

STATE HEARING DECISION

ODHS 4005 (Rev. 9/94)

County MONTGOMERY	District Hearings Section CINCINNATI	Assistance Group Name		Assistance Group Number
Place of Hearing MONTGOMERY CDHS	Initial Hearing Date 02/11/2000	Rescheduled Postponed to 04/11/2000	Rescheduled Postponed to 04/11/2000	Rescheduled Postponed to

Appellant/Representative	Appellant Representation
	Local Agency Representation Steve James, CMS Rep.; Laura Stroup, Caseworker [2-11-00]; Arvela Flint, Agency Rep. [4-11-00]

Date Notice Mailed 09/29/1999	Date Received by Local Agency	Date Received by ODHS 12/21/1999	Date Appeal Summary Received	Date Scheduling Notice Mailed 03/31/2000
Appeal Number(s)/Program(s) 9932073/FS, 9932074/DA				

Notice to Appellant

This is the official report of your hearing and is to inform you of the decision and order in your case. All papers and materials introduced at the hearing or otherwise filed in the proceeding make up the hearing record. The hearing record will be maintained by the Ohio Department of Human Services. If you would like a copy of the official record, please telephone the hearing supervisor at the CINCINNATI District hearing section at 1-800-686-1571.

If you believe this state hearing decision is wrong, you may request an administrative appeal by writing to: Ohio Department of Human Services, Office of Legal Services, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423 or FAX (614) 752-8298. Your request should include a copy of this hearing decision and an explanation of why you think it is wrong. Your written request must be received by the Office of Legal Services within 15 calendar days from the date this 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 may request a free copy of the tape recording of the hearing by contacting the district hearings section.

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.

ISSUES:

1. The agency proposed to increase the appellant's Food Stamp allotment from \$175 to \$227, effective 11-1-99. The appellant requested the hearing regarding the termination of Disability Assistance. The Food Stamp increase was not an issue for the hearing.

2. The agency notified the appellant on 9-29-99 that her Disability Assistance [DA] would be terminated, effective 10-31-99. The termination occurred because County Medical Services had determined that the appellant was no longer disabled. The appellant requested the hearing, regarding the DA termination, because she believed that she is disabled. The hearing officer finds that the DA termination was incorrect

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Appeal(s) OVERRULED 9932073 SUSTAINED 9932074	Date Issued 04/27/2000	Compliance 9932074
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Distribution: Original to appellant, one copy to local agency; one copy to district Hearing section; one copy to district office; two copies to State Hearings. *(Photocopy to appellant's authorized representative, if any, and to ODHS units as appropriate.)*

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as CMS approved the appellant's disability as a result of the hearing process.

PROCEDURAL MATTERS:

The agency terminated the appellant's Disability Assistance [DA] on 10-31-99. The appellant requested a hearing on 12-21-99. The first hearing was held on 2-11-00. The record was left open as the appellant has some new medical information at the hearing and as she indicated that she could submit new medical information to the agency the following week. She stated that she had had problems in securing the information for the hearing. The caseworker was instructed to send the medical information to CMS the following week. Nothing was heard. The hearing officer checked with the agency hearing coordinator in March and learned that the caseworker had not submitted the new medical information. The new information was faxed by the agency to CMS. On 3-13-00 the hearing officer checked with CMS to determine if the new medical information had been received. It had not been so the information was faxed by the hearing officer to CMS on 3-13-00.

CMS again determined that the appellant was not disabled. A second hearing was scheduled for 4-11-00. On 4-11-00 the appellant submitted a large quantity of medical information that she had tried to secure previously and had just gotten the day prior to the hearing. Again, the record was left open, and the new medical information was mailed to CMS on 4-11-00. On 4-26-00 the hearing officer was notified by CMS that the appellant had been determined to be disabled, beginning 5-1-99 for 24 months.

SUMMARY OF PROCEEDINGS:

Agency Testimony:

2-11-00 Hearing:

Prior to receiving testimony, the issues were clarified with the appellant. She indicated that the increase in Food Stamps was not an issue for the hearing. It was determined from the caseworker that Disability Assistance was terminated, effective 10-31-99. The appellant was receiving medical coverage under the DA Medication Dependency program at the time of the hearing. The issue for the hearing, based on the 9-29-99 termination notice, was the termination of Disability Assistance on 10-31-99. It was also determined that the appellant had been previously approved for disability by CMS, effective 2-28-96 for 36 months. The

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current denial was a result of the agency sending medical information to CMS for a review of the appellant's disability since the disability period ended in February 1999.

The County Medical Services Representative read the following appeal summary over the telephone:

A. INTRODUCTORY FACTS

1. [The appellant] of Montgomery County reapplication for continuing disability review (CDR). (Exhibit 1)
2. The case was received at County Medical Services (CMS) on March 9, 1999. It was deferred on May 14, 1999; subsequently, the case returned to CMS after the deferral on August 31, 1999, and denied on September 13, 1999. (Exhibits 43 & 45).
3. The current Medicaid application date for the client is August 9, 1999. (Exhibit 9)
4. The client's current SSI status indicates that she is on General Assistance; no date is indicated on the form (Exhibit 9)
5. CMS denied the continuing disability on September 13, 1999 (Exhibit 45).

B. RECORDS PRESENTED TO CMS

The record as presented to and reviewed by CMS is comprised of the following:

1. CDHS Referral to CMS forms, Ohio Department of Human Services (ODHS) 3605 (Exhibits 1-5)
2. Social Summary Report(s) ODHS 7004 (Exhibits 6-9)
3. Basic Medical Report(s) ODHS 7302 (Exhibits 10-18)
4. The Mental Functional Capacity Assessment(s) ODHS 7308 (Exhibits

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19-32)

5. Physician Certification of Medication Dependency form ODHS 3606 (Exhibits 33-38)
6. Objective Medical documentation (Exhibits 50-171)

Summary: CMS originally received this case, and an approval was granted on February 28, 1996 for a period of thirty-six months. (Exhibit 42) The case was returned to CMS on March 9, 1999; it was reviewed by a medical reviewer and deferred for additional information on May 14, 1999. (Exhibit 43).

Subsequently the case returned to CMS after the deferral on August 31, 1999 and was reviewed using the Continuing Disability Review process for the psychological condition and the Five-Step sequential evaluation process for conditions not prior approved. The case was reviewed in its entirety, and as a result, the case was denied on September 13, 1999. (Exhibits 42, 43, 45)

To determine disability County Medical Services (CMS) uses Ohio Public Assistance Manual (OPAM) Section 5210 which defines disability under the Disability Assistance Medical program, and the Social Security Regulations which identify the criteria that must be met to be found disabled. When a case has been previously approved for twelve or more months by a County Medical Services Reviewer and the case is resubmitted to CMS for redetermination, the eight step Continuing Disability Review (CDR) process will be used instead of the Sequential Evaluation process to determine if ongoing disability exists for the prior approved condition or conditions. If the client has a condition or conditions that were not previously approved, they will be evaluated under the Sequential Evaluation process.

FIVE STEP SEQUENTIAL EVALUATION

Step One: The step one decision determines whether the claimant is engaged in substantial gainful activity. The decision is made by the Montgomery County Department of Human Services which then submits the case to CMS for disability determination. The CMS evaluation begins with step 2 of the 5-step sequential evaluation process (Exhibit 49).

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[The appellant] asserts the following allegations are impairments:

1. Depression (a condition of grief and sadness)
2. Low Back Pain
3. Diabetes (a condition where the body is unable to handle glucose [sugar], usually called Diabetes Mellitus where there is abnormally elevated (high) blood sugar)
4. Hypertension (simply, high blood pressure)
5. GI Problems--Peptic Ulcer Disease (simply, ulcers [sores] inside of the stomach)

Allegation: Depression (a condition of grief and sadness)

Rationale: Documentation submitted showed the client without any limitations on the Mental Functional Capacity Assessment form dated January 22, 1999 (Exhibit 31). So a more current evaluation was requested on the deferral (Exhibit 43). Consequently, the information requested was not submitted. Throughout the case, there was no indication of any recent evidence of a mental impairment nor was there sufficient evidence to determine the continuation of a mental impairment, and therefore the medical reviewer was unable to determine if the condition still existed and/or was still severe. There was no evidence within the case to show that the client was not able to perform basic work activities. Basic work activities, just to name a few, are walking, standing, sitting, pushing, pulling, understanding, and remembering simple instructions. Thus, the case was denied on the continuing disability at step 6.

Step 2: The following allegations were denied at step 2 of the sequential evaluation process. These allegations were denied due to a lack of medical documentation needed to show severity of the conditions.

Allegation: Low Back Pain

Rationale: The documentation throughout the record did not present information that would indicate that the client had a severe disabling spinal condition. The case was deferred for further information. (Exhibit 43) Because there was no current documentation and no documentation after the

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deferral to show a severe spinal condition that would limit the client from performing basic work activity, therefore, the medical reviewer denied the allegation for insufficient information to make a determination. The allegation was denied at step 2 of the sequential evaluation process.

Allegation: Diabetes (a condition where the body is unable to handle glucose [sugar], usually called Diabetes Mellitus where there is abnormally elevated [high] blood sugar)

Rationale: [The appellant's] diabetes does not show that she has abnormally high blood sugars that may require the use of insulin (a hormone produced by the body to control blood sugar). Because the Diabetes results from a deficiency [lack] of insulin, often the control of the severe conditions is by the use of insulin. The less severe of the diabetic conditions are often controlled with oral medication. [The appellant's] diabetes is well controlled with oral medication [glucophage/glynase] (Exhibit 38). Her blood sugars, although they are high, have been well in control (Exhibit 97). Although Diabetic Neuropathy (a nerve disorder caused by the diabetes causing a numbness and sometimes pain in the hands, feet, or legs) is mentioned, there is no confirmation of this with any EMG results or physical findings that indicate the neuropathy. The information to determine the client disabled under the guidelines was requested on the deferral (Exhibit 43). No further information was submitted that would indicate the diabetes was a severe disabling condition preventing the client from performing basic work activity. The allegation was denied at step 2 of the sequential evaluation process for insufficient information.

The two allegations above were denied at step 2 of the sequential evaluation process on the basis of insufficient data after deferral (Exhibit 43). The requested information is needed to show the signs, symptoms and findings of a severe impairment limiting the claimant's ability to perform basic work activities.

The following allegations were denied at step 2 of the sequential evaluation process. These allegations were denied because they were not found to be severe.

Allegation: Hypertension (simply, high blood pressure)

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Rationale: [The appellant's] blood hypertension (high blood pressure) has been controlled with the use of medication therapy (Exhibits 17, 38, 55, 60). Although, when the client does not take her medication her blood pressure is elevated. (Exhibits 50, 84) The guidelines that would show [the appellant's] blood pressure condition disabling are not present. There is no associated cardiovascular (heart) complications like heart failure, stroke (a condition that would cause paralysis [loss of function]), or chronic renal failure (a condition that would show severe kidney damage). Hypertension is normally controlled with medication as shown in the client's record. The case was deferred (Exhibit 43) for further information that would indicate a severe disabling condition. No further information was submitted. [The appellant's] hypertension is denied at step 2 of the sequential evaluation process for the condition being not severe.

Allegation: GI Problems–Peptic Ulcer Disease (simply, ulcers [sores] inside of the stomach)

Rationale: [The appellant's] record does not indicate a history of recurrent GI (gastro [stomach] intestinal) bleeding. GI obstruction or GI perforation (tear). Presently, the client is on medication for GI problems that are treatable with medication and would not normally cause disability. The lab work contained in the record is stable and does now show any evidence of bleeding. The case was deferred (Exhibit 43) for further information that would indicate a severe condition that would meet the guidelines for a disabling condition. No further information was submitted. The allegation was denied at step 2 of the sequential evaluation process.

The two allegations above were denied at step 2 of the sequential evaluation process because: 1. Each separate allegation was found to be not severe, and 2. since the combination of the four conditions, taken as a whole, do not show signs, symptoms, or findings that the client would be significantly limited in her ability to perform basic work activities. [The appellant's] conditions were found to be not severe at step two of the sequential evaluation process. Based upon the rules for Continuing Disability Review (CDR) all of the client's allegations were considered in the disability determination process even though each allegation was reviewed separately.

Appendix A–Exhibits

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1. CDHS Referral to CMS–ODHS form 3605 (Exhibits 1-5)
2. Social Summary Report(s) ODHS form 7004 (Exhibits 6-9)
3. Basic Medical Report(s) ODHS form 7302 (Exhibits 10-18)
4. The Mental Functional Capacity Assessment–ODHS 7308 (Exhibits 19-32)
5. Physician Certification of Medication Dependency–ODHS 3606 (Exhibits 33-38)
6. County Medical Services Disability Determination–ODHS 3600 (Exhibits 39-45)
7. Physician Case Referral Form–ODHS 3614 (Exhibits 46-48)
8. Five Step Sequential Evaluation Process (Exhibit 49)
9. Objective Medical Documentation (Exhibits 50-171)
10. Addendum for second hearing–appeal summary
11. Disability approval

The appellant was sent notice of the 10-31-99 termination of Disability Assistance on 9-29-99.

Appellant Testimony:

The appellant indicated that she had applied for SSI and that the application was pending at the time of the hearing. She was denied SSI about three years ago, she said. The appellant read the following letter from a Dr. Robert D. Powers:

[The appellant] has been seen in our facility for the last few years for chronic recurrent symptomatology of the cervical, thoracic and lumbar regions diagnosed as cervical, thoracic and lumbar intersegmental dysfunctions, cervicalgia, thoracalgia, lumbalgia and disc bulges in the lumbar spine.

Recently, this patient was involved in an accident which caused sprain/strain-type complexes on top of her previous condition.

Results from objective orthopedic and neurologic testing, CT scan, MRI test and x-rays support the diagnoses mentioned.

Based on this patient's condition, it is unlikely she will be able to be employed

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in any gainful employment. This patient has difficulty with lifting or carrying any weight over 5 pounds. She has limitations in pushing, pulling, bending, and prolonged standing or sitting due to her condition.

This patient also has other medical symptomatology that we do not treat but that also add to her likelihood of unemployability.

Please refer to her family physician, Barbara Bennett, D.O. for further discussion of her other medical conditions.

If you have any further questions, please do not hesitate to contact me.

Rebuttals:

The CMS Representative indicated that CMS needed clinical findings that would support the appellant's reported ailments.

The appellant said that she had been unable to secure the tests but would get them within the next week. She was told to secure the necessary tests. The caseworker was instructed to send the new medical information, including the two documents submitted at the hearing, to CMS as soon as the agency received it.

The appellant did get some information to the agency, but it was not sent up for almost a month. The hearing officer finally faxed the information to CMS on 3-13-00 when it was determined that the information had not been received by CMS.

The new medical information was evaluated by CMS, and the appellant was again found not be disabled. The appellant was notified of a continued hearing, which was scheduled for 4-11-00. The CMS Representative read the following appeal summary at the 4-11-00 hearing:

SUMMARY:

Case Analysis: On February 11, 2000, a state hearing was held on the [appellant's] case. At the time of the state hearing, CMS was made aware that additional information existed. CMS agreed to review this information to determine if [the

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appellant] met the disability criteria established by the Social Security Administration. On March 13, 2000, CMS received and reviewed this information. CMS's decision remains unchanged.

Objective Medical Information:

1. Exhibits 172-174

Allegation: Chronic Fatigue, Diverticulitis, Back Pain

Rationale: No signs, symptoms or clinical findings were presented for review. The list of prescription indicators that were submitted were by themselves inconclusive.

The appellant had a considerable amount of new medical information with her at this hearing. She said this was the material she had tried to secure before but had been able to get it only the day prior to this hearing. The material was reviewed by the hearing officer, and it was decided that the material would be forwarded to CMS on that date.

On 4-26-00 the hearing officer was notified by CMS that the appellant had been approved for disability, beginning 5-1-99 for 24 months.

FINDINGS OF FACT:

Undisputed Facts:

The following facts were determined by the hearing officer from the above testimony and documentation:

1. The appellant's Disability Assistance was terminated on 10-31-99 because CMS had determined that the appellant was not disabled. She had been found to be disabled previously until February 1999.
2. After a hearing on 2-11-00 and 4-11-00 and new medical information being provided CMS, CMS determined that the appellant is currently disabled,

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beginning 5-1-99 for a period of 24 months.

POLICY:

The Ohio Administrative Code specifies the following requirements for Disability Assistance eligibility:

Section 5101:1-5-01(D)

Covered Individuals

- (1) Eligibility for DA cash assistance is limited to the following individuals:
 - a. Children under the age of eighteen (includes emancipated minors as defined in rule 5101:1-5-10 of the Administrative Code); or
 - b. Individuals age sixty or over; or
 - c. Pregnant women (regardless of age); or
 - d. Certain individuals residing in a treatment center certified as an alcohol or drug addiction program by the Ohio department of alcohol and drug addiction services (ODADAS) as set forth in paragraph (D)(4) of this rule; or
 - e. Individuals who are disabled as determined by the county medical services section (CMS). The disability determination process of provided in rule 5101:1-5-20 of the Administrative Code; or. . .
- (2) All individuals who are determined potentially eligible for DA, and who do not meet the DA requirements referenced in paragraphs (D)(1)(a) to (D)(1)(d) and (D)(1)(f) of this rule, shall have their disability determined through the county medical services section (CMS) of the ODHS.

ANALYSIS:

Based on the above OAC Section and the fact that CMS determined that the appellant is currently disabled, beginning 5-1-99, the hearing officer finds that the 10-31-99 termination of the appellant's DA assistance was incorrect. The agency shall reopen her DA assistance,

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effective 11-1-99, if all other eligibility factors are met.

HEARING OFFICER'S RECOMMENDATIONS:

ISSUE 1—FOOD STAMPS [9932073]

The appeal should be OVERRULED as the appellant did not appeal the increase in her Food Stamp allotment.

ISSUE 2—DA [9932074]

The appeal should be SUSTAINED. The agency shall take the action indicated under Conclusions.

FINAL ADMINISTRATIVE DECISION AND ORDER:

ISSUE 1—FOOD STAMPS [9932073]

Finding the hearing officer's decision to be supported by the evidence, the recommendations shown above are adopted, and Appeal Number 9932073 is OVERRULED. No orders of compliance shall be issued against the agency based on this appeal.

ISSUE 2—DA [9932074]

Finding the hearing officer's decision to be supported by the evidence, the recommendations shown above are adopted, and Appeal Number 9932074 is SUSTAINED. The agency is required to comply with each of the terms set forth in the hearing officer's recommendation above.

Ohio Administrative Code, Rule 5101:6-7-03 requires compliance with this decision within 15 calendar days from the date it is issued, but in no event later than 90 calendar days from the date of the hearing request.

EXHIBITS:

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Agency:

- (1) CDHS Referral to CMS–ODHS form 3605 (Exhibits 1-5)
- (2) Social Summary report(s) ODHS form 7004 (Exhibits 6-9)
- (3) Basic Medical Report(s) ODHS form 7302 (Exhibits 10-18)
- (4) The Mental Functional Capacity Assessment–ODHS 7308 (Exhibits 19-32)
- (5) Physician Certification of Medication Dependency–ODHS 3606 (Exhibits 33-38)
- (6) County Medical Services Disability Determination–ODHS 3600 (Exhibits 39-45)
- (7) Physician Case Referral Form–ODHS 3614 (Exhibits 46-48)
- (8) Five Step Sequential Evaluation Process (Exhibit 49)
- (9) Objective Medical Documentation (Exhibits 50-171)
- (10) Addendum for second hearing–appeal summary
- (11) Disability approval

Appellant:

- A. Material presented at 2-11-00 hearing [2 pages]
- B. Material provided agency for CMS after 2-11-00 hearing [5 pages]
- C. Material provided at 4-11-00 hearing and submitted to CMS that day [207 pp.]

Date Issued: 04/27/2000