

STATE OF VERMONT  
HUMAN SERVICES BOARD

In re ) Fair Hearing No. 10,528  
 )  
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.<sup>1</sup> The case is unusual in that it is being submitted to the Board at this time for preliminary findings of fact regarding the extent of the petitioner's impairment. Depending on those findings, the parties have stipulated that the matter shall be returned to the hearing officer for the taking of additional evidence (in the form of expert vocational testimony) regarding the existence of alternative jobs available to the petitioner in view of his age, education, and work experience.<sup>2</sup>

FINDINGS OF FACT

The petitioner is a thirty-eight-year-old man with two years of college education. He has skilled work experience as a commodities trader. Since he moved to Vermont (in 1987), however, he has worked for a country general store/gas station.

All was well (at least work-wise) with the petitioner until May, 1989, when he suffered a sudden severe heart

attack. In July, 1989, he underwent angioplasty surgery.

In October, 1989, the petitioner returned to his job at the general store, but on a part-time basis and with a substantial reduction in duties and expectations (see infra).

Throughout the fall and winter of 1989-90, the petitioner continued to experience angina-like pain and fatigue. He also was anxious and depressed about his health, and sought psychological help.<sup>3</sup>

The petitioner maintains that he continued to experience angina and fatigue through the winter and spring of 1990. With the warm weather, however, the petitioner's symptoms abated somewhat and he was able to work more hours at the general store (see infra). In July, 1990, however, a stress test was positive for continuing coronary problems. In November, 1990, a catheterization revealed a total obstruction of the petitioner's left coronary artery, and later that month he underwent coronary bypass surgery.

Following the surgery the petitioner again developed pain in his upper chest. Tests for this pain were negative.

The petitioner did not return to his job at the general store until June, 1991.

In September, 1991, the petitioner's treating physician submitted the following report of the petitioner's progress from July, 1990, to the date of the report, as well as comments, admittedly speculative, regarding the time from the petitioner's first surgery (July, 1989) up until July

1990:

As you probably know, [petitioner] had a heart attack of the inferior part of his heart on 5/29/89. This heart attack occurred at an outside hospital. He was referred to Mary Hitchcock for recurrent chest pain after the heart attack. A cardiac catheterization on 6/8/89 showed 100% blockage of his circumflex artery and a 70% blockage of his right coronary artery. His left anterior descending artery was normal. He had an exercise stress test here which showed electrocardiogram changes and a thallium study which was significant for a small amount of ischemia (not enough blood getting to the heart muscle). It was elected to treat him with medication at this time and he was discharged. Unfortunately he had recurrent chest pain and was therefore referred back to our hospital for a percutaneous transluminal coronary angioplasty. This was successfully performed on the circumflex artery which was opened to a residual 10% blockage. After this he was sent back to Dr. [physician] for follow-up and an exercise thallium study which is a fairly common procedure done several weeks after angioplasty. I do not have the results of this study and therefore cannot answer your questions regarding why the study done in 11/89 at Central Vermont Hospital did not show evidence of a recurrent problem. If it is true that the study was negative, the reason for this would be that we had successfully opened up the blockage in his coronary artery that was causing the problem.

What is clear however is that [petitioner] was lost to medical follow-up until I evaluated him for entry in the Cholesterol and Recurrent Events (CARE) Study. We began this evaluation in July of 1990. At that time [petitioner] stated that he was having stable exertional angina (chest pain). At that time I ordered an exercise stress test which was positive. [Petitioner] developed his typical neck, right chest and right arm pain at 7 minutes into exercise and there were associated changes on the electrocardiogram consistent with the heart muscle not getting enough blood. Because [petitioner] experienced an increased frequency of anginal episodes, I had a repeat cardiac catheterization performed on him which showed restenosis or blockage of his circumflex artery. This study was performed on 11/7/90 and showed 100% obstruction of the left circumflex artery without a change in the right coronary artery. The left anterior descending artery was still normal. In other words, his coronary artery blockage was back to what it had been at his previous cardiac catheterization. Clearly this explains the chest pain that he had experienced in

the last 12 months and should answer your question about what was causing his pain.

[Petitioner] had coronary artery bypass surgery performed on 11/29/90. After this was performed, he had some atypical chest pain and has been seen in the anesthesiology pain clinic for treatment of right upper back and shoulder pain focused primarily in the periscapular area and radiating into the neck and lower back. The pain was made worse with the use of the right arm. He has had injections for this by the people in pain clinic and has had physical therapy as well. A recent exercise stress test with thallium perfusion imaging failed to demonstrate any evidence of active myocardial ischemia, i.e., any pain that he is having is probably unrelated to recurrent blockage of his coronary arteries. Therefore I feel at the present time that the blockages of his coronary arteries have been adequately treated and he is not having heart-related chest pain.

In summary then [petitioner] has had cardiac-related chest pain to my knowledge between July of 1990 to the time of his coronary artery bypass surgery. While it is quite possible that he was having angina pectoris that may have been limiting his activity prior to July of 1990, I cannot specifically confirm this since I did not see him at that time. [Petitioner's] stress test from November of 1989 was performed at Central Vermont Hospital and I have not been able to review this. While it reportedly did not show evidence of myocardial ischemia, you should know that an exercise stress test using ECG criteria alone is only about 65% sensitive for the presence of active myocardial ischemia. Therefore there is a 35% chance that [petitioner] was indeed having active ischemia and therefore chest pain related to his heart although the test may have been negative. At any rate I feel that the pains he is having now are unrelated to his heart and rather related to musculoskeletal problems for which he is being treated at our pain clinic.

In July, 1991, the petitioner's employer at the general store submitted the following letter describing the petitioner's work there since 1987:

[Petitioner] started working for us in August of 1987. Within a very short period of time he proved himself to be a very valuable employee. He quickly became adept at dealing with customers and sales personnel and became quite proficient in processing Western Union, U.S. Funds, Travelers Express and credit

card transaction. His organizational skills as well as his outgoing personality give him great credentials for some of the work that we do.

In addition to our financial services we are a combination convenience store, gasoline station and landscape company, and so we find ourselves doing physical labor on a daily basis. We work outside in all weather; "full serving" gas customers, keeping the pumps and entry ways clear of snow in the winter and doing landscaping work in the summer. Inside the store we have what seems to be a never ending stream of inventory deliveries that must be stored in the basement and shelves/refrigerators that need continual restocking. Our employees can stay pretty physically fit through the exercise they get just doing our daily work.

On June 1st 1989 we were shocked to learn that [petitioner] had had a heart attack. About five months later, when he recovered sufficiently to be able to do some light work, we invited him to rejoin our staff. He agreed and in October of 1989 returned and worked about fifteen hours per week doing only those jobs that were not physically stressing. [Petitioner's] weekly schedule was arranged according to how well he felt each day. Some days he might work three hours, some days he might leave after working for just an hour and some days he'd just call to say that he couldn't come into work at all.

By May of 1990 [petitioner] had recovered enough to be able to put in about five hours per day, five days per week. He was still limited to those duties that didn't demand any physical stress. We kept his work schedule flexible so that he could easily arrange appointments with doctors and others or he could cancel coming in if his health demanded.

Unfortunately by late October of 1990 [petitioner] started having less and less energy, ultimately needing to shorten his work hours considerably. By November he was forced to quit and return to the hospital for a double by-pass.

This past June [petitioner] returned to us to pick up where he left off. Once again we have tried to see that his work hours and duties accommodate his physical limitations. Presently he works about four hours per day, five days per week when he feels well.

Intellectually [petitioner] is an excellent employee who brings a lot of creativity to his job. Because of this we are willing to dismiss his inability to perform

the physical aspects of this job that we demand of all the other members of our staff.

The most recent psychological report in the record dates from December, 1990, from the psychotherapist and supervising psychiatrist the petitioner was seeing up to that time.<sup>4</sup> That report includes the following:

We have given [petitioner] the diagnosis of dysthymia, essentially because of his complaints of loss of interest in life activities, rather frequent crying spells, and feelings of depression. He has also had periods of insomnia and poor appetite. The precipitant for his depression is quite clear, that being the loss of his health and concerns about dying.

However, it should be stated that [petitioner] does have a history of similar depression and associated suicide ideation. This was roughly in 1986 or 1987 when he was living the California. [Petitioner] essentially presents as a neat and well-groomed person, he is quite cooperative in the psychotherapy sessions.

His stream of thought is coherent and sequential and there was no evidence of major mental illness. His memory for recent and remote events is well intact. He denies hallucinations and delusions. [Petitioner's] prognosis would be considered good, particularly if his surgery proves successful and he is able to be rehabilitated back to his normal level of functioning.

Based on all the above reports the following findings are made:

1. Though the precise etiology has, at times, been unclear, there has been a sufficient and credible medical basis for the petitioner's complaints of chest pain and fatigue from the time following his first heart attack in June, 1989, at least through September 1991, the date of the most recent medical report (supra).

2. During this period the petitioner also suffered from anxiety and depression caused primarily by his concerns and fears regarding his physical health.

3. Throughout the period the petitioner's physical and psychological limitations regarding work activity have been generally as described above by his employer. At most, the petitioner was (and is) capable of working four hours a day, five days a week.

4. The exertional limits of any job the petitioner could perform would have to be sedentary or light (as defined in 20 C.F.R. § 416.967) with no other significant exertion (e.g., frequent stair climbing).

5. Also, any job would have to be accommodating to the petitioner in terms of scheduling. The petitioner would have to have the flexibility to take rest breaks (depending on his fatigue) and occasional days off if he didn't feel well.<sup>5</sup>

6. Because of the tenuous nature of the petitioner's physical and mental health, a job would also have to be relatively free of stress, rigid performance demands, and inflexible production quotas.

7. The petitioner's job at the general store cannot be considered "substantial gainful activity" because of the limited hours and the considerable accommodations made especially for the petitioner by his employers. See 20 C.F.R. §§ 971-974.

8. Because of the petitioner's education and skilled work history as a commodities trader, in the absence of expert vocational testimony it cannot be determined whether

alternative jobs exist in significant numbers in the national economy<sup>6</sup> that would accommodate the above-described limitations.

FOOTNOTES

<sup>1</sup>Also at issue in this case is whether the Department and/or the Board, on the basis of new evidence not previously available, can "reopen" an earlier application for Medicaid that was denied by the Department and subsequently affirmed by the Board. See Fair Hearing No. 9403 (a copy of which has been furnished to the Board). However, since the resolution of this issue is required only if the petitioner is ultimately found to be disabled, the board defers consideration of the petitioner's arguments in this regard until such time as such a determination is made.

<sup>2</sup>This is one of the fortunately rare cases that appears to require vocational testimony to resolve the issue of the availability of alternative jobs for the applicant. In most cases, the regulations themselves (the so-called "grids") can be used to take administrative notice of the numbers of available jobs based on an individual's level of impairment, age, education, and work experience. See 20 C.F.R. § 404, Subpart P, Appendix II. Because of the difficulty and expense for the Department in obtaining vocational experts (the burden of proof being on the Department), and the infrequency with which such experts are needed, a "protocol" has evolved in fair hearings before the Board by which the Department, when necessary (i.e., in those cases which prove to be "off the grids") can preliminarily obtain and contest the findings of fact upon which the vocational expert's testimony will necessarily be based. This also allows petitioners in such cases the opportunity to prepare a cross examination of the Department's expert and, if they can find one, to obtain and prepare the testimony of their own vocational expert.

<sup>3</sup>It was at this time that the Board considered the appeal by the petitioner of the denial of his first application for Medicaid. Based on the medical evidence available at that time the Board found that the petitioner's limitations were largely "motivational", and that the medical evidence did not support a twelve-month disability. See Footnote 1, supra. The petitioner did not appeal this decision.

<sup>4</sup>It is not clear whether the petitioner continued with counseling following his surgery in November, 1990.

<sup>5</sup>Based on the present evidence it is difficult to be precise as to how often the petitioner would actually be unable to work. Perhaps the parties could obtain an affidavit from the petitioner's employer as to his recent work attendance before the case is submitted to a vocational expert.

<sup>6</sup>It is possible that besides the usual office settings for commodities trading and similar activities, a market exists for home-based computer and phone trading. At any rate, expert testimony will be necessary to determine this and to determine the "marketability" of the petitioner's experience in this and other areas of employment.

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