CATEGORICAL FACTORS

BLINDNESS

(4) When the A/R indicates on the application that s/he is in receipt of Social Security Disability benefits or other disability pension benefits based on his/her visual impairment.

Verification Process: Verification of legal blindness for the purpose of establishing eligibility for Medicaid is certification from the Commission for the Blind and Visually Handicapped (CBVH). If the A/R is unable to provide his/her certification, the local district submits form LDSS-2353, "Eye Examination Clearance - Blind Applicant for Medicaid" to the Commission to determine if the A/R is registered. If the A/R is unknown to the Commission, a report of an eye examination by an ophthalmologist or an optometrist is submitted on the appropriate form (i.e., LDSS-3377 Rev. 2/82, Mandatory Eye Examination Report, Commission for the Blind and Visually Handicapped) to the Commission for certification.

Documentation: Sufficient to establish an audit trail:

(a) a copy of the certification of blindness from the Commission for the Blind and Visually Handicapped included in the case record; or

(b) the date of certification, Commission Registration number and/or name of the official who signed the document.

Disposition: If the A/R meets the above requirements, s/he is considered SSI-related and his/her income and resources are compared to the medically needy income levels on pages 114 and ***120.3*** and the resource levels on page 311 to determine eligibility for Medicaid. Such persons are offered a choice between the SSI-related budgeting methodology and the ADC-related budgeting methodology, provided s/he meets the requirements for ADC.

The A/R is advised of the benefits available through the SSI program. If s/he is interested, s/he is referred to the local SSA District Office for a determination of his/her SSI eligibility. Application for SSI is **not** a condition of eligibility for Medicaid.

CATEGORICAL FACTORS
SSI-RELATED

DISABILITY

Policy:

Persons under the age of 65, who are certified disabled by either the Social Security Administration (SSA), the State Medicaid Disability Review Team, or local Medicaid Disability Review Team are eligible to receive Medicaid providing they meet all the financial and other eligibility requirements.

Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve (12) months.

A child may be determined disabled if s/he has a medically determinable physical or mental impairment that results in marked and severe functional limitations that have lasted or are expected to last for at least 12 months or result in death.

The standards used to determine disability for Medicaid A/Rs are the same as those used by SSA to determine eligibility based on a disability for SSI or Retirement, Survivors' Disability Insurance (RSDI) (see Medicaid Disability Manual). ***However, for the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) (see page 34.1 for a discussion of MBI-WPD) the first step of the sequential evaluation, known as the SGA test (see page 33 for a discussion of SGA), is eliminated.***

All disability determinations for MBI-WPD are performed by the State Disability Review Team.

References:

Dept. Reg. 360-2.4(a)(2)
360-3.3(b)(2)
360-5

Medicaid Disability Manual

ADMs ***04 OMM/ADM-5***
03 OMM/ADM-4
92 ADM-52
90 ADM-17
88 ADM-42

CATEGORICAL FACTORS

DISABILITY

87 ADM-41
80 ADM-48
78 ADM-35

INFs 92 INF-41
87 INF-4

LCMs 98 OMM/LCM-009
98 OMM/LCM-003

GIS 96 MA/028

Interpretation:

The receipt of SSI or RSDI benefits based on a disability, is acceptable proof of disability. ***Persons in receipt of Railroad Retirement benefits as "totally and permanently" disabled are also considered disabled for Medical Assistance purposes.*** Workers' Compensation, New York State Disability and Veterans' Administration benefits do not confer automatic disability for Medicaid purposes. A separate disability determination is completed for recipients of these programs. Potentially disabled A/Rs are advised of any benefits that they might qualify for under SSI and/or RSDI and referred to the SSA district office. Application for SSI, however, is not a condition of eligibility for Medicaid. A/Rs for Medicaid, who claim an impairment or unemployability due to sickness or disability that has or is expected to last at least 12 months, are referred to the local or State Medicaid Disability Review Team or the Social Security Administration.

All disability determinations for MBI-WPD are performed by the State Disability Review Team.

When a non-SSI-related Medicaid recipient dies, his/her case, medical condition and expenditures are reviewed for referral to the Medicaid Disability Review Team.

Disability determinations are completed for all A/Rs under the age of 65 when they appear to meet the disability criteria. The A/R is given an informed choice between SSI-related budgeting and any other appropriate category when s/he is eligible under more than one category.

CATEGORICAL FACTORS

DISABILITY

The disability review process takes into consideration the severity and extent of the individual's medical condition and resulting functional limitations. It may also take into account the individual's age, education and previous work experience. All A/Rs who are potentially SSI-related as disabled persons, or their representatives are informed of the disability category. The information includes, but is not limited to:

(a) The disability review process;

(b) The need for the individual to cooperate in securing detailed medical documentation from treating sources and the possible need for the individual to have an examination(s), consultation(s) and/or diagnostic test(s);

(c) The need for the individual to provide social and functional information, such as education and details of their past work experience;

(d) The time frames involved in the disability process; and

(e) The potential benefit(s) to the individual of a disability certification, such as a different budgeting methodology, an increased Food Stamp benefit and the identification of medical and/or social resources that may assist the A/R.

An interview is conducted with each A/R who is potentially SSI-related as a disabled individual (or his/her representative) to complete a LDSS-1151 - "Disability Interview." Special emphasis is placed on the individual's education, special training if any, work experience during the past fifteen (15) years, disability related income, medical care received and the individual's functional capacity.

Medical evidence is gathered as soon as possible to meet the time frames of the application/recertification process. Medical evidence may include a completed LDSS-486: "Medical Report for Determination of Disability," from a physician, hospital admission and discharge summaries, clinic reports, diagnostic test results and reports from practitioners such as therapists, nurse practitioners, physicians' assistants, optometrists, chiropractors, psychiatric social workers and audiologists.

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 page 374.)

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.

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.

CATEGORICAL FACTORS

DISABILITY

Medicaid is available for recipients who are certified disabled through the second month following the month in which disability ceases. When a recipient's health improves and s/he is no longer certified disabled, the recipient remains SSI-related for two months following the month his/her disability ends. To be eligible for Medicaid, the recipient must still meet all other requirements (see pages 114 and 311).

When to Verify:

(a) When the A/R indicates that s/he is in or was in receipt of SSI benefits based on disability;

(b) When the A/R indicates that s/he is in receipt of RSDI benefits based on disability;

(c) When the A/R indicates that s/he has excessive medical bills;

(d) When the A/R indicates that s/he is in or has recently been released from a hospital, nursing home or other institution;

(e) When the A/R indicates that s/he is or was chronically sick, disabled, or mentally impaired;

(f) Substance abuse (alcoholism or drug abuse) in and of itself is not considered a disability under the Social Security disability criteria. Individuals who have substance abuse disorders are asked about and evaluated for any other co-existing mental or physical impairments they may have that prevent them from working;

(g) When the A/R indicates that a continuing illness or disability was his/her reason for leaving school or employment;

(h) When the A/R indicates receipt of benefits based on illness or disability (e.g., Workers' Compensation, Veterans' Benefits, NYS Disability, employer disability pensions, etc.);

CATEGORICAL FACTORS

DISABILITY

(i) When the A/R appears to suffer from a physical and/or mental impairment at the time of the interview. Some examples are difficulty walking, standing, breathing, concentrating, following instructions or remembering;

(j) When the A/R indicates present or past employment at a sheltered workshop or participation in a rehabilitation program;

(k) When the A/R indicates that s/he has outstanding medical bills during the three-month period prior to the date on which s/he became eligible for SSI;

(l) When the NYS Department of Health identifies cases with potentially disabling diagnoses that have not previously been reviewed for disability.

Verification: When the A/R is SSI-related because s/he receives SSI or RSDI, the A/R provides documentation of the Social Security Administration's determination of disability. A copy of the SSA benefit check is sufficient proof of disability since it shows the RSDI claim number. Certain alpha suffixes on the claim number identify the check as a disability payment (see page 85). Local districts contact the SSA office to determine the current alpha suffix for disability checks.

When an A/R loses eligibility for SSI cash for reasons unrelated to his/her medical condition, generally a disability determination is not required. If the A/R lost eligibility prior to the date when SSA was to be reevaluating the A/R's medical condition, the A/R is considered disabled until his/her medical diary reexamination date. The local district contacts the SSA district office to obtain the medical diary reexamination date and the reason why SSI benefits were terminated.

When the determination of disability is made by the local or State Medicaid Review Team, a copy of the most current LDSS-639: "Disability Review Team Certificate" is included in the case record.

CATEGORICAL FACTORS

DISABILITY

Documentation: Sufficient to establish an audit trail:

(a) A copy of the RSDI award letter, RSDI check or sufficient identifying information (i.e., date of award, name of official signing the document);

(b) A current LDSS-639 indicating Group I or Group II certificate of disability by the State or local Review Team;

(c) The code indicating disability on the SDX;

(d) An SSA 1610 completed by the SSA district office; or

(e) A copy of the information from the Third Party Query System.

Disposition: When an A/R is certified disabled, s/he is SSI-related. After following the appropriate budgeting procedures (see page 184), his/her income is compared to the Medicaid level or PA standard, whichever is higher (see pages 114 and 121). His/her resources are compared to the appropriate Medicaid resource level (see page 311). SSI-related A/Rs are offered a choice between SSI-related budgeting and ADC-related budgeting methodology, when they also meet ADC categorical requirements.

The A/R is advised of benefits which may be available to him/her under the Social Security Disability (SSD) and/or Supplemental Security Income (SSI) programs. If s/he is interested, s/he is referred to the local Social Security District Office for a determination of SSI and/or SSD eligibility.

The A/R is also informed of the possibility of receiving an increased Food Stamp benefit if an individual is certified disabled. When a PA or Medicaid recipient is certified disabled, the cost of his/her medical care and services may be claimed as SSI-related retroactively from the effective date of disability, subject to the two year federal claiming limitations.

NOTE: The Department automatically adjusts claims when appropriate, based on the date of disability onset given on the SDX.