II. OFFICIAL POLICY

A. Basic Definitions

Department Regulation Section 360-5.2

When used in this manual, unless otherwise stated, the terms below shall be defined as follows:

1. Disability is the inability of an individual to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months.

2. Blindness is the total lack of vision, or residual vision being no better than 20/200 or less in the better eye with a corrective lens, or restriction of the visual fields, or other factors which affect the usefulness of vision as prescribed in the appropriate medical criteria published in this manual. (For additional information see Section K.)

3. Medically Determinable Impairment (MDI) is an impairment resulting from anatomical, physiological, or psychological abnormalities which can be demonstrated by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, laboratory findings, or both. Objective medical evidence from an acceptable medical source is required to establish existence of an MDI. Symptoms cannot establish the existence of an MDI.

4. Substantial Gainful Activity is any work of a nature generally performed for remuneration or profit which involves the performance of significant physical or mental duties. Work may be considered substantial even if performed part-time and even if less responsible than the individual's former work. It may be considered gainful even if it pays less than former work. (The application of this definition and of the amount of earnings that could result in a finding of substantial gainful activity is set forth in Section E.)

5. Disability Review Team is composed of a medical or psychological consultant and another person who is qualified to interpret and evaluate medical reports and other evidence relating to an individual's physical or mental impairments. As necessary, the other person also must be able to determine the individual's capability to perform substantial gainful activity. The Disability Review Team must review the medical report, which must include a diagnosis and medical and non-medical evidence sufficient to determine whether the individual's condition meets the definition of disability. The Disability Review Team may choose to have a

psychologist as part of a review team; however, the psychologist may only evaluate mental impairment cases. It is not mandatory that a psychologist review case involving mental impairments.

For the purposes of the Medicaid disability review, a psychologist is qualified if he or she:

- is licensed or certified as a psychologist at the independent practice level of psychology by the State in which he or she practices; and

- possesses a doctorate degree in psychology from a program in clinical psychology of an educational institution accredited by an organization recognized by the Council for Higher Education Accreditation, formerly the Council on Post-Secondary Accreditation;

or

- is in a national register of health service providers in psychology which the Commissioner of Social Security deems appropriate; and

- possesses two years of supervised clinical experience as a psychologist, at least 1 year of which is post master's degree.

6. Disability Case Record is compiled by the Disability Review Team and should consist of the following:

- A medical report including a diagnosis and other medical records.

- Other non-medical evidence, such as a social history including the client's age, education, training, and past work experience in sufficient detail to enable the Disability Review Team to make a disability determination.

7. Group I is a classification that includes persons who show no possibility of engaging in any substantial gainful work activity because they have a physical and/or mental impairment(s) which is disabling and considered to be irreversible.

8. Group II is a classification that includes individuals who have impairments, which while disabling at the time of determination, are expected to show an improvement in physical and/or mental status which will enable them to become capable of substantial gainful activity. Some reasons for this improvement may be the condition may be arrested, a remission may occur, therapeutic advances are occurring, and/or rehabilitation is deemed feasible.

B. Disability Eligibility

Department Regulation Section 360-5.6

1. Categorical Eligibility - The following individuals shall be considered categorically disabled for purposes of Medicaid:

a. Individuals who meet the statutory definition of disability;

b. Individuals who meet the statutory definition of blindness;

c. Deceased individuals - deceased individuals are categorically eligible as disabled in the month of death. Therefore, disability reviews should be performed on single individuals and childless couples (S/CC) in receipt of Medicaid who die, as well as in instances when an application is filed on behalf of a deceased individual. Disability status for months prior to the month of death depends upon whether the individual met the disability criteria set forth in this manual for prior time periods.

d. Grandfathered cases - individuals who were determined disabled prior to January 1, 1974 under the Assistance to the Aged, Blind and Disabled (AABD) program for whom there was no interruption in their eligibility are eligible based on the medical criteria in effect at the time of the initial review.

Recipients determined disabled as a Group II prior to January 1, 1974 shall have their continuing eligibility determined on the basis of the medical criteria in effect at time of initial review. However, when there is a break in eligibility for any length of time, the individual loses their "grandfathered" status and the case would have to be reviewed under the disability standards contained in this manual.

Group I recipients who were determined Group I under the AABD program and have no break in eligibility shall continue to be categorically related to disability. An exception would be if the recipient had significant medical improvement to the point where the recipient is no longer disabled.

2. Derivative Eligibility

a. The following individuals shall not require a determination of disability by the Disability Review Team:

(1) Individuals verified in receipt of or eligible for an Old Age, Survivors and Disability Insurance (OASDI) benefit under Title II of the Social Security Act as disabled or blind shall be considered disabled or blind for Medicaid purposes.

(2) Individuals verified as eligible for Supplemental Security Income (SSI) as disabled or blind under Title XVI of the Social Security Act shall be considered disabled or blind for Medicaid. These groups of individuals are

considered disabled until the date the Social Security Administration will or would have re-evaluated the individual's medical condition (the medical diary date).

(3) Individuals verified in receipt of Railroad Retirement benefits as totally and permanently disabled.

b. Disability status under the SSI and OASDI programs shall be verified as follows:

(1) Award letter (case file information should include A/R's name, amount of award, onset of disability and date of entitlement);

(2) Completion of Form 1610, “Public Agency Information Request” by the local Social Security District Office;

(3) Presentation of a current monthly benefit check for disability; or,

(4) Inquiry through the State Data Exchange (SDX).

c. Individuals in receipt of SSI are automatically eligible for Medicaid. A separate application for Medicaid is not required, nor is a disability review necessary. (For additional information see Section I.)

C. Local District Responsibilities

1. Identifying Disabled Persons

a. Responsibility for Detecting Disability

The initial responsibility for detecting disability rests primarily with the eligibility worker. Effort should be made to identify disability-relatedness at the time of initial eligibility determination or recertification for Medicaid. In addition, all workers in the local agency should be alert in their contacts with persons receiving Medicaid in the SCC-related category to recognize when the A/R may be disabled. This is important in order to maintain cost neutrality under the 1115 waiver and also to benefit the A/R. Prompt identification of the condition, together with prompt initiation of disability certification, may be advantageous to the individual. Such advantages may include identification and provision of medical or social services needed to improve the individual's condition and provisions for more favorable budgeting disregards.

To identify all who qualify for Medicaid disability, eligibility workers should have a general knowledge of the health status of applicants and recipients. The best source for securing knowledge of an individual's health status is the A/R or, if the person is represented by another, their representative. By conveying a

sense of interest, respectful listening and inquiring as to the individual's health, the worker will find that most persons will discuss their health problems, particularly if ill health is the precipitating reason for the application for Medicaid.

Readily apparent conditions which are disabling, such as loss of arm(s) or leg(s), extensive paralysis or crippling, evidence of intellectual disability and the bizarre and inappropriate behavior a psychotic person may exhibit, may easily be identified through the worker's own observations or by speaking with family members or other representatives of the A/R. In addition, groups of persons such as those confined to nursing homes or their own home because of chronic illness and who cannot make an application in person will be readily recognized as candidates for Medicaid disability.

b. Worker's Observations of the Applicant/Recipient's Symptoms Which May Indicate Disability

The worker's observations of the A/R are also important in detecting disability. Some of the more common indicators a worker may observe or be informed about that may indicate the existence of a chronic health problem are as follows:

(1) Physical Disability

- restricted mobility/unable to walk without aid
- limited use or weakness of hands or fingers
- amputation/paralysis of limbs
- uncoordinated body movements/palsy
- difficulty in breathing, talking, or speech
- shortness of breath/asthma attacks
- difficulty in sitting, standing, lifting, bending, kneeling, pushing, pulling
- chronic coughing/wheezing
- dizziness/drowsiness/blurred vision
- nausea/diarrhea/colitis
- poor hearing/deafness/inability to use hearing aid
- poor vision/blindness/inability to read print
- memory loss/blackouts/headaches

- low energy level/chronic tiredness/fainting spells

(2) Mental Disability

- severe anxiety/nervousness
- acting out/hallucinations/crying
- disorientation/confusion/non-responsiveness
- inappropriate responses or reactions
- unusual fears, inhibitions, or mannerisms
- poor personal hygiene/unkempt appearance
- bizarre appearance/inappropriate dress
- unusual or inappropriate mood/depression
- agitated, disruptive or hostile behavior
- poor concentration or attention span
- poor memory for recent or remote events

(3) Medical Factors/History

- multiple or extended hospitalizations
- periodic confinement in mental institutions or facilities
- history of treatment with mental health clinic or private therapist
- high medication usage or drug expenditure
- use of, or dependency on, prosthesis or medical appliances such as walker, crutch, artificial limb, cane, body brace, hearing aid, special glasses, magnification device or pacemaker
- severe dietary restrictions/malnutrition
- severe or sudden weight loss/extreme obesity
- complaints of constant or periodic pain
- uncontrolled or semi-controlled epilepsy or seizures
- treatment for cancer/cancer treatment related conditions

- history of heart trouble/stroke/surgery
- recurrent chest pain

(4) Vocational Factors

- poor or inconsistent work history
- chronic unemployment/lack of work skills
- frequent job terminations
- loss or deterioration of work skills
- attendance in special education class
- previous participation in sheltered workshop or rehabilitation facility
- age 55 or over

Indicators such as the above, especially when accompanied by information from the A/R of the existence of a health problem, indicate that the A/R should be reviewed for disability.

Children under 18 years of age may demonstrate behavior and/or a level of functioning which is significantly below that which is appropriate for the child's chronological age. Such an observation may indicate that the child should be reviewed for disability.

2. Informing the Applicant/Recipient

The worker shall provide the A/R with the following information concerning the disability category for Medicaid:

a. The advantages of disability certification

b. The procedures and the time frames involved in the disability determination process

c. The A/R's responsibility to provide and/or cooperate with the Disability Review Team in obtaining medical evidence which shows that the A/R is disabled. The Disability Review Team will provide assistance to the A/R in obtaining medical reports when the A/R has given the agency permission to request them from their doctors and other medical source

d. When requested by the Disability Review Team, the responsibility of the A/R to provide information about their age, education and training, work experience,

past and current daily activities, efforts to work and any other evidence showing how the A/R's impairment(s) affects their ability to work

e. The A/R's responsibility to take part in a consultative medical examination or test which may be needed by the Disability Review Team to determine if the A/R is disabled. If the A/R fails or refuses to take part in a consultative examination without good cause, they may be found to be not disabled

f. The right of the A/R to receive written notification of the Disability Review Team's decision. Form OHIP-0040, "Notice of Medical Assistance Disability Determination", is used for this purpose. The Disability Review Team may either attach a copy of the DOH-5144 "Disability Review Team Certificate" to this notice or transfer the information from Item 10 of the certificate to the OHIP-0040 form. For approved cases only, the following standardized language may be substituted for the rationale contained in Item 10: *(insert name)*, meets the definition of disability, 18 NYCRR 360-5.2(b), which states, in part, that "disability is the inability to engage in substantial gainful activity (work) by reason of any medically determinable physical or mental impairment"

g. The right of the A/R to receive a written statement as to the reason(s) the determination has not been rendered within 90 days of the date of application/recertification

h. The A/R's right to a conference with the Disability Review Team and

i. The A/R's right to a fair hearing on the action which may ensue as a result of the A/R's failure to cooperate, or on the delay in prompt action in making the determination, or on any action or non-action which results from the determination.

3. Securing Medical Documentation

a. The Disability Review Team, in cooperation with the A/R, shall attempt to obtain all available medical information from the A/R's treating sources, since these records will help establish a longitudinal medical history. This information shall cover the time frame for which a disability determination is being considered and, in many cases, should include the 12 months prior to the date of application. These medical records may include:

(1) Medical history;

(2) Clinical findings such as the results of physical and/or mental status examinations;

(3) Laboratory findings and diagnostic procedure results, such as blood pressure, X-ray reports, electrocardiogram results, pathology reports, pulmonary function test results and blood and urinalysis reports

(4) Diagnosis (statement of disease or injury based on its signs and symptoms)

(5) Treatment prescribed, with response and prognosis

(6) Medical assessment of functional capacity (except in statutory blindness cases) including:

(a) Limitations in ability to do work-related activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking;

and

(b) In cases of mental impairments, limitations in the ability to reason, remember, understand and carry out instructions; to maintain attention and concentration; to sustain an ordinary routine; to respond appropriately to criticism from supervisors; and to get along with co-workers

b. Medical evidence forms the foundation for determination of disability. The existence of a disabling condition must be based on a substantiated medical report(s) from acceptable medical sources. Acceptable medical sources (AMSs) are:

(1) Licensed physicians (medical or osteopathic doctors)

(2) Licensed or certified psychologists at the independent practice level

(3) School psychologists, or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting, are AMSs for impairments of intellectual disability, learning disabilities, and borderline intellectual functioning only

(4) Licensed optometrists, for purposes of establishing visual disorders, or measurement of visual acuity and visual fields only

(5) Licensed podiatrists, for purposes of establishing impairments of the foot. Per NYS Education Law Article 141, the practice of Podiatry may also include diagnosing, treating, operating and prescribing for any disease, injury, deformity or other condition of the ankle and soft tissue of the leg below the tibial tuberosity if the podiatrist has obtained an issuance of a privilege to perform podiatric standard ankle surgery or advanced ankle surgery

(6) Qualified speech-language pathologists (SLPs), for purposes of establishing speech or language impairments only. For this source, "qualified"

means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency, or hold a Certificate of Clinical Competence from the American Speech-Language-Hearing Association

(7) In claims with a filing date on or after March 27, 2017, licensed physician assistant for impairments within the licensed scope of practice only

(8) In claims with a filing date on or after March 27, 2017, licensed audiologists for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice only. NOTE: Audiologists' scope of practice generally includes evaluation, examination, and treatment of certain balance impairments that result from the audio-vestibular system. However, some impairments involving balance involve several different body systems that are outside the scope of practice for audiologists, such as those involving muscles, bones, joints, vision, nerves, heart and blood vessels

(9) In claims with a filing date on or after March 27, 2017, a Nurse Practitioner (NP) may diagnose, treat, and prescribe for a patient's condition that falls within their specialty area of practice

(10) Persons authorized by a hospital, clinic, or health care facility to provide a copy or summary of the individuals medical records.

• Medical source: Only an individual, not an entity, can be a medical source. When an entity provides evidence from multiple sources, evaluate each medical source's evidence separately instead of considering as one source

c. Objective medical evidence (signs, laboratory findings, or both) is required from an acceptable medical source (AMS) to establish that an individual has an MDI(s). This is performed at **step 2** of the sequential evaluation process. Evidence includes:

• An MDI cannot be established based on symptoms, a diagnosis, or a medical opinion.

• An MDI must result from anatomical, physiological, or psychological abnormalities identified by medically acceptable clinical and laboratory diagnostic techniques.

• If objective medical evidence is needed from a consultative examination (CE) to establish the existence of an MDI, a qualified CE source who is also an AMS must personally examine the claimant, though qualified support staff may assist.

d. Considering all evidence:

Once it is established an individual has an MDI based on objective medical evidence from an AMS, evidence is used from all sources for all other findings in the sequential evaluation process, including showing the severity of a claimant's MDI at **step 2** of the sequential evaluation process. Other sources who may contribute to the disability determination may include:

(1) Medical sources who are not AMSs but are legally permitted to provide healthcare, such as naturopaths, chiropractors, and therapists;

(2) Nonmedical sources such as

• Educational personnel, for example schoolteachers, counselors, early intervention team members, developmental center workers, and daycare center workers);

• public and private social welfare agency personnel; and

• relatives (spouses, parents, siblings, etc.), caregivers, friends, neighbors, past employers, and clergy.

(3) The medical evidence, including the clinical and laboratory findings, shall be complete and detailed enough to allow a determination as to whether or not the individual is disabled. It must allow a determination of:

• The nature and severity of the impairment(s) and the extent of limitation imposed by impairments for the time period in question;

• The probable duration of the impairment(s); and

• Residual functional capacity to do work-related physical and mental activities

e. If the individual's medical sources are unable to provide sufficient medical evidence regarding the A/R to enable the Disability Review Team to make a determination, a consultative examination may be required.

4. Completion of Forms

A case record submitted for a disability determination must contain a medical report which contains a diagnosis(es) and sufficient medical and non-medical evidence to make a determination. The forms that follow solicit the necessary information to make a determination of disability. (See Section A.6. for the definition of a case record.)

a. Form DOH-5139 "Disability Questionnaire" and Form DOH-5139.1 "Disability Questionnaire Continuation Sheet" (These forms can be found in CentraPort and the DOH intranet library.) The DOH-5139 should be completed as thoroughly as possible. The DOH-5139 may be completed by the agency worker, the A/R, or the A/R's representative. If completed by the A/R or A/R's representative, the Disability Review Team will review the form and, if necessary, contact the A/R or A/R' s representative to ensure that all required information is documented on the form.

Part I- Information About Medical Conditions - should contain the A/R's description of their impairment(s), any symptoms they experience, such as shortness of breath, pain, anxiety, and how the impairment(s) affects the A/R' s ability to perform activities of daily living and work activities.

Part II- Information About Medical Records - should be thoroughly completed to help ensure that all recent medical sources and records have been identified.

Part III- Information About Education and Literacy - All areas should be completed for consideration by the Disability Review Team in the vocational evaluation.

Part IV- Information About the Work You Did in the Past 5 Years - Information about specific duties and activities in previous jobs must be thoroughly completed so the Disability Review Team can properly perform the vocational assessment in the sequential evaluation process. The kind and amount of physical activity should be documented for each job.

Part V- Agency Comments - should include any other information that may be relevant for the Disability Review Team.

The DOH-5140 is a continuation sheet and should be used to report additional medical and/or employment information concerning the A/R.

b. Form DOH-5143 "Medical Report for Determination of Disability"- This form can be found in CentraPort, Health Commerce System under OHIP Eligibility Forms or on the internet: https://www.health.ny.gov/health_care/medicaid/reference/mdm/adult.htm. This form can be used to secure medical information about the A/R. The worker may either give this form to the A/R to take to their physician or send the form directly to the physician for completion.

5. Referral to Disability Review Team

A disability referral form and any accompanying medical documentation must be submitted to the Disability Review Team in accordance with procedures detailed

in this manual. The Disability Review Team will complete form DOH-5144 “Disability Review Team Certificate" for each completed disability determination.

6. Pending of Disability Cases

Department Regulation Section 360-2.4, 360.-5.7

Generally, eligibility must be determined within 45 days of the date of application; however, when determining categorical relatedness to disability the following applies. Disability status must be determined within 90 days of application. This time standard applies except in unusual circumstances such as where the agency cannot reach a decision because of failure or delay on the part of the A/R or an examining physician, or for reasons not within the control of the agency. In such circumstances, the case record must show the cause of the delay. This pending period for acting on applications or redetermination of eligibility shall not be used as a waiting period before granting Medicaid to eligible persons. If a case is pended more than 90 days, this delay shall not be a basis for denying Medicaid or for terminating assistance.

If a case is pended, the local agency should take one of the following courses of action:

a. If the case is eligible under another category of assistance, the case should be authorized. If the case is subsequently determined eligible as disabled, an adjustment for funding under the SSI-related category of assistance can be made for medical bills paid under the S/CC category.

b. Cases which are not eligible under any other category should be pended awaiting a decision from the Disability Review Team. Medicaid cannot be provided for these individuals until they are determined disabled.

c. If the A/R has not been contacted during the 90-day period, the A/R must be sent a statement at this time informing them that a decision has not been made as yet. The Disability Review Team will be responsible for sending OHIP-0050 for this purpose.

7. Cases Requiring a Continuing Disability Review (CDR)

Cases determined Group II by the Disability Review Team have an expiration date and must be reviewed periodically. Disability Review Team will initiate a continuing disability review for all cases that are 3 months from the date of expiration. A disability packet containing a DOH-5139 Disability Questionnaire and DOH-5173 Authorization for release of medical information will be mailed to the A/R for completion. The DOH-5139 should contain current social information and a list of current medical providers.

Disability Review Team staff will ensure that continuing disability reviews have been initiated prior to the Group II expiration date. CDR evaluation process is described in Section G.

8. Responding to Disability Review Team Decisions

a. If the decision is either "Approved" or "Disapproved" the case shall be processed and the A/R shall be notified according to Section C.2.f

b. If the A/R's medical sources are unable to provide sufficient medical evidence to enable the Disability Review Team to make a determination, a consultative examination may be required according to procedures set forth in Section D.3.f.

D. Evaluation of Disability

1. General

The Disability Review Team is responsible for a determination as to whether or not an individual is disabled. The Disability Review Team must consider all of the pertinent facts of the case. In those cases where a determination of disability cannot be made based on medical evidence alone, the following vocational factors must be considered in conjunction with the medical evidence:

a. The individual's residual functional capacity as defined in Section D.4.a.

b. The individual's age, education, training and work experience in the past 5 years and

c. The kinds of substantial gainful activity (work) which exist in significant numbers in the national economy for someone with this individual's limitations. (See Section D.4.d.(3).)

2. Sequential Evaluation Process for Adults

The Disability Review Team must use the Sequential Evaluation Process to determine whether the A/R is or is not disabled. This process consists of steps which must be followed in sequence. However, if at any step of this process, a determination can be made that an A/R is disabled, evaluation under a subsequent step is unnecessary. (See the Sequential Evaluation Flow Chart which follows Section D.2.g.) Please note that this is the Sequential Evaluation Process for Adults. The Sequential Evaluation Process for children under 18 years of age is discussed in Section M.

a. Is the A/R working and is the work considered substantial gainful activity (SGA) as defined in Section E? If so, eligibility for the Medicaid Buy-In

Program for Working People with Disabilities must be considered, and the case sent to the DRT for disability determination.

b. Does the A/R have a severe medically determinable physical or mental impairment or combination of impairments which significantly limits their ability to do basic work activities? A severe impairment is an impairment or combination of impairments that significantly limits physical or mental ability to do basic work activities. Examples of basic work activities are walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, handling, seeing, hearing, speaking, understanding, carrying out and remembering simple instructions, using judgment, responding appropriately to supervision, co-workers and usual work situations, and dealing with changes in a routine work setting. If the individual does not have a severe medically determinable impairment, the individual is determined not disabled.

c. Does the A/R have a physical or mental impairment which has lasted or is expected to last 12 months or more, or result in death? If the impairment does not meet this 12-month duration requirement, the individual is determined not disabled.

d. Does the A/R have any impairment(s) which meets or equals a listing in Appendix I? When an individual's impairment(s) meets the duration requirement and either meets a listing in Appendix I or is determined to be medically the equivalent of a listed impairment, a finding of disability shall be made without the need to consider the vocational factors. ("Meeting" or "equaling" a listing is explained in Section D.3.b.&d.)

e. Does the A/R's impairment(s) prevent the performance of past relevant work? When a disability determination cannot be made based on current work activity or on medical considerations alone, an evaluation shall be made of the individual's residual functional capacity (RFC) and the physical and mental demands of their past relevant work. The Dictionary of Occupational Titles (DOT), which includes information about jobs that exist in the national economy, is used to determine the physical, mental and skill requirements of the individual's past work. If the impairment does not prevent the A/R from meeting the physical and/or mental demands of past relevant work, the A/R shall be determined not disabled. (Use of the DOT can be found in Section D.4.d.(2)(f).)

f. Does the A/R meet one of the medical-vocational profiles? The medical-vocational profiles list combinations of the vocational factors of age, education and work experience that are so unfavorable that an individual who meets one of them will be deemed to be unable to adjust to other work and therefore will be found disabled.

Consider whether a profile applies only after finding that an individual cannot do any past relevant work. Because the profiles only require that an individual have a severe impairment and because an incorrect decision might otherwise occur, it is important to consider whether a profile applies before referring to the medical-vocational guidelines in Appendix II of the Disability Manual. Medical-vocational profiles showing an inability to make an adjustment to other work:

(1) The individual has done only arduous, unskilled physical labor. If the A/R has no more than a marginal education and work experience of 35 years or more during which they did only arduous unskilled physical labor and they are not working and is no longer able to do this kind of work because of a severe impairment(s), the individual is considered unable to do lighter work and is, therefore, disabled.

Example: Mr. X is a 58-year-old miner's helper with a fourth-grade education who has a lifelong history of unskilled, arduous, physical labor. Mr. X says that he is disabled because of arthritis of the spine, hips, and knees, and other impairments. Medical evidence shows a "severe" combination of impairments that prevents Mr. X from performing his past relevant work. Under these circumstances, Mr. X will be found disabled.

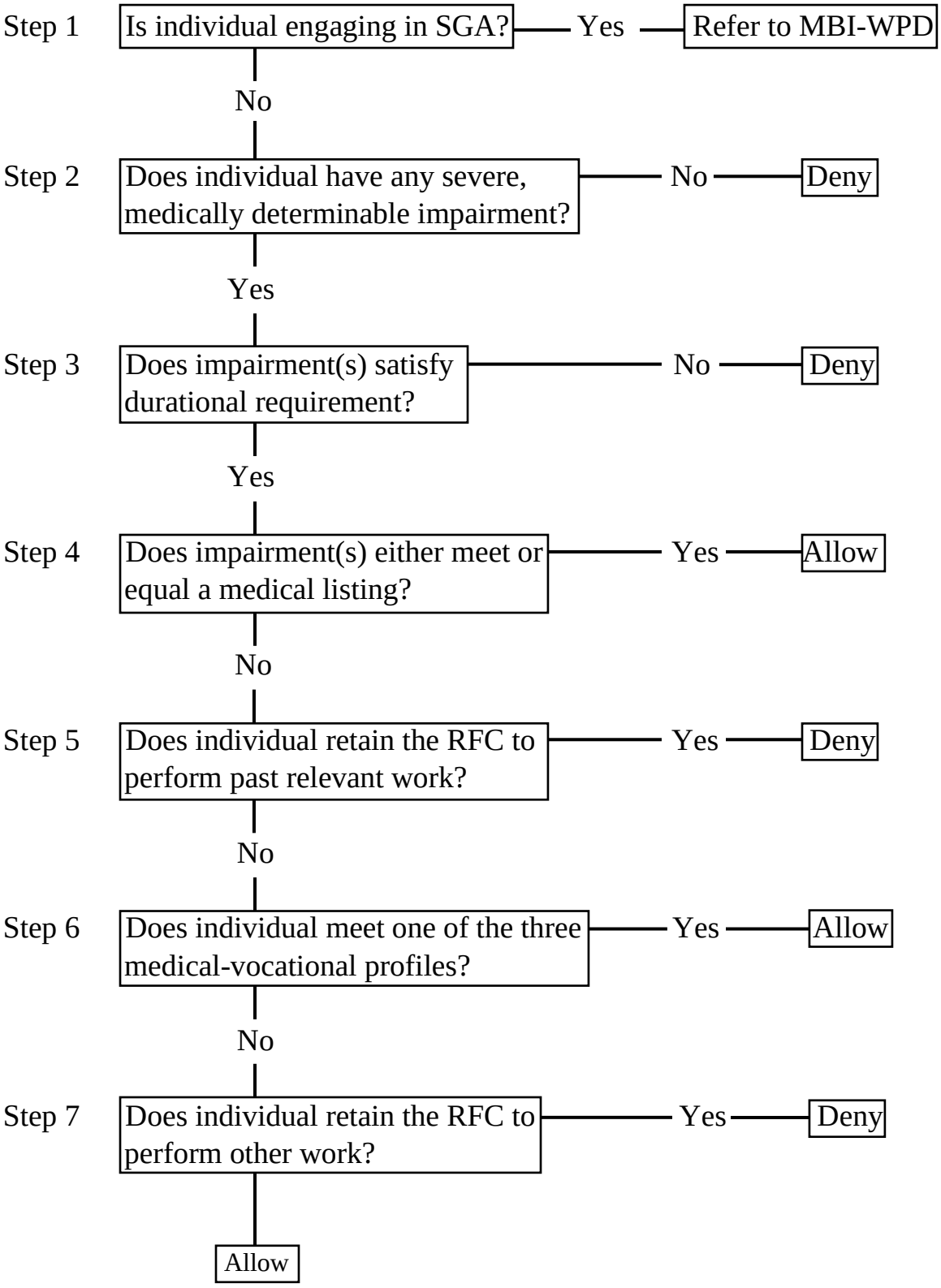
(2) The individual is at least 55 years old, has no more than a limited education, and has no past relevant work experience. If the A/R has a severe, medically determinable impairment(s), is of advanced age (age 55 or older), has a limited education or less, and has no past relevant work experience, they will be found disabled. If the evidence shows that the individual meets this profile, there is no need to assess their residual functional capacity or consider the rules in Appendix II (Medical Vocational Guidelines).

(3) The individual is closely approaching retirement age (age 60 or older), has a lifetime commitment to unskilled work, or skilled or semiskilled work but with no transferable skills. If the individual is closely approaching retirement age (age 60 or older), has no more than a limited education, has a lifetime commitment (30 years or more) to a field of work that is unskilled, or is skilled or semi-skilled but with no transferable skills, is not working at SGA level, and can no longer perform this past work because of a severe impairment, they will be found disabled. To satisfy the requirement for this profile, the 30 years of lifetime commitment work does not have to be at one job or for one employer but rather work in one field of a very similar nature. If the person has a history of working 30 years or more in one field of work, the use of this profile will not be precluded by the fact that the person also has work experience in other fields, so long as that work experience in other fields is not past relevant work which the person is still able to perform.

g. Does the A/R's impairment(s) prevent them from making an adjustment to any other work? If an individual is found unable to perform past relevant work, the factors of age, education, and work experience must then be considered in addition to the functional limitations imposed by the individual's physical or mental impairment(s) to determine whether there is any work in the national economy that the individual has the RFC to perform.

If the individual's functional capacity and vocational ability make it possible for the individual to make an adjustment to other work which exists in the national economy, the A/R shall be determined not disabled. (The Medical Vocational evaluation process is described in Section D. 4. and Appendix II.)

Adult Sequential Evaluation



3. Medical Considerations

a. Medically Determinable Impairment (MDI)- To qualify as disabled, an individual is required to have a medically determinable impairment. This is a physical or mental impairment which results from anatomical, physiological or psychological abnormalities that are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. Medical evidence consists of signs, symptoms and laboratory findings, or both as defined below.

(1) Signs- One or more anatomical, physiological, or psychological abnormalities which can be observed apart from the A/R's statements (description of symptoms). Signs must be demonstrated by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically determinable phenomena that indicate specific psychological abnormalities (e.g. Abnormalities of behavior, mood, thought, memory, orientation, development, or perception). Symptoms (the claimant's own description of his or her physical or mental impairments) **cannot establish the existence of an MDI.**

(2) Laboratory findings- One or more anatomical, physiological, or psychological phenomena that can be shown by the use of medically acceptable laboratory diagnostic techniques. Diagnostic techniques include chemical tests (such as blood test), electrophysiological studies (such as electrocardiograms, electroencephalograms), medical imaging (such as X-rays), and psychological tests.

b. Listing of Impairments in Appendix I - The Listing of Impairments describes, for each of the major body systems, impairments which may prevent an individual from doing substantial gainful activity. A listing gives specific medical findings which are required to establish or confirm the existence of and extent of impairment. The medical findings consist of signs, symptoms and laboratory findings. To "meet a listing", the A/R must have the diagnosis of a listed impairment and the specific medical findings provided in the listing for that impairment. The Listing of Impairments consists of two parts - Part A, which applies to individuals age 18 years and over and Part B which applies to individuals under the age of 18. The medical criteria in Part A may also be applied in evaluating impairments in individuals under age 18 if the disease processes have a similar effect on adults and younger persons. In evaluating disability for an individual underage 18, Part B will be used first. If the medical criteria in Part B do not apply, then the medical criteria in Part A will be used.

c. Multiple Impairments - If an individual has multiple impairments, none of which individually meets or equals a listed impairment, the combined effect of the impairments must be evaluated to determine the impact on the individual's

physical or mental capacity to engage in substantial gainful activity. The combined impact of all impairments must be considered throughout the disability determination process.

Two or more unrelated impairments shall not be combined to meet the 12-month duration test in an initial determination. If an individual has an impairment and then develops another unrelated impairment, and the two impairments in combination would last 12 months, but neither one by itself is expected to last for 12 months, the individual shall be found not disabled.

When an individual has two or more concurrent impairments which, when considered in combination, constitute a disability according to criteria set forth in this manual, a determination shall be made as to whether the combined effect can be expected to last for 12 months. If one or more of the impairments improves or is expected to improve within 12 months so that the combined effect of the remaining impairment(s) no longer meets the criteria for disability, the individual shall be found not disabled.

d. Medical Equivalence - An individual's impairment(s) is medically equivalent to a listed impairment in the Listing of Impairments if it is at least equal in severity and duration to the criteria of any listed impairment. Medical equivalence may be found in three ways:

(1) If the individual has an impairment that is described in the Listing of Impairments but the impairment does not exhibit one or more of the findings specified in the particular listing, or it exhibits all of the findings, but one or more of the findings is not as severe as specified in the particular listing, the impairment will be found to medically equal that listing if there are other findings related to the impairment that are at least of equal medical significance to the required criteria.

(2) If the individual has an impairment that is not described in the Listing of Impairments, the medical findings will be compared with those of a closely analogous listed impairment. If the findings are at least of equal medical significance to those of a listed impairment, the impairment will be found to medically equal the analogous listing.

(3) If the individual has a combination of impairments, no one of which meets a listing described in the Listing of Impairments, the medical findings will be compared with those for a closely analogous listed impairment. If the findings related to the impairments are at least of equal medical significance to those of a listed impairment, the combination of impairments will be found to medically equal that listing.

e. Evaluating Medical Opinions

(1) Every reasonable effort must be made to obtain the medical evidence necessary to evaluate an A/R's disability from his or her medical sources (that is, the A/R's own physicians or psychologists, hospitals or clinics where they have been treated or evaluated, etc.) before obtaining medical evidence from another source on a consultative basis. The definition of a medical opinion focuses on functional abilities and limitations.

(2) For claims filed on or after March 27, 2017, controlling weight is not given for any medical opinion. The focus is more on the content of medical opinions and less on weighing treating relationships against each other. This approach is more consistent with current healthcare practice.

(3) It is necessary to articulate consideration of medical opinions from all medical sources regardless of whether the medical source is an acceptable medical source (AMS).

(a) A discussion of the factors of supportability and consistency are the most important factors.

(b) The more consistent a medical opinion or prior administrative medical finding is with the evidence from other medical sources and nonmedical sources in the claim, the more persuasive the medical opinion or prior administrative medical finding. This includes whether the evidence from other medical source conflicts with medical evidence from other medical sources and whether it contains an internal conflict with evidence from the dame medical source.

(c) The appropriate level of articulation will depend on the unique circumstances of each claim. A written analysis will be performed to explain how medical opinions are considered from any medical source from whom an individual chooses to receive evaluation, examination, or treatment regardless of whether the medical source is an AMS.

The manner in which a decision should be made, once all of the medical evidence is reviewed, is discussed in Section D.3.g.

g. Consultative Examination (Department Regulation 360-5.5)

(1) The Disability Review Team will purchase a consultative examination for an A/R who does not have a current treating source or whose treating source is unwilling or unable to provide required medical evidence. If the A/R's medical source(s) cannot or will not provide sufficient medical evidence to allow the reviewer to make a disability determination, the A/R may be

required to have one or more physical or mental examinations or tests. The type of medical provider should be appropriate for the type of examination or test required. Some reasons why the Disability Review Team may need more medical evidence are:

(a) The additional evidence needed is not in the records of the A/R's medical sources;

(b) The evidence that may have been available from the A/R's treating or other medical sources cannot be obtained for reasons beyond the A/R's or district's control, such as lack of cooperation on the part of a medical source;

(c) Necessary technical or specialized medical evidence is not available from the A/R's medical sources;

(d) A conflict, inconsistency, ambiguity, or insufficiency in the evidence must be resolved, and such conflict(s) cannot be resolved by re-contacting the A/R's medical source(s); and

(e) there is an indication of a change in the A/R's condition that is likely to affect the A/R's ability to work, but the current severity of the A/R's impairment is not established.

When the A/R's treating physician is qualified, equipped, and willing to perform the additional examinations or tests, and generally provides complete and timely reports, the A/R's treating physician or psychologist will be the preferred source to perform a purchased examination. If the A/R's treating source(s) requests payment to complete the "Medical Report for Determination of Disability" (DOH-5143) or to provide available medical records, the local agency must pay for the information, if appropriate.

If the A/R objects to being examined by a designated physician or psychologist, and there is a good reason for the objection (e.g., language barrier, travel restrictions, a previous examination for disability which was unfavorable), the exam should be scheduled with another physician or psychologist, whenever practical.

Medical examinations, including psychiatric and psychological examinations, X-rays, and laboratory tests (such as pulmonary function tests, electro-cardiograms, blood tests, etc.) may be purchased from a licensed physician, psychologist, hospital, or clinic. However, tests which entail significant risk to the A/R, such as myelograms, arteriograms, or cardiac catheterizations, may not be required for the evaluation of disability.

As with any item of evidence in the case record, consultative examination reports will be reviewed for accuracy and completeness, internal consistency, and consistency with the rest of the case record.

(2) Cost of consultative examinations

(a) The Disability Review Team will be responsible for the cost of consultative examinations.

(3) Responsibility to disclose consultative examination information

(a) The A/R may request to have the consultative examination information sent to their primary treating source. If so, a consent form for release of this information shall be signed prior to the purchase of the consultative examination.

(b) The Disability Review Team shall send consultative examination information to an A/R's primary treating source if the A/R has signed the consent form for release of this information. These referrals are particularly important when the Disability Review Team determines that medical evidence obtained during a consultative examination indicates a potential life-threatening situation, such as a previously undiagnosed condition that may require immediate treatment. Examples of such conditions are suspicion of a previously undetected carcinoma, serious new electrocardiogram abnormalities, or a new mass on a chest x-ray.

(c) With or without the A/R’s permission, when the consultative exam discloses new diagnostic information or test results that reveal a potentially life-threatening situation, the local district shall send a copy of the CE report to the A/R’s treating source. The Disability Review Team shall notify the A/R if the CE report is referred to a treating source without the A/R’s permission. If the A/R does not have a treating source, or the treating source is unknown, the A/R shall be notified in writing of the potentially life-threatening situation and the need to see a physician for an examination and/or additional testing. A copy of the notification must be retained in the A/R’s file. The A/R should also be informed that the cost of the subsequent examination(s) and/or test(s) will not be paid by Medicaid unless the A/R is eligible for Medicaid and the medical service is reimbursable by Medicaid. If needed, the local district shall assist the A/R in identifying a potential treating source or inform them of any medical facility through which the required medical services may be obtained at no cost if they are financially unable to pay for such services.

(4) Failure or refusal to take part in an examination or test

The individual's failure or refusal to take part in a consultative examination or test without good cause shall be regarded as a failure or refusal by the individual to cooperate in the disability determination process.

g. Evaluation of Medical Evidence

After all of the medical evidence has been reviewed, a decision is made as to what the evidence shows. If the evidence is consistent and is sufficient to make a determination, a determination should be made. If the evidence is consistent, but is insufficient to make a determination, efforts will be made to obtain additional information.

If the evidence is inconsistent, the evidence will be weighed as a whole to decide whether a determination may be made based on the available evidence. Where there are inconsistencies that cannot be resolved, or when attempts to obtain additional information for cases which are incomplete are unsuccessful, a determination will be made based upon the available evidence.

4. Vocational Considerations

a. Residual Functional Capacity (RFC) -The individual's impairment(s) and any related symptoms, such as pain, may cause physical and mental limitations that affect what they can do in a work setting. Residual functional capacity is the most an individual can still do despite their limitations. An individual's residual functional capacity is assessed based on all the relevant evidence in the case record. If the individual has more than one impairment, the reviewer is to consider all of the individual's medically determinable impairments, including those that are not "severe", when assessing the individual's residual functional capacity. An RFC assessment includes an evaluation of the individual's physical capabilities as well as work-related limitations imposed by any non-exertional impairment(s) (e.g., mental, manipulative, seeing, hearing, speaking, etc.). This assessment is not a decision as to whether an individual is disabled but is used to determine the particular types of work an individual may be able to do despite their impairment(s). Once the individual's RFC is established, it is used to determine their maximum sustained work capacity, which is the highest functional level a person can perform on a regular work basis. In order to limit an individual to a particular functional level (i.e., sedentary, light, etc.), an individual must be limited to at least that level for the timeframe under consideration for disability.

(1) **Physical Impairment** - If the individual has a physical impairment, an assessment of the individual's ability to perform certain work-related activities, such as sitting, walking, standing, lifting, carrying, reaching, handling, pushing, pulling, stooping, and crouching, shall be made. In order to say that an individual can do a certain job, they must have physical capacities equal to the physical demands of that job.

To determine the physical exertion requirements of work in the national economy, the following classifications shall be used. These terms have the same meaning as they have in the Selected Characteristics of Occupations in the Dictionary of Occupational Titles.

(a) **Sedentary work** involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like files, ledgers, and small tools. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

(b) **Light work** involves lifting 20 pounds maximum with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, an individual must be capable of performing substantially all of the foregoing activities. The functional capacity to perform light work generally includes the functional capacity to perform sedentary work.

(c) **Medium work** involves lifting 50 pounds maximum with frequent lifting or carrying of objects weighing up to 25 pounds. The functional capacity to perform medium work includes the functional capacity to perform sedentary and light work as well.

(d) **Heavy work** involves lifting 100 pounds maximum with frequent lifting or carrying of objects weighing up to 50 pounds. The functional capacity to perform heavy work includes the functional capacity to perform work at all of the lesser functional levels.

NOTE: A finding that an individual is limited to less than the full range of sedentary work will be based on careful consideration of the evidence of the individual’s medical impairment(s) and the limitations and restrictions attributable to it. Such evidence must support the finding that the individual’s residual functional capacity is limited to less than the full range of sedentary work.

(2) **Non-exertional limitations –** Any medically determinable impairment(s) resulting in non-exertional limitations (such as mental, sensory, or skin impairments) must also be considered in terms of the limitations resulting from the impairment(s). When an individual has a non-exertional impairment in addition to an exertional impairment, the residual functional capacity must be assessed in terms of the degree of any additional narrowing of the individual's work-related capabilities.

(3) **Mental Impairment -** The assessment of an impairment because of a mental disorder includes consideration of such factors as the capacity to understand, concentrate and persist at tasks, to carry out and remember instructions, and to respond appropriately to supervision, co-workers and customary work pressures in a routine work setting. An explanation of when and how to perform a mental residual functional capacity assessment can be found on Form DOH-5258. This form can be found in CentraPort or the Health Commerce System under OHIP Eligibility Forms>Login>Repository.

(4) **Relationship of residual functional capacity to ability to do work -** When the individual's residual functional capacity is sufficient to enable the individual to do his or her past relevant work, a determination is made that the individual is not disabled.

When the individual's residual functional capacity is not sufficient to enable the individual to do his or her past relevant work, it must be determined what work, if any, the individual can do. The individual's residual functional capacity, age, education, and work experience are taken into consideration in making this determination. Consideration must also be given to whether work that the individual can do exists in significant numbers in the national economy as defined in Section D.4.d.(3).

NOTE: If an individual is limited to less than the full range of sedentary work, the individual is determined disabled. According to the Dictionary of Occupational Titles, there are no jobs in the national economy that are categorized as "less than sedentary" and, therefore, there are no jobs that this individual is able to perform.

b. Age as a vocational factor

General: The term "age" refers to chronological age. When deciding whether an individual is disabled, consideration will be given to the individual's chronological age in combination with their residual functional capacity, education, and work experience. Consideration will not be given to the individual's ability to adjust to other work on the basis of age alone. In determining the extent to which age affects an individual's ability to adjust to

other work, advancing age is considered to be an increasingly limiting factor in the ability to make such an adjustment. If the individual is unemployed but still has the ability to adjust to other work, they may be found not disabled.

How age categories are applied: When making a finding about the individual's ability to do other work, the age categories in paragraphs (1) through (3) of this section should be used. Each of the age categories that applies to the individual for the period in which disability is being determined will be used. The age categories will not be applied mechanically in a borderline situation. If the individual is within a few days to a few months of reaching an older age category, and using the older age category would result in a determination that the individual is disabled, consider whether to use the older age category after evaluating the overall impact of all the factors in the case.

(1) **Younger Individual –** In the case of a younger individual (under age 50), age is generally not considered to seriously affect the individual's ability to adjust to other work. However, in some circumstances, individuals age 45-49 may be considered more limited in their ability to adjust to other work than individuals who have not attained age 45. See Rule 201.17 in Appendix II of the Disability Manual.

(2) **Individual Closely Approaching Advanced Age –** For the individual who is closely approaching advanced age (age 50-54), the factor of age, in combination with a severe impairment(s) and limited work experience, may seriously affect the individual's ability to adjust to other work.

(3) **Individual of Advanced Age –** Advanced age (age 55 or over) represents the point where age significantly affects the individual's ability to adjust to other work. There are special rules for individuals of advanced age and for individuals in this category who are closely approaching retirement age (age 60-64). See Section D.4.d.(1) – Skill Requirements.

c. Education as a Vocational Factor

The term "education" is primarily used in the sense of formal schooling or other training which contributes to the individual's ability to meet vocational requirements (e.g., reasoning ability, communication skills, and arithmetic ability). Lack of formal schooling is not necessarily an indication that the individual is uneducated or lacks such capacities. For individuals with past work experience, the kinds of responsibilities assumed when working may indicate the existence of such intellectual capacities although their formal education is limited. Other evidence of such capacities for individuals with or without past work experience may consist of daily activities, hobbies, or the results of testing. The significance of an individual's educational background

may be affected by the time lapse between the completion of the individual's formal education and the onset of physical or mental impairments and by what the individual has done with their education in a work context. Formal education that was completed many years prior to the onset of the impairment(s) or unused skills and knowledge that were a part of such formal education may no longer be useful or meaningful in terms of the individual's ability to work. Thus, the numerical grade level of educational attainment may not be representative of an individual's present educational competencies which could be higher or lower. However, in the absence of evidence to the contrary, the numerical grade level will be used. In evaluating the educational level of an individual, the following classifications are used:

(1) **Illiteracy -** refers to the inability to read or write. An individual who is able to sign his or her name but cannot read or write a simple communication (e.g., instructions, inventory lists), is considered illiterate. Generally, an illiterate individual has had little or no formal schooling.

(2) **Marginal education -** refers to competence in reasoning, arithmetic, and language skills which are required for the performance of simple, unskilled types of jobs. Generally, formal schooling at a grade level of sixth grade or less is considered a marginal education.

(3) **Limited education -** refers to competence in reasoning, arithmetic, and language skills which, although more than that which is generally required to carry out the duties of unskilled work, does not provide the individual with the educational qualifications necessary to perform the majority of more complex job duties involved in semi-skilled or skilled jobs. Generally, a seventh grade through eleventh grade level of formal education is considered a limited education.

(4) **High school education and above -** refers to competence in reasoning in arithmetic, and language skills acquired through formal schooling at a level of grade twelve or above. Usually, these educational capacities qualify an individual for work at a semi-skilled through a skilled level of job complexity.

d. Work experience as a vocational factor.

"Work experience" means skills and abilities an individual has acquired through previously performed work. The type of work the individual has already been able to do shows the kind of work they may be expected to do. Work experience is relevant when it was done within the last 5 years, lasted long enough for the individual to learn to do it, and was considered substantial gainful activity. Work performed 5 years or more prior to the date of

application is ordinarily not considered vocationally relevant. An individual who has no prior work experience (e.g., housewife) or has worked only sporadically for brief periods of time during the 5-year period may be considered to have no relevant work experience. If an individual has no work experience or did work that started and stopped in a period of fewer than 30 calendar days during the 5-year period, this will not be considered past relevant work. Any skills acquired through work experience are vocational assets unless they are not transferable to other skilled or semi-skilled work within the individual's current capacities. When acquired skills are not transferable, the individual is considered capable of only unskilled work. (See Section D.4.d.(2) for explanation of transferability of skills.) An individual need not have work experience to qualify for unskilled work because it requires little or no judgment and can be learned in a short period of time.

(1) **Skill requirements**

For purposes of assessing the skills reflected by an individual's work experience and of determining the existence in the national economy of work the individual is able to do, occupations are classified as unskilled, semi- skilled, and skilled. These terms are used in the following manner:

(a) Unskilled work is work which requires little or no judgment to do simple duties that can usually be learned on the job within 30 days. This job may or may not require considerable physical strength. An individual does not gain work skills by doing unskilled jobs.

(b) Semi-skilled work requires some skills but does not require doing the more complex work duties. Semi-skilled jobs may require alertness and close attention to watching machine processes; or inspecting, testing or otherwise looking for irregularities; or tending or guarding equipment, property, materials, or persons against loss, damage or injury; or other types of activities which are similarly less complex than skilled work, but more complex than unskilled work. A job may be classified as semi-skilled where coordination and dexterity are necessary, as when hands or feet must be moved quickly to do repetitive tasks.

(c) Skilled work requires qualifications in which an individual uses judgment to determine the machine and manual operations to be performed in order to obtain the proper form, quality or quantity of material to be produced. Skilled work may require laying out of work, estimating quality, making precise measurements, reading blueprints, or making necessary computations or mechanical adjustments to control or

regulate the work. Other skilled jobs may require dealing with people, facts, or figures or abstract ideas at a high level of complexity.

(2) **Transferability of skills**

(a) **Definition -** An individual is considered to have transferable skills when the skilled or semi-skilled work activities that they did in past relevant work can be used to meet the requirements of skilled or semi-skilled work activities of other jobs. Transferability depends largely on the similarity of occupationally significant work activities among jobs. Transferability of skills cannot be derived from the performance of job tasks in unskilled work.

(b) **Determination of skills that can be transferred –** Transferability is most likely among jobs in which:

(i) The same or a lesser degree of skills is required;

(ii) The same or similar tools and/or machines are used;

(iii) The same or similar materials, products, processes, or services are involved; and

(iv) The work is in the same or closely related industry.

(c) **Degrees of transferability -** There are degrees of transferability of skills, ranging from very close similarities to remote and incidental similarities among jobs. A complete similarity of all the above factors is not necessary for transferability. However, when skills are so specialized or have been acquired in such an isolated vocational setting that they are not readily usable in other industries, jobs, and work settings, these skills may be considered not transferable.

(d) **Transferability of skills for individuals of advanced age -** In the case of an individual of advanced age (55 or older) with a severe impairment(s) limiting them to sedentary or light work, the individual will be found to be unable to make an adjustment to other work unless they have skills that can transfer to other skilled or semiskilled work (or unless the individual recently completed education which provides for direct entry into skilled work) that they can do despite their impairment(s). A decision as to whether the individual has transferable skills will be made as follows.

If the individual is of advanced age and has a severe impairment(s) that limits them to no more than sedentary work, the individual will be

found to have skills that are transferable to skilled or semiskilled sedentary work only if the sedentary work is so similar to the individual's previous work that they would need to make very little, if any, vocational adjustment in terms of tools, work processes, work settings, or the industry. (See Section D.4.a.(1)(a) and Rule 201.00(f) of Appendix II.)

If the individual is of advanced age but has not attained age 60 and has a severe impairment(s) that limits them to no more than light work, the rules in paragraphs (2) (a)-(c) of this section will be applied to decide if the individual has skills that are transferable to skilled or semiskilled light work (see Section D.4.a.(1)(b)).

If the individual is closely approaching retirement age (age 60-64) and has a severe impairment(s) that limits them to no more than light work, the individual will be found to have skills that are transferable to skilled or semiskilled light work only if the light work is so similar to the individual's previous work that they would need to make very little, if any, vocational adjustment in terms of tools, work processes, work settings, or the industry. (See Section D.4.a.(1)(b) and Rule 202.00 (f) of Appendix II.)

(e) **Residual Functional Capacity (RFC) -** Reduced RFC will limit the number of jobs within an A/R's physical or mental capacity to perform and will impact upon the degree to which acquired skills may be considered transferable. All functional limitations, both exertional and non-exertional, must be considered in determining transferability of job skills.

(f) **Evaluation of transferability of skills -** This evaluation is made when consideration is given to whether an individual is able to do any other work, taking into account the individual's age, education, past work experience and residual functional capacity. The Medical Vocational Rules in Appendix II are used for this purpose.

In certain instances, these rules indicate that if the individual has transferable skills, they will be determined not disabled and if the individual does not have transferable skills, they will be considered disabled. The Dictionary of Occupational Titles (DOT) and Selected Characteristics of Occupations (SCO) defined in the Dictionary of Occupational Titles should be used to determine if there are other jobs that this individual can do using transferable skills. The DOT includes a comprehensive description of job duties and related information for nearly all jobs that exist in the national economy. It groups occupations into a

classification structure based on interrelationships of job tasks and requirements. The Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles provides supplemental information about jobs including physical demands and environmental conditions.

The procedure used to determine if there are other jobs an individual can do using transferable skills is as follows:

(i) Locate the individual's past relevant job(s) in the DOT, using the Alphabetical Index of Occupational Titles, the Occupational Titles by Industry Designation, or the Occupational Group Arrangement within the Dictionary.

(ii) After locating the appropriate job title, obtain the 9-digit Occupational Code and the 6-digit Guide for Occupational Exploration (GOE) code. Obtain the Strength level (Sedentary, Light, Medium, Heavy) and the Specific Vocational Preparation (skill) number (1-2 for Unskilled, 3-4 for Semi- skilled, 5-9 for Skilled).

(iii) Search other occupations with the same or close first 3 digits of the Occupational code. Search for jobs with the same GOE code.

(iv) Within these jobs, search for jobs with the same or less SVP number and within the individual's current RFC. (Do not consider SVP numbers of 1 or 2, as these are unskilled occupations.)

(v) Locate these job possibilities in Part A of the SCO, using the GOE code. Evaluate the additional physical demands and environmental conditions required by these jobs. Determine if there are at least 3 jobs the individual could still do considering their current physical and/or environmental limitations. An individual cannot be expected to do any job that has a higher physical demand level or skill level than their past job or to do a job that has a skill level less than 3. Individuals are not expected to do more complicated jobs than they have actually performed in the past or perform a job that takes longer to learn or is more complex in regard to data, people, or things than a past job. The more similar a job is to the individual's past job in the use of tools, machines or materials, in the products or services involved, and in the type of industry, the more likely that the individual can transfer acquired skills to a new job.

(3) **Work which exists in the national economy**

Work exists in the national economy when it is present in significant numbers either in the region where the individual lives or in several other

regions of the country. It does not matter whether there is such work in the immediate area in which the individual lives, whether there is a specific job vacancy for the individual, or whether the individual would be hired if they applied for the job. A finding that work exists in the national economy is made when there is a significant number of jobs (in one or more occupations) having requirements which do not exceed the individual's physical or mental capabilities and vocational qualifications. Isolated jobs of a type that are present only in very limited numbers in relatively few geographic locations outside of the region where the individual resides are not considered to be “work which exists in the national economy." An individual will not be denied disability status on the basis of these kinds of jobs. If work that the individual can do does not exist in the national economy, the individual shall be determined disabled. If such work does exist in the national economy, the individual will be determined not disabled.

An individual will be determined not disabled if their functional capacity and vocational abilities make it possible for the individual to do work which exists in the national economy, but the individual remains unemployed because of:

(a) Inability to obtain such work;

(b) Such work does not exist in the individual's local area;

(c) The hiring practices of employers;

(d) Technological changes in the industry in which the individual has worked;

(e) Cyclical economic conditions;

(f) No job openings for the individual; or

(g) The individual does not wish to do a particular type of work.

5. Responsibilities of the Disability Review Team

Department Regulation 360-5.2

a. The Disability Review Team must review the individual's entire case record, including both medical and social records, and reach one of the following decisions. Particular attention should be given to the treating physician's opinion.

A complete discussion of how medical opinions should be weighed can be found in Section D.3.e.(1).

(1) **Approval -** The individual is determined disabled and is placed in one of the following classifications:

(a) **Group I** includes individuals who show no possibility of engaging in any substantial gainful work activity because they have a physical and/or mental impairment(s) which is disabling and considered to be irreversible. A Group I certification shall apply for the life of the individual to age 65 with the following exceptions:

(i) the case is closed for 12 months or more (See Section H regarding the reapplication process);

(ii) the individual shows medical improvement; or

(iii) the individual returns to work which is considered substantial gainful activity.

(b) **Group II** includes individuals who have impairments which, while totally disabling at the time of determination, are expected to improve, enabling the individual to become capable of substantial gainful activity. Some reasons for this improvement may be the condition may be arrested, a remission may occur, therapeutic advances are occurring, and rehabilitation is deemed feasible.

(2) **Disapproval -** The individual does not meet the disability criteria set forth in this manual.

a. The DOH-5144, Disability Review Team Certificate, must be completed for all cases reviewed by the Disability Review Team. Information on this form includes the decision, the rationale and regulatory citations for approval or disapproval, the effective date of disability, and the expiration date for Group II cases. If the Disability Review Team has insufficient evidence to make a decision, the team will request the specific medical and/or social information needed to complete the disability review.

b. The Psychiatric Review Technique Form (PRTF), DOH-5250 is a suggested form which may be completed by the Disability Review Team for cases which include a psychiatric diagnosis. A copy of this form and directions for its completion can be found in CentraPort or the Health Commerce System under OHIP Eligibility Forms. The PRTF is designed to ensure that all pertinent mental diagnoses are evaluated as necessary, that adequate documentation has been obtained, and, if a case cannot be approved on the basis of meeting a listing, that a mental residual functional capacity assessment is done. For the PRTF to be

used, it is imperative that the documentation in item 10 of the "Disability Review Team Certificate" (DOH-5144) reflects that the pertinent mental diagnosis(es) has been fully developed, that all medical and non-medical evidence pertinent to the mental diagnosis(es) has been considered, and that the sequential evaluation process has been followed. All diagnoses/listings on which the decision is based should be addressed, as well as whether the A/R's impairment(s) meets or equals a listing; if so, the specific subsections should be indicated. In psychiatric cases in which no listing is met or equaled, it may be necessary to complete a Mental Residual Functional Capacity (MRFC) Assessment, form DOH-5258. This form can be found in CentraPort or the Health Commerce System under OHIP Eligibility Forms. If a mental residual functional capacity assessment is utilized, the specific areas in which the A/R's functional capacity is limited should be noted on the DOH-5144. The rationale should address the findings, conclusions and the decision.

c. The Disability Review Team shall establish the effective date of disability in accordance with Section D.6. The effective date is the first day of the month in which the individual meets the disability criteria and not earlier than 3 months prior to the month of application for Medicaid.

d. The Disability Review Team maintains statistics as to the number and disposition of the cases reviewed. The Disability Review Team "Quarterly Statistics Report" will be completed each quarter. If requested, districts should submit this report electronically.

e. When a case is submitted for redetermination, the Disability Review Team must determine if an individual's disability continues by using the Continuing Disability Review (CDR) process set forth in this manual. If disability continues, the case is classified either Group I or Group II. If the case is classified Group II, a new expiration date is given based on how long the disability is expected to last. This certification period can be for less than or greater than 12 months.

6. Effective Date of Disability

Department Regulation Section 360-5.8

An effective date of disability shall be established by the Disability Review Team for each individual who is determined disabled. It is important to establish the effective date of disability as early as possible. The following guidelines should be used in determining this date:

a. Initial Certification - The effective date of disability cannot be more than three months prior to the month of application for Medicaid for initial certification. In order for the effective date to be established three months prior to the month of application, medical evidence must indicate that the individual was disabled during that period. Most cases will be approved for a period of at least 12 months. It is, however, important to note the distinction between the disability **onset** date, which refers to the date on which the A/R actually meets the disability criteria, and the disability **effective** date, which refers to the date from which the A/R is approved for disability for Medicaid purposes. There are cases in which the onset of the A/R's disability is prior to the earliest possible Medicaid effective date (i.e., onset date is more than three months prior to the date of application), and in which the A/R's disability has lasted or may be expected to last less than 12 months after this effective date. An example is as follows:

> John Doe is a 29-year-old male who was involved in a motor vehicle accident in June of 2008 and suffered a fractured femur. He was hospitalized for ten days, during which time he had surgery to repair the femur. Due to complications during recovery, he found it necessary to apply for Medicaid on March 1, 2009. Documentation from his physician indicated that he met disability criteria from the time of the accident (onset date June 2008), and it was anticipated that Mr. Doe would be able to return to work as of August 1, 2009. Based on this, the client was approved for disability from December 1, 2008 (effective date three months retroactive from date of application) until May 31, 2009, as it was determined that he would be able to return to work on June 1, 2009.
>
> In such a case, the individual's impairment could be expected to last for a continuous period of 12 months (June 1, 2008-May 31, 2009) and therefore, the duration requirement was met. However, the individual was approved for a period of less than 12 months from the effective date to the expiration date.

For these cases, the following procedure should be followed:

> (1) On Form DOH-5144, "Disability Review Team Certificate", the reviewer should note in the appropriate field the effective date and, in addition, include the words "onset date" with the date of disability onset.
>
> (2) On Form DOH-5144, under Item 10, the reviewer should note the period for which the A/R is determined disabled from the date of onset, in order to clearly document that the duration requirement has been met.

b. S/CC Recipients with Medicaid-Only – Generally, the effective date should be the first day of the month in which the individual became disabled based on the

criteria in this manual. This date should be no earlier than three months prior to the month of initial application for Medicaid.

(1) Mr. Y has been in receipt of Medicaid as S/CC - related from July 2007 until the present. The Disability Review Team determines that Mr. Y has been disabled since October 2009. As in the example above, funds under the SSI- related category shall be claimed for medical care only from the effective date of disability, which is October 2009.

c. SSI Recipients - SSI recipients in New York State are automatically eligible for Medicaid. To determine the effective date of disability for these individuals, the following fields on the SDX should be screened:

(1) Field 317 "Payment Status Code". If the code CO1 appears, the individual is in payment status. If the code NO1 appears, the individual is in Non-Pay status due to excess countable income.

(2) Field 98 "Onset-Disability/Blindness Code". For individuals who have been determined disabled, this code will give the effective date of disability onset.

NOTE: For SSI recipients with medical bills incurred up to three months prior to month of application, refer to Section I.

7. Expiration Dates

All Group II cases must have an expiration date. The expiration date must be at least 12 months from the effective date (or onset date) for the initial disability period. Cases may be approved for more than 12 months whenever the medical evidence warrants a longer disability period. The Disability Review Team should consider the facts of the case (such as the individual's diagnoses, medical history and findings, extent of functional impairment, age, work history, etc.) when setting the expiration date. A maximum of seven years is recommended for the most severely disabled Group II cases. Group II cases must be re-evaluated for continuing disability before the expiration date. Such cases may, if appropriate, be recertified for less than one year since the 12- month duration requirement has already been fulfilled.

Some of the medical impairment listings in Appendix I contain specified lengths of time to approve cases when certain specific criteria are met. Examples are listings for heart and kidney transplants, liver disease, acute leukemia, and other cancers. Cases approved on the basis of HIV-related illness may be approved for up to seven years, if appropriate.

E. <u>Vocational/Financial Considerations</u>

1. Substantial Gainful Activity (SGA)

Department Regulation Section 360-5.2

a. Definition - Substantial gainful activity is work activity that is both substantial and gainful as detailed below.

(1) Substantial work activity is work that involves doing significant physical and/or mental activities. Work can be considered substantial even if performed part-time and/or requires less responsibility than former work.

(2) Gainful work activity is work done for pay or profit, whether or not a profit is realized.

(3) Other activities such as household tasks, attending school, therapy, hobbies, club activities or social programs generally are not considered substantial gainful activity.

b. Evaluation Guidelines

In determining whether or not an individual, who is not statutorily blind, is able to do work at the substantial gainful activity level, the following factors shall be considered on the basis of medical and vocational evidence:

(1) **Nature of Work -** The performance of duties by the individual which involve the use of their skills or experience, supervision and responsibility, or contribute substantially to the operation of a business is evidence indicating that an individual has the ability to engage in substantial gainful activity.

(2) **Adequacy of performance -** The adequacy of an individual's performance of assigned work is also evidence as to whether or not they have the ability to engage in substantial gainful activity. An individual's failure, due to their impairment, to perform ordinary or simple tasks satisfactorily without more supervision or assistance than is usually given other people doing similar work may constitute evidence of an inability to engage in substantial gainful activity. Performance of work that involves minimal duties that make little or no demands on the individual and are of little or no use to their employer does not demonstrate ability to engage in substantial gainful activity.

(3) **Special employment conditions -** Work performed under conditions of employment which makes special provision for an employee's impairment (for example, work in a sheltered workshop or in a hospital by a patient) may provide evidence of skills and abilities that demonstrate an ability to engage

in a substantial gainful activity, whether or not such work in itself constitutes substantial gainful activity.

(4) **Time spent in work -** The amount of time spent in work is important but shall not be the sole basis for determining whether an individual is able to do substantial gainful activity. Evaluation as to whether the work is substantial and gainful is made regardless of whether the individual spends more or less time at the job than workers who are not impaired and are doing similar work as a regular means of livelihood.

(5) **Earnings from work**

(a) **General -** The amount of gross earnings from work activities (minus appropriate impairment-related work expenses as set forth in Section E.1.b.(5)(e)) may establish that the individual has the ability to engage in substantial gainful activity. Generally, activities which result in substantial earnings would show that the individual is able to do substantial gainful activity. However, the fact that the earnings are not substantial does not necessarily show that an individual is not able to do substantial gainful activity. Where an individual is forced to discontinue work activities after a short time due to an impairment, the earnings from such work do not demonstrate ability to engage in substantial gainful activity.

(b) **Subsidized earnings -** If an individual's earnings are being subsidized, the amount of the subsidy is not counted when determining whether or not work is substantial gainful activity. Where work is done under special conditions (e.g., an impaired person who does simple tasks under close and constant supervision), only the part of the pay which is actually "earned" is considered. An employer may set a specific amount as a subsidy after figuring the reasonable value of the employee's services. If the employer does not set the amount of the subsidy, a decision by the agency shall be made as to the reasonable value of the work.

(c) **Earnings at a monthly rate in excess of $1,550 for non-blind individuals and $2,590 for blind individuals -** An individual whose average monthly earnings from work activities are more than $1,550 for non-blind individuals and $2,590 for blind individuals shall be deemed to demonstrate the ability to engage in substantial gainful activity in the absence of evidence to the contrary. Effective January 1, 2024 the SGA level was increased from $1,470 to $1,550 for non-blind individuals and from $2,460 to $2,590 for blind individuals. Federal regulations provide for an annual automatic cost of living adjustment (COLA) to

this amount. An individual is generally considered not to be engaged in SGA if their earnings are less than the SGA level, unless there is evidence to the contrary.

(d) **Factors considered when an individual is self-employed -** The earnings or losses of a self-employed individual often reflect factors other than the individual's work activities in carrying on their business. For example, a business may have a small income or may even operate at a loss even though the individual performs sufficient work to constitute substantial gainful activity. Thus, less weight shall be given to such small income or losses in determining a self-employed individual's ability to engage in substantial gainful activity and greater weight shall be given to such factors as the extent of their activities and the supervisory, managerial, or advisory services rendered by the individual.

(e) **Impairment-related work expenses –** Impairment-related work expenses which, due to an individual's impairment(s), are expended to enable the individual to work shall be deducted in determining an individual's countable earned income and in deciding if they have done substantial gainful activity. These expenses must be paid by the disabled individual. No deduction will be allowed to the extent that payment has been or will be made by another source. The costs are deductible even though the items and services are also needed to carry out daily living functions unrelated to work.

The following are deductible impairment-related work expenses:

(i) Assistance in traveling to and from work or, while at work, assistance with personal functions (e.g. eating, toileting), or with work- related functions (e.g., reading, communicating),

(ii) Assistance at home with personal functions, (e.g., dressing, administering medications) in preparation for going to and returning from work. Payments made to a family member for attendant care services may be deducted only if such family member, in order to perform the services, incurs an economic loss by terminating their employment or by reducing the number of their work hours

(iii) Medical devices such as wheelchairs, hemodialysis equipment, canes, crutches, inhalators, and pacemakers

(iv) Prosthetic devices, such as artificial replacements of arms, legs and other parts of the body

(v) Work-related equipment, such as one-hand typewriters, telecommunication devices for the deaf, Braille devices, and specially designed work tools

(vi) Residential modifications, in the form of changes to the exterior of the home to permit the individual to get to their means of transportation (e.g., exterior ramps, railings, pathways)

(vii) For an individual working at home, modifications to the inside of their home in order to create a working space to accommodate an impairment (e.g., enlargement of a doorway leading into the office, modification of workspace to accommodate problems in dexterity). For a self-employed person, any cost deducted as a business expense cannot be deducted as an impairment-related work expense.

(viii) Devices or appliances which are essential for the control of a disabling condition, either at home or in the work setting, and are verified as medically necessary (e.g., electric air cleaner for an individual with severe respiratory disease who cannot function in a non-purified air environment)

(ix) Drugs or medical services, including diagnostic procedures, needed to control the individual's impairment. The drugs or services must be prescribed or used to reduce or eliminate symptoms of the impairment or to slow down its progression. The diagnostic procedures must be performed to ascertain how the impairment(s) is progressing or to determine what type of treatment should be provided for the impairment(s). Some examples of deductible drugs and medical services are anticonvulsant drugs, antidepressant medication for mental disorders, radiation treatment or chemotherapy, corrective surgery for spinal disorders, and tests to determine the efficacy of medication.

(x) Expendable medical supplies, such as catheters, elastic stockings, bandages, irrigating kits, incontinence pads, facemasks and disposable sheets and bags

(xi) Physical therapy required because of an impairment and which is needed in order for the individual to work

(xii) Costs of a seeing-eye dog, including food, licenses and veterinarian services

(xiii) Payments for transportation costs in the following situations:

-Costs of structural or operational modifications to a vehicle required by an individual in order to get to and from work;

-Mileage allowance for an approved vehicle, limited to travel related to employment; and

-Cost of driver assistance or taxicabs, where such special transportation is not generally required by an unimpaired individual in the community.

2. Trial Work Period

a. A Trial Work Period is a period during which an individual may test his or her ability to work and still maintain disability status. During a trial work period an individual, who is still medically impaired, may perform "services" in as many as nine (9), not necessarily consecutive, months.

b. "Services" in this section means any activity in employment or self-employment for pay or profit, or the kind of activity normally done for pay or profit. Work activity will be considered "services" if in any month the individual earns more than $1,110 a month. Effective January 1, 2024 the average monthly earnings from services was increased from $1,050 to $1,110. Federal regulations provide for an annual automatic cost of living (COLA) adjustment to this amount. For self-employed individuals, work will be determined to be "services" only when the individual's monthly net earnings are more than the Trial Work Period amount or when the individual works more than 80 hours a month in their business.

Work is generally not considered to be "services" for the purpose of calculating trial work period months if the work is:

(1) Part of a prescribed program of medical therapy;

(2) Carried out in a hospital under the supervision of medical and/or administrative staff;

(3) Not performed in an employer-employee relationship; or

(4) Not normally performed for payor profit.

c. The Disability Review Team may find that the individual's disability has ended at any time during the trial work period if the medical or other evidence shows that they are no longer disabled. An individual may have only one trial work period during a disability period.

3. Plans for Achieving Self-Support (PASS)

Department Regulation Section 360-4.6

Eligible blind and disabled individuals may participate in Plans for Achieving Self- Support. These plans are intended to assist certain A/Rs to accumulate money and/or set aside current income and/or resources in excess of the allowable income and/or resource level for use in accordance with a plan. The purpose of the PASS is to assist these individuals in obtaining or regaining a feasible occupational objective. PASS allows an individual to set aside money for short-term objectives like saving money for education, vocational training, or starting a business, or for a work-related item, such as a computer or even a custom van.

a. Conditions for Plans for Achieving Self-Support (PASS)

After application of all disregards for blind or disabled individuals under 65, or for blind or disabled individuals age 65 or over who received SSI payments or aid under the State Plan for the blind or disabled for the month before the month in which the individual attained age 65, any remaining countable income and/or resources may be set aside for a Plan to Achieve Self-Support (PASS).

A PASS must meet the following conditions:

(1) A specific plan for self-support must contain a feasible designated work goal objective and must exist in writing.

(2) The local Commissioner of Social Services must approve the plan and any subsequent plan changes.

(3) The individual plan must contain specific savings and/or planned disbursements for the designated work goal objective.

(4) The plan must provide for the identification and segregation of money and goods, if any, being accumulated and conserved for the purpose of achieving the feasible work goal objective.

(5) The plan must be current.

(6) The individual must be performing in accordance with the specific plan.

(7) An approved plan is limited to 18 months with the possibility of an extension for an additional 18 months. A further extension of 12 months may

be allowed in order to fulfill a plan for a lengthy education or training program.

b. Acceptable Candidates for Plans for Achieving Self-Support (PASS)

Not all A/Rs would be appropriate candidates for a self-support plan. Agencies should take care in selecting who should be considered for a self-support plan. PASS should only be used for A/Rs who, through rehabilitative efforts, can reasonably be expected to become self-supporting or more self-supporting and demonstrate a reduction in medical expenses paid through Medicaid. Whether the individual is eligible for work goal rehabilitation is an important factor in determining if a PASS is appropriate. A self-support plan may be used for an individual in a long-term care facility or the community.

In cases where both spouses are blind or disabled, each may have an active plan for achieving self-support. In such a situation, a plan should be developed for each spouse independent of the plan for the other party.

Some objectives that an individual may be striving to meet which are acceptable for self-support plans are:

(1) Saving money for a future down payment on a specially equipped vehicle to be used by the individual for daily transportation to their prospective place of work goal;

(2) Accumulating money to start a small business which is applicable to the individual's work goal background and/or training;

(3) Accumulating funds so the individual may continue their education; or

(4) Another work goal which would make the individual more self- sufficient and will lessen the person's need for Medicaid.

c. Selection of PASS Participants

The local agency should consider all A/Rs who appear to have the potential to benefit from a PASS. Additionally, A/Rs may request that they be considered for a PASS. In all instances, the local commissioner has the authority to approve or reject all plans and any subsequent changes to plans for self-support for individuals under their jurisdiction.

A decision as to whether the PASS is approvable should be reached as quickly as possible using all available information, and the individual must be notified of the decision in writing.

d. Initiation of a Plan for Achieving Self-Support

To initiate a PASS, the following steps shall be taken:

(1) At certification and recertification, if the local district identifies a disabled A/R with the potential for rehabilitation and if the A/R wants these services, the worker should make any necessary referrals. This referral may be made even if the A/R is already in a training program.

(2) The local district worker will make a written evaluation of the A/R after conducting a personal interview with the individual. If the A/R is institutionalized or is in a supervised residential setting, a conversation with a facility social worker or case manager who is familiar with the individual should be held.

(3) If the A/R is already in a training program, the local district worker will assist the individual in writing a self-support plan utilizing a PASS outline or a local equivalent.

(4) If the A/R is not in a training program and the worker is of the opinion that a PASS is indicated, a referral to Office of Vocational Rehabilitation, New York State Commission for the Blind, the Veterans Administration, etc., should be made. The servicing agency, such as one of the above, should make an in-depth medical/vocational evaluation of the individual.

(5) When this evaluation is completed and a feasible work goal objective is indicated, the worker may assist the individual in writing a PASS. The service agency may also be able to provide assistance in preparing a PASS.

(6) The amount of money to be set aside to fulfill the PASS shall be clearly identified. Separate accounts shall be established for the money with an indication that the account is for a PASS.

(7) Once the PASS is approved and signed by the local Commissioner of Social Services, the worker, and the individual involved, the plan is in effect.

(8) Every three months, a report that indicates how the individual is progressing shall be written to verify that the individual is saving and/or applying the prescribed amount of money stated in the plan and acting in accordance with all other provisions of the plan. All evaluations, PASS outlines and other information shall be filed in the individual's case folder.

(9) The PASS may be terminated as soon as the agency becomes aware of non-compliance with the plan and a satisfactory explanation is not provided. In all instances, if the individual fails to comply with the PASS for a period

of three months, the plan will be deemed to have been abandoned as of the date when performance in accordance with the plan stopped. The local agency shall re- determine the individual's eligibility for Medicaid.

A PASS may be altered if the individual can no longer fulfill the terms of the plan due to illness or change in circumstances. Such alterations or revisions are subject to approval by the local Commissioner of Social Services. Where the feasible work goal objective is changed, the revised approved plan should take into consideration any training already received and should be promptly reviewed.

(10) Upon satisfactory completion of the plan, the earmarked funds must be utilized as planned, within a reasonable length of time. If the individual refuses to use the funds as planned, the agency should consider these funds as an available resource and/or income. The individual's financial eligibility for Medicaid should be re-determined at this point.

e. Notices Related to Plans for Achieving Self-Support (PASS)

The local district shall review the A/R's plan for achieving self-support, along with any other relevant information, and determine whether or not the PASS is approvable. The district must notify the A/R of its determination in writing. The notice to the A/R must include the following information:

(1) A statement that the request for a PASS has been approved or denied

(2) If approved, the notice must identify the designated work goal objective, the specific savings and/or planned disbursements for the objective and the approved period of time for achieving the objective.

(3) If denied, the notice must detail the reason(s) for the denial.

(4) An explanation of the A/R's right to a fair hearing if they disagree with the agency's decision regarding the PASS denial or any aspect of the agency's PASS approval

(5) All other information required to be included with the agency's Notices of Intent

If the PASS approval or denial affects the A/R's eligibility for Medicaid the local district shall send the appropriate notice(s) informing the individual of this information.

F. <u>Disability Determination for Individuals Under 21 Years Old</u>

Children who are determined disabled may be eligible for Medicaid as SSI-related using the SSI-related budgeting deductions and disregards. In some cases, the SSI-related methodology may be more beneficial than other methodologies, especially if there is earned income that is deemed property of the child. Children with severe impairments who may be disabled should be referred to the Social Security Administration to apply for SSI benefits.

A child under the age of 18 who is not engaged in substantial gainful activity may be considered disabled if they have a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations and that is expected to meet the 12-month duration requirement or result in death. The children's medical impairment listings are used for individuals under the age of 18 and are found in Appendix I, Part B. The adult listings in Appendix I, Part A may be used for children in circumstances when the children's medical listings do not give appropriate consideration to a particular disease process in childhood. Children who have been certified disabled must be re-evaluated under the adult criteria upon attainment of age 18.

The medical review process for children is described in Section M. Suggested forms for collecting information from parents, caretakers, schools and medical sources can be found in CentraPort and the Health Commerce System-OHIP Eligibility Forms/Login/Repository.

G. Continuing Disability Review (CDR) Process for Adults

1. General - All disability cases classified as Group II must be reviewed by the Disability Review Team prior to the disability expiration date to determine if the individual continues to be disabled.

A number of factors are considered in determining if disability continues. It must be determined if there has been medical improvement in the individual's impairment(s) and if so, whether this medical improvement is related to their ability to work. If there has been no medical improvement, the Disability Review Team must consider whether one or more of the exceptions to medical improvement applies. If medical improvement related to the individual's ability to work has not occurred and no exception applies, the individual's disability will continue. Even where medical improvement related to the individual's ability to work has occurred or an exception applies, it must also be shown that the individual is currently able to engage in substantial gainful activity before they can be found to no longer be disabled. A determination of medical improvement in itself never constitutes reason to find that disability has ended. However, a determination that there has been no medical improvement can be the basis for determining that disability continues as long as none of the exceptions apply.

The Continuing Disability Review process consists of specific steps that are set forth in detail below. The Continuing Disability Review Process for children under 18 can be found in Section M. 6

2. Medical Improvement

a. Definition - Medical improvement is any decrease in the medical severity of the individual's impairment(s) which was present at the time of the most recent favorable medical decision that the individual was disabled or continued to be disabled. This decrease in medical severity must be based on medical evidence showing changes in the signs, symptoms and/or laboratory findings associated with the individual's impairment(s). Minor changes in signs, symptoms and laboratory findings that obviously do not represent medical improvement may be disregarded. A determination that there has been a decrease in medical severity must be based on changes (improvement) in signs, symptoms and/or laboratory findings.

b. Medical Improvement Related to Ability to Work

(1) Medical improvement <u>is not</u> related to the individual's ability to work if there has been a decrease in the severity of the impairment(s), as defined in 2.a. above, but no increase in the individual's functional capacity to do basic work activities.

If there has been medical improvement in the individual's impairment(s) but the improvement is not related to their ability to do work and none of the exceptions (as set forth below) applies, the individual continues to be disabled.

(2) Medical improvement <u>is</u> related to the individual's ability to work if there has been a decrease in the medical severity as defined in this section and an increase in the individual's functional capacity to do basic work activities as discussed below.

A determination that medical improvement related to an individual's ability to do work has occurred does not necessarily mean that their disability will be found to have ended unless it is also shown that they are currently able to engage in substantial gainful activity as discussed in this manual.

c. Functional Capacity to do Basic Work Activities - in order to determine how and to what extent the individual's impairment(s) has affected their ability to do work, consideration must be given to how their functional capacity for doing basic work activities has been affected. Basic work activities mean the abilities and aptitudes necessary to do most jobs. Included are exertional abilities, such as walking, standing, pushing, pulling and reaching; and non-exertional abilities

and aptitudes, such as seeing, hearing, speaking, handling, remembering, using judgment, and dealing with supervisors and co-workers. A person who has no impairment(s) would be able to do all basic work activities at normal levels and would have an unlimited functional capacity to do basic work activities. Depending on its nature and severity, an impairment usually results in some limitation of the functional capacity to do one or more of these basic work activities. Residual functional capacity is what physical and/or mental work-related activities an individual can do despite their impairment(s)/limitations. (See Section D.4.a.) It is this residual functional capacity, in conjunction with the individual's age, education and work experience that is used to determine whether the individual can still do their past relevant work or any other work.

(1) A decrease in the severity of an impairment, as measured by changes in signs, symptoms or laboratory findings, can result in an increase in the individual's functional capacity to do work activities. When new evidence showing a change in signs, symptoms, and/or laboratory findings establishes that both medical improvement has occurred and the individual's residual functional capacity has increased, medical improvement which is related to ability to do work has occurred. If so, the residual functional capacity assessment is also used to determine whether the individual can engage in substantial gainful activity and thus whether the individual continues to be disabled.

(2) Many impairment-related factors must be considered in assessing the individual's functional capacity for basic work activities. Age is one factor in the sense that there is a gradual decrease in organ function with age as well as a decrease in range of motion, muscle atrophy, and changes in the cardiac and respiratory systems which limit an individual's exertional range.

(3) The longer an individual is away from the workplace and is inactive, the more difficult it becomes to return to ongoing gainful employment. A gradual change occurs in most jobs so that after 5 years, it is no longer realistic to expect that the skills and abilities acquired in these jobs will continue to apply to the current workplace. If the individual is 50 years of age or older and has been determined disabled for a considerable period of time, this factor along with their age will be considered in assessing the individual's residual functional capacity.

d. Ability to Engage in Substantial Gainful Activity - in most instances, before an individual's disability can be discontinued, it must be shown that they are able to engage in substantial gainful activity. To do this, all current impairments must be considered, not just the impairment(s) present at the time of the most recent favorable determination.

e. Point of Comparison - For purposes of determining whether medical improvement has occurred, the medical severity of the impairment(s) which was present at the time of the most recent favorable medical decision shall be compared to the current medical severity of that impairment(s). If medical improvement has occurred, the Disability Review Team shall compare the individual's current functional capacity to do basic work activities based on the previously existing impairment(s) with their prior functional capacity in order to determine whether the medical improvement is related to the individual's ability to do work. The most recent favorable medical decision is the latest decision involving a consideration of the medical evidence whereby the individual was determined disabled or to have a continuing disability.

f. Previous Impairment Met or Equaled Listing - If the most recent favorable decision was based on the fact that the individual's impairment(s) at the time met or equaled the Listing of Impairments in Appendix I, an assessment of their residual functional capacity would not have been made. If medical improvement has occurred and the severity of the prior impairment(s) no longer meets or equals the same listing section used to make the most recent favorable decision, it will be found that the medical improvement was related to their ability to work. Before finding that the individual's disability has ended, it must be established that they can currently engage in substantial gainful activity.

g. Prior Residual Functional Capacity Assessment - If the most recent favorable decision was based on a residual functional capacity (RFC) assessment and not on the fact that the impairment met or equaled a listing, and if there has been a decrease in the severity of the individual's prior impairment(s), an evaluation must be made as to whether medical improvement is related to ability to work. This is done by comparing the prior and current RFC of the individual. The RFC assessment used in making the most recent favorable medical decision will be compared to the RFC assessment based on current evidence to determine if the individual's functional capacity for basic work activities has increased. There shall be no attempt made to reassess the prior RFC.

If the most recent favorable medical decision should have contained an assessment of the individual's residual functional capacity but does not, either because this assessment is missing from the file or was not done, the Review Team must reconstruct the individual's prior RFC. This reconstructed RFC shall accurately and objectively assess the individual's capacity to do basic work activities. The maximum functional capacity consistent with the favorable decision should be assigned.

h. Basis for Review Team's Decision - the decision as to whether the individual continues to be disabled shall be made on a neutral basis. It should be made without any initial inference as to the presence or absence of disability being

drawn from the fact that the individual had previously been determined disabled. All the evidence submitted by the individual as well as all evidence obtained from the treating physician(s) and other sources shall be considered, and the determination as to whether disability continues shall be made on the basis of the weight of the evidence. There must be a comparison of prior and current medical evidence to see if there has been improvement in the signs, symptoms, or findings associated with the impairment(s).

i. Prior file cannot be located - If the prior case record cannot be located, the Review Team shall first determine whether the individual is now able to engage in substantial gainful activity based on all the individual's current impairments. This will allow for a disability determination at the earliest point without addressing the often lengthy process of reconstructing prior evidence.

(1) If it is determined that the individual cannot engage in substantial gainful activity currently, their disability will continue unless one of the second group of exceptions applies. (See Section G.2.k.(2).)

(2) If the individual is able to engage in substantial gainful activity, the Disability Review Team will decide whether an attempt shall be made to reconstruct those portions of the missing case record that were relevant to its most recent favorable medical decision. Considerations in this decision will include the potential availability of old records, whether the source of the evidence is still in operation, and whether reconstruction efforts will yield a complete record of the basis for the most recent favorable medical decision. If relevant parts of the prior record are not reconstructed, either because it is decided not to attempt reconstruction or because such efforts failed, medical improvement cannot be found. The documentation of the individual's current impairments will provide a basis for any future reviews. If the missing case record is later found, it may serve as a basis for reopening any decision made under this section.

j. Impairment Subject to Temporary Remission - in assessing whether medical improvement has occurred in individuals who have impairments that are subject to temporary remission, the Disability Review Team shall consider the longitudinal history of the impairment(s) including the occurrence of prior remission(s) and prospects for future worsening. Temporary improvement in such impairments will not warrant a finding of medical improvement.

k. Exceptions to Medical Improvement

(1) First Group of Exceptions - there are certain limited situations when an individual's disability can be found to have ended even though medical improvement has not occurred. If one of the following medical exceptions

applies, an evaluation must be made as to whether the individual is now able to engage in substantial gainful activity taking into account all the individual's current impairments, not just those that existed at the time of the most recent favorable medical decision. These exceptions to medical improvement are intended to provide a way of finding that an individual is no longer disabled in the limited situations where, even though there has been no decrease in the severity of the impairment(s), evidence shows that an individual should no longer be considered disabled or never should have been considered disabled.

(a) **Substantial evidence shows that the individual is the beneficiary of advances in medical or vocational therapy or technology (related to their ability to work).** Advances in medical or vocational therapy or technology are improvements in treatment or rehabilitative methods which have increased the individual's ability to do basic work activities. This exception is applied when substantial evidence shows that the individual has been the beneficiary of services which reflect these advances and they have favorably affected the severity of their impairment or their ability to do basic work activities. This decision shall be based on new medical evidence and a new residual functional capacity assessment. This exception will have limited application.

(b) **Substantial evidence shows that the individual has undergone vocational therapy (related to the individual's ability to work).** Vocational therapy (related to the individual's ability to work) may include, but is not limited to, additional education, training or work experience that improves their ability to meet the vocational requirements of more jobs. This decision will be based on substantial evidence which includes new medical evidence and a new residual functional capacity assessment.

(c) **Substantial evidence shows that, based on new or improved diagnostic or evaluative techniques, the individual's impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision.** Changing methodologies and advances in medical and other diagnostic or evaluative techniques have given, and will continue to give, rise to improved methods for measuring and documenting the effect of various impairments on the individual's ability to do work. If substantial evidence shows that the individual's impairment(s) is not as severe as was determined at the time of the most recent favorable medical decision due to such new or improved methods, such evidence may serve as a basis for finding that the individual is no longer disabled, if they can currently engage in substantial gainful activity.

(d) **Substantial evidence demonstrates that any prior disability decision was in error.** If substantial evidence demonstrates that a prior determination was in error the exception to medical improvement based on error is applied. This evidence may be in the record at the time any prior determination of disability was made or may be newly obtained evidence which relates to that determination. A prior determination will be found in error only if:

(i) Substantial evidence shows on its face that the decision in question should not have been made. Examples are if a test result is misread or a Listing in Appendix I or a Medical-Vocational Rule in Appendix II was misapplied.

(ii) At the time of the prior evaluation, required and material evidence of the severity of the individual's impairment(s) was missing. That evidence becomes available upon review and substantial evidence demonstrates that had such evidence been present at the time of the prior determination the individual would have been found to be not disabled.

(iii) Substantial evidence which is new evidence and relates to the prior determination refutes the conclusions that were based on the prior evidence (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that had the new evidence which relates to the prior determination been considered at the time of the prior decision, the individual would have been determined not disabled. A substitution of current judgment for that used in the prior favorable decision shall not be the basis for applying this exception.

(e) **The individual is currently engaging in substantial gainful activity.** If an individual is currently engaging in substantial gainful activity, a consideration of whether the individual is entitled to a trial work period, as set forth in Section E.2., must be made before it is determined that an individual is no longer disabled. It will be found that an individual's disability has ended in the month in which they demonstrated their ability to engage in substantial gainful activity (following completion of a trial work period, if applicable).

(2) Second Group of Exceptions

The following exceptions may result in a determination that the individual is no longer disabled. In these situations, the decision that the individual is not disabled shall be made without a determination that they have medically improved or can engage in substantial gainful activity.

(a) **A prior decision was fraudulently obtained.** If it is established that any prior favorable determination was obtained by fraud, the Disability Review Team may find that the individual is not disabled.

(b) **The individual fails to cooperate.** If there is a question about whether an individual continues to be disabled, they may be asked to provide the Disability Review Team with medical and/or other evidence or to go for a physical or mental examination by a certain date. The Disability Review Team will find that disability has ended if the individual fails (without good cause) to do what is asked by the Disability Review Team.

(c) **The individual cannot be located.** If there is a question about whether an individual continues to be disabled and they are unable to be located to resolve the question, the individual's case shall be closed with timely and adequate notice.

(d) **The individual fails to follow prescribed treatment (without good cause) which would be expected to restore the individual's ability to engage in gainful activity.** If treatment has been prescribed which would be expected to restore the individual's ability to work and the individual fails to follow that treatment (without good cause), the individual would be determined not disabled.

3. Evaluation Steps

The continuing disability review process consists of specific steps to be used in reviewing the question of whether an individual's disability is to be continued. The review may cease, and disability may be continued, at any point in the process if it is determined there is sufficient evidence to find that the individual is still unable to engage in substantial gainful activity. The steps are as follows:

a. If the individual is engaging in substantial gainful activity and has completed any applicable trial work period, eligibility for the MBI-WPD Program must be considered, and the case sent to the Disability Review Team for disability determination.

b. If the individual is not engaging in substantial gainful activity and the individual has any current impairment or combination of impairments that meets or equals a listing in Appendix I, disability shall be found to continue.

c. If there has been medical improvement as defined in Section G.2.a., the procedures in Step (d) below are followed.

d. If the individual is found to have had medical improvement, it must be determined whether this medical improvement is related to the individual's ability to do work. This is in accordance with Section G.2.b. (i.e., whether or not there has been an increase in the residual functional capacity based on the individual's impairment(s) that was present at the time of the most recent favorable medical determination). If medical improvement is not related to the individual's ability to work, the procedures in Step (e) below are followed. If medical improvement is related to the individual's ability to do work, the procedures in Step (f) below are followed.

e. If there has been no medical improvement or if the medical improvement is not related to the individual's ability to work, the Disability Review Team shall determine whether any of the exceptions apply. One of the following steps shall be taken:

(1) If none of the exceptions apply, the individual will continue to be found disabled.

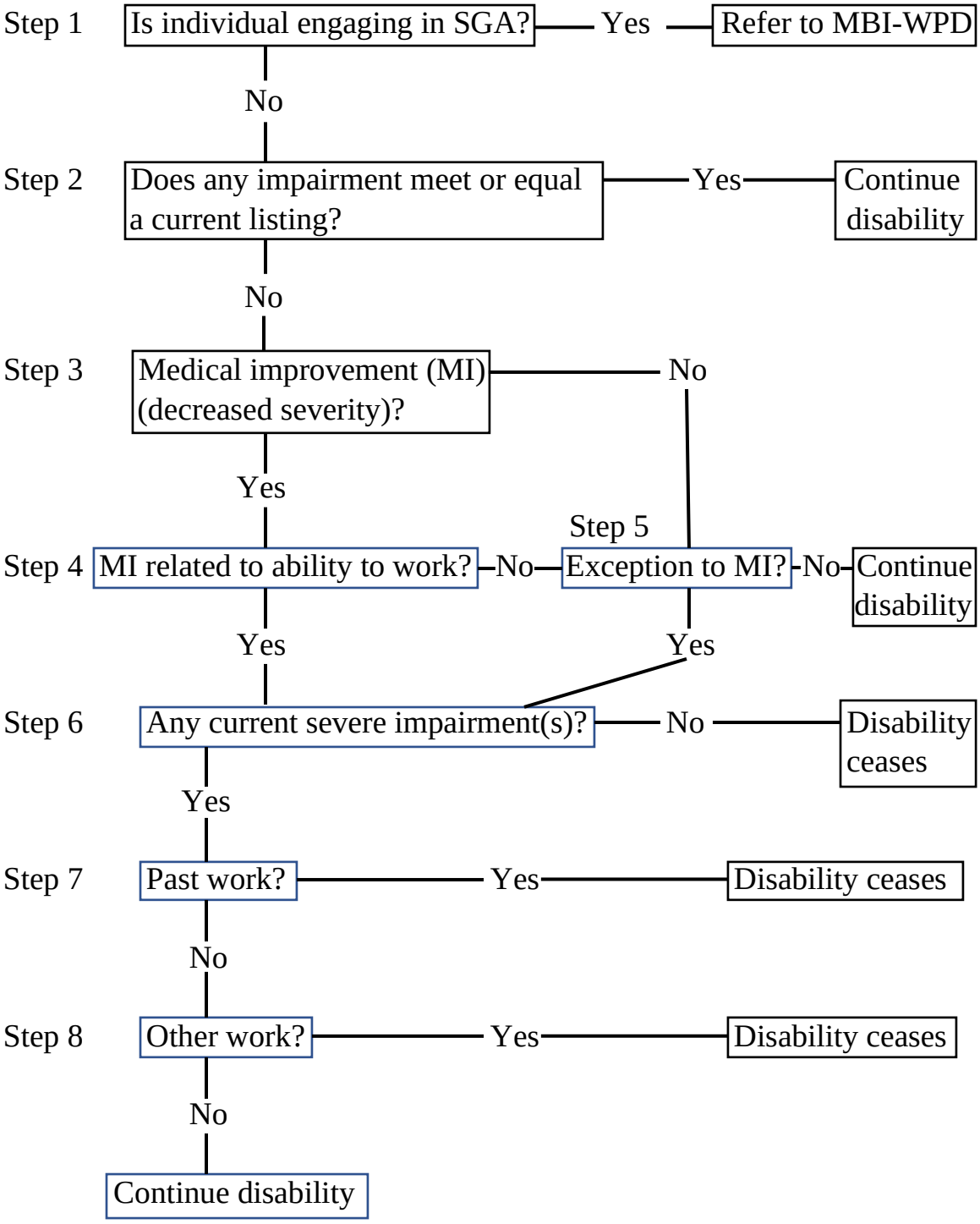
(2) If one of the first group of exceptions to medical improvement applies, the procedures in Step (f) below are followed.

(3) If one of the second group of exceptions applies, the individual will be found not disabled. The second group of exceptions to medical improvement may be considered at any point in this process.

f. If medical improvement is shown to be related to the individual's ability to do work or if one of the first group of exceptions to medical improvement applies, an assessment shall be made of the individual's residual functional capacity. This assessment will be based on the individual's current impairments and the impact of the combination of these impairments on their ability to do basic work activities. Through this assessment, the Disability Review Team shall determine whether the individual can still do the work that they have done in the past. If the individual can do such work, the individual will be found to be not disabled.

g. If the individual is not able to do their past relevant work, an assessment will be made as to whether the individual can do other work considering their age, education, and past relevant work experience and residual functional capacity based on their current impairment(s). If the individual can do other work, they will be found not disabled. If they cannot do other work, disability will be found to continue.

Adult CDR Sequential Evaluation Process



H. Reapplication for Medicaid by Certified Disabled Individuals

Department Regulation Section 360-5.4

1. When an individual who has been determined disabled reapplies for Medicaid following the termination of their Medicaid for reasons unrelated to their disability status (e.g., increased financial income or resources), re-submittal of the case to the Disability Review Team shall be required only in the following circumstances:

- Twelve months or more have elapsed since the date of last case closing;
- The individual has engaged in substantial gainful work activity in the interim;

or

- The individual has had a significant change in treatment such as major surgery or stay in a rehabilitation center or hospital in the interim.

2. Cases reopened as a Group II without review by the Disability Review Team, in accordance with this section, shall be reviewed at the expiration date which had been set before the case was closed. If reapplication of Group II cases occurs subsequent to the date previously set for review by the Disability Review Team, the local agency shall submit a referral to the Disability Review Team.

I. SSI Applicants and Recipients

Department Regulation Section 360-2.2

1. Determination of Eligibility of SSI Applicants and Recipients - The Social Security Administration (SSA) determines and re-determines eligibility for all aged, blind, and disabled applicants and recipients of SSI based on SSI financial and categorical standards. Individuals determined eligible for SSI are automatically eligible for Medicaid.

2. Local District Responsibilities- The local agency retains administrative responsibility for other phases of the Medicaid program for these individuals. These functions include, but are not limited to, the following:

a. Authorize and reauthorize Medicaid for SSI eligible individuals based on the interface between the New York State Automated Eligibility System, the Welfare Management System (WMS) and the State Data Exchange (SDX). This is referred to as the Automated SDX/WMS Interface (ASWI) upstate and the Auto-SDX in New York City.

b. Issue temporary Medicaid identification cards if necessary;

c. Determine retroactive eligibility for SSI applicants who have medical bills in the three-month period prior to the month of application for SSI;

d. Obtain information on third party health insurance from SSI eligible individuals;

e. Give prior approval, when appropriate, for specified medical services;

f. Participate with the Social Security Administration in the determination and disposition of recipient fraud; and

g. Apply adjustment and recovery provisions.

3. Department Responsibilities - The Department has the following responsibilities for the Medicaid program for SSI recipients:

a. Issue Medicaid identification cards (Common Benefit Identification Card) for SSI eligible individuals;

b. Process medical bills; and

c. Monitor utilization.

4. Individuals Denied SSI – A Medicaid-Only A/R may apply concurrently to the DRT and to SSA for disability certification. In general, individuals who are denied SSI as not being disabled would not be reviewed for Medicaid disability since both programs use the same disability criteria. An SSA disability determination is binding on a Medicaid case until the determination is changed by SSA or there is a change in the individual's circumstances as set forth in Section I.4.b. However, there are instances when a Medicaid disability review is appropriate.

a. Denial for SSI for Other Than Medical Reasons - The basis of the denial can be determined from the SDX. If an individual is denied SSI for other than medical reasons, the following are some of the codes that may appear in Field 317 (Payment Status Code):

- N06 - Non-Pay, Recipient failed to file for other benefits
- N17 - Non-Pay, Failure to pursue claim by applicant
- N36- Non-Pay, Insufficient or no medical data furnished, no visual impairment
- N37- Non-Pay, Failure or refusal to submit to consultative examination(s), no visual impairment

- N38- Non-Pay, Applicant does not want to continue development of claim, no visual impairment

Individuals denied SSI who are in receipt of cash assistance and who claim an impairment or unemployability status must appeal any denial of their initial SSI application and exhaust the available administrative remedies.

All other individuals denied SSI should be urged to cooperate with the Social Security Administration in processing their application for SSI. If the individual does not want to pursue their SSI application, a Medicaid disability review can be performed.

b. Denial for SSI for Medical Reasons - Individuals denied SSI for medical reasons who are in receipt of cash assistance and who claim an impairment or unemployability status must appeal any denial of their initial SSI application and exhaust the available administrative remedies.

All other individuals denied SSI for medical reasons should be urged to cooperate in the SSI appeals process. An individual may become disabled subsequent to an SSI denial. If an individual's medical condition deteriorates, they should be urged to reapply for SSI. For the individual who requests Medicaid-Only, a disability review is appropriate in the following circumstances:

(1) The individual alleges a **different or additional disabling condition** than that considered by SSA in making its determination; or

(2) **Less than 12 months** after the most recent unfavorable SSA disability determination, the individual alleges that their **condition has changed or deteriorated**, alleges **a new period of disability** which meets the duration requirement, **and**:

(a) SSA has refused to reopen or reconsider the allegations; **or**

(b) The individual no longer meets the non-disability requirements for SSI but may meet the State's non-disability requirements for Medicaid eligibility.

(3) **More than 12 months** after the most recent unfavorable SSA disability determination, the individual alleges that their **condition has changed or deteriorated**, alleges **a new period of disability** which meets the duration requirement, and **has not applied to SSA regarding these allegations.**

5. Loss of SSI Eligibility - No disability review is necessary for an individual who loses SSI eligibility for reasons unrelated to their medical condition prior to the individual's medical re-examination diary date. This date is the time when SSA was

to have re-evaluated the individual's medical condition. To obtain the individual's medical re-examination diary date and the reason the individual's SSI benefits were terminated, the local agency should contact the SSA District Office requesting this information.

If the individual was terminated for other than medical reasons and if there is a medical diary date, the individual can be considered disabled for Medicaid purposes until that date. To certify that the individual remains disabled beyond this date, or if no diary date is available, the local agency must submit the case to the Disability Review Team for a disability review.

6. SSI Recipients with Medical Bills for Three Months Prior to SSI Eligibility - The local agency is responsible for determining retroactive eligibility for SSI recipients who have medical bills incurred in the three-month period prior to the month of application for SSI (three months prior to the Medicaid effective date, field 277 on the SDX, or WMS Screen 5 Medicaid "From" date). In order to claim funds under the SSI-related category for these medical bills, a disability review and a financial determination is necessary for this three-month period. The local agency should consult the SDX for the disability date.

Field 98 of the SDX will usually contain the onset date of disability. This date may be earlier than the SSI effective date. If the disability onset date in field 98 covers the three-month retroactive period (or less if coverage is sought for only 1 or 2 months) then a separate Medicaid disability review is not necessary. A separate Medicaid disability review is necessary when the onset date is not found on the SDX, when it does not cover the period requested, or when it cannot be otherwise obtained from the SSA office. Medicaid coverage as disabled should occur only when the effective date or onset date of disability is established by either the SSA or the Disability Review Team. If a Medicaid disability review is necessary, the agency should submit a referral form to the Disability Review Team for a disability determination and indicate on the referral that the individual is currently in receipt of SSI, the individual's effective SSI date of disability, and that a disability determination is needed for the three-month retroactive period only.

J. <u>Substance Addiction Disorders</u>

Department Regulation Section 360-5.10

1. Evaluation of Substance Addiction

Substance addiction disorders are evaluated by determining if the drug addiction or alcoholism is a contributing factor material to the determination of disability. There is no disability listing for substance abuse. Substance addiction disorders frequently involve the behavioral or physical changes associated with the regular

use of substances that affect the central nervous system. An individual may not be considered disabled if substance abuse would be a contributing factor material to the decision that the individual is disabled.

An individual with a substance addiction disorder may have physical disorders such as liver disease, peripheral neuropathy, or chronic pancreatitis. There may be a mental disorder such as depression, anxiety, organic brain disorder, or personality disorder. If any of the referent impairments are present, these impairments must be evaluated to determine if the individual meets the listing for the impairment.

The key factor on determining whether drug addiction or alcoholism is a contributing factor material to the determination of disability is whether the individual would still be disabled if they stopped using drugs or alcohol.

If the individual does not meet or equal the listings, physical and/or mental residual functional capacity must be evaluated to determine ability to perform work activities. The residual functional capacity assessment must take into consideration all functional limitations including those that are not related to substance abuse as well as any limitations that would be expected to remain if substance abuse were to stop.

In some instances, it is difficult to distinguish between impairment of ability to perform work functions due to substance abuse from dysfunction caused by other mental and/or physical impairments. If the Disability Review Team is unable to separate the effects of the substance abuse on the ability to work from work related dysfunction caused by other impairments (for example, co-existing mental disorders such as personality disorder, anxiety or depression), the individual's deficits should all be considered and evaluated as a whole.

An individual is not considered disabled if substance abuse would be a contributing factor material to the determination that the individual is disabled. If the only impairment documented is substance abuse, the individual will be determined not disabled. Therefore, it is particularly important to ensure that all relevant medical information is compiled for the disability review. Applicants who indicate they have a substance abuse problem should be asked if they have had treatment in the past or currently need treatment for any other chronic potentially disabling impairments. The Disability Review Team may request a consultative examination to ensure that a complete and current file that addresses all impairments is available for a complete review.

K. <u>Blindness</u>

Department Regulation Section 360-5.12

1. Determination of Blindness Status - Individuals who are blind are categorically eligible for Medicaid in the SSI-related category and may qualify for special work-related disregards from their earnings. Information regarding an individual's legal blindness status may be available through the New York State Commission for the Blind (NYSCB) if the A/R does not have verification of legal blindness.

The agency must first obtain a signed release form from the A/R. The inquiry and signed consent to release information form can be mailed to the NYSCB at the address below or can be faxed to them at (518) 408-4063. The NYSCB will need the individual's name, social security number, address, and date of birth. The NYSCB can provide the local district or SDRT with a "Verification of Blindness" form if the individual is known to them. This form should be retained in the case record.

Office of Family and Children's Services
New York State Commission for the Blind (NYSCB)
Capital View Office Park
52 Washington Street
South Building, Suite 201
Rensselaer, N.Y. 12144

If the individual has not yet been determined to be blind, the local agency or Disability Review Team should assist the individual in obtaining the necessary medical evidence for submission to the NYSCB. (See 3. below.) Call NYSCB at (518) 474-6812 for further information.

Individuals with visual impairments that do not meet the legal definition of blind should be referred for a disability review for evaluation under the category of disabled. (See 4. below.)

2. Pending Cases - Cases which are not eligible for Medicaid under any other category and in which blindness is alleged should be pended awaiting a determination of blindness. These cases may be pended for a maximum of 45 days. The applicant should be informed of this time standard. This time limit is the maximum time period allowed and should not be used as a waiting period. Individuals who are eligible in another category should have their case opened. When blindness is subsequently established, the case should be claimed retroactively in the SSI-related blind category.

3. Examinations - Eye examinations can be purchased for an individual who alleges blindness and who does not have a current treating source or has a treating source who will not cooperate in completing the necessary forms. The procedures for consultative examinations are found in Section D. 3.

4. Medicaid Disability Reviews - The local agency should submit a disability referral for the cases of individuals who have visual impairments but have been determined not to be legally blind by the NYSCB. Those individuals with visual impairments shall be evaluated under Section 2.01 or 102.01, Special Senses and Speech, of the Listing of Impairments in Appendix I. Medical records should include an evaluation of the individual's visual fields by their treating physician. Form DOH-5142, "Mandatory Eye Examination Report" may be used for this purpose. This form can be found in CentraPort or the Health Commerce System under OHIP Eligibility Forms.

L. Evaluation of Symptoms and Pain

The effect of pain and symptoms on an individual's ability to work must be considered by the Disability Review Team during the disability determination process.

1. Presence of a Medically Determinable Impairment (MDI)

Before evaluating the effect of pain and symptoms on an individual's ability to work, it must be shown that:

a. the individual has a medically determinable physical and/or mental impairment(s) established by an acceptable medical source with objective medical evidence, which includes signs, laboratory findings, or both;

and

b. the medically determinable impairment(s) could reasonably be expected to produce the alleged pain.

When medical findings do not substantiate any physical impairment capable of producing the alleged pain or symptoms, the possibility of a mental impairment as the basis for the pain should be considered.

In the absence of objective findings of any medically determinable physical or mental impairment, disability cannot be established regardless of the degree of pain alleged.

2. Symptoms and Pain and the Sequential Evaluation Process

Once a medically determinable physical and/or mental impairment is documented, symptoms and pain must be considered in determining severity and at each step of the Sequential Evaluation Process.

a. **Evaluating Severity -** To be considered severe, the individual's impairment or combination of impairments must significantly limit their ability to do basic work activities.

When pain is alleged and the documented impairment(s) could reasonably be expected to produce the pain, any allegations of pain-related limitations must be considered in evaluating severity. The presence of the alleged pain-related limitations may substantiate the conclusion that one or more basic work activities are affected to more than a minimal degree and that the impairment(s) is severe.

b. **Determining Meets or Equals -** A finding of disabled is made on a medical basis alone when an impairment meets a listing in Appendix I or is medically the equivalent of a listed impairment. Some listings include pain as a criterion (e.g., Listings 1.02 and 5.06 B3). Under these listings, if the individual has pain and meets the other criteria, the listing would be met, and no further documentation of pain would be required. In contrast, Listing 4.04 requires information about the character of the pain and documentation that the pain is of cardiac origin.

An A/R's allegation of pain or other symptoms may not be substituted for a missing or deficient sign or laboratory finding in order to determine that the impairment(s) is equivalent in severity to a listed impairment.

c. **Evaluating Residual Functional Capacity (RFC)**

(1) Before symptoms and pain can be considered in assessing RFC, a determination must be made as to whether the pain or symptoms can reasonably be expected from the particular impairment(s).

(a) When objective medical evidence supports a finding that the physical or mental impairment(s) could produce the symptoms or pain, the individual's impairment(s) and any additional limitations imposed by symptoms or pain will be considered in assessing their functional limitations.

(b) In some cases, the individual's allegation about the severity and persistence of pain and pain-related limitations is greater than would reasonably be expected on the basis of the objective medical evidence. In these cases, additional information concerning the pain and pain-related limitations should be obtained only if a favorable decision is not possible based on the evidence and any alleged pain-related limitations might further reduce RFC to the point where the decision might be affected.

If the additional evidence obtained from the treating source(s), the individual, and/or third parties is insufficient to make a determination,

consideration should be given to the purchase of a consultative examination. Depending on the individual case, a consultative examination may be obtained from a pain specialist, pain clinic, neurologist, orthopedist, and/or other specialist(s) regarding pain and its effect on the individual.

(c) When alleged symptoms and pain-related limitations are clearly out of proportion to the physical findings and a favorable determination cannot be made on the basis of the evidence, the possibility of a mental impairment should be investigated.

(2) When it is determined that the symptoms or pain can reasonably be expected on the basis of the medical evidence, the impact of such pain on RFC must be considered in terms of any additional physical or mental limitations it may impose on the individual's ability to work.

Consider information about the following:

- daily activities;
- location, duration, frequency, and intensity of symptoms or pain;
- precipitating and aggravating factors;
- the type, dosage, effectiveness and side effects of medications taken to alleviate pain or symptoms;
- treatment other than medication and any other measures used to relieve pain or other symptoms; and
- consistency of the information provided.

(a) Symptoms and pain caused by physical impairments may result in limitations in an individual's ability to perform exertional activities, such as standing, lifting, walking; non-exertional activities, such as kneeling, stooping, climbing, concentrating; or a combination of both exertional and non- exertional activities.

Mental consequences of physical findings (e.g., anxiety, depression) that occur as a natural result of a physical disease process and which are not indicative of a discreet mental illness should be considered as a non-exertional impairment under a physical RFC. The "Psychiatric Review Technique Form" (DOH-5250) and the "Mental Residual Functional Capacity Assessment Form" (DOH-5258) should not be completed.

(b) Pain or symptoms that have been documented to have no linkage to a physical body system but is present purely as a mental disorder (e.g., Somatization Disorder, Psychogenic Pain Disorder) must be evaluated based on the degree of mental impairment and any resulting limitation on the individual's activities, interests, personal habits and ability to relate to others. The "Psychiatric Review Technique Form" (DOH-5250) may be used and where appropriate the "Mental Residual Functional Capacity Assessment Form" (DOH-5258) may be completed. (These forms can be found in CentraPort and the Health Commerce System-OHIP Eligibility Forms/Login/Repository.

Once the RFC has been established, the evaluation of the individual's ability to do past relevant work or other work in the national economy should be determined by following the procedures outlined in this manual.

3. Pain and Medical Improvement

Medical improvement is any decrease in the medical severity of the individual's impairment(s) since the time of the most recent favorable decision. Where medical improvement is an issue, the signs, symptoms and laboratory findings at the time of the most recent favorable decision must be compared with the current signs, symptoms and lab findings.

A lessening of symptoms such as pain reported by the individual can be the basis for a finding that medical improvement has occurred even if there is no corresponding improvement in signs or laboratory findings. However, if such signs or laboratory findings have worsened, these would have to be considered in assessing medical improvement.

If medical improvement has occurred, it must be determined whether the medical improvement is related to the individual's ability to work and if so, whether the individual is currently able to engage in substantial gainful employment.

M. <u>Evaluation of Children from Birth to Attainment of Age 18</u>

1. General

A child is considered disabled if they have a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months. To be determined disabled, the impairment must meet, medically equal, or functionally equal the requirements of the medical listings of impairments found in Appendix I, Part B. If the medical criteria in the children's listings do not apply, then the adult listings in Appendix I, Part A

may be used. Generally, a child may be found disabled if the impairment causes a marked limitation in two broad areas of function or an extreme limitation in one area.

2. Sequential Evaluation Process

As is the case for adults, the sequential evaluation process must be followed. (Please see the sequential evaluation flow chart for children which follows Section M.6.)

The steps of the sequential evaluation process for children's cases are:

• Step 1 - determining if the child is engaged in substantial gainful activity;

• Step 2 - determining if the child has a severe impairment(s); and

• Step 3 - determining if the child's impairment(s) meets or medically equals a listing, or functionally equals the listings and meets the duration requirement.

(a) Substantial Gainful Activity - Is the child engaging in substantial gainful activity?

The basic statutory definition of disability requires an inability to engage in substantial gainful activity. The same rules for determining whether an adult is engaging in substantial gainful activity also apply to children. (Please refer to Section E. 1.) Except for some older children who may be employed, most children will not be engaged in substantial gainful activity, and it will be necessary to continue with the sequential process.

If a child is at least 16 years of age and engaging in substantial gainful activity, eligibility for the Medicaid Buy-In Program for Working People with Disabilities must be considered, and the case sent to the DRT for disability determination. If the child is not engaging in SGA, the sequential evaluation process will proceed to the next step.

(b) Severity of Impairment - Does the child have a "severe" impairment or combination of impairments?

The child must have a medically determinable impairment that is severe. If the impairment is severe, the case will be reviewed further to see if the impairment(s) meets or medically equals a listing, or functionally equals the listings. If the child does not have a medically determinable impairment or their impairment(s) is a slight abnormality or combination of slight abnormalities that causes no more than minimal functional limitations, the child will be found not to have a severe impairment and will, therefore, be determined not disabled.

(c) Meeting or Equaling the Listings - Does the child have a medically determinable impairment(s) that meets or equals the severity of a listing? An impairment causes marked and severe functional limitations if it meets or medically equals the severity of a set of criteria for an impairment in the listings, or if it functionally equals the listings.

(1) Therefore, if the child has an impairment(s) that meets or medically equals the requirements of a listing or that functionally equals the listings, and that meets the duration requirement, the child will be found disabled.

(2) If the child's impairment(s) does not meet the duration requirement or does not meet or medically equal a listing, or functionally equal the listings, the child will be found not disabled.

3. Considerations in Determining Disability for Children

(a) Basic considerations. All relevant evidence in the case record is considered. The evidence in the case record may include information from medical sources, such as the child's pediatrician, other physicians, psychologist, or qualified speech-language pathologist; other medical sources such as physical, occupational, and rehabilitation therapists; and non-medical sources such as the child's parents, teachers, and other people who know the child.

(1) Medical evidence

(i) General. Medical evidence of the child's impairment(s) must describe signs, laboratory findings, or both. Only after we establish the claimant has an MDI based on objective medical evidence from an AMS, can we then evaluate the extent to which symptoms may affect the claimant’s ability to function independently, appropriately, and effectively in an age-appropriate manner for a child under age 18. Symptoms cannot establish the existence of an MDI. The medical evidence may include, but is not limited to, formal testing that provides information about the child's development or functioning in terms of standard deviations, percentiles, percentages of delay, or age or grade equivalents. It may also include opinions from medical sources about the nature and severity of the child's impairment.

(ii) Test scores. All of the relevant information in the case record will be considered. Consideration should not be given to any single piece of evidence in isolation. Therefore, test scores alone should not be relied on when deciding whether the child is disabled. See Section 6. (e) (3) for more information about how test scores are considered.

(iii) Medical sources. Medical sources should report their findings and observations on clinical examination and the results of any formal testing. A medical source's report should note and resolve any material inconsistencies between formal test results, other medical findings, and the child's usual functioning. Whenever possible and appropriate, the interpretation of findings by the medical source should reflect consideration of information from the child's parents or other people who know the child, including teachers and therapists. When a medical source has accepted and relied on such information to reach a diagnosis, this information may be considered a clinical sign.

(2) Information from other people. Every child is unique, so the effects of the child's impairment(s) on their functioning may be very different from the effects that the same impairment(s) might have on another child. Therefore, whenever possible and appropriate, attempts will be made to get information from people who can tell what the effects of the child's impairment(s) is on their activities and how the child functions on a day-to-day basis. These other people may include, but are not limited to:

(i) The child's parents and other caregivers. The child's parents and other caregivers can be important sources of information because they usually see the child every day. In addition to the child's parents, other caregivers may include a childcare provider who takes care of the child while their parent(s) works or an adult who looks after the child in a before-or after-school program.

(ii) Early intervention and preschool programs. If the child has been identified for early intervention services (in the home or elsewhere) because of their impairment(s), or if the child attends a preschool program (e.g., Headstart or a public-school kindergarten for children with special needs), these programs are also important sources of information about the child's functioning. Reports should be requested from the agency and individuals who provide the child with services or from the child's teachers about how the child typically functions when compared to other children the same age who do not have impairments.

(iii) School. If the child goes to school, information should be requested from their teachers and other school personnel about how the child is functioning there on a day-to-day basis compared to other children the same age who do not have impairments. A request should be made for any reports that the school may have that show the results of formal testing or that describe any special education instruction or services, including home- based instruction, or any accommodations provided in a regular classroom.

(b) Factors to be considered when evaluating the effects of the child's impairment(s) on their functioning.

(1) General. The child's functioning must be considered when deciding whether their impairment(s) is "severe" and when deciding whether their impairment(s) functionally equals the listings. The child's functioning must also be considered when deciding whether their impairment(s) meets or medically equals a listing if the listing being considered includes functioning among its criteria.

(2) Factors to be considered when evaluating the child's functioning. The child's limitations in functioning must result from their medically determinable impairment(s). The information obtained from the child's medical and non-medical sources can help in understanding how the child's impairment(s) affects their functioning. Once the existence of an MDI has been established, any factors that are relevant to how the child functions will be considered when evaluating the child's impairment or combination of impairments. For example, the child's symptoms (such as pain, fatigue, decreased energy, or anxiety) may limit their functioning. Some other factors that may be considered when evaluating the child's functioning are explained in paragraphs (b) (3) - (b) (9) of this section.

(3) How the child's functioning compares to the functioning of children the same age who do not have impairments.

(i) General. When the child's functioning is evaluated, consider whether the child does the things that other children the same age typically do or whether the child has limitations and restrictions because of their medically determinable impairment(s). Also, consider how well the child does the activities and how much help they need from family, teachers and others. Information about what the child can and cannot do, and how the child functions on a day-to-day basis at home, at school and in the community, allows a comparison of the child's activities to the activities of children the same age who do not have impairments.

(ii) How to consider reports of the child's functioning. When considering the evidence in the child's case record about the quality of their activities, consider the standards used by the person who gave the information. Also, consider the characteristics of the group to whom the child is being compared. For example, if the way the child does their class work is compared to other children in a special education class, consider that the child is being compared to children who do have impairments.

(4) Combined effects of multiple impairments. If the child has more than one impairment, consider whether the child has a "severe" impairment or an impairment that meets or medically equals a listing, or functionally equals the listings by looking at each of the child's impairments separately. If each separate impairment does not meet or equal the listings, consider comprehensively the combined effects of all the child's impairments on their day to day functioning instead of considering the limitations resulting from each impairment separately. (See Section 6. (c) for more information on how to consider the interactive and cumulative effects of the child's impairments on functioning.)

(5) How well can the child initiate, sustain, and complete their activities, including the amount of help or adaptations they need, and the effects of structured or supportive settings.

(i) Initiating, sustaining, and completing activities. Consider how effectively the child functions by examining how independently the child is able to initiate, sustain, and complete their activities despite their impairment(s) compared to other children the same age who do not have impairments. Consider:

- The child's range of activities;
- The child's ability to do them independently, including any prompting that the child may need to begin, carry through, and complete their activities;
- The pace at which the child does their activities;
- How much effort the child needs to make in order to do their activities; and
- How long the child is able to sustain their activities.

(ii) Extra help. Consider how independently the child is able to function compared to other children the same age who do not have impairments. Consider whether the child needs help from other people, or whether the child needs special equipment, devices, or medications to perform their day-to-day activities. For example, consider how much supervision the child needs to keep from hurting themselves, how much help the child needs every day to get dressed or, in the case of an infant, how long it takes the parents or other caregivers to feed the infant. Children are often able to do things and complete tasks when given help but may not be able to do these same things by themselves. Therefore, consider how much

extra help the child needs, what special equipment or devices the child uses, and the medication the child takes that enables them to participate in activities like other children the same age who do not have impairments.

(iii) Adaptations. Consider the nature and extent of any adaptations used by the child to enable them to function. Such adaptations may include assistive devices or appliances. Some adaptations may enable the child to function normally or almost normally (e.g., eyeglasses). Others may increase the child's functioning, even though the child may still have functional limitations (e.g., ankle-foot orthosis, hand or foot splints, and specially adapted or custom- made tools, utensils, or devices for self-care activities such as bathing, feeding, toileting and dressing). When evaluating the functioning of a child with an adaptation, consider the degree to which the adaptation enables the child to function compared to other children the same age who do not have impairments. Consider the child's ability to use the adaptation effectively on a sustained basis and any functional limitations that nevertheless persist.

(iv) Structured or supportive settings.

a. If the child has a serious impairment(s), the child may spend some or all of their time in a structured or supportive setting, beyond what a child who does not have an impairment typically needs.

b. A structured or supportive setting may be the child's own home in which family members or other people (e.g., visiting nurses or home health workers) make adjustments to accommodate the child's impairment(s). A structured or supportive setting may also be the child's classroom at school, whether it is a regular classroom in which the child is accommodated or a special classroom. It may also be a residential facility or school where the child lives for a period of time.

c. A structured or supportive setting may minimize signs and symptoms of the child's impairment(s) and help to improve their functioning while the child is in it, but the child's signs, symptoms, and functional limitations may worsen outside this type of setting. Therefore, consider the child's need for a structured setting and the degree of limitation in functioning the child has or would have outside the structured setting. Even if the child is able to function adequately in the structured or supportive setting, consider how the child functions in other settings and whether the child would continue to function at an adequate level without the structured or supportive setting.

d. If the child has a chronic impairment(s), the child may have their activities structured in such a way as to minimize stress and reduce the symptoms or signs of the impairment(s). The child may continue to have persistent pain, fatigue, decreased energy, or other symptoms or signs, although at a lesser level of severity. Consider whether the child is more limited in functioning than their symptoms and signs would indicate.

e. Therefore, if the child's symptoms or signs are controlled or reduced in a structured setting, consider how well the child is functioning in the setting and the nature of the setting in which the child is functioning (e.g., home or a special class). Consider the amount of help the child needs from their parents, teachers or others to function as well as they do; adjustments the child makes to structure their environment; and how the child would function without the structured or supportive setting.

(6) Unusual settings. Children may function differently in unfamiliar or one-to-one settings than they do in their usual settings at home, at school, in childcare or in the community. The child may appear more or less impaired on a single examination (such as a consultative examination) than indicated by the information covering a longer period. Therefore, apply the guidance in paragraph (b) (5) of this section when considering how the child functions in an unusual or one-to-one situation. Look at the child's performance in a special situation and at the child's typical day-to-day functioning in routine situations. Inferences should not be drawn about the child's functioning in other situations based only on how the child functions in a one-to-one, new, or unusual situation.

(7) Early intervention and school programs.

(i) General. If the child is very young and has been identified for early intervention services, or if the child attends school (including preschool), the records of people who know the child or who have examined the child are important sources of information about the child's impairment(s) and its effects on the child's functioning. Records from physicians, teachers and school psychologists, or physical, occupational, or speech-language therapists are examples of what information may be considered. If the child receives early intervention services or goes to school or preschool, consider this information when it is relevant and available.

(ii) School evidence. If the child goes to school or preschool, try to obtain information from the child's teacher(s) about their performance in activities throughout the school day. Consider all of the evidence received from the child's school, including teacher questionnaires, teacher checklists, group achievement testing, and report cards.

(iii) Early intervention and special education programs. If the child has had a comprehensive assessment for early intervention services or special education services, consider information used by the assessment team to make its recommendations. Consider the information in the child's Individualized Family Service Plan, their Individualized Education Program, or their plan for transition services to help understand the child's functioning. Examine the goals and objectives of the child's plan or program as further indicators of the child's functioning, as well as statements regarding related services, supplementary aids, program modifications, and other accommodations recommended to help the child function together with the other relevant information in the child's case record.

(iv) Special education or accommodations. Consider the fact that the child attends school, that the child may be placed in a special education setting, or that the child receives special accommodations because of their impairments along with the other information in the case record. The fact that the child attends school does not mean that the child is not disabled. The fact that the child does or does not receive special education services does not, in itself, establish the child's actual limitations or abilities. Children are placed in special education settings or are included in regular classrooms (with or without accommodation), for many reasons that may or may not be related to the level of their impairments. For example, the child may receive one-to-one assistance from an aide throughout the day in a regular classroom or be placed in a special classroom. Consider the circumstances of the child's school attendance, such as their ability to function in a regular classroom or preschool setting with children the same age who do not have impairments. Similarly, consider that good performance in a special education setting does not mean that the child is functioning at the same level as other children the same age who do not have impairments.

(v) Attendance and participation. Consider factors affecting the child's ability to participate in their education program. The child may be unable to participate on a regular basis because of the chronic or episodic nature of their impairment(s) or their need for therapy or treatment. If a child has more than one impairment, consider whether the effects of the child's impairments taken together make the child unable to participate on a regular basis. Consider how the child's temporary removal or absence from the program affects their ability to function compared to other children the same age who do not have impairments.

(8) The impact of chronic illness and limitations that interfere with the child's activities over time. If the child has a chronic impairment(s) that is

characterized by episodes of exacerbation (worsening) and remission (improvement), consider the frequency and severity of the episodes of exacerbation as factors that may be limiting the child's functioning. The child's level of functioning may vary considerably over time. Proper evaluation of the child's ability to function in any domain requires taking into account any variations in the child's level of functioning to determine the impact of the child's chronic illness on their ability to function over time. If the child requires frequent treatment, consider it as explained in paragraph (b) (9) (ii) of this section.

(9) The effects of treatment (including medications and other treatment). Evaluation of the effects of the child's treatment is done to determine its effect on the child's functioning in their particular case.

(i) Effects of medication. Consider the effects of medication on the child's symptoms, signs, laboratory findings, and functioning. Although medications may control the most obvious manifestations of the child's impairment(s), they may or may not affect the functional limitations imposed by the child's impairment(s). If the child's symptoms or signs are reduced by medications, consider:

(A) Any of the child's functional limitations that may nevertheless persist, even if there is improvement from the medications;

(B) Whether the child's medications create any side effects that cause or contribute to the child's functional limitations;

(C) The frequency of the child's need for medication;

(D) Change in the child's medication or the way the child's medication is prescribed; and

(E) Any evidence over time of how medication helps or does not help the child to function compared to other children the same age who do not have impairments.

(ii) Other treatment. Consider also the level and frequency of treatment other than medications that the child gets for their impairment(s). The child may need frequent and ongoing therapy from one or more medical sources to maintain or improve their functional status. (Examples of therapy include occupational, physical, or speech and language therapy, nursing or home health services, psychotherapy, or psychosocial counseling.) Frequent therapy, although intended to improve the child's functioning in some ways, may also interfere with the child's functioning in other ways. Therefore, consider the frequency of any therapy the child

must have and how long the child has received or will need it. Also, consider whether the therapy interferes with the child's participation in activities typical of other children the same age who do not have impairments, such as attending school or classes and socializing with peers. If the child's activities at school or at home are frequently interrupted for therapy, consider whether these interruptions interfere with the child's functioning. Also, consider the length and frequency of the child's hospitalization.

(iii) Treatment and intervention, in general. With treatment or intervention, the child may not only have their symptoms or signs reduced, but may also maintain, return to, or achieve a level of functioning that is not disabling. Treatment or intervention may prevent, eliminate, or reduce functional limitations.

4. Age as a Factor in the Sequential Evaluation Process for Children

(a) Age may or may not be a factor in determining whether a child's impairment(s) meets or medically equals a listing. This depends on the listing used for comparison. Age, however, is an important factor used in deciding whether a child's impairment(s) is severe and whether it functionally equals the listings. Except in the case of certain premature infants, as described in paragraph (b) of this section, age means chronological age.

(1) When determining whether a child has an impairment or combination of impairments that is severe, the child's functioning is compared to that of other children the same age who do not have impairments.

(2) When determining whether a child's impairment meets a listing, the child's age may or may not need to be considered. The listings describe impairments that are considered to be of such significance that they are presumed to cause marked and severe functional limitations.

(i) If the listing appropriate for evaluating the child's impairment is divided into specific age categories, the child's impairment will be evaluated according to their age when it is determined that the child's impairment meets that listing.

(ii) If the listing appropriate for evaluating the child's impairment does not include specific age categories, a decision as to whether the child's impairment meets the listing will be made without giving consideration to age.

(3) When comparing an unlisted impairment or a combination of impairments with the listings to determine whether the impairment(s)

medically equals the severity of a listing, consideration of the child's age will depend on the listing used for comparison. The same principles for considering age will be used as in paragraphs (a) (2) (i) and (a) (2) (ii) of this section; that is, we will consider the child's age only if we are comparing the child's impairment(s) to a listing that includes specific age categories.

(4) Consideration will also be given to a child's age and whether it affects their ability to be tested. If the child's impairment is not amenable to formal testing because of their age, all information in the child's case record must be considered in determining whether the child is disabled. In order to help evaluate the existence and severity of the child's impairment(s), consideration will be given to other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

(b) Correcting chronological age of premature infants. Chronological age (that is, a child's age based on birth date) is generally used when deciding whether, or the extent to which, a physical or mental impairment or combination of impairments causes functional limitations. However, if a child was born prematurely, the child may be considered younger than their chronological age. When evaluating the development or linear growth of a child born prematurely, a "corrected" chronological age may be used; that is, the chronological age adjusted by a period of gestational prematurity. An infant born at less than 37 weeks gestation is considered to be born prematurely.

(1) A corrected chronological age is applied in the following situations:

(i) When evaluating developmental delay in premature children until the child's prematurity is no longer a relevant factor; generally, no later than about chronological age 2 (see paragraph (b) (2) of this section);

(ii) When evaluating an impairment of linear growth, such as under the listings in 100.00 in Appendix I, Part B, until the child is 12 months old. In this situation, refer to the neonatal growth charts which have been developed to evaluate growth in premature infants (see paragraph (b) (2) of this section).

(2) A corrected chronological age is computed as follows:

(i) If the child has not attained age 1, the child's chronological age will be corrected. The corrected chronological age is computed by subtracting the number of weeks of prematurity (i.e., the difference between 40 weeks of full-term gestation and the number of actual weeks of gestation) from the child's chronological age. The result is the child's corrected chronological age.

(ii) If the child is over age 1, has a developmental delay, and prematurity is still a relevant factor in the case (generally no later than about chronological age 2), a decision whether to correct the child's chronological age must be made. The decision should be based on judgment and all the facts in the child's case. If a decision is made to correct the child's chronological age, it may be corrected by subtracting the full number of weeks of prematurity or a lesser number of weeks. A decision may also be made not to correct the child's chronological age if it can be determined from the evidence that the child's developmental delay is the result of the child's medically determinable impairment(s) and is not attributable to the child's prematurity.

(3) Notwithstanding the provisions in paragraph (b) (1) of this section, a corrected chronological age will not be computed if the medical evidence shows that the child's treating source or other medical source has already taken the child's prematurity into consideration in his or her assessment of the child's development. Also, a corrected chronological age is not required to satisfy listing 100.04.

5. Medical Equivalence

(a) How medical equivalence is determined.

A decision will be made that the child's impairment is medically equivalent to a listed impairment in Appendix I if the medical findings are at least equal in severity and duration to the listed findings. The signs, symptoms and laboratory findings related to the child's impairment(s), as found in the medical evidence, are compared with the corresponding medical criteria shown for any listed impairment. When making a finding of medical equivalence, all relevant evidence in the case record should be considered. Medical equivalence can be found in two ways:

(1) If the child has a listed impairment but does not exhibit one or more of the medical findings specified in the listing, or exhibits all of the medical findings but one or more of the findings is not as severe as specified in the listing, the child may be found to equal the listing if there are other medical findings related to the impairment that are at least of equal medical significance.

(2) If the child has an unlisted impairment or a combination of impairments none of which meets or equals a listing, the medical findings are compared to medical findings for a closely related impairment. If the medical findings are at least of equal significance to a closely analogous listed impairment, the child may be found to equal the listings.

(b) If the impairment meets or medically equals the severity of a listed impairment, and also meets the duration requirement, the impairment will be found to cause marked and severe limitations, and the child will be determined disabled. (Note: If the medical criteria in the children's criteria do not apply, the adult medical listings should be used.)

(c) If the impairment does not meet or medically equal the severity of a listed impairment, proceed to determine whether the impairment(s) functionally equals the listings.

6. Functional Equivalence for Children

(a) General. If the child has a severe impairment or combination of impairments that does not meet or medically equal any listing, a decision must be made as to whether the impairment(s) results in limitations that functionally equal the listings. "Functionally equaling the listings" means that the child's impairment(s) is of listing-level severity; i.e., it must result in "marked" limitations in two domains of functioning or an "extreme" limitation in one domain, as explained in this section. An assessment of the functional limitations caused by the child's impairment(s) must be done; i.e. what the child cannot do, has difficulty doing, needs help doing, or is restricted from doing because of their impairment(s). When making a finding regarding functional equivalence, assess the interactive and cumulative effects of all of the impairments for which there is evidence, including any impairments the child has that are not "severe". When assessing the child's functional equivalence, consider all relevant factors including, but not limited to:

a. How well the child can initiate and sustain activities, how much extra help the child needs, and the effects of structured or supportive settings (see Section 3. (b) (5));

b. How the child functions in school (see Section 3. (b) (7)); and

c. The effects of the child's medication or other treatment (see Section 3. (b)(9)).

(b) How the child's functioning is considered.

Look at the information contained in the child's case record about how the child's functioning is affected during all of their activities when deciding whether the child's impairment or combination of impairments functionally equals the listings. The child's activities are everything they do at home, at school, and in their community. Review how appropriately, effectively, and independently the child performs their activities compared to the performance of other children the same age who do not have impairments.

(1) How the child functions in their activities will be considered in terms of six domains. These domains are broad areas of functioning intended to capture all of what a child can or cannot do. In paragraphs (g) through (l), each domain is described in general terms. For most of the domains, examples are also provided of activities that illustrate the typical functioning of children in different age groups. For all of the domains, examples are provided of limitations within the domains. However, it is recognized that there is a range of development and functioning, and that not all children within an age category are expected to be able to do all of the activities in the examples of typical functioning. It is also recognized that limitations of any of the activities in the examples do not necessarily mean that a child has a "marked" or "extreme" limitation as defined in paragraph (e) of this section. The domains that are used are:

(i) Acquiring and using information;

(ii) Attending and completing tasks;

(iii) Interacting and relating with others;

(iv) Moving about and manipulating objects;

(v) Caring for oneself; and

(vi) Health and physical well-being.

(2) When evaluating the child's ability to function in each domain, ask for and consider information that will help answer the following questions about whether the child's impairment(s) affects their functioning and whether the child's activities are typical of other children the same age who do not have impairments.

(i) What activities is the child able to perform?

(ii) What activities is the child not able to perform?

(iii) Which of the child's activities are limited or restricted compared to other children the same age who do not have impairments?

(iv) Where does the child have difficulty with their activities - at home, in childcare, at school, or in the community?

(v) Does the child have difficulty independently initiating, sustaining, or completing activities?

(vi) What kind of help does the child need to do their activities, how much help does the child need, and how often do they need it?

(3) Try to get information from sources who can tell about the effects of the child's impairment(s) and how the child functions. Try to obtain information from the child's treating and other medical sources who have seen the child and can give their medical finding and opinions about the child's limitations and restrictions. Also, obtain information from the child's parents and teachers and others who see the child often and can describe the child's functioning at home, in childcare, at school, and in the community.

(c) The interactive and cumulative effects of an impairment or multiple impairments. When evaluating the child's functioning and deciding which domains may be affected by the child's impairment(s), consider first the child's activities and their limitations and restrictions. Any given activity may involve the integrated use of many abilities and skills; therefore, any single limitation may be the result of the interactive and cumulative effects of one or more impairments. And any given impairment may have effects in more than one domain; therefore, evaluate the limitations from the child's impairment(s) in any affected domain(s).

(d) How to decide if the child's impairment(s) functionally equals the listings. The child's impairment(s) will be found to functionally equal the listings if it is of listing level severity. The child's impairment is of listing-level severity if the child has "marked" limitations in two of the domains in paragraph (b) (1) of this section, or an "extreme" limitation in one domain. The child's functioning should not be compared to the requirements of any specific listing. The terms "marked" and "extreme" are explained in paragraph (e) of this section. An explanation of how to use the domains is found in paragraph (f) of this section, and a description of each domain can be found in paragraphs (g) - (l). The duration requirement must also be met.

(e) How "marked" and "extreme" limitations are defined.

(1) General.

(i) When deciding whether the child has a "marked” or an "extreme" limitation, consider the functional limitations resulting from all of the child's impairments, including their interactive and cumulative effects. Consider all of the relevant information in the child's case record that will help in determining the child's functioning, including the child's signs, symptoms, and laboratory findings, the descriptions provided about the child's functioning from thier parents, teachers, and other

people who know the child, and the relevant factors explained in the previous sections.

(ii) The medical evidence may include formal testing that provides information about the child's development or functioning in terms of percentiles, percentages of delay, or age or grade equivalents. Standard scores (e.g., percentiles) can be converted to standard deviations. When such scores are available, consider them together with the information obtained about the child's functioning to determine whether the child has a "marked" or "extreme" limitation in a domain.

(2) Marked limitation.

(i) The child will be found to have a "marked" limitation in a domain when their impairment(s) interferes seriously with their ability to initiate, sustain, or complete activities. The child's day-to-day functioning may be seriously limited when their impairment(s) limits only one activity or when the interactive and cumulative effects of the child's impairment(s) limit several activities. "Marked" limitation also means a limitation that is "more than moderate" but "less than extreme." It is the equivalent of the functioning that would be expected to be found on standardized testing with scores that are at least two, but less than three, standard deviations below the mean.

(ii) If the child has not attained age 3, it will generally be found that the child has a "marked" limitation if they are functioning at a level that is more than one- half but not more than two-thirds of their chronological age when there are no standard scores from standardized tests in the child's case record.

(iii) A child of any age (birth to the attainment of age 18) will be found to have a "marked" limitation when the child has a valid score that is two standard deviations or more below the mean, but less than three standard deviations, on a comprehensive standardized test designed to measure ability or functioning in that domain, and when the child's day-to-day functioning in domain-related activities is consistent with that score. (See paragraph (e) (4) of this section.)

(iv) For the sixth domain of functioning, "Health and physical well-being", the child may be considered to have a "marked" limitation if they are frequently ill because of their impairment(s) or has frequent exacerbations of their impairment(s) that result in significant, documented symptoms or signs. For the purposes of this domain, "frequent" means that the child has episodes of illness or exacerbations

that occur on an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more. A "marked" limitation may also be found if the child has episodes that occur more often than 3 times in a year or once every 4 months but do not last for 2 weeks, or occur less often than an average of 3 times a year or once every 4 months but last longer than 2 weeks, if the overall effect (based on the length of the episode(s) or its frequency) is equivalent in severity.

(3) Extreme limitation.

(i) The child will be found to have an "extreme" limitation in a domain when the child's impairment(s) interferes very seriously with their ability to independently initiate, sustain, or complete activities. The child's day-to-day functioning may be very seriously limited when their impairment(s) limits only one activity or when the interactive and cumulative effects of the child's impairment(s) limit several activities. "Extreme" limitation also means a limitation that is "more than marked" and is the rating given to the worst limitations. However, "extreme" limitation does not necessarily mean a total lack or loss of ability to function. It is the equivalent of the functioning expected to be found on standardized testing with scores that are at least three standard deviations below the mean.

(ii) If the child has not attained age 3, it will generally be found that the child has an "extreme" limitation if they are functioning at a level that is one-half of their chronological age or less when there are no standard scores from standardized tests in the child's case record.

(iii) A child of any age (birth to the attainment of age 18) will be found to have an "extreme" limitation when they have a valid score that is three standard deviations or more below the mean on a comprehensive standardized test designed to measure ability or functioning in that domain, and when the child's day-to-day functioning in domain-related activities is consistent with that score. (See paragraph (e) (4) of this section.)

(iv) For the sixth domain of functioning, "Health and physical well-being", the child may be considered to have an "extreme" limitation if they are frequently ill because of their impairment(s) or has frequent exacerbations of their impairment(s) that result in significant, documented symptoms or signs substantially in excess of the requirements for showing a "marked" limitation in paragraph (e) (2) (iv) of this section. However, if the child has episodes of illness or exacerbations of their impairment(s) that would be rated as "extreme"

under this definition, the child's impairment(s) should meet or medically equal the requirements of a listing in most cases.

(4) How test scores are considered.

(i) As indicated in Section 3. (a) (1) (ii), any test scores alone should not be relied on. No single piece of information taken in isolation can establish whether a child has a "marked" or an "extreme" limitation in a domain.

(ii) The child's test scores should be considered together with the other information obtained about the child's functioning, including reports of classroom performance and the observation of school personnel and others.

(A) It may be found that the child has a "marked" or "extreme" limitation when they have a test score that is slightly higher than the level provided in paragraph (e) (2) or (e) (3) of this section, if other information in the child's case record shows that their functioning in day-to-day activities is seriously or very seriously limited because of their impairment(s). For example, the child may have IQ scores above the level in paragraph (e) (2), but other evidence shows that the child's impairment(s) causes them to function in school, home, and community far below their expected level of functioning based on this score.

(B) On the other hand, it may be found that the child does not have a "marked" or "extreme" limitation, even if the child's test scores are at the level provided in paragraph (e) (2) or (e) (3) of this section, if other information in the child's case record shows that their functioning in day-to-day activities is not seriously or very seriously limited by their impairment(s). For example, the child may have a valid IQ score below the level in paragraph (e) (2), but other evidence shows that the child has learned to drive a car, shop independently, and read books near their expected grade level.

(iii) If there is a material inconsistency between the child's test scores and other information in the child's case record, try to resolve it. The interpretation of the test is primarily the responsibility of the psychologist or other professional who administered the test. But it is also the reviewer's responsibility to ensure that the evidence in the child's case record is complete and consistent or that any material inconsistencies have been resolved. Therefore, the following guidelines will be used to resolve concerns about the child's test scores:

(A) The inconsistencies may be able to be resolved with the information on hand. It may be necessary to obtain additional information, e.g., by recontact with the child's medical source(s), by recontact with a medical source who provided a consultative exam, or by questioning individuals familiar with the child's day-to-day functioning.

(B) Generally, a test score should not be relied on as a measurement of the child's functioning within a domain when the information obtained about the child's functioning is the kind of information typically used by medical professionals to determine that the test results are not the best measure of the child's day-to-day functioning. When test scores are not relied on, an explanation of the reasons for doing so should be documented on the "Disability Review Team Certificate" (DOH-5144).

(f) How domains are used to help evaluate the child's functioning.

(1) When considering whether the child has a "marked" or "extreme" limitation in any domain, examine all the information in the child's case record about how the child's functioning is limited because of their impairment(s). Compare the child's functioning to the typical functioning of children the same age who do not have impairments.

(2) The general descriptions of each domain in paragraphs (g) - (l) will help in deciding whether the child has limitations in any given domain and whether these limitations are "marked" or "extreme".

(3) The domain descriptions also include examples of some activities typical of children in each age group and some functional limitations that may be considered. These examples also help in deciding whether the child has limitations in a domain because of their impairment(s). The examples are not all-inclusive and developing evidence about each specific example is not required. When the child has limitations in a given activity or activities in the examples, a decision may or may not be made that the child has a "marked" or "extreme" limitation in that domain. Consider the activities in which the child is limited because of their impairment(s) and the extent of the child's limitations under the rules in paragraph (e) of this section.

(g) Acquiring and using information. In this domain, consideration is given to how well the child acquires or learns information, and how well the child uses the information they have learned.

(1) General.

(i) Learning and thinking begin at birth. A child learns as they explore the world through sight, sound, taste, touch, and smell. As a child plays, they

acquire concepts and learns that people, things, and activities have names. This lets the child understand symbols, which prepares them to use language for learning. Using the concepts and symbols acquired through play and learning experiences, the child should be able to learn to read, write, do arithmetic, and understand and use new information.

(ii) Thinking is the application or use of information the child has learned. It involves being able to perceive relationships, reason, and make logical choices. People think in different ways. When a child thinks in pictures, they may solve a problem by watching and imitating what another person does. When a child thinks in words, they may solve a problem by using language to talk their way through it. A child must also use language to think about the world and to understand others and express themselves; e.g., to follow directions, ask for information, or explain something.

(2) Age group descriptors.

(i) Newborns and young infants (birth to attainment of age 1). At this age, a child should show interest in and explore their environment. At first, a child's actions are random; for example, when the child accidentally touches the mobile over their crib. Eventually, the child's actions should become deliberate and purposeful, such as when they shake noisemaking toys like a bell or rattle. The child should begin to recognize, and then anticipate, routine situations and events, such as when they grin at the sight of their stroller. The child should also recognize and gradually attach meaning to everyday sounds, such as when they hear the telephone or their name. Eventually, the child should recognize and respond to familiar words, including family names and what their favorite toys and activities are called.

(ii) Older infants and toddlers (age 1 to attainment of age 3). At this age, the child is learning about the world around them. When the child plays, they should learn how objects go together in different ways. The child should learn that by pretending, their actions can represent real things. This helps the child understand that words represent things, and that words are simply symbols or names for toys, people, places, and activities. The child should refer to themselves and the things around them by pointing and eventually naming. The child should form concepts and solve simple problems through purposeful experimentation (e.g., taking toys apart), imitation, constructive play (e.g., building with blocks), and pretend play activities. The child should begin to respond to increasingly complex instructions and questions, and to produce an increasing number of words and grammatically correct simple sentences and questions.

(iii) Preschool children (age 3 to attainment of age 6). When the child is old enough to go to preschool or kindergarten, the child should begin to learn and use the skills that will help them to read and write and do arithmetic when they are older. For example, listening to stories, rhyming words, and matching letters are skills needed for learning to read. Counting, sorting shapes, and building with blocks are skills needed to learn math. Painting, coloring, copying shapes, and using scissors are some of the skills needed in learning to write. Using words to ask questions, give answers, follow directions, describe things, explain what they mean, and tell stories allows the child to acquire and share knowledge and experience of the world around them. All of these are called "readiness skills", and the child should have them by the time they begin first grade.

(iv) School-age children (age 6 to attainment of age 12). When the child is old enough to go to elementary and middle school, they should be able to learn to read, write, do math, and discuss history and science. The child will need to use these skills in academic situations to demonstrate what they have learned; e.g., by reading about various subjects and producing oral and written projects, solving mathematical problems, taking achievement tests, doing group work, and entering into class discussions. The child will also need to use these skills in daily living situations at home and in the community (e.g., reading street signs, telling time, and making change). The child should be able to use increasingly complex language (vocabulary and grammar) to share information and ideas with individuals or groups, by asking questions and expressing their own ideas, and by understanding and responding to the opinions of others.

(v) Adolescents (age 12 to attainment of age 18). In middle and high school, the child should continue to demonstrate what they have learned in academic assignments (e.g., composition, classroom discussion, and laboratory experiments). The child should also be able to use what they have learned in daily living situations without assistance (e.g., going to the store, using the library, and using public transportation). The child should be able to comprehend and express both simple and complex ideas, using increasingly complex language (vocabulary and grammar) in learning and daily living situations (e.g., to obtain and convey information and ideas). The child should also learn to apply these skills in practical ways that will help them enter the workplace after they finish school (e.g., carrying out instructions, preparing a job application, or being interviewed by a potential employer).

(3) Examples of limited functioning in acquiring and using information.

The following examples describe some limitations found in this domain. The child's limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in a child's case may depend on the child's age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitation must result from their medically determinable impairment(s). However, all of the relevant information in the child's case record should be considered when deciding whether the child's medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

(i) The child does not demonstrate understanding of words about space, size, or time; e.g., in/under, big/little, morning/night.

(ii) The child cannot rhyme words or the sounds in words.

(iii) The child has difficulty recalling important things they have learned in school yesterday.

(iv) The child has difficulty solving mathematics questions or computing arithmetic answers.

(v) The child talks only in short, simple sentences and has difficulty explaining what they mean.

(h) Interacting and relating with others. In this domain, consideration is given to how well the child initiates and sustains emotional connections with others, develops and uses the language of their community, cooperates with others, complies with the rules, responds to criticism, and respects and takes care of the possessions of others.

(1) General.

(i) Interacting means initiating and responding to exchanges with other people, for practical or social purposes. A child interacts with others by using facial expressions, gestures, actions, or words. The child may interact with another person only once, as when asking a stranger for directions, or many times, as when describing their day at school to their parents. The child may interact with people one at a time, as when they are listening to another student in the hallway at school, or in groups, as when they play with others.

(ii) Relating to other people means forming intimate relationships with family members and with friends who are the child's age and sustaining

them over time. The child may relate to individuals, such as their siblings, parents or best friend, or to groups, such as other children in childcare, their friends in school, teammates in sports activities, or people in their neighborhood.

(iii) Interacting and relating requires the child to respond appropriately to a variety of emotional and behavioral cues. The child may be able to speak intelligibly and fluently so that others can understand them; participate in verbal turn- taking and nonverbal exchanges; consider others' feelings and points of view; follow social rules for interaction and conversation; and respond to others appropriately and meaningfully.

(iv) The child's activities at home, school or in their community may involve playing, learning, and working cooperatively with other children, one at a time or in groups; joining voluntarily in activities with the other children in their school or community; and responding to persons (e.g., a parent, teacher, bus driver, coach, or employer).

(2) Age group descriptors.

(i) Newborns and young infants (birth to the attainment of age 1). The child should begin to form intimate relationships at birth by gradually responding visually and vocally to their caregiver(s), through mutual gaze and vocal exchanges, and by physically molding their body to the caregiver's while being held. The child should eventually initiate give-and-take games (such as pat-a-cake, peek-a-boo) with their caregivers, and begin to affect others through their own purposeful behavior (e.g., gestures and vocalizations). The child should be able to respond to a variety of emotions (e.g., facial expressions and vocal tone changes). The child should begin to develop speech by using vowel sounds and later consonants, first alone, and then in babbling.

(ii) Older infants and toddlers (age 1 to attainment of age 3). At this age, the child is dependent upon their caregivers, but should begin to separate from them. The child should be able to express emotions and respond to the feelings of others. The child should begin initiating and maintaining interactions with adults, but also show interest in, then play alongside, and eventually interact with other children their age. The child should be able to spontaneously communicate their wishes or needs, first by using gestures, and eventually by speaking words clearly enough that people who know them can understand what they say most of the time.

(iii) Preschool children (age 3 to attainment of age 6). At this age, the child should be able to socialize with children as well as adults. The child

should begin to prefer playmates their own age and start to develop friendships with children who are the same age. The child should be able to use words instead of actions to express themselves, and also be better able to share, show affection, and offer to help. The child should be able to relate to caregivers with increasing independence, choose their own friends, and play cooperatively with other children, one at a time or in a group, without continual adult supervision. The child should be able to initiate and participate in conversations, using increasingly complex vocabulary and grammar, and speak clearly enough that both familiar and unfamiliar listeners can understand what they say most of the time.

(iv) School-age children (age 6 to attainment of age 12). When the child enters school, they should be able to develop more lasting friendships with children who are the same age. The child should begin to understand how to work in groups to create projects and solve problems. They should have an increasing ability to understand another's point of view and to tolerate differences. The child should be able to talk to people of all ages, to share ideas, tell stories, and to speak in a manner that both familiar and unfamiliar listeners readily understand.

(v) Adolescents (age 12 to attainment of age 18). By the time the child reaches adolescence, they should be able to initiate and develop friendships with children who are the same age and to relate appropriately to other children and adults, both individually and in groups. The child should begin to be able to solve conflicts between themselves and peers or family members or adults outside their family. The child should recognize that there are different social rules for them and for their friends and for acquaintances or adults. The child should be able to intelligibly express their feelings, ask for assistance in getting their needs met, seek information, describe events, and tell stories, in all kinds of environments (e.g., home, classroom, sports, extra- curricular activities, or part-time job), and with all types of people (e.g., parents, siblings, friends, classmates, teachers, employers, and strangers).

(3) Examples of limited functioning in interacting and relating with others.

The following examples describe some limitations that may be considered in this domain. The child's limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or an "extreme" limitation. Whether an example applies in the child's case may depend on the child's age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitations must result from their medically determinable impairment(s). However, all of the relevant

information in the child's case record should be considered when deciding whether the child's medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

(i) The child does not reach out to be picked up and held by their caregiver.

(ii) The child has no close friends, or their friends are all older or younger than they.

(iii) The child avoids or withdraws from people they know, or they are overly anxious or fearful of meeting new people or trying new experiences.

(iv) The child has difficulty playing games or sports within the rules.

(v) The child has difficulty communicating with others; e.g., in using verbal and nonverbal skills to express themselves, carrying on a conversation, or in asking others for assistance.

(vi) The child has difficulty speaking intelligibly or with adequate fluency.

(i) Moving about and manipulating objects. In this domain, consider how the child moves their body from one place to another and how the child moves and manipulates things. These are called gross and fine motor skills.

(1) General.

(i) Moving the body involves several different kinds of actions: rolling; rising or pulling from a sitting to a standing position; pushing up; raising one's head, legs, and twisting one's hands and feet; balancing one's weight on the legs and feet; shifting one's weight while sitting or standing; transferring oneself from one surface to another; lowering oneself to or toward the floor as when bending, kneeling, stooping, or crouching; moving oneself forward and backward in space as when crawling, walking, or running, and negotiating different terrains (e.g., curbs, steps, and hills).

(ii) Moving and manipulating things involves several different kinds of actions: engaging one's upper and lower body to push, pull, lift, carry objects from one place to another; controlling shoulders, arms, and hands to hold or transfer objects; coordinating one's eyes and hands to manipulate small objects or parts of objects.

(iii) These objects require varying degrees of strength, coordination, dexterity, pace, and physical ability to persist at the task. They also require a sense of where one's body is and how it moves in space; the integration of sensory input with motor output; and the capacity to plan, remember and execute controlled motor movements.

(2) Age group descriptors.

(i) Newborns and infants (birth to attainment of age 1). At birth, a child should begin to explore their world by moving their body and by using their limbs. The child should learn to hold their head up, sit, crawl, and stand, and sometimes hold onto a stable object and stand actively for brief periods. The child should begin to practice their developing eye-hand control by reaching for objects or picking up small objects and dropping them into containers.

(ii) Older infants and toddlers (age 1 to attainment of age 3). At this age, the child should begin to explore actively a wide area of their physical environment, using their body with steadily increasing control and independence from others. The child should begin to walk and run without assistance and climb with increasing skill. The child should frequently try to manipulate small objects and to use their hands to do or get something that they want or need. The child's improved motor skills should enable them to play with small blocks, scribble with crayons, and feed themselves.

(iii) Preschool children (age 3 to attainment of age 6). As a preschooler, the child should be able to walk and run with ease. The child's gross motor skills should let them climb stairs and playground equipment with little supervision and let them play more independently; e.g., the child should be able to swing by themselves and may start learning to ride a tricycle. The child's fine motor skills should also be developing. The child should be able to complete puzzles easily, string beads, and build with an assortment of blocks. The child should be showing increasing control of crayons, markers, and small pieces in board games, and should be able to cut with scissors independently and manipulate buttons and other fasteners.

(iv) School-age children (age 6 to attainment of age 12). As a school age child, the child's developing gross motor skills should let them move at an efficient pace about their school, home and neighborhood. The child's increasing strength and coordination should expand their ability to enjoy a variety of physical activities, such as running and jumping, and throwing, kicking, catching and hitting balls in informal play or at organized sports.

The child's developing fine motor skills should enable them to do things like use many kitchen and household tools independently, use scissors, and write.

(v) Adolescents (age 12 to attainment of age 18). As an adolescent, the child should be able to use their motor skills freely and easily to get about their school, the neighborhood, and the community. The child should be able to participate in a full range of individual and group physical fitness activities. The child should show mature skills in activities requiring eye-hand coordination and should have the fine motor skills needed to write efficiently or type on a keyboard.

(3) Examples of limited functioning in moving about and manipulating objects.

The following examples describe some limitations that may be considered in this domain. The child's limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in the child's case may depend on the child's age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitations must result from their medically determinable impairment(s). However, all of the relevant information in the child's case record should be considered when deciding whether the child's medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

(i) The child experiences muscle weakness, joint stiffness, or sensory loss (e.g., spasticity, hypotonia, neuropathy, or paresthesia) that interferes with their motor activities (e.g., the child unintentionally drops things).

(ii) The child has trouble climbing up and down stairs or has jerky or disorganized locomotion or difficulty with their balance.

(iii) The child has difficulty coordinating gross motor movements (e.g., bending, kneeling, crawling, and running, jumping rope, or riding a bike).

(iv) The child has difficulty with sequencing hand or finger movements.

(v) The child has difficulty with fine motor movement (e.g., gripping or grasping objects).

(vi) The child has poor eye-hand coordination when using a pencil or scissors.

(j) Caring for oneself. In this domain, consideration is given to how well the child maintains a healthy emotional and physical state, including how well the child gets their physical and emotional needs met in appropriate ways; how well the child copes with stress and changes in their environment; and whether they take care of their own health, possessions, and living area.

(1) General.

(i) Caring for oneself effectively, which includes regulating oneself, depends upon the child's ability to respond to changes in their emotions and the daily demands of their environment to help themselves and cooperate with others in taking care of their personal needs, health and safety. It is characterized by a sense of independence and competence. The effort to become independent and competent should be observable throughout childhood.

(ii) Caring for oneself effectively means becoming increasingly independent in making and following one's own decisions. This entails that the child relies on their own abilities and skills and display consistent judgment about the consequences of caring for themselves. As the child matures, using and testing their own judgment helps them develop confidence in his/ her independence and competence. Caring for oneself includes using one's independence and competence to meet one's physical needs, such as feeding, dressing, toileting, and bathing, appropriately for one's age.

(iii) Caring for oneself effectively requires the child to have a basic understanding of their body, including its normal functioning, and of his/ her emotional needs. To meet these needs successfully, the child must employ effective coping strategies, appropriate for their age, to identify and regulate their feelings, thoughts, urges, and intentions. Such strategies are based on taking responsibility for getting one's needs met in an appropriate and satisfactory manner.

(iv) Caring for oneself means recognizing when one is ill, following the recommended treatment, taking medication as prescribed, following safety rules, responding to circumstances in safe and appropriate ways, making decisions that do not endanger oneself, and knowing when to ask for help from others.

(2) Age group descriptors.

(i) Newborns and infants (birth to attainment of age 1). The child's sense of independence and competence begins by being able to recognize their

body's signals (e.g., hunger, pain, discomfort), to alert a caregiver to their needs (e.g., by crying), and to console themselves (e.g., by sucking on their hand) until help comes. As the child matures, their capacity for self-consolation should expand to include rhythmic behaviors (e.g., rocking). The child's need for a sense of competence also emerges in things they try to do for themselves, perhaps before they are ready to do them, as when insisting on putting food in their own mouth and refusing a caregiver's help.

(ii) Older infants and toddlers (age 1 to attainment of age 3). As the child grows, the child should be trying to do more things for themselves that increase their sense of independence and competence in their environment. The child might try to console themselves by carrying a favorite blanket everywhere. The child should be learning to cooperate with their caregivers when they take care of the child's physical needs, but the child should also want to show what they can do (e.g., pointing to the bathroom, pulling off their coat). The child should be experimenting with their independence by showing some degree of contrariness (e.g., "No! No!") and identity (e.g., hoarding their toys).

(iii) Preschool children (age 3 to attainment of age 6). The child should want to take care of many of their physical needs by themselves (e.g., putting on shoes, getting a snack), and also want to try doing some things that they cannot do fully (e.g., tying their shoes, climbing on a chair to reach something up high, taking a bath). Early in this age range, it may be easy for the child to do what a caregiver asks. Later, that may be difficult for the child because they want to do things their way or not at all. These changes usually mean that the child is more confident about their ideas and what they are able to do. The child should also begin to understand how to control behaviors that are not good for them (e.g., crossing the street without an adult).

(iv) School-age children (age 6 to attainment of age 12). The child should be independent in most day-to-day activities (e.g., dressing themselves, bathing themselves), although they may still need to be reminded sometimes to do these routinely. The child should begin to recognize that they are competent in doing some activities and that they have difficulty with others. The child should be able to identify those circumstances when they feel good about themselves and when they feel bad. The child should begin to develop understanding of what is right and wrong, and what is acceptable and unacceptable behavior. The child should begin to demonstrate consistent control over their behavior and should be able to avoid behaviors that are unsafe or otherwise not good

for them. The child should begin to imitate more of the behavior of adults they know.

(v) Adolescents (age 12 to attainment of age 18). The child should feel more independent from others and should be increasingly independent in all of their day-to-day activities. The child may sometimes experience confusion in the way they feel about themselves. The child should begin to notice significant changes in their body's development, and this could result in anxiety or worrying about themselves and their body. Sometimes these worries may make the child angry or frustrated. The child should begin to discover appropriate ways to express their feelings, both good and bad (e.g., keeping a diary to sort out angry feelings or listening to music to calm down). The child should begin to think seriously about their future plans, and what they will do when school is finished.

(3) Examples of limited functioning in caring for oneself.

The following examples describe some limitations that may be considered in this domain. The child's limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in a child's case may depend on the child's age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitations must result from their medically determinable impairment(s). However, consider all of the relevant information in the child's case record when deciding whether the child's medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

(i) The child continues to place non-nutritive or inedible objects in their mouth. The child often uses self-soothing activities showing developmental regression (e.g., thumb- sucking, re-chewing food), or they have restrictive or stereotyped mannerisms (e.g., body rocking, head banging).

(ii) The child does not dress or bathe themselves appropriately for their age because they have an impairment that affects this domain.

(iii) The child engages in self-injurious behavior (e.g., suicidal thoughts or actions, self-inflicted injury, or refusal to take their medication), or they ignore safety rules.

(iv) The child does not spontaneously pursue enjoyable activities or interests.

(v) The child has a disturbance in eating or sleeping patterns.

(k) Health and physical well-being. In this domain, consideration is given to the cumulative physical effects of physical or mental impairments and their associated treatments or therapies on the child's functioning that were not considered in paragraph (j) of this section. When the child's physical impairment(s), mental impairment(s), or combination of physical and mental impairments has physical effects that cause "extreme" limitations in the child's functioning, the child will generally have an impairment(s) that "meets" or "medically equals" a listing.

(1) A physical or mental disorder may have physical effects that vary in kind and intensity and make it difficult for the child to perform their activities independently or effectively. The child may experience problems such as generalized weakness, dizziness, shortness of breath, reduced stamina, fatigue, psychomotor retardation, allergic reactions, recurrent infection, poor growth, bladder or bowel incontinence, or local or generalized pain.

(2) In addition, the medications that the child takes (e.g., for asthma or depression) or the treatments the child receives (e.g., chemotherapy or multiple surgeries) may have physical effects that also limit the child's performance of activities.

(3) The child's illness may be chronic with stable symptoms, or episodic with periods of worsening and improvement. Consider how the child functions during periods of worsening and how often and for how long these periods occur. The child may be medically fragile and need intensive medical care to maintain their level of health and physical well-being. In any case, as a result of the illness itself, the medications or treatment the child receives, or both, the child may experience physical effects that interfere with their functioning in any or all of their activities.

(4) Examples of limitations in health and physical well-being. The following examples describe some limitations we may consider in this domain. The child's limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in the child's case may depend on the child's age or developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitations must result from their medically determinable impairment(s). However, consider all of the relevant information in the child's case record

when deciding whether the child's medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

(i) The child has generalized symptoms, such as weakness, dizziness, agitation (e.g., excitability), lethargy (i.e., fatigue or loss of energy or stamina), or psychomotor retardation because of their impairment(s).

(ii) The child has somatic complaints related to their impairment (e.g., seizure or convulsive activity, headaches, incontinence, recurrent infections, allergies, changes in weight or eating habits, stomach discomfort, nausea, headaches, or insomnia).

(iii) The child has limitations in their physical functioning because of their treatment (e.g., chemotherapy, multiple surgeries, chelation, pulmonary cleansing, or nebulizer treatments).

(iv) The child has exacerbations from one impairment or a combination of impairments that interfere with their physical functioning.

(v) The child is medically fragile and needs intensive medical care to maintain their level of health and physical well-being.

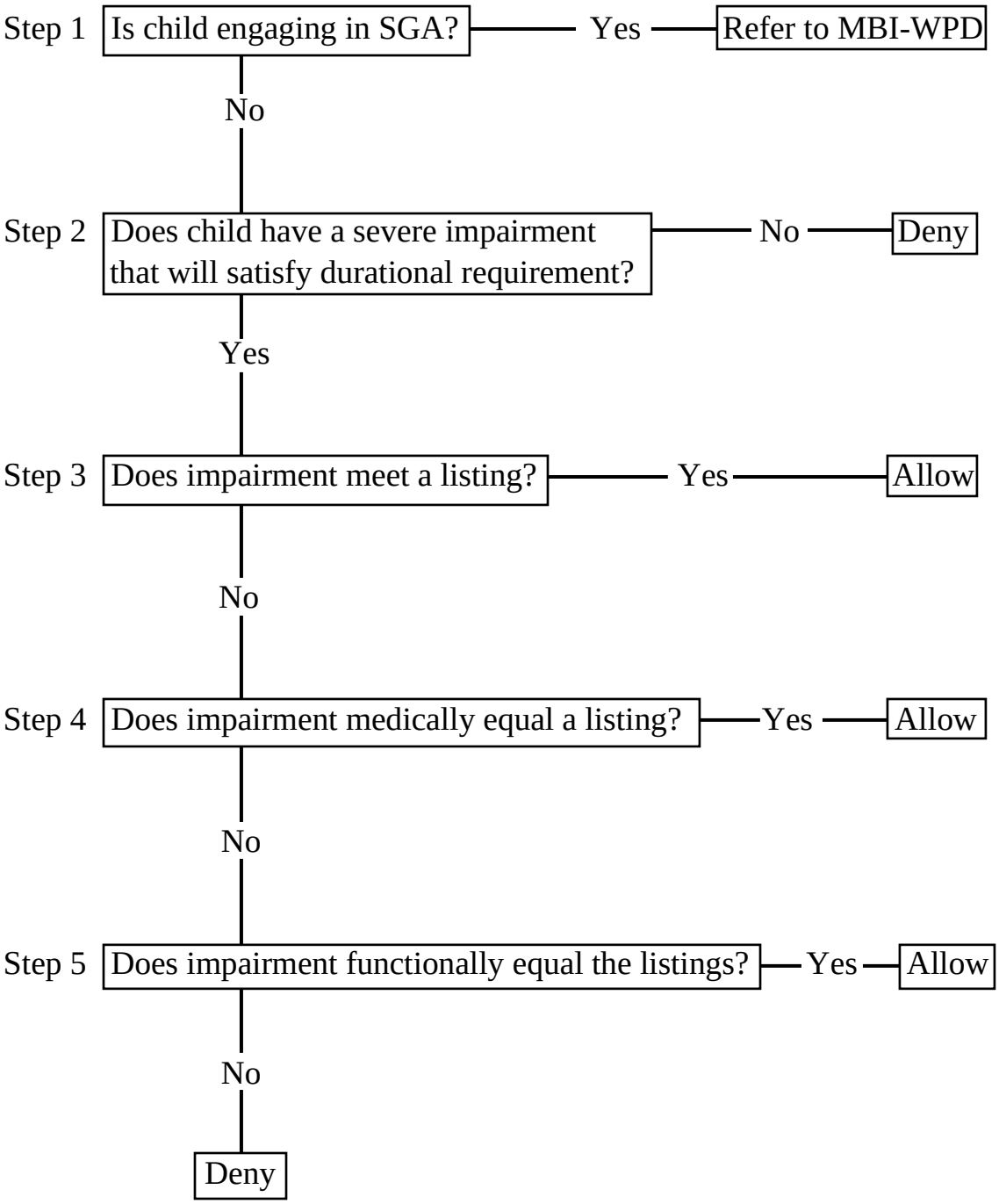
(l) The following are some examples of impairments and limitations that functionally equal the listings. Findings of equivalence based on the disabling functional limitations of a child's impairment(s) are not limited to the examples in this paragraph, because these examples do not describe all possible effects of impairments that might be found to functionally equal the listings. As with any disabling impairment, the duration requirement must also be met (see DI 25505.025 and DI 25201.001 ff.).

a. Any physical impairment(s) or combination of physical and mental impairments causing complete inability to function independently outside the area of one's home within age-appropriate norms.

b. Requirement for 24-hour-a-day supervision for medical (including psychological) reasons.

c. Major congenital organ dysfunction which could be expected to result in death within the first year of life without surgical correction, and the impairment is expected to be disabling (because of residual impairment following surgery, or the recovery time required, or both) until attainment of 1 year of age.

Sequential Evaluation Flow Chart Children (New)



7. Continuing Disability Review for Children

a. General. As with adults, all children's disability cases classified as Group II require a continuing disability review prior to the expiration date to determine if the child continues to be disabled. It is important to note that substantial gainful activity is not considered in children's continuing disability review.

Continuing disability review determinations which are approved based on lack of medical improvement as described below should refer to 20 CFR 416.994a as a regulatory basis on the DOH-5144, "Disability Review Team Certificate".

Please note that much of the information pertaining to children's continuing disability review is the same as that for adults. Therefore, to avoid repetition, some of the information which is covered in the section on adult continuing disability review is referenced for sections in which this is appropriate.

b. Sequential Evaluation Process. The steps of the sequential evaluation process for children's continuing disability review cases are:

Step 1 - Has there been medical improvement?

Step 2 - Does the impairment still meet or equal the severity of the listed impairment that it met or equaled before?

Step 3 - Is the child currently disabled?

NOTE: Steps in the sequence may be skipped if it is clear this would lead to a more prompt decision that disability continues. For example, the issue of medical improvement does not have to be considered if it is obvious from the evidence that an impairment meets the severity of a listed impairment.

c. **Step 1, Medical Improvement - Has there been medical improvement in the child's condition?**

(i) Medical Improvement. Medical improvement is defined as any decrease in the medical severity of the child's impairment(s) which was present at the time of the most recent favorable decision that they were disabled or continued to be disabled. This is called the comparison point decision (CPD). Although the decrease in severity may be of any quantity or degree, disregard minor changes in signs, symptoms, and laboratory findings that obviously do not represent medical improvement and could not result in a finding that disability has ended. A determination that there has been a decrease in medical severity must be based on changes (improvement) in the symptoms, signs, or laboratory findings associated with the child's impairment(s).

(ii) The most recent favorable decision. The most recent favorable decision is the latest final determination or decision involving a consideration of the medical evidence and whether the child was disabled or continued to be disabled.

(iii) Temporary remissions. Some impairments are subject to temporary remissions, which can give the appearance of medical improvement when in fact there has been none. If the child has the kind of impairment that is subject to temporary remission, consider the longitudinal history including the occurrence of prior remissions and prospects for future worsening. Improvements that are only temporary do not warrant a finding of medical improvement.

(iv) Evaluation. Has there been medical improvement in the child's condition(s)?

Determine whether there has been medical improvement in the impairment(s) since the time of the most recent favorable determination or decision. If there has been no medical improvement, disability continues, unless one of the exceptions to medical improvement applies. (Refer to Section G.2.k.) It should be noted that the "Advances in Medical or Vocational Therapy or Technology" and "Vocational Therapy" exceptions do not apply to children.

If one of the first group of exceptions to medical improvement applies, proceed to Step 3. If one of the second group of exceptions to medical improvement applies, disability may be found to have ended.

If medical improvement has occurred, proceed to Step 2.

d. **Step 2, Does the impairment(s) still meet or equal the severity of the listed impairment that it met or equaled before?**

(i) Under the functional equivalence policies applied prior to January 2, 2001, a comparison of the child's impairment(s) to a specific listing was required. Findings of functional equivalence made on or after January 2, 2001 are no longer based on a specific listing. Instead, we determine whether a child's impairment(s) "functionally equals the listings", that is, whether the impairment(s) results in marked limitations in two domains of functioning or an extreme limitation in one domain. Therefore, evaluation at step 2 of the CDR sequential evaluation process depends on the date and basis for the CPD. A sequential evaluation flow chart summarizing these policies on applying step 2 follows the completion of the CDR explanation.

(ii) **If the CPD was made <u>before January 2, 2001</u>:** Consider whether the CPD impairment(s) now meets or medically equals the same listing that it

met, medically equaled, or functionally equaled at the CPD, as that listing was written at that time, even if it has since been revised or removed from the Listing of Impairments. If the CPD impairment(s) now meets or medically equals the severity of that listed impairment as it was written at the time, find the child still disabled. If the CPD impairment(s) does not now meet or medically equal the CPD listing, consider whether the CPD impairment(s) now "functionally equals the listings" under the current rules. If it does, find the child still disabled. If it does not, proceed to step3.

(iii) **If the CPD was made on or after January 2, 2001:** If the CPD impairment(s) met or medically equaled a listing, consider whether that same impairment(s) now either meets or medically equals that same listing, as it was written at that time. If it does, find the child still disabled. If it does not, consider whether the CPD impairment(s) now functionally equals the listings under the current rules. If it does, find the child still disabled. If it does not, proceed to Step 3.

If the CPD was based on functionally equaling the listings, consider only whether the CPD impairment(s) currently functionally equals the listings. If it does, find the child still disabled. If it does not, proceed to Step 3.

e. **Is the child currently disabled?**

(i) In determining whether the child is currently disabled, consider all current impairments, including those not present at the time of the most recent favorable decision, or that were not considered at that time. The steps in determining current disability are summarized as follows:

(a) Does the child have a current severe impairment or combination of impairments that results in more than minimal functional limitations? If no current impairment or combination of impairments is severe, find that disability has ended. If an impairment or combination of impairments is severe, consider next whether it meets or medically equals the severity of a listed impairment.

(b) Does a current impairment(s) meet or medically equal the severity of any impairment listed in Appendix I? If a current impairment(s) meets or medically equals the severity of any current listed impairment, find that disability continues. If not, consider whether the current impairment(s) functionally equals the listings.

(c) Does a current impairment(s) "functionally equal the listings"? If a current impairment(s) results in marked limitations in two domains of

functioning, or an extreme limitation in one domain, find that disability continues. If not, find that disability has ended.

Sequential Evaluation Flow Chart Children (CDR)

Step 1 Medical improvement (MI) in any CPD impairment(s)? → No → Disability continues *

↓

Yes

↓

Step 2 CPD impairment(s) now meets or equals severity of CPD listing? Follow A or B as appropriate

A. If the CPD was made before January 02, 2001:

CPD impairment(s) now meets or medically equals CPD listing? → Yes ▸ Disability continues*

↓

No

↓

CPD impairment(s) now functionally equals the listings? → Yes → Disability continues*

↓

No, proceed to step 3

B. If the CPD was made on or after January 02, 2001, follow 1 or 2 as appropriate:

1. CPD impairment(s) met or medically equaled a listing:

CPD impairment(s) now meets or medically equals CPD listing? → Yes ▸ Disability continues*

↓

No

↓

CPD impairment(s) now functionally equals the listings? → Yes → Disability continues*

↓

No, proceed to step 3

2. CPD impairment (s) functionally equaled the listings:

CPD impairment(s) now functionally equals the listings? → Yes → Disability continues*

↓

No, proceed to step 3

Step 3 Currently disabled, considering all impairments?

Any severe impairment(s)? → No → Disability ceases

↓

No

↓

Any impairment(s) meets or medically equals a current listing? ▸ Yes ▸ Disability continues**

↓

No

↓

Any impairment(s) functionally equals the listings? → Yes → Disability continues**

↓

No → Disability ceases

*unless an exception applies- if a Group I exception applies, go to step 3, if a group II exception applies, disability ceases
**unless a group 2 exception applies, in which case disability ceases