

**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS  
EXECUTIVE OFFICES OF HEALTH AND HUMAN SERVICES  
APPEALS OFFICE**

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Docket # 13-2046  
Hearing Date: April 29, 2014

Date: July 25, 2014

**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 policy reference(s) were the matters before the hearing:

**THE DHS POLICY MANUAL: MEDICAL ASSISTANCE  
SECTION: 0352.15 ELIGIBILITY BASED ON DISABILITY**

The facts of your case, the Agency policy, 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), Deany Hall, ROI for Kent Hospital (your representative), and Agency representatives: Julie Hopkins RN, Joan Masse, and Judith Malpino Anderson.

Present at the hearing were: You (the appellant), Deany Hall, and Jennifer Duhamel, RN (DHS Agency representative).

**DHS POLICIES:**

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 Kent Hospital, Crossroads, The Providence Center, and Rhode Island Hospital.
- The MART was unable to obtain consultative examination reports from Disability Determination Services (DDS), because, his SSI claim had already been denied, and the case was closed.
- He had already been found eligible for Medicaid through the MAGI program.
- A review of the available medical records revealed diagnoses including chronic obstructive pulmonary disease (COPD), bradycardia (slow heart rate) and a history of coronary artery disease with stent placement in 2012.

- There was also information regarding opiate dependency and maintenance on methadone.
- The MA-63 completed by a Kent Hospital physician during an admission there indicated no physical limitations.
- He was admitted to Kent Hospital for an overnight stay after experiencing an exacerbation of COPD due to lack of medication since February.
- He was started on a medication maintenance regimen and was stable upon release.
- He was readmitted in September with pneumonia, and treated with antibiotics.
- He was discharged when significant improvement had been achieved.
- On September 4, 2013 his objective physical examination was normal including respiratory evaluation.
- He reported his cardiac history, and explained that he had not seen a cardiologist for about eight months.
- The original MA-63 submitted with the application did not include any mental health diagnoses.
- Mental health issues were not discussed within the Crossroads records, and there was no evidence of anti-depressant use.
- An initial assessment completed at Providence Center in October discussed his homelessness and history of substance abuse.
- He reported that he had been substance free for a few weeks.
- His mood was depressed, but stable, and a treatment plan was prepared.
- There were no follow-up treatment notes or a psychiatric evaluations included.
- Rhode Island Hospital records documented an injury of the left upper extremity resulting from an assault on February 1, 2014.
- The injury occurred several months after the agency decision had been made, and was not related to any previous diagnosis.

- He received treatment for contusions at Rhode Island Hospital and was to follow up with his primary care physician.
- Allegations appeared on the AP-70 form that there were musculoskeletal problems in the neck, and a rotator cuff, as well as two surgeries completed on the wrists, but there was no medical evidence support for those claims.
- The medical evidence reviewed did not support the existence of a medically determinable impairment that would limit functioning, meet the durational requirements or have residual deficits when following prescribed treatment.
- He was not disabled for the purpose of the Medical Assistance program.

**The appellant testified:**

- He is currently unemployed.
- His left arm is continuing to be a problem, and he needs to get another opinion.
- Daily living is a challenge for him.
- He often concealed information about his conditions because he was afraid he would not get hired.
- He does not believe he will be hired currently because of his impairments.
- He gets very depressed about his personal circumstances.
- Physically, he could probably sit at a desk, but he does not have skills or experience to perform most office work.
- He is gaining insight into his mental state while working with the Providence Center staff.
- All of his mental health treatment including medication and counseling is being managed by the Providence Center.
- Since the Agency reviewed his case, he has established a regular treatment schedule with a psychiatrist, Dr Myers.
- He also sees a therapist every three weeks.

- He has difficulty giving honest answers to questions about his behavior, because he does not want to focus on negative characteristics.
- He has abstained from substance abuse for almost a year.
- Methadone helps him to control his pain level.
- He has experienced low back pain radiating to the right leg.
- In the past, that pain prevented him from performing a job as a truck driver, which he felt he had to quit that work in order to avoid causing an accident.
- He had completed two consultative examinations as well as X-rays which were ordered by Disability Determination Services for his Social Security claim.
- He has a disc protrusion in his neck, and has had shoulder surgery.
- His fingers ache because he has broken them numerous times.
- Thundermist physicians diagnosed arthritis and fibromyalgia.
- Fibromyalgia was diagnosed in 2011, but he does not continue to follow up with that provider.
- His primary care physician (PCP) has recommended that he make an appointment with his cardiologist, but he has not done that yet.
- He could occasionally lift 25-30 lbs.
- He has difficulty sustaining walking or standing for two hours some days, but not others.
- He can remain in a seated position for two-hour blocks of time.
- He is sometimes forgetful, but his memory is generally adequate.
- Concentration is reduced by ADHD which he has had since childhood.
- Reduced concentration did not interfere with his ability to perform his past relevant work.
- He typically can get along well with others.

- He is able to complete personal care and household activities independently, but moves slowly and takes breaks.
- He is trying to obtain housing through a community program, but is uncertain when arrangements will be complete.
- 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 August 30, 2013.
- The Agency issued a written notice of denial of MA dated November 15, 2013.
- The appellant filed a timely request for hearing received by the Agency on December 5, 2013.
- Per request of the appellant's representative, the hearing appointment of February 18, 2014 was rescheduled to March 27, 2014.
- Per request of the appellant's representative, the hearing appointment of March 27, 2014 was rescheduled to April 29, 2014.
- Per the appellant's request, the record of hearing was held open through the close of business on June 3, 2014 for the submission of additional evidence.
- Additional evidence from Crossroads, The Providence Center, Jorge Armesto, PhD, EdM, and Paul Dionisopoulos, MD that was received by the MART during the held open period was forwarded to the Appeals Office on June 4, 2014 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 had severe, medically determinable impairments including cervical spine spondylosis, and affective disorders, and non-severe conditions including obesity, substance addiction disorder currently in remission, and coronary artery disease (status post stent placement),

hypertension, and COPD which are currently well controlled with prescribed treatment and have a minimal impact on functioning.

- The appellant did not have an impairment or combination of impairments that met or medically equaled any of the listed impairments in the Social Security listings.
- Based on the appellant's residual functioning, he retains the ability to perform light work.
- The appellant was born on November 24, 1971 and is 42 years old, which is defined as a younger individual.
- The appellant has a 10<sup>th</sup> grade education and communicates in English.
- Transferability of job skills is not an issue in this case.
- The appellant is not 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 August 29, 2013 and signed by Kent Hospital attending physician, Ahmed Hamed, MD.
- ✓ An Agency AP-70 dated August 29, 2013 and signed by the appellant.
- ✓ Records of Kent County Hospital for August 28, 2013 to September 29, 2013.
- ✓ Records of Providence Community Health Centers (Crossroads) for August 27, 2013 to April 30, 2014.
- ✓ Records of The Providence Center for August 15, 2013 to February 14, 2014.
- ✓ Records of Rhode Island Hospital for February 1, 2014 to February 4, 2014.
- ✓ A consultative physical examination report with x-ray of the cervical spine dated December 19, 2013 and signed by Paul Dionisopoulos, MD.
- ✓ A consultative psychological evaluation report dated December 19, 2013 and signed by psychologist, Jorge Armesto, PhD, EdM
- ✓ Hearing testimony.

Medical and other evidence of an individual's impairment is treated consistent with (20 CFR 416.913).

All medical opinion evidence is evaluated in accordance with the factors set forth at (20 CFR 416.927). The appellant has provided records of three brief hospital admissions, consultative examination reports of two examining specialists, six months of progress notes from a mental health provider, and some primary care reports. As the frequency, length, nature and extent of treatment provided by the available sources do not justify controlling weight of opinion of any one source, the medical records and testimony will be considered in combination for the purpose of this determination.

The MART is considered a non-examining source when expressing opinions regarding an individual's condition. At the time application, the available medical evidence reviewed and considered for their determination addressed treatment for respiratory symptoms, cardiac conditions and substance dependence. Several others complaints were reported, but were either newly diagnosed, not supported by medical evidence, and/or unlikely to meet the durational requirements. The MART found him not disabled due to a lack of acceptable clinical and diagnostic medical evidence to support his claims.

Additional records were received after hearing and added to the evidence file. As of the date of this decision, the MART had not found that the new evidence and testimony compelled them to reverse the original decision. Their final rationale has not been communicated to this Appeals Officer.

The appellant has alleged that symptoms of COPD, emphysema, cervical spine disc abnormality, rotator cuff injury, bilateral carpal tunnel syndrome (CTS), back pain radiating to the right leg, left arm injury, fibromyalgia (FMS), bipolar disorder, anxiety disorder, major depressive disorder (MDD), mood disorder, and ADHD (attention deficit hyperactivity disorder) impair him. His PCP has added information relative to coronary artery disease (CAD) status post stent placement in 2012, bradycardia, benign essential hypertension (Htn), obesity, and substance dependence treatment with methadone.

The evidence record does not address low back pain, radicular right extremity pain, rotator cuff damage, or wrist pain. Consultative evaluation of the right wrist revealed no abnormalities. The existence of fibromyalgia, bipolar disorder, and mood disorder has not been demonstrated by any of the evidence records. ADHD has been reported as diagnosed during childhood, but the appellant testified that it had never impaired his ability to work at any of his past relevant work assignments, and therefore does not appear to have more than a minimal impact on functioning.

PCP, Dr Wolfson, noted in the most recent progress notes of April 2014 that the appellant was medication compliant. His blood pressure on that date was 134/75 indicating good control of hypertension with prescribed remedies. CAD had been diagnosed and treated with stenting performed in 2012. He had also been treated for bradycardia, a slow heart rate, in 2013. His most current cardiac

examination resulted in normal findings with respect to heart rate, rhythm, and sounds. There were no murmurs and no edema present. On that same date, his respiratory conditions were stable, and a new medication was being added to optimize control of COPD symptoms.

Two weeks earlier, he had been evaluated at Rhode Island Hospital following an assault. Although the effects of that incident occurred after the Agency had reviewed his case and rendered a decision, the results of the hospital examination were considered. Evaluation of the head was normal with no sign of fracture, or soft tissue swelling. Chest x-rays revealed the left lower lobe disease for which he was already being treated. There were no acute abnormalities of the abdomen, cervical spine, thoracic spine, or lumbar spine, and a normal ECG was completed.

Despite the fact that he had been hospitalized at Kent Hospital in August 2013 for bradycardia and COPD, the attending physician, Dr Hamed completed an MA-63 assessment indicating that his prognosis was "good" for reducing or eliminating those conditions with adherence to prescribed treatment. Based on his condition when examined at Rhode Island Hospital several months later, Dr Hamed's good prognosis appeared to be correct as supported by the more recent examination results. The Kent physician also opined that he would not be expected to experience any significant restrictions to capabilities for walking, standing, lifting or sitting throughout a workday.

Consistency of physician opinion was again seen in the consultative examination report of Dr Dionisopoulos performed in December 2013. His heart rate and rhythm were regular, and although he reported back pain, his gait was within normal limits, straight leg raises were negative, and a lumbar spine X-ray was essentially normal. There was no indication of deficits to strength, or reflexes. Cervical spine evaluation revealed mild spondylosis with some tenderness and disc height loss. The only pain treatment of record was methadone, which the appellant testified helped to adequately control his pain level, and made it possible for him to sustain from addictive pain remedies, which he has done successfully for approximately one year.

Pain is evaluated in accordance with the standards set forth at (20 CFR 416.929). The appellant has presented evidence of a medically determine impairment of the cervical spine including mild disc height loss, mild spondylosis, tenderness and limited range of motion on one side. Although he has alleged other musculoskeletal abnormalities, diagnostic imaging and examination of the lumbar spine was normal, the left upper extremity injury had been treated, and evidence showed no follow up. Carpal tunnel was ruled out by imaging, and appears to have been corrected at some time in the past. Fibromyalgia is completely unsupported. The cervical spine condition, which has been established by medical evidence, could be expected to result in some pain, although not of the severity which the appellant alleges. The only treatment

known as of the date of this decision is that he follows prescribed methadone maintenance for the dual purpose of pain reduction, and substance addiction control. He has reported successful results of the treatment for both purposes. Functional restrictions associated with the cervical spine condition are minimal, and would not be expected to impact his ability to complete either basic work activities or activities of daily living independently.

In August 2013, the appellant started a treatment program at The Providence Center (TPC) to address mental health issues. A psychiatric evaluation was completed in January 2014. He was diagnosed with depressive symptoms, anxiety disorder, and substance dependency. A mental status evaluation established that he was pleasant and cooperative, his speech was coherent, and he required some refocusing to stay on topic. His mood was described as depressed, but memory was intact, and he had good recall as demonstrated by the mental activities employed. A treatment plan was devised, and during a February 2014 follow-up visit, it was documented that he was making progress, and would be discharged when mental health symptoms were stable, coping skills developed and a good support system was established. The goal date was six months.

He had also been evaluated by a consulting psychologist, Dr Armesto, in December 2013. He found no history of inpatient mental health treatment, and acknowledged the current care arranged at TPC. Although he had a history involving four or five residential detoxification programs, he was compliant with methadone maintenance, and was presently sober. He was also IQ tested with a WAIS-IV (Wechsler Adult Intelligence Scale-edition IV) test score FSIQ=72 (full scale intelligence quotient of 72) indicating borderline intellectual functioning. Attention, concentration, and mental control were all considered borderline. His ability to process simple information fell within the low average range. He was most challenged by language skills. On that date he was alert and oriented in all spheres, his speech was normal, affect and mood euthymic, and attention and concentration were found to be grossly intact. During memory testing he was easily able to recall immediate, recent, and past information.

The appellant's credibility is questionable. Medical records reviewed during the application process indicated that his sobriety had been sustained for about four months, at hearing he stated that is was coming up on one year, but during the consultative examination with Dr Armesto, he indicated that he had remained sober since 2010, which is not true. Additionally, he reported impairment from conditions that had affected him the past such as CTS, and rotator cuff injury, which had been surgically corrected, a left arm injury which had been treated per hospital records, and ADHD which did not impact psychological testing, and had never prevented him from working in the past. It was very challenging to establish exactly what was occurring con-currently in order to consider the combined effect of his legitimate conditions.

**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 appellant had alleged that he was disabled based on a combination of conditions including several that had been successfully treated. Some injuries were not durational, and other impairments were well maintained with prescribed treatments. Presently the medical evidence records provided, support that his impairments relative to cervical spine spondylosis, and affective disorders are severe due to their impact on basic work activities. His history of coronary artery disease (status post stent placement), hypertension, obesity, COPD, and substance addiction disorder which are currently well controlled with prescribed treatment, are also considered as non-severe conditions in combination with the severe impairments for the purpose of this evaluation.

**Step three:** 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 (20 CFR Part 404, Subpart P, Appendix 1). If the individual's impairment or combination of impairments meets or medically equals the criteria of a listing and also meets the duration requirement (20 CFR 416.909), the individual is disabled. If it does not, the analysis proceeds to the next step.

In this matter, listings 1.04 (Disorders of the spine), and 12.06 (Affective disorders) have been reviewed. The medical evidence records have not established that existence of a particular disorder of the spine resulting in compromise of a nerve root, or the spinal cord, spinal arachnoiditis, or lumbar spinal stenosis resulting in pseudoclaudication. Additionally, the mental evidence has not established that his affective disorders are characterized by a medically documented persistence of symptoms resulting in marked restrictions to activities of daily living, maintaining social functioning, or concentration, persistence, or pace; and there have been no documented episodes of decompensation of extended duration. The medical evidence record does not support the existence of an impairment that rises to the level of the listings.

**Step four:** 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 CFR 416.920(e)). An individual's functional capacity is his/her ability to do physical and mental work activities on a sustained basis despite limitations from his/her impairments. In making this finding, all of the individual's impairments, including impairments that are not severe must be considered. The individual's RFC will be assessed in accordance with (20 CFR 416.945) and based on all relevant medical and other evidence including evidence regarding his/her symptoms (such as pain) as outlined in (20 CFR 416.929). Next, it must be established whether the individual has the RFC to perform the requirements of his/her past relevant work either as he/she had actually performed it or as it is generally performed in the national economy. Using the guidelines in (20 CFR 416.960 (a)-(b)(3)), the RFC assessment is considered together with the information about the individual's vocational background to make a disability decision. 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.

### Physical RFC

**Exertional:** Medical evidence from Dr Hamed after treating his respiratory and cardiac conditions supported the physician's opinions that he would be capable of lifting up to 50 lbs maximum and 25 lbs frequently, walking, standing and sitting for 6 hours per workday, and could perform occasional pushing or pulling motions. This combination of exertional function is consistent with medium work capability.

**Postural:** No restrictions to climbing, balancing, stooping, kneeling, crouching, or crawling have been established.

**Manipulative:** Reaching, handling, fingering, and feeling have not been restricted by the evidence.

**Visual:** No deficits to near acuity, far acuity, depth perception, accommodation, color vision, or field of vision have been indicated.

**Communicative:** Abilities for hearing and speaking are intact.

**Environmental:** Based on his respiratory sensitivities, hypertension, and cardiac condition, he should avoid concentrated exposure to extreme cold, heat, wetness, humidity, fumes, odors, dusts, gases, and poor ventilation.

### Mental RFC

**Understanding and Memory:** Based on recent testing of memory, he was able to satisfactorily recall immediate, recent, and past information. He could be expected to remember locations and procedures, and to understand and remember short, simple, 1-2-3 step instructions. Due to borderline intellectual functioning, he could be overwhelmed with complex instructions.

**Sustained Concentration and Persistence:** Evidence does not rule out his ability to carry out simple tasks. He could be expected to carry out short, simple instructions, maintain attention and concentration for 2-hour blocks of time throughout a workday with allowances for customary breaks, sustain a routine without special supervision, and make simple work-related decisions.

**Social Interaction:** There are no indications that he would have difficulty interacting appropriately with the public, that he could recognize when to request assistance, accept instructions and criticism from supervisors, get along with coworkers, maintain socially appropriate behavior, or adhere to basic standards of grooming.

**Adaptation:** Mental health assessments have not ruled out the probability that he could respond appropriately to basic work-related changes, be aware of normal hazards and take precautions, arrange transportation, or set realistic goals.

The appellant has indicated that his past relevant work history consists of construction site roofing work, auto mechanics, and truck driving. Current RFC for medium exertional level work with environmental restrictions, and MRFC for simple, routine tasks would preclude him from performing his past work due to the heavy exertion required of an auto mechanic, and the skill level required of each of his past occupations. As a result, the evaluation continues to Step five.

**Step five:** At the last step of the sequential evaluation process, consideration is given to the assessment of 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 CFR 416.920(g)). If the individual is able to make an adjustment to other work, he/she is not disabled. If the individual is not able to do other work and meets the duration requirement, he/she is disabled. At step five, it may be determined if the individual is disabled by applying certain medical-vocational guidelines (20 CFR Part 404, Subpart P, Appendix 2). The medical-vocational tables determine disability based on the individual's maximum level of exertion, age, education, and prior work experience. In some cases, the vocational tables cannot be used, because the

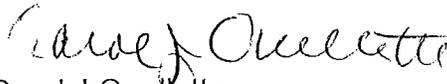
individual's situation does not fit squarely into the particular categories or because his/her RFC includes significant nonexertional limitations, such as postural, manipulative, visual, or communicative; or environmental restrictions on his/her work capacity. If the individual can perform all or substantially all of the exertional demands at a given level, the medical-vocational rules direct a conclusion that the individual is either disabled or not disabled depending upon the individual's specific vocational profile (SVP). When the individual cannot perform substantially all of the exertional demands or work at a given level of exertion and/or has non-exertional limitations, the medical-vocational rules are used as a framework for decision-making unless that directs a conclusion that the individual is disabled without considering the additional exertional and/or non-exertional limitations. If the individual has solely non-exertional limitations, section 204.00 in the medical-vocational guidelines provides a framework for decision-making (SSR 85-15).

The appellant is a 42-year old male with a 10<sup>th</sup> grade education, and a positive work history. He is currently impaired by symptoms of cervical spine spondylosis, and affective disorders. His ability to function is also complicated by several non-severe conditions, including coronary artery disease status post stent placement, medically managed hypertension, and COPD, obesity, and substance addiction disorder currently in remission.

Based on the appellant's age of 42 (younger individual), 10th grade education (high school or more), work history (medium to heavy exertion, semi-skilled to skilled, not transferable), RFC (medium exertion with environmental restrictions, MRFC simple, routine tasks: the combined factors direct a finding of "not disabled" according to the Social Security regulations. The appellant retains the ability to perform other types of work.

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