

**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
EXECUTIVE OFFICES OF HEALTH AND HUMAN SERVICES
APPEALS OFFICE – LP Bldg.
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Cranston, RI 02920
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Docket # 13-1803
Hearing Date: January 22, 2014

Date: June 20, 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 (MART), Jacqueline Duffy, Michael Richardson, and Denise Tatro.

Present at the hearing were: You (the appellant), and Agency representative Julie Hopkins, RN. Also present for observation/training purposes was Karen Walsh (EOHHS Appeals Officer).

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?

TESTIMONY AT HEARING:**The Agency representative testified:**

- In order to be eligible for Medical Assistance (MA) an applicant must be either aged (age 65 years or older), blind, or disabled. Since the appellant is neither blind nor aged, the Agency looked at the disability characteristic.
- To be considered disabled for the purposes of the Medical Assistance Program, the appellant must have a medically determinable impairment that is severe enough to render her incapable of any type of work, not necessarily her past work. In addition, the impairment must last, or be expected to last for a continuous period of not less than twelve (12) months.
- The Medical Assistance Review Team (MART) determines disability for the MA Program.
- The MART is comprised of consultant public health nurses, a social worker, and doctors specializing in internal medicine, surgery, psychology, and vocational rehabilitation.
- The MART follows the same five-step evaluation as SSI for determining whether someone is disabled.
- The evidence reviewed included an Agency MA-63 form (Physician's Examination Report), an Agency AP-70 form (Information for the Determination of Disability), records from Thundermist Health Center, and records from Dr. Herbert.
- Records requested from Blackstone Valley Health Center were not received.
- An SSI denial was issued so any consultative reports were not accessible.
- The appellant has been found eligible for the Modified Adjusted Gross Income (MAGI) program as of January 2014.

- The MA63 and the medical evidence reviewed provided the diagnoses of Chronic Fatigue, Depression, Attention Deficit Disorder (ADD), and Hypogonadism, or low hormones and/or sperm count
 - A June 2013 Thundermist note discussed a good response to over-the-counter medications taken for complaints of ongoing lower back pain that he has suffered with for many years and they indicated there was a review of home exercises to be performed.
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- The Thundermist record noted that Northern Rhode Island Community Services (NRI) had prescribed the appellant's one medication (Provigil), which is generally used to improve wakefulness in adults. NRI was not mentioned by the appellant on the AP-70 and records requested from Thundermist were not received.
 - Provigil is not as effective if not taken on a regular basis and part of the MART decision is based upon treatment compliance.
 - Dr. Herbert's records revealed that an annual exam occurred in June 2013 to provide documentation needed to obtain health insurance. The exam was normal with no complaints of excessive fatigue or difficulties in functioning. Vital signs and weight were stable.
 - At the June 2013 exam visit, the appellant reported his depressive symptoms had worsened since the discontinuance of Cymbalta. He requested Zoloft and it was prescribed. The objective exam was normal with no complaints of excessive fatigue, or difficulties in functioning. Vital signs and weight were stable.
 - An August 2013 appointment note indicated complaints of right sided chest pains which had responded to Percocet. An exam was normal and muscular issues were suspected.
 - A September 2013 detailed medical note was requested for a court date. The note indicated that the appellant had recently started taking Depakote for moodiness but the appellant was not sure if it was working and he was asking for a different medication.
 - Moodiness and/or Depakote were not mentioned in the previous appointment record and it is unclear who had prescribed it.
 - The medical evidence does not support that a medically determined impairment exists that would limit functioning, meets the durational requirements, or has residual deficits when following prescribed treatment and therefore the appellant does not meet the severity requirements.

- The MART stopped at step 2 of the evaluation finding the appellant not disabled.

The appellant testified:

- He had previously been found disabled due to chronic fatigue and depression and did have Medicaid coverage several years ago, but when it came up for recertification he let it lapse, even though he had not gotten any better, because it was too much of a process.
- He had applied for and was denied SSI in 2008 or 2009 and he has never reapplied for that after losing his appeal.
- He has medical insurance now but would take the Medicaid coverage if he is found disabled.
- He graduated high school in 2002.
- He is currently unemployed and has never held a job for more than a month because he is too tired to get out a bed on a regular basis.
- He started feeling tired soon after high school but was not diagnosed with chronic fatigue and depression until later.
- His Primary Care Physician (PCP), Dr. Christine Herbert, diagnosed him with chronic fatigue in 2008 or 2006. Blood work helped establish the chronic fatigue diagnosis by ruling out other things.
- He sees Dr. Herbert, or her assistant Derrick, about every month or two and he did see her in 2012 so he does not know why no records from 2012 were submitted.
- He just started going to the Thundermist doctor and has only gone there once in June 2013.
- He began seeing a doctor at NRI around 2012. He just recently went back to NRI because he needed an anti-depressant which his doctor would not prescribe. He did not list NRI on the application because he was not going there at that time. He only went to NRI once before, but now has gone about an additional three times.
- He thinks he sees a Psychiatrist at NRI. He also thinks he was sent for a psychiatric evaluation by Social Security.

- NRI prescribes Provigil, which he takes on and off when he feels he needs it, because some days he can't get out of bed as easily as other days. He does not know if it is fatigue or depression which affects his ability to get out of bed. He probably takes it about five times a week and still has trouble getting out of bed when he does take it.
 - Provigil is the only medication that he currently takes.
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- He had taken other medications on a consistent basis but he stopped taking Cymbalta and mood stabilizers due to the side effects and Zoloft did not work well. He might have taken the Zoloft for a month and a half. He can't remember how long he has been off it, but it wasn't working.
 - Some previous medications helped a little, because he was not so depressed and thinking suicidal thoughts, but he was still tired.
 - He keeps going on and off Cymbalta. When he is off it he feels like he has more motivation but he is more depressed when he is off it.
 - Over six years ago, he was brought to the hospital because he was drinking and tried to kill himself. He does not really drink at all now because he can't drink and drive, so he chooses not to.
 - He lives in the home with his dad, and stays home most of the time because he does not have the energy to do anything.
 - He gets tired doing physical activity due to his chronic fatigue.
 - His ability to do mental work activities differs daily. His ability to remember depends on how tired he is and/or how well he sleeps but he is at his worse maybe a couple times per week.
 - He thinks his back is not straight. When it hurts he takes over-the-counter medication, which help to a degree. If he starts to do strenuous work his back will really hurt and then the medication will help. His back does not hurt all the time because if he is too tired to get out of bed then it does not hurt as much.

FINDINGS OF FACT:

- The appellant filed an application for Medical Assistance (MA) on July 29, 2013.
- The Agency issued a written notice of denial of MA dated October 15, 2013.

- The appellant filed a timely request for hearing dated October 22, 2013.
 - Per the appellant's request, the record of hearing was held open through the close of business on February 19, 2014 for the submission of additional evidence.
 - No additional evidence was received while the record of hearing was held open.
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- The appellant is not engaging in substantial gainful activity.
 - The appellant's treating physicians have provided diagnoses of Chronic Fatigue Syndrome (CFS), Depression, Attention Deficit Disorder (ADD), Hypogonadism, and Rhinitis Allergic.
 - The appellant claims disability due to CFS and Depression.
 - The appellant claims some functional loss due to low back pain.
 - The appellant does not have a severe medically determined impairment, either alone or in combination, that has been or is expected to be severe for a period of at least 12 months.
 - The appellant is not disabled as defined in the Social Security Act.
 - The appellant is not disabled for the purposes of the Medical Assistance Program.

DISCUSSION OF THE MEDICAL EVIDENCE RECORD (MER):

On July 29, 2013, the appellant submitted an application for Medical Assistance (MA) with the Department of Human Services (DHS) and claimed he was disabled. Since the appellant was not receiving disability benefits through the Social Security Administration, the Executive Office of Health and Human Services (EOHHS) Medical Assistance Review Team (MART), as required by MA policy, completed an evaluation of disability. The MART found the appellant not disabled and his request for MA was denied.

The Agency submitted the following evidence at hearing:

- An MA63 form (Physician Examination Report) signed by Derrick Robinson MS, PA-C on July 17, 2013.
- An AP70 form (Information for Determination of Disability) signed by the appellant on July 26, 2013.

- Records from Thundermist Health Center consisting of a Patient Summary and a June 3, 2013 exam record.
 - Records from University Internal Medicine, Inc. (Christine V. Herbert, MD and Derrick M. Robinson MS, PA-C,) consisting of a Patient Chart Report and exams records covering the time period from January 15, 2013 through September 9, 2013
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The MART representative testified that they found the appellant not disabled at step 2 of the evaluation, arguing that while the medical evidence provided diagnoses of Chronic Fatigue, Depression, Attention Deficit Disorder (ADD), and Hypogonadism, it did not support the existence of a medically determined impairment that would limit functioning, meet the durational requirements, or have residual deficits when following prescribed treatment.

According to the AP70 completed by the appellant on July 26, 2013, he is unable to work due to severe depression, which he claimed causes lack of energy, motivation, and difficulty in getting out of bed. At hearing, the appellant alleges disability due to Chronic Fatigue Syndrome (CFS) and Depression. He testified that symptoms of fatigue began soon after graduating high school in 2012 and such was to the extent to render him incapable of getting out of bed in the morning on a regular basis, thereby rendering him incapable of ever holding down a job for more than a month. He further testifies that he gets tired doing any physical activities, and that his ability to perform mental work activities, specifically relative to memory, is affected by how tired he is and/or how well he has slept. The appellant testified he takes Provigil, prescribed by Northern R.I. Community Services (NRI), when he feels he needs to. The appellant further testified that Provigil was his only prescribed medication at the time of hearing. While the record lacks any evidence from the prescribing physician or medical provider to explain why it was prescribed for the appellant, the Agency testifies that Provigil is generally used to improve wakefulness in adults but that it is not as effective if not taken on a regular basis. The appellant testifies in response that he takes the medication approximately five times a week and even when he does take it he is still tired to the point that he has trouble getting out of bed. The appellant also testifies that he has depression and that he tried to commit suicide more than 6 years ago while under the influence of alcohol. He testifies that he is not currently taking any antidepressant medication, explaining that he stopped taking Cymbalta due to side effects and stopped taking Zoloft because it did not help. The only other impairment-related condition mentioned by the appellant at hearing was back pain, which he opined was due to his back not being "straight". He testifies that he takes over-the-counter medication if his back hurts a lot and it helps somewhat. He argues that his back does not hurt all the time because he is too tired to get out of bed to do anything, but argues that it would hurt more and more often if he were doing strenuous things.

The medical evidence reviewed and submitted by the Agency did not contain any records from NRI and did not include evidence of a previously conducted Social Security psychiatric consultative examination and/or any other evidence of evaluation and/or treatment by a psychiatrist or by a mental health professional. The appellant also testified that he had been seen at Dr. Herbert's office in 2012 and those records were not submitted. Per the appellant's request, the record of hearing was held open to allow him to submit or arrange for submission of the missing/additional evidence, but no additional evidence was received while the record of hearing was held open. The Administrative Decision must thereby be rendered based upon the record of hearing as it exists.

A full review of the evidence finds that during the time period from January 15, 2013 through September 9, 2013, the appellant was seen four times by Derrick Robinson, the physician assistant (PA) at his PCP's (Dr. Herbert) office. On January 15, 2013 the appellant presented complaining of a mouth sore having appeared several days prior. He was diagnosed with an aphthous ulcer on his gum with no further complications and was prescribed topical medication for treatment. While the January 15, 2013 exam record indicated that the appellant had other active medical problems/diagnoses of Attention Deficit Disorder (ADD), Chronic Fatigue Syndrome (CFS), Depression, Hypogonadism, and Rhinitis Allergic, the appellant offered no complaints relative to these conditions and the PA reported no objective signs relative to any of these conditions. The record also reported that the appellant was not taking any prescribed medication at that time. According to the appellant's patient chart, all prior medications had lapsed prior to September 19, 2011. He was to return to the clinic if his current symptoms worsened or new symptoms presented.

Prior to returning to PA Robinson approximately five months later, the appellant presented at Thundermist Health Center on June 3, 2013 where he was seen by Linda J. Berman, MD relative to complaints of low back pain. Back pain reportedly had existed for several years but had recently increased slightly. It was described as intermittent, increasing with activity, without any radiation, numbness, weakness, or tingling, and was relieved somewhat with over-the-counter medication. An objective physical exam was normal, specifically noting that the appellant retained a normal gait and full ROM of the back, with a negative SLR (straight leg raise) and no tenderness to palpation. Home PT exercises and stretching were recommended. He was to return if symptoms did not resolve and/or worsened. There is no evidence of the appellant returning to Thundermist HC. While Dr. Berman also reported a secondary diagnosis of Depression, her objective exam noted good eye contact, orientation X3, normal speech, intact judgment, and appropriate mood and affect without the current use of any prescribed antidepressant medication. Follow-up with NRI was recommended. While no mention was made in the June 3, 2013 record of fatigue, a review of the Thundermist HC Patient summary finds that on July 29, 2012, Dr. Berman indicated that fatigue appeared to her at that time to be psychogenic. Dr. Berman planned on reviewing prior medical records before

ordering any diagnostic testing. No diagnosis of CFS was made at this time and/or subsequently by Thundermist nor is there any further discussion of diagnostic testing relative to complaints of fatigue.

When the appellant next presented to PA Robinson on June 25, 2013 for an annual exam in order to get some paperwork completed, his only complaint on that date was a recent increase in depression. No further explanation is given as to the extent of the current depression, current symptoms, and/or the functional effects of the reported depression. The appellant reported to the PA that he had stopped taking Cymbalta because his prescription ran out and he did not have health insurance. At hearing the appellant had testified that he stopped taking Cymbalta because of side effects. According to his patient chart, Cymbalta had lapsed as of September 13, 2011 with no evidence of any other antidepressant or psychiatric medication being prescribed since. Other than to state that the appellant was oriented to time, place, and person, no objective mental status exam (MSE) appears to have been done. The full objective physical exam was normal. Despite such, the PA concluded the exam with diagnoses of CFS and ADHD and prescribed Zoloft instead of Cymbalta, per the request of the appellant. The appellant was to return if his condition worsened or new symptoms arose. According to the June 25th record, the appellant also reported that he was now taking Provigil, prescribed to be taken daily. The appellant testifies that Provigil was prescribed by NRI when he returned to NRI after a lapse in treatment, and that he takes it as needed. As the NRI records were not submitted, the record lacks confirmation as to whether this medication was prescribed, why it was prescribed and/or at what dosage and frequency, and/or any beneficial or adverse effects of the medication.

PA Robinson completed an Agency MA63 form on July 17, 2013 and reported diagnoses of CFS, ADD, and Depression. While he reported that symptoms of CFS and depression began in 2002 and both were diagnosed in November 2004, he reported no supportive symptoms, objective findings, and/or diagnostic tests or findings to support the diagnoses and/or explain the extent of the conditions. He provides no information as to onset, date of diagnosis, and/or supporting signs/symptoms relative to the reported diagnosis of ADD. Treatment consists of follow-up medical appointments, prescribed medication (Provigil and Zoloft), and daily rest. There is reportedly no history of any medical or psychiatric hospitalizations. Despite the lack of detailed information about the appellant's diagnoses, the PA reports that the appellant is limited in his ability to walk and stand to less than two hours a day and limited to sitting four out of eight hours. The appellant can reportedly lift/carry up to 25 pounds frequently and 50 pounds occasionally, and has no limitations with reaching, bending, or pushing/pulling with either the upper or lower extremities. While the PA reports that the appellant can make simple work related decision, interact appropriately with co-workers and supervisors and respond appropriately to changes in the work routine or environment without any limitations, he reports that the appellant is slightly limited in his ability to remember and carry out simple instruction, moderately

limited in his ability to maintain attentional and concentration in order to complete tasks in a timely manner, and markedly limited in his ability to work at a consistent pace without extraordinary supervision.

The appellant next presented to PA Robinson on August 7, 2013 complaining of right sided chest pain, which upon exam was determined to most likely be muscular in nature. He was prescribed 800 mg Ibuprofen. No mention was made by the appellant and/or the PA of any current symptoms, signs, or functional loss relative to ADD, CFS, and/or depression and while the exam record reports that the appellant was still taking Provigil and Zoloft, it failed to mention any beneficial or adverse effects of either of these medications.

On September 9, 2013 the appellant presented to PA Robinson to request a note detailing his medical problems for some type of court appointment. No physical exam was conducted on that date and the PA's report states that as of that date the appellant was taking Depakote and Provigil. He offers no explanation as to why Zoloft was stopped except to state that the appellant recently began taking Depakote for some moodiness. On this date the appellant questions the effectiveness of the Depakote and asks about the possibility of taking something else. The appellant testifies at hearing, approximately four months later, that he is only taking Provigil. He makes no mention of Depakote and testifies that he stopped taking Zoloft because it was not working. Further review of the appellant's Patient Chart finds that Depakote was prescribed by Dr. Christine Herbert on August 13, 2013 or six days after his August 7, 2013 exam with the PA. The PA's September 9, 2013 record concludes with diagnoses of CFS/depression with a mood disorder without any reports or explanation of current sign/symptoms and/or the frequency and/or intensity of any ongoing signs/symptoms, though indicates the appellant was to speak to Dr. Herbert about his mood. The record lacks any exam records or reports from Dr. Herbert, either before or after this date, describing symptoms and/or signs of moodiness and/or her reasoning for prescribing the Depakote. The record also lacks any evidence and/or explanation as to how long the appellant took the Depakote and/or why it was stopped.

All medical opinion evidence is evaluated in accordance with the factors set forth at (20 CFR 416.927). Medical opinions of treating physicians, which are physician's opinions about the nature and severity of impairment, are afforded more weight than non-treating physicians and/or other medical sources. If a treating source's medical opinion is well-supported and not inconsistent with other substantial evidence in the record, it is given controlling weight, which means it is adopted. Opinions from non-examining medical sources per Social Security regulations are generally afforded less weight than examining medical sources. In this case, University Internal Medicine (Christine V. Herbert, MD and Derrick M. Robinson, PA) and Thundermist HC (Linda J. Berman, MD) are considered treating physicians. Due to inconsistencies and lack of support, the opinions of neither treating source is afforded controlling weight, and for these

same reasons are afforded only minimal weight. Thundermist HC records provide evidence of only one recent exam and indicate that the appellant had not been seen there for almost one year prior. Dr. Berman offers no definitive opinion as to the cause of the appellant's fatigue and defers to NRI relative to the appellant's depression. Dr. Berman's one exam focused on evaluation and treatment of LBP. Her opinion relative to that condition is consistent with her own objective exam and is not inconsistent with evidence or lack of evidence provided by the other treating source relative to LBP, but Dr. Berman offers no explanation as to the underlying cause of the reported back pain. While the records from University Internal Medicine cover a longer time period, four appointments from January 15, 2013 through September 9, 2013, the reason for and focus of each exam differs, with two exams focusing on conditions, mouth sore and chest pain, which are not alleged to be disabling conditions. Diagnoses of CFS and depression as well as opinions as to the effect of such conditions on the appellant's ability to engage in work activity are offered without providing sufficient diagnostic evidence to support the diagnoses, treatment, and/or the level of impairment indicated. The records from this provider lack evidence of long-term consistent treatment of any alleged disabling condition and additionally contain inconsistencies between the PA and the MD as to dates of onset and/or diagnosis of Depression and/or CFS.

A full review of the MART's testimony finds that other than their testimony as to why Provigil is generally prescribe to a patient and their opinion as to the effectiveness of such medication when not taken on a regular basis, the MART's testimony is generally just a reiteration of the appellant's own complaints and the treating sources' own findings as reported in the exam records. The MART is a non-treating non-examining medical source and as such their medical opinion would generally be afforded less weight than either of the treating physicians but as the MART's opinion relative to the severity of the appellant's medical impairment is more consistent with the treating physicians' objective exams than the unsupported opinion relative to functional impairment offered by PA Robinson on the MA63, the MART's opinion will be afforded more weight in this instance. Also, as the prescribing provider did not provide any information and neither of the treating sources provided any opinion as to the Provigil, the MART's undisputed opinion relative to the Provigil is afforded substantial weight.

The appellant alleges that symptoms of fatigue, lack of energy, and poor memory have affected his ability to perform both physical and mental work activities for many years, thereby resulting in a disability. Reported symptoms alone are not sufficient to establish disability. There must be a medically established impairment which could reasonably be expected to cause the alleged symptom or symptoms. A treating physician has provided diagnoses of CFS and Depression, both of which could reasonably be expected to cause such symptoms, but the medical evidence does not provide detailed and consistent evidence as to the basis and timing of either diagnosis. From January 15, 2013 through September 9, 2013 the appellant offered no specific complaints of

tiredness nor is there any objective findings of such. The appellant does on two occasions complain of depression. On the first occasion he does not elaborate as to what his depressive symptoms are and/or the persistence or severity of such. While an antidepressant was prescribed, the record also lacks any mental status exam or other objective evidence and/or explanation of the appellant's depressive symptoms. While at a later date the appellant complains of mood issues, the record again lacks any specifics as to the actual issue and/or as to intensity and persistence of the mood issue. Again, while another medication is prescribed, there is no mental status exam or other objective evidence of impairment and/or explanation as to the persistence and intensity of any reported mood issues. By the time of hearing, prescribed anti-depressant medication had stopped without any reported evaluation by a medical provider as to the effectiveness or ineffectiveness of the medication and/or whether current symptoms or signs exist that would currently require any prescribed psychiatric medication. While the record contains evidence of a prescribed medication to improve wakefulness, thereby indicating some support for complaints of tiredness, the record lacks any objective evidence from the prescribing physician that might provide evidence to establish the extent and/or functional effects of tiredness both with and/or without the prescribed medication. The appellant was seen for complaints of low back pain once within a year's time but no medical opinion was offered as to the cause of the pain. No objective signs of pain and/or loss of functioning were evident, no further diagnostic testing was ordered, and no pain medication was prescribed. Recommended home exercises and stretching appear to have had good results as the appellant did not return for further evaluation and/or treatment and there is no evidence of any subsequent complaints of LBP.

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 working. As there is no evidence that the appellant is engaging in SGA, the evaluation continues to step two.

Step two: A determination is made whether the individual has a medically determinable impairment that is severe, or a combination of impairments that is severe (20 CFR 416.920(c)) and whether the impairment has lasted or is expected to last for a continuous period of at least twelve months (20 CFR 416.909). If the durational standard is not met, he/she is not disabled. An impairment or combination of impairments is not severe within the meaning of the regulations if it does not significantly limit an individual's physical or mental ability to perform basic work activities. Examples of basic work activities are listed at (20 CFR 416.921(b)). A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by the individual's statement of symptoms. Symptoms, signs and laboratory findings are defined as set forth in (20 CFR 416.928). In determining severity, consideration is given to the combined effect of all of the individual's impairments without regard to whether any single impairment, if considered separately, would be of sufficient severity (20 CFR 416.923). If a medically severe combination of impairments is found, the combined impact of the impairments will be considered throughout the disability determination process. If the individual does not have a severe medically determinable impairment or combination of impairments, he/she will not be found disabled. Factors including age, education and work experience are not considered at step two. Step two is a *de minimis* standard. Thus, in any case where an impairment (or multiple impairments considered in combination) has more than a minimal effect on an individual's ability to perform one or more

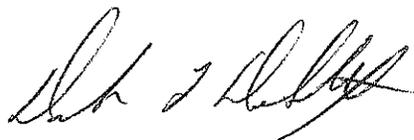
basic work activities, adjudication must continue beyond step two in the sequential evaluation process.

Per the previous discussion of the MER, the record as it exists establishes diagnoses of chronic fatigue syndrome (CFS), depression, and low back pain (LBP). While there are reports in the record that all three conditions have existed for many years, the MER fails to establish that at the time of the appellant's MA application and claim of disability, any of these conditions, alone or in combination, had resulted in functional loss on a persistent basis for a period of at least 12 months and/or that they affected the appellant's ability to function to such a degree and/or persistence to have more than a minimal effect on his ability to perform one or more basic work activities at the time of application, with the expectation that such impairment would last for a period of at least 12 months.

In conclusion, at step two of the evaluation, a determination is made as to whether a severe medically determined impairment or combination of impairments exists and if so, whether it existed or was expected to exist for a period of at least twelve months from onset. To meet the durational standard, not only must the impairment exist for at least 12 months, it must meet the severity standard for a continuous period of at least 12 months. The burden at step 2 lies with the appellant and the appellant has failed to establish that he has a medically determinable impairment or combination of impairments that are severe or expected to be severe for a period of at least 12 months.

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

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



Debra L. DeStefano
Appeals Officer