Colorado Department of Health Care Policy and Financing 1575 Sherman St., Denver, CO 80203-1714	**NUMBER:** HCPF 03-007 **CROSS REFERENCE:**
DIVISION OR OFFICE: Medical Assistance Office	**DATE:** April 25, 2003
SUBJECT AREA: Medical Disability Determinations	
SUBJECT: New DDS Medical Release Form; Changes and Clarification in information pertaining to medical disability determinations and appeals. **TYPE:** P - Procedure	**APPROVED BY:** Vivianne M. Chaumont Vivianne M. Chaumont

Medicaid Agency Letters can be accessed online at:
www.chcpf.state.co.us >>Departmental Reference Material >>Agency Letters

Intended Recipients: This agency letter is written for the following county personnel:

1. Medicaid Managers
2. Adult Medicaid Supervisors
3. Medicaid Technicians who process applications for the aged, blind and disabled

Purpose:

This agency letter will provide county workers with the new HIPAA compliant medical release, DDS Release 2. Information regarding the appeals process, contact names for questions, application forms, acceptable medical information, and destruction of medical records are also addressed

Background:

In the past, county technicians had applicants/clients sign DDS Release 1 that was sent to DDS with the application. A new release form, DDS Release 2, is now in effect. A new release form was necessary in order to ensure that the Medicaid disability determination process was in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

General information about how to properly fill out the application form and the consequences of inadequate information is also addressed.

The high number of appeals has caused confusion with the process and whom to contact with questions. The appeals process is explained in addition to contact information regarding the current status of appeal is provided.

Procedure or Information:

I. New Medical Release Forms

A. Why a new release is needed. Due to the implementation of HIPAA on April 15, 2003, all medical release forms need to state specific information. Failure to send a HIPAA compliant medical release form is not only in violation of federal law, it is already resulting in many vendors refusing to provide medical information. Failure to use this release form may result in significant delays in processing time for Medicaid disability determinations. The new DDS Release 2 is attached to this letter and can also be accessed online as an attachment to the agency letter. This form must be used with all Medicaid Disability Determination Applications (the yellow form) that are sent to DDS.

B. Effective date. Any DDS Release 1 forms sent after April 25, 2003 will result in the application and release forms being sent back to the county technician in order to obtain the proper release forms.

C. Correctly completing DDS Release 2. Properly completing the release form will result in prompt processing of the disability application. Please have only the client sign the form. **DO NOT HAVE THE CLIENT FILL IN ANY MEDICAL INFORMATION OR DATE THE FORM.** If DDS Release 2 form is mailed to the client, it is acceptable to highlight the signature area or to staple a note or cover sheet on the release specifically instructing the client to only sign in the signature box. Due to the scrutiny of the new form, it is also advisable to have a witness signature on each release form. This may be either the county technician or any person 18 years or older who either knows the client or who may verify the client's identity through valid identification. While the DDS Release 2 may be sent via facsimile to DDS with the application to initiate the determination process more quickly, the original application and signed DDS Release 2 form must be mailed immediately to DDS. Please provide an adequate number of DDS Release 2 forms with the application. There should be a release form for every medical source the client tells you about or writes down and then **THREE (3)** additional release forms must also be signed. These additional forms allow DDS to contact any new medical sources since the date of application or any discovered medical sources that the client did not mention. Failure to include these additional release forms will result in a delay of processing time.

D. DDS address. All applications should be sent directly to DDS. No application should be sent to HCPF.

Facsimile: 303-752-5761
Address: Disability Determination Services
2530 S. Parker Road #500
Aurora, CO 80014

II. Application Forms

A. Correctly filling out the application. Due to the increasing number of incomplete application forms, DDS will begin returning application forms to county technicians if they are no filled out properly. All information must be completed on the application in order for it to be processed. ***It is the county technician's responsibility to review the application prior to it being sent to DDS in order to ensure that all information is complete.*** **The following items will result in an application being returned back to the county technician**:

1. Incomplete address. "Address unknown" or "homeless" are not sufficient addresses. A current, mailing address is needed to complete to disability process. An application can not be denied if a person is homeless, however since all correspondence, including determinations, are mailed, an address is essential. The applicant can use any person or location who will accept mail on their behalf.

2. Application date. An application date is often needed to establish the onset date.

3. Social security number. If the client has a social security number, it must be listed. Failure to list the number by the client does not necessarily mean the client does not have one. It is the county technicians responsibility to ask if there is a social security number. If the client states that they do not have one, then the inquiry stops. However, if the client states that they do not know what it is, the county technician should assist them in contacting SSA to obtain their social security number. If the client does not have a social security number or is undocumented, please make a note in the space for the social security number space that an inquiry was made, however the client does not have an SSN.

4. Alleged impairment. All alleged impairments stated by the client must be thoroughly completed on the application form. Failure to provide why the client is applying for Medicaid will result in the application being returned back to the county technician.

5. Medical sources. The name, address, and phone number of all medical sources must be completed on the application. It is not uncommon for the client to have incomplete information about their medical providers. This is particularly true in smaller communities. It is the county technicians responsibility to help the client obtain this information. Having complete medical information will help process the claim much more quickly and ensure that a correct determination is made.

6. Highest level of education. This information is crucial in determining a client's medical disability.

7. County technician information. The county technician who is processing the application must provide their name and phone number. This must be legible.

Please provide this information on the last page of the application and also on the cover letter sent with the facsimile.

B. Application cover letter. Attached and online is an HCPF approved cover letter that may be included or retyped on county letter head that must be included with all applications which are sent to clients through the mail. This letter states the information that is necessary to complete the application. While this letter will provide guidance to the client, it is still the ultimate responsibility of the county technician to ensure that it is complete prior to sending it to DDS.

III. Appeals Process

A. Disability process. After the application is completed by the county technician, it is sent to DDS for the medical disability determination. The criteria used by DDS is the same that is used in all Federal Social Security claims, which includes SSI. If the claim is denied, the client has the right to request an appeal hearing with an Administrative Law Judge (ALJ). Many questions arise about what happens after the ALJ makes a decision. Once the ALJ makes a decision, the case is sent to the Office of Appeals at HCPF. The Office of Appeals reviews both the DDS file and the ALJ's Initial Decision to make a Final Agency Decision (FAD). The ALJ's decision is never the final decision. This is why there will never be an onset or diary date set by the ALJ. If the client was not allowed by DDS, please always look at the decision made in the FAD, not the Initial Decision, to determine the client's disability status.

B. Final Agency Decision Inquiries. If a case went to an appeals hearing and has not been returned, inquires may be made to the Office of Appeals as to the status of the FAD. For inquires please call Toni Carranco at 303-866-5654.

IV. Determining Medical Disability

A. Acceptable. The disability determination, either an allowance directly from DDS or the FAD from HCPF, for Medicaid are the only decisions allowed to establish disability.

B. Not acceptable. Med-9 forms and any other form or opinion that labels the client as disabled. The Med-9 forms are collateral medical information that is used in making the medical disability determination for AND, but it is never the sole determination of disability for Medicaid. The medical information in a Med-9 is evaluated the same as any other medical information from the client. Please refer back to the Agency Letter dated October 10, 2001 for more clarification.

V. Destruction of Materials in Green Case Folder

A. Medical Records.

1. Denials. All medical records and releases must be destroyed for any case that is denied by DDS, the ALJ, or in the Final Agency Decision.

2. Allowances. Medical records for cases with a three (3) year or less diary date may not be destroyed. These records may be recalled by DDS for a redetermination. Any case with a diary for more than three (3) years can have all medical records and releases destroyed.

B. What records must remain in the green folder. The following items must remain in the green folder for auditing purposes.

1. Yellow Medicaid Application
2. Form SSA- 831
3. CAASE Development Sheet
4. Form SSA-4734 Physical Residual Functional Capacity (RFC)
5. Form SSA-4734 Mental Residual Functional Capacity (MRFC)
6. Form SSA-2506 Psychiatric Review Technique (PRTF)
7. Form SSA-3369 Work History
8. Form SSA-538 Childhood Disability Evaluation Form
9. Any Vocational Worksheet
10. Activities of Daily Living
11. Pain Form
12. Any forms completed by the client
13. Any forms in file other than medical records or release forms.

C. If you receive any requests from DDS that are outside the scope of this agency letter, please refer those requests to HCPF.

Effective Date:
April 25, 2003

Contact Persons:
Kimberly Brebner
SSI/Medicaid Eligibility Policy Analyst
(303) 866-4475
kimberly.brebner@state.co.us

Enclosures:
DDS Release 2
Application Cover Letter

WHOSE *Records to be Disclosed*		
NAME	*First*	*Middle* / *Last*
SSN	Birthday (mm/dd/yy)	
DDS USE ONLY NUMBER HOLDER (If other than above)		
NAME		
SSN		

AUTHORIZATION TO DISCLOSE INFORMATION TO DISABILITY DETERMINATION SERVICES (DDS)

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records;*** **also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, and not limited to:**
   - **Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)**
   - **Drug abuse, alcoholism, or other substance abuse**
   - **Sickle cell anemia**
   - **Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV) or sexually transmitted diseases**
   - **Gene-related impairments (including genetic test results)**
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluation.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by DDS
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY DDS (as needed). Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed.

TO WHOM **The State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.**

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances where this information may be redisclosed to other parties (see page 2 for details).
- I may write to DDS and my sources to revoke this authorization at any time (see page 2 for details).
- DDS will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

INDIVIDUAL authorizing disclosure		**IF not signed by subject of disclosure, specify basis for authority to sign** ☐ Parent of minor ☐ Guardian ☐ Other personal representative (expla	
SIGN ▶		(Parent/guardian sign here if two signatures required by State law) ▶	
Date Signed	Street Address		
Phone Number (with area code	City	State	ZIP
WITNESS	*I know the person signing this form or am satisfied of this person's identity:*		
SIGN ▶		**IF** needed, second witness sign here (e.g., if signed with "X" above **SIGN** ▶	
Phone Number (or Address)		Phone Number (or Address)	

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 733; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form DDS Release 2
"Authorization to Disclose Information to the Disability Determination Services (DDS)"

We need your written authorization to help get the information required to process your application for benefits, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a Form DDS Release 2. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source, and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to DDS. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; DDS can tell you if we identified any sources you didn't tell us about. Information disclosed prior to revocation may be used by DDS to decide your claim.

It is DDS' policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. DDS makes every reasonable effort to ensure that the information in the DDS Release 2 is provided to you in your native or preferred language.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by DDS is protected by the Privacy Act of 1974. Under a Business Associates Agreement with the State of Colorado (HCPF), your private health information is protected and will not be used for any purpose other than to make a medical disability determination. Your personal health information remains protected under the health information privacy provisions of 45 CFR 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). After a medical determination is made and the necessary waiting period for appeal purposes and passed, all medical information is sent to the county which you applied. Once the medical information is returned to the county, it will be destroyed in order to protect your personal health information.

DDS is authorized to collect the information on form DDS Release 2 by sections 205(a), 223 (d)(5)(A), 1614(a)(3)(H)(i), 163(d)(1) and 1631 (3)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility for benefits, and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in DDS. In some cases, your information may also be reviewed by Administrative Law Judges and by Health Care Policy and Financing (HCPF) personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. The information we obtain with this form will only be used for the purpose of determining eligibility for Medicaid. The only two instances where your information will be released will be:

1. To enable a third party (e.g. consulting physicians) or other government agency to assist DDS to determine eligibility to for Medicaid.
2. To provide necessary medical information for the purpose of consulting examinations.

Other than the above limited circumstance, DDS will not redisclose any medical information without proper prior written consent information (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Agencies may use matching programs only to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from DDS or HCPF.

PAPERWORK REDUCTION ACT

This information collection meets the requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING IN THE COMPLETED FORM TO YOUR DDS OFFICE. The office is listed under State Government agencies in your telephone directory or you may call DDS at 1-800-332-8087.**

Date _____

Dear _____:

Enclosed is the application for Medicaid. The following information must be filled out ***COMPLETELY*** in order for your disability claim to be looked at. Please fill in ***ALL*** information.

APPLICATION (YELLOW) FORM:

- Fill in name and address. You must have a valid address where mail can be sent. If you do not currently have an address, please list a friend or family member's address where your mail can go.
- Please fill in your social security number, if you have one.
- You must complete ***ALL DOCTOR/HOSPITAL INFORMATION***. You must give your doctor's name, address, and phone number. This must be provided for ***ALL*** doctors and hospitals you have been seen at for at least the last two years.
- You must state the highest level of education you went through.

MEDICAL RELEASE FORMS:

- Only sign your name on this form. ***DO NOT DATE THESE FORMS OR FILL IN ANY OTHER INFORMATION***.
- Have someone witness you signing these forms. This can be your county technician, friend, or family member. They must be at least 18 years of age.
- If you fill in any other information on this form other than your signature and a witnesses' signature, it will slow down how quickly we can process your claim.

IF YOU DO NOT COMPLETE ALL INFORAMTION ON THIS FORM, IT WILL BE SENT BACK TO YOU. THIS WILL SLOW DOWN HOW FAST A DECISION CAN BE MADE ON YOUR CLAIM.

Please complete these forms and send them back as soon as possible. If you have any questions, you can contact _____, your county worker, at _____ _____.

Sincerely,