

STATE OF VERMONT  
HUMAN SERVICES BOARD

In re ) Fair Hearing No. 9905  
 )  
Appeal of )

INTRODUCTION

The petitioner appeals the decision by the Department of Social Welfare denying his application for Medicaid. The issue is whether the petitioner is disabled within the meaning of the pertinent regulations.

FINDINGS OF FACT

The petitioner is a forty-eight-year-old man with college-level training in electrical engineering. From 1974 to November, 1989, he was self-employed in the construction and maintenance of electronic and mechanical equipment, although it appears that from an economic standpoint the business was marginal. He claims that he has been unable to work since that time because of pain in his neck, shoulders, and upper back.

The medical evidence in this case is inconclusive. The following are the office notes of the orthopedic specialist the petitioner initially consulted for his problem:

12/26/89 Right shoulder pain - onset 2 months

This 46 year old white male was seen and evaluated because of right shoulder pain. The patient had no particular trauma or injury to his shoulder but developed pain along the vertebral border of the right scapula. The pain is not really in his shoulder. He has not noticed a decreased ROM of his shoulder. He did take a

long motorcycle ride in September and then in October had a fall where he fell on his outstretched arms. The patient has also noted numbness and tingling in his right arm in his 4th and 5th finger. He works at his home, self-paced, does electronic work and of course, is using his neck a lot.

Physical examination is that of a well-developed, well-nourished male. Exam of the cervical spine reveals no tenderness to percussion of the spinous process of the cervical vertebrae. There is a decreased ROM. His left lateral flexion and left rotation are full but right lateral flexion and right rotation is diminished.

Right rotation causes some numbness and tingling in his right arm. It is my impression the patient has acute cervical syndrome with probable cervical disc. I would like to give him a decreasing dose of Prednisone and a prescription for P.T. to include intermittent cervical traction, heat and massage.

2/8/90 Recheck

[Petitioner] is seen in follow-up. He has proven to be a very difficult patient. It is for certain that he is the most exasperating patient I have ever had. He continues to talk and talks at such lengths that unfortunately he doesn't listen, doesn't answer questions and doesn't accept my advise. One wonders that he has to be convinced that he is the patient and I am the doctor. In any event, the patient complains of continued, persistent pain along the vertebral border of the right scapula. This pain, he insists, is a primary problem in that area or the thoracic spine. He is unable to accept that the pain is coming from his cervical spine and most commonly pain in this area is radiated from the cervical spine. He has not had neck pain but has had a stiff neck. He also has had some numbness and tingling his right upper extremity. The patient states that he is unable to sit for any period of time. If he rides in a car for more than two minutes he has to lie in the car because of the amount of discomfort and distress that he is having in his back. He does not work but does do some electrical work and he has been unable to do that and has been unable to ride his motorcycle because of the amount of his discomfort.

Examination has changed very little. He has a decreased ROM of the cervical spine with some pain on motion. The reflexes were physiological, sensation intact, power is normal. I tried to explain what I

thought was the pathophysiology of his problem. I would suggest conservative treatment. I have suggested a home cervical traction device. The patient does not have any insurance and he is applying for Medicaid. I am not sure of the role this application has in his symptoms. Patient advised, see prn.

3/28/90

[Petitioner] returns. Again, he is his usual self. Again, has the same complaints. The pain is now getting so severe he says he is unable to make it through the day. He has taken two Tylenol a day for relief of the discomfort but the pain is severe. It is chronic and constant and located in the vertebral border of the right scapula. He is now ready to accept that it may be from his cervical spine. We did do X-rays of his cervical and dorsal spine and did not find a great deal. At this juncture I think he is probably going to need a CAT scan.

I did reexamine him, found his neck to be supple. Reflexes in the upper extremities were physiological, sensation intact, power was normal.

A CAT scan was ordered and the patient will be seen in follow.

4/26/90

[Petitioner] is seen in follow-up. He has taken his CAT scan, reviewed it himself. He went to Castleton where he looked up some articles. He asked questions like: "Could he have a percutaneous diskectomy of his cervical spine?" It was difficult to explain to him that he could not and by the time our conversation had finished I was rather hoping that someone might try a percutaneous diskectomy on this C6/7 area. In any event, his symptoms have persisted. I still recommend conservative therapy. He would like to have something else done. Someone has spoken about Dr. [physician] to him and we would agree and recommend that he be seen by Dr. [physician]. We will go from there.

The CAT scan of the cervical spine done in April, 1990 (referred to in the above report) revealed a "small central disc herniation at C4-5" and "osteophyte formation with associated disc herniation at C6-7 on the right". X-rays taken in February, 1991, showed "slight C5-6 and mild C6-7

disc spaces narrowing" and "moderate narrowing of the L5-S1 disc, with mild narrowing of the L4-5 disc".

In February, 1991, the petitioner underwent a consultative neurological examination. The report of that examination is as follows:

As you know, I saw [petitioner] at your kind suggestion on 2/26/91, at which time he came with a chief complaint of pain in his upper back and neck region on the right side of about 15 months' duration.

Present illness: This 48 year old white male electronics technician states that he was in his usual good health until about 6-8 months ago, when he was swimming in a quarry and hit the wall with his head. He apparently was able to climb out and did not have any substantial difficulties at that time. However, a week or two after this incident, the patient began to complain of pain in his neck and upper back, particularly on the right side. This pain gradually increased to the point that it became constant. He therefore sought medical advice about it. He was told that he had some changes in his cervical spine of a degenerative nature which might be causing the pain. This was revealed on his cervical spine films and later on a CT scan. He was subsequently referred to Dr. [physician]. The results of that visit are not known to me. He was then referred to Dr. [physician] in Burlington who felt that he might have some cervical disc protrusive disease but not evidence of cord or root compression on neurologic examination. Dr. [physician] ordered an MRI; this was accomplished and simply confirmed the CT findings, that is of a small central disc herniation at C5-6 of doubtful clinical significance and a narrowing of the right and left neural foramina at the levels of C5-6 and C6-7, also of minimal clinical significance other than perhaps for pain. In any event, the treatment has variously been treated with traction with a little benefit, anti-inflammatory agents with a little benefit, and simple analgesics. I gather there is a consensus of opinion up to this point that he is not a surgical candidate. At least it was not recommended by Dr. [physician] or Dr. [physician].

The patient tells me that because of these difficulties he has not worked over the last 15 months other than for 1-2 hours here and there with minimal income as a consequence.

Past history reveals that he has had a herniorrhaphy but no major surgery or illness. Family history: The patient's mother is living, but disabled by arthritis.

His father died of an MI. There are no siblings. Review of systems is somewhat positive. The patient has a rash in his groin of fungal origin. He admits to being somewhat high strung and occasionally depressed.

Social history: The patient is educated through college at UVM. He married 15 years ago, had one child. His wife left him and he has since lived with his mother. He does not smoke or take alcoholic beverages. His diet is adequate. The only medications he is using currently are simple analgesics.

Physical examination: I found the patient to be well developed and well nourished, to have normal vital signs though his blood pressure is borderline at 150/90 in the right arm. Eyes, ears, nose and throat are unremarkable. Heart, lungs and abdomen seem normal. Skin is clear except for the rash in his groin. There is no lymphadenopathy. Extremities and spine are normal except when he turns his head and neck to the right, there is a little pain at the base of his neck and back of his right shoulder. At times this movement causes rather severe pain. There is no paraspinal muscle spasm.

NEUROLOGIC EXAMINATION was done in detail and was within normal limits. I would note though that his reflexes are on the brisk side at 2-3+.

Discussion: The history and findings of this examination reveal no evidence of central or peripheral nervous system compression. He does have changes in his cervical spine consistent with a small central disc at C5-6 and with a neuroforaminal narrowing, but without apparent nerve compression or cord compression.

He is not considered a surgical candidate on these accounts. I would list his problems as follows:

Problem List:

- 1) Health maintenance.
- 2) Mild cervical disc protrusion, C5-6 with foraminal narrowing at C5-6 and C6-7 with spur formation.

Recommendations: The above was discussed briefly with the patient. It is my opinion that he has a legitimate complaint of pain as a consequence of these difficulties. He does not appear to be a candidate for surgical intervention at this time. He should respond to conservative therapy if properly applied. He needs frequent cervical traction at a weight of 8-10 lbs. while taking muscle relaxant drug and an analgesic.

Unfortunately, this patient is alienating his physicians and apparently no one is willing to treat him. He clearly has a partial disability, not a total disability. One would normally expect persons with this amount of difficulty to recover. I believe I have covered all of the specific questions you have asked. I could perhaps reiterate that he walks normally, has no nervous system compression signs and grasps and can manipulate perfectly normally with his hands, has a good memory, though he talks constantly and profusely. I believe he has not had more than moderately severe pain as far as I can judge, and this is relieved by the medications he is taking on a PRN basis.

At the hearing the petitioner's complaints and demeanor were consistent with the descriptions in the above reports.

The petitioner's mother, with whom the petitioner has lived for the past sixteen years (and out of whose house the petitioner carried out his electronics repair business during that time) testified that the petitioner complains of pain constantly and that he lies in bed most of the day.

The petitioner's complaints as to the persistence and intensity of his pain, and his response to it, struck the hearing officer as highly exaggerated and inconsistent. For example, at the hearing the petitioner testified that the pain began after he took a hike in the woods in November, 1989. However, in December, 1989, the petitioner's orthopedist noted only that the petitioner had reported taking a long motorcycle ride and then falling while walking (supra). The petitioner then told the consulting neurologist that the pain began after he hit his head while swimming (supra).

After the hearing, the Department offered and the hearing officer recommended that the petitioner undergo a

consultative psychiatric or psychological examination. The petitioner adamantly refused.<sup>1</sup>

On the basis of the medical evidence, it cannot be concluded that the petitioner is totally disabled--i.e., that he cannot perform sedentary or light work. Based on the reports of his examining physicians (supra) and on the petitioner's demeanor at the hearing, it is suspected that there is an emotional overlay to the petitioner's complaints that goes beyond the physical symptoms themselves. Inasmuch, however, as the petitioner refuses any inquiry or examination into that area, there is no medical evidence upon which to make any conclusions regarding a non-exertional aspect to any disability.

The medical evidence indicates that the petitioner's physical problems are, at most, "moderate", but that they would respond to conservative treatment. Although the petitioner complains that past attempts as traction, heat therapy, and medication did not work, it does not appear that the petitioner has truly accepted and cooperated with the recommendations of any of his doctors. The petitioner maintains that he wants Medicaid to pursue further testing and treatment. However, given the petitioner's confrontational attitude and his resistance to the suggestions of his doctors, it is doubtful the petitioner will benefit from any enhanced access to medical care.

ORDER

The Department's decision is affirmed.

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 this case all the medical evidence describes the petitioner's orthopedic problems as "slight", "mild", or "moderate". The examining physicians have confirmed the basis for his pain, but both reports strongly suggest significant exaggeration and lack of acceptance and cooperation on the petitioner's part. The neurologists report specifically notes that the petitioner's "disability" is "partial" but "not. . .total".

The petitioner is relatively young and well educated. Absent a more compelling medical basis for his complaints, it cannot be concluded that he meets the above definition of disability. See 20 C.F.R. § 416.908. The Department's decision is, therefore, affirmed.

FOOTNOTES

<sup>1</sup>A potential irony in the petitioner's refusal (which, hopefully, his counsel pointed out to him) is that psychological assessments are often valuable in enhancing the credibility of a claimant's complaint of pain when, as

here, such complaints are not adequately supported by evidence of physical findings. The petitioner is, of course, free to reapply for benefits.

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