STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

October 3, 1991

TO: All County Welfare Directors
All County Administrative Officers
Medi-Cal Specialists/Liaisons

Letter No.: 91-83

SUBJECT: IMPLEMENTATION OF THE 1990 DISABILITY REGULATIONS AND THE RADCLIFFE AND HARRIS V. LOPEZ, ET AL. SETTLEMENT

The purpose of this All County Welfare Directors' Letter (ACWDL) is to provide information and instructions to counties regarding changes required by the new federal disability regulations and the negotiated settlement in the Radcliffe and Harris, v. Lopez, et al. (Radcliffe) lawsuit. No new actions are being required of the county welfare departments with this letter.

Background

The Department of Social Services (DSS), Disability Evaluation Division (DED), State Programs, makes disability determinations for applicants who file for Medically-Needy Medi-Cal under Title XIX of the Social Security Act. Federal Medicaid regulations call for using essentially the same process to determine the eligibility as those used in Supplemental Security Income (SSI) Title XVI of the Social Security Act and Social Security Title II benefits based on disability. Because applicants may apply for Medi-Cal, SSI and/or Social Security Title II disability benefits at or about the same time, methods have been developed by the federal and state programs to reduce duplicate development and subsequent costs. This is known as the duplicate development process. Recently, this process and other program aspects have been impacted by the Radcliffe lawsuit and the adoption of new federal regulations.

1990 Disability Regulations:

In December 1989, final Federal disability regulations were adopted by Health Care Financing Administration (HCFA). These regulations, which are known as the 1990 Disability Regulations, amended parts 435 and 436, Title 42 of the Code of Federal Regulations (CFR) and were effective January 10, 1990. The new regulations make the following changes:

1. The regulations extend the time limit for making eligibility determinations based on disability from 60 to 90 days. Section 50177 of Title 22 of the California Code of Regulations (CCR) has been amended to reflect the extension of the eligibility determination time limit from 60 to 90 days.

   a. The time limit was extended in order to reduce the number of Medi-Cal applications for which DED must make a determination without the benefit of a Social Security Administration (SSA) disability determination.

2. The regulations clarify the controlling nature of federal SSA disability determinations.

   a. When SSA or SSI disability applications and disability based Medi-Cal applications are filed on or about the same time, DED must adopt the SSA disability decision which is rendered within 90 days of the Medi-Cal application date.

   b. A SSA disability decision has a binding prospective effect on a Medi-Cal disability determination. If SSA makes a decision which is different from one already made by DED, the SSA disability decision supersedes the DED determination. For example, in a duplicate development process, there will be times when SSA is unable to make a disability decision within a 90 day period and it becomes necessary for DED to initiate independent development. If this occurs and DED makes a favorable disability determination, but later SSA makes an unfavorable decision on this same case, Medi-Cal must adopt the SSA decision. The applicant must appeal through SSA if he/she is dissatisfied with the decision.

   c. DED must adopt a federal disability decision made <u>within 12 months</u> of the Medi-Cal application date unless the applicant alleges additional and/or different disabling conditions from those originally claimed.

3. The regulations specify when DED must make independent disability determinations.

   a. If the federal disability decision is issued within 90 days of the Medi-Cal application date, or prior to DED rendering its independent decision, DED must adopt that decision. DED will be required to initiate independent development in an effort to render independent decisions within 90 days on all duplicate development cases, where the federal disability decision will not be issued within the same 90 day period.

   b. DED will be required to make independent decisions on all applications for disability based Medi-Cal where an individual applies for Medi-Cal as a medically needy person <u>more than 12 months</u> after a final federal disability determination that the individual was not disabled and where the individual alleges that his or her condition has changed or deteriorated since that final determination and where the individual has not reapplied for SSA (Title II) or SSI (Title XVI) disability benefits on the basis of these new allegations.

c. DED will be required to make independent decisions on all applications for disability based Medi-Cal where, even though 12 months has not lapsed since issuance of a final disability based SSA decision, the applicant alleges a disabling condition which is different from or in addition to those alleged as a basis for the SSA application. (See further discussion under "Consideration of New and Material Evidence and Allegations of Additional and/or Different Disabling Conditions ")

Consideration of New and Material Evidence And Allegations of Additional and/or Different Disabling Conditions:

Under the 1990 Disability Regulations, DED will be required to make independent decisions on all disability based Medi-Cal applications where an applicant alleges a changed or deteriorated condition more than 12 months after a previous SSA disability denial determination of his or her claim. Any allegations of deterioration of the condition for which SSA made a determination that is filed less than 12 months after the most recent SSA determination must be resubmitted to SSA for reconsideration or reopening.

However, where a disability based Medi-Cal application alleges disabling condition(s) which are in addition to or different from those alleged as the basis for a previously denied SSA disability based application, DED will be required to make an independent decision within 90 days of the date of application even though 12 months may not have passed since the most recent SSA determination.

To implement the changes necessitated by the new regulations and to reduce the number of referrals to DED that will need to be returned to a county, modifications to form MC 223, Applicant's Supplemental Statement of Facts for Medi-Cal, were necessary. The modified MC 223 will be released soon. When the MC 223 is released, information will be sent explaining the modifications and the date the form should begin to be used. (A copy of the modified MC 223 is enclosed.) Until the modified form is released, the current MC 223 should be used and existing procedure should be followed.

The Radcliffe Case:

Radcliffe was filed by San Francisco Neighborhood Legal Assistance Foundation prior to the enactment of the 1990 Disability Regulations. The plaintiff alleged that the independent disability determination process has taken longer than the law allowed. The plaintiff made two demands: (1) that independent disability determinations be made within the time limit required by law (60 days at the time the lawsuit was filed, now 90 days because of the

newly enacted federal regulations); and (2) that a status letter be sent to an applicant whose disability determination will not be decided within 90 days from the date an applicant applied as a blind or disabled, medically needy, individual.

Under the settlement agreement entered into with the plaintiff, the DED analysts are responsible for sending the status letter (enclosed) as required on those cases which were received prior to the 90th day from application date where a decision will not be rendered within that 90 day period. The letter provides the reason(s) for the delay and the name and telephone number of the disability evaluation analyst whom the applicant should contact if they require additional information on the status of their Medi-Cal application. The telephone number for filing an appeal of an application exceeding 90 days is also provided on the status letter.

In order for the DED analyst to make a disability decision or send a status letter within 90 days, it is imperative that counties adhere to Title 22, Section 50167, of the California Code of Regulations (CCR), which requires counties to forward all completed disability packets to DED no later than 10 days after the receipt of the MC 210 or other applicant/beneficiary's statement of disability as received by the county, unless the county is unable to comply with this requirement due to circumstances beyond the county's control pursuant to Medi-Cal Eligibility Procedures section 50167, page 4A-3.

In order to determine whether the counties are complying with their obligation under Title 22, CCR, Section 50167, DED identified, during the first three months of implementation of the Radcliffe settlement, those cases which were not timely referred by a county. After this information is compiled and evaluated, it may be decided that a county shall be responsible for mailing a status letter to the applicant on cases not referred to DED in a timely manner. IT IS EXTREMELY IMPORTANT THAT A COUNTY ACT TO FORWARD DISABILITY PACKETS IN A TIMELY MANNER TO MEET THE LEGAL REQUIREMENTS FOR TIMELY PROCESSING OF THESE CLAIMS.

Summary of Impact of the 1990 Disability Regulations and the Radcliffe Settlement On County Operations

The adoption of the 1990 Disability Regulations and the implementation of the Radcliffe settlement will impact the county operations as follows:

1. All disability based Medi-Cal applications, either filed by themselves or in conjunction with a SSA disability application, will receive either an initial eligibility decision within 90 days or the applicant will be provided with a status letter on approximately the 90th day explaining the reason(s) for delay.

2. A county eligibility worker must accept and process, in a timely manner, disability based Medi-Cal applications even if filed less than 12 months after the most recent SSA disability decision, where the applicant(s) alleges an additional or different disabling condition for disability.

3. A county eligibility worker must refer an applicant for disability based Medi-Cal back to SSA when the applicant alleges a deterioration of a condition for which SSA made a determination and the application is filed less than 12 months after the most recent SSA decision. Form MC 223 was modified to clarify the necessary information to be obtained. It will be released soon. The current form and procedure should be used until that time.

4. A county must adhere to the requirement that a complete disability packet be sent to DED within 10 days from the date of the receipt of the MC 210 or other applicant/beneficiary's statement of disability as received by the county (see exception to this requirement under Medi-Cal Eligibility Manual Procedures section 50167, page 4A-3).

5. If it is determined that substantial numbers of cases are not being referred to DED in a timely manner, a county may be required to send a status letter to an applicant to inform him or her about the delay.

As further changes occur, we will provide you with additional instructions. If you have any questions on this issue, please call Marie Taketa of my staff at (916) 657-1250/ATSS 437-1250.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

PPLICANT'S SUPPLEMENTAL STATEMENT OF FACTS OR MEDI-CAL

J Original to DED

COUNTY USE ONLY		
County	Aid	Case Number

ART 1 – PERSONAL AND MEDICAL INFORMATION

1. First, Middle, and Last Name

2. Home Address	City	ZIP Code
3. Mailing Address	City	ZIP Code

3. Phone Number ( )	CHECK IF: ☐ no phone ☐ message phone	4. Date of Birth	5. Social Security Number	6. Height	Weight

7. Do you speak English? YES ☐ NO ☐	8. If NO, what language do you speak?	9. Do you have a translator?
10. Translator's Name:	Translator's Phone Number:	Best time to call translator:

11. Have you applied for Social Security or Supplemental Security Income (SSI) disability benefits in the past 2 years? YES ☐ NO ☐
IF YES, PLEASE ANSWER THE FOLLOWING:

A. Was your Social Security or SSI application allowed or denied? Allowed ☐ Denied ☐ Unknown/pending ☐

B. Date of most recent decision on your Social Security or SSI application: _____

C. Has your medical problem(s) worsened since your last decision? YES ☐ NO ☐
IF YES, please explain _____

D. Do you have any new medical problem(s) which you did not have when the last decision on your Social Security/SSI application was made? YES ☐ NO ☐
IF YES, what medical problem(s) _____

12. List all medical problems (physical or mental) that keep you from working or limit your daily activities, and give the date that each of these problems first began to bother you:

Type of medical problem:	Beginning Date (month/year)

13. Describe how your medical problem(s) affect your ability to work or limit your activities (such as sitting, standing, walking, lifting, bending, reaching, etc.)

14. Did you have to stop working because of your medical problem(s)? YES ☐ NO ☐
IF YES, what is the date you had to stop working? _____

. Have you had any of the following tests in the last 12 months:

Test	Check Appropriate Block or Blocks		If "Yes", Show	
	Yes	No	WHERE DONE: (clinic, lab, hospital, doctor)	WHEN DONE: month-year
ectrocardiogram (EKG)				
eadmill (exercise heart test)				
iest X-ray				
her X-ray (Name the body part ire: _____)				
eathing Tests (PFT)				
ood Tests				
her (Specify: _____)				

OTE: Be sure to include the names and addresses of any offices, clinics, labs, or hospitals noted above in Section 16 or 17 of this form.

5A. IDENTIFY BELOW ALL DOCTORS WHO HAVE SEEN OR TREATED YOU FOR YOUR MEDICAL PROBLEM(S) IN THE PAST 12 MONTHS:

If you have not been treated in the past 12 months, check here: ☐

AME:	ADDRESS		
	number	street	suite#
LEPHONE NUMBER (include area code))	city	state	zip code

HOW OFTEN DO YOU SEE THIS DOCTOR?	DATE FIRST SEEN?	DATE LAST SEEN?

EASONS FOR VISITS (show illness or injury for which you had an examination/treatment)

YPE OF TREATMENT OR MEDICINES RECEIVED (such as surgery, chemotherapy, radiation, and the medicines you take for your illness injury, if known. If no treatment or medicines, write "NONE".)

3. IDENTIFY BELOW ANY OTHER doctor you have seen since your illness or injury began:

AME:	ADDRESS		
	number	street	suite#
LEPHONE NUMBER (include area code))	city	state	zip code

HOW OFTEN DO YOU SEE THIS DOCTOR?	DATE FIRST SEEN?	DATE LAST SEEN?

EASONS FOR VISITS (show illness or injury for which you had an examination/treatment)

YPE OF TREATMENT OR MEDICINES RECEIVED (such as surgery, chemotherapy, radiation, and the medicines you take for your illness injury, if known. If no treatment or medicines, write "NONE".)

3C. IDENTIFY BELOW ANY OTHER DOCTOR YOU HAVE SEEN SINCE YOUR ILLNESS OR INJURY BEGAN:

AME:	ADDRESS number / street / suite#
' EPHONE NUMBER (include area code) ( )	city / state / zip code

HOW OFTEN DO YOU SEE THIS DOCTOR?	DATE FIRST SEEN?	DATE LAST SEEN?

EASONS FOR VISITS (show illness or injury for which you had an examination/treatment)

/PE OF TREATMENT OR MEDICINES RECEIVED (such as surgery, chemotherapy, radiation, and the medicines you take for your illness injury, if known. If no treatment or medicines, write "NONE".)

OTE: IF YOU HAVE SEEN OTHER DOCTORS SINCE YOUR ILLNESS OR INJURY BEGAN, LIST THEIR NAMES, ADDRESSES, DATES AND REASONS FOR VISITS ON AN ATTACHED SHEET OF PAPER.

'. Have you been hospitalized or treated at a clinic for your illness or injury? YES ☐ NO ☐
If YES, show the following:

Name of hospital or clinic:	Address number / street / suite#
tient or clinic number:	city / state / zip code
ere you an inpatient (stayed overnight)? YES ☐ NO ☐ If "YES", SHOW DATES →	Dates of Admissions / Dates of Discharges
ere you an outpatient? YES ☐ NO ☐ If "YES", SHOW DATES →	Dates of visits

on for hospitalization or clinic visits:

pe of treatment received:

Name of hospital or clinic:	Address number / street / suite#
tient or clinic number:	city / state / zip code
ere you an inpatient (stayed overnight)? YES ☐ NO ☐ If "YES", SHOW DATES →	Dates of Admissions / Dates of Discharges
ere you an outpatient? YES ☐ NO ☐ If "YES", SHOW DATES →	Dates of visits

eason for hospitalization or clinic visits:

pe of treatment received:

. IS THERE ANYONE ELSE (a friend, relative, social worker, etc.) we may contact for more information about your illness or injury and how it limits your daily activities or keeps you from working?

If so, please list below:

NAME	ADDRESS	PHONE NUMBER	RELATIONSHIP TO YOU

Social and Educational Information:

Describe your daily activities in the following areas and state how much you do and how often.

A. HOUSEWORK (including cooking, cleaning, shopping, and odd jobs around the house and other similar activities):

_____

_____

_____

B. RECREATION AND HOBBIES (gardening, hiking, sewing, bowling, reading, fishing, musical interests, etc.):

_____

_____

_____

C. SOCIAL ACTIVITIES (visits with relatives, friends, neighbors, etc. Include phone contacts as well as personal visits.):

_____

_____

_____

D. MEANS OF TRANSPORTATION (drive car, ride bus, motorcycle, walk, ride with someone else, etc.):

_____

_____

E. What is the highest grade you completed in school? _____

F. I completed school in 19_____.

G. I passed the GED in 19_____.

☐ I have NOT worked in the last 15 years. Sign below.

☐ I have worked in the last 15 years. Sign below AND COMPLETE PART 2 OF THIS FORM.

ave completed this form correctly and truthfully to the best of my knowledge and abilities.

_____ _____

SIGNATURE DATE

_____ _____ _____

AUTHORIZED REPRESENTATIVE (if applicable) TITLE TELEPHONE

)MPLETED WITH
SISTANCE OF: _____ _____ _____

NAME TITLE OR RELATIONSHIP TELEPHONE

ART 2 – VOCATIONAL INFORMATION

PLICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL
end Original to DED

irst , Middle, and Last Name	2. Social Security Number

I have worked in the last 15 years. This is a description of all the jobs I have done for at least 30 days during the last 15 years. I have started with my most recent job. (If you had more than two jobs, complete additional pages of this form.)

a. Job Title _____ Type of Business _____

Dates Worked (Month and Year) From _____ To _____

Hours Per Week _____ Rate of Pay _____ Per _____

DESCRIPTION OF THE JOB

This is what I did and how I did it.

These are the tools, machines, and equipment I used.

I took this long to learn the job _____ days or _____ months

I wrote, completed reports, or performed similar duties. ☐ Yes ☐ No

I had supervisory responsibilities. ☐ Yes ☐ No

PHYSICAL ACTIVITY

	Circle One								
I walked this many hours a day at work:	0	1	2	3	4	5	6	7	8
I stood this many hours a day at work:	0	1	2	3	4	5	6	7	8
I sat this many hours a day at work:	0	1	2	3	4	5	6	7	8

I climbed this much: ☐ never ☐ occasionally ☐ frequently ☐ constantly

I bent over this much: ☐ never ☐ occasionally ☐ frequently ☐ constantly

Heaviest weight I lifted:

☐ 10 lbs. ☐ 50 lbs.

☐ 20 lbs. ☐ Over 100 lbs.

Weight I often lifted/carried:

☐ Up to 10 lbs. ☐ Up to 50 lbs.

☐ Up to 25 lbs. ☐ Over 50 lbs.

Did you have any of your current medical problems when you performed this job? ☐ Yes ☐ No

If yes, name of medical problem(s) _____

If yes, did your employer make special arrangements (such as extra breaks, special equipment, change in job duties, etc.) so you could continue to work? ☐ Yes ☐ No

If yes, describe the special arrangements made _____

PLEASE COMPLETE REVERSE SIDE OF THIS PAGE.

b. Job Title _____ Type of Business _____

Dates Worked (Month and Year) From _____ To _____

Hours Per Week _____ Rate of Pay _____ Per _____

DESCRIPTION OF THE JOB

This is what I did and how I did it.

These are the tools, machines, and equipment I used.

I took this long to learn the job _____ days or _____ months

I wrote, completed reports, or performed similar duties. ☐ Yes ☐ No

I had supervisory responsibilities. ☐ Yes ☐ No

PHYSICAL ACTIVITY

	Circle One								
I walked this many hours a day at work:	0	1	2	3	4	5	6	7	8
I stood this many hours a day at work:	0	1	2	3	4	5	6	7	8
I sat this many hours a day at work:	0	1	2	3	4	5	6	7	8

I climbed this much: ☐ never ☐ occasionally ☐ frequently ☐ constantly

I bent over this much: ☐ never ☐ occasionally ☐ frequently ☐ constantly

Heaviest weight I lifted:

☐ 10 lbs. ☐ 50 lbs.

☐ 20 lbs. ☐ Over 100 lbs.

Weight I often lifted/carried:

☐ Up to 10 lbs. ☐ Up to 50 lbs.

☐ Up to 25 lbs. ☐ Over 50 lbs.

Did you have any of your current medical problems when you performed this job? ☐ Yes ☐ No

If yes, name of medical problem(s) _____

If yes, did your employer make special arrangements (such as extra breaks, special equipment, change in job duties, etc.) so you could continue to work? ☐ Yes ☐ No

If yes, describe: _____

CHECK ONE OF THE FOLLOWING:

☐ I have had other jobs in the last 15 years and have completed another page of vocational history.

☐ I have <u>not</u> had any other jobs in the last 15 years.

I have completed this form correctly and truthfully to the best of my knowledge and abilities.

ature | Date

DEPARTMENT OF SOCIAL SERVICES - DISABILITY EVALUATION DIVISION
STATE PROGRAMS BRANCH
P.O. Box 30541, Terminal Annex
Los Angeles, CA 90030

Dear Applicant:

Your application for Medi-Cal based on disability has been referred to us by your County Welfare Department.

Federal law requires that eligibility be determined within 90 days except where unusual circumstances exist. In your case, that is the situation.

This letter is to advise you that all of the information necessary to evaluate your medical condition and how it affects your ability to work has not yet been received.

We are awaiting the following information:

( ) results of your scheduled Consultative Examination
( ) copies of medical records
( ) copies of records from your Social Security or SSI disability application which have been requested from the office processing that application
( ) your response to our letter of _____
( ) other: _____

_____

If you would like additional information about the status of your Medi-Cal application, you may call me at (213) 965-1111. If you are in California, you may call station-to-station collect between the hours of 8:00 a.m. and 4:00 p.m.

You will be notified by your County Welfare Department when a final decision has been made regarding your claim.

Sincerely,

Disability Evaluation Analyst
Los Angeles State Programs

IF YOU ARE HEARING IMPAIRED USING T.D.D. YOU MAY CALL (213) 938-7252.

If you disagree with the reason for this delay, you may request an administrative hearing by calling toll free 1-800-952-5253 or for those who are hearing impaired and using T.D.D. call 1-800-952-8349.

Revised. EXHIBIT A