

**OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
BUREAU OF STATE HEARINGS**

In the matter of:

<u>Appeal:</u>	<u>Program:</u>	<u>Disposition:</u>
1258106	MED	SUSTAINED
Compliance Required		
Decision Date:	02/10/2006	
Request Date:	11/18/2005	
Hearing Officer:	MARYBETH RINARD	

State Hearing Decision

ISSUE SECTION

On 11/7/05, the Trumbull County Department of Job and Family Services (Agency) denied the Appellant's 1/7/05 application for Medicaid for the Disabled (MAD) because County Medical Section (CMS) found the Appellant not to be disabled pursuant to Ohio Administrative Code § 5101:1-3-03 and 5101:1-5-20(B). The Appellant takes issue with the denial and asserts there is medical information that needs to be presented to CMS for consideration, and that she has no means to have the testing that was on the CMS deferral. The issue on appeal is whether the Agency acted in accordance with the Ohio Administrative Code in denying the Appellant's 1/7/05 application for Medicaid for the Disabled, because CMS found that there was insufficient data after the deferral.

Based on the evidence and law presented within, the hearing officer concludes that there is no indication that the Agency satisfied CMS' request for current medical information, and the Agency has not acted within the time frames for the determination of eligibility. Therefore, the denial of Medicaid for the Disabled cannot be upheld and it is recommended that appeal be sustained with compliance.

PROCEDURAL MATTERS

On 10/28/05, the CMS mailed the adverse disability determination notice and on 11/7/05, the Agency mailed the Medicaid denial notice. On 11/18/05, the Appellant requested a state hearing. The matter was set for an evidentiary hearing which commenced on 2/7/06. The presiding hearing officer heard sworn testimony from the Appellant, and the Agency's representatives, Joe Roscoe and Toni Orlando. The Agency presented an appeal summary which was entered into the record. The Appellant did not submit documentary evidence.

FINDINGS OF FACT

1. The Appellant, age 45, lives with her fiancé and alleges impairments of anemia, back problems, hypertension, hypothyroidism, and hyperlipidemia.
2. The Appellant does not have a pending Supplemental Security Income (SSI) application.
3. The Appellant underwent surgery when the SSI application was denied and was unaware of the denial.
4. The Appellant was to apply for SSI on the date of this hearing.

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5. The Appellant applied for Medicaid for the Disabled on 1/7/05 and medical documentation was gathered by the Agency and was sent to CMS for a disability determination; the records were received by CMS on 6/6/05.
6. Information sent to CMS was the Social Summary dated 1/7/05, a basic medical form dated 2/17/05, and the medication dependency form dated 4/16/05.
7. On 7/13/05, the case was deferred by CMS for additional information, and the case returned to CMS on 8/23/05.
8. The deferral requested current signs and symptoms with 2005 testing/reports, current x-rays including CT scan, MRI, range of motion studies, EMG, gait and grip test results, hospital/clinic visits, and documentation from the orthopedic surgeon.
9. No additional medical documentation was gathered or sent to CMS.
10. CMS denied disability on 10/28/05 due to insufficient information after deferral.
11. The Agency denied the Medicaid application on 11/7/05.

CONCLUSIONS OF POLICY

Policy

Ohio Administrative Code § 5101:1-39-03 (2005) sets forth the regulations regarding the Medicaid limiting physical factor and states, in part that the "CMS packet" consists of all required forms specified in paragraph (C) of this rule and all available current medical information to support the disability claim. The CMS packet is submitted by the administrative agency to the CMS unit for a disability determination.

"Limiting physical factor" is a physical or mental characteristic or impairment or combination of characteristics or impairments that may limit an individual's ability to work. For the purposes of Medicaid eligibility, limiting physical factor is a non-financial eligibility criterion. There are three ways an individual can meet the eligibility criterion of limiting physical factor one of which is "Disabled", as defined in 42 USC 1382c, (12/17/1999): An individual age eighteen or over who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months.

Administrative agency responsibilities: The administrative agency shall determine Medicaid eligibility. In accordance with policy the administrative agency shall determine the limiting physical factor is not met and shall submit a CMS packet to the CMS unit for a disability determination when: An individual has, alleges, or appears to have a physical or mental impairment or combination of impairment s that may limit his or her ability to work. Upon request, the administrative agency shall assist the individual in obtaining medical documentation to support the disability claim. Upon request, the administrative agency shall utilize administrative funds to assist the individual in receiving an eye examination or medical/psychological examination to determine whether an individual is blind or disabled.

The administrative agency shall obtain all available current medical information as well as any other information requested by the CMS unit and submits it in the CMS packet. The administrative agency shall include in the CMS packet all available current medical information for all alleged impairment(s) or combination of impairments. The administrative agency shall g medical information, tests, services or records from

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other entities such as the Social Security Administration (SSA), Ohio rehabilitation services commission, workers' compensation, etc. The eligibility rules are contained in Chapters 5101:1-37 to 5101:1-42 of the Administrative Code.

The application process is a series of activities which begins with a request for assistance and ends with the authorization of benefits or a notice of denial. The application process requires the complete cooperation of the assistance group (AG) and the prompt responsiveness of the CDJFS. The application process shall be administered with courtesy, consideration, and respect. Administrative duties shall be performed in such a manner as to secure for every AG the full amount of aid to which it is legally entitled according to program regulations.

The CDJFS is responsible for determining eligibility for all Medicaid programs with the exception of the Ohio breast and cervical project as outlined in chapter 5101:1-41-05 of the Administrative Code. The CDJFS is responsible for documenting and recording the determination of eligibility, and subsequently informing the AG of the eligibility decision. A determination of eligibility shall be made as soon as possible after the application requirements are complete. The determination of eligibility, including the gathering of any verifications, shall be completed as rapidly as possible within thirty Calendar days (forty- five days if a disability determination is required) from the date of application. No more that forty-five days may elapse between the date of application and an JFS 04074 "Notice of Approval of Your Application for Assistance" (or CRIS-E equivalent) or an JFS 07332 "Notice of Denial of Your Application for Medicaid in Cases Involving Community Spouse." However, when a Medicaid application is pending a disability or blindness determination, the application may pend up to ninety days before the appropriate notice is mailed.

The CDJFS must not use the time standards as a waiting period before determining eligibility. The CDJFS must not use the time standards as a reason for denying eligibility because it has not determined eligibility within the time standards. The determination of eligibility shall proceed concurrently with the determination of blindness or disability and shall be completed within forty- five calendar days. The specific forty-five day or ninety-day limit may be exceeded in situations where completion of the determination of eligibility is delayed because of circumstances beyond the control of the CDJFS.

The following circumstances are considered beyond the control of the CDJFS. Failure with good cause to secure necessary verifications includes failure or delay on the part of an examining physician to provide all needed information. When there is an administrative or other emergency beyond the CDJFS' control, the reasons for delay must be documented in the assistance group's case record. Ohio Administrative Code § 5101:1-38-01.2 (2003)

Analysis

After careful consideration of the evidence presented at the hearing, the hearing officer finds that the limiting physical factor must be met for the Medicaid for the Disabled program by age, blindness or disability. CMS determines disability pending an SSI appeal process. The Agency obtained limited medical information and sent the case to CMS. The case was deferred by CMS to the Agency for current specific medical documentation. The Agency did not follow-up on the requested medical documentation nor does it appear that they did anything in this case and the Agency is not within the time frame for determining eligibility on this case. Agency and CMS

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have the responsibilities to show by the preponderance of the evidence that its action or inaction is in accordance with Ohio Administrative Code § 5101:6-6-02(C) (2), and 5101:6-7-01(C) (1) (c). The Agency had the responsibility to secure current medical information and utilize administrative funds, if necessary, and there is no indication that the Agency satisfied the request for current medical information. Thus, the Medicaid denial can not be affirmed and the issue is remanded back to the both CMS and the Agency to coordinate the scheduling of the tests and examinations required by CMS to determine if the Appellant's mental status and physical impairments meet the severity criteria either alone or in combination with the Appellant's other alleged disabling conditions.

HEARING OFFICER'S RECOMMENDATION

Based on the record developed at the hearing, the hearing officer recommends that that appeal be sustained and the issue is remanded back to the both CMS and the Agency to coordinate the scheduling of the tests and examinations required by CMS to determine if the Appellant's mental status meets the severity criteria either alone or in combination with the Appellant's other alleged disabling conditions. The 12/20/04 Medicaid application date shall be preserved. The Agency shall notify the Appellant, in writing, of the CMS determination and subsequent Medicaid eligibility determination, affording the Appellant hearing rights. Compliance shall be considered achieved upon a showing that the Agency has pended the Medicaid application and has referred the case to CMS for a disability determination. A copy of the referral form to CMS shall be attached to the JFS 04068, state hearing compliance form. Once CMS receives the additional information they will make a determination and Agency shall notify Appellant of the determination. Appellant retains the right to appeal the CMS determination and any subsequent Medicaid eligibility determination made by the Agency.

FINAL ADMINISTRATIVE DECISION AND ORDER

Finding the hearing officer's decision to be supported by the evidence, the recommendations above are adopted, and the appeal is sustained. The Agency is required to comply with the Hearing Officer's recommendations. Ohio Admin. Code § 5101:6-7-03(B)(1)(a) requires compliance with this decision within fifteen calendar days from the date of this decision, but no later than ninety calendar days from the hearing request date. Compliance shall be promptly reported to ODJFS, Bureau of State Hearings, via JFS 04068, compliance form, accompanied by supporting documentation. (2003)


Sue Roseborough, Hearing Authority

February 10, 2006

Notice to Appellant

This is the state hearing decision in your case. All papers and materials introduced at the hearing or otherwise filed make up the hearing record. The hearing record will be maintained by the Ohio Department of Job and Family Services. If you believe this state hearing decision is wrong, you may request an administrative appeal by writing to: Ohio Department of Job and Family Services, Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825 or FAX (614) 728-9574. Your request should state why you think the hearing decision is wrong. You can complete the appeal request form included with this decision. Your written request or appeal form must be received by the Bureau of State Hearings within 15 calendar days from the date this

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decision is issued. (If the 15th day falls on a weekend or holiday, this deadline is extended to the next work day.) During the 15-day administrative appeal period, you or your representative may request a free copy of the hearing record and recording of the hearing by calling the Bureau of State Hearings at 1-866-635-3748 (select option 1 from main menu). If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free, at 1-800-589-5888, for the local number.

Aviso a la Apelante

Esta es la decisión estatal administrativa de su caso. Todos los documentos y materiales presentados como prueba en la vista o de otra manera radicados componen el récord administrativo. El récord administrativo será mantenido por el Ohio Department of Job and Family Services.

Si usted cree que esta decisión estatal administrativa es errónea, usted puede solicitar una apelación administrativa escribiendo al: Ohio Department of Job and Family Services, Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825 o facsímil (614) 728-9574. Su solicitud debe indicar por qué usted piensa que la decisión administrativa es errónea. Usted puede completar la solicitud de apelación incluida con esta decisión. Su solicitud escrita o formulario de apelación tiene que ser recibido por el Bureau of State Hearings dentro de los 15 días calendario desde la fecha en que esta decisión es expedida. (Si el 15to. día recae sobre un fin de semana o un día feriado, esta fecha límite es extendida al próximo día laborable). Durante el período de 15 días de apelación administrativa, usted o su representante pueden solicitar una copia gratuita del récord administrativo y de la grabación de la vista llamando al Bureau of State Hearings al 1-866-635-3748 (seleccione la opción 1 del menú principal).

Si usted quiere información sobre servicios legales gratuitos pero no sabe el número de su oficina local de servicios legales, usted puede llamar al Ohio State Legal Services Association, gratuitamente, al 1-800-589-5888, para el número local.

Appendix

Agency's Exhibits

- A. CMS appeal summary, two pages
- B. Agency's referral to CMS, one page
- C. Social summary report, two pages
- D. Basic medical form, two pages
- E. Medication dependency form, one page
- F. CMS determination forms, two pages
- G. Agency's appeal summary, two pages
- H. Notice history, three pages
- I. Case profile, four pages
- J. Running record comments, nine pages

Appellant's Exhibit

- 1. State hearing request, one page