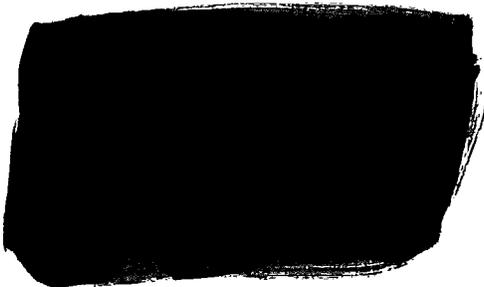


**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
APPEALS OFFICE – Louis Pasteur Building
57 Howard Avenue
Cranston, Rhode Island 02920
(401) 462-2132 / Fax # (401) 462-0458
TDD # (401) 462-3363**

Date: August 8, 2014

Docket #13-891
Hearing Date: August 21, 2013



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 MEDICAID POLICY MANUAL
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 in c/o your authorized representative ROI/Kent Hospital, and Agency representatives Sandra Brohen (MART), Mary Hitte, Kristen Grosso, Betty Perez, and the Policy Unit

Present at the hearing were: You (the appellant), your boyfriend, your authorized representative from ROI/Kent Hospital, and Agency representative Sandra Brohen.

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. Since the appellant is neither blind nor aged, the Agency looked at the disability characteristic.
- The Medical Assistance Review Team (MART) determines disability for the MA Program.
- The MART is comprised of consultant 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 her incapable of any type of work, not necessarily her 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 sequential evaluation process as Social Security for determining whether someone is disabled.
- For step one, the Agency asked the appellant if she is presently unemployed.
- At step 2 the MART reviewed the medical evidence submitted to determine if the appellant's impairment was severe.
- The evidence reviewed included the MA-63 form, which is the physician's report, an Agency AP-70 form that was completed by an ROI representative, and records from WellOne, Kent Hospital, and Dr. Thomas. Additional medical records that were received during the processing of a subsequent MA application filed by the appellant were also reviewed in preparation for this hearing. These included another MA63 form and records from WellOne and Kent Hospital.

- The MART requested any available consultative examination reports but none have been received to date.
- The appellant has since been denied Social Security benefits.
- The MA63 and the medical records reviewed at the time of the MART's decision provided the diagnosis of a history of myocardial infarction with subsequent stent placement in January 2012, recurrent angina, and chronic obstructive pulmonary disease.
- In June of 2013 the appellant was diagnosed with a recurrent Major Depressive Disorder (MDD) and a Panic Disorder by a licensed social worker at WellOne.
- The most recent MA63 dated July 31, 2013, which was completed by a nurse practitioner at WellOne, did not make any reference to either of these two new diagnoses of MDD and Panic DO.
- The appellant receives her routine care at WellOne.
- The September 12, 2012 visit notes discussed the appellant's recent complaints of shortness of breathe. A pulmonary function test performed in September 2012 indicated severe obstruction with an FEV1 of 1.31. Following use of a prescribed bronchial dilator, no follow-up evaluative measurement was taken which could have shown a favorable or reversible response to the medication.
- The appellant was counseled to stop smoking and was prescribed an inhaler to use every 8 hours as needed.
- The October 2012 appointment revealed continued reports of shortness of breath aggravated by physical exertion, as well as complaints of chest pains.
- In June 2013, a Well One behavioral health assessment determined that the current symptoms of depression and anxiety were the result of the appellant's experiences of lost capacity and fear of infirmity secondary to her cardiac diagnosis.
- The record contains only one behavioral note which indicates a recommendation for a referral to a medication consultation.
- The Cardiologist, Dr. Thomas, provided documentation of a March 2013 report of recurrent angina, and noted an unremarkable physical exam. Recommendations for a repeat catheterization were made but declined by the appellant.

- Notes from the May follow-up appointment noted the results of the February stress tests done at Kent. These revealed a small inferior wall fixed defect. EKG results were normal, and angina was stable. No specific restrictions were recommended, and cardiac medication adjustments were made.
- As of this date, it is unknown if the appellant began any antidepressants, and what response she might have had to them.
- The MART determined that the appellant's history of a cardiac stent and recurrent angina, COPD, MDD and Panic DO result in a severe impairment and proceeded to Step 3 of the evaluation.
- At Step #3 of the evaluation, the MART determined that the appellant's impairment(s) do not meet or equal any of the Social Security Listings, taking into consideration 3.00 Respiratory System, 3.02 Chronic Pulmonary Insufficiencies, 12.04 Affective Disorders; and 12.06 Anxiety-Related Disorders and they proceeded to Step 4 of the evaluation.
- The medical records provide evidence that the appellant does have functional restrictions and at Step #4 the MART completed a residual function capacity (RFC) assessment. Based on the medical records submitted, the MART found that due to physical restrictions, the appellant is precluded from performing her past relevant work (PRW) as a retail store manager or bartender, which is considered light work, but that she is able to do at least sedentary work.
- A mental residual functional capacity (MRFC) assessment could not be completed based on a single exam note in the record. Although depression and anxiety disorders were acknowledged, the record lacked evidence that the symptoms could not be medication managed.
- At step #5, the MART determined that the appellant is capable of performing at least sedentary work, taking into account her age of 47, her college level education, and her past relevant work (PRW), as well as her ability to be retrained according to Vocational rules (Medical-vocational Rules 201.22), in combination with consideration of any non exertional limitations, the MART found the appellant was able to perform at least sedentary work.

The appellant, with the assistance of her boyfriend and her authorized representative from ROI/Kent Hospital, testified:

- She is currently unemployed.

- She is 47 years old.
- She has a high school education and she completed the Sawyer School in 1994 but she never worked as a secretary. She has been a bartender and she last worked March 1, 2010 as a liquor store manager which required her to stock the store and work six days a week.
- She had a heart attack on January 12, 2012.
- She has COPD. She has always had lung problems but the heart attack made it worse. When she was about 28 years old she had a spontaneous pneumothorax and had a lung operation and a catheter was placed in her lung and she had a piece of her lung removed and stapled. It didn't affect her life then and there is no information in the record about it.
- She also has anxiety and depression.
- Dr. Thomas is her cardiac doctor. He put her stents in and she sees him for follow-up every two months.
- Once you have heart damage you are always limited.
- She has constant breathing problems, even when sitting. She also has numbness in her left arm, heart palpitations, chest pains, and migraines.
- She used to get chest pains and arm numbness about five times per day, but now gets them about three or four times per day.
- Dr. Thomas recently changed her heart medication because the current medication is making her nauseous and are not making the chest pains go away but she has not yet made the switch because she is using up the old medication that she has left.
- Dr. Thomas gives her blood pressure pills but they do not make the palpitations go away.
- She is afraid she is going to have another heart attack because they run in her family and she has incurable heart damage.
- She is extremely depressed and has anxiety, especially when she has to leave the house, so she does not go out much.
- She receives her primary medical care at Well One, where she sees the Nurse Practitioner. She started telling the Well One nurse about her anxiety and breathing problems several months ago. The nurse tested her lung capacity and gave her a bronchiolar inhaler but it does not help much.

- Once, in July, she saw the counselor at Well One who does the psychiatric evaluations. He wants to try some relaxation techniques and thinks she could at least leave the house if she had medicine. At the end of the month he plans on referring her to the woman there who prescribes the psychiatric medication.
- She used to ski and was active but now she can't do anything, because she is afraid.
- She cannot babysit her grandchildren any longer due to the anxiety.
- Even without the anxiety she would not be able to do any physical work. She can't even walk up the stairs without taking Nitro because of the chest pains.
- She uses Nitro three to four times a day up to a maximum of six times per day, but she's only supposed to use it three times.
- She does not do any household chores any longer.
- She is able to do her own personal care.
- She drives sometimes but it's stressful because she is afraid of a heart attack.
- She went to South County for her Social Security consultative exams. She was denied the first time by the heart specialist on her pulmonary exam; and she then went for a lung test about one month ago. She also has a psychiatric consultative evaluation scheduled for the end of August.

FINDINGS OF FACT:

- The appellant filed an application for Medical Assistance (MA) on February 22, 2013.
- The Agency issued a written notice of denial of MA dated May 7, 2013.
- The appellant filed a timely request for hearing received by the Agency on May 17, 2013.
- An Administrative Hearing was convened on August 21, 2013.
- Per the appellant's request, the record of hearing was held open for six weeks, through the close of business on October 2, 2013, for the submission of additional evidence.

- Per the appellant's request, the record of hearing was held open an additional four weeks, through the close of business on October 30, 2013.
- Additional evidence submitted to the MART during the held open period was forwarded to the Appeals Office on October 30, 2013 and made part of the record of hearing upon receipt on October 31, 2013.
- In an effort to fully develop the record, the appellant was given another opportunity to provide additional evidence prior to the completion of the Administrative Hearing Decision, but no additional evidence was available/provided.
- The appellant is not engaging in substantial gainful activity
- A myocardial infarction (MI) with stent placement, angina, hypertension, and chronic obstructive pulmonary disease (COPD) have been medically established.
- Major depressive disorder (MDD) and Panic Disorder with agoraphobia, and/or any other psychiatric impairment, have not been medically established.
- The appellant's medically determinable impairments are severe in combination.
- The appellant's medically determined impairments do not meet or equal any of the Social Security Listings, alone or in combination.
- Based on the appellant's residual functioning, the appellant retains the ability to perform sedentary work.
- The appellant was born on July 8, 1966.
- The appellant graduated high school as well as medical assistant/secretarial school.
- 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 (MER):

The MART (Medical Assistance Review Team) submitted the following evidence at hearing:

- An Agency MA63 form (Physician's Examination Report) signed on February 26, 2013 by Virginia Pierce, RNP at WellOne Primary Medical and Dental Care.
- An Agency AP70 (Information for the Determination of Disability signed by the appellant on February 19, 2013.
- WellOne Health Center records, which include WellOne exam records from April 17, 2012 to May 20, 2013, copies of Kent Hospital records, a May 7, 2012 office note from Edward S. Thomas, MD, and several letters from August 27, 2012 through May 30, 2013 addressed to Sara F. Nugent, MD at WellOne and signed by Dr. Thomas.
- Records from Edward S. Thomas, MD covering the time period from May 7, 2012 through March 12, 2013.
- A Kent Hospital discharge summary dated February 12, 2013.
- A WellOne Health Center Behavioral Health Assessment dated June 20, 2013.
- A MA63 form signed on July 31, 2013 by Virginia Pierce RNP at WellOne.

The MART concluded upon review of the submitted evidence that the appellant has a severe impairment relative to recurrent angina and cardiac stent placement, Chronic Obstructive Pulmonary Disease (COPD), Major Depressive Disorder (MDD), and Panic Disorder but that such impairment does not meet or equal any of the Social Security listings after taking into consideration 3.00 Respiratory System, 3.02 Chronic Pulmonary Insufficiencies, 12.04 Affective Disorders, and 12.06 Anxiety-Related Disorders. The MART further concluded that the appellant's severe impairment prevented her from performing her past work as a retail store manager and/or a bartender but that despite her impairment, she retained the ability to perform at least sedentary work.

The appellant testifies/argues that she had a heart attack on January 12, 2012 and that she still experiences chest pains, heart palpitations, numbness in her left arm, and migraines. She testifies that chest pains and arm numbness currently occur three to four times a day and that she uses nitroglycerin three to six times per day, though she is only supposed to use it three times. The appellant argues that she is unable to return to work as a liquor store manager and/or a bartender because she is unable to do any physical labor and has to use nitroglycerin just to walk up the stairs. The appellant further testifies that she had a spontaneous pneumothorax at age 28. While resolved at that time with surgery, the appellant testified that she has had breathing difficulties since her heart attack and has subsequently been diagnosed with COPD. The appellant further testifies that she has difficulty breathing even when sitting and that a recently prescribed

inhaler only helps a little. She further testifies that she is extremely depressed because she is unable to live the active life she was living before and is anxious, especially when she has to leave the house, because she is afraid that she is going to have another heart attack. The appellant reports that she had been evaluated by the counselor at WellOne and that he plans on trying some relaxation techniques with her and also refer her to the psychiatric nurse at WellOne for prescribed psychiatric medication, in the hopes that it will help her leave the house. The appellant also testified that she recently had a pulmonary test at South County Hospital that was scheduled by Social Security and has an appointment for a Social Security consultative psychiatric evaluation in the next couple of weeks.

At hearing the appellant submits a duplicate copy of the Kent Hospital Discharge Summary dated February 13, 2013. While the record of hearing was held open, the following evidence was submitted:

- A Rhode Island Hospital discharge summary dated January 15, 2012.
- Two South County Hospital ER records dated April 26, 2012 and June 30, 2012.
- Kent Hospital ER record from February 11, 2013 and February 12, 2013.
- Records from Dr. Edward S. Thomas dated March 12, 2013 through August 26, 2013 which included a Pulmonary Function Report from South County Hospital dated July 23, 2013.
- WellOne Behavioral Health records dated June 20, 2013 through September 12, 2013.

No Social Security consultative psychiatric exam was submitted. Prior to the issuing of this decision, the appellant, through her authorized representative, was given an opportunity to submit additional evidence but no additional evidence was available and/or submitted.

At the time of the appellant's Medical Assistance (MA) application on February 22, 2013, she was 46 years old, had a high school degree and had also completed a medical assistant/secretarial program at the Sawyer School. It appears that her MA application was precipitated by an emergency room (ER) visit to Kent Hospital on February 11, 2013. A review of the Kent ER report finds that she presented complaining of chest pain and they noted her history of coronary artery disease (CAD) and MI (myocardial infarction) and began testing to rule out acute coronary syndrome. An objective physical exam was normal, Troponin was negative, and a chest x-ray provided no evidence of any cardiopulmonary disease. Despite such, due to her high risk factor, she was started on a heparin drip and evaluated by Cardiologist, Dr. Edward S. Thomas.

The drip was discontinued and she was sent for a nuclear stress test. The exercise part of the test was inconclusive because she was not able to reach her maximum heart rate. The appellant later reported that she had experienced some left upper extremity pain during the exercise part of the test. An electrocardiogram (EKG) was unremarkable. Despite such, because she was considered high risk, discharge was to be delayed until the nuclear report of the stress test was complete, but the appellant left the ER against medical advice while the results were still pending.

A full review of the evidence and testimony submitted finds that approximately one year prior, on January 12, 2012, the appellant had presented at The Kent Hospital complaining of chest pain radiating to her left arm. She was noted to have an inferior posterior myocardial infarction (MI) and was transferred to Rhode Island Hospital (RIH) for cardiac catheterization. Stents were successfully placed in her right coronary artery. Subsequent testing revealed highly elevated LDL cholesterol and she was started on a high dose of Lipitor along with a nicotine patch. She was discharged from the hospital three days later, at which time she was advised to refrain from driving, heavy lifting, exercising, and/or working, and to follow-up with Cardiologist Edward S. Thomas, MD. Medication on discharge included aspirin, Plavix, Pravachol, Metoprolol, Lisinopril, and a nicotine patch. In the Spring of 2012 the appellant applied for Social Security disability benefits. That application was denied and was not appealed.

A review of the evidence submitted from South County Hospital finds evidence of two ER visits between the time of the appellant's January 12, 2012 heart attack and her application for MA in February 2013, one on April 26, 2012 and one on July 30, 2012. Both visits were for evaluation of tooth pain caused by an abscessed tooth. Neither ER record provides any evidence of cardiac, pulmonary, and/or psychiatric signs and/or symptoms.

In between the time of her heart attack and her MA application, the appellant did receive primary medical care at WellOne Health Center as well as cardiac follow-up with Dr. Thomas. The submitted medical records/evidence from that time period include a May 7, 2012 office note and an August 27, 2012 letter from Dr. Thomas, and WellOne exam records dated May 10, 2012, September 12, 2012, and October 17, 2012. A review of this evidence finds that Dr. Thomas lowered and then subsequently stopped the appellant's Lopressor and her Lisinopril due to adverse side effects of fatigue and cough. Dr. Thomas indicated that the appellant had done well since her MI and stent placement. Dr. Thomas' objective exams of the appellant's lungs and heart during this time period found no abnormalities but he indicated some concern of possible restenosis because the appellant was reporting some exertional chest pain. He scheduled follow-up in three months but advised the appellant to contact him sooner if her symptoms worsened. The record provides no evidence of any further evaluation and/or treatment by Dr. Thomas until after the appellant presented in the ER approximately 5½ months later on February 11, 2013. One month after her ER

visit, on March 12, 2013, the appellant was seen by Dr. Thomas in his office, at which time Dr. Thomas reported that there were no EKG changes but noted that the appellant's heart rate was somewhat limited at 127. Laboratories were unremarkable. Imaging showed a small, inferior, mostly fixed defect. Dr. Thomas indicated that despite no complaints of chest pain, he had some concerns about her complaints of left arm pain during the ER nuclear stress test. While the appellant testified at hearing that she had to use nitroglycerin three to six times a day, the appellant reported to Dr. Thomas on this date that she was using her nitroglycerin spray approximately every other day and that her symptoms were relieved by one spray. Dr. Thomas's objective exam was normal but due to the appellant's complaints of recurrent angina, he wanted to do another catheterization. The appellant declined and medication was added. Two and a half months later, on May 30, 2013, the appellant reported that she was feeling better but she still reported having some exertional symptoms. An objective exam was again normal with no EKG changes and Dr. Thomas concluded that the appellant had stable angina. He increased her medication slightly but concluded she would only need a repeat catheterization if her symptoms worsened. Included in Dr. Thomas' records was a Pulmonary Function Report from South County Hospital dated July 23, 2013 establishing a diagnosis of COPD (chronic obstructive pulmonary disease) though showing improved lung functioning when compared to the September 12, 2012 testing which showed severe obstruction. On August 26, 2013, the appellant presented complaining of fatigue and with a high BP of 150/100. Dr. Thomas's objective exam was again normal except for the increased BP and he concluded that the fatigue was a medication side effect and her medication was changed and adjusted to alleviate both the fatigue and the increased BP. The appellant continued to report that she was having some chest pain, for which she was taking nitroglycerin. There was no indication that such treatment was ineffective. Dr. Thomas described the chest pain as atypical but he offered no further explanation as to the frequency and/or intensity of such pain.

While Dr. Thomas indicates through his letters that Dr. Sara Nugent is the appellant's Primary Care Physician (PCP), the appellant testifies that she has never met Dr. Nugent and all WellOne records confirm that all medical appointments were with a registered nurse practitioner (RNP). The record provides evidence of three WellOne exams in the intervening time between the appellant's heart attack and her 2013 ER visit for chest pain; one dated May 10, 2012, one dated September 12, 2012 and one dated October 17, 2012. A review of the three WellOne exams records finds that the appellant complained of fatigue, palpitations, shortness of breath (SOB), and weight gain. She reported to WellOne that Dr. Thomas believed her fatigue could be due to her residual effects of her MI or could be related to her thyroid. At the May 10, 2012 WellOne visit, the appellant reported no chest pain but that SOB and palpitation occurred with exertional activity, climbing stairs, and walking uphill, and rest provided relief. Her sitting BP was 120/82, HR was 115 and O2 was 98. An objective exam of her thyroid, lungs, and heart showed no abnormalities. She reportedly

continued to smoke cigarettes but was attempting cessation. Blood work was planned to determine the cause of her reported fatigue. On September 12, 2012 she complained of difficulty breathing and SOB on a daily basis, aggravated by walking and climbing stairs, and stated she thought it was COPD. The appellant reported no headaches and an objective exam showed no abnormalities relative to the heart. While the appellant stated that Dr. Thomas told her that previously reported chest pains could be a blockage, she stated that she thought it was anxiety and she therefore was not using Nitroglycerin for the chest pains. A spirometry did show some obstruction and a trial of albuterol inhaler was started. On this date, the RNP concluded that the cause of the appellant's SOB could not be definitively established, though suspected that respiratory, cardiac, and anxiety could all be factors. A chest x-ray was ordered to further evaluate the SOB and the appellant was advised to go to the ER if she experienced severe SOB and/or chest pain. The September 17, 2012 x-ray showed that the appellant's lungs were clear and without any abnormalities. On October 17, 2012 the appellant presented at WellOne for her preventive exam and she complained of left flank pain and SOB aggravated by physical exertion, improved with rest. She did not report any chest pain and/or palpitations on this date but did report that she was experiencing chest pain and SOB with anxiety on a weekly basis. There were no reports of headaches and/or depressed mood. A score of 2 on a PHQ-9 Mental Health Screening Questionnaire completed by the WellOne RNP resulted in no diagnosis. The record contains no evidence of any other evaluations/treatments at WellOne in the four months between the October 17, 2012 visit to WellOne and the appellant's ER visit at Kent Hospital on February 11, 2013, and while Kent Hospital notified WellOne of the appellant's February ER visit, the record establishes that her next exam at WellOne was not until June 20, 2013.

Two MA63 forms, both completed by the WellOne RNP, one on February 26, 2013 and one on July 31, 2013, were submitted. An MA63 is an Agency medical form which is completed by an applicant's medical provider to establish what medical conditions (mental and/or physical) that an individual has and provide information about those conditions, including associated signs, symptoms, and treatment, and the effect that the conditions and treatments have on the individual's ability to perform work functions. The first MA63 was completed on February 26, 2013, approximately two weeks after the appellant's Kent Hospital ER visit and a year after her heart attack. It provided a primary diagnosis of cardiac stent placement and a secondary diagnosis of SOB secondary to cardiac issues. No further description of symptoms or signs was noted, including frequency and/or intensity, but both physical and mental limitations were reported. Specifically, the MA63 form reported that the appellant was limited to less than two hours of walking, less than two hours of standing, and four hours of sitting, occasional reaching, bending, stooping, and pushing and pulling, and to occasionally lifting/carrying up to ten pounds and slightly limited in her ability to work at a consistent pace and respond appropriately to changes in the work routine or environment. The prognosis for eliminating or reducing these

conditions through medication or other treatment was good. Treatment included re-stenting and medications as needed. The second MA63 completed five months later provided a sole diagnosis of stable angina. While no further explanation was provided as to the frequency and intensity of signs and/or symptoms, both physical and mental limitations were again noted. The appellant's ability to sit had increased to six hours while her limitations with walking and standing remained the same. While limitations with reaching and bending remained at occasional, the MA63 now reported that the appellant could do no stooping and/or pushing and pulling, but that her ability to lift/carry up to ten pounds had increased from occasionally to frequently. Her only reported limitation with mental work activities was reported as moderately limited in her ability to work at a consistent pace without extraordinary supervision. Her prognosis for eliminating or reducing her condition through medication or other treatment was now fair. There is no explanation on the form to explain the limitations and/or the changes in limitations since completion of the February MA63.

The WellOne records subsequent to the application of MA are reviewed in an attempt to obtain further explanation of the appellant's medical condition subsequent to the Kent ER visit and/or further explanation and/or understanding of the MA63 forms. WellOne had been notified by Kent Hospital of the appellant's February 11, 2013 ER visit. When the appellant next presented at WellOne on June 20, 2013, mainly for evaluation/treatment of a urinary tract infection, she also reported having irregular heartbeats/palpitations and a depressed mood. She had a sitting BP of 130/86, a HR of 116, and a pulse O2 of 97. An objective exam found her in no acute distress and oriented to time, place, person and situation and made no further mention of any abnormalities. The WellOne nurse offered no psychiatric diagnosis but she did refer the appellant for a WellOne Behavioral Health Assessment that same date and this initial behavioral health assessment was completed by a licensed social worker. According to the written assessment, the appellant complained that she was depressed due to the change in lifestyle and loss of functioning that had occurred since her heart attack and that she was experiencing anxiety about having another heart attack. A mental status exam conducted by the social worker found her well groomed, oriented to person, place, and time, with normal speech, attention, thought processes, and perceptions, normal affect, and intact intellectual functioning, but with depressed and anxious mood, and feelings of worthlessness and hopelessness, and recent memory impairment. The WellOne social worker concluded that the appellant had moderate and recurring Major Depressive Disorder (MDD) and Panic Disorder with agoraphobia, both secondary to her perceived loss of functioning and fear of continued illness subsequent to a heart attack. Planned treatment included behavioral health therapy and a possible referral to the PCNS (psychiatric clinical nurse specialist) for evaluation and possible treatment with psychiatric medication. It must be noted, despite the social worker's assessment, the RNP reported no psychiatric diagnosis on the MA63 she completed approximately one month later on July 31,

2013. On August 29, 2013 the appellant presented for her first therapy session with the social worker, complaining of worrisome thoughts related to COPD and her heart condition and/or possible need for another stent placement, as well as some personal/family issues. The plan was to return in 2-3 weeks for CBT (cognitive behavioral therapy) focusing on following through with scheduling tasks. On September 9, 2013, the appellant continued to offer complaints of anxiety relative to her heart condition and frustration relative to lifestyle changes and the social worker concluded that symptoms of both depression and anxiety had increased slightly since the last session. The appellant was to return in 2-4 weeks for CBT with a focus on relaxation training and resolution of frustration regarding her medical situation. While there was mention at the prior session of a referral for a psychiatric medication evaluation, on this date there was no mention as to whether a referral and/or a medication evaluation had occurred.

All medical opinion evidence is evaluated in accordance with the factors set forth at 20 CFR 416.927. Medical opinions of treating physicians, which are physician's opinions about the nature and severity of impairment, are afforded more weight than non-treating physicians and/or other medical sources. If a treating source's medical opinion is well-supported and not inconsistent with other substantial evidence in the record, it is given controlling weight, which means it is adopted. Opinions from non-examining medical sources per Social Security regulations are generally afforded less weight than examining medical sources. Rhode Island Hospital, Kent Hospital, South County Hospital, Dr. Thomas, and the WellOne Health Center are all treating sources. The Department of Human Services (DHS) Medical Assistance Review Team (MART) is a non-examining medical source who formulated their opinion upon reviewing the medical evidence submitted by the treating sources. Dr. Thomas has been the appellant's Cardiologist for over a year and clearly has the most expertise relative to the appellant's ongoing cardiac condition. His opinion as to her cardiac condition is thereby afforded the most weight. While his opinion is generally well supported and not inconsistent with other medical evidence, including the RIH records and the Kent Hospital ER evaluations and diagnostic testing, his opinion is not afforded controlling weight because he fails to clearly describe the frequency, intensity, and effectiveness of medication and/or the ongoing residual effects on functioning. His opinion will thereby be considered in combination with that of the WellOne RNP who did offer an opinion relative to functional restrictions. The WellOne records contain opinions from a RNP as well as a LICSW. While RNPs at clinics generally work under the authority of a physician and there is some indication that the appellant's medical care was provided under the supervision of a physician, the WellOne records provide no evidence of any examinations and/or direct opinions from a physician and the appellant testifies that she has had no contact with any physician at WellOne. Per Social Security regulations, a RNP is a non-acceptable medical source and a LICSW is non-medical source, and neither is thereby considered an acceptable medical source per the Social Security. Per the Social Security regulations, a medical impairment, either physical or mental, must be established by medical

evidence consisting of signs, symptoms, and laboratory findings, not just the individual's statement of symptoms. While non-acceptable medical sources may offer opinions as to the severity and functional effects of a medical impairment, they can do so only after a medically determinable impairment has been established by an acceptable medical source. The LICSW has offered diagnoses of MDD and Panic DO with agoraphobia. The record lacks any evidence that such diagnoses were established by an acceptable medical source and the RNP, who is at least a medical source, does not indicate any support and/or agreement with those diagnoses. While the MART's opinion as to the severity of the appellant's medical impairment takes these two diagnoses into consideration, they have also failed to provide any evidence that these and/or any psychiatric impairment has been established by an acceptable medical source. For these reasons, all opinions relative to psychiatric impairment are afforded no weight. South County Hospital provided minimal treatment for a medical condition not claimed to be disabling and their opinion as to the alleged disabling conditions will thereby be afforded the least weight.

Symptoms, including fatigue, pain, and SOB, are evaluated in accordance with the standards set forth at (20 CFR 416.929). The record establishes that fatigue is an adverse side effect to medication and changes to medication should thereby resolve that symptom. The record establishes medical conditions, both cardiac and respiratory, that could reasonably be expected to cause pain and/or SOB, but the record fails to establish pain and/or SOB to the extent alleged by the appellant. Though the record does establish that some exertional chest pain does occur and that nitroglycerin is used, there is a discrepancy in the alleged frequency and intensity of chest pain as well as the frequency in which nitroglycerin is needed and used as testified to at hearing and as described in the medical records. While the MER also establishes SOB, it does not establish SOB at rest as testified to by the appellant at hearing.

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 testifies that at the time of her MA application and at the time of the Administrative Hearing she was not working and the record indicates that she had not worked since March of 2010 or 2011. The evaluation of disability will thereby continue 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 20CFR 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.

Per the previous discussion of the MER, a myocardial infarction (MI) with stent placement, angina, hypertension, and chronic obstructive pulmonary disease (COPD) have been medically established. Major depressive disorder (MDD) and Panic DO with agoraphobia, and/or any other psychiatric impairment, have not been medically established. When determining whether the appellant has a medical impairment and/or combination of impairments that is severe, only those conditions which have been medically established can be considered. Per the previous discussion of the MER, the appellant's COPD results in SOB with physical activity and thereby places some restrictions on her ability to perform basic physical work activities such as walking, climbing, lifting/carrying, pushing, and pulling. The record fails to provided evidence of SOB at rest or when sitting, and thereby fails to establish any limitations with sitting and/or any significant limitations with standing. Hypertension and stable angina remain subsequent to an MI and stent placement, but to a lesser degree. Per the appellant's Cardiologist, Dr. Thomas, the appellant has recovered well from her MI and stent placement. While recurring angina existed at the time of the appellant's MA application causing some concern as to restenosis, symptoms occurred only upon exertion and were well treated with nitroglycerin. Only three months later Dr. Thomas concluded, based on objective examinations and the results of diagnostic testing, that the appellant's angina was stable. Blood pressure, while still somewhat elevated, is being controlled with medication. While statements by the appellant as well as additional evidence in the record from WellOne indicate a possible psychiatric cause for her chest pain, as discussed previously, a psychiatric condition that could be expected to cause chest pain has not been medically established. In summary, the MER establishes some loss of physical functioning due to stable angina, hypertension, and COPD. The MER fails to medically establish any diminished capacity to perform mental work activities. As the appellant has a combination of medically determined impairments that are severe, the evaluation of disability continues to step three.

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, Listing Sections 3.00 Respiratory System and 4.00 Cardiovascular System, were reviewed relative to the conditions that were found to be severe in

combination. The reported effects of conditions that have not been medically established cannot be considered and the record contains no evidence of any medically established non-severe conditions to be considered. A full review of EKGs and objective physical exams of the heart subsequent to the appellant's treated MI finds no evidence of further abnormalities to indicate heart disease to the level of severity to meet a listing. While pulmonary function tests (PFTs) subsequent to the appellant's MI establish COPD, FEV1 results were not to the level to meet the Listing for chronic pulmonary insufficiency. Continued high blood pressure is controlled somewhat with medication and the record lacks any evidence of elevated BP, at rest or with activity, that would result in listing level cardiac disease. Additionally, reported symptoms of chest pain and SOB occur only with physical activity and are well treated with medication. In summary, the record fails to establish the existence of an impairment or impairments that rise to the level of the listings, either alone or in combination, and the evaluation thereby proceeds to step 4.

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.

Per the previous discussion of the MER, the appellant's cardiac and pulmonary disease is severe and results in functional loss, specifically with the following physical work activities: standing, walking, climbing, pulling, pushing, and lifting/carrying. Despite such impairment, per the MER, the appellant retains the physical ability to sit for at least 6 hours a day and walk and stand at least two hours a day, alternating with sitting and with customary breaks. The appellant also retains the ability to lift/carry up to 10 pounds. The record fails to indicate any limitations relative to environmental factors but it is logical to conclude that the appellant's pulmonary impairment would result in some environmental restrictions, specifically related to environmental factors such as humidity, poor ventilation, and fumes. There is no indication of any visual or communicative

limitations and/or any fine motor loss. Per the previous discussion of the MER, the MER fails to establish any limitations with mental work activities due to any medically determined impairment and the appellant therefore is found to retain the full capacity to perform all mental work activities. The record establishes that the appellant worked as a bartender and a liquor store manager. Due to the appellant's limited capacity to perform physical work activities as described, she is incapable of physically performing her PRW (past relevant work) either as she describes it or as it is generally performed in the national economy and the evaluation of disability thereby proceeds to the fifth and final step.

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 younger individual at age 47, with a post high school education, semi-skilled work experience, and the ability to communicate in English. Per the previous discussion at step 4, the appellant has the residual functional capacity (RFC) to perform substantially all of the exertional demands of sedentary work. The implied environmental limitations are not to the extreme to significantly erode the sedentary base. The non-exertional postural limitation of climbing also does not significantly erode the sedentary base. Using the medical-vocational rules, specifically rule 202.21, as a framework for decision-making, the appellant is thereby found not disabled.

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.



Debra L. DeStefano
Appeals Officer