MEDICAID OPERATIONS MANUAL
TRANSMITTAL LETTER

September 13, 2011

TO: CUSTODIANS OF MEDICAID OPERATIONS MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE

SUBJECT: MEDICAID OPERATIONS MANUAL CHANGES
CHAPTER – 1000 DISABILITY DETERMINATION PROGAM

BACKGROUND AND EXPLANATION

Currently, in the disability determination process, there are no established time limits for the receipt of requested medical records and if indicated the death certificate. Not having established time limits results in multiple requests for records at the District Office level, applications being held in pending status at the District Office level and disability applications being sent to DHCFP contracted physicians for review with insufficient records.

Changes to this chapter include a 45-day time limit for individuals and/or providers to submit requested medical records. If the requested records are not received within this time frame, the applications will be denied at the District Office level.

Language has also been added to the chapter to clarify that requests for reimbursement of emergency medical services, where disability is an eligibility factor, are subject to the billing time frames (stale dates) pursuant to Medicaid Services Manual Chapter 100, Section 105.2B.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized (the acronym DO was changed back to District Office), and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These policy changes are effective September 14, 2011.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 21/11 CHAPTER – 1000 DISABILITY DETERMINATION PROGRAM	MTL 15/19, 43/10 CHAPTER – 1000 DISABILITY DETERMINATION PROGRAM

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1000	**Introduction**	Replaced NMO with DHCFP.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1001	**Statutory Authority**	Removed reference to Title 42 CFR Part 435.911.
1002	**Definitions**	The following definitions were moved into alphabetical order: • Consultative Examinations (CE) • Emergency Medical Care and Services • Incapacity • Medical Evidence • Treating Sources Effective Date and Timeliness of Disability Determination definitions were changed. Financial Criteria and Parental Financial Responsibility definitions were removed. The following definitions were added: • Medical Assistance for the Aged, Blind and Disabled (MAABD) • Timely Provider Requests for Reimbursement • Timely Submission of Medical Records
1003.1	**Eligibility Determination**	Policy was added regarding a 45-day timeline for medical records and death certificates or the application will be denied.
1003.5	**Denial of Disability Application**	Timeliness of Disability Determination section was removed, and Denial of Disability Application was renumbered 1003.5. Updated Policy on Reasons for Denial of Application.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID OPERATIONS MANUAL
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DISABILITY DETERMINATION PROGRAM

1000 INTRODUCTION

The primary purpose of the Division of Health Care Financing and Policy (DHCFP) disability determination program is to assist in eligibility determinations for Nevada Medicaid programs which provide health recovery and health maintenance assistance.

1001 STATUTORY AUTHORITY

Federal regulations at 42 CFR Chapter 435.540, 435.541, 435.909 and 435.914 prescribe certain requirements for Medicaid related disability decisions. The CFR requires Medicaid to use the definition of disability in the most recently published electronic version of Disability Evaluation Under Social Security (U.S. Department of Health and Human Services, Social Security Administration (SSA) Publication No. 64-039, ICN No. 468600) in determining disability.

The Disability Evaluation Under Social Security has been specially prepared to provide physicians and other health professionals with an understanding of the disability programs administered by the Social Security Administration. It explains how each program works, and the kind of information a health professional can furnish to help ensure sound and prompt decisions on disability claims.

Statutes and Regulations

- Administration, SSA Publication No. 64-039, ICN No. 468600 in determining disability
- Social Security Act: 1902(w) for eligibility
- Social Security Act: 1902(e)(3) for Katie Beckett
- Medicaid Services Manual (MSM) Chapter 3100 for guidance in Appeals and Hearings
- Title 42 CFR Part 435.540
- Title 42 CFR Part 435.541
- Title 42 CFR Part 435.909
- Title 42 CFR Part 435.914
- CMS State Medicaid Manual Chapter 3, Sections 3210 and 3211

1002 DEFINITIONS

These are brief definitions. Full detail is located in the section addressing the definition.

ACCEPTABLE MEDICAL SOURCES

Documentation of the existence of a claimant's impairment must come from medical professionals defined by the Social Security Administration (SSA) as acceptable medical sources, which generally includes:

a. licensed physicians (medical or osteopathic doctors);

b. licensed or certified psychologists (including school psychologists or other licensed individuals with other titles who perform the same functions as a school psychologist in a school setting);

c. licensed optometrist;

d. licensed podiatrist; and

e. qualified speech-language pathologists (for the purpose of establishing speech and language impairments).

CONSULTATIVE EXAMINATIONS (CE)

In cases where the evidence provided by the individual's own medical sources is inadequate to determine if he or she is disabled, additional medical information may be sought by re-contacting the treating source for additional information or clarification, or by arranging for a CE. The treating source is the preferred source for a CE if he or she is qualified, equipped, and willing to perform the examination for the authorized fee.

An independent source (other than the treating source) may be used to perform the CE if:

a. the treating source prefers not to perform the examination.

b. the treating source does not have the equipment to provide the specific data needed.

c. there are conflicts or inconsistencies in the file that cannot be resolved by going back to the treating source.

d. the individual prefers another source and has good reason for doing so or prior experience indicated that the treating source may not be a productive source.

DIAGNOSIS

The determination of the nature or cause of physical or mental disease or abnormality through the combined use of health history, physical developmental examination and laboratory tests.

DISABILITY

Disability is an eligibility factor for medical assistance for persons under 65 years of age who are not eligible for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) and also for persons 18 years of age or younger who otherwise qualify under Section 1902(e)(3) (Katie Beckett) of the Social Security Act. SSA defines disability as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) 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.

DISABILITY DETERMINATION TEAM

The Division of Health Care Financing and Policy (DHCFP) physician consultants and professional staff make up the disability determination team. The team reviews medical documentation and determines if the applicant qualifies based on Social Security standards.

EFFECTIVE DATE

The effective date of coverage is the day the applicant is determined to meet the definition of disability. Dates of coverage can be up to three months prior to the month of the Division of Welfare and Supportive Services (DWSS) Medical Assistance for the Aged, Blind and Disabled (MAABD) application for medical assistance if there is evidence that treatment was received and that the evidence submitted meets the eligibility criteria for that period.

ELIGIBILITY

References a person's status to receive Medicaid program benefits. Eligibility is determined bythe DWSS based upon specific criteria.

EMERGENCY MEDICAL CARE AND SERVICES

Emergency medical condition means a condition with a sudden onset, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could result in:

a. placing the patient's health in serious jeopardy;

b. serious impairment to bodily function;

c. serious dysfunction of any bodily organ; or

d. with respect to a pregnant woman who is having contractions.

EVIDENCE RELATING TO SYMPTOMS

In developing evidence of the effects of symptoms, such as pain, shortness of breath, or fatigue on an applicant's ability to function, Medicaid investigates for evidence relating to the symptoms.

INCAPACITY

The qualifying medical criteria for determining incapacity are identical to "disability", except that the durational requirement is reduced to 30 days. The incapacity must be supported by competent medical evidence.

KATIE BECKETT ELIGIBILITY OPTION

States are allowed the option to make Medicaid benefits available to eligible children with disabilities who would not ordinarily qualify for SSI benefits because of their parents' income or resources.

MEDICAL ASSISTANCE FOR THE AGED, BLIND AND DISABLED (MAABD) APPLICATION

The DWSS MAABD Program provides medical assistance for persons who are aged, blind or disabled and who meet the requirements of one of the DWSS eligible categories.

MEDICAL EVIDENCE

Each person who files for a disability determination is responsible for providing medical evidence of the disabling impairment(s) and the severity of the impairment(s). The medical evidence must be provided by acceptable medical sources as defined by the Division. Once the existence of impairment is established, all the medical and non-medical evidence is considered in assessing the severity of the impairment.

MEDICALLY DETERMINABLE IMPAIRMENT

A medically determinable physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic tests. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by the individual's physician.

OTHER EVIDENCE

Information from other sources is also considered in assessing the extent to which a person's impairment(s) affects his or her ability to function in a work setting; or in the case of a child, the ability to function compared to other children the same age who do not have any impairments. These sources include public and private agencies, non-medical sources such as schools, parents, caregivers, social workers, employers, and other sources such as naturopaths, chiropractors, and audiologists.

TIMELINESS OF DISABILITY DETERMINATION

All disability determinations will be issued with reasonable promptness by Nevada Medicaid. Reasonable promptness means Nevada Medicaid will take action to approve or deny a disability request within the time standards the DWSS has established to determine Medicaid eligibility. DWSS' established time frame for determining Medicaid eligibility, on the basis of disability, is within ninety days from the date the Medicaid application is received by DWSS. If there is a delay in the disability determination because of unusual circumstances the cause of the delay will be well documented. Unusual circumstances may include but are not limited to situations where DHCFP has requested additional medical records for review.

TIMELY PROVIDER REQUESTS FOR REIMBURSEMENT

Requests for reimbursement of emergency medical services, where disability is an eligibility factor, must be received by DHCFP in a timely manner. Claims must be received by the fiscal agent within 180 days from the date of service or the date of the eligibility decision, whichever is later. For out-of-state providers or when a third party resource exists, the timely filing period is 365 days. Refer to Medicaid Services Manual (MSM) Chapter 100, Section 105.2B.

TIMELY SUBMISSION OF MEDICAL RECORDS

For disability determinations, the medical records and if indicated the death certificate must be received by the DHCFP District Office within 45 days of request. If the appropriate records are not received within this time period, the application will be denied at the District Office level.

TREATING SOURCES

A treating source is the individual's own physician, psychologist, or other acceptable medical source that has provided the individual with medical treatment or evaluation and has or has had an ongoing relationship with the individual. The treating source is usually the best source of medical evidence about the nature and severity of an individual's impairment(s).

Although a treating source is not expected to make a decision whether the individual is disabled, he or she will be usually asked to provide a statement about the individual's ability despite his or

her impairment to do work-related physical or mental activities or a child's functional limitations compared to children the child's age who do not have an impairment.

1003 POLICY

Disability determinations, to allow access for eligible Nevadans to Medicaid programs which provide health and recovery and health maintenance assistance, are performed by Medicaid's Disability Determination Team. The team consists of a medical and psychological consultant and licensed professional staff.

1003.1 ELIGIBILITY DETERMINATION

Applicants or participants must meet and maintain all eligibility criteria during the period of time the participant is determined eligible for Medicaid and receives services. Eligibility determinations are made on an annual basis by the combined efforts of the Division of Welfare and Supportive Services (DWSS) and the Division of Health Care Financing and Policy (DHCFP).

DWSS processes applications to determine Medicaid eligibility and submits disability determination requests to Medicaid.

a. DHCFP staff in the District Offices are responsible to:

1. facilitate the evaluation of disability determinations for:

a. State Plan Medicaid disability program (must be under 65 years of age);

b. Home and Community-Based Waiver (HCBW) for Persons with Physical Disabilities (must meet the eligibility criteria in the most current Medicaid Services Manual (MSM) Chapter 2300);

c. Katie Beckett Option (must meet the eligibility criteria in the most current Medicaid Operations Manual (MOM) Chapter 600; and

d. Emergency medical services.

2. request and receive necessary medical evidence from the applicant's acceptable medical sources. A completed packet containing sufficient evidentiary information (medical, psychological and applicable vocational and/or social information) to determine disability must be submitted from the DHCFP District Office to the DHCFP Central Office (CO).

3. assist the applicant in obtaining their medical reports when the applicant has given the District Office permission to do so. Medical reports generally come from sources that have treated or evaluated the individual for his or her impairment(s).

Although the agency will assist the applicant in obtaining medical records, each individual who files a disability application is responsible for providing medical evidence showing that he or she has impairment and the severity of the impairment.

The medical records and, if indicated, the death certificate must be received by the DHCFP District Office within 45 days of request. If the appropriate records are not received within this time period, the application will be denied at the District Office level.

1003.1A DISABILITY TEAM

The DHCFP disability determination team's medical or psychological consultant will review the application and determine eligibility based on the most recent edition of Disability Evaluation under Social Security.

Applicants or participants must meet and maintain the disability eligibility criteria as defined in the most recently published electronic version of Disability Evaluation Under Social Security (U.S. Department of Health and Human Services (DHHS), Social Security Administration (SSA) Publication No. 64-039, ICN No. 468600).

The disability determination team may not make an independent determination of physical disability if SSA has made a disability determination within the requested timeframes. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under 42 Code of Federal Regulations (CFR) 435.909.

1003.1B MEDICAL EVIDENCE

Medical evidence includes: medical history, clinical and laboratory findings, diagnosis, treatment and prognosis. In addition, medical evidence should also include a statement by the treating source providing an opinion of the applicant's ability to perform work-related activities or in the case of a child, their ability to function independently, appropriately and effectively in an age-appropriate manner.

Medical evidence from treating sources should be given special emphasis per SSA because they are likely the medical professionals most able to provide detailed longitudinal picture of the individual's impairments and may bring a unique perspective to the medical evidence that cannot be obtained from the medical findings alone or from reports of individual examinations or brief hospitalizations.

The Disability Evaluation Under Social Security provides more detailed information on medical evidence.

1003.1C ACCEPTABLE MEDICAL SOURCES

Documentation of the existence of an individual's impairment must come from medical professionals as defined in the Disability Evaluation Under Social Security.

Acceptable medical sources per SSA are:

1. licensed physicians (medical or osteopathic doctors);

2. licensed or certified psychologists. Included are school psychologists, or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting, for purposes of establishing mental retardation, learning disabilities, and borderline intellectual functioning only;

3. licensed optometrists, for purposes of establishing visual disorders only (except, in the U.S. Virgin Islands, licensed optometrist, for the measurement of visual acuity and visual fields only);

4. licensed podiatrists, for purposes of establishing impairments of the foot, or foot and ankle, depending on whether the State in which the podiatrist practices permits practice of podiatry on the foot only, or the foot and ankle;

5. qualified speech-language pathologists, for purposes of establishing speech or language impairments only. For this source, "qualified" means that the speech language pathologist must be licensed by the State professional licensing agency or be fully certified by the State education agency in the State in which he or she practices, or holds a Certificate of Clinical Competence from the American Speech-Language-Hearing Association.

Copies of medical evidence from hospitals, clinics, or other health facilities where an individual has been treated are also requested. All medical reports received are considered during the disability determination.

Information from other sources is also considered in assessing the extent to which a person's impairment(s) affects his or her ability to function. Other sources include public and private social welfare agencies, non-medical sources such as teachers, day care providers, social workers, employers, and practitioners such as naturopaths, chiropractors, audiologists, occupational or physical therapists, and/or speech and language pathologists.

1003.1D CONSULTATIVE EXAMINATIONS (CE)

In cases where the medical evidence provided by the individual's medical sources is insufficient to determine disability, the disability team's medical or psychological consultant may request more information or clarification from the individual's treating source or arrange for a CE with the treating source or an independent source (other than the treating source).

A complete CE involves all the elements of a standard examination applicable to the medical specialty. A complete CE report should include the following elements:

1. The individual's major or chief complaint(s);

2. A detailed description, within the area of specialty of the examination, of the history of the major complaint(s);

3. A description, and disposition, of pertinent "positive" and "negative" detailed findings based on the history, examination, and laboratory tests related to the major complaint(s), and any other abnormalities or lack thereof reported or found during the examination or laboratory testing;

4. Results of laboratory and other tests (for example, X-rays) performed according to the requirements stated in the Listing of Impairments (Disability Evaluation Under Social Security);

5. The diagnosis and prognosis for the individual's impairment(s);

6. A statement about what the claimant can still do despite his or her impairment(s), unless the claim is based on statutory blindness. This statement should describe the opinion of the consultant about the claimant's ability, despite his or her impairment(s), to do work related activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling; and, in cases of mental impairment(s), the opinion of the consultant about the individual's ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and work pressures in a work setting. For a child, the statement should describe the child's functional limitations in learning, motor functioning, performing self-care activities, communicating, socializing, and completing tasks (and, if the child is a newborn or young infant from birth to age 1, responsiveness to stimuli); and

7. The consultant's consideration, and some explanation or comment on the claimant's major complaint(s) and any other abnormalities found during the history and examination or reported from the laboratory tests. The history, examination, evaluation of laboratory test results, and the conclusions will represent the information provided by the consultant who signs the report.

1003.1E EVIDENCE RELATING TO SYMPTOMS

In developing evidence of the effects of symptoms, such as pain, shortness of breath, or fatigue on an applicant's ability to function, Medicaid investigates for evidence relating to the complaints. This includes information provided by treating physician or other sources regarding:

1. the applicant's daily activities;

2. the location, duration, frequency and intensity of the pain or other symptoms;

3. precipitating and aggravating factors;

4. the type, dosage, effectiveness and side effects of any prescribed medication(s);

5. treatments other than medication(s), for the relief of pain or other symptoms; and

6. other factors concerning the claimant's functional limitations due to pain or other symptoms.

1003.2 DECEASED APPLICANTS

A. District Office Staff

Health Care Coordinators from the DHCFP/District Office may approve disability applications for deceased individuals without the DHCFP CO Disability Determination Team's review and approval. The submitted evidence must meet the criteria listed below:

1. The length of requested coverage is three months or less.

2. The individual's death certificate is received.

3. The death certificate must show the diagnosis or conditions causing death occurred at least two days before death. This can be determined by comparing the "Date of Injury" with the "Date of Death" and "Date Pronounced Dead" blocks on the certificate. Certificates sometimes state the date of injury in the block titled, "Interval Between Onset and Death".

4. Medical records documenting the minimum two day pre-death existence of the fatal diagnosis or condition may be used when the chronological information is absent from the death certificate.

5. The death certificate must show one of the following diagnoses as a cause or contributing factor for the death:

   a. A metastatic carcinoma of any kind originating in one of the following locations: brain, gastric (stomach), colon, pancreas, skin, breast, kidney (renal) and lung.

   b. Sarcomas, lymphomas and leukemia (cancers).

   c. Hepatic (liver) failure secondary to ETOH abuse (chronic alcohol abuse).

   d. End-stage liver disease.

   e. End-stage renal (kidney) disease.

   f. Cardiomyopathy.

   g. Encephalopathy.

   h. Extreme prematurity at birth.

   i. Arteriosclerotic vascular disease.

   j. Gunshot wound of the head.

   k. Cerebral vascular accident.

   l. Hypoxic brain injury/infarct (intracerebral hemorrhage).

   m. head injury (traumatic, closed, open, etc.).

6. When the death certificate does not list one of the following diagnoses as a cause of death, medical records may be used to document their existence before death.

   a. Amputation of two limbs.

   b. Amputation of a leg at the hip.

   c. Down’s Syndrome (Mongolism, trisomy 21 or trisomy G).

   d. Paraplegia, Hemiplegia, Quadriplegia.

   e. Acquired Immune Deficiency Syndrome (AIDS).

B. The District Office Will Not Approve:

1. any application in which the individual may have been deceased at the time of emergency response.

2. any application which varies from the criteria listed above in section 1003.2A.

3. any application in which the details of the case are complex, and the determination is difficult to make with certainty.

For further consideration provide the Disability/Incapacity Determination Request form NMO-3004 and forward the death certificate and other information to the DHCFP CO.

C. CO Disability Determination Team

The CO Disability Determination Team will review disability applications to determine:

1. if the individual had vital signs at the time of emergency response. This may involve requesting EMS records for review. Disability applications will not be approved for individuals who were deceased at the time of emergency response.

2. if there is sufficient evidence to support, within a reasonable degree of medical certainty, that the causes of death were severe impairments that meet the SSA definition of disability which is: The inability to engage in any Substantial Gainful Activity (SGA) by reason of any medically determinable physical or mental impairment(s) 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.

1003.3 EMERGENCY MEDICAL CARE AND SERVICES

When DWSS receives a Medicaid application requesting emergency medical services they will send a request to the DHCFP District Office for a disability determination. The District Office will obtain the medical records and forward them with the Disability/Incapacity Determination request form NMO-3004 to the CO Disability Determination Team for review.

Emergency medical condition means a condition with a sudden onset, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could result in:

a. placing the patient's health in serious jeopardy;

b. serious impairment to bodily function;

c. serious dysfunction of any bodily organ; or

d. with respect to a pregnant woman who is having contractions.

1003.4 COVERAGE AND LIMITATION

A. Services provided must meet the Medicaid regulatory criteria and must be provided by an authorized provider who meets all of the conditions of participation as stated in the Nevada.

B. MSM Chapter 100, all inclusive.

C. Services are those services which are authorized Medicaid services received during the eligibility period.

D. Services for recipients of the HCBW for Persons with Physical Disabilities are only those services as prescribed in the most current Waiver approved by the Center for Medicare and Medicaid (CMS). More detailed policy is included in Chapter 2300 of the MSM.

E. Services for the Katie Beckett Eligibility Option are services prescribed in the most current Medicaid State Plan approved by CMS. More detailed policy is included in Chapter 600 of the MOM.

F. Medicaid coverage for emergency medical care and services are limited only to necessary treatment(s) for an emergency medical condition(s), and the care and services are not related to either an organ transplant procedure or routine prenatal or post-partum care as prescribed in Chapter 3 of CMS State Medicaid Manual, 3211.11 (C).

1003.5 RESERVED

1003.6 DENIAL OF DISABILITY APPLICATION

An application for disability may be denied if the applicant:

a. does not meet the disability criteria;

b. does not meet the level of care criteria for the Waiver for Persons with Physical Disabilities or Katie Beckett Eligibility Option;

c. does not meet the age requirement for emergency medical services as recipients must be under 65 years of age;

d. has failed to cooperate by providing medical evidence within required time frames;

e. is deceased and a death certificate has not been provided on behalf of the applicant; and/or

f. does not meet the timeliness requirement.

1004 REFERENCES AND CROSS REFERENCES

1004.1 MEDICAID SERVICES AND OPERATIONS MANUALS

MEDICAID SERVICE MANUALS (MSMs)

Chapter 100	Medicaid Program
Chapter 200	Hospital Services
Chapter 300	Radiology Services
Chapter 500	Nursing Facilities
Chapter 600	Physician Services
Chapter 700	Rates and Cost Containment
Chapter 800	Laboratory Services
Chapter 900	Private Duty Nursing
Chapter 2300	HCBW Persons with Physical Disabilities
Chapter 3100	Hearings
Chapter 3300	Program Integrity
Chapter 3600	Managed Care Organization

MEDICAID OPERATIONS MANUALS (MOMs)

Chapter 600	Katie Beckett Option

1005 CONTACTS

DIVISION OF WELFARE AND SUPPORTIVE SERVICES (DWSS) OFFICES

Locate DWSS Offices at http://dwss.nv.gov/

DIVISION OF DIVISION OF HEALTH CARE FINANCING & POLICY (DHCFP) OFFICES

Locate DHCFP Office at http://dhcfp.nv.gov