium level of 3.0. He was instructed to increase his KCL and get a redraw in several days, but he did not do that.

On March 2, 2012, Claimant saw his primary care physician for a recheck of his headaches. The onset of the headaches had been sudden and had been occurring in an intermittent pattern for years. In January 2011, Claimant was hospitalized for high blood pressure and ever since then he has been getting frontal lobe headaches. He had improved on Depakote, in that he was not getting them as frequently. The headaches were described as being located in the frontal area. The symptoms were aggravated by tension, nervous strain, noise and fatigue. The symptoms had been associated with blurring of vision, eye pain, chronic behind left eye, with migraines, and insomnia. He was averaging a headache twice a week and a migraine once a week typically lasting 3 hours. He stated he frequently gets dizzy spells with the migraines and aura, but no light or sound sensitivity. Claimant's blood pressure was also checked. He had associated chest pain, but no syncope, fainting or edema. He had been compliant with medications and was following a low sodium diet and exercising twice a week. Claimant is on Hctz and Diltiazem and had elevations intermittently. He was to continue with the same medications and continue to work on his diet.

On March 13, 2012, Claimant underwent a sleep study. Claimant was diagnosed with moderate obstructive sleep apnea with an apnea hypopnea index of 15.7. The plan was for nasal CPAP at 7 cm of water pressure.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, Claimant has presented some limited medical evidence establishing that he does have some physical limitations on his ability to perform basic work activities. The medical evidence has established that Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. Claimant has alleged physical and mental disabling impairments due to migraines, hypertension, sleep apnea, asthma, dyslipidemia, gastroesophageal reflux disease (GERD), hyperlipidemia, morbid obesity and hypokalemia.

Listing 5.00 (digestive system), Listing 6.00 (genitourinary impairments), and Listing 9.00 (endocrine disorders) were considered in light of the objective evidence. Based on the foregoing, it is found that Claimant's impairment(s) does not meet the intent and severity requirement of a listed impairment; therefore, Claimant cannot be found

disabled, or not disabled, at Step 3. Accordingly, Claimant's eligibility is considered under Step 4. 20 CFR 416.905(a).

The fourth step in analyzing a disability claim requires an assessment of the individual's residual functional capacity ("RFC") and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if he/she can perform past relevant work. *Id*.; 20 CFR 416.960(b)(3). Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s) and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

To determine the physical demands (exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967. Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). 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. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b). Even though 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. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.* Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.* Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.* Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands (exertional requirements, e.g., sitting, standing, walking, lifting, carrying, pushing, or pulling) are considered nonexertional. 20 CFR 416.969a(a). In considering whether an individual can perform past relevant work, a comparison of the individual's residual functional capacity to the demands of past relevant work must be

made. *Id.* If an individual can no longer do past relevant work, the same residual functional capacity assessment along with an individual's age, education, and work experience is considered to determine whether an individual can adjust to other work which exists in the national economy. *Id.* Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (e.g., can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2). The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.*

Claimant's prior work history consists of working in construction 11 years. In light of Claimant's testimony, and in consideration of the Occupational Code, Claimant's prior work is classified as unskilled, heavy work.

Claimant testified that he is able to walk short distances and can lift/carry approximately 20 pounds and can stand for 15 or 20 minutes and walk for only 30 minutes at a time. If the impairment or combination of impairments does not limit an individual's physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. 20 CFR 416.920. In consideration of Claimant's testimony, medical records, and current limitations, it is found that Claimant is unable to return to past relevant work; thus Claimant would be found not disabled at Step 4.

In Step 5, an assessment of the individual's residual functional capacity and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v) At the time of hearing, the Claimant was 45 years old and was, thus, considered to be a younger individual for MA-P purposes. Claimant has a high school degree. Disability is found if an individual is unable to adjust to other work. *Id.* At this point in the analysis, the burden shifts from the Claimant to the Department to present proof that the Claimant has the residual capacity to substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). The age for younger individuals (under 50) generally will not seriously affect the ability to adjust to other work. 20 CFR

416.963(c). Where an individual has an impairment or combination of impairments that results in both strength limitations and non-exertional limitations, the rules in Subpart P are considered in determining whether a finding of disabled may be possible based on the strength limitations alone, and if not, the rule(s) reflecting the individual's maximum residual strength capabilities, age, education, and work experience, provide the framework for consideration of how much an individual's work capability is further diminished in terms of any type of jobs that would contradict the non-limitations. Full consideration must be given to all relevant facts of a case in accordance with the definitions of each factor to provide adjudicative weight for each factor.

In this case, the evidence reveals that Claimant suffers from migraines, hypertension, sleep apnea, asthma, dyslipidemia, gastroesophageal reflux disease (GERD), hyperlipidemia, morbid obesity and hypokalemia. The objective medical evidence lists no limitations. In light of the foregoing, it is found that Claimant maintains the residual functional capacity for work activities on a regular and continuing basis which includes the ability to meet the physical and mental demands required to perform at least sedentary work as defined in 20 CFR 416.967(a). After review of the entire record using the Medical-Vocational Guidelines [20 CFR 404, Subpart P, Appendix II] as a guide, specifically Rule 201.22**,** it is found that Claimant is not disabled for purposes of the MA-P, Retro-MA and SDA programs at Step 5.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Claimant not disabled for purposes of the MA-P, Retro-MA and SDA benefit programs. Accordingly, it is ORDERED:

The Department's determination is AFFIRMED.

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

Date Signed: 6/21/12

Date Mailed: 6/21/12

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

[redacted]