



day, she constantly changes positions and must lie down four to five times daily. She describes the pain as a "burning sensation" that radiates from her lower back down her right leg to her foot and toes.

The condition has also defied treatment. Medications that have been prescribed have either caused side-effects or are ineffective. The petitioner's recent history of treatment is summarized in the following office notes from her treating physicians, who are orthopedic specialists:

6-22-88

[Petitioner] is back in for my examination of her right wrist. She has been wearing a wrist immobilizer since being here in the office two weeks ago and states that it really isn't any better. She apparently is a divorced, single parent, has to work. It appears as though she cannot work with her wrist the way it is and is wondering if there is anything that can be done. It is difficult for me to believe that she needs excision of the distal end of the ulna without a more prolonged course of conservative treatment but perhaps she does.

Patient was advised that I would value Dr. Keller's opinion regarding the etiology and treatment of her pain prior to scheduling her for any surgery. In looking back over her chart I remember that in the past she has had some aches and pains that we were really not able to support with much in the way of clinical findings. She was evaluated a few years ago by Dr. Thomas Martenis and he did not find any inflammatory arthropathy.

7-5-88

The chart has been reviewed. The pain is coming in the ulnar aspect of the right wrist. It has been present for two months. It is hard to localize it completely. I have the impression that there is some swelling about the ulnar styloid. A lot of her pain seems to be where the extensor carpi ulnaris articulates or rides over the ulnar styloid. We have injected that tendon sheath with Depo-Medrol and Lidocaine. Perhaps it will help.

If she does not get better I think the next step would be an arthrogram of her wrist to better evaluate the triangular fibrocartilage. Possibly this could be torn although admittedly there is no clicking that can be detected on examination.

The patient will follow up with Dr. Holmes.

7-13-88

Patient is seen. She has had some diagnostic testing and evaluation by Dr. Keller since I saw her last and at this time I do not think that any surgery would be helpful to her and I subsequently advised her of this fact.

10-25-88

[Petitioner] is seen. She comes in essentially to get an examination hopefully to get on SSI. I advised her today, in my opinion, she would not really qualify as her exam is too good, her x-rays are too good. I think she has intermittent low back pain secondary to abuse of her spine and that she is going to have to take it a little bit easier. She has been doing things like helping her son change a motor in her car, etc.

8-21-89

This 40-year-old white female was seen and evaluated because of low back and right hip pain. Actually the patient's symptoms go back to 1987 when she originally saw Dr. Darrow. I saw her in 1988 and evaluated her for what I thought was a trochanter bursitis. I did a bone scan which was positive over the right pubic area and subsequent x-rays, however, were negative and we never really did get a diagnosis. She was referred to a rheumatologist, Dr. Lynn Brown where she was worked up and had no definite arthritis noted. This spring she planted her garden, has been weeding it during the summer and the pain has been increasing. Now she states she can barely stand or walk or get around. She complains of low back pain which radiates to the right buttock area and occasionally in the leg. The pain is worse with exercise and activity.

On examination I find her gait is antalgic on the right. She stands straight with a pelvic tilt with a

decreased ROM of the LS spine. She has pain on motion. SLR test is positive bilaterally about 50 degrees but she also has pain on ROM of the hips. Reflexes were physiological, sensation was intact and power was normal.

IMPRESSION: I am not exactly sure the cause of [petitioner's] problems. Certainly she could have some nerve root pressure. She never really had a CAT scan of the lumbar spine. A CAT scan was taken of her pelvis and so we will go ahead and carry out a CAT scan of the lumbar spine.

8-30-89

[Petitioner] is seen in follow-up. She is still quite symptomatic. She can barely walk around. She is having a considerable amount of back pain and right leg pain. We did, of course, carry out a CAT scan. I reviewed the CAT scan. It is completely normal. I went over the findings with her. This is not just a recent problem. It is a problem that has been going on for years. She has had a fairly extensive workup. We did refer her to a rheumatologist even and I am not sure there is much we can offer her. I think she has one of those syndromes that is probably yet to be described and there is little medically we could offer her. We have advised her regarding that. We will be glad to see her prn. We thought maybe she could try a nonsteroidal anti-inflammatory.

10-5-89

[Petitioner] is seen in follow-up. Her back pain is worse. She is having a lot of right leg pain, radiation down the big toe. When she gets out of bed in the morning she can hardly get around. She finds difficulty doing any work because of the severity of her discomfort.

On examination things have changed very little. Exam is that as quoted above.

Again, in view of this patient's long history of back problems and leg problems without any significant objective findings and in view of our recent CAT scan which was completely normal and in view of our referrals to several specialists in the past including rheumatologists I am not sure there is anything we can offer her. I did mention that perhaps a chiropractor would be of some help and suggested Dr. Ashcroft. We will be glad to see her on a prn basis if things change at all.

12-26-89

[Petitioner] was seen in follow-up. She really is quite desperate. She is having a considerable amount of pain in the back, right hip and leg area. She really doesn't know where to turn. She is living under strenuous conditions and she lives in a small trailer with her friend and her boyfriend. She is unable to work, unable to help them. She is really kind of anxious to turn her life around and states that she would do anything to get rid of the pain. Unfortunately we have not been able to make a surgical diagnosis on her back and have very little to offer her in the way of treatment. Dr. Ashcroft sent her for a MRI and I did review the MRI. It is of excellent quality. It does show some posterior protrusion of the disc at 3/4 and some lateral recessed stenosis at 4/5. It does not, however, show any real disc herniation or any real nerve root pressure. I explained that to her as Dr. Ashcroft already had, the fact that there is really very little we can offer her. It is a situation where she has to make do. She has to try to either work or live with her condition the best she can and I don't think anyone would attempt surgery on her without more localization of a problem. When I compare the CAT scan and the MRI the findings are not significant enough to warrant the invasive surgery necessary. Thus I would continue conservative therapy unless things change significantly. As far as work goes I am not sure she can work. She has certainly tried it several times and hasn't been able to work so maybe she will not be able to work in the future. In any event I told her I would be glad to see her on a prn basis.

The record also contains the report of a consultative examination done on May 10, 1989. It was essentially negative as for findings that would explain the petitioner's back pain.

In the absence of clear medical findings substantiating the degree of pain and limitation alleged by the petitioner, it is necessary to evaluate the credibility of the petitioner, herself, in describing her symptoms. In this regard, the hearing officer deems the petitioner's testimony credible. Also, the petitioner's allegations were fully

corroborated by the credible testimony of a friend and neighbor of the petitioner, who sees the petitioner regularly and who is a registered nurse. It is also noteworthy that the petitioner's treating physicians, though at a loss to diagnose her condition, do not intimate that the petitioner is malingering (see supra).

It is, therefore, found that the petitioner is precluded from performing any activity that involves prolonged sitting and/or standing, even light lifting, any repetitive leg or torso movements, and repetitive use of the hands for grasping and/or manipulating. It is also found that any job the petitioner might do would also have to accommodate her need to lie down several times a day. These limitations would, of course, preclude the petitioner's past work as a nurses aide. It is inconceivable to the hearing officer that there are a significant number of other jobs in the national economy that would accommodate these restrictions.

ORDER

The department's decision is reversed.

REASONS

Medicaid Manual Section M211.2 defines disability as follows:

Disability is the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment, or combination of impairments, which can be expected to result in death or has lasted or can be expected to last for a continuous period of not fewer than twelve (12) months. To meet this definition, the applicant must have a severe impairment, which makes him/her

unable to do his/her previous work or any other substantial gainful activity which exists in the national economy. To determine whether the client is able to do any other work, the client's residual functional capacity, age, education, and work experience is considered.

In addition to the above, 20 C.F.R. § 416.929 provides as follows:

If you have a physical or mental impairment, you may have symptoms (like pain, shortness of breath, weakness or nervousness). We consider all your symptoms, including pain, and the extent to which signs and laboratory findings confirm these symptoms. The effects of all symptoms, including severe and prolonged pain, must be evaluated on the basis of a medically determinable impairment which can be shown to be the cause of the symptom. We will never find that you are disabled based on your symptoms, including pain, unless medical signs or findings show that there is a medical condition that could be reasonably expected to produce these symptoms.

In this case, though her condition is undiagnosed, the petitioner does not rely solely on naked personal statements as to evidence of her pain. As her treating physician indicates in his 12-16-89 office notes (supra), there is diagnostic (MRI) evidence of at least some "mild" degenerative changes and "posterior Protrusion" in the petitioner's spine. Also, in the 8-21-89 office notes (see supra) the physician made several significant clinical findings regarding the petitioner's gait, posture, ranges of motion, and leg raising. As noted above, swelling and arthritic changes have been found in the petitioner's hands.

Although one of the petitioner's physicians did state in the 10-25-88 note that the petitioner's X-rays were "too good" to qualify for SSI, based on their subsequent medical

findings and comments<sup>1</sup> it is clear that the petitioner's physicians are themselves satisfied that the petitioner's alleged symptoms are present and real.

In light of the above, and absent any evidence that the petitioner is exaggerating or malingering, and in view of the credible testimony of the petitioner and a knowledgeable witness, it is concluded that the petitioner meets the regulatory definition of disability. The department's decision is reversed.

FOOTNOTES

<sup>1</sup>See 20 C.F.R. § 416.913.

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