102.09 ABD NON-FINANCIAL REQUIREMENTS

The non-financial requirements which pertain only to the Aged, Blind and Disabled programs are discussed in this section.

102.09.01 DEFNITIONS

Definition of Adult Disability

The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment 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.

This means the adult is unable to do his previous work or any other substantial gainful activity which exists in the national economy. The adult's residual functional capacity, age, education and work experience are considered in the disability determination process.

Definition of Childhood Disability

An individual under the age of 18 is considered disabled under SSI policy if that child has a medically determinable physical or mental disability, which results in marked and severe functional limitation, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least 12 months.

No individual under the age of 18 who engages in substantial gainful activity may be considered disabled.

Definition of Blindness

Statutory blindness is central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which has a limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less. An individual's ability to work will not affect eligibility based on blindness.

NOTE: Throughout the remainder of this section, the term "disability" also refers to blindness.

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102.09.02 DISABILITY DETERMINATION PROCESS

In Mississippi, an application for SSI is also an application for Medicaid. This does not mean a separate Medicaid application cannot be filed by an SSI applicant; however, the regional office is not required to obtain a separate Medicaid disability determination for any months of potential SSI eligibility, starting on the effective filing date of the SSI application. The applicant is required to wait until SSA makes the SSI eligibility determination.

Independent Disability Determinations

However, the regional office will make an independent disability determination when a separate Medicaid application has been filed under one of the following circumstances:

- The individual has not applied for SSI or has applied and been denied for a reason other than disability.
- An individual applies separately for both SSI and Medicaid and SSI fails to make a decision within 90 days. In this instance, DDS must provide Medicaid with a decision prior to the SSI decision.
    - When DDS approves Medicaid disability prior to an SSI decision, a tickler must be set to check on the final SSI decision. If the SSI decision is a disability denial, the case must be closed for Medicaid purposes and the case referred to state office along with all medical information in the case record for routing to DDS for a final decision.
- An individual applies for Medicaid and alleges a disabling condition that is different from, or in addition to, that considered by SSA.
- An individual meets all 3 of the criteria below:

(1) Applies for Medicaid more than 12 months after SSA last made a final determination that the individual was not disabled; **and**
(2) The individual alleges his condition has deteriorated since that final decision; **and**
(3) The individual has not reapplied for SSI.

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Independent Disability Determinations (Continued)

If the above conditions do not exist and the individual is potentially eligible for SSI, he must be advised to file or re-file for SSI benefits. This does not mean a separate Medicaid application cannot be filed; however, Medicaid eligibility decision will be tied to the SSI decision.

Example: An individual applied for SSI and was denied due to disability in June 2008. In October 2008, the individual files for Medicaid only but alleges no change in his physical condition since his SSI application was denied. In this case, the SSI disability denial controls the Medicaid decision. The individual must be denied Medicaid eligibility based on the previous SSI denial and referred to SSA to reapply for SSI.

Requesting Reconsideration

Under SSA rules, an individual may request reconsideration within 60 days of receipt of the notice denying SSI disability. If the individual does not appeal the decision within 60 days, he may still request reopening of the determination within 1 year for any reason and within 2 years for good cause, such as new or material evidence.

Therefore, if an individual alleges deterioration of the condition on which the previous disability denial was based, he can submit this to SSA for reconsideration or reopening within 12 months of the most recent final SSI determination.

102.09.03 EXCEPTIONS TO OBTAINING DDS DISABILITY APPROVALS

There may be instances when DDS has already determined disability using SSI criteria for the same period of time to be covered by a Medicaid application. If so, a separate Medicaid determination is not needed. However, if the disability onset date, as established by SSA, does not include all months of requested Medicaid eligibility, a separate DDS decision is required.

Situations Which Do Not Require a Separate Disability Determination

In the following situations a separate blindness/disability determination for Medicaid is not needed. The Specialist can consider the applicant/beneficiary to be blind/disabled and complete the eligibility determination process.

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Situations Which Do Not Require a Separate Disability Determination (Continued)

- **Applicant Receives Title II Disability –** The Medicaid applicant receives Title II disability benefits on an ongoing basis based on his own disability and the disability onset date is verified to include all months to be covered by the Medicaid application, i.e., the month of application and any retroactive months. Receipt of Title II disability must be re-verified at each redetermination.

- **Disability Decision Overturned by Administrative Law Judge (ALJ) Order** - An Administrative Law Judge (ALJ) reverses a disability denial and establishes disability with a disability onset date which covers all months of the Medicaid application.
  If the Medicaid applicant is otherwise eligible, eligibility can be established as of the date of the onset of disability as established by the ALJ order, but no earlier than:

  - The Medicaid application date; or
  - Three months before the Medicaid application date if retroactive benefits are an issue.

  Example: An ALJ order reversed a disability decision and established disability effective February 2008. The application for Medicaid is filed on July 2, 2008. If the Medicaid applicant met all other requirements and requested retroactive benefits, eligibility could be established effective April 1, 2008.

- **Deceased Applicants** - A verified death date establishes disability if a disability, due to any illness or accident which resulted in death, existed in all months for which Medicaid eligibility was requested.

  Example: A traumatic onset of disability occurred on September 14, 2008, due to an accident. On October 12, 2008, individual dies as a result of injuries sustained in the accident. The application for Medicaid is filed on November 3, 2008. Under this exception, Medicaid eligibility can only be established starting September, the month of the accident, forward.

- **Disabled Adult Children –** Disability has previously been established by SSA for an applicant who is over age 18, entitled to Medicare and receiving Title II benefits as a child (C1-C9 beneficiary). The disability onset date must be determined.

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102.09.04 OBTAINING DDS DISABILITY DECISIONS

If there is no indication that any of the above exceptions apply, the Medicaid Specialist will use the following procedures to obtain a DDS decision when an applicant applies for Medicaid on the basis of disability or blindness.

Procedures for DDS Forms Completion

- Complete Form DOM-323, Disability or Blindness Report. This form is used to record the applicant's condition and medical background based on the applicant's responses and worker observations. If the applicant has medical records from the providers listed on the 323 in his possession, submit the medical records with the 323.
- If the applicant is a child, complete Form DOM-323A, Disabled Child Questionnaire, in addition to the DOM-323. The 323A is used for children age 18 or under to record medical and educational information based on the parent/representative's responses.
- If the applicant is currently employed, include detailed information regarding work hours, income, name and type of employer, etc., on the DOM-323. Also indicate whether the applicant has been examined by a physician within the last 3 months. If so, specify the physician.
- If the applicant has a communication problem due to language, speech or hearing difficulties which would make it hard for DDS to contact the applicant, complete Form DOM-324, Vocational Report, as a supplement to the DOM-323.
- The applicant must sign a DOM-301A, Authorization to Release Medical Information, for the number of providers identified on the DOM-323. In addition, the applicant must sign, but not date, two additional "Authorization to Release Medical Information" forms.
    - Signatures on blank releases are required so that DDS will have sufficient releases for providers indicated on the DOM-323 and other providers they feel it necessary to contact without having to delay the process to get additional releases. Medicaid Specialists must explain this reasoning to applicants.
    - If an applicant refuses to sign blank forms, have the applicant complete the provider's name and sign the form. Explain that there could be a delay in the process if the applicant has to be contacted for any additional releases that may be needed.

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OBTAINING DDS DISABILITY DECISIONS

Procedures for DDS Forms Completion (Continued)

- Signatures required on the DOM-301A, Authorization to Release Medical Information:
  - The applicant or an individual who has the legal authority to act on behalf of the applicant, such as a parent, power of attorney, agency or individual holding custody, or conservatorship, must sign the release.
  - When someone other than the applicant signs the release, the individual must sign his name (not the name of the applicant) and indicate his relationship to the applicant.
  - If the applicant is unable to sign the release and the designated representative signs in the applicant's place, the authorized representative must state why the applicant is unable to sign his name, e.g., "patient unconscious", "patient senile", etc.
  - If a representative signs the DOM-301A, attach a copy of the DOM-302 Designated Representative Statement". If the DOM-302 is signed as self-designation, there must be an explanation of why the applicant did not sign the 302 before medical information is released.
  - If the release is signed with an "X", two witnesses must also sign.

- Complete Form DOM-325, Disability Determination and Transmittal. This form serves as the transmittal form for submitting DOM-323, DOM-323A and DOM-324, if applicable, medical releases and prior medical information from the case record.
  - If the individual is applying under the Working Disabled coverage group, this should be clearly indicated in "Remarks".
  - If the applicant is a child, put the parent or representative's name on the DOM-325 in the same space with the case name.
  - For example, enter Jane Doe (parent) for Janie Doe.

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Submission to DDS

Include all material discussed above in a file folder labeled with the client's name, Social Security Number and case number: **Jane Doe**
425-45-9999
300-74-8855

Mail the folder to DDS as follows: **Disability Determination Service**
P O Box 1271
Jackson, MS 39205

Timeframes

For initial DDS submissions and re-submissions, set a ticker for 75 days. If a disability decision is not received within 75 days or if any problem occurs pertaining to the medical decision the regional bureau director should be notified to contact DDS. The DDS toll free telephone number is: (800) 962-2230. The local DDS telephone number is (601) 853-5100.

Procedures for Receiving DDS Decisions and Reevaluations

- DDS will return the medical information file and a disability or blindness decision to the regional office. The decision will be recorded on the lower portion of the DOM-325. Any 325 that does not have physician's signature should have a physician's rating referenced in the "Remarks" section.
- DDS will attach this cross-referenced documentation to the 325. Each regional office will ensure DDS sends all relevant material for a decision.
- When an approved DOM-325 is received, the need for a re-examination and date is indicated in section 15. If no re-examination is needed, the DOM-325 is valid indefinitely or until the recipient is determined "no longer disabled". If a re-examination date is given, the DOM-325 is valid until that re-examination date. The valid DOM-325 can be used for reapplications when the Medicaid closure reason was not loss of disability.
- A case must not be sent in for reevaluation prior to the date specified on the DOM-325 in section 15. However, the worker must set a tickler for a date prior to the due date to ensure the medical information is resubmitted following the above procedures for submission to DDS on the specified due date.

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Procedures for Receiving DDS Decisions and Reevaluations (Continued)

- Upon receipt of the decision from DDS, the regional office will take appropriate action on the case and notify the recipient of the decision.

- When an SSI individual is medically approved for the retroactive period, but denied SSI benefits ongoing on a medical denial, the case should be referred to the Bureau Director, Deputy, responsible for the region to be re-submitted to DDS for an explanation of the action taken.

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102.09.05 TEMPORARY SSI CLOSURES

Cases that are SSI-eligible but terminate once per quarter and are reinstated by SSI after one or two months of ineligibility are referred to as "ping-pong" cases. The usual cause of the temporary SSI closure is earned income in a 5-week month.

The individual whose SSI is temporarily terminated can apply for Medicaid coverage during the missing SSI months by filing an application with the regional office. The procedures below should be followed when processing "ping-pong' cases.

Procedures for Handling "Ping-Pong" Cases:

- At initial application, handle the case according to ongoing policy. Obtain a DDS decision and verify all other required information. Advise the client or representative to contact the regional office each time the SSI terminates.

- The initial application form is valid for the first 12 months. When SSI terminates again, update the initial application form. An interview is not required but the form must be dated and signed each time.

  Use the initial DDS decision (and 260DC if applicable) unless a re-examination is specified.

- When the initial application is 12 months old, complete a redetermination. The redetermination form is valid for another 12-month period and may be updated as discussed above each time SSI terminates within the year.

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102.09.06 ESTATE RECOVERY REQUIREMENTS

The Division of Medicaid is required to seek recovery of payments for nursing facility services and Home and Community-Based Services (HCBS) as well as related hospital and prescription drug services from the estates of deceased Medicaid recipients who were fifty-five (55) or older when Medicaid benefits were received.

The estate recovery provision applies to all Medicaid recipients in a nursing facility as of July 1, 1994, and all Medicaid recipients who entered the Home and Community-Based Waiver (HCBS) Program on or after July 1, 2001, who:

- Are age 55 or older at time of death;
- Own real or personal property at time of death that can be considered an estate.

NOTE: Individuals who entered the HCBS Waiver Program prior to July 1, 2001, are "grandfathered in" and will not have their case referred to estate recovery unless the individual is discharged from the program and readmitted after July 1, 2001. In which case, "grandfathered" status is lost and the individual will be referred to estate recovery as a new HCBS client subject to the provision.

Estate Property

Estate property includes any real or personal property owned by the recipient in its entirety or by shared ownership. Ownership of life estate interests or ownership of property that has been transferred into a trust is not subject to estate recovery.

Real property includes the home and any other real property, including ownership of mineral rights and/or timber rights. Personal property includes ownership of any cash reserves, stocks, bonds, automobiles, RVs, mobile homes or any other type of property with value known to be owned by the recipient in full or in part.

Exceptions to the Estate Recovery Provision

Estate recovery rules to not apply to a deceased recipient if at the time of death the recipient has a:

- Legal surviving spouse, or
- A surviving dependent child under the age of 21 or

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Exceptions to the Estate Recovery Provision (Continued)

- A dependent blind or disabled child of any age. The blind or disabled individual must be dependent on the Medicaid recipient for a home or income, such as a disabled child drawing benefits from the parent's record.

Assets and Resources Exempt from Estate Recovery

The following assets and resources of American Indians and Alaska natives are exempt from estate recovery:

- Interest in and income derived from Tribal land and other resources currently held in trust status and judgment funds from the Indian Claims commission and the U. S. Claims Court;

- Ownership interest in trust or non-trust property, including real property and improvements located on a reservation;

- Reservation payments to special populations.

Estate Recovery Referrals to Third Party Liability (TPL)

TPL has established a $5000 liquid asset threshold for use in determining whether a case record is to be referred to TPL for estate recovery purposes. The $5000 threshold is set so that the client will have sufficient funds for burial.

When calculating the $5000 threshold, do not include burial or insurance or life estate property. Life insurance will be referred only when the estate is the beneficiary. Joint bank accounts, annuities and promissory notes will not be referred to TPL.

Procedures for Referral or Estate Recovery Cases

- If a client owned real property (regardless of CMV) or personal property totaling more than $5000, the case record is to be referred to TPL via DOM-TPL-411.

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Procedures for Referral or Estate Recovery Cases (Continued)

- If the client owned no real property and the total value of all personal property (liquid assets) is $5000 or less, complete DOM-TPL-412, and send the form only to TPL.

  This will let TPL know the client is deceased but the case record is not being referred to TPL because total assets are below the established threshold.

- If a client owned an annuity purchased on or after February 8, 2006, the case is to be referred to TPL via DOM-TPL-411.