STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF: [redacted],

Claimant

Reg. No: 2008-28341
Issue No: 2009;4031
Case No: [redacted]
Load No: [redacted]
Hearing Date:
November 18, 2008
Macomb County DHS

ADMINISTRATIVE LAW JUDGE: Jay W. Sexton

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon claimant's request for a hearing. After due notice, a telephone hearing was held in Clinton Township on November 18, 2008. Claimant personally appeared and testified under oath.

The department was represented by Donna Staton (ES).

ISSUES

(1) Did claimant establish a severe mental impairment expected to preclude him from substantial gainful work, **continuously**, for one year (MA-P) or 90 days (SDA)?

(2) Did claimant establish a severe physical impairment expected to preclude him from substantial gainful work, **continuously**, for one year (MA-P) or 90 days (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) Claimant is a MA-P/retro/SDA applicant (May 13, 2008) who was denied by SHRT (August 26, 2008) based on claimant's failure to submit medical evidence of an impairment which meets the department's severity and duration requirements. Claimant requests retro MA for February, March and April 2008.

(2) [redacted]

(3) Claimant has not performed Substantial Gainful Activity (SGA) since October 2005 when he was a line [redacted]

(4) Claimant has the following unable-to-work complaints:

(a) Unable to stand more than 10 minutes;
(b) Unable to sit more than 30 minutes;
(c) Unable to shop for groceries on his own without an Amigo cart;
(d) Goes downstairs very slowly.

(5) SHRT evaluated claimant's medical evidence as follows:

OBJECTIVE MEDICAL EVIDENCE (August 26, 2008)

X-ray of the left hip, dated 8/2007 showed avascular necrosis of the left femoral head. There was some collapse of the superior portion of the left femoral head (page 107). A MRI, dated 12/2007, showed deformity of the left femoral head with flattening with an area of deformity, with old non-united fracture in the superior lateral aspect of the femoral head, with patchy sclerosis, suggestive also of avascular necrosis with mild secondary osteoarthritis (page 108).

A DHS-49 form, dated 4/2008 showed claimant had depression, hypertension, and avascular necrosis of the left femoral head. He had problems with ambulation and left hip pain. The doctor indicated claimant needed left hip replacement surgery (page 86). The doctor stated claimant required a cane for ambulation. He can stand/walk less than 2 hours and lift less than 10 pounds frequently (page 85).

> On exam, in 6/2008, claimant had decreased range of motion (ROM) of the right ankle, the spine and the left hip. He could walk without any walking aid, but with a limp. He could not tiptoe, heel walk or tandem gait. Deep reflexes were brisk all over (page 120).
>
> A mental status exam was done in 6/2008, but the actual exam is not in the file.
>
> ANALYSIS: Claimant has avascular necrosis of the left hip and would be limited to sedentary work. A mental status exam was done in 6/2008, but it is not legible in the file.

(6) Claimant lives alone and performs the following Activities of Daily Living (ADLs): dressing, bathing, cooking (sometimes), dish washing, mopping (sometimes), laundry (needs help) and grocery shopping (needs an Amigo cart). Claimant uses a cane and a crutch in combination on a daily basis. He uses a walker to get out of the shower on a daily basis. He uses a wheelchair approximately 7 times a month. He does not use a shower stool. He does not wear a brace on his back, neck, arms, or legs. Claimant received inpatient hospital treatment for a fractured right ankle in June 2007.

(7) Claimant has a valid driver's license and drives an automobile approximately 25 times a month. Claimant is computer literate.

(8) The following medical records are persuasive:

(a) A June 23, 2008 internal medicine evaluation was reviewed.

> The consulting internist provided the following history: claimant said that he has pain in the lower part of the back and the left hip joint since August 2005. He attributed this to moving furniture while helping a friend. He said since October 2006 it has become aggravated. He had an x-ray of the back and the hip in August 2006 but they were normal. He also complains of numbness of the legs and feet off and on. He said in 2007 he fractured his right ankle when he fell down the steps. He had surgery for it. He had pain and swelling following the surgery, but he had no pain and swelling in the right ankle joint since September 2007. He

said he has been using a walker since the last 5 weeks. Without the walker, he can walk a few steps and stand for 2½ hours. With the walker he can walk 2-3 houses at street level and stand for 2½ hours. He can climb 9 steps holding onto rails, but it takes time. He can sit and lie on the bed for several hours. He can do some housework such as laundry, wash dishes, make the bed and dust. He can vacuum, clean, and sweep and mop in a sitting position. Using both hands he can lift about 10 pounds from the floor and carry it up to a distance of 10 feet. Coughing and sneezing do not aggravate the back pain. He can take care of his personal hygiene, dress and undress and drive an automatic car. His joint pain has no relation to weather or time of day. He takes Advil, 8 a day. He said prior to using the walker he had used crutches for three months. He has been using a cane off and on at home. He uses it while climbing stairs. He has been using the cane since November 2006. He has been using the cane and walker to keep pressure off the back.

He is a known hypertensive for the last 8 months, but does not take any medications for it or any low salt diet. He has no chest pain, palpitations, swelling of the legs or cardiac failure.

His appetite is good, bowels are regular and he has been overweight for several years. He has gained 42 pounds over the last one year. He says he tries to lose weight with diet and exercise, but did not have any success. He has no abdominal pain, nausea, vomiting, heartburn or GI bleeding.

He has been suffering from depression and anxiety state and takes medications for it prescribed by his psychiatrist. His memory is good. As mentioned earlier, he gets numbness of the legs and feet off and on. He has no weakness, dizziness or involuntary movements.

The consulting internist provided the following diagnosis:

(1) Osteoarthritis of the lumbar spine, both hip joints and post traumatic osteoarthritis of the right ankle joint. Patient has functional limitations orthopedically.
(2) Hypertension. It is well controlled with present regimen.

(3) Depression and anxiety state. Memory is good. He was fair in grooming and hygiene. He responded fairly well to the examining situation.
(4) Exogenous obesity with no limitation of mobility or activity from it.

(b) A June 23, 2008 consulting psychiatric evaluation was reviewed.

The psychiatrist provided the following history:

[redacted] who came to the interview alone and presented his chief complaints as he is suffering from depression, anxiety, sense of worthlessness, low self esteem since age 10 which has been highlighted in recent years. Claimant stated he is currently under psychiatric treatment as of 10/2007 visiting Clinton Counseling Center being treated by psychologist C.M.D. [redacted] psychiatrist who has prescribed him Celexa 40 mg a day. He attends group therapy, relapse prevention once a week and AA meetings 4 to 6 times a week. Claimant stated despite taking Celexa 40 mg a day, he continues to wake up in the middle of the night occasionally although he has made some improvement in the frequency of awaking at night. He also expressed some degree of anxiety relief from Celexa. Claimant stated he has shown control of his anger and frustration. His appetite was described as good and allegedly he has gained 15 pounds in the past one year. Claimant stated as his mother passed away when he was 10 years old, he was psychologically being abused by his stepmother; therefore, he sustained unhappiness throughout his childhood and growing stages of life to the extent that he became truant from home and school at age 13-14 and generally adolescence. Claimant denied past psychiatric treatment of any modality.

SUBSTANCE ABUSE HISTORY: Claimant claimed during high school he experimented with marijuana. Claimant stated in the past 7 months he has been abstinent and sober from alcohol. As alluded above, he attends relapse prevention group therapy once a week and participates in AA meetings 4-6 times a week. He additionally isolates himself from peers that influence him on drinking alcohol.

MEDICAL CONDITIONS: Claimant came to the interview while assisting himself with a walker and claimed that he is suffering from pain unbearably to the extent that he alleviates himself with Darvocet. Claimant reports diagnosis of Avascular Necrosis in both hips, more severe on the left hip and alleged that his hips collapse, therefore he is unable to walk without assistance of a walker.

EMPLOYMENT HISTORY: Claimant stated his last day of employment was 10/2005. He was working [redacted] and also indulgence of alcohol. Claimant quit that job. He stated prior to that he was a caregiver for a man who was ill for a period of 2 years. Since he passed away, he is affected by grief of his death and therefore indulged himself in heavy drinking more than before. He had worked in a factory, odd jobs such as landscaping, plumbing, and maintenance, but he claims he had never to hold a job for a long time.

DSM DIAGNOSIS: The DSM diagnosis on this report was illegible.

(c) An April 8, 2008 Medical Examination Report (DHS-49D) was reviewed.

The family practice physician provided the following diagnoses:

(1) Depression;
(2) Avascular necrosis of left femoral head;
(3) Hypertension.

The family practice physician reported the following limitations: claimant is able to lift less than 10 pounds frequently. He is able to stand/walk less than 2 hours in an 8 hour day, able to sit less than 6 hours in an 8 hour day. Claimant is able to use his hands/arms normally to perform simple grasping, reaching, pushing/pulling and fine manipulating. Claimant has normal use of his right foot and leg but is unable to use his left foot and leg to operate foot controls.

Under medical findings the physician states: claimant has avascular necrosis of the left femoral head. It is a debilitating illness. He requires left hip replacement. He

needs medical insurance to cover this procedure. The family practice physician did not state that claimant is totally unable to work.

(d) An April 8, 2008 Medical Examination Report (DHS-49) completed by an orthopedic surgeon was reviewed.

The orthopedic surgeon provided the following current diagnosis: avascular necrosis left and right hips.

The orthopedic surgeon provided the following work limitations: claimant is able to lift up to 10 pounds occasionally. He is able to stand or walk less than 2 hours in an 8 hour day. No restriction on sitting was reported. Claimant is able to use his hands/arms normally. Claimant is not able to use his feet/legs to operate foot controls.

(e) An October 12, 2007 [redacted] physical capacity assessment was reviewed. The physician provided the following physical capacities assessment: claimant is never able to lift up to 50 pounds, lift over 50 pounds, squat, crawl, kneel, stair climb or climb.

Claimant has the physical capacity to perform the following activities sometimes: sit, stand, walk (less then twice a day), lift up to 25 pounds, bend, and pushing and pulling.

The physician stated that claimant is able to perform the following physical capacities frequently: lift up to 10 pounds, reach over shoulder, grasping (right side), grasping (left side).

The physician reported the following environmental restrictions: claimant should avoid work involving unprotected heights. Claimant should avoid work involving marked temperature or humidity changes.

(f) A September 5, 2007 [redacted] provided the following narrative report:

Enclosed is a copy of the left hip x-ray you had on 8/24/07. The radiologist reads the x-ray as avascular necrosis of the left femoral head.

You will need a hip replacement on the left eventually. This is usually a progressive degenerative process. To try to slow down the process, I suggest non-weight bearing on your left hip as much as possible, in other words up with crutches and continue to keep the muscles strong with therapy-like water therapy. This condition is often related to overuse of steroids or alcohol intake. You must refrain from any prednisone intake and quit drinking. Use of ibuprophen with acetaminophen is recommended for pain control.

(g) An August 11, 2007 [redacted]

The internist provided the following history: claimant was examined and evaluated orthopedically by me at [redacted] he is not working since October 2005 and he used to work as a cook in a restaurant.

Claimant said he stopped working due to lower back pain and pain in the left hip. There is also minor pain in the right hip area. Recently, he sustained a fracture of his right ankle in June 2007, and had surgical repair. He is now walking with a pair of crutches. He complains of stiffness and pain in his right ankle.

Claimant said that he is not able to work now because of pain in the left hip as well as back pain. Pain is constant to the intensity of 7/10 when the maximum pain is 10. Walking up and down stairs, bending, lifting and carrying is difficult. There is no history of acute lower back pain. He is not taking any medications at present.

History revealed that in August 2005, he started to experience pain in his back and the left hip area. There is no history of any specific injury, but apparently he was moving from one place to another, carrying and lifting furniture. Because of the pain in the hip, which is more pronounced as compared to lower back, he consulted a doctor, but no treatment or medication was given. Only recently he had an x-ray of his back and the hip area. He said there was no history of any back pain or hip trouble prior to this instance.

In June 2007, he injured his right ankle and was treated by surgery for a broken bone. He is still walking with a pair of crutches, complaining of some difficulty in walking.

Personal history revealed that he is right handed and single. He can do minor housework at home.

Physical examination revealed that claimant is a healthy looking, tall, overweight man and has a pair of crutches with him. He walks with the help of crutches limping and trying to overt pressure on his right ankle. However, his equilibrium is normal.

Upper limbs are negative for any neurological deficiency and both shoulders have full range of motion without any complaint.

His lower back revealed normal lumbar lordosis. Muscle tone is good and there is no spasm or atrophy. Range of motion revealed extension 20 degrees with complaint of pain. Flexion 45 degrees also with complaint of pain. Right and left lateral flexion 25 degrees and rotation 25 degrees.

Both lower limbs revealed that there is about ¾ inch shortening on the left side. There is no muscle atrophy. Sensation is normal.

Left hip examination revealed that flexion 80 degrees with complaint of pain. Abduction 25 degrees also with complaint of pain. Adduction 20 degrees. Internal rotation 15 degrees with complaint of pain in the hip and external rotation of 35 degrees.

Right hip examination revealed flexion 90 degrees, abduction 45 degrees, adduction 20 degrees, internal rotation 25 degrees and external rotation 30 degrees.

[redacted] broke his right ankle and is still walking with a pair of crutches.

History revealed that in August 2005, he began to experience pain in his hip and back area. There is no history of any specific injury, but he was moving from one

> place to another. He has been trying to go back to work since then, but pain in the hip got worse. About a year ago he had another x-ray of his back and hip. He has not had any treatment from any doctor. In 2007, he fractured his right ankle and was treated by surgery. His ankle is still weak and he is walking with a pair of crutches.
>
> Examination today revealed that he is an overweight male and walks with crutches. His equilibrium is normal. There is limited motion with pain in his left hip and left lower limb is somewhat shorter than the right. Lower back revealed minor limitation of motion without any neurological deficiency. His right ankle is mildly tender, with some limitation of motion. Power is satisfactory.

(9) The probative psychological evidence does not establish an acute (non-exertional) mental condition expected to prevent claimant from performing all customary work functions for the required period of time. There are no psychological/psychiatric reports in the record to substantiate a severe mental impairment. One physician reported depression NOS but did not provide any clinical support for his diagnosis. Also, claimant did not provide a DHS-49D or a DHS-49E to show his mental residual functional capacity.

(10) The probative medical evidence does not establish an acute (exertional) physical impairment expected to prevent claimant from performing all customary work functions for the required period of time. The medical reports in the record provide the following diagnoses:

(1) Status post right ankle fracture (2007);
(2) Status post surgical repair of right ankle;
(3) Obesity;
(4) Hypertension/controlled;
(5) Avascular necrosis of the left femoral hip head.

The physicians who provided medical reports did not report that claimant is totally unable to work based on the combination of his impairments. However, the medical records do report that claimant's ability to lift is substantially impaired, and his ability to sit and stand is moderately impaired.

(11) Claimant recently applied for federal disability benefits with the Social Security Administration. Social Security denied his application. Claimant filed a timely appeal.

CONCLUSIONS OF LAW

CLAIMANT'S POSITION

Claimant thinks he is entitled to MA-P/SDA based on the impairments listed in paragraph #4, above.

DEPARTMENT'S POSITION

The department thinks that claimant's medical records are insufficient to establish eligibility for MA-P/SDA.

The department denied MA-P/SDA eligibility based on insufficient information. The department suggested that claimant provide additional medical evidence from a licensed practitioner. The department also requested that claimant provide a complete copy of the June 23, 2008 psychiatric evaluation.

LEGAL BASE

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 Program Administrative Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM).

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 Program Administrative Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM).

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

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

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

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

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

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

> ...Medical reports should include –
>
> (1) Medical history.

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

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

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

> (1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;
>
> (2) Capacities for seeing, hearing, and speaking;
>
> (3) Understanding, carrying out, and remembering simple instructions;
>
> (4) Use of judgment;
>
> (5) Responding appropriately to supervision, co-workers and usual work situations; and
>
> (6) Dealing with changes in a routine work setting. 20 CFR 416.921(b).

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

Medical evidence may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about

the nature and severity of the impairment(s), including your symptoms, diagnosis and prognosis, what an individual can do despite impairment(s), and the physical or mental restrictions. 20 CFR 416.927(a)(2).

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

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

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

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

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

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

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

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

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

Claimant has the burden of proof to show by a preponderance of the medical evidence in the record that his mental/physical impairments meet the department's definition of disability for MA-P/SDA purposes. PEM 260/261. "Disability" as defined by MA-P/SDA standards is a legal term which is individually determined by a consideration of all factors in each particular case.

STEP 1

The issue at Step 1 is whether claimant is performing substantial gainful activity (SGA). If claimant is working and is earning substantial income, he is not eligible for MA-P/SDA.

SGA is defined as the performance of significant duties over a reasonable period of time for pay. Claimants who are working, or otherwise performing Substantial Gainful Activity, are not disabled regardless of medical condition, age, education or work experience. 20 CFR 416.920(b).

The vocational evidence of record shows that claimant is not currently performing SGA.

Therefore, claimant meets the Step 1 disability test.

STEP 2

The issue at Step 2 is whether claimant has impairments which meet the SSI definition of severity/duration.

Claimant must establish that he has an impairment which is expected to result in death or has lasted or is expected to last for 12 months and thereby totally precludes all work activities. 20 CFR 416.909.

Since the severity/duration requirement is a *de minimus* requirement, claimant meets the Step 2 disability test.

STEP 3

The issue at Step 3 is whether claimant meets the listing of impairments in the SSI regulations. Claimant does not allege disability based on the Listings.

Therefore, claimant does not meet the Step 3 disability test.

STEP 4

The issue at Step 4 is whether claimant is able to do his previous work. Claimant previously worked as a line cook at a [redacted]. Claimant's work as a line cook was medium work. It also required him to stand continuously for his 8 hour shift. Claimant's work also required that he lift heavy containers weighing up to 25 pounds.

The medical evidence of record establishes that claimant is not able to lift more than 10 pounds on a regular basis. Since claimant's previous work as a line cook involved heavy lifting, he is not able to return to his previous job as line [redacted]

Therefore, claimant meets the Step 4 disability test.

STEP 5

The issue at Step 5 is whether claimant has the Residual Functional Capacity (RFC) to do other work.

Claimant has the burden of proof to show, by the medical/psychological evidence in the record, that his combined impairments meet the department's definition of disability for MA-P/SDA purposes.

First, claimant alleges disability based on depression. There are no formal psychological reports in the record to establish a credible diagnosis of depression. Also, claimant did not submit a DHS-49D or a DHS-49E to establish his mental residual functional capacity.

Second, claimant alleges disability based on avascular necrosis primarily in the left hip and to a lesser extent in the right hip. The medical evidence of record clearly supports a diagnosis of avascular necrosis of the left hip/femoral head. Claimant also has a diagnosis of status post right ankle fracture (2007) and status post right ankle surgical repair (2007). These diagnoses severely restrict claimant's ability to stand, walk and lift. However, claimant's combined diagnoses do not preclude all employment.

Third, claimant alleges disability based on back and leg pain secondary to his hip necrosis and a 2007 surgery to repair his fractured ankle. Unfortunately, evidence of pain, alone, is insufficient to establish disability for MA-P/SDA purposes.

The Administrative Law Judge concludes that claimant's testimony about his pain is profound and credible, but out of proportion to the objective medical evidence as it relates to claimant's ability to work.

In short, the Administrative Law Judge is not persuaded that claimant is totally unable to work based on his status post right ankle repair/avascular necrosis of the left hip/hypertension/ depression. Claimant currently performs a long list of activities of daily living, drives an automobile 25 times a month and has significant computer skills. Considering the entire medical record, in combination with claimant's testimony, the Administrative Law Judge concludes that claimant is able to perform simple unskilled sedentary work (SGA). In this capacity, he is able to work as a ticket taker for a theater and as a parking lot attendant. Claimant would also be able to work as a telephone salesman.

Based on this analysis, the department correctly denied claimant's MA-P/SDA application using Step 5 of the sequential analysis, as presented above.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that claimant does not meet the MA-P/SDA disability requirements under PEM 260/261.

Accordingly, the department's denial of claimant's MA-P/SDA application is, hereby, AFFIRMED.

SO ORDERED.

/s/ _____
Jay W. Sexton
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: December 29, 2008

Date Mailed: January 5, 2009

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.

JWS/vmc