Cardiology Listings: (Equaling and Meeting) and Functional Capacity

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Cardiovascular System: Listing, Equivalence, and Other Functional Considerations

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4.00 Cardiovascular System

I. Initial Concerns:

What Constitutes a Cardiovascular Impairment?

It is any disorder that affects the proper functioning of the heart or the circulatory system (that is, arteries, veins, capillaries, and the lymphatic drainage) and can be congenital or acquired. 20 C.F.R. § 404, subpt. P, app. 1 § 4.00(A)(1)(a).

Diagnosis alone is insufficient to meet the requirements of a listed impairment. *Palmer v. Colvin,* No. 5:13-CV-190-C, 2014 WL 3855324 (N.D. Tex. 2014) (citing *Sullivan v. Zebley*, 493 U.S. 521, 530 (1990)).

Naturally, the Cardiovascular Listings contemplate more, including one or more of four consequences of heart disease:

(i) Chronic heart failure or ventricular dysfunction
(ii) Discomfort or pain due to myocardial ischemia, with or without necrosis of the heart muscle.
(iii) Syncope, or near syncope, due to inadequate cerebral perfusion from any cardiac cause, such as obstruction of flow or disturbance in rhythm or conduction resulting in inadequate cardiac output.
(iv) Central cyanosis due to right-to-left shunt, reduced oxygen concentration in the arterial blood, or pulmonary vascular disease.

20 C.F.R. § 404, subpt. P, app. 1 § 4.00(A)(1)(b).

The listing-level cardiovascular impairments are shown through symptoms, signs, laboratory findings, response to a regimen of prescribed treatment, and functional limitations. 20 C.F.R. § 404, subpt. P, app. 1 § 4.00(A)(2).

Terms of Medical, but also Legal Significance: Persistence, Recurrence, and Uncontrolled.

Social Security may want proof that the listed cardiovascular impairment is "**persistent**". In other words, this restates the one-year duration requirement: "the longitudinal clinical record shows that, with few exceptions, the required finding(s) has been present, or is expected to be present, for a continuous period of at least 12 months, such that a pattern of continuing severity is established." 20 C.F.R. § 404, subpt. P, app. 1 § 4.00(A)(3)(b).

Other listings may require a showing that the impairment is **recurrent**: "The longitudinal clinical record shows that, within a consecutive 12-month period, the finding(s) occurs at least three times, with intervening periods of improvement of sufficient duration that it is clear that separate events are involved." § 4.00(A)(3)(c).

Be aware of treatment noncompliance issues:

Social Security defines an **uncontrolled** cardiovascular impairment as one which *does not adequately respond to standard prescribed medical treatment*. 20 C.F.R. § 404, subpt. P, app. 1 § 4.00(A)(3)(b). The lack of treatment can be especially harsh when looking at the whether the claimant meets the cardiovascular listings: "[I]f you do not receive treatment, you cannot show an impairment that meets the criteria of most of these listings." 20 C.F.R. § 404, subpt. P, app. 1 § 4.00(B)(3).

II. Evidence:

Generally, the claimant needs a minimum of three (3) months of observation and treatment to evaluate severity and duration. 20 C.F.R. § 404, subpt. P, app. 1 § 4.00(B)(1)

If the claimant's file contains cardiovascular treatment, look for two common and critical pieces of evidence:

(1) <u>ECG: Electrocardiograph/Electrocardiogram</u>
(2) <u>ETT: Exercise Tolerance Test (or Exercise Stress Test)</u>

ECG and ETTs can help identify information needed to establish listing level impairments, especially when considering Listings 4.02, Chronic Heart Failure, and 4.04, Ischemic Heart Disease. *See* 20 C.F.R. § 404, subpt. P, app. 1 §§ 4.02, 4.04. *See also* 20 C.F.R. § 404, subpt. P, app. 1 § 4.00(C)(3)(b).

These tests will generally provide some of the key medical evidence such as the claimant's ejection fraction (EF) or an estimate of aerobic capacity for walking.

Other useful evidence to identify in the medical file includes *chest x-rays* and *cardiac catheterization reports*.

Can Social Security Assist If the Claimant's File Lacks Critical Evidence to Establish a Listing Level Cardiovascular Impairment?

Yes, however, the help may be limited. For instance, the Cardiovascular Listings contain three sections covering whether an exercise stress test should be purchased. *See* 20 C.F.R. § 404, subpt. P, app. 1 § 4.00(C)(6)-(8). In at least one Federal District Court, the matter of whether the ALJ failed to order an ETT receives substantial evidence discretion. *Palmer*, 2014 WL 3855324 at *6 (citing *Brock v. Chater*, 84 F. 3d 726, 728 (5th Cir. 1996). Thus, consider community medical resources or an independent medical examiner if available.

III. Major Listings: 4.02, 4.04

4.02, Chronic Heart Failure

It is necessary to review § 4.00(D)(1) and (D)(2). Section 4.00(D)(2), in particular, describes the specific evidentiary requirements, including how abnormal cardiac imaging provides "the objective measures of left ventricular function and structural abnormality in the heart." The chronic component of chronic heart failure is established through documented symptoms and signs such as easy fatigue, weakness, shortness of breath (SOB), cough, or chest discomfort at rest or with activity, and more. 20 C.F.R. § 404, subpt. P, app. 1 § 4.00(D)(2)(b)(i)(ii).

The claimant must meet one of the criteria in subsection A and one of subsection B.

A Criteria:

"1. Systolic failure (see 4.00D1a(i)), with left ventricular end diastolic dimensions greater than 6.0 cm or ejection fraction of 30 percent or less during a period of stability (not during an episode of acute heart failure); or
2. Diastolic failure (see 4.00D1a(ii)), with left ventricular posterior wall plus septal thickness totaling 2.5 cm or greater on imaging, with an enlarged left atrium greater than or equal to 4.5 cm, with normal or elevated ejection fraction during a period of stability (not during an episode of acute heart failure);" § 4.02(A)

Key Point(s): These findings must be established during periods of stability. For instance, a claimant may suffer an acute episode, visit the hospital, and testing could show an ejection fraction below 30%, which does not necessarily establish what is asked for above.

AND

B Criteria:

"Resulting in one of the following:

1. Persistent symptoms of heart failure which very seriously limit the ability to independently initiate, sustain, or complete activities of daily living in an individual for whom an MC, preferably one experienced in the care of patients with cardiovascular disease, has concluded that the performance of an exercise test would present a significant risk to the individual; or
2. Three or more separate episodes of acute congestive heart failure within a consecutive 12-month period (see 4.00A3e), with evidence of fluid retention (see 4.00D2b(ii)) from clinical and imaging assessments at the time of the episodes, requiring acute extended physician intervention such as hospitalization or emergency room treatment for 12 hours or more, separated by periods of stabilization (see 4.00D4c); or

3. Inability to perform on an exercise tolerance test at a workload equivalent to 5 METs or less due to:

    a. Dyspnea, fatigue, palpitations, or chest discomfort; or
    b. Three or more consecutive premature ventricular contractions (ventricular tachycardia), or increasing frequency of ventricular ectopy with at least 6 premature ventricular contractions per minute; or
    c. Decrease of 10 mm Hg or more in systolic pressure below the baseline systolic blood pressure or the preceding systolic pressure measured during exercise (see 4.00D4d) due to left ventricular dysfunction, despite an increase in workload; or
    d. Signs attributable to inadequate cerebral perfusion, such as ataxic gait or mental confusion."

20 C.F.R. § 404, subpt. P, app. 1 § 4.02(B)

Key Point(s): Objective findings are only one-half of the equation. In some sense similar to Listing 12.04 for Affective Disorders, the B criteria focus more on the functional limitations, or signs, symptoms, and events which accompany the objective findings. Identifying exercise tolerance testing in the claimant's file can be vital to evaluating and establishing the B criteria. *See Prange v. Astrue*, 547 F. Supp. 2d 926 (S.D. Ind. 2008)(finding that the B criteria of 4.02 were not established and giving greater weight to the testimony of the medical expert who opined that a "treadmill test" would be useful in evaluating the claimant under 4.02).

While on the topic of ETTs: Social Security requires a Medical Consultant (MC) to determine if performance of an exercise test would present a significant risk to the claimant. § 4.02(B)(1). Social Security defines an MC in § 4.00(A)(3)(a) and 20 C.F.R. §§ 404.1616(a) and 416.1016(a). MCs are not consultative examiners; they are member(s) of the disability determination team with the State Agency or Social Security. 20 C.F.R. § 404, subpt. P, app. 1. Although they may play a role in evaluating whether the claimant meets § 4.02(B)(1), the MC generally must give great weight to the treating source's opinion about the risk of exercise testing to the claimant. If the MC wishes to override that opinion, he or she must prepare a written rationale documenting the reasons for overriding the treating opinion. 20 C.F.R. § 404, subpt. P, app. 1 § 4.00(C)(7)(c).

4.04, Ischemic Heart Disease

" . . . with symptoms due to myocardial ischemia, as described in 4.00E3-4.00E7, while on a regimen of prescribed treatment (see 4.00B3 if there is no regimen of prescribed treatment), with one of the following:

A. Sign-or symptom-limited exercise tolerance test demonstrating at least one of the following manifestations at a workload equivalent to 5 METs or less:

    1. Horizontal or downsloping depression, in the absence of digitalis glycoside treatment or hypokalemia, of the ST segment of at least –0.10 millivolts (–1.0 mm) in at least 3 consecutive complexes that are on a level baseline in any lead other than a VR, and depression of at least –0.10 millivolts lasting for at least 1 minute of recovery; or

2. At least 0.1 millivolt (1 mm) ST elevation above resting baseline in non-infarct leads during both exercise and 1 or more minutes of recovery; or
3. Decrease of 10 mm Hg or more in systolic pressure below the baseline blood pressure or the preceding systolic pressure measured during exercise (see 4.00E9e) due to left ventricular dysfunction, despite an increase in workload; or
4. Documented ischemia at an exercise level equivalent to 5 METs or less on appropriate medically acceptable imaging, such as radionuclide perfusion scans or stress echocardiography.

OR

B. Three separate ischemic episodes, each requiring revascularization or not amenable to revascularization (see 4.00E9f), within a consecutive 12-month period (see 4.00A3e).

OR

C. Coronary artery disease, demonstrated by angiography (obtained independent of Social Security disability evaluation) or other appropriate medically acceptable imaging, and in the absence of a timely exercise tolerance test or a timely normal drug-induced stress test, an MC, preferably one experienced in the care of patients with cardiovascular disease, has concluded that performance of exercise tolerance testing would present a significant risk to the individual, with both 1 and 2:

1. Angiographic evidence showing:

   a. 50 percent or more narrowing of a nonbypassed left main coronary artery; or
   b. 70 percent or more narrowing of another nonbypassed coronary artery; or
   c. 50 percent or more narrowing involving a long (greater than 1 cm) segment of a nonbypassed coronary artery; or
   d. 50 percent or more narrowing of at least two nonbypassed coronary arteries; or
   e. 70 percent or more narrowing of a bypass graft vessel; and

2. Resulting in very serious limitations in the ability to independently initiate, sustain, or complete activities of daily living."

20 C.F.R. § 404, subpt. P, app. 1 § 4.04.

Key Point(s): Unlike § 4.02, which requires one of A and one of B, § 4.04 requires only one of either subsection A, B, OR C. Although note that subsection C does contain an AND component when it comes to evaluating coronary artery disease. *See* 20 C.F.R. § 404, subpt. P, app. 1 § 4.04(C)(1) and (2). Like § 4.02, however, § 4.04 also contains a preamble which is useful in understanding the full requirements of the listing. *See*, § 4.00(E). For 4.04A: "The ETT must be a sign-or-symptom limited test in which you exercise *while connected to an ECG* until you develop a sign or symptom that indicates that you have exercised as much as is considered safe for you." § 4.00(C)(3)(b); emphasis added.

IV. The Listings and Beyond: Additional Functional Considerations

Equaling the Listings

Social Security evaluates equivalence under 20 C.F.R. §§ 404.1526 and 416.926. Consider co-morbid conditions, including obesity. SSR 02-01p, 2002 WL 34686281 (2002); *see also* 20 C.F.R. § 404, subpt. P, app. 1 § 4.00(I). Bear in mind the ALJ may be bound by policy to consult a medical expert before reaching a conclusion regarding equivalence. *See* SSR 96-6p, 1996 WL 374180 (July 2, 1996). Seek the opinion of your client's cardiologist on equivalence.

New York Heart Association Functional Classification

According to the American Heart Association, the New York Heart Association Functional Classification is the most commonly used classification system for heart failure. It places patients in one of four categories depending patient symptoms and limitations.

I	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea (shortness of breath).
II	Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea (shortness of breath).
III	Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnea.
IV	Unable to carry on any physical activity without discomfort. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.

American Heart Association, *Classes of Heart Failure,* http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-Heart-Failure_UCM_306328_Article.jsp#.VwKpXywUWJA (Last updated Sep. 30, 2015).

Look for and highlight the claimant's NYHA Classes, if you see them in the evidentiary record. See *Gunter v. Astrue*, No. 3:09-CV-0292, WL 3293567, at *9 (S.D. Ohio, June 28, 2010) (rejecting the Commissioner's argument that the Plaintiff's proof did not establish persistent symptoms of heart failure, which very seriously limit the ability to independently initiate, sustain, or complete activities of daily living, in part, by reference to two treating physician's who reported that the claimant suffered from a NYHA functional class III impairment, and reversing and remanding for an award of benefits to the claimant).

Consider SSR 96-8p

Cardiovascular impairments can result in both exertional and nonexertional limitations depending on the case. SSR 96-8p provides that "it is the nature of an individual's limitations or restrictions that determines whether the individual will have only exertional limitations or restrictions, only nonexertional limitations or restrictions, or a combination of exertional and

nonexertional limitations or restrictions." SSR 96-8P, 1996 WL 374184 (July 2, 1996). Symptoms of heart failure, for instance, may involve fatigue and weakness, difficulty concentrating or decreased alertness, shortness of breath, and chest pain, among others. See, Diseases and Conditions: Heart Failure. Mayo Clinic, Heart Failure, http://www.mayoclinic.org/diseases-conditions/heart-failure/basics/symptoms/con-20029801 (last updated Aug. 18, 2015).