State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

DIANA M. BONTÁ, R.N., Dr. P.H.
Director

July 3, 2002

GRAY DAVIS
Governor

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All Mental Health Directors
All County Health Executives
All CalWORKS Programs Managers

Letter No.: 02-40

PROCESSING DISABILITY EVALUATIONS UNDER SB 87

Ref.: All County Welfare Directors Letter (ACWDL) No. 01-36

The purpose of this ACWDL is to provide additional information regarding the disability portion of Senate Bill (SB) 87, as well as to clarify existing policy regarding disability evaluation procedures.

AID CODES

There are four new aid codes to be used for clients who have lost linkage to Medi-Cal, and who have indicated that they would like to have a disability evaluation completed. These aid codes are to be used **only** in situations where the Medi-Cal beneficiary has lost linkage, and a disability determination is being processed. These aid codes must not be used for any month in which there is eligibility under another aid code, or for a beneficiary who reports a disability more than 30 days after the effective date of discontinuance for loss of linkage. The aid codes are:

6J Full-scope benefits – no share of cost
6R Full-scope benefits – share of cost
5J Restricted benefits (unsatisfactory alien status) – no share of cost
5R Restricted benefits (unsatisfactory alien status) – share of cost

Medi-Cal Managed Care will continue to be mandatory for aid codes 6J and 6R in counties with County Organized Health Systems, and aid code 6J will be voluntary in Two Plan counties, Geographic Managed Care, Prepaid Health Plans, and fee-for -service Managed Care counties. All four aid codes are now ready for county use. All cases that were flagged until the new aid

Flex your POWER
Do your part to help California save energy. To learn more about saving energy, visit the following web site: www.consumerenergycenter.org/flex/index.html

codes were ready should now be changed to the appropriate new aid code effective the date that the change took place, but not prior to August 1, 2001.

Once the disability determination has been completed, the eligibility worker (EW) will take the appropriate action to change the aid code to the correct disability aid code, or send a ten-day notice of action (NOA) and terminate the case.

Example:

Mother and son receiving Medi-Cal under aid code 34.

The son turned 21 on January 10, 2002. A thorough review (using SB 87 requirements for an ex parte review, then a phone call, followed by an MC 355 **if necessary**) was completed prior to the month in which he turned 21. He was not found to have any other linkage, so he received a 10-day NOA and his Medi-Cal was discontinued effective January 31, 2002. The mother was not found to have other linkage either, but during the review process she informed the EW, in writing, that she has a disability. The EW began the disability evaluation process for the mother, and on February 1, 2002, she began to receive Medi-Cal under aid code 6J. When the EW receives the "Disability Determination and Transmittal" (MC 221), if it indicates that the mother meets the requirements for a disability determination, the EW will change the 6J aid code to the appropriate disability aid code effective February 2002. The worker will also complete a new budget effective that date using the appropriate aged, blind, and disabled (ABD) deductions. If, however, the MC 221 indicates that the mother was not found to be disabled, she will be discontinued at the end of the month in which the county can issue a ten-day NOA.

DISABILITY EVALUATIONS

SB 87 did not change the regulations for referring disability applications to the Social Security Administration or State Programs – Disability and Adult Programs Division (SP-DAPD). If there are questions about when to process a disability evaluation and when to refer the individual to SSA, please refer to the Medi-Cal Eligibility Procedures Manual, Section 22 C-1.

EWs are reminded that the disability evaluation should be processed any time an applicant/beneficiary informs the county that he/she has a disability. This is true whether the person with the disability is a child or an adult, and whether or not the individual is currently receiving Medi-Cal under a different linkage. Once the evaluation has been processed, if the individual is determined to be disabled, the county worker should evaluate the whole case situation to determine whether or not it would be more advantageous for the individual/family to receive their benefits through the appropriate ABD Program.

The "Disability Evaluation for Medi-Cal" (MC 223) and the Authorization for Release of Information (MC 220) can be completed by one of three methods, at the **beneficiary's** request:

1. MC 223 and ten (10) MC 220s can be mailed to the applicant/beneficiary to be completed, signed, and returned to the EW.

2. The applicant/beneficiary can go to the county welfare office and complete the MC 223 and MC 220s during an interview with the EW.

3. The county worker can complete the MC 223 in a telephone interview with applicant/beneficiary. The MC 223 and MC 220s can then be mailed to applicant/beneficiary to be signed, dated, and returned to the EW.

SUBSTANTIAL GAINFUL ACTIVITY (SGA)

Counties are reminded that there is now a program, the 250 Percent Working Disabled Program, that allows individuals to earn above SGA and still qualify for linkage through disability. Because of this, it is very important that counties not base a decision to process a disability determination for working individuals on SGA. When an applicant is working, all other factors should be reviewed and followed, but the earned income requirement cannot be used to deny a disability determination. The MC 221 must be flagged before being sent to SP-DAPD to alert the analysts to evaluate the applicant's disability based on the criteria for the 250 Percent Working Disabled Program.

CHILDREN

Since it may be in the best interest of the family/child to receive benefits under a disability linked program, it is very important that children be given the opportunity to have a disability determination processed. Therefore, even though the child may already be linked and receiving benefits, if the EW receives information indicating that the child is disabled, a disability packet must be processed immediately.

MC 223

The MC 223 is being revised and is being separated into two forms, one for adults (MC 223 A) and one for children (MC 223 C). The forms are targeted for release sometime in 2002. The new forms are intended to be more user-friendly, as well as to provide all the information that

SP-DAPD will need to make a disability determination. The new forms will also encourage the applicant/beneficiary to sign an MC 220 for each provider who will be requested to send medical records. Counties are reminded that applicants/beneficiaries are not to be required to sign blank MC 220s.

If you have any questions, please contact Ms. Betty Mosher of my staff at (916) 654-0630.

Sincerely

ORIGINAL SIGNED BY

Richard Brantingham
Acting Chief
Medi-Cal Eligibility Branch