CATEGORICAL FACTORS

DISABILITY

The local or State Medicaid Disability Review Team evaluates the medical evidence, considering such factors as the individual's age, education, work experience and residual functional capacity to determine if the A/R is disabled. The Medicaid Disability Review Team completes the LDSS-639: "Disability Review Team Certificate" for each potentially disabled A/R. The LDSS-639 contains the determination and the regulatory basis for that determination. It documents any request(s) for additional medical and/or social information, the effective date of disability and expiration date of disability, if applicable. The entire disability determination process is completed within 90-days of the initial application/recertification. If the process takes more than 90 days, on the 90th day the A/R is sent a written statement giving the reason for the delay. When the disability process is completed, the A/R is given a written notice of the determination, the reasons for it and the regulatory basis. (See **OTHER ELIGIBILITY REQUIREMENTS** DECISION AND NOTIFICATION)

There are two categories of disability:

Group I includes persons who show no possibility of engaging in any substantial gainful work activity. They have a physical and/or mental impairment(s) which is disabling and considered irreversible. These cases have no disability end date on the LDSS-639 “Disability Review Team Certificate.”

Group II includes individuals who have disabling impairments at the time of determination, but are expected to show an improvement in physical and/or mental status, enabling them to become capable of substantial gainful activity. Some reasons for improvement are: the condition is arrested; a remission occurs; therapeutic advances occur; and/or rehabilitation.

NOTE: End dates for all Group II certifications must be tracked through WMS and medical evidence gathered for a continuing disability review prior to the Group II disability end date.

When an individual re-applies after previously being certified disabled, another disability review is not necessary if the disability end date has not yet expired, unless: 12 months or more have elapsed since the date of the last case closing, or the individual has in the interim engaged in a useful occupation, or has had a significant change in treatment such as surgery or rehabilitation.