

STATE OF VERMONT
HUMAN SERVICES BOARD

In re) Fair Hearing No. 11,928
)
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-nine-year-old man with a high school education. His relevant work history is as a "warehouse man" at an agricultural supply store.

The medical evidence shows that since at least 1987 the petitioner has suffered from severe episodes of vertigo and fatigue. From the outset his symptoms have been brought on by exertion and sudden head movements. The frequency and severity of his symptoms have progressively increased. During and for several hours after such an episode he is completely incapacitated and must lie down until he recovers his strength and equilibrium. He has not worked regularly since 1989.

Despite regular and continuing visits to doctors over the years the petitioner's condition has, to date, eluded firm diagnosis. He has been prescribed several different medications, with only limited success. At present, he is

taking Valium several times a day. While he has not had a severe "attack" for three or four months now, his medication leaves him chronically tired and "hung over". He leads a restricted lifestyle and does only a few light chores at his own pace. His most strenuous activity is occasionally mowing lawns on a riding lawnmower.

The petitioner's history and symptoms are described in the following report, dated November 30, 1992, from the petitioner's treating neurologist:

[Petitioner] is a 48-year-old man referred by [name] for persistent symptoms of vertigo and headaches. He describes occasional problems with vertigo going back over 20 years ago. These were attributed to sunstroke. Over the last 3 months, he has been having increasing problems to the point where these are occurring on a daily basis. He describes a combination of vertigo in duration as well as positional unsteadiness which occur with quick head movement. He is also bothered by passive motion such as watching moving things from the side of a car. Although these symptoms have been extremely frequent over the past 3 months, they have been an infrequent problem for about 5 to 6 years. He is also describing a pressure type headache going from ear to ear across the forehead. When his pressure headache and vertigo occur, they are often by nausea and vomiting. He also describes some dysarthria, decrease in memory, phonophobia, and photophobia. When he has a bad spell of vertigo, he usually goes to sleep, sleeps for several hours and wakes up feeling better.

Has had multiple head injuries as a young child and then a more major injury 15 years ago when he had a motorcycle accident which was accompanied by a whiplash injury. He has had some prostate problems controlled with medications. Recently a weight gain of 70 pounds in the past 5 years, 15 pounds in the last month. Allergies: Propranolol caused chest discomfort and a sense of difficulty breathing. Demerol caused syncope. Medication: Valium 2 mg. t.i.d. 4 to 5 times per day when he is having more severe symptoms with dizziness.

[Petitioner] does not describe the hearing loss or fluctuating hearing or tinnitus or aural fullness. Audiogram in the past has shown a consistent finding of a mild high

frequency, sensori-neural hearing loss consistent with a history of noise exposure.

On exam, [petitioner] is a mildly overweight, anxious appearing, middle-aged man. Tympanic membranes are normal bilaterally. Mouth, oropharynx, nose, and neck are normal. EOM's intact, No open eye nystagmus. Cranial nerves II through XII intact. Open eye Romberg is normal. Closed eye Romberg - he does tend to sway a bit from side to side. Gait is narrow although he is hesitant when walking. MRI normal. I discussed this with him over the phone. I suggested that he proceed with the prescriptions for Klonopin and amitriptyline. I asked him to call me in about three weeks to let me know how he is doing.

Apparently, the petitioner enjoyed a brief improvement in his symptoms for a few weeks immediately following the date of the above report. In a brief office note dated December 22, 1992, his neurologist reported as follows:

He is on Amitriptyline up to 30 mg at night. His dizziness and instability and headaches have almost completely resolved. He gets very brief periods of instability with quick movements, but thinks that may be due to the fact that he is a lot more active. He has very brief period of headaches which are very easy to tolerate.

Plan: Suggest that he stay on the present doses of the Amitriptyline, along with the Klonopin, and will see me back in three months.

Unfortunately, however, the petitioner's improvement was short-lived. In a February, 1993, report (see infra) from his treating family doctor it was noted that the petitioner's symptoms were continuing. And, in an April 5, 1993, office note the petitioner's neurologist stated:

[Petitioner] is again having spontaneous episodes of vertigo, feeling vertiginous for about two hours each morning. He continues to have an annoying dry mouth and feels somewhat hung over in the morning.

Present medications include Klonopin 1/2 of a 0.5 mn tablet TID, Amitriptyline three 10 mg tables QHS.

Plan: Gradually taper off the Amitriptyline and increase the Klonopin in three day steps to the point where she (sic) is off the Amitriptyline and on 0.5 mg TID. He will call if symptoms are not improved in two weeks.

As noted above, the petitioner's family physician submitted a report (to DDS) in February, 1993, which states as follows:

I have been following [petitioner] for a balance problem since 1987 when he was referred by [name] of Middlebury. He has had problems with intermittent balance symptoms that have been incapacitating. They have occasionally occurred daily and have kept him from meaningful employment. He has found physical activity and certain head postures and positions are likely to precipitate symptoms.

He has had extensive workup including hearing tests. He has had neurological consultation with [name] of Rutland, Vermont. He had an electronystagmogram on 8-24-87. He has had consultation with [treating neurologist] at Hitchcock.¹

It is our present feeling that [petitioner] may be experiencing basilar migraines. There is also a possibility of vestibular hydrops. We have not been able to control him on medication to this point and [treating neurologist] is making an effort in that regard, using Amitriptyline.

I would not be able to make an exhaustive statement regarding [petitioner's] ability to work at this time, but his consistent reports that activity tends to provoke and worsen symptoms will likely keep him from physical exertion as a part of his work opportunity.

We will have to await medical efforts to treat the possibility of a migraine equivalent disorder before making a statement regarding other work effort.

¹The consultation "at Hitchcock" that is mentioned in this report refers to the petitioner's treating neurologist whose reports are cited above. The "neurological consultation" in Rutland that is referred to was essentially negative as to specific findings, but does not contradict any of the other reports as to their description of the petitioner's symptoms and their attempts at diagnosis.

In July, 1993, the petitioner's family physician submitted his responses to "Medical Interrogatories" posed by the petitioner's attorney. They include the statements that the petitioner's impairment is expected to be "indefinite", that a side effect of his medication is "sedation", that the petitioner's severe episodes occur "0-4 times a month", and that when they do occur it "precludes all activity". It is also noted that the petitioner's symptoms are precipitated by "neck extension", and that this would effect the petitioner's ability to work because he "cannot move about". The report concludes with the comment: "There are aspects of (petitioner's) illness that suggest a labyrinthine disorder and other symptoms suggest basilar migraine."

Based on the above reports, and on the petitioner's testimony, which is consistent with those reports, it is found that since at least November, 1992, the petitioner's symptoms have precluded virtually any activity that includes even slight physical exertion or head movement. Moreover, the amount and type of medication necessary to control the frequency and severity of the petitioner's severe episodes of vertigo and nausea leave the petitioner in a chronically fatigued and unalert state. Unfortunately, it appears that the petitioner's condition will not improve in the foreseeable future.

This leaves the petitioner unable to perform anything but

the most undemanding sedentary work in terms of exertion, concentration, perseverance, and head movement. There is no question that these latter restrictions would severely restrict the "range" of sedentary jobs the petitioner could perform. He couldn't be exposed to dangerous machinery, and would generally not be able to adhere to rigid production quotas, hours of attendance, and attention to detail. Under the regulations (see infra) this dictates a finding that the petitioner is disabled.

ORDER

The Department's decision is reversed.

REASONS

Medicaid Manual Section M 211.2 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.

The petitioner in this case is forty-nine with a high school education and a work history limited to unskilled physical labor. As noted above, the evidence clearly

establishes that if there are any jobs at all that the petitioner could perform it would be only very limited sedentary work--far from the "full range of sedentary jobs" contemplated by the regulations. 20 C.F.R. § 404, Subpart P, Appendix II, Section 200.00. The petitioner's additional physical limitations markedly offset the less-than-one-year of "younger age" the petitioner has in comparison to a fifty-year-old person of similar education and work experience who is capable of a "full range of sedentary work"--but who, under the regulations, would have to be found disabled. See id., Rule 201.12. Thus, the regulations dictate that the petitioner also be found disabled. Id., Section 201.00(h). The Department's decision is, therefore, reversed.

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