

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

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Docket # 14-1396
Hearing Date: October 16, 2015

Date: February 4, 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 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), and Agency representatives: Julie Hopkins, RN, Cynthia Barrington, and Neil Weintraub.

Present at the hearing were: You (the appellant), 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), consultative examination reports, and records of Rhode Island Hospital.
- He was denied for SSI, and has an appeal request pending.
- Limitations noted on the MA-63 were based on patient input, and the physical examination of the same date was normal.
- A review of the available records revealed diagnoses of coronary artery disease, with history of a stent placement in 2012, chronic hepatitis C, gastro-esophageal reflux disease (GERD), costochondral chest pain, alcohol dependence, and a history of left wrist fracture in 2013.
- A physical medical consultative examination was completed on May 21, 2013.

- He was able to ambulate well, had full and unrestricted range of motion in all four extremities, had a negative straight leg raise test, was able to flex at the waist, and had normal fine manipulation capabilities.
- There was no evidence of any pain during the exam.
- He reported at that time that he had had no cardiac care for a year.
- A psychological consultative examination was completed on July 2, 2013.
- At that time, he did not feel that his depression was serious, and that it was mostly situational, secondary to his medical problems.
- Ongoing alcohol intake was noted.
- There was no indication that depressive symptoms interfered with activities of daily living (ADLs).
- There was no evidence of any psychosis.
- Insight, judgment, memory and attention were normal.
- A Rhode Island Hospital examination note of September 24, 2013 indicated that he had tripped and fallen while helping a friend move, and had sustained fractures to the left wrist fracture and two ribs.
- His left arm was in a cast on that date.
- The October 2013 note documented that he had completed an extensive cardiac workup due to reports of chest pain.
- There was no evidence of cardiac etiology for the pain at that time.
- A diagnosis of costochondral chest pain was made.
- Effects of pain symptoms and pain medication on ability to function were taken into consideration.
- To prepare for treatment of hepatitis C, a needle biopsy of the liver was completed and noted a grade one (out of four) for inflammation and fibrosis.
- No further discussion of treatment was documented.

- There were no recent x-rays of the left wrist ordered, and no imaging reports included within the records.
- Recent physical exams did not reflect any weakness, limited range of motion, or inability to perform activities of daily living.
- Evidence did establish the existence of severe impairment relative to coronary artery disease with stent placement, costochondral chest pain, and chronic hepatitis C.
- His impairments did not meet or equal any of the Social Security listings for musculoskeletal, cardiovascular or digestive systems.
- A residual functional capacity assessment was completed resulting in light work capability, which precluded his ability to perform his past relevant work.
- Considering light work capability along with his age, education, past relevant work experience, and ability to be retrained; he was not disabled consistent with Social Security medical vocational rules.
- He was not disabled for the purpose of the Medical Assistance program.

The appellant testified:

- He is presently unemployed.
- He does not currently consume alcohol with significant frequency, although it may have been a problem years ago.
- He underwent a liver biopsy, and his liver was fine.
- He is unable to bend and stretch without getting dizzy.
- He had a coronary artery stent placement done in January 2012.
- He was informed that he had a second artery which was 50% blocked.
- The second artery was not repaired during the 2012 procedure, because the blockage had not reached the required level for that action.
- Dr Ruissi was his cardiologist, but he has not seen him for about one year.

- Dr Cohen is his primary care physician (PCP).
- He has had several cardiac tests that did not reveal much information.
- He currently takes medication to manage blood pressure, and cholesterol, as well as aspirin therapy.
- He has low blood platelets which he believes contributes to clogging of the arteries.
- He has not been to a doctor for about eight months.
- He recalls having a stress echo cardiogram which showed no significant problem.
- He fell while trying to help someone move, breaking his (left) wrist and two ribs.
- He believes that the fractures may eventually get better, but coronary artery disease is his primary concern.
- He still needs to have his neck and his foot evaluated.
- He is right side dominant.
- He has lost more than half of the strength in his (left) arm even after physical therapy.
- He went to Kent Hospital for the injury, and then followed up with an orthopedist, and physical therapist.
- He has been evaluated for atypical chest pain.
- His left wrist is still painful, and he drops things.
- He is able to move the hand and fingers adequately, but has lost strength which reduces his ability to lift.
- His therapist is reluctant to continue working on the wrist without an updated MRI to identify the specific problem.
- He did not feel that the physician who completed the MA-63 form knew him very well, and that he may have overstated the prognosis.
- He is going to see his regular physician next week.

- He expects that he could get more updated information to support his claim.
- He is hoping that his treating sources can evaluate his conditions and find a remedy for the fatigue he experiences after about three hours of activity.
- He also hopes to get more information about his heart blockage.
- He wants to include information from his primary care visit on October 21 with the hearing evidence.
- He is waiting for an appointment with the cardiology clinic, as his previous cardiologist has moved.
- 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 June 27, 2014.
- The Agency issued a written notice of denial of MA dated July 25, 2014.
- The appellant filed a timely request for hearing received by the Agency on August 25, 2014.
- An administrative appeal hearing was held on October 16, 2014.
- Per the appellant's request, the record of hearing was held open through the close of business on November 20, 2014 for the submission of additional evidence.
- Per the appellant's request for extension of the held open period, the record remained open until close of business on December 18, 2014.
- Additional evidence from Kent Hospital Outpatient Therapy Services that was received by the MART during the held open period was forwarded to the Appeals Office on December 19, 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 histories of coronary artery disease (CAD), costochondral chest pain, degenerative disc disease (DDD), osteoarthritis of the hips and sacroiliac joints, and left wrist fracture, as well as non-severe conditions including hypertension, hepatitis C, GERD, and situational affective disorders.
- 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 medical evidence, the appellant retains a residual functional capacity adequate to perform light work.
- The appellant was born on [REDACTED] and is 52 years old, which is defined as closely approaching advanced age.
- The appellant has some post high school education and communicates in English.
- The appellant has acquired transferable skills as a foreman of construction carpentry.
- 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 June 223, 2014 and signed by Desmond Wilson, MD.
- ✓ An Agency AP-70 dated June 25, 1024 and signed by the appellant.
- ✓ A consultative examination report dated July 5, 2013 and signed by psychologist, Adam J. Cox, PhD.
- ✓ A consultative examination report dated May 21, 2013 and signed by William Palumbo, MD
- ✓ An EKG completed on May 21, 2013.
- ✓ Pulmonary Function Tests (PFT) completed on May 7, 2013.
- ✓ An x-ray of the lumbar spine dated May 21, 2013.
- ✓ Records of Rhode Island Hospital for September 24, 2013 to June 23, 2014.
- ✓ Records of Kent Hospital Outpatient Therapy Services for October 25, 2013 to January 15, 2014.
- ✓ Hearing testimony.

Medical and other evidence of an individual's impairment is treated consistent with (20 CFR 416.913). The evidence record was held open per the appellant's request to submit updated records, including, but not limited to, records of Memorial Hospital's Family Care Center (FCC), and Northern Rhode Island Community Services (NRICS). He was also considering obtaining physical therapy notes from the previous year. Five weeks were allowed, and subsequently four more weeks were added at his request. At the close of business on December 18, 2014, additional information from Kent outpatient therapy performed about one year ago had been received. New records from FCC and NRICS, however, were not submitted. No additional requests for extension of the held open period had been received, and the appellant allowed the evidence record to close without that information.

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 evidence record includes two consultative examinations documenting single visits with examining sources. Examining sources are not given controlling weight although their findings are carefully considered. A series of diagnostic tests including EKG, stress echo, PFT, a liver biopsy and a lumbar spine X-ray performed in 2013 were reviewed, but are not necessarily indicative of current conditions. Records of Rhode Island Hospital clinics covered 9 months prior to June of last year, and 2 1/2 months of Kent Hospital PT notes from one year ago were added. There are no sources documenting treatment from June 2014 to the present. As records presented do not represent frequency, length, nature, or extent of treatment relationships to be assigned controlling weight of opinion, all evidence 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 MART review of available medical evidence resulted in a finding that he was able to complete light work. Diagnostic testing and physical examinations were all essentially normal or resulting in mild abnormalities. Cardiac etiology for chest pains was ruled out. Fractures sustained during a fall were not expected to meet the durational requirements. Range of motion, straight leg raises, and manipulative characteristics were intact. He was independent with his ADLs. Mental evaluation demonstrated good memory, attention, insight, and judgment with no evidence of psychosis.

The MART acknowledged his history of coronary artery disease (CAD) status post stent placement, continuing costochondral chest pain, and hepatitis C, finding those conditions severe. A residual functional capacity assessment was completed indicating that he retained the ability to perform light work which would preclude his past relevant work as a carpenter. Although he was unable to perform his past relevant work, the MART concluded that based on his age, education, work skills, and light work capability, he would be able to perform other types of work. As a result, he was not disabled.

The appellant alleged that symptoms of chest pain, shortness of breath, and left wrist weakness status post fracture impair him. Medical evidence also documents a history of rib fractures, as well as complaints of neck pain, osteoarthritis, sciatica, and extremity numbness. Progress notes document treatment for GERD, evaluations of hepatitis C, and depressive symptoms.

Chest pain was a primary complaint in this matter. Evidence shows a history of stenting of one artery in January 2012. In October 2013 an extensive cardiac workup was completed. Diagnostic evaluations revealed no evidence of cardiac etiology for chest pains. He testified that he was also concerned about a second artery blockage, but there was no evidence containing evaluation of the condition, or indicating necessary treatment. He does take medication to manage hypertension, and cholesterol, but has had no other targeted cardiac care during the past year. He was hoping to restart care in the near future with a new provider.

His current chest discomfort was believed to be primarily musculoskeletal rather than cardiac, and is diagnosed as costochondral chest pain which he understood to involve inflammation of the cartilage in the chest. Although his physicians have not been specific about the cause of costochondritis, he had experienced two rib fractures which could also impact chest wall pain. It is understandable that he would need to avoid strenuous physical activity to reduce risk of exacerbation of chest pain. There is no additional information about the condition of the ribs at the present time.

He also claims that he experiences shortness of breath with minimal exertion. As a result, pulmonary function tests (PFTs) were completed. Results revealed normal spirometry with no significant obstructive ventilatory impairment.

While records documented history of a left wrist fracture in January 2012, there is no specific information relative to the appellant's claim that the fracture has not healed correctly, as no recent diagnostic images appear to have been taken. An occupational therapy note indicated that he had reported having had an x-ray prior to December 23, 2013 which revealed non-union, but there is no x-ray report or physician assessment of fracture non-union included in the evidence records. He acknowledged that he was able to move his fingers adequately, and a consultative examination report affirmed that fine manipulation capabilities are

within normal limits. That examination also revealed no weakness or reduced range of motion, although he complained of decreased strength on the left side. His dominant right hand is strong. A therapist, however, did rule out moderate to heavy lifting for the left upper extremity only. He was also seen at Kent Outpatient Therapy Services for cervical pain with left radiculopathy. A discharge summary note indicated that he had been inconsistent with attending and completing therapy, but reported pain levels of 2/10-3/10 and a neck disability score of 20/50 representing moderate impairment. There is no clinical or diagnostic evaluation of the neck condition or associated radiculopathy completed by a physician. Consequently, no treatment recommendations, compliance or effectiveness have been documented.

GERD is being medication managed, and there is no evidence indicating that residual damage has occurred within the gastrointestinal system. He has also been evaluated for liver functions and diagnosed with hepatitis C. Although a liver biopsy test revealed a slight abnormality affirming the existence of hepatitis C, there is no indication of progression of the disease, or recommendation for aggressive treatment at this time.

The only x-ray image of the lumbosacral spine available was taken in May 2013. Mild degenerative disc disease (DDD) was observed at S1-L5, and L5-L4. There was also mild to moderate osteoarthritis (OA) at the hip and sacroiliac (SI) joints bilaterally. A physical examination revealed that his gait was normal and straight leg raise evaluation was negative. Degenerative changes did not have critical impact on range of motion (full in all four extremities) at that time, but that was nearly two years ago. There is no evidence that he has sought attention for his back condition more recently, and no updated imaging or treatment records are included. No known referrals have been made for neurological examination.

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 (including any lack of facility with the English language) will be considered to determine if he has an acceptable reason for failure to follow prescribed treatment in accordance with 20 CFR 416.930. Although the presence of an acceptable reason 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 CFR 416.930 (c)).

In this matter, the appellant has had access to treatment throughout the period being considered. He has been compliant with maintenance medications, and has attended some routine appointments. However, he has complaints of several symptoms including increase in chest pain, neck pain, extremity numbness, and sciatica for which there is no acceptable clinical and diagnostic evidence regarding treatment recommendations and compliance. Even some of

the established conditions that have been treated, such as wrist fracture, and CAD, are described within significantly outdated records, and treatment efforts are not continuously documented by appropriate treating sources, and there has been no cardiac follow up within the past year. Not following prescribed remedies and/or infrequently seeking medical treatment undermine complaints of disabling symptoms. Additionally, updated records from current treating sources were not received after nine weeks had been allowed for the submission of evidence. The material nature of any characteristics regarding non-compliance will be addressed at the final step of the sequential evaluation only if there is a finding of disability based on the available evidence.

Mental evaluation was completed by consultative examination arranged for his Social Security case. The appellant informed the examining psychologist that his depression was not serious, and that he had no prior history of mental health issues. He was diagnosed with depression by a primary care physician who observed changes following a cardiac event. There were no psychological impediments interfering with his ability to perform ADLs, to keep appointments, or to get along with others. His attention and memory are within normal limits. He was well focused during the interview. He denied any loss of mental acuity, and was perceived as average in intellectual range. His communication was logical, and affect cooperative. He minimized emotional problems. There were no indications of psychosis, stream of thought was normal, and he was fully oriented. Attention and memory were also within normal limits, and insight and judgment were good. He was diagnosed with adjustment disorder accompanied by depressed mood and his global assessment of functioning (GAF) score was 67, which was indicative of mild symptoms. Based on his history and mental status at evaluation his prognosis was good. He has continued psychotherapy. Although no further details are available, his PCP completed an Agency MA-63 nearly a year after the psychological evaluation was completed, and indicated that mental condition did not pose any limitations to functioning in any category.

Although there was some indication that he consumed alcohol, evidence does not support a significant substance addiction problem. Physicians have apparently been mindful of his past habits due to sensitivity of his liver, and overall benefit of abstinence from alcohol consumption to his general health.

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 in this case had been diagnosed with coronary artery disease, and underwent stent placement in one artery. All diagnostic cardiac tests performed since the stenting was completed have been within normal limits. Although he continues to experience chest pains, his treating sources have ruled out cardiac etiology, and rendered a musculoskeletal diagnosis of costochondral chest pains. Based on the provided medical history, managing CAD and costochondral chest pains would involve some basic, common sense restrictions, and are considered severe by a *de minimis* standard for the purpose of this evaluation.

Also considered severe in this evaluation is the reduced exertional capacity of the left wrist. Although the evidence has not established that non-union of the fracture is the reason for reduced functioning, or that manipulative characteristics have been significantly affected, a therapist did find adequate cause from his assessment and physician information provided to him to restrict moderate to heavy lifting with the left upper extremity.

In addition, the appellant has been diagnosed with hepatitis C which was at an early stage when last tested. No treatment had been prescribed or implemented. No associated deficits have been documented, although the condition would minimally require monitoring. GERD, and hypertension are being medication managed, and no residual damage has been indicated. Mental health treatment

has been recommended to manage situational depressive symptoms occurring secondary to adjustments and/or fears related to his heart condition. No adverse mental health history has been indicated. An examining source, a treating source, and the appellant have each affirmed that mental conditions have no more than minimal impact on ability to function. Existing conditions including hepatitis C, GERD, Htn, and affective disorder, likewise, have not been demonstrated to have more than a minimal effect on his ability to perform basic work activities, and therefore, are considered non-severe for the purpose of this evaluation.

The appellant had severe, medically determinable impairments including coronary artery disease, costochondral chest pain, left wrist fracture, and non-severe impairments relative to hepatitis C, gastro intestinal reflux disorder, hypertension, osteoarthritis, and situational affective disorder. The evaluation 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, listings 4.04 (Ischemic heart disease), and 1.02 (Major dysfunction of a joint), as well as instructions at 1.00 for evaluating musculoskeletal conditions have been reviewed. Evidence documenting results of cardiac testing has not revealed any symptom limited exercise tolerance. There is no history of coronary artery disease requiring bypass surgery, no evidence establishing degree of narrowing of coronary arteries, and no serious limitations in ability to independently sustain, or complete activities of daily living. Musculoskeletal evaluations do not support marked level loss of range of motion, strength, reflexes, or sensation. Reductions in exertional functioning appear to be based on precautionary recommendations. As a result, 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 records document lifting restrictions for the left upper extremity indicating that heavy and moderate activity should be avoided. Although he is right hand dominant, partial loss of use of one arm is a stand-alone limitation affecting all ranges of work. Consequently, light exertional rules are used as a framework (POMS DI25020.005A5). No significant restrictions to walking or standing have been established, as cardiac factors are under treatment, and a battery of diagnostic tests was essentially normal. No measurable cause for shortness of breath was supported by pulmonary function evaluation. Evidence has not ruled out ability to work in a seated position throughout a workday with allowances for customary breaks. Pushing or pulling may be restricted for the left upper extremity due to discomfort and cautionary use of the joint due to previous fracture.

Postural: Based on musculoskeletal and cardiac conditions, he should avoid frequent climbing, or crawling.

Manipulative: No restrictions to ability to reach, handle, finger, or feel have been established.

Visual: Near acuity, far acuity, depth perception, accommodation, color vision, and field of vision are intact.

Communicative: Hearing and speaking capabilities are intact.

Environmental: Due to hypertension and musculoskeletal conditions he should avoid concentrated exposure to extreme cold, heat, wetness, and humidity.

Medical evidence records in this matter have established that the appellant has been treated for severe conditions, but have also ruled out many potential residual effects of his impairments through diagnostic testing and clinical evaluation. Results do support that he would be limited to light exertional work activity with some postural and environmental restrictions. No restrictions to basic mental functioning have been established. His current residual functional capacity would clearly preclude him from performing his long-time career activity as a carpenter. The sequential evaluation, therefore, proceeds 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 52-year old male with post-high school education and a positive work history as a carpenter. Evidence has established that he has been treated for severe impairments including coronary artery disease, costochondral chest pain, and a left wrist fracture; as well as non-severe impairments including hepatitis C, gastro intestinal reflux disorder, hypertension, and situational affective disorder. His current residual functioning is limited by his conditions to a physical exertional level of light work activity which precludes him from returning to the field of carpentry.

Based on the appellant's age of 52 (closely approaching advanced age), education (high school or more), work history (medium exertional skilled work activity, transferable), RFC (light work capability with some postural and environmental restrictions), and using vocational rule 202.15 as a guide while considering all additional non-exertional characteristics; 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

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.