MA-2525 DISABILITY
REVISED 11/01/17 - CHANGE NO. 05-17

I. INTRODUCTION

Individuals under age 65 may be eligible for Medicaid if they are disabled according to the Social Security definition of disability. The aid program/category is MAD (Medicaid Aid to the Disabled).

Under Title II and Title XVI of the Social Security Act, disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments that is expected to result in death or which has lasted or is expected to last for a continuous period of not less than 12 months.

The working disabled may be eligible for Medicaid under the Health Coverage for Workers with Disabilities Program (HCWD). See MA-2180, Health Coverage for Workers with Disabilities. To be eligible under this program, the individual must meet the Social Security definition of disability except for the substantial gainful activity requirement.

Individuals who receive Social Security (RSDI) or Supplemental Security Income (SSI) because they are disabled are considered to meet the disability requirement for Medicaid. All other individuals who apply for MAD must have a determination of disability (refer to V.D. below for exceptions). In addition, if an RSDI/SSI beneficiary requests MAD coverage for a period prior to the disability onset date established by Social Security, he must have a disability determination for that period of time.

North Carolina Disability Determination Services (DDS) determines disability for North Carolina residents who apply for RSDI, SSI and Medicaid.

This section provides instructions on whether a disability determination is required and how to request it, processing Medicaid cases reopened due to appeal reversals or Social Security approvals, reacting to changes in disability status and periodic reviews of disability.

A. SSI Beneficiaries

A person under age 65 who receives SSI disability is automatically eligible for Medicaid as MAD without a separate application or a disability determination. If the SSI beneficiary requests Medicaid for a period prior to his authorization for SSI, he must apply for MAD for that period and be determined disabled. Refer to MA-1000, SSI Medicaid - Automated Process and to MA-1100, SSI Medicaid - County Responsibility and to IV. below.

(I.)

B. Social Security Disability Beneficiaries (RSDI)

A person who receives Social Security based on disability meets the disability requirement for Medicaid. However, he is not automatically eligible for Medicaid. He must apply for Medicaid and must meet all other eligibility requirements. If the Social Security disability beneficiary requests Medicaid for a period prior to his onset date for disability, he must apply for that period and be determined disabled.

C. Persons Not Receiving Social Security Disability or SSI

A person who wishes to apply for Medicaid based on disability and who is not receiving Social Security Disability or SSI must be determined disabled by DDS (Refer to V.D. below for exceptions).

II. DEFINITIONS

A. Disability

The Social Security Administration (SSA) defines disability as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments that is expected to result in death or which has lasted or is expected to last for a continuous period of not less than 12 months. A disability determination for HCWD is made without regard to Substantial Gainful Activity.

B. Social Security Administration (SSA)

SSA is the agency of the federal government that issues regulations for the RSDI and SSI programs, as well as Medicare and Medicaid, under the Social Security Act.

C. Retirement, Survivors, Disability Insurance (RSDI)

RSDI is a program administered under Title II of the Social Security Act through the SSA that pays benefits to persons who have contributed enough quarters to the Social Security system, or who are the dependents of one who has contributed to the system, when they are aged or retired, are a surviving spouse or dependent child, or are disabled.

An individual under age 65 may be receiving RSDI as a retired person. and must be determined disabled to be eligible under MAD. Receipt of early retirement benefits does not establish disability, unless the individual actually received a disability benefit and then switched to early retirement benefits at age 62. For an individual under age 65 receiving RSDI, verify with SSA whether he has been determined disabled.

(II.)

D. Supplemental Security Income (SSI)

SSI is a program administered under Title XVI of the Social Security Act through the SSA. It is an assistance program based on need that guarantees a minimum level of income for aged, blind, and disabled persons. SSI beneficiaries have not contributed enough to the Social Security system to be able to receive benefits on their own wage accounts. Effective January 1, 1995, SSI beneficiaries in North Carolina automatically receive Medicaid.

E. Disability Determination Services (DDS)

This is the section of the North Carolina Department of Health and Human Services (DHHS) which is responsible for making determinations of disability for RSDI, SSI, and Medicaid.

F. Disability Onset Date

This is the date that the disability began. The onset date is established by DDS as part of the disability determination for SSI, RSDI or Medicaid. Eligibility for Medicaid can begin no earlier than the first day of the month of the onset date. If the person applies for Medicaid for a period prior to an established onset date, disability must be determined for that period.

G. Diary/Re-Exam Date

This is the date when a continuing disability review (CDR) is due as established by DDS and is found on the DMA-4037, Disability Determination Transmittal. If the approval was the result of an appeal decision, the "Diary/Re-Exam Date" is found in the body of the decision letter.

H. Health Coverage for Workers with Disabilities (HCWD)

A program which allows individuals with disabilities to work and maintain Medicaid benefits through a higher resource limit and no limitation on total countable income. There is a 150% of FPL limit on unearned income for these individuals. Based on their total countable unearned and earned income, some beneficiaries may have to pay an annual enrollment fee and/or a monthly premium to obtain Medicaid coverage.

III. POLICY PRINCIPLES

A. When A Disability Determination by DDS Is Required

A disability determination by DDS is required in the following situations:

(III)

1. The person requesting Medicaid is ineligible in any other aid program category, and he:

   a. States that he is disabled, and

   b. His disability has not already been established.

2. The person requesting Medicaid may be eligible in another category but policies in MAD are more favorable to him, and he

   a. States that he is disabled, and

   b. His disability has not already been established.

3. The person is working and states that he is disabled but:

   a. Has not had a disability determination; or

   b. Has not received disability in the twelve months prior to the date of application; or

   c. Exceeds regular Medicaid income and resource limits.

   NOTE: If an HCWD applicant has been found disabled within the twelve months prior to the month of application he is considered disabled for HCWD purposes.

4. The person requesting Medicaid has been determined disabled, but an earlier onset date must be established to cover dates prior to the established onset date.

5. Ongoing Cases: Some MAD beneficiaries require a periodic continuing disability review (CDR). The date when a CDR is due is called a "Diary/Re-Exam Date" which is established by DDS or by the Hearing Officer in the hearing decision. If a Diary/Re-exam date is established, enter the date in the "Date of Diary/Re-Exam" field in the beneficiary's DISABILITY Evidence to flag the case for a disability review at the scheduled time.

B. Applicants who are Working

When an applicant alleges he is disabled and is working request a disability determination from DDS using the DMA-4037, Disability Determination Transmittal.

(III.C.)

C. Application Time Standards

For all applications involving disability, the time standard for processing the application is 90 days. Key the application in NC FAST. Complete in NC FAST the Disability Determination Assessment when a disability must be determined. When a disability determination is not needed complete DISABILITY evidence.

D. Verification of Disability Status

Verify whether an individual has applied for or been determined disabled for RSDI/SSI through SOLQ, BENDEX, or SDX inquiry. For individuals receiving RSDI who are under age 65, the county must verify with SSA whether the individual has been determined disabled in order to be eligible under MAD.

E. Continue Eligibility Determination

For applications, continue to determine eligibility while disability is being determined by DDS. If prior to receiving a disability determination from DDS the county determines that the applicant is ineligible for regular MAD and HCWD, immediately contact DDS and tell them that a disability determination is no longer necessary. Denying the application, which sends an "Application Denied/Withdrawn" task to DDS, is not sufficient. Call the appropriate Medicaid Unit Supervisor. (See DDS contact information at IV.B.10. below.)

IV. APPLICATIONS/REAPPLICATIONS - DISABILITY NOT ESTABLISHED

A. Complete a disability referral under the following circumstances:

1. The individual is applying for ongoing and/or retroactive Medicaid, or

2. The individual is requesting Medicaid for a period of time prior to an established onset date, or

3. The individual has applied for RSDI/SSI but no decision has been rendered. DDS will associate the Medicaid determination with the SSA case.

B. A complete disability referral includes the following forms that MUST be completed by the IMC and submitted to DDS:

DDS will not process a claim if all the forms below are not submitted or the information is incomplete. They will return the transmittal.

1. Complete the DMA-4037, Disability Determination Transmittal, in NC FAST. Only one copy of the DMA-4037 is required.

(IV.B.)

a. Complete the top portion, **making sure that all fields are completed.**

b. Indicate in the "Remarks" block of the DMA-4037:

(1) Whether there is need for a retroactive onset date and the month(s) in which retroactive Medicaid is needed.

(2) The date of application and where an out-of-state application for RSDI/SSI was filed, if any.

(3) The **date of death** if the applicant is deceased at the time of application. Complete all other material listed below.

2. DMA-5009, Social History Summary for the Disabled or Disability Determination Assessment. Include with the Disability Determination Assessment, the name, Social Security number and telephone number of the applicant or the person providing the information if different than the applicant.

(NOTE: Refer to the Income Maintenance Caseworker's Guide to the Disability Determination Process for instructions on completing the DMA-5009.)

a. The IMC must document all activities thoroughly. It is the responsibility of the IMC to make sure that the information is complete and accurate, including those situations in which the DMA-5009 is completed by another entity. DDS will not accept the DMA-5009 that is incomplete, has blank spaces, or has "N/A" entered in any spaces.

b. List on the DMA-5009, in the "Medical Sources" section, the complete names, addresses, phone numbers and dates of all medical treating sources. Include all out of state medical providers. List all medical conditions for which treatment was received.

c. For all children, and for adults who are alleging disability, include in the listing of treatment sources the current or most recent school attended and the highest level of education completed. Provide contact information for a third party to include name, address and phone number

3. DMA-5028, Authorization to Disclose Information

a. The DMA-5028 must be submitted as a one page document, front and back with signature. The form must be duplexed, signed, dated and witnessed.

(IV.B.)

b. Submit a signed copy for each treating source and school listed on the DMA-5009. Submit at least one signed DMA-5028, if there is no treating source/school.

d. Include one extra signed copy for a possible additional source.

e. If an a/b has an objection with any source listed on the DMA-5028 he may choose not to release records from that source. If there is an objection, follow these procedures:

(1) Under the section "From Whom" on the front page of the DMA-5028, there is a list of sources that authorization is given to release information. If the a/b does not want records released from a particular source, a line should be drawn through the source

(2) If there is a specific source, the a/b can list the source to the left of the "From Whom" section, line through it and initial.

f. If the disability is a mental impairment, DDS may request that the local agency obtain witnessed DMA-5028's.

(1) If the individual is incompetent or comatose, and there is a power of attorney (POA) or legal guardian, obtain the signature of the power of attorney or legal guardian. Submit a copy of the power of attorney or guardianship documents.

(2) If there is no POA or guardian, contact the provider to determine how to obtain medical records (i.e. release form signed by spouse). If necessary, contact a Medicaid supervisor at DDS by telephone for assistance.

Note: DMA-5200, Appendix C, Authorized Representative Form, cannot be used in place of a POA or guardianship document. It is not HIPPA compliant and cannot be used to request medical evidence.

g. **An electronic signature for a DMA-5028 will NOT be accepted**. The local agency worker must always sign in the "Witness" section of the DMA-5028. If a/b signs with an "X", the signatures of two witnesses are also needed or a Power of Attorney (POA) document is required.

4. Submit any local agency file copies of medical evidence and DMA-4037, Disability Determination Transmittals previously reviewed by DDS prior to the current application, including prior files within the past 12 months on other applications as well.

(IV.B.5.)

5. Send the DMA-4037, DMA-5028, DMA-5009 and any medical records, stapled together in the order listed, to the address listed below. Mark envelopes "Medicaid Unit" or "MAO" in a prominent place.

   Disability Determination Services
   2802 Mail Service Center
   Raleigh, North Carolina 27699 - 2802

6. File one copy of all forms in the case record, including a control copy of the DMA-4037 and an extra DMA-5028. There must be at least one DMA-5028 in the case record AND one sent to DDS, even if there are no medical sources or schools listed.

7. Send or call in to DDS the following additional information which could affect the application:

   a. Names and addresses of additional treating sources

   b. Any new medical information

   c. Application for RSDI/SSI

   d. Death of applicant

   e. Change of address and/or telephone of applicant

8. If the contact with DDS is by telephone, document the date of the contact and the name of the person contacted in the case record. The Medicaid Unit numbers are 09, 42, 44 and 45. Ask for any of these units or ask for the Medicaid Unit. The toll-free numbers below are all Medicaid Unit numbers.

9. If the contact is by mail, use a copy of the original DMA-4037. DO NOT SEND A SECOND ORIGINAL DMA-4037. Document clearly the individual's name and correct Social Security number. Check the box marked “Additional Information” in the “Remarks” section. List and highlight the new or changed information.

10. If the applicant is found ineligible based on a non-disability related requirement, deny the application without waiting for the disability decision. Notify the Medicaid unit Supervisor at DDS by means of a telephone call or a facsimile (FAX) to any one of the following numbers:

Medicaid Unit	Telephone Number	Fax Number
09	888-847-4547	888-237-9339
42	800-662-9741	800-213-8254
44	800-634-2986	800-213-8256
45	866-498-3809	866-542-8153

C. Referrals for Individuals Entitled to RSDI (Title II) Benefits

Explain to the applicant that it is a post eligibility requirement to apply for all benefits to which he may be entitled. Refer the applicant to the local SSA office to apply for RSDI and suggest that the applicant also apply for SSI if he has not already done so. (See MA-2250, Income, II.A.) An SSI application is not a requirement.

D. Disability Decision

Verify whether a disability decision has been made by checking the DDS Disability Determination screen daily.

1. DDS will return the DMA-4037, Disability Determination Transmittal, to the county agency.

   DDS will also return all medical evidence used to make the disability decision on all Medicaid only applications. The county must retain this evidence in the record in accordance with the North Carolina Department of Health and Human Services Office of the Controller's Record Retention and Disposition Schedule/Medicaid Records Alert.

   a. The following responses indicate an MAD disability decision by DDS:

      (1) Disability Approval: DMA-4037 with disability onset date indicated in the section "Under a disability since...," and "Diagnosis," "Diary/Re-Exam," and "Reg. Basis Code" completed.

          D- Under a disability

      (2) Disability Denial: DMA-4037 with "Not under a disability," "Diagnosis," "Reg. Basis Code," and "Rationale" completed and including one or more of the attachments.

          (a) N- Not under disability

          (b) I- Denial Decision. This means there was insufficient medical evidence or failure to attend consultative exam.

(IV.D.1.b.)

b. The following response indicates an SSA disability decision:

(1) Disability Approval: DMA-4037, Disability Determination Transmittal, with "Under a disability since..." and "Rationale" marked, an attachment indicating whether the application is RSDI or SSI, and the Medical Assistance Disability Allowance form.

D-Under a disability

(2) Disability Denial: DMA-4037 with “Not under a disability” and "Rationale" marked, an attachment indicating whether the application is RSDI or SSI, and the Medical Assistance Disability Denial form with one of the codes indicated.

(a) N- Not under a disability

(b) I- Denial Decision. This means there was insufficient medical evidence or failure to attend consultative exam

2. Unable to locate: This means DDS has exhausted all means of trying to locate an applicant by mail or phone, and the attempts were unsuccessful or the applicant’s whereabouts were unknown. The local agency must assist DDS in locating the individual. To dispose of the application, the county must follow procedures for unable to locate outlined in MA-2304, Processing the Application.

3. Upon receipt of the disability decision, approve or deny the application, or place in deductible status, as appropriate. If the application is approved, check the DMA-4037 for a "Diary/Re-Exam Date" to enter in the Special Review Code.

NOTE: When a Medicaid Disability allowance is a based on the adoption of a federal SSA or SSI disability decision,there will not be a Diary/Re-Exam date on the DMA-4037. Continued medical entitlement to Medicaid is based upon continued entitlement to SSA/SSI. All federal disability decisions will be designated on the DMA-4037 as an SSA/SSI decision. All other independent Medicaid determinations should have an established Diary/Re-Exam date on the DMA-4037. If there is not a Diary/Re-Exam date and there is not an attachment that indicates the disability decision was a SSA/SSI decision, then contact DDS to obtain a Diary/Re-Exam date. (See IV.B.10. above for contact numbers)

(IV.)

E. Substantial Gainful Activity

Disability is defined in part as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments. DDS makes the determination of whether an individual meets the medical criteria for disability. In MAD, MAB and HCWD cases, the determination of whether the individual is engaging in Substantial Gainful Activity (SGA) is made by the local agency SGA is an amount set by SSA on a yearly basis. Those whose earned income exceeds the SGA amount do not meet the Social Security definition of disability. SGA amounts for blind and non blind individuals are updated yearly.

Note: SGA determinations are not needed for individuals who receive RSDI based on disability.

1. MAD/MAB Cases

   a. Individuals who are paid wages or a salary

      Compare the a/b's gross monthly earned income to the appropriate SGA amount to determine if he meets the financial criteria for disability.

      (1) If gross monthly earned income is equal to or less than the SGA limit, the individual is not engaging in substantial gainful activity. Evaluate the individual for regular MAD. If the individual is over income and/or reserve for MAD, evaluate for HCWD.

   b. If the gross monthly earned income is greater than the appropriate SGA amount, deduct the following from the gross monthly income:

      (1) Impairment Related Work Expenses (MA-2250 IX.G.), including Work Expense Exclusion for the Blind (MA-2250 IX.F.), and

      (2) Subsidized Earnings

         An employer may subsidize the earnings of an employee with a serious medical impairment by paying more in wages than the reasonable value of the actual services performed. When this occurs, the excess will be regarded as a subsidy rather than earnings. If it is suspected that the a/b is receiving subsidized earnings, contact the employer and ask:

         (a) Is the employee receiving a subsidy, if so,

         (b) The amount of the subsidy, and

(IV.E.1.b.(2))

(c) How the subsidy was calculated.

Note: Subsidized earnings are counted as unearned income for budgeting purposes.

(3) The resulting amount in 1.b. above is the income used to determine whether the a/b is engaging in SGA.

(a) If the resulting amount is more than the appropriate SGA amount, evaluate for HCWD.

(b) If the resulting amount is equal to or less than the appropriate SGA amount:

1) Evaluate for regular MAD, and

2) If over regular MAD income and/or resource requirements, evaluate for HCWD.

c. Self-employed individuals

(1) If gross income minus allowable expenses averages less than the SGA amount, the individual is not engaging in SGA. Evaluate the individual for regular MAD. If income and/or reserve is over the MAD limits, evaluate the individual for HCWD.

(2) If gross income minus allowable expenses averages more than the SGA amount, the individual is engaging in SGA. Evaluate the individual for HCWD.

2. HCWD Cases

If the individual is engaged in SGA, evaluate for HCWD eligibility according to policy in MA-2180, Health Coverage for Workers with Disabilities.

V. APPLICATIONS/REAPPLICATIONS - DISABILITY ALREADY ESTABLISHED

A. Procedures to Follow When Disability Has Been Established:

1. Disability is already established due to receipt of RSDI/SSI and there are no prior denials/terminations of MAD. (Refer to B. and C., below.) or

2. Disability is already established and MAD was previously denied/ terminated for reasons not related to disability. (Refer to D., below.)

(V.)

B. Disability Already Established - Receives SSI

SSI beneficiaries are automatically eligible for ongoing Medicaid without a separate Medicaid application. Refer to MA-1000, SSI Medicaid-Automated Process.

SSI beneficiaries may request retroactive Medicaid for the three months prior to the SSI application date. Since the SSI disability onset date is established beginning with the month of SSI application or later, DDS must make a determination of disability if an earlier onset date must be established for retroactive coverage. Refer to MA-1100, SSI Medicaid - County DSS Responsibility for procedures to establish eligibility. Follow procedures in IV.B. above to submit to DDS to establish an earlier disability onset date for retroactive SSI Medicaid.

C. Disability Already Established - Receives RSDI

An RSDI beneficiary who is receiving RSDI based on a determination of disability by SSA is considered disabled for Medicaid purposes. No additional disability determination is needed. Determine whether other eligibility factors are met.

D. Disability Already Established - MAD Was Previously Terminated or Denied for Reasons Unrelated to Disability

1. If an MAD applicant who does not receive RSDI/SSI was previously determined to be disabled by SSA, DDS or a Hearing Officer, but MAD was terminated or denied for reasons unrelated to disability (such as income or resources), do not submit to DDS for a determination of disability if the following conditions are met:

    a. There is no indication of medical improvement or there has been no SSA disability denial or termination during the closed period. An example of medical improvement would be the applicant is working or is receiving Unemployment Insurance.

    b. There has been no review of disability previously scheduled (diary/re-exam date), or if there is a diary/re-exam date it has not yet occurred.

2. If an HCWD applicant is not receiving RSDI/SSI but was previously determined to be disabled by SSA, DDS or a Hearing Officer he still may be considered disabled for HCWD purposes. The IMC must consider the length of time between termination of RSDI or SSI benefits, the DDS decision, or the Hearing Officer's decision and application for HCWD.

(V.D.2.)

If the termination of RSDI or SSI benefits, or the DDS decision or the Hearing Officer's decision occurred 12 months or less prior to the date of application, a DDS determination of disability is not necessary.

3. If the conditions in either 1 or 2 are not met, or if the applicant requests coverage prior to the previously established disability onset date, follow instructions in IV.B, above, to submit to DDS.

VI. APPLICATIONS/REAPPLICATIONS - DISABILITY ESTABLISHED BY SSA - PRIOR MAD DISABILITY DENIAL

When SSA determines that an individual is disabled but a MAD application was previously denied due to disability, AND the onset date of disability is the same as or prior to the date of the previous MAD denial, follow procedures below to reopen the denied MAD and determine eligibility.

A. RSDI/SSI Disability Approval on SSA Appeal

SSI - If an application for SSI disability was denied by SSA but the denial is reversed on SSA appeal, the individual will receive MAD effective the month SSI is effective.

No action is required by the local agency unless the individual requests retroactive coverage. Refer to MA-1100, SSI Medicaid - County DSS Responsibility for procedures to establish eligibility. Also, refer to IV., above, if you must establish an earlier disability onset date for retroactive SSI Medicaid.

RSDI - If an application for RSDI was denied by SSA but the denial is reversed on SSA appeal, the reversal of the SSA disability decision is considered a reversal of the MAD disability decision.

1. Reopen the application. This should be treated as a new application. Follow instructions in MA-2303, Verification Requirements for Applications. Complete a date screen in the field "RSDI or SSI Appeal Reversal/SSI Appl." (See EIS 2400: Application Processing.) if:

   a. Medicaid was denied as the result of an RSDI disability denial, and

   b. RSDI disability was subsequently approved as the result of an SSA reconsideration, Administrative Law Judge's (ALJ) ruling, or other appeal decision (verify by viewing the decision or other Social Security documentation), and

   c. The onset date is the same as or is prior to the date of the denial of a Medicaid application. and

(VI.A1.)

d. There is documentation that medical need still exists, that is, a medical expense which Medicaid can cover.

2. The application date is the date the local agency learns of the RSDI appeal reversal by means of:

   a. An award letter,

   b. SDX/BENDEX or SOLQ, or

   c. Letter from Administrative Law Judge (ALJ) or Appeals Council.

3. Authorize assistance based on the original date of application if all other eligibility factors are met, and there is documentation that there is an unpaid medical expense that Medicaid can cover, including bills which may already have been used to meet a deductible for a later certification period. Accept the a/b's statement of the names of the providers of the services and dates of service.

B. Request for Override

At the same time the application is dispositioned, request an override of the 12 months' claims processing time limit if services were provided more than 12 months prior to disposition.

1. Follow instructions in MA-2395, Corrective Actions and Responsibility for Errors, to complete the Request For Claims Override. Include all requested information. Send the Request for Claims Override to the Claims Analysis Unit at the following address. Claims Analysis will notify the local agency by copy of the letter to the provider or by memo whether or not the override is approved.

   Division of Medical Assistance
   Claims Analysis Unit
   2501 Mail Service Center
   Raleigh, NC 27699-2501
   Phone: 1-919- 813-5580

2. Begin authorization on the date all eligibility factors are met, but no earlier than the later of:

   a. The first day of the month of onset of disability, or

   b. Three months retroactive to the application date of the denied Medicaid application.

(VII.)

VII. APPEAL REVERSAL OF MAD DISABILITY DENIAL

A. When an MAD application was denied by DDS but was subsequently approved as the result of a state appeal that reversed the DDS decision:

1. Reopen the original application within 5 work days of the date the Notice of Decision is final. Process the reversed decision. Refer to MA-2304, Processing the Application, for instructions for state appeal reversals.

2. Verify RSDI status through BENDEX, SDX, and/or SOLQ.

3. Open an MAD application but do not require a disability determination. A signed application is not required.

4. The date of application is the date the application is reopened (the current date).

B. Check the Notice of Decision for a Diary/Re-exam date.

1. If there is one, enter the "Diary/Re-Exam Date" in the" Date of Diary/Re-Exam" field in the beneficiary's DISABILITY evidence. A "Diary/Re-Exam Date" will only be listed for cases in which a federal SSA /SSI disability allowance is not involved.

2. If the "Diary/Re-Exam Date" is not listed on the Notice of Decision for a case that was not a federal SSA/SSI disability allowance, contact the Hearing Officer for this information.

   The Hearing Officer will also return all medical evidence used to make the disability decision on cases without a SSA/SSI disability allowance. The county must retain this evidence in the record. These records must be used to determine if the beneficiaries condition has improved during the re-exam review. If records are not available for the re-exam, DDS cannot document the beneficiary's improvement; therefore, Medicaid must be continued until the next review or county reports beneficiary has returned to work

VIII. ACTIVE MAD BENEFICIARY WITH SSA/SSI TERMINATION OR DENIAL

A. Certain MAD beneficiaries may have Medicaid continued when RSDI/SSI has been denied or terminated and the beneficiary is appealing the disability decision. (See X. below for HCWD cases).

The MAD beneficiary has to also meet other Medicaid non-disability criteria. The following conditions must be met for Medicaid to be continued throughout the RSDI/SSI appeal process:

(VIII)

1. The individual is an active (non-HCWD) MAD beneficiary and is denied or terminated from RSDI/SSI, due to no longer being disabled. Refer to MA-1100, SSI Medicaid/Automated Process for ex parte procedures.

   An ex parte review means to review information available to the agency to make a determination of eligibility, without requiring the beneficiary to come into the agency or make a separate application. The county must explore and exhaust all possible avenues of eligibility in all Medicaid coverage groups. If information is not available to make a determination of eligibility, the county must provide the beneficiary reasonable opportunity to provide the necessary information.

2. He requests the RSDI/SSI appeal timely within 65 days of the RSDI/SSI denial or termination or he appeals after the 65 day deadline and SSA accepts the appeal as late with good cause. If the local agency learns that SSA accepted the appeal request, reinstate and continue MAD while the SSA appeal process continues.

B. When you learn from the beneficiary, SSA, DDS, BENDEX, SDX, SOLQ, or from any other source that SSA/SSI has denied or terminated due to no longer being disabled, take the following actions in cases where the individual is not working (for cases involving working individuals see X. below):

1. Continue the disability status for the MAD beneficiary assuming all other eligibility factors continue to be met, until either:

   a. The last day of the month in which falls the 65 day deadline for requesting or initiating an RSDI/SSI disability appeal through SSA. The four month ex parte period begins the month of the SSI termination. Refer to MA-1000, SSI Medicaid/Automated Process. The 65 day period begins with the date of the RSDI or SSI denial or termination, or

   b. Until a final decision is rendered by the Appeals Council with no right to further administrative appeal.

2. Do not continue Medicaid beyond the Appeals Council level, even if the beneficiary appeals to federal court or reapplies for RSDI/SSI.

3. Flag the case for 65 days from the date of the notice of denial or termination from SSA.

4. Advise the beneficiary to notify the local agency if/when he appeals and if/when he receives a decision from SSA.

(VIII.B.)

5. Encourage the beneficiary to keep all correspondence from SSA. Ask the beneficiary if he is receiving Medicare. If receiving Medicare contact your local SSA representative to determine if the Medicare Part B will continue while beneficiary is in appeal status.

6. No later than the flagged date, contact the beneficiary to ask if he has appealed the denial. If no appeal is filed, he is no longer eligible for MAD.

   Evaluate for coverage in other aid program/categories following procedures in MA-2352, Terminations/Deletions and MA-1000, SSI Medicaid-Automated Process.

7. If he states he has appealed, verify his statement by:

   a. Written acknowledgment of appeal by SSA, or

   b. SDX, or

   c. Established local agency procedures to communicate with the SSA District Office.

8. If the appeal request is verified, continue MAD.

   a. Advise the beneficiary to notify the local agency within 5 days of receipt of a decision on his appeal from SSA.

   b. Flag the case a second time for 65 days from the date of the appeal request in order to verify the status.

   c. If the beneficiary has not contacted the local agency regarding the status of his appeal by the second flagged date, contact the beneficiary or the SSA District Office again to verify the status.

      (1) If no decision has been made, continue MAD.

      (2) If a favorable decision has been made, verify and continue Medicaid.

      (3) If the appeal is denied, continue Medicaid for 65 days from the date of decision to allow the beneficiary time to exercise his further appeal rights.

d. If the beneficiary fails to appeal timely, or later with good cause he is no longer eligible for MAD. Conduct an ex parte review to evaluate for coverage in other categories, following procedures in MA-2352, Terminations/Deletions and MA-1000, SSI Medicaid - Automated Process. If ineligible, send a timely notice to propose termination. Refer to **IX.** below for state hearing appeal rights and the right to continued benefits after such a termination. Explain these rights to the beneficiary.

1. Continue the process described above until a final decision is made, either through the appeals council or at any point the beneficiary fails to continue the appeals process.

2. If the regular "Diary/Re-Exam Date" falls during this process, do not submit to DDS for a disability review. The SSA denial/hearing decision takes precedence over this Diary/Re-Exam date. If the RSDI/SSI denial or termination is overturned and ongoing benefits are approved, a new re-exam date will be established by SSA.

IX. ACTIVE MAD BENEFICIARY APPEALS MEDICAID TERMINATION OF DISABILITY THROUGH THE STATE HEARING PROCESS

When an active MAD beneficiary is terminated for failure to pursue an SSA appeal or completion of the SSA appeal process, the beneficiary still has the right to appeal the Medicaid termination to a state hearing officer. If the terminated MAD beneficiary requests an appeal through the local agency on his Medicaid termination based on an allegation of disability, the appeal is a State level hearing.

A. The State Hearing Officer will hear the appeal. The Hearing Officer will conduct a hearing to determine if the beneficiary meets one of the conditions in 1, 2, or 3 below:

1. Has a disabling condition different from, or in addition to the conditions considered in the original SSA disability decision, or

2. Alleges more than 12 months after the most recent SSA termination for not being disabled that his condition has changed or deteriorated and his period of disability meets the 12 month durational requirement, and he has not reapplied at SSA based on those new allegations, or

3. Alleges less than 12 months after the most recent SSA termination for not being disabled, that his condition has changed or deteriorated, and his period of disability meets the 12 month durational requirement, and

(IX.A.3.)

a. He has applied to SSA for reconsideration or reopening and SSA refuses to consider the changes, and /or

b. He does not meet other SSI eligibility requirements e.g., reserve, but may meet the state's Medicaid eligibility requirements for MAD.

B. If the State Hearing Officer determines that A.1, 2, or 3 above apply, then the State Hearing Officer will determine if the beneficiary meets the disability requirements. If the Hearing Officer determines the beneficiary is still disabled, MAD is continued or reinstated. A continuing SSA appeal is not a requirement if the hearing officer determines that A. 1, 2, or 3 apply and that the a/b is disabled. Refer the applicant to the local SSA office to apply for RSDI and suggest that the applicant also apply for SSI if he has not already done so. (See MA-2250, Income, II.A.) An SSI application is not a requirement. If the a/b requests the appeal prior to the end of the timely notice period, the a/b has a right to have Medicaid benefits continued through the decision on the State level hearing. Refer to MA-2420, Notice and Hearings Process.

X. MAB/MAD BENEFICIARIES WHO ARE WORKING AND TERMINATED FROM RSDI/SSI

If the IMC learns from the beneficiary, SSA, DDS, BENDEX, SDX, SOLQ, or from any other source that RSDI/SSI has been denied or terminated due to non-medical factors, evaluate for continuing MAB/MAD eligibility. If the individual is not eligible as MAB/MAD, do an ex parte review to determine if he is eligible in any other program. If the individual is working and meets all other HCWD eligibility criteria, assume that he is disabled for HCWD purposes. At the next regular eligibility review, submit to DDS and write "SPECIAL REVIEW" on the DMA-4037, Disability Determination Transmittal. Indicate in the "Remarks" that the purpose of the review is to obtain a diary date.

If the IMC does not know the reason for the termination, or if it is known that the individual was terminated for medical reasons, do an ex parte review to determine if the individual is eligible in any other program. If the individual is not eligible in any program, send a timely notice and terminate. If the individual reapplies and is working, he must be referred to DDS for a disability determination.

A. Individuals who were not HCWD

1. If the review results in a determination of disabled and the individual is employed, evaluate for eligibility in the HCWD Basic Coverage Group.

2. If the review results in a determination of not disabled, evaluate for eligibility in all other Medicaid programs.

(X.)

B. Individuals who were eligible in HCWD Basic Coverage Group

If the review results in a determination of not-disabled and the individual is employed, evaluate for eligibility in the HCWD Medically Improved Group (Refer to MA-2180, Health Coverage for Workers with Disabilities, IV.C.

XI. REDETERMINATIONS OF DISABILITY FOR NON-SSI MAD CHILDREN UNDER AGE 18

A. For MAD children who receive SSI, SSA will conduct the redeterminations of disability on a periodic basis. Do not initiate disability reviews for SSI children.

B. Non-SSI MAD Children

Most non-SSI MAD children have a "Diary/Re-Exam Date" indicated on the lower right hand side of the current DMA-4037, Disability Determination Transmittal. If the approval was the result of an appeal decision, the "Diary/Re-Exam Date" is found in the body of the decision letter.

1. At the next regular Medicaid eligibility redetermination, review the DMA-4037 in the county case record to determine the "Diary/Re-Exam Date."

2. Ensure that the case is flagged in NC FAST for a disability review at the Diary/Re-exam date. No special redetermination of disability is required.

3. If there is not a "Diary/Re-Exam Date", submit to DDS for a disability review at the time of the next redetermination or eligibility following procedures in IV.B above.

4. Once a diary/re-exam date has been established, ensure that the case is flagged so the case can be submitted to DDS for disability reviews at the Diary/Re-exam date established by DDS.

XII. REDETERMINATIONS OF CONTINUED DISABILITY FOR NON-SSI ADULTS OVER AGE 18

Refer to MA-1000, SSI Medicaid-Automated Process for requirements for disability determinations for SSI beneficiaries when SSI ends.

Beneficiaries Not Receiving RSDI or Receiving RSDI Not Based on Disability

1. For MAD beneficiaries who do not receive RSDI, request a redetermination of disability on the Diary/Re-Exam Date. The re-exam date is documented on the DMA-4037, Disability Determination Transmittal, or in the body of the state hearing decision.

a. Flag the case at least 30 days in advance of the due date for review.

b. Follow instructions in IV.B., above to submit to DDS. Also, include a copy of the favorable disability decision from the case record. Write "REVIEW" on the DMA-4037. Omit the date of application.

2. If it is suspected that the beneficiaries medical condition has improved or the local agency learns that the a/b has started working since disability was established, a special redetermination of eligibility may be requested. Submit to DDS and write "SPECIAL REVIEW" on the DMA-4037.

A. Beneficiaries Receiving RSDI Based on Disability

If a beneficiary is receiving RSDI based on a disability, the Social Security Administration is responsible for the review of disability. Do not submit to DDS for a disability review, as long as an MAD beneficiary continues to receive RSDI Disability.

If RSDI disability terminates, the beneficiary is no longer eligible for Medicaid for the Disabled unless the beneficiary has appealed the disability termination through Social Security. (Refer to VIII.) If not in appeal status conduct an ex parte review to evaluate eligibility in other categories following procedures in MA-2352, Terminations/Deletions.

XIII. TRANSPORTATION FOR MAD APPLICANTS TO ESTABLISH DISABILITY

A. Requirement to Assist with Transportation

1. The local agency **must assist** the applicant who requests transportation to medical appointments that are required to establish disability. The transportation arrangement must be the most cost effective means appropriate to the applicant's needs.

2. Regular Medicaid (Title XIX) transportation reimbursement is unavailable because the applicant is not authorized for Medicaid.

3. DDS will reimburse the local agency for travel charges that are greater than $2.00. No payments may be made for travel by means other than train, bus, or private automobile unless approved in advance by DDS. Taxi costs in excess of $14.00 must also be approved in advance.

(XIII.)

B. Informing the Applicant

Inform the applicant that he may request assistance with transportation to medical appointments in order to establish disability if DDS requires a consultative examination.

C. Authorization and Reimbursement

1. Complete the Authorization and Request for Reimbursement of Travel Costs, document for reimbursement. The document may be requested from DDS by contacting the DDS Medicaid Unit associated with the application.

2. Either the local agency or the applicant may use the Authorization and Request for Reimbursement of Travel Costs, form for reimbursement, depending on whether the transportation is provided by the county or arranged for the applicant.

3. Submit the completed Authorization and Request for Reimbursement of Travel Costs, form for reimbursement.