

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

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Docket # 13-2031
Hearing Date: February 6, 2014

Date: June 11, 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), Susan Geary, RILS and Agency representatives: Julie Hopkins RN, Robert Fox, and Rita Graterol.

Present at the hearing were: You (the appellant), and Sandra Brohen, SCW (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 Kent Center, and Comprehensive Community Action Program (CCAP).
- No records of admissions to Kent Hospital were received.
- Social Security had denied eligibility for SSI in January 2014, and therefore, no consultative examination reports were accessible.
- The MA-63 form received with the application was incomplete, as omissions of diagnoses dates and objective supportive findings were not included.
- A review of the available medical records revealed diagnoses of a depressive disorder, intermittent explosive disorder, personality disorder and obesity.

- CCAP records included a preventive examination report from July 2013, documenting a body mass index (BMI) of 41.4 which falls within the obesity range.
 - The remainder of the physical examination was normal.
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- No anxiety was indicated, and attention and concentration were normal.
 - A patient's health care questionnaire that he completed on the same date reflected his self-report of moderate to severe depression.
 - He was participating in counseling, but not seeing a psychiatrist at the time.
 - He reported hearing voices when he was upset.
 - A consultative note from the ear, nose, and throat clinic at Rhode Island Hospital was included for the May 17, 2013 appointment to evaluate asymmetric hearing loss.
 - His MRI results were completely normal, and did not establish a cause for hearing loss.
 - The degree of hearing loss was not indicated, but he had no difficulty carrying on discussion during the examination.
 - Kent Center records reported regular counseling appointments.
 - No psychiatric evaluation was included.
 - It was unclear who made the diagnoses.
 - He discussed marital problems and associated depression.
 - The staff assisted him with applications for various sources of medical benefits.
 - The medical evidence did not support that a medically determinable impairment exists that would limit functioning, meet the durational requirements, or have residual deficits when following prescribed treatment.
 - He was not disabled for the purpose of the Medical Assistance program.

The appellant testified:

- He is currently unemployed.
 - He keeps monthly appointments with Cathy Kennedy, (PCNS-Kent Center).
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- They have discussions about different issues, review his symptoms, and she prescribes medication.
 - He has been in treatment there for about six months.
 - He had been admitted to Butler Hospital for one week late in 2013.
 - He had never been on medication prior to that admission.
 - His medications have been adjusted to avoid side effects.
 - He agrees with Cathy Kennedy's assessment that he can understand, remember, concentrate, and complete simple tasks.
 - He has had difficulty in the past interacting appropriately with coworkers and supervisors.
 - He agreed that he would need support and encouragement to sustain work pace.
 - He was not confident that he could respond appropriately to work-related change.
 - He completed a post high school education at New England Institute of Technology in computer sciences.
 - He last worked as a truck driver, although the job did not last long.
 - He also prepared formulas for a soap manufacturer which required him to follow recipe instructions.
 - He has also been employed in a market, and as a floor cleaner.
 - Physically, he is capable of performing work activity, but his mental symptoms interfere with functioning.
 - He believes that his attitude is a barrier to finding and keeping employment.

- He would try to conceal his anxiety while working, but would eventually become explosive.
 - His outbursts resulted in losses of jobs he previous held.
 - He felt tired on his first day of taking new medication, but was pleased that he slept well.
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- He has had problems with mental health since childhood.
 - He finds that his conditions have affected family relationships.
 - He performs activities of daily living (ADLs) independently to the best of his ability.
 - 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 August 22, 2013.
- The Agency issued a written notice of denial of MA dated November 13, 2013.
- The appellant filed a timely request for hearing received by the Agency on November 21, 2013.
- Per the appellant's request, the record of hearing was held open through the close of business on March 6, 2014 for the submission of additional evidence.
- Additional evidence from Butler Hospital, Kent Center, and Kent Hospital that was received by the MART during the held open period was forwarded to the Appeals Office on March 7, 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 a severe, medically determinable impairment secondary to psychotic disorder (cognitive type).
 - 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.
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- Based on the appellant's residual functioning, he retains the ability to perform semi-skilled work that does not involve working closely with others.
 - The appellant retains the ability to perform past relevant work as a truck driver, soap maker, and floor cleaner.
 - The appellant is not disabled as defined in the Social Security Act.
 - The appellant is not disabled for the purposes of the Medical Assistance Program.

DISCUSSION OF THE MEDICAL EVIDENCE RECORD:

The record of hearing consists of:

- ✓ An Agency MA-63 dated September 11, 2013 and signed by primary care physician (PCP) Liza Famador, MD.
- ✓ An Agency MA-63 dated October 15, 2013 and signed by psychiatric clinical nurse specialist (PCNS), Cathy Kennedy.
- ✓ An Agency MA-63 dated February 26, 2014 and signed by Cathy Kennedy, PCNS.
- ✓ An Agency AP-70 dated August 27, 2013 and signed by the appellant.
- ✓ Records of Kent Center for May 15, 2012 to February 5, 2014.
- ✓ Records of CCAP Family Health Services for November 27, 2012 to September 11, 2013.
- ✓ Records of Butler Hospital for October 4, 2013 to October 9, 2013
- ✓ 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 had a relationship with Kent Center for a significant length of time. However, while he reports to Cathy Kennedy, PCNS for medication maintenance, many of his visits there are devoted to housing, pharmacy, and insurance needs. He has not been evaluated or treated by a psychiatrist during the time there on record. The frequency, nature, and extent of ~~treatment of his actual mental health conditions have been steady, but~~ conservative, as typically seen in clinic settings. Furthermore, contradictions between the mental health progress notes and restrictions expressed on agency forms impact the reliability of the conclusions, which will be discussed further in the review of the evidence. Additionally, he has seen a PCP for routine physicals, and spent 5 days at Butler Hospital. There are no sources that would deserve controlling weight of opinion in this matter. Consequently, all evidence will be considered in combination.

The MART is considered a non-examining source when expressing opinions regarding an individual's condition. At the time of application, the Agency reviewed a normal physical examination report, noted normal attention and concentration, as well as normal results of an MRI. They reported that there were no psychological evaluations within the records they had received from Kent Center. As a result, they found that evidence did not support the existence of a severe impairment.

Additional medical evidence was received after the hearing. As of the date of this decision, the Agency has not withdrawn the notice of denial under appeal based on the new information. The final rationale for their determination has not been communicated to this Appeals Officer.

The appellant has alleged that symptoms of mental illness with psychotic features impair him. During a recent admission to Butler Hospital, psychiatrist, Dr Baill, diagnosed psychotic disorder NOS, (alternately described as cognitive disorder, NOS). His PCP added diagnoses of obesity, and hyperlipidemia.

With regard to his physical conditions, records refer to an appearance at Kent Hospital in 2012 with complaints of chest pains. Follow up physical examination reports were essentially normal with the exception that he was overweight. While he has had elevated cholesterol and body mass index results which are risk factors for cardiac conditions, no such conditions have been diagnosed. He had regular heart rate and rhythm with no murmurs, gallops or rubs, no coughs, shortness of breath, irregularity of heartbeat, or palpitations; and blood pressure was good. He has been prescribed maintenance medications. His PCP also assessed hearing loss. No audiology reports were indicated, but the inner ears were studied with MRI, which revealed no underlying abnormalities. He had no auditory difficulty completing office examinations, or responding during the hearing. No residual effects of any physical condition have a demonstrable impact on functioning. There are no physical medical findings which support

limitations to walking which was the only reduction of functioning noted by the PCP responding to an MA-63. He could stand, sit, lift & carry without any significant restrictions.

Records document a history of mental health disorders. He described a long struggle with anger management issues dating back to his elementary school years. He also reported a family history of schizophrenia, and bipolar disorder within his immediate family. While he participated in treatment with outpatient counseling for depression, he reported no psychiatric hospitalizations until October 2013. At that time, he experienced an increase in symptoms to include violent dreams, and command hallucinations. Presence of suicidal and homicidal ideations had been documented. Although he tried to minimize the significance of harmful thoughts, he was considered to be at high risk for violence outside of the hospital setting.

During a detailed evaluation at Butler Hospital, Dr Baill noted the appellant's feelings of hopelessness, auditory hallucinations, reduced intellectual functioning, and impaired judgment and insight. The psychiatrist, Dr Baill, had diagnosed psychotic disorder that was not evident at the time of the agency review. While in treatment at Butler, the appellant soon indicated that he felt the prescribed medication was helpful, as he was calmer, and reported diminished interference from hearing voices as well as from suicidal and homicidal ideations. He was not agitated, was sleeping well, and expressed that he did not want to harm anyone. At discharge, he was instructed to follow up with Kent Center where he had been previously receiving services.

After his release from the hospital in October 2013, Kent Center nurse, Cathy Kennedy, completed a psychiatric assessment. Her written evaluation was very consistent with the Butler Hospital findings from the previous week. She documented his long history of anger issues, and noted challenges in the past secondary to his inability to get along with others. She also identified the need to address his negative thinking. Ms. Kennedy acted on Dr Baill's previous diagnosis of psychotic disorder. The appellant affirmed for her that he had been compliant with the medication regimen established during hospitalization, which was to be continued.

In order to get benefits, an individual must follow treatment prescribed by his physician if the 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 (20 CFR 416.930). In this matter, the appellant noted that he had not had any prior psychiatric hospitalizations, and had reached a turning point in October 2013, due to inability to cope with significant life changes at a time when he was not taking important steps to manage his symptoms. As a result, the potential for effectively treating his condition was uncertain, and his prognosis was guarded. Records do document a period of four months (beginning with his hospital admission and continuing with Kent Center) when a treatment

regimen was established and implemented, and he was noted to be compliant with prescribed remedies. Treatment was highly effective from implementation, and he was able to manage ADLs independently. The issue of non-compliance is considered as part of the disability evaluation only if the appellant is determined to be disabled based on all other factors. The failure to follow the prescribed treatment or to establish good cause for not adhering to prescribed remedies will only be evaluated at the end of this decision if there is a finding of disability.

Kent Center provided various counseling services, and monitoring of medication. After two months of following prescribed treatment, a December 2013 progress note from Cathy Kennedy, PCNS revealed that although he still experienced some depressed moods, many positive signs existed. He was experiencing good sleep, periods of enjoyment, and noted the absence of paranoia, delusions, hallucinations, or harmful ideations. She indicated that he was cooperative, and motivated. He remained calm, well engaged, and exhibited appropriate affect. His thought process was logical, and content was clear and organized. He was alert and oriented in all spheres, and had normal ability to concentrate. Remote, recent, and immediate memory were all normal. His critical judgment was intact; he had some insight into his condition, and was demonstrating good impulse control. Ms. Kennedy established that risk factors relative to suicidal & homicidal ideations, and violent tendencies had ceased. That evaluation clearly identified numerous areas of improvement when compared to her previous psychiatric assessment completed in October 2013 at the start of his treatment regimen.

Unfortunately, it is not possible to rely on Ms. Kennedy's opinions of restrictions to mental activities, as the limitations she has noted on the two MA-63 physician examination report forms which she completed in October 2013 and February 2014 are not supported by her progress notes and other evidence. In the month of October 2013, after he had reached a critical level and required hospitalization, she conducted a complete psychiatric assessment and indicated that he retained good memory, attention, concentration and ability to carry out tasks. The appellant testified that those conclusions were accurate. She did identify some moderate limits to social skills, work pace, and response to change. She found no restrictions had reached marked level of severity at that time. Conversely, in February 2014, after he had been in treatment, and her notes documented significant improvement with total cessation of psychotic features, she indicated that he experienced marked level restrictions in every category on a new MA-63 form. Only one medical office visit occurring in February 2014 appears in the evidence record. There was no indicated change of attitude, speech, and affect, overall behavior, thought process, thought content, insight, judgment, memory, or impulse control to justify the expressed limitations.

The only exception to the continuation of progress occurred when he reported sudden increase in anxiety and depressive symptoms secondary to stopping his medication for five days. He was beginning to experience return of auditory hallucinations. Ms. Kennedy attributed the brief, intermittent changes directly to the interruption in his medication regimen. He justified that choice to stop taking highly effective maintenance medication by reporting sexual side effects. Only ~~he and his physician can determine whether or not the prescribed medication~~ had anything to do with the side effects he reported, or if his treatment remedies should be changed. In any event, the evidence does not support that any symptoms were more severe in February 2014 than they were in October 2013 as inaccurately noted on the MA-63 forms.

The Butler Hospital and Kent Center records clearly document that after a diagnosis was made, and a treatment plan established, the appellant's good compliance had resulted in exceptional results. He repeatedly indicated to his treatment providers, that he had not experienced any side effects secondary to use of the psychiatric medications. The return of certain symptoms occurred concurrent to his decision to stop taking the medications that had provided such significant results. The appellant claimed no additional reasons for stopping his compliance with the prescribed treatment medication other than the occurrence of sexual dysfunction which he assumed was a side effect. He made the decision to stop taking medication on his own, prior to any medical consultation. He did not report and allow either his physical or mental health care providers to establish if his condition had any relationship to a specific psychiatric medication he was taking, if side effects could reasonably be attributed to other medications he was taking for hypertension or hyperlipidemia, if there was likely to be a cause unrelated to medication, or if there were medically sound adjustments to be made to his currently prescribed remedies that would address the problem without interrupting an effective treatment.

Evidence records in this case clearly indicate that he had recognized and struggled with interference from mental symptoms which escalated after a long period without treatment. He responded quickly and completely to prescribed remedies, and was significantly improved for a defining period of four months. Based on his concerns regarding the type of medications he was taking, Ms. Kennedy did prescribe some adjustments and immediately restart his treatment regimen. According to the response to medication management of symptoms he has experienced in the past, he could reasonably be expected to continue at the improved level of functioning.

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

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

In this matter the appellant has indicated that he is impaired by mental disorders, and that his physical health does not prevent him from working. His PCP treats him for hyperlipidemia with maintenance medication, and notes that he is overweight. Otherwise, evidence does not support the existence of any physical medical condition that would result in more than a minimal impact on functioning. As the appellant has agreed that is the case, the mental health history is the central issue to be examined. He does have a long history of mental health disturbances which have been either left untreated or addressed with counseling in the past. There was no prior history of medication management or any psychiatric hospitalizations. In 2013 he experienced an exacerbation of psychotic features concurrent with some unfortunate life events. In October, he voluntarily admitted himself to Butler Hospital for evaluation. Psychiatrist, Dr Baill, diagnosed him with psychotic disorder. He prescribed treatment consisting of medication management and counseling with instructions for him to follow up with Kent Center.

Continuation of the established treatment regimen was documented by Cathy Kennedy, PCNS. Progress notes indicate significant reduction or elimination of adverse symptoms, and improved mental status. As he had not previously received adequate treatment for his chronic mental condition, it appeared that the prescribed plan not only ameliorated signs and symptoms of his condition for a

period of approximately four months after it was started, but had potential to restore functioning adequate to perform work activity. Clearly, however, the records have established that symptoms of psychotic disorder have escalated throughout a period of time that exceeds the durational requirement, and have interfered with functioning to a degree that would 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 12.03 (Schizophrenic, paranoid, and other psychotic disorders) is reviewed. Treating sources have documented that he has experienced episodes of auditory command hallucinations. Escalation of that symptom led to hospitalization, and corrective treatment. His treating source documented that the symptoms had ceased during the months when he was compliant with prescribed remedies. There was some return of the problem to a lesser degree during a five-day lapse from taking his medication.

He has affirmed that he retains the ability to complete ADLs independently, and agreed with his treating source's opinion that he was able to maintain concentration and persistence. There was no evidence supporting repeated episodes of decompensation. Social functioning was clearly his most limited category of functioning. However, evidence does not establish that his conditions remain at a marked degree of functional limitations in at least two of the criteria required to meet a listing. The medical evidence record does not support the existence of an impairment or combination of impairments that rises to a 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.

Mental RFC

Understanding and Memory: According to the appellant's treating sources, no significant reduction to his ability to understand and remember most instructions has been indicated or supported. He testified that he did not experience significant restrictions in this category. Based on all available evidence, he could also reasonably be expected to remember locations and procedures.

Sustained Concentration and Persistence: He also agreed with his treating source assessments concluding that he could sustain concentration and persistence adequately to carry out essential instructions. Evidence did not rule out his ability to maintain attention and concentration for 2-hour blocks of time with allowances for customary breaks, to perform activities within a schedule, to sustain a routine without special supervision, or to make simple work-related decisions.

Social Interaction: He has indicated that he struggles with interpersonal skills. Prior to hospitalization he was challenged by relationship problems. His treating sources have indicated that he may have some difficulty interacting appropriately with co-workers. He would be best suited for occupations not requiring him to relate to the public, or to work in close team situations. Evidence does not rule out judgment required to recognize when to request assistance, to recognize and maintain socially appropriate behavior, or to adhere to basic standards of grooming.

Adaptation: There is no indication that he would be unable to be aware of normal hazards and take precautions, arrange transportation, set realistic goals, or respond appropriately to basic work-related change. He is able to perform ADLs independently.

In this matter, the appellant has alleged that mental health symptoms have interfered with his ability to perform past relevant work activities, and to sustain employment. He does not allege that he experiences physical restrictions, and no physical impairment that would limit standing, sitting, walking, lifting, or carrying and creates more than a minimal reduction to his work capability has been established.

Although he has a history of mental problems, his condition has clearly shown considerable recovery with treatment. Currently, evidence demonstrates that he is able to think, communicate, and care for his own needs. He can perform usual daily activities, and remember and follow instructions. Residual functioning assessment reveals that he retains the ability to function adequately to perform a variety of tasks that do not involve working closely with others.

He has reported past relevant work as a prep cook which is precluded due to the cooperation required with other workers, and market counter worker which is precluded based on the substantial public contact required to perform that work. However, he also has past relevant work experience as a truck driver, a soap maker, and a floor cleaner. As these occupations can be performed without excessive amounts of interpersonal contact, they are not precluded by the current MRFC. The appellant retains the ability to perform past relevant work activity. As a result, the sequential evaluation stops at step four. Because the available evidence has not established the existence of a disabling impairment, no further consideration of non-compliance issues is required.

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