DISABILITY

REVISED 2/26/2021 - CHANGE NO. 04-21

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 applicants/beneficiary (a/b) who apply for MAD must have a determination of disability. 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

An individual under age 65 who receives SSI 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 their authorization for SSI, they 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 DSS Responsibility .

B. Social Security Disability Beneficiaries (RSDI)

An individual who receives Social Security based on disability meets the disability requirement for Medicaid. However, they are not automatically eligible for Medicaid. The individual must apply for Medicaid and must meet all other eligibility requirements. If the Social Security disability beneficiary requests Medicaid for a period prior to the onset date for disability, the individual must apply for that period and be determined disabled.

C. Persons Not Receiving Social Security Disability or SSI

An individual 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.

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 Health Coverage for Workers with Disabilities (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 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 they have been determined disabled.

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 guarantee the minimum level of income. 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 individual 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 DHB-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:

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

    a. States they are disabled, and

b. Disability has not already been established.

2. The person requesting Medicaid may be eligible in another category but coverage in MAD may be a greater benefit and:

   a. States they are disabled, and

   b. Disability has not already been established.

3. The person is working and

   a. states they are disabled, and

   b. Disability has not already been established, or

   c. Has not received RSDI/SSI for more than twelve months prior to the date of application; and

   Income and/or resources exceeds regular Medicaid limit.

   If an HCWD applicant has been found disabled within the twelve months prior to the month of application, they are 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 DISABILITY evidence in NC Fast. This will create a task to notify the caseworker for a disability review at the scheduled time.

B. Application Time Standards

For all applications based on disability, the time standard for processing the application is 90 days.

C. Verification of Disability Status

Verify whether an a/b has applied for or been determined disabled for RSDI/SSI through the Online Verification System (OVS). For a/b (s) receiving RSDI who are under age 65, confirm they are receiving a disability benefit.

D. Continue to Determine Eligibility for other Medicaid Programs

1. At application, continue to determine Medicaid eligibility including Family

Planning Program (FPP) while disability is being determined by DDS.

2. When DDS determination is pending and the caseworker determines the applicant is ineligible due to financial or non-financial requirements, deny the application and evaluate for other Medicaid programs.

IV. APPLICATIONS/REAPPLICATIONS - DISABILITY NOT ESTABLISHED

A. Complete a disability referral under the following circumstances:

1. When the a/b is applying for ongoing and/or retroactive Medicaid and has not previously been determined disabled,

or

2. When the a/b is requesting Medicaid for a period of time prior to an established onset date,

or

3. When the a/b has applied for RSDI/SSI, but no decision has been rendered. DDS will associate the Medicaid determination with the SSA case.

B. When the local agency receives a manual DHB-5009, Social History Summary for the Disabled, all information must be keyed into the Assessment in NC FAST. Do not upload the completed DHB-5009, within NC FAST.

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

C. A complete disability referral includes the DHB-5028, Authorization to Disclose Information and DHB-4037, Disability Determination Transmittal forms that MUSTbe completed by the caseworker and submitted to DDS. If the forms are not submitted or incomplete, DDS will return the transmittal to the local agency. Refer to section E and F below for instructions on how to complete the forms.

D. The Disability Determination Assessment must be keyed in NC FAST for all applications.

The DDS Assessment must include the following:

1. The names, addresses, phone numbers and dates of service for all medical treating sources, all out of state medical providers, in the Medical Sources section. Include all medical conditions for which treatment was received.

2. Indicate current or most recent school attended and highest level of education completed for all applicants alleging disability regardless of age.

3. Provide contact information for a third party to include name, address and phone number only for the following:

   a. An individual that may have mental impairment,

   b. There is evidence of drug or alcohol abuse, or

   c. An individual who is homeless, in a shelter or in a halfway house.

E. DHB-5028, Authorization to Disclose Information

1. DHB-5028 must be complete when uploaded in NC FAST.

2. One complete DHB-5028 must be signed and dated by the claimant and include both front and back pages.

3. The DHB-5028 must be uploaded to NC FAST even if there is no treating source/school. DDS will use this DHB-5028 for all medical sources.

   An electronic signature for a DHB-5028 is acceptable.

4. If an a/b has an objection with any source listed on the DHB-5028, they 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 DHB-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.

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

   a. 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.

   b. 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 at any of the numbers shown below.

c. DMA-5202C, Designation of Authorized Representative – Appendix C 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.

d. If the individual is deceased, the caseworker will fax a copy of the death certificate to the General DDS Medicaid Fax 1-800-887-7596.

F. DHB-4037, Disability Determination Transmittal

1. DHB-4037 must be complete when uploaded in NC FAST.

2. Only one copy of the DHB-4037 is required.

   a. Complete the top portion, ensuring that all fields are complete.

   b. Indicate in the "Remarks" section of the DHB-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 the Medicaid application.

      (3) Where an out-of-state application for RSDI/SSI was filed, if any.

      (4) The **date of death** if the applicant is deceased at the time of application.

3. If an incomplete DSS Assessment or DHB-5028 is submitted, DDS will:

   a. Document what is incomplete on an updated DHB-4037 ,

   b. Upload the updated DHB-4037 in NC FAST, and

   c. Call the caseworker listed on the DHB-4037 as the direct contact for the application to notify them of the update.

G. Medical Records

Fax any previous copies of medical records and previous DDS decisions prior to the current application to the General DDS Medicaid fax number 1-800-887-7596 This includes medical records within the past 12 months from other prior applications.

Records will be retained by DDS. Any medical records retained by DDS or the local agency must be kept 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.

H. Additional Information

1. The caseworker will use the original DHB-4037. DO NOT CREATE A NEW DHB-4037.

2. Check the box marked "Additional Information" in the "Remarks" section.

3. List and highlight the new or changed information and fax to DDS.

4. The applicant / beneficiary may provide the following additional information which could affect the disability determination:

   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 number of applicants

5. List and highlight the new or changed information and fax to DDS.

6. If contact is by phone, use one of the toll-free telephone numbers listed below and ask for the DDS Medicaid Unit.

DDS Medicaid Unit	Toll-Free Telephone Number
General DDS Medicaid Fax	1-800-887-7596
09	888-847-4547
42	800-662-9741
44	800-634-2986
45	866-498-3809

V. POST ELIGIBILITY

When MAD is approved, the caseworker must request the applicant to apply for RSDI/SSI. Refer to MA-2301, Post Eligibility Verification.

VI. DISABILITY DECISION

Verify whether a disability decision has been made by checking the DDS Disability Determination screen daily. DDS will return the DHB-4037, Disability Determination Transmittal as a task in NCFAST.

The following responses on the uploaded DHB-4037 indicate an MAD disability decision by DDS:

A. Disability Approval

DHB-4037 with disability onset date indicated in the section:

1. "Under a disability since" and "Diagnosis"

2. "Diary/Re-Exam" and "Reg. Basis Code"

3. D - Under a disability

B. Disability Denial

DHB-4037 will indicate in the section with:

1. "Not under disability", "Diagnosis", "Reg. Basis Code" and "Rationale" completed and including one or more of the attachments.

2. N – Not under a disability

3. I - Denial Decision- Insufficient Evidence- This means there was insufficient medical evidence or failure to attend consultative exam.

C. SSA Disability Approval

DHB-4037 will indicate in the section with:

1. "Under a disability since..." and "Rationale"

2. An attachment indicating whether the application is RSDI or SSI, and the Medical Disability Allowance form.

3. D-Under a disability

D. SSA Disability Denial

DHB-4037 will indicate in the section with:

1. "Not under a disability" and "Rationale" marked,

2. 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-Insufficient Evidence
   This means there was insufficient medical evidence or failure to attend consultative exam.

E. Unable to locate

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-2300, Application.

F. 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 DHB-4037 for a "Diary/Re-Exam Date" to enter the date in the Disability evidence in NC FAST. If the decision is denied, the caseworker will deny the application and evaluate for all other Medicaid programs.

1. When a Medicaid Disability allowance is based on the adoption of a federal SSA or SSI disability decision, there will not be a Diary/Re-Exam date on the DHB-4037 . Continued medical entitlement to Medicaid is based upon continued entitlement to SSA/SSI.

   a. All federal disability decisions will be designated on the DHB-4037 as an SSA/SSI decision.

   b. All other independent Medicaid approval determinations should have an established Diary/Re-Exam date on the DHB-4037 .

2. If there is not a Diary/Re-Exam date and there is not an attachment that indicates the disability decision was an SSA/SSI decision, contact DDS to obtain a Diary/Re-Exam date. (See above for contact numbers)

VII. SUBSTANTIAL GAINFUL ACTIVITY (SGA)

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.

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.

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

A. MAD/MAB Cases

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

2. 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 a/b for regular MAD. If the a/b is over income and/or reserve for MAD, evaluate for HCWD.

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

    a. Impairment Related Work Expenses Exclusion for the Disabled, including Work Expense Exclusion for the Blind (MA-2250, Income) , and

    b. 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:

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

    (2) The amount of the subsidy, and

    (3) How the subsidy was calculated.

    Subsidized earnings are counted as unearned income for budgeting purposes.

    c. The resulting amount in A.3. above is the income used to determine whether the a/b is engaging in SGA.

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

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

    (a) Evaluate for regular MAD, and

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

4. Self-employed individuals

   a. 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.

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

B. 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.

VIII. APPLICATIONS/RE-APPLICATIONS - DISABILITY ALREADY STABLISHED

A. 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)

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 Section IV 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 and 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 Benefits.

   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 they still may be considered disabled for HCWD purposes. The caseworker 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.

   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 Section IV. to submit to DDS.

IX. 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 Section 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.

   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

      d. There is documentation that a medical need still exists, and the is, medical expense can be covered by Medicaid.

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 which can be covered by Medicaid, 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.

   If there is a deductible, follow policy in MA-2360, Medicaid Deductible to verify medical expenses for the appropriate certification period(s).

B. Request for Override

At the same time the application is activated, 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 Action and Responsibility for Errors, to complete the Request For Claims Override. Include all requested information. Refer to Job Aid: DHB Queue for Claims.

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.

X. 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-2300, 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 application date is the reopen or current date.

B. Diary/Re-exam Date

1. If the Notice of Decision contains a Diary/Re-Exam Date enter the date 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 listed on the Notice of decision for this information.

The Hearing Officer will also return all medical evidence used to make the disability decision on cases without an SSA/SSI disability allowance to DDS. DDS must retain the records. 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.

XI. 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 must also continue to meet other Medicaid non-disability

criteria. The following conditions must be met for Medicaid to be continued throughout the RSDI/SSI appeal process:

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-1000, 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 local agency 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 local agency must provide the beneficiary reasonable opportunity to provide the necessary information.

2. The beneficiary requests the RSDI/SSI appeal timely within 65 days of the RSDI/SSI denial or termination or they appeal 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 the MAD case and continue the SSA appeal process.

B. When the caseworker learns 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 section XI. 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 the 65th day falls for requesting or initiating an RSDI/SSI disability appeal through SSA.

   b. 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

   c. 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 they appeal and if/when they receive a decision from SSA.

5. Encourage the beneficiary to keep all correspondence from SSA. Ask the beneficiary if they are receiving Medicare. If yes, contact, the 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 they have appealed the denial. If no appeal is filed, they are no longer eligible for MAD.

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

7. If a/b states they have appealed, verify their 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 their 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 their 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 their further appeal rights.

   d. If the beneficiary fails to appeal timely, or later with good cause they are no longer eligible for MAD. Conduct an ex-parte review to evaluate for

coverage in other categories, following procedures in MA-2352, Termination/Deletions/Ex-parte and MA-1000, SSI Medicaid Automated Process, If ineligible, send a timely DSS-8110, Notice of Modification, Termination, or Continuation of Public Assistance notice to propose termination.

Refer to below for state hearing appeal rights and the right to continued benefits after such a termination. Explain these rights to the beneficiary.

9. 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.

10. If the regular "Diary/Re-Exam Date" occurs 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.

XII. 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 for the Medicaid termination based on an allegation of disability, the appeal is a State level hearing. The State Hearing Officer will determine if the beneficiary meets the disability requirements. Refer to MA-2420, Notice and Hearing Process.

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 the beneficiary:

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

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

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

Refer the applicant to the local SSA office to apply for RSDI and suggest that the applicant also apply for SSI if they have 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.

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

If the caseworker 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 they are eligible in any other program. If the individual is working and meets all other HCWD eligibility criteria, assume that they are disabled for HCWD purposes.

At the next regular eligibility review, submit to DDS and write "SPECIAL REVIEW" on the DHB4037, Disability Determination Transmittal.
Indicate in the "Remarks" that the purpose of the review is to obtain a diary date.

If the caseworker does not know the reason for the termination, or if it is known that the individual was terminated for medical reasons, complete 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 DSS-8110, Notice of Modification, Termination, or Continuation of Public Assistance and terminate. If the individual reapplies and is working, they 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.

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~~.

XIV. RECERTIFICATION OF DISABILITY FOR NON-SSI MAD CHILDREN UNDER AGE 18

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

B. Non-SSI MAD Children

Most children who do not receive SSI and receive MAD will have a "Diary/Re-Exam Date" indicated on the lower right hand side of the current DHB-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 recertification, review the DHB-4037 in NC FAST 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 recertification 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 recertification or eligibility following procedures in Section IV. above.

4. Once a diary/re-exam date has been established, ensure that the date is entered in the Disability Evidence in NC FAST. -The case should be submitted to DDS for disability reviews at the Diary/Re- exam date established by DDS using the diary re-exam submission process.

XV. RECERTIFICATION 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.

A. Beneficiaries Not Receiving RSDI or Receiving RSDI Not Based on Disability

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

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

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

B. 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 a disability review to DDS, as long as the 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 Section VIII.) If not in appeal status conduct an ex parte review to evaluate eligibility in other categories following procedures in MA-2352, Termination/Deletions/Ex-partes,

XVI. TRANSPORTATION FOR MAD APPLICANTS TO ESTABLISH DISABILITY

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.

Refer to MA-2910, Non-Emergency Medical Transportation (NEMT)