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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 14F-09330

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPT OF
CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66292

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, a hearing in the above-referenced matter convened on December 18, 2014 at 400 W. Robinson Street in Orlando.

APPEARANCES

For the petitioner: Lourdes Cosme, pro se

For the respondent: Evelyn Ross, ACCESS supervisor

STATEMENT OF ISSUE

At issue is whether the Department correctly denied the petitioner's application for Medicaid disability benefits.

PRELIMINARY STATEMENT

By notice dated October 21, 2014, the respondent notified the petitioner that her Medicaid application was denied because they "did not receive all the information requested to determine eligibility." Petitioner timely requested a hearing to challenge the denial.

Petitioner's son [redacted] ppeared to observe. Witness for the respondent Lauren Coe, program operation administrator with the Division of Disability Determination (DDD) and Dawn Burdock, unit supervisor appeared to observe.

At the hearing respondent submitted four exhibits, entered as Respondent Exhibits "1" through "4". The record was held open until close of business on January 6, 2015 for submission of additional evidence from the respondent. After the hearing, petitioner submitted an exhibit, which was accepted and entered as "Petitioner Exhibit 1". Additional evidence was also received from respondent on December 23, 2014 and marked as Respondent Exhibit "5". The record closed on January 6, 2015.

FINDINGS OF FACT

1. On September 15, 2014, petitioner (49) submitted an application for Medicaid Assistance on the basis of disability. The petitioner is not aged or blind and does not have any minor children.

2. The respondent mailed the petitioner on September 18, 2014 a pending notice requested petitioner to apply for disability benefits with Social Security Administration, sign the Authorization to Disclose Information form, the Financial Release form and complete an interview due no later than 10 days. On September 18, 2014, petitioner completed a disability interview, petitioner asserts that she is disabled and has the following conditions: a herniated disk, sciatic Neuralgia, and trimallecolor fracture on the legs.

3. On September 19, 2014, the respondent forwarded the information obtained from the petitioner to the Division of Disability Determination (DDD), which conducts disability determinations for the Department (Respondent Exhibit 3).

4. Petitioner's primary diagnosis is listed as DJD of the back and secondary diagnosis as Tibia/ fibula fracture. DDD Case Analysis Form, SSA-416, dated October 20, 2014 states in part (Respondent Exhibit 5 page 33):

> Is the claimant currently engaging in "substantial gainful activity"? NO
> Is claimant condition severe? YES
> Does impairment meet or equal a Listing? NO
> Can claimant perform PRW? UNKNOWN
> Can claimant perform other work? UNKNOWN

5. DDD testified that the examiner attempted to contact twice by letters mailed to the petitioner on September 29, 2014 and October 9, 2014 each notice allowing 10 days to respond and was unsuccessful. Furthermore, DDD alleged mailing two letters to Good Health Doctor [redacted] M.D., and no one responded to the letters.

6. As a result, it was determined the petitioner failed to cooperate with the processing of her disability claim. DDD determined petitioner not disabled at step three of the five steps.

7. On October 20, 2014, DDD completed a disability review that resulted in an unfavorable determination (N36). Decision code N36 indicates insufficient or no medical documentation received (Respondent Exhibit 5).

8. On October 21, 2014, the Department issued a Notice of Case Action that informed the petitioner that her application for Medicaid disability was denied due to no household member is eligible for this Program.

9. Petitioner confirmed she received the letters from DDD. Petitioner explained she was waiting for medical records from Nicaragua. Additionally, her mail is sent to a post office box and cannot travel as she is wheelchair bound. She waits for her son to assist

her. At the hearing, petitioner submitted a medical record from Doctor [redacted] [redacted], an orthopedic specialist, that petitioner visited on April 20, 2014 in Nicaragua; however, the medical report does not address the length of her disability. Petitioner requested the respondent to consider the medical record submitted at the hearing. On November 3, 2014, petitioner filed for Social Security Disability.

10. Respondent explained the time standard for Medicaid Assistance review has been exceeded. The respondent encouraged the petitioner to submit a new application.

CONCLUSIONS OF LAW

11. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 120.80. This order is the final administrative decision of the Department of Children and Families under Fla. Stat. § 409.285.

12. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

13. The burden of proof was assigned to the petitioner pursuant to Fla. Admin. Code R. 65-2.060(1).

14. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for SSI-Related Medicaid Coverage Groups. The MEDS-AD Demonstration Waiver is a coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m). For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states in part:

> (a) The law defines disability as the inability to do 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 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see § 416.960(b)) or any other substantial gainful work that exists in the national economy.

15. Federal Regulation 42 C.F.R. § 435.541 provides that a state Medicaid determination of disability must be in accordance with the requirements for evaluating evidence under the SSI program specified in 20 C.F.R. §§ 416.901 through 416.998.

> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
> ...
> (c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:
> ...
> (e) Medical and nonmedical evidence. The agency must obtain a medical report and other nonmedical evidence for individuals applying for Medicaid on the basis of disability. The medical report and nonmedical evidence must include diagnosis and other information in accordance with the requirements for evidence applicable to disability determinations under the SSI program specified in 20 CFR part 416, subpart I.
>
> (f) Disability review teams—(1) Function. A review team must review the medical report and other evidence required under paragraph (e) of this section and determine on behalf of the agency whether the individual's condition meets the definition of disability.

16. In evaluating the first step, it was determined petitioner is not engaging in SGA. The first step is considered met. In evaluating the second step, it was determined petitioner's physical impairments are considered met. It is the DDD testimony; they could not proceed with step three, due to insufficient medical records not provided.

17. Fla. Admin. Code R. 65A-1.205 addresses the eligibility determination process and states in relevant part:

> (a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter.
> (b) Time standards for processing applications vary by public assistance program in accordance with 7 C.F.R. § 273.2(g), 45 C.F.R. § 206.10(a)(3)(i) and 42 C.F.R. § 435.911. For Food Assistance and Cash Assistance Programs, time standards begin the date following the date the application was filed and end on the date the Department makes benefits available or mails a notice concerning eligibility. For the Medicaid Program, the time standard ends on the date the Department mails an eligibility notice. The Department must process and determine eligibility within the following time frames:...
> All days counted after the date of application are calendar days. Applicant delay days do not count in determining compliance with the time standard. The Department uses information provided on the Screening for Expedited Medicaid Appointments form, CF-ES 2930, 04/2007, incorporated by reference, to expedite processing of Medicaid disability-related applications.
> (c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification...the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later.
> (d) In accordance with 42 C.F.R. § 435.911, unusual circumstances that might affect the timely processing of Medicaid applications include applicant delay, physician delay and emergency delay as defined below. Unusual circumstances are non-agency processing delays, and the calendar time passing during such delay(s) does not count as part of the 90-day time standard for determining the timeliness of Medicaid eligibility decisions based on disability.

18. The ACCESS Florida Program Policy Manual at 0640.0104, Expedited Service for Disability-Related Medicaid (MSSI, SFP) further explains:

> Screen applications for disability related Medicaid to see if an expedited interview is necessary. Provide eligible AGs expedited services regardless of whether or not they are requested.
> Individuals or families are entitled to expedited services if an AG member is:

1. under age 65 and claiming a disability; and
2. not currently receiving SSI or SSDI benefits from the Social Security
Administration (SSA); and
3. not applying for Nursing Home coverage.

This expedited service does not apply to waiver, Hospice groups, or ICP (non DDD) cases.
Provide the individual a copy of the Screening for Expedited Medicaid Appointments form. Inform the individual that the Department uses all recorded information to determine eligibility for an expedited interview. Provide individuals eligible for expedited services with a notice of the time and date of the scheduled interview.
Schedule an interview for an expedited applicant within three working days; conduct an interview and complete the disability packet within seven calendar days of the date of application. If the application is dropped off or mailed, contact the household by phone to tell them of the scheduled appointment, and mail a follow-up appointment notice. If unable to reach the applicant by phone, schedule the appointment five to seven calendar days from the application date.
Provide individuals with a brochure titled Notice of Disability Information and Request Form. The brochure includes a list of the information the individual will need to bring to the interview to complete the disability forms used by the Division of Disability Determinations to determine whether the applicant is disabled. The date of the scheduled interview is the verification due date for these households. The notice/brochure will also advise the individual that failure to show for the interview or to bring the requested information to the interview may delay application processing. Document the date the applicant receives the notice/brochure.

19. The above-cited authorities set forth the rules for processing applications and determining eligibility in the Medicaid Program. It is the petitioner's testimony she confirmed to receiving the two notices send from DDD needing more information. The time standard for Medicaid Assistance application had been exceeded and a decision was required to be rendered.

20. After careful review of the evidence and the controlling legal authorities provided, the undersigned concludes the Department's action in this matter was proper.

DECISION

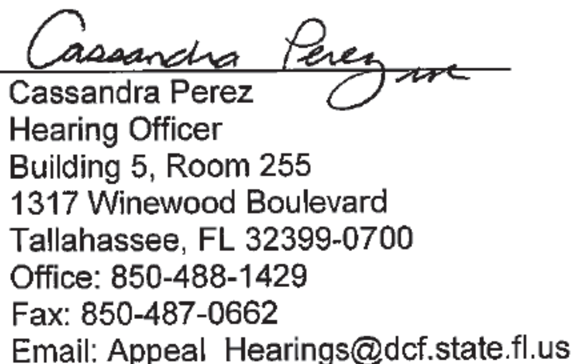
Based upon the foregoing Findings of Fact and Conclusions of Law, the Petitioner's appeal is hereby denied and Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 2nd day of February, 2015,

in Tallahassee, Florida.



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