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LOCAL COMMISSIONERS MEMORANDUM

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DEPARTMENT OF HEALTH
Office of Medicaid Management

TO: **Local District Commissioners**

SUBJECT: New Medicaid Disability Standards For Children Under Age 18

ATTACHMENTS: (All available on-line)

A. Children's Sequential Evaluation Flow Chart

B. Children's Continuing Disability Review Flow Chart

C. Childhood Disability Evaluation Form

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SUMMARY

This release advises social services districts of new criteria for the evaluation of childhood disability cases in the Supplemental Security Income (SSI) and Medicaid programs. These criteria replace those established subsequent to the Supreme Court ruling in Zebley v. Sullivan, as described in Administrative Directive 91 ADM-35, and as contained in the Medical Assistance Disability Manual.

On August 22, 1996, Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), was enacted. Section 211 of the PRWORA changed the definition of childhood disability for the SSI program. Prior to this change, childhood disability was defined in the Social Security Act as an impairment of "comparable severity" to that which would disable an adult. In 1990 the Zebley Supreme Court decision nullified the Social Security Administration's "listings only" approach to evaluating childhood disability, and led to the creation of the "individualized functional assessment" (IFA). The PRWORA states, in part, that "an individual under the age of 18 shall be considered disabled...if that individual has a medically determinable impairment which results in marked and severe functional limitations...". Along with this new definition, the Social Security Administration (SSA) was directed to eliminate the IFA, as well as references to "maladaptive behaviors" in the medical listings at 112.00C2 and 112.02B2c(2). SSA subsequently revised Federal SSI regulations to conform to the PRWORA.

Effective July 1, 1997, the Balanced Budget Act of 1997 provides Medicaid for children who were receiving SSI on August 22, 1996 and whose SSI was discontinued due to the change in disability criteria for children. These children must continue to meet the income and resource standards for SSI in order to be eligible for Medicaid under this provision. SSI-related children who were receiving only Medicaid (not SSI) on August 22, 1996 are not affected by this provision. Local Commissioners Memorandum 98 OMM LCM-002, "Medicaid for Children Who Lose SSI Due to Changes in Disability Criteria", was issued with a district-specific list of affected children and the actions to be taken.

PROGRAM IMPLICATIONS

Under the new statutory definition of disability, a child's impairment or combination of impairments must cause more serious impairment-related limitations than the prior definition and prior regulations required. To be found disabled, an individual under age 18 must now have "marked and severe functional limitations", which means that the child's impairment or combination of impairments must meet, medically equal, or functionally equal, the severity of a listed impairment. More specifically, where the IFA previously required either marked impairment in one functional area (formerly referred to as "domains" or "behaviors") and a moderate impairment in another, or generally a moderate impairment in three areas, **the new standard for functional equivalence is marked impairment in two functional areas, or extreme impairment in at least one functional area.**

In the new regulations, specific references to "maladaptive behavior" have been eliminated from listing 112.00C, which explains the severity criteria used to evaluate a mental impairment in most of the childhood mental disorder listings, and from 112.02B2c(2), which was a particular paragraph B criterion for persistent, serious maladaptive behaviors in children aged 3 to 18. Portions of the regulations and the medical listings that previously referred to children's impairments being of comparable severity to adult impairments, or to a child's ability to function in an age appropriate manner have been eliminated.

The PRWORA specifies that disability redeterminations for current recipients will be based on the new regulations, rather than the medical improvement review standard. The medical improvement review standard used in conducting a continuing disability review (CDR) and the CDR sequential evaluation process have also been revised.

A. IMPLEMENTATION INSTRUCTIONS

All State and county Medicaid Disability Review Teams must evaluate children's disability cases using the new criteria. The new criteria, which are explained and summarized in this release, apply to all disability determinations performed on and after the date of this release without regard to the Medicaid application date.

NOTE: Children who are determined disabled under the new disability criteria are entitled to have their financial eligibility determined using the SSI-related budgeting methodology. If the child is SSI-related and Medicaid eligible under another category, the choice of category must be offered; expanded eligibility for children under the poverty levels may also be more beneficial than the SSI-related category in some cases.

1. **Undercare Cases**

Some children who were previously determined disabled and who are currently eligible in the SSI-related category will need to have their disability re-evaluated at the next financial eligibility recertification. Cases that need to be reviewed again are those children who were previously approved based on an IFA or who met (or equalled) a mental impairment listing because they had maladaptive behavior.

The most recent DSS-639, "Disability Review Team Certificate" should be reviewed at recertification to determine if the case needs to be re-evaluated. Workers should look for specific references to listing 112.02B2c2 or language that indicates that maladaptive behavior was a factor in the determination. Common examples of maladaptive behavior are behaviors that are destructive to self, others or property, or aggressive behavior that results in difficulties at school or with law enforcement authorities. The following diagnoses are usually accompanied by

maladaptive behavior: personality disorder, conduct disorder, oppositional defiant disorder, attention deficit and hyperactivity disorder. Therefore, cases with any of these diagnoses as the basis for the approval should be re-reviewed. If the basis of the determination is unclear, the case should be re-evaluated. Cases that were previously approved based on an IFA or maladaptive behavior will need to be re-evaluated under the new criteria as specified herein, even if an earlier medical review set a later expiration date. When re-evaluating undercare cases, the new guidelines for evaluating new cases are to be used rather than the usual CDR process, which requires demonstration of medical improvement before terminating disability status.

2. **Notices/Forms**

Previously approved undercare cases which will now be denied disability because they do not meet the new criteria should have the following language included in the DSS-4141, "Notice of Medical Assistance Disability Decision":

> "Federal legislation changed the definition of disability for children. The law now states that a child must have a marked and severe impairment. This case was reviewed under the new law and regulations and does not meet the new definition of disability."

The notice should also include the regulatory basis for the disability denial which is found in section 10 of the DSS-639, as specified in 90 ADM-17.

The medical findings and other pertinent information summarizing the revised criteria and rationale for the case decision must be documented by the disability review team (DRP) on section 10 of the DSS-639. The reviewer should summarize the signs, symptoms, and laboratory findings pertinent to the child's impairment(s), including relevant test results and descriptions of the child's functioning on a daily basis. It should identify all functional limitations resulting from the impairment(s) and any other necessary information that helps to explain the decision. The rationale should also include a reference to the Federal regulations for undercare cases.

The forms for obtaining information about the child's function (Questionnaire of School Performance and Description of Child's Activities), as well as the Childhood Medical Disability Report, as contained in the Medical Assistance Disability Manual, may still be used to obtain information about the child.

B. Definitions

1. **Disability for Children**

A child is considered disabled if s/he has a medically determinable physical or mental impairment or combination of impairments that cause marked and severe functional limitations, and that can be expected to cause death or has lasted or can be expected to last for a continuous period of not less than 12 months.

2. **Marked and Severe Functional Limitations**

The term "marked and severe functional limitations", when used as a phrase, means the standard of disability in the Social Security Act for children, and is a level of severity that meets, medically equals, or functionally equals the severity of a listing in the Listing of Impairments.

The words "marked" and "severe" are also used as separate terms to describe measures of functional limitations and are each used independently in the listings. These words, when used separately, do not have the same meaning as when used in the context of the phrase "marked and severe functional limitations".

C. Sequential Evaluation for Children

The steps of the revised sequential evaluation process for children's cases require determining if the child:

- is engaged in substantial gainful activity;
- has a severe impairment(s); and,
- has an impairment(s) that meets, medically equals or functionally equals the severity of a listed impairment and meets the 12 month duration requirement.

The following sections describe these steps in more detail. Attachment A is a flow chart which graphically outlines this procedure.

1. **Substantial Gainful Activity**

Is the child engaging in substantial gainful activity (SGA)? (This step in unchanged).

No individual, including a child, may be found disabled if he or she is actually working and performing SGA. The same rules for determining whether an adult is engaging in substantial gainful

activity also apply to children. These rules provide for consideration of such things as subsidies, impairment-related work expenses, medical expenses, and other special considerations in determining the level of earnings, (please refer to the Medical Assistance Disability Manual for further explanation of SGA). 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 engaging in substantial gainful activity, the child will be determined not disabled. If not, the reviewer will proceed to the next step in the sequence.

2. **Severity of Impairment**

Does the child have a "severe" medically determinable impairment or combination of impairments?
(This step is unchanged).

If the child is found to have a slight abnormality or a combination of slight abnormalities that cause no more than minimal functional limitations, the child will be determined not disabled. If a child has an impairment or combination of impairments that cause more than a minimal functional limitation, the reviewer will go on to the next step in the process.

3. **Meeting, Medically Equaling or Functionally Equaling the Listings**

Does the child have an impairment(s) that meets a listing? If so, the child will be determined disabled. If not, does the child have an impairment or combination of impairments that is equivalent in severity to any impairment in the Listing of Impairments, either medically or functionally?

Note: To determine a child disabled at the "meets or equals" step, the 12-month duration requirement must also be met.

a. Meeting a Listing

While all possible impairments or combinations of impairments are not described in the listings, the listings are a standard and a set of examples against which every impairment or combination of impairments can be judged. If an impairment meets a listing, the child will be determined disabled. If the impairment does not meet a listing, the reviewer will determine whether medical equivalence is present. (This step is unchanged).

There have been a number of changes in the listings to eliminate references to comparable severity. Comparable severity language has been removed in 103.00A (Respiratory System), 104.00A (Cardiovascular System), and 114.00D6 (Immune System). The most substantive change, and the only one which will be fully quoted here, is the revision to 112.02B2c, (part of the so-called "B criteria", which previously contained maladaptive behavior as a criterion), which no longer contains subsections. This now reads as follows:

> 112.02B2c. Marked impairment in age-appropriate personal functioning, documented by history and medical findings (including consideration of information from parents or other individuals who have knowledge of the child, when such information is needed and available), and including, if necessary, appropriate standardized tests; or

b. Medical Equivalence to the Listings
(This step is unchanged).

(1) **With a listed impairment.** Medical equivalence is established when the child has an impairment described in the Listing of Impairments, but:

(a) one or more of the medical findings specified in the particular listing is not exhibited, or,

(b) all of the medical findings are exhibited, but one or more of the findings is not as severe as specified in the listing; but

(c) there are other medical findings related to the impairment that are at least of equal medical significance.

(2) **With an unlisted impairment or combination of impairments.** Medical equivalence is established when the child has an impairment that is not described in the Listing of Impairments, or a combination of impairments, no one of which meets or is medically equivalent to a listing, but the medical findings related to the impairment(s) are at least of equal medical significance to those of a listed impairment.

If the impairment or combination of impairments meets or medically equals the severity of a listed impairment, and also meets the duration requirement, it will be found to cause marked and severe limitations, and the child will be determined disabled.

If the impairment or combination of impairments does not meet or medically equal the severity of a listed impairment, the reviewer will need to determine whether it functionally equals the severity of a listed impairment.

4. **Functional Equivalence to the Listings**

Does the child have functional limitations that are the same as the disabling functional limits caused by a listed impairment?

(The new Federal regulations, provide more guidance on how to make the determination of functional equivalence.)

If medical equivalence cannot be established, the child must then be evaluated for functional equivalence, i.e., whether the child's functional limitation(s) which results from the impairment(s) is functionally equivalent in severity to any listed impairment.

If the functional limitation(s) resulting from the impairment(s) is the same as the disabling functional limitation(s) of a listed impairment, the child's impairment(s) will be found functionally equivalent to the listed impairment. The child's impairment does not need to be medically related to the listed impairment. The primary focus is on whether the functional limitation(s) is disabling, as long as there is a direct, medically determinable cause for these consequences.

If the impairment or combination of impairments, functionally equals the severity of a listed impairment, and also meets the duration requirement, it will be found to cause marked and severe limitations, and the child will be determined disabled.

If the impairment or combination of impairments does not functionally equal the severity of a listed impairment, it will be found not to cause marked and severe limitations, the child will be determined not disabled, and the sequential evaluation process ends.

a. **Methods of Assessing Functional Equivalence**

There are four methods which may be used to determine whether an impairment is functionally equivalent in severity to a listing. There is no set order in which these methods must be considered, and they need not all be considered if an impairment is found to be

functionally equivalent to a listing. However, all of these methods must be considered before a decision is made that an impairment is not functionally equivalent in severity to a listing.

(1) Limitation of Specific Functions

An impairment may be found to be functionally equivalent to the severity of a listing because of extreme limitation of one specific function, such as walking or talking (The term "extreme limitation" is discussed in section 4.b.1 below.) With respect to listings which require limitation of more than one specific function, such as walking and talking, each limitation in itself is not enough to show disability, but the combination of limitations establishes the presence of marked and severe functional limitations. If a child has an impairment or a combination of impairments which produce functional limitations that are the same as the disabling functional limitations of a listed impairment, the impairment(s) will be found to be functionally equivalent to the listing.

(2) Episodic Impairments

If the child has a chronic impairment that is characterized by frequent episodes of illness or attacks, or by periods of exacerbation and remission, the child's functional limitations may vary and the other methods described in this subsection may not be appropriate. In such a case, it may be more appropriate to compare the child's functional limitations to those in any listing for a chronic impairment with similar episodic criteria to determine whether the impairment(s) has such a serious impact on functioning over time that it is functionally equivalent in severity to one of those listings. Limitations that are characteristic of episodic impairments are not necessarily related to a single, specific function. Episodes of disabling functional limitations may occur with specified frequency despite treatment. If the child's episodic impairment(s) produces functional limitations that are the same as the disabling functional limitations of a listed impairment with similar episodic criteria, the child will be found disabled even though s/he may be able to function adequately between episodes.

(3) Limitation Related to Treatment or Medication Effects

Some impairments require treatment over a long period of time (i.e., at least a year) and the treatment itself (e.g., multiple surgeries) causes marked and severe functional limitations. Marked and severe functional limitations may also result from the combined effects of limitations caused by ongoing treatment (including side effects of medication) and limitations caused by an impairment(s). If treatment produces functional limitations that are the same as the disabling functional limitations of a listed impairment, the case is considered to be functionally equivalent to the listing.

(4) Broad Areas of Development or Functioning

In some cases, it may be more appropriate to assess the effects of an impairment(s) on broad areas of development or functioning, such as social functioning, motor functioning, or personal functioning, rather than looking at specific functions. If a child has an extreme limitation in one such area or marked limitation in two such areas, the impairment(s) will be found to be functionally equivalent to the severity of the listings.

b. **Assessing Broad Areas of Development or Functioning**

When determining functional equivalence based on broad areas of development or functioning, the functional effects of the impairment(s) will be assessed in several areas of development or functioning to determine if the child's functional limitations are equivalent in severity to the disabling functional limitations of listing 112.12 or listing 112.02. These functional areas are described below.

(1) Definition of "marked" and "extreme" limitation.

"Marked" limitation means:

(a) when standardized tests are used as the measure of functional abilities, a valid score that is two standard deviations or more below the norm for the test (but less than three standard deviations); or

(b) for children from birth to age three, functioning at more than one-half but not more than two-thirds of chronological age; or

(c) for children from age three to attainment of age 18, "marked" means "more than moderate" but "less than extreme". Marked limitation may arise when several activities or functions are limited or even when only one function is limited.

"Extreme" limitation means:

(a) when standardized tests are used as the measure of functional abilities, a valid score that is three standard deviations or more below the norm for the test; or

(b) for children from birth to attainment of age three, functioning at one-half of chronological age or less; or

(c) for children from birth to age 18, no meaningful function in a given area. There may be extreme limitation when several activities or functions are limited or even when only one is limited.

(2) Areas of Development or Functioning.

(These areas were previously described as domains and behaviors. The new Federal regulations address the same general areas of function to be evaluated; however, there is now more descriptive language and reordering of some of these categories).

Please note that, in the absence of references to maladaptive behavior, the description of social function has been revised to include behavioral impairments that may have previously been considered under "maladaptive behavior". Additionally, some self-injurious behaviors may be most appropriately considered under the area of personal function (formerly designated personal/behavioral function).

The following are the areas of development or functioning that may be addressed in a finding of functional equivalence.

(a) Cognition/communication: The ability or inability to learn, understand, and solve problems through

intuition, perception, verbal and nonverbal reasoning, and the application of acquired knowledge; the ability to recall and retain information, images, events, and procedures during the process of thinking. The ability or inability to comprehend and produce language (e.g., vocabulary and grammar) in order to communicate (e.g. to respond, as in answering questions, following directions, acknowledging the comments of others; to request, as in demanding action, meeting needs, seeking information, requesting clarification, initiating interaction; to comment, as in sharing information, expressing feelings and ideas, providing explanations, describing events, maintaining interaction, using hearing that is adequate for conversation, and using speech (articulation, voice, and fluency) that is intelligible.)

(b) Motor: The ability or inability to use gross and fine motor skills to relate to the physical environment and serve one's physical purposes. It involves general mobility, balance, and the ability to perform age-appropriate physical activities involved in play, physical education, sports, and physically related daily activities other than self care, (see Personal area).

(c) Social: The ability or inability to form and maintain relationships with other individuals and with groups. Ability is manifested in responding to and initiating social interaction with others, sustaining relationships, and participating in group activities. It involves cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity appropriate to a child's age. Ability is also manifested in the absence of inappropriate, externalized actions (e.g., running away, physical aggression, but not self-injurious actions, which are evaluated in the personal area of function), and the absence of inappropriate internalized actions (e.g., social isolation, avoidance of interpersonal activities, mutism). Social functioning in play, school, and work situations may involve interactions with adults, including responding appropriately to persons in authority (e.g., teachers, coaches, employers) or cooperative behaviors involving other children.

(d) Responsiveness to stimuli (birth to age 1 only): The ability or inability to respond appropriately to stimulation (visual, auditory, tactile, vestibular, proprioceptive).

(e) Personal (age 3 to 18 only): The ability or inability to help oneself and to cooperate with others in taking care of personal needs, health, and safety (e.g., feeding, dressing, toileting, bathing, maintaining personal hygiene, proper nutrition, sleep, health habits, adhering to therapy or medication regimens, following safety precautions).

(f) Concentration, persistence, or pace: The ability or inability to attend to, and sustain concentration on, an activity or task, such as playing, reading, or practicing a sport, and the ability to perform the activity or complete the task at a reasonable pace. (please note that this section was previously titled "Concentration, Persistence, and Pace".)

(3) Description of Areas of Development or Functioning for Specific Age Groups

(The new regulations expand many of the descriptions of function by age category).

(a) **Newborns and young infants** (birth to attainment of age one)

Children in this age group are evaluated in four areas of development:

(i) Cognitive/communicative development: the ability or inability to show interest in, and actively seek interaction with, the environment, first randomly, then through trial and error, and finally, with deliberate and purposeful intent. This area also includes the ability or inability to first recognize, then attach meaning to, routine situations and events, gradually to everyday sounds, and eventually to familiar words. This area also includes the ability or inability to vocalize, both imitatively and spontaneously, using vowels and later consonants, first in isolation, and then in increasingly longer babbling strings.

(ii) Motor development: the ability or inability to explore and manipulate the environment by moving the body and using the hands; e.g., by increasingly controlling position and movement of the head, sitting with support, creeping or crawling, pulling to standing position, walking with hand held, standing alone briefly, waving small rattle, reaching for or grasping objects, transferring toys, picking up small objects, and attempting to scribble.

(iii) Social development: the ability or inability to form and maintain intimate relationships and to respond to, and eventually initiate reciprocal interactions with, primary caregivers (e.g., through games such as pat-a-cake, peek-a-boo, so big). This area also includes the ability or inability to begin to regulate the behavior of others through intentional behavior (e.g., gestures, vocalizations). Also included is the ability or inability to recognize and produce a variety of emotional cues (e.g., facial expressions, vocal tone changes).

(iv) Responsiveness to stimuli: the ability or inability to form patterns of self-regulation, i.e., to recognize internal cues (e.g., hunger, pain), to organize external experiences (e.g., light, sound, temperature, movement), and to regulate reactions (e.g., brightening in response to sights and sounds, enjoying being touched, stroked, or held).

NOTE: Please see page 21 for revised guidelines for evaluating premature and low birthweight infants.

(b) **Older infants and toddlers** (age one to attainment of age three)

Children in this age group are evaluated in terms of three areas of development:

(i) Cognitive/communicative development: the ability or inability to understand by responding to increasingly complex requests, instructions, and questions; to refer to oneself and the surroundings by pointing and eventually by naming; to form concepts and to solve simple problems through purposeful experimentation (e.g.,

disassembling toys), imitation (immediate and delayed), and constructive play (e.g., putting things in and out of containers, building with blocks, exploring spaces); to demonstrate knowledge of objects, actions, and situations previously encountered through pretend play activities; to spontaneously communicate wishes or needs by using gestures, an increasing number of intelligible words, and eventually grammatically correct simple sentences and questions with increasingly rich and broad vocabulary.

(ii) Motor development: the ability or inability to move in the environment using the body with steadily increasing dexterity and independence from support from others, and the increasing ability to manipulate small objects and to use the hands to do, or to get, something that is wanted or needed.

(iii) Social development: the ability or inability to exhibit normal dependence on, and intimacy with, primary caregivers, as well as increasing independence from them; to initiate and respond to a variety of emotional cues; to regulate and organize emotions and behaviors; to be interested in initiating and maintaining interactions with others, first during brief yet frequent encounters, and gradually increasing to longer, sustained ones. Also includes the ability or inability to show interest in, initially watch, then play alongside, and eventually interact with similarly aged peers.

(c) **Preschool children** (age three to attainment of age six)

Children in this age group are evaluated in terms of five areas of development:

(i) Cognitive/communicative development: the ability or inability to learn, understand, and solve problems through intuition, perception, verbal and nonverbal reasoning, and the application of acquired knowledge; to retain and recall images, information, events, and procedures during the process of thinking (as in the development of readiness skills for formal learning, such as learning letters, shapes, and colors), and skills for daily living (e.g., putting toys in proper places). Also includes the ability or inability

to communicate by expressing needs, feelings, and preferences; by telling, requesting, predicting, and relating information; by describing actions and functions; by providing explanations; by following and giving directions; and by engaging in conversation in a spontaneous, interactive, and increasingly intelligible manner, using increasingly complex vocabulary and grammar.

(ii) Motor development: the ability or inability to move and use the arms and legs in increasingly more intricate and coordinated activity, and to use the hands with increasing coordination to manipulate small objects during play (e.g., drawing, using building blocks, constructing puzzles), and physically related daily activities other than self care (see Personal area).

(iii) Social development: the ability or inability to initiate social exchanges, to organize and regulate emotions and behaviors, and to respond to the social environment through appropriate and increasingly complex interactions, such as showing affection, sharing, and helping, as well as to relate to caregivers with increasing independence, to choose friends, and to play cooperatively with other children, one at a time or in a group.

(iv) Personal development: the ability or inability to help oneself and to cooperate with others in taking care of personal needs, health and safety (e.g., bathing, dressing, maintaining sleep habits, crossing the street with an adult).

(v) Concentration, persistence, or pace: the ability or inability to engage in an activity for a period of time at a reasonable pace (e.g., playing a simple board game).

(d) **School age children** (age 6 to attainment of age 12)

Children in this age group are evaluated in terms of five areas of functioning:

(i) Cognitive/communicative functioning: the ability or inability to learn, understand, and solve problems through intuition, perception, verbal and nonverbal reasoning, and the application of acquired knowledge; the ability to retain and

recall information, images, events, and procedures during the process of thinking, as in formal learning situations (e.g., reading, class discussions), and in daily living (e.g., telling time, making change). Also includes the ability or inability to comprehend and produce language (e.g., vocabulary, grammar), in order to communicate in social conversation (e.g., to express feelings, meet needs, seek information, describe events, tell stories), and in learning situations (e.g., to exchange information and ideas with peers and family or with groups such as school classes) in a spontaneous, interactive, sustained, and intelligible manner, using increasingly complex vocabulary and grammar.

(ii) Motor function: the ability or inability to use fine and gross motor skills in order to engage in the physical activities involved in normal mobility, school work, play, physical education, sports, and other physically related daily activities other than self care (see Personal area).

(iii) Social function: the ability or inability to play alone, with another child, and in a group; to initiate and develop friendships; to respond to social environments through appropriate and increasingly complex interpersonal behaviors, such as empathizing with others and tolerating differences, and to relate appropriately to individuals and in group situations (e.g., siblings, parents or caregivers, peers, teachers, school classes, neighborhood groups).

(iv) Personal function: the ability or inability to help oneself and to cooperate with others in taking care of personal needs, health, and safety (e.g., eating, dressing, maintaining personal hygiene, following safety precautions).

(v) Concentration, persistence, or pace: the ability or inability to engage in an activity, and to sustain the activity for a period of time and at a reasonable pace.

(e) **Adolescents** (age 12 to attainment of age 18)

Children in this age group are evaluated in terms of five areas of function:

(i) Cognitive/communicative function: the ability or inability to learn, understand, and solve problems through intuition, perception, verbal and nonverbal reasoning, and the application of acquired knowledge; to retain and recall information, images, events and procedures during the process of thinking, as in formal learning situations (e.g., composition, classroom discussion), and in daily living (e.g., using the post office, using public transportation). Includes the ability or inability to comprehend and produce language (e.g., vocabulary, grammar), in order to communicate in conversation (e.g., to express feelings, meet needs, seek information, describe events, tell stories), and in learning situations (e.g., to obtain and convey information and ideas) both spontaneously and interactively, in all communication environments (e.g., home, classroom, game fields, extra-curricular activities, job), and with all communication partners (e.g., parents, siblings, peers, school classes, teachers, employers).

(ii) Motor function: the ability or inability to use fine and gross motor skills in order to engage in the physical activities involved in normal mobility, school work, play, physical education, sports, and other physically related daily activities other than self-care (see Personal area).

(iii) Social function: the ability or inability to initiate and develop friendships, to relate appropriately to individual peers and adults and to peer and adult groups, and to reconcile conflicts with peers, family members, or other adults outside the family.

(iv) Personal function: the ability or inability to help oneself in taking care of personal needs, health, and safety (e.g., dressing, bathing, doing laundry, adhering to medication or therapy regimens).

(v) Concentration, persistence, or pace: the ability or inability to engage in an activity, and to sustain the activity for a period of time and at a reasonable pace.

c. Examples of Impairments that are Functionally Equivalent in Severity to a Listed Impairment:

(These examples are similar to those in the previous regulations, however, there are some modifications).

The following are examples of impairments and limitations that are functionally equivalent to the listings. Findings of equivalence based on the disabling functional limitations of a child's impairment(s) are not limited to these examples, because these examples do not describe all possible effects of impairments that might be found functionally equivalent in severity to a listed impairment. As with any disabling impairment, the duration requirement must be met.

(1) Documented need for major organ transplant (e.g., liver). Such cases of equivalence may be referenced to 106.02D (Renal Transplant) or 104.09 (Cardiac Transplantation), though there may be cases in which other listings would be more appropriate.

(2) Any condition that is disabling at the time of onset, requiring a series of staged surgical procedures within 12 months after onset as a life-saving measure or for salvage or restoration of function, and such major function is not restored or is not expected to be restored within 12 months after onset of the condition. Cases of equivalence may be referenced to the adult Listing 1.13, Soft Tissue Injuries of an Upper or Lower Extremity, though there may be cases in which other listings would be more appropriate.

(3) Frequent need for a life sustaining device (e.g., central venous alimentation catheter), at home or elsewhere. (For some medical conditions, this may be equivalent to Listing 103.02C, Chronic Pulmonary Insufficiency.)

(4) Ambulation possible only with obligatory bilateral upper limb assistance. (For some medical conditions, this may be equivalent to Listing 101.03B Deficit of Musculoskeletal Function.)

(5) Any physical impairment(s) or combination of physical and mental impairments causing marked restriction of age-appropriate personal functioning and marked restriction in motor functioning.

(6) 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. (For some medical conditions, this may be equivalent to the adult Listing 12.06C, Anxiety Related Disorders.)

(7) Requirement for 24 hour a day supervision for medical (including psychological) reasons. (For some medical conditions, this may be equivalent to listing 112.05B, Mental Retardation.)

(8) Infants weighing less than 1200 grams at birth, until attainment of one year of age. (Generally this is equivalent to Listing 100.02, Growth Impairment.)

(9) Infants weighing at least 1200 but less than 2000 grams at birth, and who are small for gestational age, until attainment of one year of age. (Small for gestational age means a birth weight that is at or more than 2 standard deviations below the mean or that is below the third growth percentile for the gestational age of the infant.) Generally, this is equivalent to Listing 100.02, Growth Impairment.

(10) In an infant who has not attained age one year, any limitations caused by a physical impairment or a combination of physical and mental impairments that causes the same functional limitations in listing 112.12, Developmental and Emotional Disorders of Newborn and Younger Infants (Birth to Age One).

(11) 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 one year of age. Cases of equivalence should be referenced to a listing for the appropriate body system; for example, Listing 104.06H, Congenital Heart Disease.

(12) Gastrostomy in a child who has not attained age three. Cases of equivalence may be referenced to Listing 103.02D, Tracheostomy, though there may be cases in which other listings would be more appropriate.

If the child's impairment is functionally equivalent in severity to a listed impairment, and it meets the duration requirement, the child will be determined disabled.

If the child's impairment is not functionally equivalent in severity to a listed impairment, or the duration requirement is not met, the child will be determined not disabled.

d. Terms Used to Describe Functioning

Terms used to describe functioning are as follows. Definitions of these terms can be found in the Medical Assistance Disability Manual.

(1) **Age-appropriate activities.**

(2) **Developmental milestones.**

The regulations lowered the ages for considering developmental milestones and specifies that ordinarily, failure to achieve developmental milestones are the most important indicators of functional limitations in children from birth until age 3 although they may be used to evaluate older children, especially pre-school children. (Previously this referred to children from birth until age 6 and school age children.)

(3) **Activities of daily living.**

The regulations change ages for considering activities of daily living to read as follows:
"Ordinarily, activities of daily living are the most important indicators of functional limitations in children age 3 to 16 although they may be used to evaluate children younger than age 3." (Previously this referred to children age 6 to 18 and pre-school children).

Please refer to the Medical Assistance Disability Manual for a discussion of the impact of an impairment(s) on a child's ability to grow and develop.

e. Other Factors to be Considered

When an assessment of a child's function is done, all factors that are relevant to the evaluation of the effects of the child's impairment(s) in regard to functioning will be considered. Therefore, when assessing the effect of the child's impairment(s) on functioning, all evidence will be considered from both medical and nonmedical sources. Some of the factors to be considered include but are not limited to the following:

(1) **Chronic illness.**

The regulations added the following new sentence to the beginning of this section:

> "If the child has a chronic impairment that is characterized by episodes of exacerbation, (worsening), or remissions (improvement), consider the frequency and severity of exacerbation and periods of remission as factors in determining whether the child has a severe impairment(s) and, if so, whether it meets or equals in severity any listing, and is therefore, disabling."

(2) **Effects of medication.**

(3) **Effects of structured or highly supportive settings.**

(4) **Adaptations.**

(5) **Multidisciplinary therapy.**

(6) **School attendance.**

(7) **Treatment and intervention, in general.**

The regulations added the following as the first sentence to this section:

> "Treatment or intervention may prevent, eliminate, or reduce functional limitations; if such limitations were disabling in the absence of treatment or intervention, treatment or intervention may eliminate them or reduce them so that they are not disabling."

For detailed discussion of each of these factors, please refer to the Medical Assistance Disability Manual.

f. Childhood Disability Evaluation Form

The Childhood Disability Evaluation Form (CDEF), Attachment C, is a new form that provides reviewers with a means of documenting the evaluation process in children's cases. It helps to ensure thorough consideration of a child's impairment(s) through the functional equivalence process, and helps subsequent reviewers understand the basis for the disability determination.

The form must be completed for every child's case and must be signed by the medical consultant, (review team physician or psychologist) and the reviewer. This form should be reproduced locally.

Only section I must be completed when a child's case is denied because the impairment is not severe or does not meet the duration requirement, or when the case is approved because the impairment meets or medically equals the severity of a listing.

The other sections must be completed in all other cases to determine whether a child's impairment(s) is functionally equivalent in severity to a listed impairment.

The DSS-639 should reflect the reasons for the decision indicated on the CDEF.

g. Continuing Disability Review (CDR)

1. **General**

All disability cases with an expiration date require a continuing disability review prior to that date to determine if the child continues to be disabled.

This section of the rules has been revised significantly. Since there is no longer an IFA, children who were previously determined disabled on this basis, or on the basis of meeting or equaling a listing utilizing the maladaptive behavior criterion, must have a redetermination performed, based on the new rules, rather than as a CDR. See the implementation instructions at the beginning of this document for undercare cases.

For children who have attained the age of 18, the rules for determining initial eligibility for adults will be used, rather than the CDR process.

The sequential review process for CDRs has been revised, as described below. Attachment B is a flow chart illustrating the revised process.

As the determination of disability for children is no longer tied to the adult definition of disability, the step of assessing medical improvement related to the ability to work has been eliminated. A statement has also been added to the definition of medical improvement which allows that minor improvements which would not change the decision should be disregarded.

Continuing disability review determinations which are approved based on lack of medical improvement as described below should continue to refer to 20 CFR 416.994a as a regulatory basis on the DSS-639, "Disability Review Team Certificate".

2. **CDR Process**

The steps of the sequential evaluation process for children's continuing disability review cases include determining if:

- there has been medical improvement.
- the child continues to meet or equal the severity of the listing which the child's condition met or equalled previously.
- the child is currently disabled.

a. Medical Improvement

Has there been medical improvement in the child's condition?

(1) **General.** 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 he or she was disabled or continued to be disabled. 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). Although the decrease in severity may be of any quantity or degree, 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, should be disregarded.

(2) **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.

(3) **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 remissions, the reviewer should be careful to consider the longitudinal history of the impairment, including the occurrence of prior remissions and prospects for future worsenings, when deciding whether there has been medical improvement. Improvements that are only temporary will not warrant a finding of medical improvement.

A determination of medical improvement does not necessarily mean that the reviewer will find that the child's disability has ended. If medical improvement is found to have occurred, the reviewer will proceed to the next step. If the reviewer determines that medical improvement has not occurred, the child will continue to be found disabled unless an exception applies. (Please refer to the Medical Assistance Disability Manual for definition/discussion of exceptions.) If a group I exception applies, the reviewer will proceed to the next step. If a group II exception applies, the reviewer will determine that disability has ended. If no exception applies, the child will continue to be found disabled.

b. Meeting or Equaling the Listing Previously Met

Does the child's impairment(s) still meet or equal the severity of the listed impairment that it met or equalled before?

If there has been medical improvement, the reviewer will consider whether the impairment(s) that was considered at the time of the most recent favorable decision still meets or equals the severity of the listed impairment that was met or equalled at that time. In making this decision, the reviewer will consider the current severity of the impairment(s) present and documented at the time of the most recent favorable decision, and the same listing section used to make that determination or decision as it was written at that time, even if it has since been revised or removed from the Listing of Impairments. If the impairment(s) still meets or equals the severity of that listing, and no exception applies, disability will be found to continue. If the impairment no longer meets or equals the severity of that listed impairment, proceed to the next step.

c. Currently Disabled

Is the child currently disabled?

If there has been medical improvement, and the impairment(s) no longer meets or equals the severity of the listing that was previously met or equalled, the reviewer will consider the second and third steps of the sequential evaluation for initial determinations:

(1) Does the child have a severe impairment or combination of impairments?

If the child is determined to no longer have a severe impairment, the child will be determined not disabled. If it is determined that there continues to be a severe impairment(s), the reviewer will proceed to the next step.

(2) Does the child's impairment(s) meet or medically equal the severity of any listed impairment?

If it is determined that the impairment(s) meets or medically equals the severity of a listed impairment, disability will be continued. If not, the reviewer will proceed to the next step.

(3) Does the child's impairment(s) functionally equal the severity of any listed impairment?

If it is determined that the impairment(s) functionally equals (as described in this document) the severity of a listed impairment, disability will be continued. If not, the child will be determined "not disabled" and the process ends.

5. **Evaluating premature and low birth weight infants.** Chronological age, (i.e., a child's age based on birth date) is generally used when deciding whether, and the extent to which, a physical or mental impairment(s) causes functional limitations. However, if the child was born prematurely, he or she may be considered to be younger than the actual 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 premature.

A corrected chronological age will be applied in the following situations:

(a) 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 two.

(b) When evaluating an impairment of linear growth, such as under the growth impairment listings in 100.00, until the child is 12 months old. In this situation, the reviewer will refer to neonatal growth charts which have been developed to evaluate growth in premature infants.

A corrected chronological age will be computed as follows:

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

(b) If the child is over the age of one, has a developmental delay, and prematurity is still a relevant factor in the child's case (generally, no later than about chronological age two), the reviewer will decide whether to correct chronological age. This decision will be based on the reviewer's judgement and all the facts of 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. The reviewer should not correct the child's chronological age if it can be determined from the evidence that developmental delay is the result of a medically determinable impairment(s), and is not attributable to the child's prematurity.

Notwithstanding the provisions in this section, the reviewer will not compute a corrected chronological age if the medical evidence shows that the treating or other medical source has already taken prematurity into consideration in the assessment of the child's development. Also, a corrected chronological age will not be computed when the child is found disabled using the examples of functional equivalence based on low birth weight.

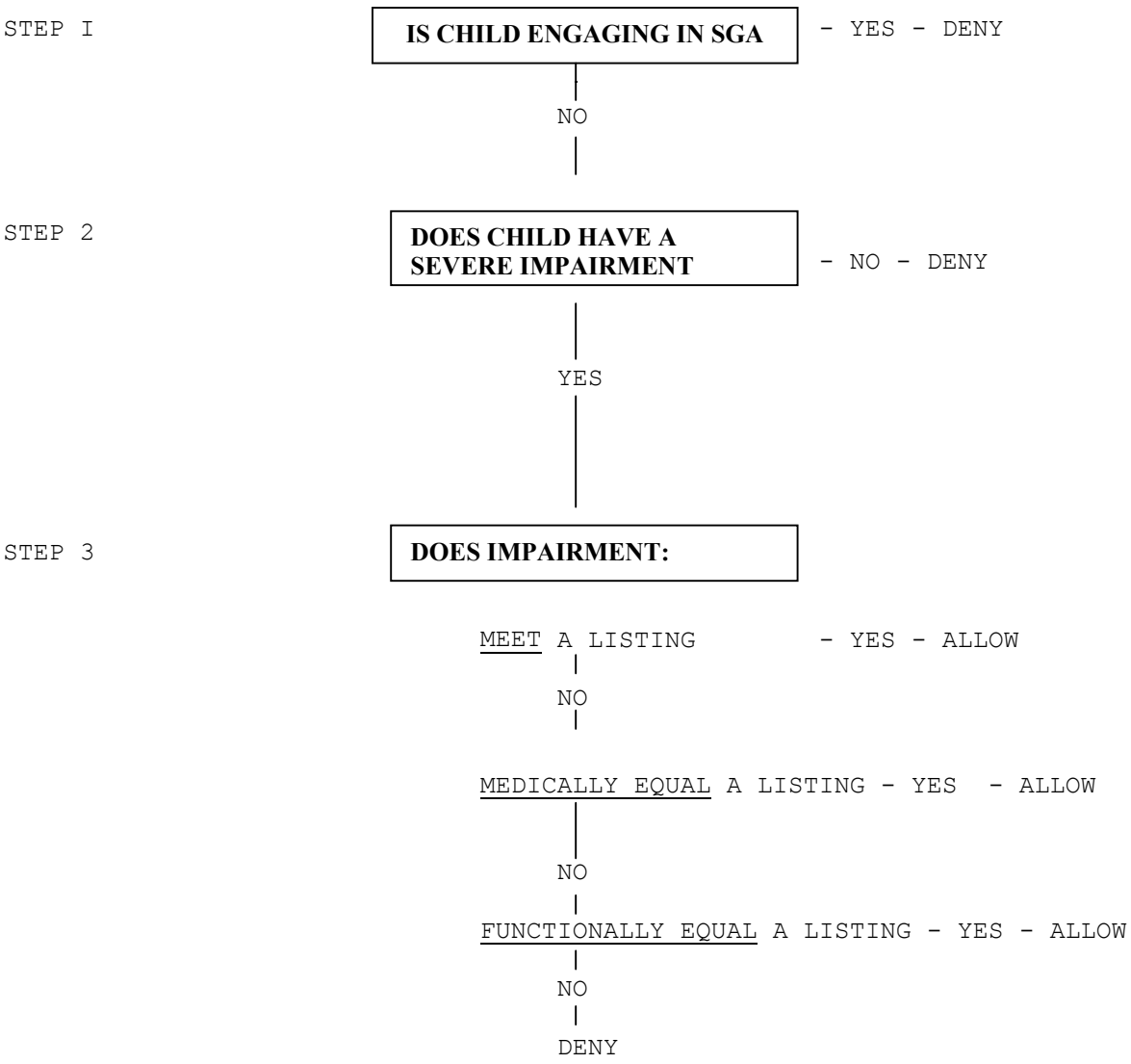
The changes described in this LCM will be issued in the next update to the Medical Assistance Disability Manual.

Please contact your Medicaid Disability Review Team representative if you have questions about the contents of this memorandum.

Ann Clemency Kohler, Deputy Commissioner
Office of Medicaid Management

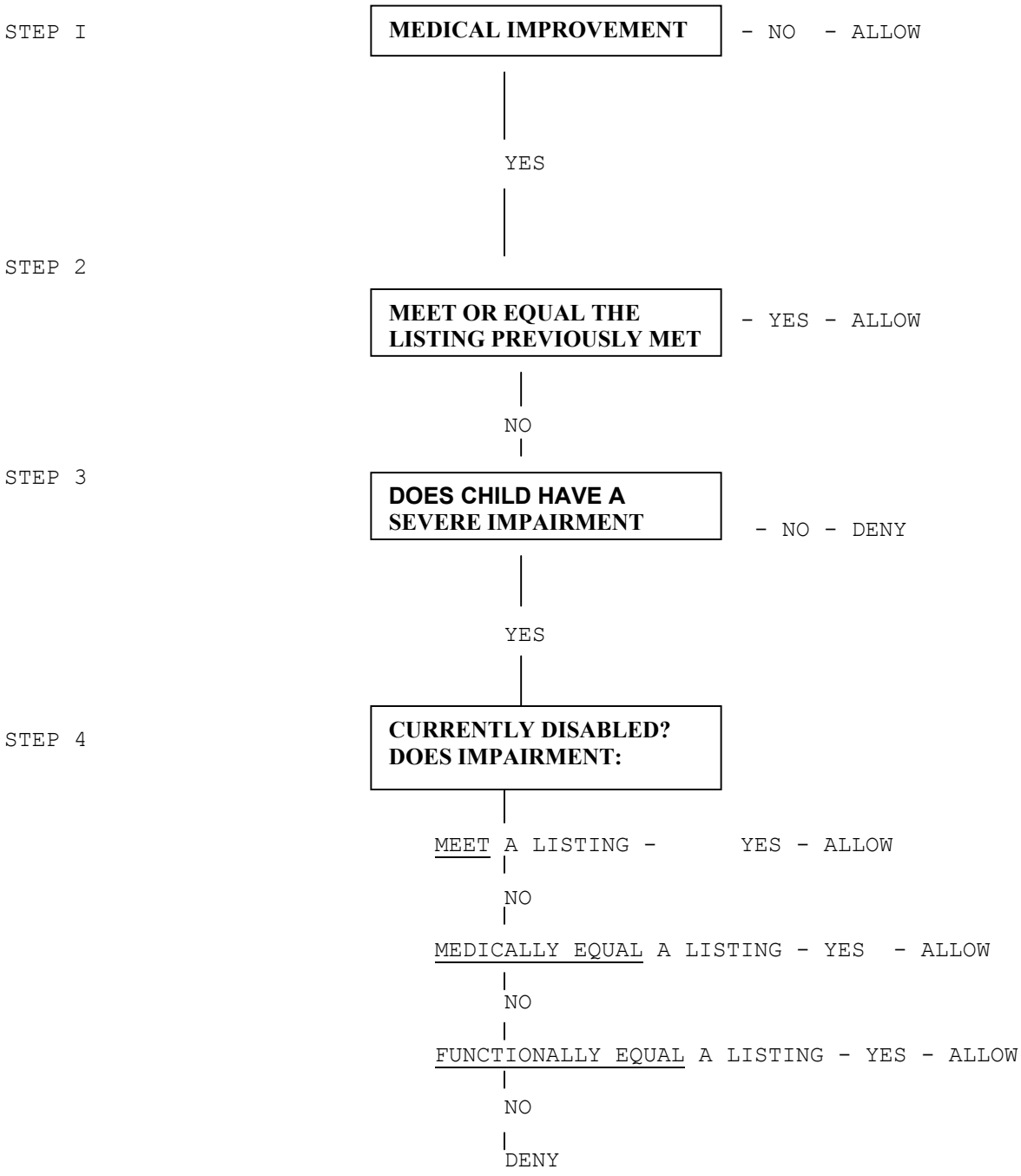
ATTACHMENT A

SEQUENTIAL EVALUATION FLOW CHART
CHILDREN



ATTACHMENT B

CONTINUING DISABILITY REVIEW (CDR)
CHILDREN



ATTACHMENT C

CHILDHOOD DISABILITY EVALUATION FORM
MEDICAID PROGRAM

Name	Case Number	Date of Birth

Agency

_____ New Case _____Continuing Disability Review (CDR)

Reviewer Signature	Date of Review

Physician Signature

I. **MEDICAL SUMMARY**

List all established physical and mental impairments and associated symptoms: ("Impairment(s)" here and throughout this form means a medically determinable physical or mental impairment or a combination of impairments.)

B. Medical Disposition(s) - Complete only after completion of any other necessary sections:

1. ___ No Medically Determinable Impairment

2. ___ Impairment(s) Not Severe

3. ___ Meets Listing _____(Cite Listing and subsection).

4. ___ Medically Equals Listing _____ (Cite Listing and subsection).

5. ___ Functionally Equals Listing _____ (Cite Listing and subsection).

6. ___ Impairment(s) Severe, But Does Not Meet, Medically Equal, or Functionally Equal the Severity of a Listing.

7. ___ Impairment(s) Is or Was of Listing-Level Severity, But Is Not Expected To Be, or Was Not, of Listing-Level Severity for 12 Months.

8. ___ Other (specify) _____.

II. **FUNCTIONAL EQUIVALENCE**

Consider functional equivalence in every childhood disability case in which the impairment(s) is severe but does not meet or medically equal the severity of any listed impairment. Compare the child's functional limitations with the disabling functional limitations of any listed impairment in part A or part B of the Listings that includes the same functional limitations. The listing used for comparison need not be medically related to the child's impairment.

Use the following 4 methods to determine if the child's impairment(s) is functionally equivalent to a listing. There is no set order to the methods. If a child is found disabled according to any one of the methods, it is not necessary to consider the others; use any of these methods that is appropriate to, or best describes, the child's impairment(s) and functional limitations. However, you must consider all of the guidelines before determining that a child is not disabled; i.e., "No" must be checked in A through D.

A. Limitation of Specific Function(s)

Does the child's impairment(s) produce limitation(s) of specific function(s) that is/are the same as that/those in a listed impairment?

___ Yes _____ Cite the Listing

___ No

B. Limitation Related to Episodic Impairment(s)

If the child's impairment(s) is characterized by frequent illnesses or attacks, or by exacerbations and remissions, does it produce disabling functional limitations that are the same as the disabling functional limitations of a listed impairment with similar episodic criteria?

___ Yes _____ Cite the Listing

___ No

C. Limitation Related to Treatment or Medication Effects

If the child's impairment(s) requires treatment over a long period of time (i.e., at least a year), are the functional limitations resulting from treatment, by themselves (e.g., multiple surgeries) or in combination with limitations caused by the impairment(s), the same as the disabling functional limitations of any listing with criteria based on treatment (including side effects of medication)?

___ Yes _____ Cite the Listing

___ No

D. Broad Functional Limitations

Assess the severity of any broad functional limitations in the areas below. Consider whether limitation(s) in one area affects functioning in other areas; e.g., some physical impairments may have global effects and should be evaluated in all affected areas. Consider all relevant factors; i.e., the nature of the child's impairment(s), the child's age, and other relevant factors (e.g., child's ability to be tested given his/her age, effects of chronic illness or treatment, need for help from others).

Areas of Development or Functioning

Function	No Evidence of Limitation	Less than Marked	Marked	Extreme
Cognitive/Communicative (all ages)	_____	_____	____	____
Motor (all ages)	_____	_____	____	____
Social (all ages)	_____	_____	____	____
Responsiveness to Stimuli (birth to attainment of age 1)	_____	_____	____	____
Personal (age 3 to attainment of age 18)	_____	_____	____	____
Concentration, Persistence, or Pace (age 3 to attainment of age 18)	_____	_____	____	____

"Marked" limitation: A valid standardized test score two standard deviations (SD) or more below the norm for the test (but less than three SD): or

From birth to attainment of age 3, functioning at more than one-half but not more than two-thirds of chronological age; or

From age 3 to attainment of age 18, a limitation that interferes seriously with the child's functioning. Marked limitation may arise when several activities or functions are limited, or even when only one is limited.

"Extreme" limitation: A valid score three SD or more below the norm for the test; or

From birth to attainment of age 3, functioning at one-half chronological age or less; or

From birth to attainment of age 18, a limitation that prevents meaningful functioning in an area of functioning. Extreme limitation may arise when several activities or functions are limited or even when only one is limited.

D. Broad Functional Limitations - continued

Based on your findings in the relevant areas of development or functioning, is the physical impairment(s) or combination of physical and mental impairments equivalent in severity to Listing:

112.12 infants to attainment of age 1,

112.02B.1. children age 1 to attainment of age 3, or

112.02B.2. children age 3 to attainment of age 18

___ Yes Extreme limitation in any one of the applicable areas rated.

___ Yes Marked limitation in any two of the applicable areas.

___ No

REVIEWER NOTES: