Medical Documentation Guide

Disability Review

A person who is disabled may be eligible for Medicaid in Nebraska based on their circumstances.

Nebraska Medicaid has services available to allow individuals to remain in their homes or communities. These services are often called “waiver” services. Waiver services may be provided to individuals who meet specific criteria.

For purposes of Nebraska Medicaid, “disabled” is defined as meeting the disability criteria established by the Social Security Administration (SSA). Sometimes SSA will make this determination. When SSA has not made a determination, the Nebraska Department of Health and Human Services (DHHS) State Review Team (SRT) can. The SRT uses the same criteria as the SSA to determine if a person is disabled.

- Federal disability guidelines for children: https://www.ssa.gov/disability/professionals/bluebook/ChildhoodListings.html
- Federal disability guidelines for adults: https://www.ssa.gov/disability/professionals/bluebook/AdultListings.htm

An individual’s disability status must be re-reviewed regularly. Nebraska Medicaid will give the individual, their parent, or their guardian notification when it is time to re-review a case.

The Individual’s Responsibility

The person with a disability, or their parent/guardian, has responsibility in the disability determination process. This person is responsible for calling or visiting their, or their child’s, healthcare provider(s) who evaluated the disabling condition. This may include an MD, DO, APRN, CNP, or PA.

Medical records from within the last 12 months must be submitted to support meeting disability guidelines. Ensure medical records are submitted by the deadline in the verification request.

To submit medical records:

- Online: iserve.nebraska.gov
- Email: DHHS.ANDICenter@nebraska.gov
- Fax: 402-742-2351
- In-Person: Drop off at a local DHHS office.

When information is not provided, the SRT cannot review the case.

The SRT will review medical records provided to Nebraska Medicaid. Based on this information, the

SRT will determine if disability criteria are met. Nebraska Medicaid will send written notice of the decision. This notice will include information about appeal rights.

The following are examples of the medical documentation Nebraska Medicaid finds helpful to make the disability determination. Please send additional medical records that may be helpful for this review.

Medical Records from Treating Providers that Document Limitations

Records listed below should be submitted from the last 12 months.

Documentation Requirements by Category

Low Birth Weight and Failure to Thrive (age three and under only)

- Birth weight and gestational age
- Developmental milestones
- Height, weight, growth charts, BMI-for-age percentiles, and weight for length graph

Musculoskeletal (spinal disorders, major weight-bearing joints, amputation, reconstructive surgery, non-healing fractures)

- PT/OT evaluation and notes on patient's functional ability
- Imaging reports (X-ray, MRI, CT, etc.)
- Patient's mobility
    - Assistive device
    - Ability to use prosthetic
    - Balance
- Operative notes (when applicable)

Special Senses and Speech (visual or hearing impairment, loss of speech)

- Eye Examination
    - Visual acuity and visual field test (perimetry)
- Hearing examination
    - Otologic exam and audiometric testing
    - ABR (Auditory Brainstem response) testing
    - Air conduction thresholds
    - Word recognition testing
    - Speech and language evaluation
    - Hearing aids
    - Cochlear implants
- Operative notes (when applicable)
- Inability to produce speech that can be heard, understood, or sustained

Respiratory (asthma, Cystic Fibrosis, lung transplant, chronic respiratory disorders, pulmonary hypertension)

- Imaging and laboratory reports (X-rays, CT)
- Supplemental oxygen need
- Oxygen saturation on room air
- Pulmonary Function Testing (PFTs)
    - *Pulmonary function tests* include *spirometry*, *DLCO* tests, *ABG* tests, and *pulse oximetry.*
        - All respiratory testing must be completed on room air
    - During testing, when the FEV_1 is less than 70 percent of the predicted normal value, repeat spirometry after inhalation of a bronchodilator to evaluate the respiratory disorder, unless it is medically contraindicated.
    - The patient must be medically stable at the time of the test. Examples of when the patient would be considered medically unstable include:
        - Within two weeks of a change in their prescribed respiratory medication.
        - Experiencing, or within 30 days of completion of treatment for, a lower respiratory tract infection.
        - Experiencing, or within 30 days of completion of treatment for, an acute exacerbation of a chronic respiratory disorder. Wheezing by itself does not indicate that the patient is medically unstable.
        - Hospitalized or within 30 days of a hospital discharge, for an acute myocardial infarction.
- Six-minute walk test (for adults)
- Tracheostomy
    - Diagnosis for the trach and date of initial placement
    - Description of trach management
- Ventilator use
    - Diagnosis for the ventilator and date of initiation
    - Description of ventilator prescription: settings and hours of use per day and night
- Respiratory therapy progress notes
- Pulmonology consultant medical records
- Thoracentesis (when applicable)

Cardiovascular (congenital heart disease, chronic heart failure, transplant, arrythmias, aneurysm,)

- Echocardiogram
    - Ejection Fraction (EF) during a period of stability
    - Cardiac measurements and function
- Dopplers, angiographic findings

- Holter monitor results
- Exercise and stress testing
- Cardiac catheterization
- Operative reports
- Cardiac symptoms
- Oxygen saturation on room air

Digestive (G-tube under three years of age, gastrointestinal hemorrhaging, liver disease, bowel disease, transplant)

- Imaging reports (X-ray, ultrasound, MRI, CT)
- Endoscopy and colonoscopy report
- Weight, height, and BMI
- Feeding tube (G-tube) or parenteral (intravenous) nutrition (TPN)
- Pertinent labs, such as albumin, hemoglobin, total bilirubin, creatinine, and INR
- CLD score
- EEG in the evaluation of encephalopathy
- Paracentesis or thoracentesis (when applicable)
- Blood transfusions
- Liver/pancreas/small intestine transplant

Genitourinary (chronic kidney disease, kidney transplant, dialysis, congenital disorders, nephrotic syndrome)

- Lab reports – at least two different sets of labs
    - Second set has to be at least 60 days after the first set, but within six months.
    - Albumin, creatinine, INR, urine test results and total bilirubin reports.
    - eGFR (estimated glomerular filtration rate).
- Kidney biopsy reports
- BMI, height and weight
- Kidney transplant
- Dialysis notes – initial plan and expected length of time
    - Dialysis Form 2728 (when applicable)

Hematological (blood disorders, anemia, bleeding disorders, bone marrow disorders)

- Lab reports (Hemoglobin, etc.)
- Clotting factor testing
- Any hospitalizations due to condition
- Need for transfusions
- Definitive testing done to diagnose the disorder
- Bone marrow or stem cell transplant

Skin disorders (burns, genetic photosensitivity disorders, non-healing wounds)

- Definitive testing done to diagnose the disorder
- Surgical notes

- Duration of wound, documentation of ongoing management, and prognosis onset, duration, and frequency of exacerbations treatment plan and prognosis.

Congenital Disorders (Down syndrome, catastrophic congenital disorder for children)

- Genetic testing
- Karyotype analysis
- Specific functional limitations
- Description of facial and physical features

Neurological (seizures, strokes, cerebral palsy, spinal cord disorders, Muscular Dystrophy, Central Nervous System disorders, Traumatic Brain Injury, Multiple Sclerosis, motor neuron disorders, Parkinson's, post-polio syndrome, persistent vegetative state)

- Imaging reports (CT, MRI, X-ray)
- PT/OT/ST evaluation and notes on patient's functional ability
- Neurological testing (EMG or EEG)
- For brain injuries, strokes, neurological or neuromuscular disorders, or spinal cord disorders:
    - Evidence from at least three months after the vascular insult/injury, to evaluate whether the patient has disorganization of motor functioning, or the impact the disorder has on the patient's physical and mental functioning.
- Cognitive testing and developmental ability
- Patient's mobility
    - Assistive device
    - Balance
- Seizures
    - Medication regimen
    - Type and frequency

Mental and Behavioral Health (Autism, schizophrenia, depression, intellectual disorder, anxiety, OCD, PTSD,

- Psychological evaluation and notes on diagnosis, severity and symptoms of mental disorder, and ability to function
    - The initial evaluation and diagnosis can be more than 12 months old but must include updated progress notes within the past 12 months on severity and functional ability.
- Current adaptive, executive and cognitive functioning
- IEPs/MDTs from school
- Intellectual testing and IQ testing
    - For adults: testing must have been done prior to the age of 22

- The initial evaluation and diagnosis can be more than 12 months old, but must include updated progress notes within the past 12 months on severity and functional ability

- Previous and current treatment, including psychotherapy
- Behavioral health progress notes from your provider
    - ABA records alone are not sufficient

Cancer (Lymphoma, Leukemia, retinoblastoma, neuroblastoma, solid organ, etc.)

- Origin and extent of cancer, including metastasis (spread to another area of the body) and prognosis
    - Date of diagnosis
    - Pathology reports
    - Stage and grade
    - Recurrent, relapse, unresectable or inoperable
- Imaging reports (MRI, CT, PET, Xray)
- Treatment
    - Surgery, chemotherapy, radiation
    - Response to treatment and remission date, when applicable
- Hematology/Oncology consultant medical records and follow ups
- Bone marrow or stem cell transplant

Immune system (Lupus, HIV, immune deficiency, connective tissue disorders, Sjogren's syndrome)

- Constitutional symptoms or signs
- Definitive testing done to diagnose the disorder
- Lab results, CD4 count
- Biopsy and other pathology reports
- Onset, duration, and frequency of exacerbations
- Stem cell transplant (when applicable)
- Treatment and response; any hospitalizations