# Procedural Standard 06-01

# August 6, 2012

TO: All Disability Reviewers and Physician Advisors

FR: A. E. Adams, Ph.D. Director, Disability Evaluation Services

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**RE: Development of Medical and Other Information in DTA-Originated Cases (Use of Decision Code 255)**

**Purpose:** This document describes the procedures for handling DTA-originated case approvals when the available medical and other relevant information is deemed to be insufficient to meet the requirements for a Supplemental Security Income (SSI) level disability determination for MassHealth. It is designed to assure that DTA only applicants receive a timely determination of disability and to avoid duplicative case processing expenditures.

**Background**: The Disability Evaluation Services (DES) consolidated review process simultaneously develops the medical information necessary to determine disability under three separate disability-based programs even if the individual has applied for only one of those programs. The offices/programs are the Office of Medicaid/MassHealth and the Department of Transitional Assistance (DTA)/Emergency Aid to the Elderly, Disabled and Children (EAEDC) and Transitional Aid to Families with Dependent Children (TAFDC). Title XVI Supplemental Security Income (SSI) federal rules are used to determine MassHealth eligibility and DTA program rules are defined in the Code of Massachusetts Regulations.

The consolidated review process prevents duplication of administrative costs in the development of medical evidence and evaluation of disability claims. Furthermore, consolidated review facilitates better customer service for MassHealth and DTA applicants through coordination of disability determination processes and benefits.

Because the medical, vocational and durational requirements for Department of Transitional Assistance (DTA) program approvals are generally less than those for MassHealth applications, there are instances when there is sufficient information to approve DTA originated claim(s) but additional information is required to make a MassHealth determination under SSI rules. As a result, additional development, documentation, and/or expert consultation are often needed on DTA originated cases solely to make a determination under the SSI requirements.

For example, Title XVI requires 12 month disability duration, while EAEDC and TAFDC require a shorter term, 60 and 30 days respectively. Due to the shorter duration requirement, a decision can appropriately be made for DTA cases with less comprehensive and/or longitudinal medical records.

In DTA approval situations when there is insufficient information to make a determination at the Title XVI level and there is not a MassHealth application, under some conditions development of additional medical information may be curtailed and the MassHealth decision is “not disabled.”

However, the Disability Reviewer (DR) is particularly careful to exercise clinical judgment in considering whether or not it is appropriate to pursue the additional information required to determine disability at the Title XVI level. If, in the judgment of the DR based on available information, there is a reasonable probability that further development would result in a Title XVI level approval, the DR pursues the necessary information required to complete a Title XVI level review.

In assessing whether there is a reasonable probability of approval, the DR is particularly cognizant of the presence of a prior application(s), especially with a prior approval (either DTA or SSI) based on the same claims as in the current application. The DR carefully considers the longitudinal history from treating sources to examine the reasonable probability of Title XVI level approval.

**Important:** This procedural standard does **NOT** apply to DTA denials or to concurrent MassHealth/DTA applications or MassHealth only applications. When there is a MassHealth application, the case must be fully developed for purposes of adjudication under SSI rules exploring all relevant treating sources, purchase of a CE(s) and full vocational assessment and documentation, as appropriate.

**Procedure:** For DTA-originated approvals, when additional information is required but unavailable to make a SSI level determination and in the professional judgment of the Disability Reviewer (DR), based on the available information, there is not a reasonable probability of approval at the Title XVI level if the information were obtained, further development is curtailed. In this situation, the denial basis code **“255-Not disabled at Title XVI level based on available information”** is used on the Disability Determination Tracking Form to close the case. Item 19 is checked “no” for SSI and the decision is coded “255”.

On cases with multiple alleged impairments, when the DTA approval is based on evidence of only one or some, but not all, of the impairments listed on the problem list, it is not necessary for the DR to consider severity and duration for the impairments that were not the basis for approval. In such an instance, the DR uses a sticker at that place on the review form with the language “DTA case-255. Further assessment of severity and/or duration at Step II is curtailed.”  
If development of the Title XVI case is curtailed at a later step in the disability determination process, the DR annotates the review form at that point.

DR’s may use the “255” procedure in appropriate case situations as guided by the Disability Determination Review Form for Adults as follows:

* At “Step IIIA, SSI Listing of Impairments” when a DTA approval is established but it cannot be determined if the applicant meets the Title XVI requirements and there is not a reasonable probability based on available information that further development would result in a Title XVI level approval.

* At “Step IV, SSI Vocational Review” when evidence for one or more impairments is insufficient and/or additional RFC assessment(s) is needed to make a Title XVI level disability determination or sufficient evidence has been received on all impairments and all RFCs have been obtained and there is not a reasonable probability that further development would result in a Title XVI level approval.

At this step, the DR must carefully exercise his/her medical and vocational expertise in estimating a Residual Functional Capacity (RFC) and in assessing its impact on the individual’s ability to work using the vocational rules as a guide. If the DR is uncertain regarding the sufficiency of evidence or the likely maximum RFC, he/she may request one or more applicable RFCs to determine if the evidence is sufficient for completion of the review at the Title XVI level. The case is coded “255” if the information is still insufficient to do an RFC or the completed RFC(s) does not support an approval at the Title XVI level. Documentation of the decision to curtail development or to complete the vocational review at this step is entered in the “Vocational Data” section of the adult disability review worksheet.

It is not appropriate to use code “255” when a client fails to keep a consultative examination appointment, instead use code “252” or when a client fails to cooperate, code “253”.

When the “255” code is used, reviewers document their rationale in DEScovery progress notes as well as on the adult disability review worksheet.

The Physician Advisor (PA) signing-off on cases before closure considers whether or not the decision to curtail development is appropriate. The PA also assures that the disability review date assigned to cases coded “255” does not exceed a maximum of 11 months.

**Summary:** The DES consolidated review is a simultaneous process for applications for MassHealth and both DTA disability-based programs (EAEDC and TAFDC). DES disability reviews include development of necessary medical and vocational information and expert evaluation of medical-vocational factors to determine eligibility under the particular rules that govern each of the three programs, even if there is only an application for one program. Consolidated review provides administrative efficiency in the disability determination process and facilitates coordinated service delivery to applicants.

The MassHealth disability definition and documentation requirements are generally the most difficult to satisfy so there are situations when there is sufficient information to approve a DTA applicant but additional information is needed to make a decision for MassHealth. In such instances, if the case is a DTA only originated case and there is not a reasonable probability based on the available information that additional development will result in an approval at the SSI level, the review process is curtailed and the “255” code is used for the MassHealth decision.

However, if there is a prior application(s), particularly prior DTA or SSI approvals, with the same allegation(s) as in the current claim, care must be taken to fully consider the available evidence including longitudinal records from prior claims to be sure that there is not a reasonable probability that additional development will result in an SSI level approval

If there is a reasonable probability of approval, treating source information CE(s) and/or RFC(s) maybe pursued, if necessary, to obtain sufficient information to make a Title XVI level disability determination.