



Rhode Island Executive Office of Health and Human Services  
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Docket # 14-2419  
Hearing Date: February 17, 2015

Date: March 23, 2015



### **ADMINISTRATIVE HEARING DECISION**

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

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

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

Copies of this decision have been sent to the following: You (the appellant), and Agency representatives: Julie Hopkins RN, Cynthia Barrington, and Neil Weintraub.

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

**EOHHS RULES AND REGULATIONS:**

Please see the attached APPENDIX for pertinent excerpts from the Executive Office of Health and Human Services Medicaid Code of Administrative Rules (MCAR).

**APPEAL RIGHTS:**

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

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

**TESTIMONY AT HEARING:**

**The Agency representative testified:**

- In order to be eligible for Medical Assistance (MA) an applicant must be either aged (age 65 years or older), blind, or disabled.
- The Medical Assistance Review Team (MART) determines disability for the MA Program.
- The MART is comprised of public health nurses, a social worker and doctors specializing in internal medicine, surgery, psychology and vocational rehabilitation.
- To be considered disabled for the purposes of the Medical Assistance Program, the appellant must have a medically determinable impairment that is severe enough to render him incapable of any type of work, not necessarily his past work. In addition, the impairment must last, or be expected to last for a continuous period of not less than twelve (12) months.
- The MART follows the same five-step evaluation as SSI for determining whether someone is disabled.
- The MART reviewed an Agency MA-63 form (Physician's Examination Report), an Agency AP-70 form (Information for the Determination of Disability), and records of WellOne, Urologic Specialists, and CCAP Family Health Services of Coventry.
- There was no pending SSI application at the time of review by the MART, and they were unable to access any consultative examination reports that may have been completed.
- No record of admission to either Rhode Island Hospital or Kent Hospital was found.
- A review of the available records revealed diagnoses of chronic prostatitis, bilateral non-obstructive nephrolithiasis (renal calculi), chronic low back pain and depression.

- He had a history of involvement in a motor vehicle accident (MVA) in 2009.
- His initial urology consult took place in August 2014.
- Diagnostics provided evidence of renal stones or calculi that were found, although they did not obstruct the flow of urine.
- His primary care provider (PCP), had prescribed treatment for his renal condition, but no significant relief was achieved.
- Recommendations were made to try prescription Flomax, and to arrange for a cystography procedure, which he declined based on past experiences.
- He did agree to have ultrasound imaging completed.
- A bladder ultrasound was performed on September 6, 2014.
- The bladder appeared normal, but moderate post-void residual was noted.
- The ultrasound showed non-obstructive renal calculi in both kidneys.
- Renal calculi and associated symptoms would not be expected to last for twelve months, although intermittent recurrence is possible.
- Temporary obstruction could occur if the stones are passed.
- Effects of pain and side effects of pain medication are taken into account relative to ability to function.
- It was decided that he would try medication management of his symptoms, and in October, progress notes indicated good results.
- WellOne records included a single exam note from August 2013, and Kent Hospital laboratory test results from August 2014.
- The exam notes discussed complaints of back pain and depression.
- He had been prescribed anti-depressant medication in the past, but reported poor effect from that medication, and it was changed.
- The general physical examination did not note any abnormalities relative to his back.

- He was referred to behavioral health, but no follow up was documented.
- He requested pain medication, but at that time the request was denied.
- CCAP records received started with an initial appointment on August 26, 2014.
- His objective physical examination was normal and lab work was ordered.
- After Kent ER diagnostic reports were reviewed, he was referred to Urology specialists.
- The available evidence did not support the existence of a medically determinable impairment that would limit functioning, meet the durational requirements or have residual deficits when following prescribed treatments.
- As a result, they stopped at step two of the Social Security evaluation finding him not disabled.
- He was not disabled for the purpose of the Medical Assistance program.

**The appellant, assisted by a witness, testified:**

- He is currently unemployed.
- He did not intend to claim disability based on the presence of kidney stones.
- The kidney stones are a non-issue, as they only hurt when being passed.
- As he has passed the kidney stones, he does not care about that condition any longer.
- He is being followed by new doctors for chronic pelvic pain syndrome (CPPS).
- He has had the CPPS diagnosis for a couple of years.
- He had visited the Rhode Island Hospital urology clinic many years ago.
- He is currently seeing a gastroenterologist, but did not bring any evidence records from that source, as the explanation for his condition is still unknown.

- He has had a colonoscopy and is scheduled for endoscopy, but they do not yet have a precise diagnosis.
- At this time he is impaired by a combination of conditions
- His sciatic condition is highly controllable, and only becomes an issue based on activity level.
- Prostatitis cause problems all the time, but the primary issue is the undiagnosed gastrointestinal condition that his doctor suspects may be Crohn's disease.
- Continued testing is expected.
- He requested to submit a note from urologist, Dr Cambio, affirming that he has been providing care for pelvic pain of unknown etiology since August 2014.
- He has not had any additional visits with Dr Cambio since August 2014, and is expected to return yearly.
- He had been treated for primary care at WellOne in past years, went to CCAP for one visit, and changed to Benjamin Bauer, MD, who is his current PCP.
- He requested to submit a February 4, 2015 note from Dr Bauer as evidence.
- His gastroenterologist cannot offer an opinion until testing and evaluations are completed.
- He emphasized that his conditions flare up with increased activity.
- He has been examined and tested for prostatitis by more than one doctor, and records should reflect that fact.
- He believes he has had the condition for six years, but he could not get a specialist to agree until recently when he met Dr Cambio.
- His conditions do not interfere with ability to complete personal care.
- He is unable to perform household chores, as pain escalates, and he experiences significant fatigue secondary to his other conditions.
- He is able to lift 20 lbs occasionally.

- He feels he is unable to stand or walk for two hours, as it would exacerbate sciatica.
- His mother affirmed that he does not walk very quickly, and that he takes a long time to complete activities such as grocery shopping.
- He thinks he could sit for two hours, although he would be uncomfortable.
- A doctor told him to avoid prolonged sitting.
- He does not drive.
- He has not had any behavioral health counseling or treatment.
- Social Security arranged three consultative examination appointments for him.
- His attorney has copies of the examination reports, but he is suspicious about the objective of those evaluations.
- He did not want to appeal the MA denial, but was encouraged to do so by his caseworker.
- 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 September 16, 2014.
- The MART arrived at a decision resulting in denial of MA on November 26, 2014, which was verbally explained to the appellant by his case worker.
- The appellant filed a timely request for hearing received by the Agency on December 18, 2014.
- Per the appellant's request, the record of hearing was held open through the close of business on March 17, 2015 for the submission of additional evidence.
- Additional evidence from Benjamin Bauer, MD and Zachary Garner, DO that was received by the MART during the held open period was forwarded to the Appeals Office on March 18, 2015, and was added to the record of hearing.
- As of the date of this decision, the MART had not withdrawn the notice under appeal.
- The appellant is not engaging in substantial gainful activity.
- The available medical records did not establish the existence of any impairment relative to disorders of the spine, sciatica, or depressive symptoms.
- The appellant had a medically determinable impairment of non-obstructive nephrolithiasis which did not meet the durational requirements of a disability.
- The appellant had not met his burden of proof relative to establishing that alleged impairments including prostatitis; and CPPS secondary to an unspecified gastrointestinal disorder, continue to result in more than a minimal impact on functional capacity as required to perform basic physical work activities.
- 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 September 23, 2014 and signed by Liza Famador, MD.
- ✓ An Agency AP-70 dated September 24, 2014, and signed by the appellant.
- ✓ Records of WellOne Health Center for August 20, 2013 and including Kent Hospital diagnostic reports dated August 6, 2014.
- ✓ Records of Urologic Specialists of New England for August 29, 2014 to October 16, 2014.
- ✓ Records of CCAP for August 26, 2014 to September 22, 2014.
- ✓ A note from Angelo Cambio, MD dated February 4, 2015.
- ✓ A note from Benjamin Bauer, MD dated February 4, 2015.
- ✓ Records of Benjamin Bauer, MD for October 16, 2014 to February 28, 2015.
- ✓ Records of Zachary Garner, DO for October 29, 2014 to January 14, 2015.
- ✓ Hearing testimony.

Medical and other evidence of an individual's impairment is treated consistent with (20 CFR 416.913). The record of hearing was held open for the submission of additional evidence identified as missing, and addressing conditions not thoroughly represented within the records received during the Agency's processing of the application. At the close of business on the agreed upon date, records from two physicians had been added. The appellant testified that the Disability Determination Unit (DDU) had arranged three consultative examinations (CE) to help him obtain missing information for his Social Security Administration (SSA) disability claim. He was advised that he could request those reports from his attorney or directly from the Social Security office. The instructions were reiterated in writing and provided to both parties. He seemed somewhat reluctant to include the CE reports, as he believed the consulting physicians were conspiring with SSA to deny his benefits. At the close of business on March 17, 2015 no CE reports had been submitted, and he had not made a request for extension of the deadline, therefore, allowing 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 appellant in this matter had made two changes of primary care treating sources, resulting in limited progress notes from each. One report was submitted from WellOne Health Center dating back to August 2013. The next PCP record documented an initial examination with CCAP Coventry Family Health Center one year later in August 2014, and subsequently he changed to become a patient of Benjamin Bauer, MD in October 2014. The PC physicians had prescribed maintenance medication, and made referrals to specialists as needed. The PCP who completed the MA-63 form had completed only one visit with the appellant, and had no substantive clinical and diagnostic evidence to support the opinions indicated on the form relative to the appellant's physical and mental functional capabilities. There are no longitudinal treatment relationships documented within the available records, which the appellant explained was due to his lack of access to health care prior to acquiring health insurance late last year. As there are no treating sources that would justify controlling weight of opinion, all records are 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 reviewed the available information and found that records mentioned chronic prostatitis, back pain and depression, but did not provide the required details regarding symptoms, signs, evaluations, treatments, and treatment results as required by the Social Security regulations. They found that records primarily documented his renal conditions and formation of kidney stones. They did not expect the renal condition to meet the duration requirements, which proved to be a correct projection based on the appellant's testimony that the symptoms had resolved, and his request that we disregard that condition. Having no evidence of ongoing impairment, they were unable to establish duration or severity of any of his reported conditions, and stopped at step two of the evaluation.

Additional medical records were submitted during the held open period, and two notes from his new physicians were submitted during the hearing. The new evidence was added to the record. As of the date of this decision, the MART has not found sufficient evidence to compel them to reverse the original decision of not disabled. Their final rationale for that decision has not been communicated to this Appeals Officer.

The appellant has alleged that symptoms of chronic pelvic pain syndrome (CPPS) secondary to undiagnosed gastrointestinal dysfunction, prostatitis, low back pain, and sciatica impair him. The medical record also addressed his history of renal calculi currently resolved, and complaints of depressive symptoms.

The records of a single visit with a WellOne nurse practitioner were reviewed. During that visit, complaints of insomnia, low back pain, sciatica, prostatitis, and depressive symptoms were discussed. The physical examination notes documented that balance and gait were intact, and did not identify any deficits to range of motion, strength, sensation, reflexes, or straight leg raises in the context of low back pain and sciatic pain complaints. No references to diagnostic imaging capturing the lumbosacral spine were indicated. There was distant history of a motor vehicle accident noted, but with no connection made to his musculoskeletal pain. There are no additional records relative to orthopedic or neurological evaluation which revealed any specific abnormality of the spine such as vertebral fracture, disc herniation, or degenerative conditions; nor is there any identification of nerve impingement that could be expected to result in radicular pain to the lower extremities. Medical records from late 2013 to the present made have not documented prescribed treatment recommendations for back pain or associated sciatic nerve problems.

A CT scan of the abdomen and pelvic region was completed on August 7, 2014 at Kent Hospital. It is unclear what they were searching for at that time, as the appellant has made claims that multiple gastrointestinal and genitourinary conditions affect him. The diagnostic imaging did locate and identify kidney stones which the appellant testified he had since passed out of his system, and as they were temporary and no longer an issue, he adamantly stated that he did not intend to imply that the renal condition was a contributor to his alleged disability. However, he did feel strongly that CPPS was a significant factor limiting his functional capabilities. The imaging report noted that the liver was unremarkable, the gall bladder was normal without evidence of stones, and pancreas, spleen and bowel were normal and without apparent changes such as thickening, dilatation or inflammation. Pelvic organs were unremarkable and musculoskeletal/abdominal wall was normal for his age. Dr Famador documented complaints of sharp left lower quadrant pain occurring after meals in September 2014. As he reported increased discomfort caused by eating, she recommended further gastrointestinal workup and a need to rule out celiac disease. He testified that evaluation was ongoing, as specialists continue to explore possible explanations for his symptoms.

Reports from his urologist regarding chronic prostatitis confirm that the prostate is enlarged without tenderness or masses, and that his patient did endorse incomplete, unpredictable, and inconsistent voiding. The appellant reported that previous physicians had tried various remedies without lasting results. Treatment with nortriptyline and gabapentin was proposed. Evidence does not establish if the treatment was successful, or if it could be expected to control the condition long term. No urgency was demonstrated, as he was placed on an annual visit schedule.

In October 2014 he established care with a new PCP, Dr Bauer. The objective medical examination revealed that his renal condition was asymptomatic, prostatitis was to be addressed by urology as needed, and he had good movement of all extremities and normal gait. The focus was on evaluation of chronic abdominal pain. Lab tests to check liver function, pancreatic enzymes, protein levels and inflammatory markers were ordered and a referral was made to a GI specialist. They were to discuss results of labs and consultation in one month. Lab results revealed some abnormal liver functions, and elevated cholesterol which is now being managed with a statin medication.

He started evaluation of abdominal pain with Dr Garner. Based on associated bloating, constipation/diarrhea, he recommended further testing for irritable bowel syndrome (IBS) while considering underlying celiac disease. Trial medication and a daily fiber supplement were prescribed, and a colonoscopy was scheduled for January 13, 2014. Evidence confirms that the colonoscopy procedure with biopsy and polypectomy was completed on that date. Although the evidence record was held open until March 17, 2015 allowing two months' time for further assessment and pathology results to be reported, no conclusions or follow up plans were included within the records submitted.

Symptoms including pain are evaluated in accordance with the standards set forth at (20 CFR 416.929). The appellant must show evidence of a medically determinable impairment which could reasonably be expected to cause not just pain, or some pain, or pain of some kind of severity, but the pain the claimant alleges he suffers.

He has described low back pain with radiation into the lower extremities from involvement of the sciatica nerves, which is completely unproven. There are no diagnostic images of the spine, no specialists evaluating the condition of the spine, no prescribed therapies such as physical therapy, epidural steroid injections, or surgical interventions, and no pain management specifically targeting the spine. Examinations do not include any loss of range of motion, strength, sensation or reflexes, and no positive straight leg tests have been indicated. Objective physical examination notes repeatedly identify gait as normal. He has described escalation of pain when he increases exertional activity. While that seems logical, pain could be limiting without being disabling.

Claims of abdominal pain vary throughout the record as the appellant has experienced the pain of kidney stones, and has been diagnosed with prostatitis. The renal condition has resolved, and the prostate examination described the gland to be enlarged, but without tenderness.

Additionally, he has described gastrointestinal pain. Records repeatedly document complaints of GI issues that have not been definitively identified. Records show that he has reported eating just once daily because of the resulting pain. Certain foods are tolerated better than others. Several trials of

medications have been prescribed. Although he has rejected some medications as unpleasant or ineffective, there is no information regarding adverse side effects, or facts that would help to advance the treatment of his condition. He is clearly underweight, but most other adverse symptoms described have not been substantiated by reports of any physicians.

With regard to depressive symptoms, the only information gained from review of the current evidence record is that physicians have noted depressed affect, and that at least one recommendation for behavioral health counseling had been made. There is no follow-up information indicating that the appellant ever underwent psychological evaluation or entered into a treatment relationship with anyone specializing in mental health. As there are no psychological or psychiatric evaluations, treating sources, or reports of prescribed remedies and their effectiveness, it is not possible to determine the impact of symptoms on mental performance as required to perform basic work activity.

The credibility of the appellant is in question in this matter for several reasons. He has not only complained of back and sciatic pain, which has not recently been seriously evaluated or proven; but he has requested pain medications of a primary care physician who he left after denial of his request, and is currently seeking authorization for medical marijuana. It is assumed to be a request related to the alleged back pain, as it is unusual to prescribe such pain remedies for abdominal pain due to the danger of masking symptoms that could serve as a warning of an urgent condition. Furthermore, of the five treating sources represented within the evidence record, no one has been committed to treatment of back pain. During hearing testimony he was often argumentative and resistant to providing facts that could serve to support his claim. He was critical of the agency representative's presentation which clearly reported on exactly what his physicians' records had documented. He was angry and resistant when his mother tried to assist him with identifying missing records. Reluctance to submit consultative examination reports appeared to be the result of his belief that there was a deliberate concerted effort at Social Security to deny him. Additionally, several of his treating sources found they could not rely on his self-report, and documented that he was a poor historian.

The appellant believed that his physicians had labelled him as disabled. Notes from his PCP and gastroenterologist affirm that his CPPS is of unknown etiology, but requires evaluation. Work activity was not totally precluded, although the possibility that his work ability could be limited by symptoms was noted to be dependent upon the type of work activity being considered. In the disability evaluation process it is not unusual to preclude some occupations based on an individual's limitations, yet still find that some less exertional jobs would be manageable. Furthermore, his PCP did not indicate that his conditions were unlikely to be corrected to adequately restore functioning. Any possibility that treatment can reduce symptoms or restore his ability to perform appropriate work activity must be considered.

**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 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 available medical records do not contain any clinical and diagnostic evidence to support disorders of the spine, or sciatica. Consequently, it is impossible to ascertain what specific medical condition (if any) exists, how treatable the condition might be, and to what degree it could reasonably be expected to impact work activity.

Well documented records regarding history of renal calculi have established that while the condition was severe in the past, it was not durational. The appellant has affirmed that the condition has resolved, and that it is no longer a contributing factor in his claim of disability.

Prostatitis has been acknowledged, and monitored, yet there is no evidence which establishes that the condition would have more than a minimal effect on ability to perform basic physical work activity.

An unspecified persistent gastrointestinal disorder has been treated with medication, dietary fiber, and polyps were removed during an exploratory colonoscopy. There is no evidence within the past two months following the procedure's completion that identifies whether or not a more exact diagnosis has been made, or if recent treatment efforts have reduced or eliminated symptoms.

Treating sources have not been committed to a need for mental health evaluation and treatment. Although mention of depressed mood was noted, there is no evidence that it was more than a situational depression in response to his a period of physical illness. As there are no psychological or psychiatric evaluations, treating sources, or reports of prescribed remedies and their effectiveness, evidence does not establish the existence of impact from symptoms on mental performance as required to perform basic work activity.

At step two of the sequential evaluation, the appellant bears the burden of proof relative to the requirement to support allegations of disability with acceptable clinical and diagnostic medical evidence. Although the evidence documented a past history of conditions requiring medical attention, the records do not establish that a medically determinable impairment with a measurable impact on functional ability has persisted for a continuous period of twelve months, or could be expected to do so. Therefore, the sequential evaluation of disability ends at Step two.

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

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

  
Carol J. Ouellette  
Appeals Officer

## APPENDIX

### 0352.15 ELIGIBILITY BASED ON DISABILITY

REV:07/2010

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

### 0352.15.05 Determination of Disability

REV:07/2010

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

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

### **0352.15.10      Responsibility of the MART**

REV:07/2010

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

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

- i. If the Department finds a medically severe combination of impairments, then the combined impact of the impairments will be considered throughout the disability determination process.
    - ii. If the individual does not have a severe medically determinable impairment or combination of impairments, the Department will find that he/she is not disabled.
  - c. The Department will not consider the individual's age, education, or work experience at Step 2.
  - d. Step 2 is a de minimis standard. In any case where an impairment (or multiple impairments considered in combination) has more than a minimal effect on the individual's ability to perform one or more basic work activities, adjudication must continue beyond Step 2 in the sequential evaluation process.
4. Step 3  
A determination is made whether the individual's impairment or combination of impairments meet or medically equal the criteria of an impairment listed in the Social Security Administration's Listings of Impairments (20 C.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.