



Rhode Island Executive Office of Health and Human Services
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Docket #15-689
Hearing Date: April 30, 2015

Date: July 9, 2015



ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided against you upon a de novo (new and independent) review of the full record of hearing. During the course of the proceeding, the following issue(s) and Agency regulation(s) were the matters before the hearing:

**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)
SECTION: 0352.15 ELIGIBILITY BASED ON DISABILITY**

The facts of your case, the Agency rules and regulations, and the complete administrative decision made in this matter follow. Your rights to judicial review of this decision are found on the last page.

Copies of this decision have been sent to the following: You (the appellant), and Agency representatives: Julie Hopkins RN, Mary Marcos, and Rita Graterol.

Present at the hearing were: You (the appellant), your witness, and Jennifer Duhamel, RN (Agency representative).

EOHHS RULES AND REGULATIONS:

Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Department of Human Services Policy Manual.

APPEAL RIGHTS:

Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision.

ISSUE: Is the appellant disabled for the purposes of the Medical Assistance Program (MA)?

TESTIMONY AT HEARING:

The Agency representative testified:

- In order to be eligible for Medical Assistance (MA) an applicant must be either aged (age 65 years or older), blind, or disabled.
- The Medical Assistance Review Team (MART) determines disability for the MA Program.
- The MART is comprised of public health nurses, a social worker and doctors specializing in internal medicine, surgery, psychology and vocational rehabilitation.
- To be considered disabled for the purposes of the Medical Assistance Program, the appellant must have a medically determinable impairment that is severe enough to render him incapable of any type of work, not necessarily his past work. In addition, the impairment must last, or be expected to last for a continuous period of not less than twelve (12) months.
- The MART follows the same five-step evaluation as SSI for determining whether someone is disabled.
- The MART reviewed an Agency MA-63 form (Physician's Examination Report), an Agency AP-70 form (Information for the Determination of Disability), and records of Dr Ambrad.
- Consultative examination reports (if any) were requested from the DDU (Disability Determination Unit), but none were received.
- SSI eligibility was denied on March 27, 2015.
- A review of the available medical records revealed diagnoses of panic disorder, adjustment disorder and hypertension.
- In April 2014 he reported symptoms of irritability, and sadness.
- He was worried about his wife's medical conditions, and was having some difficulty at work.

- He was referred to a psychotherapist, and was advised to take a leave of absence from his job.
- At his May 18, 2014 medical examination he reported feeling somewhat better, and his blood pressure was stable with medication.
- His wife was in good health and it was expected that his condition would improve more rapidly.
- He had been seeing a counselor.
- At his June 15 appointment he reported a lapse in the use of his medication due to loss of health insurance.
- He had lost his job, but did not feel ready to find new employment.
- On July 3, his physician noted that he was expected to continue to improve, and to be ready to return to work by the end of August.
- He was collecting TDI at that time.
- In August his medications were adjusted to help manage his complaints of anxiety episodes.
- On November 19 he reported improved mood stability with medication management.
- As TDI had expired, he had applied for SSI and for Medical Assistance,
- He planned to find a therapist once health benefits were approved.
- There were no more recent progress notes from Dr Ambrad to review.
- There were some notes from South County Orthopedics regarding treatment of a left hand injury in 2014.
- He had sustained a fracture of the third finger and some lacerations, which were expected to heal in less than twelve months.
- The evidence reviewed did not support the existence of a medically determinable impairment that would limit functioning, meet the durational requirements, or have residual effects when following prescribed treatment.
- He was not disabled for the purpose of the Medical Assistance program.

The appellant, assisted by his father, testified:

- He is currently unemployed.
- He attends counseling sessions with James Manko, LICSW, and requested to submit a letter explaining his psychotherapy treatment program.
- Prior to starting a psychotherapy schedule, he was first evaluated by psychiatrist, Laura Fixman MD.
- Dr Fixman, has since passed away, so he is uncertain about the access to records.
- In addition to psychotherapy, the doctor also had prescribed medication management, and he submitted information about the prescribed remedies.
- The fracture of a digit on the left hand has healed, but numbness remains.
- Hypertension is well controlled with medication.
- There are no physical conditions that would currently interfere with his functioning.
- His disability is primarily related to impaired mental capabilities.
- Dr Fixman had suggested that he be evaluated by a neurologist, and he has an appointment scheduled for May 26.
- There is a psychiatrist filling in for Dr Fixman until Family Associates can hire a new doctor.
- He had suffered a severe concussion at the age of about 7 or 8.
- Throughout high school he suffered additional head trauma from football and street hockey activity.
- The neurologist is expected to evaluate for post-concussion syndrome.
- He has had one adjustment made to his medication because the previous remedy was not effective.
- He takes his medications daily as prescribed, but he is concerned that he is not getting the desired results.

- One medication, Clonazepam, which he takes for anxiety, does help him to stay calm, and he needed to take some prior to attending the hearing to avoid a panic attack.
- He often gets very sad or irritable and angry.
- He does not like to leave the house without another family member to accompany him, which gives him a sense of security.
- He has experienced feeling of paranoia and vulnerability for the past year.
- Previously he was outgoing and personable.
- His father can attest to the changes in his personality.
- He was once very independent, and now is reluctant to do things alone.
- He has experienced a decline in ability to remember things he needs to do for his job, and believes his former boss could confirm that fact.
- His concentration level has also been affected.
- His past work in retail management required a significant amount of multi-tasking which he can no longer do.
- He has to re-read things several times because of reduced comprehension.
- After about thirty seconds his mind wanders from conversations.
- He cannot stay focused even when trying to enjoy pleasurable activities.
- He does drive, but limits driving to familiar areas.
- His father has noticed that his son's requests for rides, or to accompany him on errands or to appointments have increased considerably in the past two years.
- He is currently 44 years old and has a college education.
- He was employed for seven years at his last job, and worked second to the business owner.
- He performed administrative duties, as well as being involved with some mechanical responsibilities.

- The business owner was very difficult to work for.
- He typically worked 70-75 hours per week.
- He has been out of work for about one year.
- He had many arguments with the boss.
- He gets very angry, and has to try very hard to control his response.
- He has not been tested for cognitive functioning by his treating sources.
- Social Security sent him to a consultative examination with a psychologist, and he requested that the results be provided to Dr Fixman.
- He has not seen Dr Ambrad since November 19, (2014).
- He was treated by Dr Lee at University Medical Foundation for sleep apnea and pulmonary care in the past.
- He has been using a CPAP machine which is helpful, and he has not had any follow-up appointments with Dr Lee since 2011.
- When he visits a neurologist, he plans to discuss the sleep apnea condition with him, as well as migraine headaches.
- His father has witnessed much change in his personality.
- Something changed which prevented him from handling the challenges he had at work.
- He does become irritable very easily, which was not typical in the past.
- He finds the increase in panic attacks to be disturbing.
- He requested to hold the record of hearing open for the submission of additional evidence.

FINDINGS OF FACT:

- The appellant filed an application for Medical Assistance (MA) on November 25, 2014.
- The Agency issued a written notice of denial of MA dated February 10, 2015.
- The appellant filed a timely request for hearing received by the Agency on February 27, 2015.
- Per the appellant's request, the record of hearing was held open through the close of business on June 11, 2015 for the submission of additional evidence.
- The appellant submitted a letter dated April 4, 2015 signed by G. James Manko, LICSW (exhibit #1) and a current list of treating physicians and prescribed medications. (exhibit #2).
- Additional evidence from NeuroHealth, and Family Associates that was received by the MART during the held open period was forwarded to the Appeals Office on June 12, 2015 and was added to the record of hearing.
- As of the date of this decision, the MART had not withdrawn the notice under appeal.
- The appellant is not engaging in substantial gainful activity.
- The appellant did not meet his burden of proof to establish the existence of a severe medically determinable impairment that would have a measurable impact on functional capabilities.
- The evidence has not established that the appellant is disabled as defined in the Social Security Act.
- The appellant is not disabled for the purposes of the Medical Assistance Program.

DISCUSSION OF THE MEDICAL EVIDENCE RECORD:

The record of hearing consists of:

- ✓ An Agency MA-63 dated December 12, 2014 and signed by Jamiel J. Ambrad, MD.
- ✓ An Agency AP-70 dated December 5, 2015 and signed by the appellant.
- ✓ Records of primary care physician (PCP) Jamiel, Ambrad, MD for April 17, 2014 to November 19, 2014.
- ✓ Records of South County Orthopedic for October 4, 2013 to April 1, 2014.
- ✓ A letter dated April 4, 2015 and signed by Family Associates psychotherapist, G. James Manko, LICSW.
- ✓ A list of physicians and prescribed medications prepared by the appellant.
- ✓ Records of NeuroHealth neurologist, Vlad Zayas, MD for May 26, 2015.
- ✓ Records of Family Associates signed by G James Manko, LICSW for January 19, 2015 to May 13, 2015.
- ✓ Hearing testimony.

Medical and other evidence of an individual's impairment is treated consistent with (20 CFR 416.913). The record of hearing was held open through the close of business on June 11, 2015. During that period of time, additional information from Family Associates, and a NeuroHealth evaluation of Dr Zayas was received. Evidence does not include any evaluations or progress notes of psychiatrist Dr. Fixman, or the psychological consultative examination report completed for the Social Security disability claim. Additionally, Dr Zayas referred to diagnostic imaging which is not part of the evidence record. Although the appellant's psychiatrist was recently deceased, he was encouraged to pursue access to his prior evaluations and progress notes in order to have support of a specialist's opinion. Those records were not received.

According to 20 CFR 416.916 (If you fail to submit medical and other evidence): You must co-operate in furnishing us with, or in helping us to obtain or identify, available medical or other evidence about your impairment(s). When you fail to cooperate with us in obtaining evidence, we will have to make a decision based on the information available in your case. We will not excuse you from giving us evidence because you have religious or personal reasons against medical examinations, tests, or treatment.

All medical opinion evidence is evaluated in accordance with the factors set forth at (20 CFR 416.927). The appellant has received mental health counseling for four months from a licensed clinical social worker. He has also provided seven months of office records from a former primary care provider who prescribed psychiatric medications, and record of a single visit with a neurologist which was initiated to explore possible effects of concussions sustained in early years on current mental functioning. An assessment of an orthopedic specialist was also included. As there are no treating sources providing the frequency, length, nature and extent of treatment to justify assignment of controlling weight of

opinion, all evidence and testimony is considered in combination for the purpose of this decision.

The MART is considered a non-examining source when expressing opinions regarding an individual's condition. At the time of application, the available records documented panic disorder, adjustment disorder, and hypertension. As hypertension was well controlled with medication management, there was no evidence of a severe physical impairment. Although he was seeing a psychotherapist, there was no support for any mental health diagnosis provided by a psychiatrist or psychologist.

Additional medical evidence was submitted during and after the hearing. As of the date of this decision, the MART has not withdrawn the denial under appeal. The final rationale for that decision has not been communicated to this Appeals Officer.

The appellant has alleged that reduced mental functioning secondary to PTSD, depression, anxiety, sleep apnea, and migraine headaches impairs him. Medical records and testimony have added a history of concussions, fracture and lacerations of the left hand, treatment for hypertension, and reports of Lyme disease.

The primary care physician completed an MA-63 form at the time of application. His diagnoses were focused on mental health conditions. He noted no specific physical functioning limitations. He did not indicate any remaining restrictions secondary to the left hand injury sustained the previous year. He prescribed medication for hypertension, and noted no residual damage to organs associated with that condition. Although the physician did not discuss migraine headaches or post-concussion syndrome, further evaluation with a neurologist was arranged.

An orthopedic examination performed more than a year ago was documented by Dr Coppes of South County Orthopedics. A review of symptoms included history of fatigue and joint pain, but noted no headaches, dizziness, or memory loss, as well as no mood change, depression or nervousness in contrast to the appellant's current complaints. He was there primarily for follow up of left hand wound care. The condition was presumed likely to heal in less than twelve months. Although the appellant stated that he experienced some residual numbness, no additional visits were detailed.

The appellant self-reported Lyme disease when completing the AP-70, as well as during psychosocial evaluation. Records of the therapist contained multiple references to the disorder. There is absolutely no support within the medical treatment records establishing that Lyme disease testing had been completed, or if it had confirmed the existence of the condition. Furthermore, it appears rather unusual that the PCP had not been monitoring the progression of the disease, or

arranging treatment. There is no information about when it was diagnosed, or by whom; what treatment was used, and whether or not the condition is chronic. The appellant continues to report symptoms of post-Lyme disease syndrome including fatigue, joint pain, and cognitive changes, but no conclusions have been made by any treating source. Lyme disease was not explored as a factor during a recent neurological evaluation.

Sleep apnea is also mentioned periodically throughout the records, and is without supportive evidence. There are no references to sleep studies, or evaluations of the condition or of treatment effectiveness, although the appellant testified that he gets satisfactory results from use of a CPAP machine which he apparently has had for several years. Sleep apnea was not discussed during the neurology appointment as expected.

A letter dated April 14, 2015 from the appellant's psychotherapist lists diagnoses of major depressive disorder (MDD) with psychotic features, and panic disorder without agoraphobia. He also expressed that PTSD and ADHD (inattentive type) are yet to be ruled out. The therapist's letter itemizes various symptoms without the support of detailed signs and objective findings. The records do not contain any evaluations of a psychiatrist or a psychologist who would be given greater weight of opinion than a licensed clinical social worker per the regulations. Although the appellant has adequately described symptoms that concern him, there is no actual documentation that affective disorders or anxiety-related disorders have ever been diagnosed by a physician, and based on acceptable clinical and diagnostic evidence.

A psychosocial evaluation was conducted at the start of his treatment relationship with James Manko, LICSW. Records document visits from January 19, 2015 through May 13, 2015, during which plans to promote relaxation, manage stress, improve communication and social skills, and strengthen assertiveness and conflict resolution capabilities were indicated. The evolution of his conditions seemed to begin with challenges involving his former boss that resulted in the loss of his job. Subsequent financial stressors led to further discouragement and hopelessness. Additionally, he had to manage legal issues and separation from his wife. Escalation of depressive symptoms in response to unfortunate life events, is somewhat foreseeable, and although it presented challenges, the reaction is not necessarily abnormal.

The appellant stated that he had a history of experiencing multiple concussions as a child, and as a teen. As the symptoms he described could have been associated with post-concussion syndrome, he was referred to a neurologist, for assessment. During the NeuroHealth evaluation he demonstrated normal attention, concentration, fund of knowledge, remote and recent memory and language function. He was oriented in all spheres. Funduscopic examination revealed optic discs were sharp, visual fields intact, pupils systemic and reactive, and extra-ocular movements were full. Sensory exam of the face was

unremarkable. Hearing was intact. Dr Zayas referred to imaging by CT scan and by MRI having been completed, but no reports of either diagnostic test were available, and they were not described in the office notes. In addition, gait, motor strength, sensation, reflexes and coordination were all normal. Other factors, such as social history were documented by a questionnaire which was not included within the records submitted. The neurologist's recommendations discussed complaints of migraines, but did not relate their occurrence to post-concussion syndrome. Basic lifestyle modifications designed to avoid dietary, physical and psychological triggers were recommended.

His witness did offer testimony regarding the appellant's decline in functioning and reliance on help of others to transport and accompany him to errands and appointments. He has observed concerning changes of mood, as well as reduced self-sufficiency. While the statements are credible, and his concern is understood, the regulations further require support of acceptable clinical and diagnostic evidence to establish a disability.

CONCLUSION:

In order to be eligible for Medical Assistance (MA) benefits, an individual must be either aged (65 years or older), blind, or disabled. When the individual is clearly not aged or blind and the claim of disability has been made, the Agency reviews the evidence in order to determine the presence of a characteristic of eligibility for the Medical Assistance Program based upon disability. Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months.

Under the authority of the Social Security Act, the Social Security Administration has established a **five-step** sequential evaluation process for determining whether or not an individual is disabled (20 CFR 416.920). DHS policy directs that disability determination for the purposes of the MA program shall be determined according to the Social Security sequential evaluation process. The individual claimant bears the burden of meeting steps one through four, while the burden shifts to DHS to meet step five. The steps must be followed in sequence. If it is determined that the individual is disabled or is not disabled at a step of the evaluation process, the evaluation will not go on to the next step. If it cannot be determined that the individual is disabled or not disabled at a step, the evaluation continues to the next step.

Step one: A determination is made if the individual is engaging in substantial gainful activity (20 CFR 416.920(b)). Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. Substantial work activity is work that involves doing significant physical or mental activities (20 CFR 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 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 416.974 and 416.975). If an individual is actually engaging in SGA, he/she will not be found 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.

The appellant has testified that he is not currently working. As there is no evidence that the appellant is engaging in SGA, the evaluation continues to step two.

Step two: A determination is made whether the individual has a medically determinable impairment that is severe, or a combination of impairments that is severe (20 CFR 416.920(c)) and whether the impairment has lasted or is expected to last for a continuous period of at least twelve months (20 CFR 416.909). If the durational standard is not met, he/she is not disabled. An impairment or combination of impairments is not severe within the meaning of the regulations if it does not significantly limit an individual's physical or mental ability to perform basic work activities. Examples of basic work activities are listed at (20 CFR 416.921(b)). A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by the individual's statement of symptoms. Symptoms, signs and laboratory findings are defined as set forth in (20 CFR 416.928). In determining severity, consideration is given to the combined effect of all of the individual's impairments without regard to whether any single impairment, if considered separately, would be of sufficient severity (20 CFR 416.923). If a medically severe combination of impairments is found, the combined impact of the impairments will be considered throughout the disability determination process. If the individual does not have a severe medically determinable impairment or combination of impairments, he/she will not be found disabled. Factors including age, education and work experience are not considered at step two. Step two is a *de minimis* standard. Thus, in any case where an impairment (or multiple impairments considered in combination) has more than a minimal effect on an individual's ability to perform one or more basic work activities, adjudication must continue beyond step two in the sequential evaluation process.

The evidence record in this case has actually created more questions than it has answered. While it is believable that the appellant has experienced some stressors impacting mental state, there is no clinical or diagnostic evidence establishing severity and expected duration of a particular condition. Depressive symptoms are described briefly in the record, and are often documented according to appellant self-report rather than physician opinion. Progress notes refer to situational responses that may be unfortunate, but could be natural responses rather than impairments. It is expected that he would respond with sadness to his wife's illness, loss of a job, legal problems and financial hardships. When he wrote a statement expressing the reason for his appeal of the "not disabled" finding, he used a "financial need" argument rather than a medical one. Discouragement and anxiousness are also likely results of unfortunate life events. Treating and examining sources have not established limitations to cognitive functioning. The available medical records do not demonstrate that his conditions have become disabilities unlikely to respond to treatment which could sufficiently restore his ability to work.

In order to get benefits, an individual must follow treatment prescribed by his physician if this treatment can restore his ability to work. If the individual does not follow the prescribed treatment without good reason, he will not be found disabled. The individual's physical, mental, educational, and linguistic limitations will be considered to determine if he has an acceptable reason for failure to follow prescribed treatment in accordance with 20 CFR 416.930. The appellant in this case has not established the existence of any physical, mental, educational or linguistic limitations that would interfere with his ability to follow prescribed treatment. Records reveal periods of time when treatment was interrupted, once for lapse of insurance, and another for loss of a doctor. However, he has otherwise shown efforts to be compliant. The available evidence has established that he has been prescribed medication for anxiety and depressive symptoms. The PCP has noted that remission of symptoms had not been achieved with medication management in 2014. Since that date, adjustments have been made to prescribed remedies, and there is no follow-up information addressing treatment effectiveness since November 2014. The appellant did testify that the current anti-anxiety medication prescribed was effective for reducing symptoms.

Although his former psychiatrist is no longer available to him, there should have been records kept, and he was informed that another physician would be available to stand in as needed. No psychiatric updates have been presented. Additionally, Disability Determination Services arranged a psychiatric consultative evaluation for his Social Security case, and that report was not submitted. The only current mental health information available are the progress notes of a licensed clinical social worker. The source of the reported diagnoses, and associated supportive evidence are not included in his records.

Additionally, the appellant has described physical symptoms of conditions that have been treated, stabilized or healed. He testified that there are no physical conditions that would currently interfere with his ability to function. He described his impairment as mental rather than physical. His PCP had also indicated that no physical limitations to exertional, postural, or manipulative functioning exist.

At step two of the sequential evaluation, the appellant bears the burden of proof. The record, as it exists, reveals that the appellant has not met his burden of proof relative to the requirement to support allegations of disability with acceptable clinical and diagnostic medical evidence. Although the evidence has noted self-reported claims, various symptoms, and conditions to be evaluated, the records do not establish that a medically determinable impairment with a measurable impact on functional ability exists. Therefore, the sequential evaluation of disability ends at Step two.

After careful and considerate review of the Agency's policies as well as the evidence and testimony submitted, this Appeals Officer concludes that the appellant is not disabled as defined in the Social Security Act, and for the purpose of the Medical Assistance Program.

Pursuant to DHS Policy General Provisions section 0110.60.05, action required by this decision, if any, completed by the Agency representative must be confirmed in writing to this Hearing Officer.



Carol J. Ouellette
Appeals Officer

APPENDIX

0352.15 ELIGIBILITY BASED ON DISABILITY

REV:07/2010

- A. To qualify for Medical Assistance, an individual or member of a couple must be age 65 years or older, blind or disabled.
- B. The Department evaluates disability for Medical Assistance in accordance with applicable law including the Social Security Act and regulations (20 C.F.R. sec. 416.901-416.998).
 - 1. For any adult to be eligible for Medical Assistance because of a disability, he/she must be unable 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 twelve (12) months (20 C.F.R. sec. 416.905).
 - 2. The medical impairment must make the individual unable to do his/her past relevant work (which is defined as "work that you have done within the past 15 years, that was substantial gainful activity, and that lasted long enough for you to learn to do it" (20 C.F.R. sec. 416.960(b)) or any other substantial gainful employment that exists in the national economy (20 C.F.R. sec. 416.905).
 - 3. The physical or mental impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. The individual's statements alone are not enough to show the existence of impairments (20 C.F.R. sec. 416.908).

0352.15.05 Determination of Disability

REV:07/2010

- A. Individuals who receive RSDI or SSI based on disability meet the criteria for disability.
 - 1. A copy of the award letter or similar documentation from the Social Security Administration is acceptable verification of the disability characteristic.
 - 2. For individuals who were receiving SSI based on disability and were closed upon entrance into a group care facility because their income exceeds the SSI standard for individuals in group care, a copy of the SSI award letter serves as verification of the disability characteristic.

- B. For all others, a disability review must be completed and a positive finding of disability must be made before eligibility for MA based on disability can be established.
1. In such cases, it is the responsibility of the agency representative to provide the applicant with the following:
 - a. Form letter AP-125, explaining the disability review process
 - b. Form MA-63, the Physician Examination Report with instructions
 - c. Form AP-70, the applicant's report of Information for Determination of Disability
 - d. Three copies of form DHS-25M, Release of Medical Information
 - e. A pre-addressed return envelope
 2. When returned to DHS, the completed forms and/or other medical or social data are date stamped and promptly transmitted under cover of form AP-65 to the MA Review Team (MART).
 - a. If the completed forms are not received within thirty (30) days of application, a reminder notice is sent to the applicant stating medical evidence of their disability has not been provided and needs to be submitted as soon as possible.
 - b. If all completed forms are not received within forty-five (45) days from the date of application, the referral to MART is made with the documentation received as of that date.
 3. It is the responsibility of the applicant to provide medical and other information and evidence required for a determination of disability.
 - a. The applicant's physician may submit copies of diagnostic tests which support the finding of disability.
 - b. The physician may also choose to submit a copy of the applicant's medical records or a letter which includes all relevant information (in lieu of or in addition to the MA-63).

0352.15.10 Responsibility of the MART

REV:07/2010

- A. The Medical Assistance Review Team (MART) is responsible to:
1. Make every reasonable effort to assist the applicant in obtaining any additional medical reports needed to make a disability decision.
 - a. Every reasonable effort is defined as one initial and, if necessary, one follow-up request for information.
 - b. The applicant must sign a release of information giving the MART permission to request the information from each potential source in order to receive this assistance.
 2. Analyze the complete medical data, social findings, and other evidence of disability submitted by or on behalf of the applicant.

3. Provide written notification to the applicant when a decision on MA eligibility cannot be issued within the ninety (90) day time frame because a medical provider delays or fails to provide information needed to determine disability.
 4. Issue a decision on whether the applicant meets the criteria for disability based on the evidence submitted following the five-step evaluation process detailed below.
 - a. The decision regarding disability is recorded on the AP-65 and transmitted along with the MART case log to the appropriate DHS field office where the agency representative issues a decision on MA eligibility.
 - b. All medical and social data is retained by the MART.
- B. To assure that disability reviews are conducted with uniformity, objectivity, and expeditiously, a five-step evaluation process is followed when determining whether or not an adult individual is disabled.
1. The individual claimant bears the burden of meeting Steps 1 through 4, but the burden shifts to DHS at Step 5.
 - a. The steps must be followed in sequence.
 - b. If the Department can find that the individual is disabled or is not disabled at a step of the evaluation process, the evaluation will not go on to the next step.
 - c. If the Department cannot determine that the individual is disabled or not disabled at a step, the evaluation will go on to the next step (20 C.F.R. sec. 416.920).
 2. Step 1
A determination is made if the individual is engaging in substantial gainful activity (20 C.F.R. sec. 416.920(b)). If an individual is actually engaging in substantial gainful activity, the Department will find that he/she is not disabled. "Substantial gainful activity" is defined at 20 C.F.R. sec. 416.972.
 3. Step 2
A determination is made whether the individual has a medically determinable impairment that is severe, or a combination of impairments that is severe (20 C.F.R. sec. 416.920(c)) and whether the impairment has lasted or is expected to last for a continuous period of at least 12 months (20 C.F.R. sec. 416.909). If the durational standard is not met, the Department will find that he/she is not disabled.
 - a. An impairment or combination of impairments is not severe within the meaning of the regulations if it does not significantly limit an individual's physical or mental ability to perform basic work activities (20 C.F.R. sec. 416.921). Examples of basic work activities are listed at 20 CFR sec. 416.921(b)).
 - b. In determining severity, the Department considers the combined effect of all of an individual's impairments without regard to whether any such impairment, if considered separately, would be sufficient severity (20 C.F.R. sec. 416.923).

- i. If the Department finds a medically severe combination of impairments, then the combined impact of the impairments will be considered throughout the disability determination process.
 - ii. If the individual does not have a severe medically determinable impairment or combination of impairments, the Department will find that he/she is not disabled.
 - c. The Department will not consider the individual's age, education, or work experience at Step 2.
 - d. Step 2 is a de minimis standard. In any case where an impairment (or multiple impairments considered in combination) has more than a minimal effect on the individual's ability to perform one or more basic work activities, adjudication must continue beyond Step 2 in the sequential evaluation process.
- 4. Step 3

A determination is made whether the individual's impairment or combination of impairments meet or medically equal the criteria of an impairment listed in the Social Security Administration's Listings of Impairments (20C.F.R. Pt 404, Appendix 1 to Subpart P).

 - a. If the individual's impairment or combination of impairments meets or medically equals the criteria of a listing and meets the duration requirement, the individual is disabled.
 - b. If it does not, the analysis proceeds to the next step.
- 5. Step 4

A determination is made as to the individual's residual functional capacity (RFC) and whether, given the RFC, he/she can perform his/her past relevant work (20 C.F.R. sec. 416.920(e)).

 - a. An individual's RFC is his/her ability to do physical and mental work activities on a sustained basis despite limitations from his/her impairments.
 - i. In making this finding, all of the individual's impairments, including impairments that are not severe will be considered (20 C.F.R. sec. 416.920(e), 416.945, and Social Security Ruling ("S.S.R.") 96-8p as applicable and effective).
 - ii. The Department will assess the individual's RFC in accordance with 20 C.F.R. sec. 416.945 based on all of the relevant medical and other evidence, including evidence regarding his/her symptoms (such as pain) as outlined in 20 C.F.R. sec. 416.929(c).
 - b. It must be established whether the individual has the RFC to perform the requirements of his/her past relevant work either as he/she has actually performed it or as it is generally performed in the national economy.

- c. The Department will use the guidelines in 20 C.F.R. sec. 416.960 through 416.969, and consider the RFC assessment together with the information about the individual's vocational background to make a disability decision. Further, in assessing the individual's RFC, the Department will determine his/her physical work capacity using the classifications sedentary, light, medium, heavy and very heavy as those terms are defined in 20 C.F.R. sec. 416.967 and elaborated on in S.S.R. 83-10, as applicable and effective.
 - d. If the individual has the RFC to do his/her past relevant work, the individual is not disabled. If the individual is unable to do any past relevant work, the analysis proceeds to the fifth and final step in the process.
6. Step 5
- The Department considers the individual's RFC, together with his/her age, education and work experience, to determine if he/she can make an adjustment to other work in the national economy (20 C.F.R. sec. 416.920(g)).
- a. At Step 5, the Department may determine if the individual is disabled by applying certain medical-vocational guidelines (also referred to as the "Grids", 20 C.F.R. Pt. 404, Appendix 2 to Subpart P).
 - i. The medical-vocational tables determine disability based on the individual's maximum level of exertion, age, education and prior work experience.
 - ii. There are times when the Department cannot use the medical-vocational tables because the individual's situation does not fit squarely into the particular categories or his/her RFC includes significant non-exertional limitations on his/her work capacity. Non-exertional limitations include mental, postural, manipulative, visual, communicative or environmental restrictions.
 - b. If the individual is able to make an adjustment to other work, he/she is not disabled.
 - c. If the individual is not able to do other work, he/she is determined disabled.

0352.15.15 Evidence

REV:07/2010

- A. Medical and other evidence of an individual's impairment is treated consistent with 20 C.F.R. sec. 416.913.
- B. The Department evaluates all medical opinion evidence in accordance with the factors set forth at 20 C.F.R. sec. 416.927.

- C. Evidence that is submitted or obtained by the Department may contain medical opinions.
1. "Medical opinions" are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of an individual's impairments, including:
 - a. Symptoms
 - b. Diagnosis and prognosis
 - c. What the individual can do despite impairments
 - d. Physical or mental restrictions
 2. Medical opinions include those from the following:
 - a. Treating sources - such as the individual's own physician, psychiatrist or psychologist
 - b. Non-treating sources - such as a physician, psychiatrist or psychologist who examines the individual to provide an opinion but does not have an ongoing treatment relationship with him/her
 - c. Non-examining sources -such as a physician, psychiatrist or psychologist who has not examined the individual but provides a medical opinion in the case
 3. A treating source's opinion on the nature and severity of an individual's impairment will be given controlling weight if the Department finds it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record.
 - a. If a treating source's opinion is not given controlling weight, it will still be considered and evaluated using the same factors applied to examining and non-examining source opinions.
 - b. The appeals officer will give good reasons in the administrative hearing decision for the weight given to a treating source's opinion.
 4. The Department evaluates examining and non-examining medical source opinions by considering all of the following factors:
 - a. Examining relationship
 - b. Nature, extent, and length of treatment relationship
 - c. Supportability of opinion and its consistency with record as a whole
 - d. Specialization of medical source
 - e. Other factors which tend to support or contradict the opinion.
 - f. If a hearing officer has found that a treating source's opinion is not due controlling weight under the rule set out in the foregoing paragraph, he/she will apply these factors in determining the weight of such opinion.
 - g. Consistent with the obligation to conduct a de novo (or new and independent) review of an application at the administrative hearing, the appeals officer will consider any statements or opinions of the Medical Assistance Review Team (MART) to be a non-examining source opinion and evaluate such statements or opinions applying the factors set forth at 20 C.F.R. sec. 416.927(f).

- D. Symptoms, signs and laboratory findings are defined as set forth in 20 C.F.R. sec. 416.928.
- E. The Department evaluates symptoms, including pain, in accordance with the standards set forth at 20 C.F.R. sec. 416.929 and elaborated on in S.S.R. 96-7p, as applicable and effective.

0352.15.20 Drug Addiction and Alcohol

REV:07/2010

- A. If the Department finds that the individual is disabled and has medical evidence of his/her drug addiction or alcoholism, the Department must determine whether the individual's drug addiction or alcoholism is a contributing factor material to the determination of disability; unless eligibility for benefits is found because of age or blindness.
 - 1. The key factor the Department will examine in determining whether drug addiction or alcoholism is a contributing factor material to the determination of disability is whether the Department would still find the individual disabled if he/she stopped using drugs or alcohol.
 - 2. The Department applies the standards set forth in 20 C.F.R. sec. 416.935 when making this determination.

0352.15.25 Need to Follow Prescribed Treatment

REV:07/2010

- A. In order to get MA benefits, the individual must follow treatment prescribed by his/her physician if this treatment can restore his/her ability to work.
 - 1. If the individual does not follow the prescribed treatment without a good reason, the Department will not find him/her disabled.
 - 2. The Department will consider the individual's physical, mental, educational, and linguistic limitations (including any lack of facility with the English language) and determine if he/she has an acceptable reason for failure to follow prescribed treatment in accordance with 20 C.F.R. sec.416.930.
 - 3. Although the question must be evaluated based on the specific facts developed in each case, examples of acceptable reasons for failing to follow prescribed treatment can be found in 20 C.F.R. sec. 416.930(c) and S.S.R. 82-59, as applicable and effective.

352.15.30 Conduct of the Hearing

REV:07/2010

- A. Any individual denied Medical Assistance based on the MA Review Team's decision that the disability criteria has not been met, retains the right to appeal the decision in accordance with Section 0110; COMPLAINTS AND HEARINGS in the DHS General Provisions.
1. A hearing will be convened in accordance with Department policy and a written decision will be rendered by the Appeals officer upon a de novo review of the full record of hearing.
 2. The hearing must be attended by a representative of the MART and by the individual and/or his/her representative.

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.