STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
EXECUTIVE OFFICES OF HEALTH AND HUMAN SERVICES
APPEALS OFFICE
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Docket # 13-1767
Hearing Date: March 6, 2013

Date: June 24, 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, Marion Fath, and Judith Malpino Anderson.

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

DHS POLICIES:
Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Department of Human Services Policy Manual.

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

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

TESTIMONY AT HEARING:

The Agency representative testified:

- In order to be eligible for Medical Assistance (MA) an applicant must be either aged (age 65 years or older), blind, or disabled.
- The Medical Assistance Review Team (MART) determines disability for the MA Program.
- The MART is comprised of public health nurses, a social worker and doctors specializing in internal medicine, surgery, psychology and vocational rehabilitation.
- To be considered disabled for the purposes of the Medical Assistance Program, the appellant must have a medically determinable impairment that is severe enough to render him incapable of any type of work, not necessarily his past work. In addition, the impairment must last, or be expected to last for a continuous period of not less than twelve (12) months.
- The MART follows the same five-step evaluation as SSI for determining whether someone is disabled.
- The MART reviewed an Agency MA-63 form (Physician's Examination Report), an Agency AP-70 form (Information for the Determination of Disability), and records of Brain & Spine Neurosurgical Institute (BSNI), Newport Hospital, Kent Hospital, and University Medicine Foundation.
- Consultative examination reports were requested from the Disability Determination Unit, but none had been received as of the date of hearing, as he had been denied eligibility for SSI in October 2013.
- A review of the available records revealed diagnoses of lumbar spine herniation with radiculopathy status post lumbar discectomy in January 2013, and lumbar spine fusion in May 2013, and hypertension.
- He was admitted to Kent Hospital in February 2013 for viral gastroenteritis, and subsequent dehydration.

- He had two additional admissions in March 2013 for nausea, vomiting and diarrhea.
- He was diagnosed with C. diff, which is infection causing colon inflammation.
- A lumbar fusion and fixation was performed at Newport Hospital in May 2013.
- Office records from February and April 2013 indicated that his blood pressure was stable on medication.
- Physical examinations on both occasions were listed as normal despite having had lumbar surgery.
- A referral to a GI specialist (gastroenterology) was given after the Kent Hospital admissions, but no follow up information was received.
- The MA-63 form submitted did not include any information relative to his physical restrictions.
- Due to lack of insurance, he had not participated in any physical therapy as of the date the form was signed in August 2013.
- At that time he was doing some home exercise.
- Dr Das discussed his low back pain with right leg weakness.
- An MRI revealed evidence of a disc herniation and surgical intervention was recommended.
- A February, 2013 note indicated that he did well post-operatively.
- Following the admission to Kent later that month, he reported the return of low back pain with radiation to both legs
- In April 2013 his neurosurgeon decided to order a new MRI to examine for any pathology that would explain the occurrence of the new symptoms.
- The new MRI revealed degenerative disc disease with evidence of some disc protrusions and bulges, along with some granulation and scar tissue near the L4-L5 discs.
- Lumbar fusion surgery was recommended, and completed in May 2013.

- A custom fitted back brace was designed to be used for 6-8 weeks after completion of the surgical procedure.
- He was also prescribed a bone stimulator to aid in the healing process.
- Progress notes indicate that he did well post-operatively.
- At a follow-up appointment it was recommended that he increase his exercise program and walking.
- He reported back pain in the morning and after physical activity.
- The effects of pain were taken into consideration.
- The MART determined that his impairment was severe.
- His conditions did not meet or equal any of the Social Security listings.
- Based on the records reviewed, the MART determined that he retained the ability to perform light work.
- His past relevant work as a printing press operator was precluded based on his residual functioning.
- Taking into account his age of 44, 10th grade education, past relevant work and ability to be retrained, and using the applicable medical vocational rule as a guide, he was not disabled according to the Social Security requirements.
- He was not disabled for the purpose of the Medical Assistance program.

The appellant testified:

- He is currently unemployed.
- He was unable to follow up with the gastroenterologist after the C diff infection because he was not insured.
- He was also diagnosed with a MRSA infection.
- His back condition has been developing over a period of twenty years.
- He has been to therapy at least five different times for his back condition.

- His original injury occurred when he was nineteen.
- He opted for conservative treatments including several courses of steroid injections in the years prior to the surgery.
- He agrees that he can stand, sit, or walk for six hours, but cannot do any one of those activities continuously.
- After sustaining one position for too long, his pain increases, and he has to change to a different position.
- He prefers to be in a situation where he can sit to relieve pressure if he becomes uncomfortable.
- He has been hospitalized at Kent Hospital twice since the surgery was completed.
- The diagnosis of MRSA was made prior to surgery, and detected by a swab in the nose.
- He does not know the results of the last round of testing for C diff or MRSA.
- He has not applied for health care under the Affordable Care Act, as he believed he would have to cancel his GPA medical to do that.
- He requested to submit Kent Hospital physical therapy intake records, and a summary of emergency services as evidence.
- He required additional surgery in December that is not included in the record.
- Weight lifting at physical therapy was increasing his pain.
- His PT regimen has been lightened due to limited tolerance of lower extremity exercises.
- His conditions interfere with his sleep quality.
- He has experienced pain and loss of sensation in his legs.
- He continues to take pain medications and muscle relaxants.
- He relies on medication to support functioning.

- His blood pressure medication has been increased, as recent blood pressure readings have been elevated.
- Dr Austin, his primary care physician (PCP) at Wilcox Center, monitors his hypertension.
- He has received treatment at the Wilcox Center, BSNI, Kent Hospital, and the Kent outpatient rehabilitation center, not included in the evidence record.
- He continues to use the back brace and the bone stimulator.
- He still has difficulty with his legs, which has caused him to fall.
- He sometimes experiences incontinence.
- 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 July 9, 2013.
- The Agency issued a written notice of denial of MA dated September 25, 2013.
- The appellant filed a timely request for hearing received by the Agency on October 21, 2013.
- Per the appellant's request, the hearing scheduled for January 22, 2014 was rescheduled to March 6, 2014.
- Additional records from Kent Hospital Outpatient Rehabilitation and emergency discharge instructions were submitted during the hearing.
- Per the appellant's request, the record of hearing was held open through the close of business on April 3, 2014 for the submission of additional evidence.
- At the close of business on April 3, 2014, no new records had been received.

- 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 a herniated nucleus pulpous with resulting compromise of a nerve root, a non-severe condition of hypertension, and non-durational infections.
- The appellant did not have an impairment or combination of impairments that met or medically equaled any of the listed impairments in the Social Security listings.
- Based on the appellant's residual functioning, he retains the ability to perform light work.
- The appellant was born on July 22, 1969 and is 44 years old, which is defined as a younger individual.
- The appellant has a 10^{th} 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 August 16, 2013 and signed by physician's assistant, Christine Boyer, PA-C.
- ✓ An Agency AP-70 dated July 11, 2013 and signed by the appellant.
- ✓ Records of BSNI for January 16, 2013 to August 15, 2013.
- ✓ Records of Newport Hospital for May 20, 2013 to May 24, 2013.
- ✓ Records of Kent Hospital for February 20, 2013 to March 30, 2013.
- ✓ University Medicine Foundation for February 27, 2013 to June 14, 2013.
- ✓ Kent Hospital Outpatient Rehabilitation for November 25, 2013 to March 5, 2014.
- ✓ Kent Hospital Emergency Services discharge instruction dated February 8, 2014.
- ✓ Hearing testimony.

Medical and other evidence of an individual's impairment is treated consistent with (20 CFR 416.913). Per the appellant's request, the record of hearing was held open through the close of business on April 3, 2014. No additional records were received. The appellant did not request extension of the deadline to submit new evidence, and allowed the record to close on April 3, 2014 without adding the updates from BSNI, Kent Hospital, Kent Outpatient Rehabilitation, and the Wilcox Center that he identified were missing during the hearing.

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 has been evaluated and treated by neurosurgeon, Sumit Das, MD, and physician assistant, Christine Boyer, PA-C of Brain & Spine Neurosurgical Institute (BSNI). He has a longitudinal treatment relationship with BSNI, as they have evaluated his conditions with diagnostic imaging taken in January 2013, and performed two surgical procedures on the spine occuring in January and May of 2013. Although BSNI records have not been updated beyond August 2013, the specialists associated with that practice are given controlling weight of opinion with respect to the disorder of the spine. Records of Kent Hospital document emergency visits required to address symptoms of infections in the months between his surgical events. Partial records of the Kent Outpatient Rehabilitation were submitted during the hearing, although no updates were received after that date. Early 2013 primary care information from University Medicine Foundation provides some basic information about general physical health up until the time that he changed

primary care providers and initiated care with The Wilcox Center. No records from Wilcox have been made available. The opinions of the less frequently used providers will be considered in combination with the BSNI progress reports 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 found that the nature of his spinal condition was well supported by clinical and diagnostic evidence. They determined that his impairment was severe, as symptoms continued to reduce his functional capabilities even after two surgeries had been completed. According to the available records reviewed, they found that he retained adequate functioning to perform light work activity, which precluded his ability to return to his past relevant work. After considering other factors including age, education, past work experience, and his potential to retrain and transition to new work activity, the MART found he was not disabled in accordance with the Social Security medical vocational guidelines.

The appellant has alleged that low back pain with radiculopathy impaired him. He indicated that after more than twenty years of conservative treatment, and subsequent surgical interventions, he still experienced pain which limited his activity, interrupted his sleep, and was only about 50% controlled by prescribed treatment remedies.

The appellant has a history of multi-level degenerative changes in the lumbar spine. A right-sided paracentral disc at L2-L3, and a large right paracentral disc extrusion causing severe impingement of the right L5 nerve root were addressed during the January 2013 surgery. Although he tolerated the procedure well, and appeared to be healing on schedule post operatively, he developed progressive back and right leg symptoms requiring further surgical intervention immediately following emergency hospitalization for extreme vomiting and diarrhea believed to have been triggered by C diff colitis. He was hospitalized twice for the acute gastrointestinal symptoms.

At a later date, he also tested positive for MRSA infection colonized in the nose. There is no evidence of infections at surgical sites which healed normally. Both infections were treated with appropriate courses of medication. There is no evidence that infections failed to respond well to treatment, and that any residual impact remains.

A neurosurgical follow up examination in April 2013 revealed tenderness to palpation of the midline lumbar spine from L1 to S1, and mild tenderness to the SI joints bilaterally. The examiner was unable to elicit deep tendon reflexes bilaterally, and sensation was decreased in the right lower extremity. His gait was guarded and he had a right side limp. Coordination, range of motion and stability were normal for all four extremities. Strength was somewhat reduced to 4/5 for the right lower extremity. A second surgical intervention was planned.

Subsequently, a posterior lumbar interbody fusion with posterior fixation rods connecting vertebrae L3-S1 and with insertion of a disc spacer at L4-L5 was performed. A follow-up X-ray of the LS spine, status post fusion, confirmed that hardware was in place.

The last progress note of record from BSNI noted that he reported overall improvement after the surgery. He reported that back pain was present first thing in the morning and after prolonged exertional activity. He was following an at-home exercise program and walking. His incision was well healed, and he was encouraged to increase physical activity.

Symptoms, including pain are evaluated in accordance with the standards set forth at (20 CFR 416.929). The appellant has demonstrated with acceptable evidence that disorders of the lumbosacral (LS) spine could reasonably be expected to cause pain. Complaints of pain include the lower back and lower extremity radicular pain. He testified that prolonged activity in any posture eventually resulted in pain, and required a change of position. His conditions have been treated with injections, surgical repair, home exercise, physical therapy, a bone stimulator, a brace, and pain medication. He has been compliant with most recommendations, although he did postpone physical therapy due to lack of insurance coverage for that treatment. The combination of various treatment remedies had improved his condition as of the last available assessment completed at BSNI. The most recent information relative to his rehabilitation was documented at Kent Outpatient Therapy Services. Several months after the surgical procedure, the physical therapist set goals to increase strength, flexibility, range of motion and activity tolerance with minimal impact on pain. Updates of progress notes from physical therapy have not been submitted. It is unknown how long he participated in physical therapy, if he was compliant with treatment recommendations, or if any of the stated goals were achieved. The appellant indicated on the AP-70 form that he is able to perform ADLs independently and walks up to 2 hours per day.

The appellant has also been treated for hypertension with maintenance medication. Records show that the condition was being well managed with medication maintenance. He testified that recently his blood pressure had significantly increased, and his medication had to be adjusted. Readings have improved with the treatment change, although they are not yet ideal. As no current primary care records have been submitted, there is no recent information regarding hypertension.

Hypertension generally causes disability through its effects on other body systems. The evidence has not established that any limitations have been imposed by hypertension to the heart, brain, kidneys, or eyes. Records show no indication that hypertension has resulted in any end organ damage, or could be expected to affect functioning in this case.

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 currently unemployed. 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 a history of a lumbar herniated disc with nerve impingement and right side radicular pain, status post surgical repair and fusion. BSNI records document complete evaluation of his condition, the surgical procedures that have been completed, and follow up until 3 months after the last operation. At that point in time, the controlling treating source reported good healing, and progress on schedule. Physical examination was generally normal. He had not participated in physical therapy, but was using a home exercise and walking plan for rehabilitation which he was encouraged to increase.

Medical treatment including surgery must be considered according to its effectiveness in ameliorating the signs, symptoms, and laboratory abnormalities of the disorder, and in terms of any side effects that would limit functioning. The neurosurgery specialists elected not to provide opinions regarding specific elements of physical functioning. The appellant testified that he could sustain activity for six hours if he were able to vary the type of exertion required rather than prolong a single posture for an extended period of time. Clearly, some reduction to range of motion in the lower spine is inherent with fusion procedure, and the need to limit physical exertion to avoid further exacerbation of pain would be a common sense precaution. As a result, the disorder of the LS spine is considered severe for the purpose of this evaluation.

Hypertension is being medication managed with no evidence of residual effects, and is deemed a non-severe impairment. His history of hospital acquired infections is documented in part, and records do not support the expectation that they would meet the durational requirements with treatment.

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

In this matter, listing 1.04 (Disorders of the spine) had been reviewed. The appellant underwent two surgical procedures to address herniated nucleus pulpous compromising a nerve root. Following the surgical fusion of vertebrae, there is no information establishing that nerve root compression continues. Neither spinal arachnoiditis nor lumbar spinal stenosis has been indicated. Evidence does not identify occurrence of non-radicular pain, or inability to ambulate effectively as defined in 1.00B2b. The medical evidence record does not support the existence of an impairment that rises to the level of the listings.

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

Physical RFC

Exertional: Based on the appellant's surgical history, his ability to lift would be limited to 10 lbs frequently and 20 lbs occasionally, as required to perform light work. He testified that he could sustain up to 6 hours of varied activity. He was exercising and walking for therapy prior to staring physical therapy. It was anticipated that recuperation time and physical therapy would increase activity tolerance. Evidence has not ruled out his ability to walk, stand, or sit for two-hour blocks of time throughout a workday with allowances for customary breaks.
Postural: He should avoid frequent climbing, balancing, stooping, kneeling, crouching, or crawling.
Manipulative: No restrictions to reaching, handling, fingering, or feeling have been established.
Visual: Near acuity, far acuity, depth perception, accommodation, color vision, and field of vision are unlimited.
Communicative: Abilities for hearing and speaking are intact.
Environmental: Due to hypertension, and musculoskeletal pain he should avoid concentrated exposure to extreme cold, heat, wetness, or humidity.

The evidence presented affirms that the appellant's functioning was limited by low back pain and radiculopathy secondary to a herniated disc and nerve impingement prior to treatment including two surgical interventions. Information from the controlling neurosurgical treating source documents post-surgical improvement of his symptoms and creates the expectation that continued strengthening and functional advancements could be achieved. Actual updates were not submitted. Based on the available information, the appellant had reached a point after surgery when his residual functioning was limited to light work activity. Light work capability would preclude his ability to perform his past relevant work as a printing press operator. As a result the evaluation continues to step five.

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

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

The appellant is a 44-year-old male with a tenth-grade education and trade school training. He has a positive work history involving offset printing jobs, which have been precluded by the physical restrictions imposed by a severe LS spine condition. Although his impairment has reduced his physical exertional capacity, evidence has documented improvement with treatment, and a reasonable expectation that he could retrain and/or perform other types of work in the future.

Based on the appellant's age of 44 (younger individual) 10th-grade education (limited), work history (medium exertion, semi-skilled, not transferable), RFC (light work with some postural and environmental restrictions), and using vocational rule 202.18 as a guide, with consideration of non-exertional factors including pain; the combined characteristics direct a finding of "not disabled" according to the Social Security regulations.

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