STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 9848
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals the decision of the Department of Social Welfare denying her application for ANFC-Incapacity related Medicaid coverage based upon a finding that she is not disabled.

FINDINGS OF FACT

1. The petitioner is a thirty-eight-year-old woman who lives with her four children and her husband who is a farmer. She has a high school education and has worked as a homemaker for close to twenty years.

2. Some six or seven years ago, during her last pregnancy, the petitioner was determined by the Department to be disabled and was found eligible for Medicaid through the ANFC incapacity program. Although no records of the basis for this initial finding were presented by the petitioner, she claims that it was based on arthritis, urinary tract infection and kidney malfunctioning.

3. The petitioner continued to receive Medicaid for two or three more years until it was determined that she no longer met financial criteria for the program.

4. In 1988, she reapplied again for Medicaid, and was

initially determined to be ineligible. That decision was, however, reversed by the Department after she appealed.

5. Medical records, including reports of her physician and physical therapist, filed in support of her 1988 application indicate that the petitioner was suffering from migraine headaches, kidney malfunctioning, low back pain due to scoliosis and significant swelling and pain in her joints. Largely due to these latter two problems, the petitioner was determined to be unable to lift weights over five pounds, sit, stand or walk more than 1-2 hours per day, push or pull arm controls, squat, bend, crawl, or reach without pain, and climb more than twenty steps. With regard to her scoliotic condition, it was noted by her physician that there had been "no substantial change and there is no change expected in the underlying process."

6. The petitioner was again terminated from Medicaid for financial reasons (a small inheritance) but reapplied on March 28, 1990. At that time she was asked to have her doctor fill out a medical report. Because her doctor had recently retired, she asked a doctor who was familiar with some of her records, but who had not treated her, to prepare the report. She also filed a "social report" informing the Department that she still had considerable trouble lifting, carrying, walking and sitting, and that she needed to rest frequently during the day.

7. The doctor's report filed by the petitioner stated that she suffered from a long history of renal disease,

including a non-functioning left kidney, multiple arthralgias (in the neck, knees, etc.), and overweight. The physician did not conduct a full exam and found no acute joint inflammation or abdominal abnormalities. A urinalysis he performed showed protein in the urine, but was otherwise normal. He concluded that the petitioner continued to suffer from a non-functioning left kidney and multiple arthralgias but stated he was unable to make any assessment involving her ability to work. He also stated that her response to current therapy is "static".

8. On the basis of the report filed by the petitioner, the Department denied her application because there was "no evidence of medical disability". The petitioner appealed that decision.

9. The petitioner testified at hearing that she continues to suffer the restrictions detailed in her prior medical reports and is, in fact, somewhat worse. Due to kidney malfunctioning and swollen painful joints, she is unable to sit or stand for more than an hour or two. Her back problems still prevent her from lifting heavy objects. She is assisted in most of her household chores (cleaning, shopping and meal preparations) by her two adolescent children, but still must lie down to rest 3-5 hours during the day. When her remaining operative kidney malfunctions, she must stay in bed for 2-3 days until her swelling subsides. She has followed the therapy prescribed by her doctor, mainly rest, avoidance of pain exacerbating

movement and medication, with no evidence of improvement. Feldene, an anti-inflammatory prescribed for her joint pain and swelling, had to be stopped because it interfered with her kidney functioning. Physical therapy sessions loosened up her joints somewhat but did not relieve the pain. Her current treatment regime consists of hot baths and Ibuprofen. The petitioner's testimony is found to be credible, based not only on her obvious sincerity, but also because it is consistent with the 1988 detailed medical reports.

ORDER

The Department's decision is reversed.

REASONS

The issue in this application for Medicaid is whether the petitioner has met her burden of showing that her condition falls within the definition of "incapacitated" in the ANFC statute. "Physical or Mental Incapacity" is defined by the regulations, in pertinent part, as follows:

> A child is deprived of "parental support" when a parent is unable, due to his or her physical or mental condition, to maintain his or her earning capacity for a period of not less than 30 days from the date of application. If an applicant for ANFC Incapacity works 35 hours or more per week he or she is not eligible on the basis of incapacity.
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> . . .
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> A parent may also be found incapacitated if unable to perform the duties of a homemaker due to the incapacity. Incapacity of a homemaker is considered "deprivation of parental care" when one's physical or mental condition prevents one from performing essential homemaking activities, such as physical care of the home and children, for a period of not less

> than 30 days. Provisions for substitute care by another person in the home under the homemaker's supervision may be involved, although this is not required to establish incapacity.
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> Applicants who have been determined to be "disabled" by the Social Security Disability Determination Unit will meet the incapacity criteria for ANFC.
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The regulations further provide a method for this determination:

> 2332.1 Method of Determination
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> Physical or mental incapacity, as defined, requires professional medical determination based on a physician's report or other adequate written medical information which includes a diagnosis of physical or mental disability which may reasonably be expected to continue for 30 days or longer. The District Office shall inform the applicant of the method and procedures for establishing incapacity and refer the applicant to the Incapacity Examiner for follow up action and decision.
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> The reasonable charge for medical examination(s) required to render a decision on incapacity shall be paid from administrative funds.
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> When an incapacitated recipient's prognosis indicates a need for review of continuing incapacity at specified future interval(s), the Income Maintenance Specialist is responsible for following up, gathering current information and transmitting this material to the Incapacity Examiner so that it can render a decision in accordance with the same initial procedures used in the determination. Whenever Department personnel observe or otherwise become aware of a significant change in an incapacitated recipient's condition, referral shall be made to the Incapacity Examiner for follow-up and/or re-determination of eligibility based on incapacity.

The petitioner argues that the medical reports contemplated by the regulations in this matter were already on file from her prior applications and, as her doctor in 1988 had said no change was expected in the underlying process and the new report she filed confirmed the

continuation of her diagnosis, she should have been found eligible on these documents alone. She objects to what she perceives as a re-evaluation of the same evidence with a different result.

The Department denies that it is re-evaluating the same evidence and argues that the petitioner failed on this application to provide the Department with sufficient information to find that her prior incapacitating condition continues or has worsened. The Department maintains that had the petitioner provided a statement from her treating doctor that both her diagnosis and functional limitations, as outlined in prior medical reports, continued or had worsened, she would have been found to have met her burden. Following her testimony at the hearing, the Department offered, in fact, to obtain a new report which might address its concerns.

There appears to be no disagreement between the parties with the principle that the Department is bound by its own prior determination that a condition is incapacitating if the applicable law and medical facts remain the same.[1] The crucial question in this matter is whether the petitioner showed that the medical facts remain the same, and whether the Department met its obligations with regard to assisting her in developing this evidence.

It must be concluded that the petitioner's medical report fell somewhat short of meeting her burden in that it provided no information regarding the continuation of her

functional limitations. See Fair Hearing No. 8295. Unfortunately, the petitioner's customary physician was not asked, due to his retirement, to fill out this form and a new physician (chosen by the petitioner) who saw only some of the records and who briefly examined her could not provide information on her present ability to work, even to say as little as it remained "unchanged".[2] Such an assessment is important in a case such as this, because the petitioner does not suffer from medical ailments which are per se disabling, and her impairments (basically pain and swelling) are potentially amenable to treatment.[3] Therefore, the Department was not incorrect insofar as it determined that the medical evidence was inadequate for purposes of making a determination.

The action denying the application taken by the Department at that point, however, is certainly at odds with the evidence and regulations. The regulations provides as follows:

> 2332.3 Provisional Grant
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> When the Incapacity Examiner, or District Income Maintenance Supervisor, believe that a positive decision on incapacity is more probable than not because of the facts in the case, but further medical documentation is required to render a decision, a provisional grant of assistance may be authorized by the District Income Maintenance Director until it is possible for the Incapacity Examiner to render a decision.
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> Notice to the applicant of a decision to grant assistance provisionally shall clearly specify the reason for and terms of such provisional grant (see also Notice of Decision - Money Grants).

In addition to the new incomplete medical report, the evidence the Department had at the time of the petitioner's application consisted of all the detailed limitations contained in the 1988 reports, its prior decisions finding incapacity, and the petitioner's current written statements that she continued to have restrictions on lifting, carrying, walking, sitting, and needed frequent rest. Based on all this information, the only reasonable course open to the Department under its own regulations, was to find it more probable than not that the petitioner continued to be disabled and to provisionally grant her application while confirmation of the continuing restrictions were sought, either from a medical examiner or through further documentation or conversations with the petitioner.[4]

At this juncture, this matter could be remanded to the Department with an order to provisionally grant the application while confirmation of her continuing restrictions is made through a medical report. However, given the fact that the petitioner now has no long-standing treating physician who can give an independently observed assessment of her functioning and as the petitioner herself gave detailed and credible testimony regarding her own restrictions, (and who should know better than she?), it should be found that the petitioner has now met her burden under the regulations of showing that her medical facts have not changed since her prior determination of

eligibility.

FOOTNOTES

[1]The Department may, of course, reject a prior determination if it proves it was based on fraud, mistake or the like.

[2]The physician checking the "static" box in response to the question "How is the patient responding to the current therapy?" does not address the question of whether her ability to function has improved since 1988.

[3]The petitioner's treating physician's statement that the underlying process of scoliosis probably would not change does not dispose of the issue of the limiting conditions she may have at any given time due to that problem and/or a continuation of other problems.

[4]There is no reason under its regulations why the Department could not accept the petitioner's own detailed statements as to her functional ability as evidence in this matter if it had reason to believe her. The regulations require only "adequate written information" in addition to a diagnosis (which presumably must be written by a physician). Medical evidence is by no means the only form of evidence acceptable under the regulations. See Fair Hearing No. 8295.

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