TO: Local District Commissioners, Medicaid Directors

FROM: Judith Arnold, Director
Division of Health Reform and Health Insurance Exchange Integration

SUBJECT: Medical Evidence Gathering for Disability Determinations – Adult Cases

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Support Unit
Upstate (518)474-8887 NYC (212)417-4500

The purpose of this GIS message is to inform local departments of social services (LDSS) of a revision in the process to be followed to gather medical information for adult disability determinations for submission to any Disability Review Team (DRT), whether it be the State or a local DRT. This message clarifies the necessary medical and non-medical documentation to be gathered and provides for a uniform medical information gathering and submission process statewide.

Information from an applicant/recipient's (A/R) treating medical providers is considered the optimal medical evidence to use when performing a disability determination. Historically, the NYS Medicaid Disability Manual gave districts the option to ask medical providers to complete pages 1 and 2 and all applicable body system sections of the twenty-five page "Medical Report for Determination of Disability" (LDSS-486T) or to complete pages 1 and 2 of that form and submit copies of the individual's medical records for the most recent 12 months or for the desired disability determination timeframe.

The LDSS-486T form, as currently submitted by providers, often does not supply a disability reviewer with sufficient medical information to complete a disability determination. The forms are frequently incomplete and/or contain insufficient documentation to make a determination of disability. In many instances, providers are refusing to complete the form. For this reason, disability reviews are frequently returned with a decision of "No Action" for more medical information. This results in the delayed processing of the A/R's Medicaid eligibility while more medical evidence, such as office notes, laboratory results, medical imaging evidence and treatment records are obtained. In addition, insufficient medical documentation on the LDSS-486T form frequently results in unnecessary consultative exams (CE). This practice is costly, supplies a mere "snapshot" of the A/R's condition and should be used only if a treating provider is unwilling or unable to provide necessary medical evidence or the A/R does not have a treating provider. For these reasons, the LDSS-486T form and the procedure for gathering medical information have been revised. The body system sections have been eliminated and only a brief functional capacity assessment remains (see attachment I).

Effective immediately, for all adult disability determinations, districts are instructed to begin using the revised LDSS-486T form and to follow the process of information gathering described in this message. There is no change to information gathering for a child case as the forms used in those cases have proven to gather sufficient information.

For adult cases, the following documentation must be obtained prior to submission of the case for disability review.

- **"Disability Interview" form (LDSS-1151)** – This form has been revised and re-named the **"Disability Questionnaire"** (see attachment II) since disability interviews have been eliminated and it is now often mailed to a recipient. This form may be completed by the A/R, the A/R's representative, or a local district worker, if the worker assists the A/R via the telephone or in person. If the form is completed by the A/R or A/R's representative, a district worker must ensure that all required information is documented on the form, including the A/R's SSI/SSDI history, with date of application (month/year), decision date (month/year), reason for a denial, and appeal date, if applicable. The completion of the education and work history portions of the form are also extremely important because these vocational factors are necessary when determining disability based on an A/R's residual functional capacity. The work history portion must include documentation of the job title, type of business, dates worked (month/year), hours worked per week, and rate of pay. In addition, the kind and amount of physical activity involved in each job must be documented. The revised form is intended to be user-friendly while gathering all the appropriate information needed for a disability determination.
- **"Medical Report for Determination of Disability" form (LDSS-486T) and provider medical records -** The revised LDSS-486T form must be sent to each of the A/R's treating providers. In addition, the A/R's medical records, e.g., progress notes, testing reports, etc., for the most recent 12 months, or for the desired disability determination timeframe, must be requested. If the treating providers refuse to complete the LDSS-486T one-page form but send the medical records, submit the medical records to the SDRT or DRT for disability review. If a disability determination cannot be made based on all of the available medical records and a functional capacity assessment is needed, a consultative examination must be arranged by the district.
- **Hospital/Treatment facility records** – In general, admission and discharge summaries from hospitalizations occurring during the desired disability determination time period, in addition to medical records from other treatment facilities, e.g., mental health facilities, nursing homes, etc., must be obtained and submitted.

All requests for medical evidence must be accompanied by a cover letter (see sample letter, attachment III) which clearly documents the medical evidence needed for the time period requested. If a district currently sends the LDSS-486T form and a cover letter for the provider to the A/R instead of directly to providers and hospitals/treatment facilities, that process may continue provided the newly revised form is utilized and the provider cover letter contains all the information in the sample letter attached to this GIS message.

Districts are reminded that when submitting a disability package to the SDRT, a completed “Transmittal Sheet - Disability Determination Request” (LDSS-654) must accompany each submission. This form has also been revised, to provide clarity regarding case types (see attachment IV). In filling out the transmittal form, districts are reminded to check all applicable boxes at the top of the form and enter the A/R’s name and case number, case type (New or CDR), the district’s name and address, and the date submitted. The name, title, and phone number of the district contact person must also be documented at the bottom of the form.

The revised information gathering process will help ensure that a complete disability packet is gathered and eliminate the need for time-consuming “No Action” decisions and costly CEs. It will also create a uniform process for information gathering statewide, which will become increasingly important as state takeover of Medicaid functions proceeds. The NYS Medicaid Disability Manual has been revised to reflect this new process. All revised LDSS forms may be found on CentraPort.

Attachments

MEDICAL REPORT FOR DETERMINATION OF DISABILITY

NEW YORK STATE DEPARTMENT OF HEALTH

SECTION I – IDENTIFICATION (To Be Completed by Submitting Agency)

AGENCY'S NAME AND ADDRESS:	PATIENT'S NAME *(Last, First, Middle):*	CASE NUMBER:	
	PATIENT'S ADDRESS *(Street, City, State & Zip Code):*	SOCIAL SECURITY NUMBER:	
		SEX: ☐ MALE ☐ FEMALE	DATE OF BIRTH:

SECTION II – MEDICAL REPORT – NOTICE TO PHYSICIAN

This individual has made an application (reapplication) for Disability Medicaid. Your cooperation in completing this form to show the individual's current condition, focusing on both remaining capabilities and limitations, is requested. Your promptness will ensure an early decision on the individual's application.

Please return the completed form to the agency in Section I above.

Diagnosis(es):	**Date of last exam:** ____________________
	Height: ____ **ft.** ____ **in.**
	Weight: _______ **lbs.**

Exertional Functions. Please indicate what the individual is CAPABLE of doing:

Lifting:	Carrying:	Standing:	Walking:	Sitting:	Pushing:	Pulling:
☐ < 10 lbs.	☐ < 10 lbs.	☐ < 2 hrs./day	☐ < 2 hrs./day	☐ < 6 hrs./day	☐ Using R arm	☐ Using R arm
☐ Max. 10 lbs.	☐ Max. 10 lbs.	☐ 2 hrs./day	☐ 2 hrs./day	☐ 6 hrs./day	☐ Using L arm	☐ Using L arm
☐ Max. 20 lbs./freq. 10 lbs.	☐ Max. 20 lbs./freq. 10 lbs.	☐ 6 hrs./day	☐ 6 hrs./day		☐ Using R leg	
☐ Max. 50 lbs./freq. 25 lbs.	☐ Max. 50 lbs./freq. 25 lbs.				☐ Using L leg	
☐ > 50 lbs.	☐ > 50 lbs.					

Non-Exertional Functions. Please check if LIMITATIONS exist in any of the areas below:

Sensory: ☐ No Limitations
- ☐ Seeing
- ☐ Hearing
- ☐ Speaking

Postural: ☐ No Limitations
- ☐ Stooping/Bending
- ☐ Crouching/Squatting
- ☐ Climbing

Manipulative: ☐ No Limitations
- ☐ R Upper Extremity
- ☐ L Upper Extremity

Environmental: ☐ No Limitations
- ☐ Tolerating dust, fumes, extremes of temperature
- ☐ Tolerating exposure to heights or machinery
- ☐ Operating a motor vehicle

Mental: ☐ No Limitations
- ☐ Understanding, carrying out, remembering instructions
- ☐ Making simple work-related decisions
- ☐ Responding appropriately to supervision, co-workers, work situations
- ☐ Dealing with changes in a routine work setting

Signature of Physician:	**(Print Name):**	**Date Signed:**
Specialty:	**Office Address:**	**Office Phone Number:**

AGENCY/ADDRESS:

DISABILITY QUESTIONNAIRE

NEW YORK STATE **DEPARTMENT OF HEALTH**

Name (Last, First, Middle)	**TO BE COMPLETED BY LOCAL AGENCY:**
	Case Number: ____________________
	Client Identification Number: _________________
	Medicaid application date: _________________
	Ineligible without disability review? ☐ Yes ☐ No
Social Security Number (last 4 digits)__________	Family Health Plus eligible? ☐ Yes ☐ No
Date of Birth: ____/___/____	Medicaid Waiver? ☐ Yes ☐ No
Telephone No.: ( ) ______/_____________	Waiver type: _________________________________

Have you ever applied to the Social Security Administration (SSA) for disability benefits? ☐ Yes ☐ No	
If "Yes", when? (month/year) ________________	SSA decision date: (month/year) _____________
What was the decision?	
If denied for benefits, what was the reason (medical or non-medical)?	
Did you appeal the decision? ☐ Yes ☐ No	If "Yes", when? (month/year) ______________

PART I – INFORMATION ABOUT YOUR MEDICAL CONDITIONS

A. Please list all of your medical conditions (diagnoses):

B. How do your medical conditions affect your ability to function? (Please include any limitations in your ability to perform activities of daily living and work-related activities.)

C. Please list your medications (or attach a list).

PART II – INFORMATION ABOUT YOUR MEDICAL RECORDS

In order to make a disability determination, current medical evidence is needed to evaluate your physical and/or mental impairments. If you have not seen a medical provider for your impairment(s) within the past 12 months, a consultative exam may be arranged for you by the local agency.

A. Do you have a primary care provider? ☐ Yes ☐ No
(If "Yes", please provide name, address, phone number.)

Date of last visit (month/year): ___________________

B. Have you seen any other medical provider(s) within the past 12 months? ☐ Yes ☐ No
(If "Yes", please complete the section below.)

Please list the name, address, and phone number of all medical providers you have seen for the past 12 months (for example, physicians, nurse practitioners/physician assistants, mental health counselors, physical/occupational/speech therapists, audiologists, etc.). (Continuation sheets are available.)

NAME	ADDRESS	PHONE NO.	REASON FOR SEEING:

C. Have you received medical care in a hospital or other health care facility within the past 12 months? ☐ Yes ☐ No
(If "Yes", please complete the section below.)

Please list the name and address of all hospitals and other medical facilities at which you have sought treatment in the past 12 months. (Continuation sheets are available.)

Hospital/Facility	Address	Reason:

D. Have you received services from any agencies to assist you with your impairment(s) within the past 12 months?

☐ Yes *(If "Yes", please complete the section below.)*
☐ No

Please list the name and address of any other agencies that you have seen for assistance with your medical conditions in the past 12 months (for example, vocational rehabilitation agencies, supported employment or housing agencies, case management agencies, etc.).

Name	Address	Reason:

PART III – INFORMATION ABOUT YOUR EDUCATION, LITERACY AND ABILITY TO COMMUNICATE IN ENGLISH (*Complete ONLY if you are an adult, age 18 or over.*)

If a disability determination cannot be made based on your medical conditions alone, the factors of education, literacy, ability to communicate in English, and work history will be used to determine disability.

A. What is the highest grade level of schooling that you have completed? ________________________________

B. Were (are) you involved in Special Education classes in school? ☐ Yes ☐ No

C. Did (do) you receive any special help or accommodations in school? ☐ Yes ☐ No
(If "Yes", please describe.)

D. Have you received any vocational training or additional education within the past 12 months? ☐ Yes ☐ No
(If "Yes", please describe.)

E. Can you read a simple message in English (such as simple instructions, or a list of items)? ☐ Yes ☐ No

F. Can you write a simple message in English? ☐ Yes ☐ No

G. If English is not your primary language, please answer the next 3 questions:

1. Can you understand a simple message spoken in English?
2. Can you speak a simple message in English?
3. Was assistance or an interpreter necessary to complete this application?
(If "Yes", please describe.)

PART IV – INFORMATION ABOUT WORK YOU DID IN THE PAST 15 YEARS

In as much detail as possible, please list jobs (up to 5) that you performed in the past 15 years, starting with your most recent job. Be sure to complete all portions to the best of your ability.

Dates of Employment:	**Job Title:**	**Type of Business:**
From: ________________ **To:** ________________		
	Number of hours/week: __________	**Rate of Pay:** __________

Describe your basic duties:

During a typical day, how many hours did you: Stand__________ Walk__________ Sit__________

How much did you frequently lift? _________ pounds

Reason for leaving:

Dates of Employment:	**Job Title:**	**Type of Business:**
From: ________________ **To:** ________________		
	Number of hours/week: __________	**Rate of Pay:** __________

Describe your basic duties:

During a typical day, how many hours did you: Stand__________ Walk__________ Sit__________

How much did you frequently lift? _________ pounds

Reason for leaving:

Dates of Employment:	**Job Title:**	**Type of Business:**
From: ________________ **To:** ________________		
	Number of hours/week: __________	**Rate of Pay:** __________

Describe your basic duties:

During a typical day, how many hours did you: Stand__________ Walk__________ Sit__________

How much did you frequently lift? _________ pounds

Reason for leaving:

Dates of Employment:	**Job Title:**	**Type of Business:**
From: __________________ **To:** __________________		
	Number of hours/week: ___________	**Rate of Pay:** ___________
Describe your basic duties:		
During a typical day, how many hours did you: Stand___________ Walk___________ Sit___________		
How much did you frequently lift? __________ pounds		
Reason for leaving:		

Dates of Employment:	**Job Title:**	**Type of Business:**
From: __________________ **To:** __________________		
	Number of hours/week: ___________	**Rate of Pay:** ___________
Describe your basic duties:		
During a typical day, how many hours did you: Stand___________ Walk___________ Sit___________		
How much did you frequently lift? __________ pounds		
Reason for leaving:		

PART V – AGENCY COMMENTS

Name of Agency Worker reviewing this form:	Date:

DISABILITY QUESTIONNAIRE CONTINUATION SHEET

AGENCY/ADDRESS

New York State **Department of Health**

Name (Last, First, Middle)	Social Security Number *(last 4 digits)*	Case Number

PART II – INFORMATION ABOUT YOUR MEDICAL RECORDS

In order to make a disability determination, current medical evidence is needed to evaluate your physical and/or mental impairments. If you have not seen a medical provider for your impairment(s) within the past 12 months, a consultative exam may be arranged for you by the local agency.

B. Have you seen any other medical provider(s) within the past 12 months? ☐ Yes ☐ No
(If "Yes," please complete the section below.)

Please list the name, address, and phone number of all providers you have seen for the past 12 months (for example, physicians, nurse practitioners/physician assistants, mental health counselors, physical/occupational/speech therapists, audiologists, etc.)

Name	Address	Phone No.	Reason for Seeing:

C. Have you received medical care in a hospital or other health facility within the past 12 months? ☐ Yes ☐ No
(If "Yes," please complete the section below.)

Please list the name and address of all hospitals and other medical facilities at which you have sought treatment in the past 12 months.

Hospital/Facility	Address	Reason:

Attachment III

INSERT DISTRICT LETTERHEAD HERE

Medical provider/facility
Address

Date:__________________________

Re: (Name of client)

Date of Birth:__________________

Dear ________________________________:

Enclosed find a release for medical information concerning the above noted individual. This individual has applied for Medicaid benefits in the disabled category. In many cases, Medicaid eligibility is dependent on a determination of disability.

Medical evidence forms the foundation for determination of disability. It must allow a determination of the severity and duration of an impairment and the extent of limitation imposed for the time period in question.

Please note that individuals who have been previously approved for disability must be reviewed periodically in order to continue to be eligible for disability benefits.

The medical evidence checked below is requested at this time:

____ Copy of medical records (e.g., progress notes, consultation reports, diagnostic test reports) for the following year(s): ___________________________
____ Hospital records for the following year(s) ____________________
____ LDSS-486T form, signed or co-signed by a physician (**Adult cases only**)
____ Childhood Medical Disability Report (OHIP form 0005), signed by physician
____ Questionnaire of School Performance (OHIP form 0006), completed by teacher, along with current IEP report
____ Description of Child's Activities (OHIP form 0007), completed by parent/guardian

Please submit requested medical evidence to the above noted address.

If you have not seen this individual in the timeframe noted above, please check the line below, and sign and return this letter to the above noted address.
_____ No medical records exist for this individual for the timeframe noted above.

____
(Signature)

Thank you for your cooperation.

Signed/Title _____________________________________Telephone number:________________

Attachment III

INSERT DISTRICT LETTERHEAD HERE

NEW YORK STATE DEPARTMENT OF HEALTH

TRANSMITTAL SHEET

DISABILITY DETERMINATION REQUEST

Batch cases by type. Use separate transmittal sheet for each type listed below. Check applicable box(es).

☐ **ADULT** (*Choose one below*):
- ☐ Aid to Disabled
- ☐ MBI-WPD
- ☐ Over 65 Pooled Trust
- ☐ Non-applying Adult Child

☐ **CHILD** (Under 18 years of age) (*Choose one below*):
- ☐ Aid to Disabled
- ☐ MBI-WPD

SUBMITTING AGENCY/ADDRESS

DATE SENT: ____________________

Adult Cases: Attach LDSS-1151 Disability Questionnaire. LDSS-486T Medical Report for Determination of Disability and all available supporting evidence.
Child Cases: Attach LDSS-1151 Disability Questionnaire. Childhood Medical Report, Child's Activities Report, Questionnaire of School Performance and all available supporting medical evidence.
Continuing Disability Review (CDR) Cases: Submit entire case record including all previous LDSS-639 Disability Review Team Certificates.

Submit two (2) copies of each transmittal sheet.

FOR AGENCY COMPLETION			**REVIEW TEAM DETERMINATIONS**		
Name of Client (Last Name, First Name)	**Case Number**	**Case Type**	**Disability Type**	**Decision**	**Effective Date of Disability**

KEY

Case Type
N – New
CDR – Continuing Disability Review

Disability Type
MI – Mental Impairment
PI – Physical Impairment
MI/PI – Combination of Both

Decision
I – Group I
II – Group II
DIS – Disapproved
MIG – MBI Medical Improvement Group
NA – No Action

NEW YORK STATE DEPARTMENT OF HEALTH

NAME OF AGENCY WORKER	TITLE	TELEPHONE NO.