

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

**Louis Pasteur Building- # 57 Howard Avenue
Cranston, Rhode Island 02920
(401) 462-2132/Fax# (401) 462-0458
TDD# (401) 462-3363**

Docket # 14-867
Hearing Date: July 22, 2014

Date: October 6, 2014

ADMINISTRATIVE HEARING DECISION

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

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

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

Copies of this decision have been sent to the following: You (the appellant), and Agency representatives: Julie Hopkins RN, Rosemarie Victoria, and Cruz Gomez.

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 two Agency MA-63 forms (Physician's Examination Report), an Agency AP-70 form (Information for the Determination of Disability), and records of Thundermist Health Center, Gateway Healthcare, Landmark Medical Center, and a medical summary from a Thundermist nurse practitioner.
- No consultative examination reports were available from Disability Determination Services (DDS), as he had already been denied by Social Security.
- A review of the available medical records revealed diagnoses including hypertension, chronic obstructive pulmonary disease (COPD), asthma, mood disorder, opioid abuse, depression, bunions, gastrointestinal reflux disease (GERD), and a history of coronary artery disease (CAD).

- One of the MA-63 forms received was from Northern Rhode Island Community Services (NRICS), although that agency was not listed as a treating source on the application paperwork.
- Information provided identified NRICS as a past treating source, and noted that care had been transferred to Gateway.
- He had presented to the (Landmark) emergency room on September 13, 2013 with complaints of chest pain, and was kept there for observation until cardiac issues were ruled out.
- Treatment was initiated at Thundermist in October 2013.
- Enlargement at the bases of his great toes was noted, but the rest of the physical exam was normal.
- He had been provided with anti-hypertensive medication while at Landmark hospital and his blood pressure appeared to be well controlled.
- On October 24, 2013, there was a visit to Thundermist recorded for a blood pressure check.
- In November 2013 he complained of bilateral great toe pain.
- No inflammation was present, and the nurse practitioner prescribed pain medication.
- The effects of pain as well as side effects of pain medication on ability to function were taken into consideration.
- December 9, 2013 progress notes discussed his plan to transfer psychiatric care of NRICS to Gateway.
- He had only been seen at NRICS for about 1 month.
- Until January 31, 2014 there had not been any mention of COPD or asthma.
- He had presented with cold symptoms, and an asthma diagnosis was added.
- He was prescribed two metered dose inhalers to help with breathing.
- At a February 4, 2014 appointment, he indicated that he had not taken his blood pressure medications due to the expense.

- Notes also indicated that he was using suboxone from the street after a recent drug relapse.
- Dr Berman decided to perform a drug screen and start an organized suboxone treatment plan.
- Suboxone use dated back to 2009, but had not been previously reported to the primary care provider or to Gateway at the start of treatment in January 2014.
- In April 2014 Gateway notes indicated that he was transitioning mental health care to a new location in Pawtucket.
- He had been started on anti-depressant medication, but still had some residual symptoms.
- Hypertension, GERD, and asthma/COPD symptoms were well managed with medication.
- Individuals with respiratory diagnoses should avoid being exposed to respiratory irritants or extreme temperatures.
- Thundermist records showed no difficulty breathing, and no need to increase use of inhalers.
- Bunions can be removed surgically, and would not be expected to meet the twelve month durational requirement for disability.
- Thundermist records did not reveal any difficulty with ambulation, but did note complaints of pain.
- Although mental health records were limited, the available information did establish the existence of severe impairment which met the durational requirement.
- Records also established continued use of opiates, and no disclosure of that use to treatment providers.
- Thundermist Health Center indicated that he was seeking more specialized treatment.
- Evidence supported the existence of a combination of severe impairments including bilateral foot pain, asthma, COPD, hypertension, history of coronary artery disease (CAD), depression, mood disorder, and opioid abuse.

- His impairments did not meet or equal any of the Social Security listings of impairments.
- They completed a physical residual functional capacity assessment and concluded that he retained the ability to perform light exertional level work.
- Mental residual functioning assessment determined that he could carry out activities of daily living, manage keeping his appointments, interact appropriately with others, as well as understand and remember simple instructions.
- Based on the residual functioning assessments they found that he was able to perform his past relevant work.
- The ability to perform past relevant work resulted in a finding of "not disabled".
- He was not disabled for the purpose of the Medical Assistance program.

The appellant testified:

- He is currently unemployed.
- The previous diagnosis of bunions has been changed to arthritis.
- He went to a foot doctor, and was told that they could not operate because of his coronary problems.
- The podiatry referral was made by his primary care physician (PCP) at Thundermist, and he believes that she would have received a copy of the examination notes.
- He has not used opiates for more than two years.
- He objects to being labelled as an addict because of his past behavior.
- He has worked very hard since 2009 to become a better person.
- In October (2013) he was tempted to drink in response to a difficult situation, but he was able to overcome that feeling and resist drinking.

- He is disappointed that the incident was labelled as a relapse although he never drank.
- He has sustained sobriety for 2 ½ years.
- He has been advised to take aspirin for foot pain.
- He also uses ice packs, and has a cane.
- The foot pain limits his ability to walk.
- He has many pairs of shoes that he cannot wear due to foot pain.
- The pain seems to be associated with a bone condition.
- X-rays have been taken, and problems with the bones were mentioned by the physician.
- He believes that inflammation was also a problem.
- He continues treatment with Thundermist for CAD.
- Currently, the PCP prescribes blood pressure medication.
- He has an enlarged heart secondary to untreated hypertension.
- His blood pressure changes periodically.
- During an emergency when he was taken to Landmark Hospital they had to give him two nitroglycerin tablets and four baby aspirins.
- He must continue taking the blood pressure medication to keep his condition stable.
- He was also told to modify his diet, but finds that recommendation to be a challenge as he has been homeless, and accepts food that is given to him.
- He now receives food stamps, but he has no way to cook or prepare food.
- He has been told that he may need a stent placement in the future.
- He has had surgery in the past to repair two hernias.
- He cannot lift anything heavier than a phone book.

- Foot pain gets worse as the day goes on if he tries to remain active.
- Prescribed medication works well to control his asthma when he uses it.
- He believes that he has required emergency hospital treatment for asthma twice within the past year.
- He has not attended any consultative examinations for his Social Security case.
- He is currently working with Gateway for mental health treatment, as he was not satisfied with the response from NRI Community Services.
- He now has a regular caseworker at the Gateway Pawtucket location.
- He has a new psychiatrist who is a better listener than his last doctor.
- His medication doses have been increased, and he has an appointment in August for medication review.
- He has never missed a mental health appointment except for one day when he was not allowed to leave his building after a dead body was discovered.
- He is currently taking three medications for psychiatric symptoms, but still experiences some nightmares.
- He requested to submit a letter dated July 17, 2014 from a Gateway clinician as evidence.
- He requested to submit a letter dated May 3, 2014 from a Thundermist nurse practitioner.
- He requested to submit a Thundermist medication list dated July 3, 2014.
- He has a good memory and could find the office of the foot doctor again.
- 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 February 26, 2014.
- The Agency issued a written notice of denial of MA dated May 5, 2014.
- The appellant filed a timely request for hearing received by the Agency on May 16, 2014.
- Per the appellant's request, the record of hearing was held open through the close of business on August 19, 2014 for the submission of additional evidence.
- Additional evidence from University Foot and Ankle, Gateway Healthcare, and Thundermist Health Center that was received by the MART during the held open period was forwarded to the Appeals Office on August 20, 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 Hallux rigidus of the great toes bilaterally, substance addiction disorder in sustained remission, depressive disorder, and personality disorder; as well as non-severe conditions including hypertension, GERD, and COPD.
- The appellant did not have an impairment or combination of impairments that met or medically equaled any of the listed impairments in the Social Security listings.
- Based on the appellant's residual functioning, he retains the physical ability to perform sedentary work, and mental ability to think, communicate, act in his own interest and care for his own needs.
- The appellant was born on [REDACTED] and is [REDACTED] years old, which is defined as a younger individual.
- The appellant has a 7th grade education and communicates in English.
- 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 March 7, 2014 and signed by nurse practitioner, Nancy Castro, FNP.
- ✓ An Agency MA-63 dated December 20, 2013 and signed by psychiatrist, Stephen DiZio, MD.
- ✓ An Agency AP-70 dated February 26, 2014 and signed by the appellant.
- ✓ Records of Landmark Medical Center for September 12, 2013 to September 13, 2013.
- ✓ Records of Thundermist Health Center for October 16, 2013 to July 31, 2014 including assessment of Cardiovascular Associates of Rhode Island.
- ✓ Records of Gateway Healthcare for January 3, 2014 to July 30, 2014.
- ✓ A letter dated July 17, 2014 and signed by Zachary Gerber, MA.
- ✓ A letter dated May 3, 2014 and signed by Nancy Castro, FNP.
- ✓ A medication list documented on July 3, 2014.
- ✓ Records of University Foot and Ankle Center for April 10, 2014.
- ✓ Hearing testimony.

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

All medical opinion evidence is evaluated in accordance with the factors set forth at (20 CFR 416.927). The appellant has a longitudinal primary care relationship with Thundermist Health Center, and has provided medical records from the treating source covering the period from October 2013 to July 2014 and including single evaluations of specialists in podiatry and cardiology. Although they have a significant treatment relationship, reliability of the records has been affected by recent discoveries relative to patient-reported medical history which challenges the accuracy of previous records and could impact the appropriateness of recommendations for treatment. Other medical records include a Gateway psychiatric evaluation and clinical progress notes. Mental health information is substantively very limited. However, conclusions of the psychiatrist are examined for consistency with other evidence and considered within the context of the entire record.

The MART is considered a non-examining source when expressing opinions regarding an individual's condition. At the time of application, the MART found sufficient evidence to establish that the appellant had a combination of severe impairments that would limit functioning to light exertional level physical work and simple, routine mental tasks. Although his conditions would reduce the occupational base, the MART did not find that based on the required factors of age, education, residual functioning and training potential that he would be precluded by his conditions from performing all work.

The appellant has alleged that heart conditions, high blood pressure, acid reflux and mental issues impair him. Medical records add history of substance dependence in remission, treatment for chronic obstructive pulmonary disease (COPD), and foot pain.

The appellant established primary care at Thundermist Health Center in October 2013 after being treated at Landmark for chest pains. Although Landmark ruled out cardiac issues, Thundermist progress notes have documented monitoring of hypertension. His condition is classified as well controlled, benign, essential hypertension. Because hypertension generally causes disability through its effects on other body systems, the record is examined for any limitations imposed by hypertension to the heart, brain, kidneys, or eyes. While a heart condition has been alleged, review of the available evidence showed no support for the existence of any specific cardiac defect. Records show no evidence that hypertension has resulted in any end organ damage, or could be expected to affect functioning as it is being effectively medication managed at this time.

During the hearing and at various office visits he has self-reported a history of coronary artery disease (CAD) and two prior myocardial infarctions (MIs) occurring in May 2012 and September 2013. A review of the records reveals that both Rhode Island Hospital and Landmark Medical Center where he was treated for each of those episodes, found no evidence of heart attack on either occasion. Thundermist records included recent cardiology evaluation completed by specialist, Arnoldas Giedrimas, MD of Southcoast Cardiovascular Associates. An electrocardiogram performed on June 3, 2014 was unremarkable. He had no current symptoms suggestive of cardiac ischemia, congestive heart failure, or arrhythmias. There was no history of cardiac catheterization or stent placement. A full review of symptoms was obtained. Other than some shortness of breath with exertion, and brief palpitations, all findings were negative. Heart rate and rhythm were normal.

He returned to Dr Giedrimas for follow up in July 2014. An echocardiogram had been completed on June 18, 2014 demonstrating normal left ventricle function. He continued to complain of atypical chest pains without other serious symptoms, and a stress test was recommended. At the time of this decision no further cardiac testing is available.

The most recent physical examination was held on July 31, 2014 with Thundermist physician, Linda Berman, MD. On that date he was continuing suboxone to main his abstinence from substance use, and was prescribed his medications for management of COPD and was encouraged to consider tobacco cessation. He had no shortness of breath, or wheezing, no chest pain, palpitations, light headedness, or edema and no uncontrolled depression, or anxiety symptoms. There were no complaints of any problems related to GERD with continued use of the prescribed medication. The overall examination was

grossly normal for both physical and mental characteristics. He was using a cane for stability affected by foot pain.

A podiatrist, James Pascalides, DPM had evaluated his foot pain in April 2014. Pain and stiffness in the great toes bilaterally had been diagnosed by x-rays revealing exostoses at the base of each metatarsophalangeal (MTP) joint. Treatment for his conditions was complicated by the appellant's report to the physician of cardiac impairment. While there are surgical options for correcting the disorder according to the severity of the problem, the physician opted for very conservative recommendations such as topical ointments, anti-inflammatory medication, and proper shoes; based on the assumption that the patient-reported cardiac history was accurate. At his time, no correction to the MTP impairment is known.

Symptoms, including pain, fatigue, etc. are evaluated in accordance with the standards set forth at (20 CFR 416.929). The appellant has presented evidence of a medically determinable impairment, hallux rigidus of the 1st MTP joint bilaterally which could reasonably be expected to result in pain. He has reported that the pain increases with exertion, and limits his ability to walk or stand for prolonged amounts of time. Progress notes indicated that his gait was normal, with use of a cane. A podiatrist had recently prescribed conservative pain management. There is no information about compliance or effectiveness relative to the pain management recommendations. Furthermore it has been determined that since the podiatry visit took place, the appellant has learned that his understanding of his cardiac history was incorrect. This opens up the possibility of surgical repair of the great toes. He was advised during the last visit with his PCP to follow up with the orthopedic surgeon, and to obtain approval from the cardiologist for surgical repair of his foot problem. At this time, evidence has not established that this condition could be expected to continue to impact functioning upon completion of the recommended correction.

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 podiatrist did discuss surgical intervention with the appellant. The appellant, however, had provided inaccurate information regarding his heart condition which significantly altered the physician's treatment recommendation. His PCP has now specified follow up to correct that matter.

Mental health evaluation was initiated at Gateway in January 2014. He did not have a significant mental health treatment history prior to that time, although His primary care provider had recognized some mild to moderate restrictions impacting mental activities.

Psychiatrist, Sajid Choudhry, MD observed a depressed affect, hopelessness, helplessness, and attitude of victimization. There was no evidence of psychomotor abnormality, no suicidal or homicidal ideation, and no psychosis. He diagnosed depressive disorder NOS, polysubstance dependence, and personality disorder. Goals and objectives were set, and anti-depressant medication was started. In April 2014, Dr Choudhry noted he appeared less depressed, despondent and hopeless. He was alert and oriented in all spheres, and had no formal thought disorder or harmful ideations.

His counseling sessions were moved to another office in April 2014, and progress was documented by therapist, Zachary Gerber. Depression was mild, and anxiety slight, with no other significant abnormalities reported. Many of the sessions documented challenges with finding housing. He had remained sober, and was trying to utilize coping skills as recommended. Medication was changed in May 2014 with escalation of symptoms. After the June 27, 2014 visit, all progress notes revealed better control of symptoms with reduction of the impact of depression and anxiety.

In cases involving a history of drug dependence or alcoholism, the material nature of the addiction may impact the determination of disability. In this matter, records show that the appellant's sobriety has been sustained for a significant period of time with suboxone therapy, and that he continues regular follow up treatment with his PCP. The material nature of substance dependence is addressed at any step that is the last step in a particular case, only if there is a finding of disability. (20 CFR 416.935).

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. He has reported a work history of short-term and part-time attempts at employment. 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 has been treated for hypertension, GERD and COPD which are each currently well managed with prescribed medications. No residual effects of the conditions have been indicated, and they are considered non-severe for the purpose of the sequential evaluation, as they have not been demonstrated to have more than a minimal impact on functioning.

Foot pain secondary to hallux rigidus of the great toes bilaterally is pending evaluation for surgical correction. Currently, symptoms are severe, although there is an expectation that surgery would restore functioning without exceeding the durational requirement to be considered disabling. However, as a corrective procedure had not been identified or approved, the limitations created by the existing symptoms will be considered for the purpose of this evaluation.

Mental symptoms secondary to depressive disorder, personality disorder, and substance dependence disorder in remission are improved, but ongoing. The mental conditions will be considered severe for the purpose of this evaluation.

Step three: A determination is made whether the individual's impairment or combination of impairments meet or medically equal the criteria of an impairment listed in the Social Security Administration's Listings of Impairments (20 CFR Part 404, Subpart P, Appendix 1). If the individual's impairment or combination of impairments meets or medically equals the criteria of a listing and also meets the duration requirement (20 CFR 416.909), the individual is disabled. If it does not, the analysis proceeds to the next step.

In this matter listings 12.09 (Substance Addiction disorders), 12.04 (Affective disorders), 1.02 (Major dysfunction of a joint) are reviewed. Physical medical evidence has not established the existence of an extreme inability to ambulate independently which would prevent completion of daily activities. Mental health records have revealed slight to moderate impact within each of the required domains, but have not documented marked level restrictions in any category. The medical evidence record does not support the existence of an impairment that rises to the level to meet or equal any 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: Currently, the appellant would be limited by foot pain to sedentary exertional functioning for lifting no more than 10 lbs, standing or walking no more than 2 hours out an 8 hour workday, and sitting for 6 hours. Correction of his foot problem, if medically approved, could be expected to improve exertional capabilities. At the present, however, he is limited to sedentary exertional level activity.

Postural: He should avoid jobs requiring frequent climbing, balancing, stooping, kneeling, crouching, and crawling.

Manipulative: No limitations to reaching, handling, fingering, or feeling have been established.

Visual: No restrictions to near acuity, far acuity, depth perception, accommodation, color vision, and field of vision are indicated.

Communicative: Abilities for hearing and speaking are intact.

Environmental: Due to hypertension and COPD, he should avoid concentrated exposure to cold, heat, wetness, humidity, fumes, odors, dusts, gases, and poor ventilation.

Mental RFC

Understanding and Memory: The appellant stated that he had a good memory. Evidence does not rule out his ability to remember locations and procedures, to understand and remember short, simple instructions, or even to recall some detailed instructions.

Sustained Concentration and Persistence: He could be expected to carry out instructions, and to maintain attention and concentration for 2-hour blocks of time throughout a workday with allowances for customary breaks, and to make simple work-related decisions. He may have difficulty sustaining a routine without special supervision due to feelings of helplessness and perception of himself as a victim.

Social Interaction: Medical evidence has not ruled out his ability to interact appropriately with others, recognize when to request assistance, accept instructions from supervisors, maintain socially appropriate behavior, and adhere to basic standards of grooming.

Adaptation: He could be expected to be aware of normal hazards and take precautions, respond appropriately to basic work-related change, arrange transportation, and set realistic goals.

The appellant is limited by physical conditions to sedentary exertional level activity with some postural and environmental restrictions. Although he has a history of substance abuse, he has significantly sustained sobriety, and is able to perform normal daily activities. His diagnoses of affective and personality disorders, have been treated with medication management and counseling. Current evidence has established that he is able to think, communicate and care for his own needs. He can perform activities of daily living independently, and is capable of remembering and following instructions. As he has not identified any work assignment included in his reported work history as substantial gainful activity which he could presently perform, the evaluation continues to Step five.

Step five: At the last step of the sequential evaluation process, consideration is given to the assessment of the individual's RFC together with his/her age, education and work experience to determine if he/she can make an adjustment to other work in the national economy (20 CFR 416.920(g)). If the individual is able to make an adjustment to other work, he/she is not disabled. If the individual is not able to do other work and meets the duration requirement, he/she is disabled. At step five, it may be determined if the individual is disabled by applying certain medical-vocational guidelines (20 CFR Part 404, Subpart P, Appendix 2). The medical-vocational tables determine disability based on the individual's maximum level of exertion, age, education, and prior work experience. In some cases, the vocational tables cannot be used, because the individual's situation does not fit squarely into the particular categories or because his/her RFC includes significant nonexertional limitations, such as postural, manipulative, visual, or communicative; or environmental restrictions on his/her work capacity. If the individual can perform all or substantially all of the exertional demands at a given level, the medical-vocational rules direct a conclusion that the individual is either disabled or not disabled depending upon the individual's specific vocational profile (SVP). When the individual cannot perform substantially all of the exertional demands or work at a given level of exertion and/or has non-exertional limitations, the medical-vocational rules are used as a framework for decision-making unless that directs a conclusion that the individual is disabled without considering the additional exertional and/or non-exertional limitations. If the individual has solely non-exertional limitations, section 204.00 in the medical-vocational guidelines provides a framework for decision-making (SSR 85-15).

The appellant is a 47-year-old male with a 7th-grade education, and primary language of English. Although he has not reported details of a past relevant work history, he identified several short-term work attempts at the time of application, as well as during psychiatry evaluations. He is a viable candidate for vocational rehabilitation.

Based on the appellant's age of 47 (defined as a younger individual), education (limited), past relevant work experience (none), RFC (sedentary with some postural and environmental restrictions), MRFC (adequate mental functioning with reduced concentration, persistence, and pace) and using vocational rule 201.18 as a guide along with consideration of 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 activity.

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.