

**FILED**

**JUN 30 2014**

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

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DEPT OF CHILDREN & FAMILIES



APPEAL NO. 14F-02678

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT OF  
CHILDREN AND FAMILIES  
CIRCUIT: 07 Flagler  
UNIT: 88317

RESPONDENT.

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 22, 2014 at 11:34 a.m.

**APPEARANCES**

For the Petitioner: The petitioner was present and represented herself.

For the Respondent: Frank Ciotti, Economic Self-Sufficiency Specialist II for the Department of Children and Families (DCF).

**STATEMENT OF ISSUE**

The petitioner is appealing the Department's action on March 19, 2014 to deny her SSI-Related Medicaid application as she did not meet the disability requirement.

**PRELIMINARY STATEMENT**

Appearing as a witness for the petitioner was Roxanne Berroyer, patient advocate for Florida Hospital.

The record was held open until 5:00 p.m. on June 2, 2014 to allow the petitioner and the respondent to submit additional evidence. Evidence was received and entered as the Respondent Exhibit 4 and the Petitioner Exhibits 1-3.

### **FINDINGS OF FACT**

1. The petitioner (age 52) filed an application for SSI-Related Medicaid on February 21, 2014 with assistance from the patient advocate from Florida Hospital.
2. The Division of Disability Determination (DDD) interview was conducted with the petitioner on March 4, 2014. The petitioner's disability information was forwarded to the DDD on the same date. The DDD determined that the petitioner was not considered disabled due to the SSA denial of her disability claim. The Department denied the petitioner's Medicaid application based on the SSA denial of her disability claim with code N35 on March 19, 2014. The Department explained that code N35 means "Non-pay-Impairment is severe at time of adjudication but not expected to last twelve months, no visual impairment." (Respondent Exhibit 4)
3. The petitioner and her witness do not agree with the Department's denial of her SSI-Related Medicaid application because she received a diagnosis of ovarian cancer. The petitioner and her witness believes that her application for SSI-Related Medicaid was denied because the Department did not forward all of her medical documentation to the Social Security Administration (SSA) for it to review her claim for disability. The petitioner argues that it is not her fault that the Department did not forward her medical documentation to Tallahassee. The petitioner's witness was surprised at the SSI-Related Medicaid denial. The petitioner's witness believes that the

petitioner should have automatically been approved for SSI-Related Medicaid because her condition meets the criteria of one of the twelve medical conditions recognized by the SSA that would allow the Department to automatically approve her for SSI-Related Medicaid benefits.

4. The petitioner's witness provided a letter signed by the petitioner's physician who opined that her medical condition is expected to last 12 months or longer (Petitioner Exhibit 2, page 12 of 48). The petitioner's witness contends that she contacted the Department after receiving notification of the denial and spoke with a supervisor who reviewed the denial by SSA. The petitioner's witness contends that the supervisor informed her that the reason for the denial was because it adopted the SSA denial decision. The petitioner's witness believes if the Department had forwarded the petitioner's medical records to SSA, her disability claim would have been approved. The petitioner's witness argues that the hospital scanned the petitioner's medical records to the Department, which was supposed to forward the document to the Department of Health and forward the documents to SSA.

5. The petitioner's witness argues that the petitioner did everything she needed to do and that someone within the Department failed to submit the medical documents to SSA. The petitioner's witness believes that the SSA denial code 35 means the claim was denied due to no medical records. The petitioner's witness argues that the Florida Hospital and Jacksonville Memorial Hospital has a contract with the Department and that the hospitals have a specialized unit that handles all of the hospital's SSI-Related Medicaid applications and forwards all medical records to the Department of Health.

The petitioner's witness argues that she is one of seven patient advocates and they do not send the medical records to SSA; it is the Department's responsibility.

6. The petitioner applied for Social Security disability on January 23, 2014. The petitioner believes that her medical condition of ovarian cancer was reviewed by the SSA. She acknowledges that her condition has not worsened. The petitioner and petitioner's witness is not sure if an appeal was filed for the SSA denial.

7. The Department explained that there are two different processes when applying for disability. The Department explained that each applicant applying for disability is required to apply for Social Security disability benefits through the federal government and may also apply for SSI-Related Medicaid for a temporary disability determination while the disability claim is reviewed by SSA; it is a separate process.

8. The Department explained that it is the applicant's responsibility to send the medical records to SSA when filing for disability. The Department explained that N35 denial code means that the claim was denied due to a severe impairment not expected to last for 12 months. The petitioner may appeal the SSA denial, especially if her condition has changed and is expected to last 12 months or more. The Department may approve SSI-Related Medicaid temporarily based on the medical records sent by an applicant as long as SSA has not yet made a decision on an applicant's disability claim. The Department's position is that it is required to adopt SSA's decision if made within one year of an application for SSI-Related Medicaid and cannot make an independent disability decision.

**CONCLUSIONS OF LAW**

9. 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 § 409.285. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

10. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

11. In accordance with Fla. Admin. Code § 65-2.060 (1), the burden of proof was assigned to the petitioner.

12. Fla. Admin. Code, Section 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, 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...

13. Additionally, the controlling federal authority at 42 C.F.R. § 435.541

**Determination of Disability**, states:

(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...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under 435.909.

(b) *Effect of SSA determinations.*

(1)...

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c) (4) of this section.

(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...

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and-

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirement of the Act, and - ...

14. The above federal regulation indicates that the Department **may not** make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application. The regulation also states that the Department **must** make a determination of disability if the individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA and alleges a disabling condition

different from, or in addition to, that considered by SSA in making its determination or alleges more than 12 months after the most recent SSA determination. The Department is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA. There was no such evidence in this case.

15. The Department's ACCESS Florida Program Policy Manual, 165-22, section 1440.1204 Blindness/Disability Determinations (MSSI, SFP), states in part:

If the individual has not received a disability decision from SSA, a blindness/disability application must be submitted to the Division of Disability Determinations (DDD) for individuals under age 65 who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien Programs. State disability determinations for disability-related Medicaid applications must be done for all applicants with pending Title II or Title XVI claims unless SSA has denied their disability within the past year. If SSA has denied disability within the past year and the decision is under appeal with SSA, do not consider the case as pending. Use the decision SSA has already rendered. The SSA denial stands while the case is pending appeal. When the individual files an application within 12 months after the last unfavorable disability determination by SSA and provides evidence of a new condition not previously considered by SSA, the state must conduct an independent disability determination. Request a copy of the SSA denial letter. The SSA denial letter contains an explanation of all the conditions considered and the reason for denial.

16. The above authority explains that a disability application must be sent to the DDD to be reviewed for applicants who are under the age of 65, who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien programs. However, if SSA has denied disability within the past year, the SSA decision is to be adopted. If the individual applies for Medicaid within one

year of an SSA denial and provides evidence of a new disabling condition that was not considered by SSA, the Department must make an independent disability decision.

17. In this case, the petitioner is under age 65 and has ovarian cancer for which she needs medical treatment. The petitioner and her witness argue that the Department did not submit medical records to SSA and believes this is the reason her disability claim was denied, causing the Department to have to deny her SSI-Related Medicaid application. The findings show that the petitioner's medical condition of ovarian cancer was reviewed in the SSA decision but her disability claim was denied on March 19, 2014 due to her severe medical condition not expected to last more than 12 months.

18. The undersigned concludes that the petitioner did not meet his burden of proof to show that the Department's action was incorrect. The undersigned concludes that the respondent was correct to adopt the SSA disability denial from March 19, 2014 (within 12 months of the Medicaid application denial with the Department) which resulted in the Medicaid denial).

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

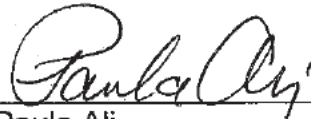


**NOTICE OF RIGHT TO APPEAL**

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 30<sup>th</sup> day of June, 2014,

in Tallahassee, Florida.



Paula Ali  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
Office: 850-488-1429  
Fax: 850-487-0662  
Email: Appeal\_Hearings@dcf.state.fl.us

Copies Furnished To: [REDACTED] Petitioner  
ACCESS Circuit 7 - Lynn Dann