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A. Death usually expected within the first months of life.
OR

B. Very serious interference with development or functioning.

111.00 Neurological

A. *Which neurological disorders do we evaluate under these listings?*

We evaluate epilepsy, coma or persistent vegetative state (PVS), and neurological disorders that cause disorganization of motor function, bulbar and neuromuscular dysfunction, or communication impairment. Under this body system, we evaluate the limitations resulting from the impact of the neurological disease process itself. If you have a neurological disorder(s) that affects your physical and mental functioning, we will evaluate your impairments under the rules we use to determine functional equivalence. If your neurological disorder results in only mental impairment or if you have a co-occurring mental condition that is not caused by your neurological disorder (for example, Autism spectrum disorder), we will evaluate your mental impairment under the mental disorders body system, 112.00.

B. *What evidence do we need to document your neurological disorder?*

1. We need both medical and non-medical evidence (signs, symptoms, and laboratory findings) to assess the effects of your neurological disorder. Medical evidence should include your medical history, examination findings, relevant laboratory tests, and the results of imaging. Imaging refers to medical imaging techniques, such as x-ray, computerized tomography (CT), magnetic resonance imaging (MRI), and electroencephalography (EEG). The imaging must be consistent with the prevailing state of medical knowledge and clinical practice as the proper technique to support the evaluation of the disorder. In addition, the medical evidence may include descriptions of any prescribed treatment and your response to it. We consider non-medical evidence such as statements you or others make about your impairments, your restrictions, your daily activities, or, if you are an adolescent, your efforts to work.
2. We will make every reasonable effort to obtain the results of your laboratory and imaging evidence. When the results of any of these tests are part of the existing evidence in your case record, we will evaluate the test results and all other relevant evidence. We will not purchase imaging, or other diagnostic tests or laboratory tests that are complex, may involve significant risk, or that are invasive. We will not routinely purchase tests that are expensive or not readily available.

C. *How do we consider adherence to prescribed treatment in neurological disorders?* In 111.02 (Epilepsy) and 111.12 (Myasthenia gravis), we require that limitations from these neurological disorders exist despite adherence to prescribed treatment. “Despite adherence to prescribed treatment” means that you have taken medication(s) or followed other treatment procedures for your neurological disorder(s) as prescribed by a physician for three consecutive months but your impairment continues to meet the other listing requirements despite this treatment. You may receive your treatment at a health care facility that you visit regularly, even if you do not see the same physician on each visit.

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D. *What do we mean by disorganization of motor function?-*

1. Disorganization of motor function means interference, due to your neurological disorder, with movement of two extremities; i.e., the lower extremities, or upper extremities (including fingers, wrists, hands, arms, and shoulders). By two extremities we mean both lower extremities, or both upper extremities, or one upper extremity and one lower extremity. All listings in this body system, except for 111.02 (Epilepsy) and 111.20 (Coma and persistent vegetative state), include criteria for disorganization of motor function that results in an extreme limitation in your ability to:
 - Stand up from a seated position; or
 - Balance while standing or walking; or
 - Use the upper extremities (e.g., fingers, wrists, hands, arms, and shoulders).
2. Extreme limitation means the inability to stand up from a seated position, maintain balance in a standing position and while walking, or use your upper extremities to independently initiate, sustain, and complete age-appropriate activities. The assessment of motor function depends on the degree of interference with standing up; balancing while standing or walking; or using the upper extremities (including fingers, hands, arms, and shoulders).
 - a. Inability to stand up from a seated position means that once seated you are unable to stand and maintain an upright position without the assistance of another person or the use of an assistive device, such as a walker, two crutches, or two canes.
 - b. Inability to maintain balance in a standing position means that you are unable to maintain an upright position while standing or walking without the assistance of another person or an assistive device, such as a walker, two crutches, or two canes.
 - c. Inability to use your upper extremities means that you have a loss of function of both upper extremities (e.g., fingers, wrists, hands, arms, and shoulders) that very seriously limits your ability to independently initiate, sustain, and complete age-appropriate activities involving fine and gross motor movements. Inability to perform fine and gross motor movements could include not being able to pinch, manipulate, and use your fingers; or not being able to use your hands, arms, and shoulders to perform gross motor movements, such as handling, gripping, grasping, holding, turning, and reaching; or not being able to engage in exertional movements such as lifting, carrying, pushing, and pulling.
3. For children who are not yet able to balance, stand up, or walk independently, we consider their function based on assessments of limitations in the ability to perform comparable age-appropriate activities with the lower and upper extremities, given normal developmental milestones. For such children, an extreme level of limitation means developmental milestones at less than one-half of the child's chronological age.

E. *What do we mean by bulbar and neuromuscular dysfunction?* The bulbar region of the brain is responsible for controlling the bulbar muscles in the throat, tongue, jaw, and face. Bulbar and neuromuscular dysfunction refers to weakness in these muscles, resulting in breathing, swallowing, and speaking impairments. Listings 111.12 (Myasthenia gravis) and

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111.22 (Motor neuron disorders) include criteria for evaluating bulbar and neuromuscular dysfunction. If your neurological disorder has resulted in a breathing disorder, we may evaluate that condition under the respiratory system, 103.00.

F. *What is epilepsy, and how do we evaluate it under 111.02?*

1. Epilepsy is a pattern of recurrent and unprovoked seizures that are manifestations of abnormal electrical activity in the brain. There are various types of generalized and “focal” or partial seizures. In children, the most common potentially disabling seizure types are generalized tonic-clonic seizures, dyscognitive seizures (formerly complex partial seizures), and absence seizures. However, psychogenic nonepileptic seizures and pseudoseizures are not epileptic seizures for the purpose of 111.02. We evaluate psychogenic seizures and pseudoseizures under the mental disorders body system, 112.00.
 - a. Generalized tonic-clonic seizures are characterized by loss of consciousness accompanied by a tonic phase (sudden muscle tensing causing the child to lose postural control) followed by a clonic phase (rapid cycles of muscle contraction and relaxation, also called convulsions). Tongue biting and incontinence may occur during generalized tonic-clonic seizures, and injuries may result from falling.
 - b. Dyscognitive seizures are characterized by alteration of consciousness without convulsions or loss of muscle control. During the seizure, blank staring, change of facial expression, and automatisms (such as lip smacking, chewing or swallowing, or repetitive simple actions, such as gestures or verbal utterances) may occur. During its course, a dyscognitive seizure may progress into a generalized tonic-clonic seizure (see 111.00F1a).
 - c. Absence seizures (petit mal) are also characterized by an alteration in consciousness, but are shorter than other generalized seizures (e.g., tonic-clonic and dyscognitive) seizures, generally lasting for only a few seconds rather than minutes. They may present with blank staring, change of facial expression, lack of awareness and responsiveness, and a sense of lost time after the seizure. An aura never precedes absence seizures. Although absence seizures are brief, frequent occurrence may limit functioning. This type of seizure usually does not occur after adolescence.
 - d. Febrile seizures may occur in young children in association with febrile illnesses. We will consider seizures occurring during febrile illnesses. To meet 111.02, we require documentation of seizures during nonfebrile periods and epilepsy must be established.
2. Description of seizure. We require at least one detailed description of your seizures from someone, preferably a medical professional, who has observed at least one of your typical seizures. If you experience more than one type of seizure, we require a description of each type.
3. Serum drug levels. We do not require serum drug levels; therefore, we will not purchase them. However, if serum drug levels are available in your medical records, we will evaluate them in the context of the other evidence in your case record.
4. Counting seizures. The period specified in 111.02A or B cannot begin earlier than one month after you began prescribed treatment. The required number of seizures must occur within the period we are considering in connection with your application or continuing

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disability review. When we evaluate the frequency of your seizures, we also consider your adherence to prescribed treatment (see 111.00C). When we determine the number of seizures you have had in the specified period, we will:

- a. Count multiple seizures occurring in a 24-hour period as one seizure.
 - b. Count status epilepticus (a continuous series of seizures without return to consciousness between seizures) as one seizure.
 - c. Count a dyscognitive seizure that progresses into a generalized tonic-clonic seizure as one generalized tonic-clonic seizure.
 - d. We do not count seizures that occur during a period when you are not adhering to prescribed treatment without good reason. When we determine that you had a good reason for not adhering to prescribed treatment, we will consider your physical, mental, educational, and communicative limitations (including any language barriers). We will consider you to have good reason for not following prescribed treatment if, for example, the treatment is very risky for you due to its consequences or unusual nature, or if you are unable to afford prescribed treatment that you are willing to accept, but for which no free community resources are available. We will follow guidelines found in our policy, such as § 416.930(c) of this chapter, when we determine whether you have a good reason for not adhering to prescribed treatment.
 - e. We do not count psychogenic nonepileptic seizures or pseudoseizures under 111.02. We evaluate these seizures under the mental disorders body system, 112.00.
5. Electroencephalography (EEG) testing. We do not require EEG test results; therefore, we will not purchase them. However, if EEG test results are available in your medical records, we will evaluate them in the context of the other evidence in your case record.

G. *What is vascular insult to the brain, and how do we evaluate it under 111.04?*

1. Vascular insult to the brain (cerebrum, cerebellum, or brainstem), commonly referred to as stroke or cerebrovascular accident (CVA), is brain cell death caused by an interruption of blood flow within or leading to the brain, or by a hemorrhage from a ruptured blood vessel or aneurysm in the brain. If you have a vision impairment resulting from your vascular insult, we may evaluate that impairment under the special senses body system, 102.00.
2. We generally need evidence from at least 3 months after the vascular insult to determine whether you have disorganization of motor function under 111.04. In some cases, evidence of your vascular insult is sufficient to allow your claim within 3 months post-vascular insult. If we are unable to allow your claim within 3 months after your vascular insult, we will defer adjudication of the claim until we obtain evidence of your neurological disorder at least 3 months post-vascular insult.

H. *What are benign brain tumors, and how do we evaluate them under 111.05?* Benign brain tumors are noncancerous (nonmalignant) abnormal growths of tissue in or on the brain that invade healthy brain tissue or apply pressure on the brain or cranial nerves. We evaluate their effects on your functioning as discussed in 111.00D. We evaluate malignant brain tumors under the cancer body system in 113.00. If you have a vision impairment resulting from your benign brain tumor, we may evaluate that impairment under the special senses body system, 102.00.

I. *What is cerebral palsy, and how do we evaluate it under 111.07?*

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1. Cerebral palsy (CP) is a term that describes a group of static, nonprogressive disorders caused by abnormalities within the brain that disrupt the brain's ability to control movement, muscle coordination, and posture. The resulting motor deficits manifest very early in a child's development, with delayed or abnormal progress in attaining developmental milestones; deficits may become more obvious as the child grows and matures over time.
2. We evaluate your signs and symptoms, such as ataxia, spasticity, flaccidity, athetosis, chorea, and difficulty with precise movements when we determine your ability to stand up, balance, walk, or perform fine and gross motor movements. We will also evaluate your signs, such as dysarthria and apraxia of speech, and receptive and expressive language problems when we determine your ability to communicate.
3. We will consider your other impairments or signs and symptoms that develop secondary to the disorder, such as post-impairment syndrome (a combination of pain, fatigue, and weakness due to muscle abnormalities); overuse syndromes (repetitive motion injuries); arthritis; abnormalities of proprioception (perception of the movements and position of the body); abnormalities of stereognosis (perception and identification of objects by touch); learning problems; anxiety; and depression.

J. What are spinal cord disorders, and how do we evaluate them under 111.08?

1. Spinal cord disorders may be congenital or caused by injury to the spinal cord. Motor signs and symptoms of spinal cord disorders include paralysis, flaccidity, spasticity, and weakness.
2. Spinal cord disorders with complete loss of function (111.08A) addresses spinal cord disorders that result in complete lack of motor, sensory, and autonomic function of the affected part(s) of the body.
3. Spinal cord disorders with disorganization of motor function (111.08B) addresses spinal cord disorders that result in less than complete loss of function of the affected part(s) of the body, reducing, but not eliminating, motor, sensory, and autonomic function.
4. When we evaluate your spinal cord disorder, we generally need evidence from at least 3 months after your symptoms began in order to evaluate your disorganization of motor function. In some cases, evidence of your spinal cord disorder may be sufficient to allow your claim within 3 months after the spinal cord disorder. If the medical evidence demonstrates total cord transection causing a loss of motor and sensory functions below the level of injury, we will not wait 3 months but will make the allowance decision immediately.

K. What are communication impairments associated with neurological disorders, and how do we evaluate them under 111.09?

1. Communication impairments result from medically determinable neurological disorders that cause dysfunction in the parts of the brain responsible for speech and language. Under 111.09, we must have recent comprehensive evaluation including all areas of affective and effective communication, performed by a qualified professional, to document a communication impairment associated with a neurological disorder.
2. Under 111.09A, we need documentation from a qualified professional that your neurological disorder has resulted in a speech deficit that significantly affects your ability to communicate. Significantly affects means that you demonstrate a serious

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limitation in communicating, and a person who is unfamiliar with you cannot easily understand or interpret your speech.

3. Under 111.09B, we need documentation from a qualified professional that shows that your neurological disorder has resulted in a comprehension deficit that results in ineffective verbal communication for your age. For the purposes of 111.09B, comprehension deficit means a deficit in receptive language. Ineffective verbal communication means that you demonstrate serious limitation in your ability to communicate orally on the same level as other children of the same age and level of development.
4. Under 111.09C, we need documentation of a neurological disorder that has resulted in hearing loss. Your hearing loss will be evaluated under listing 102.10 or 102.11.
5. We evaluate speech deficits due to non-neurological disorders under 2.09.

L. What are neurodegenerative disorders of the central nervous system, such as Juvenile-onset Huntington's disease and Friedreich's ataxia, and how do we evaluate them under 111.17? Neurodegenerative disorders of the central nervous system are disorders characterized by progressive and irreversible degeneration of neurons or their supporting cells. Over time, these disorders impair many of the body's motor or cognitive and other mental functions. We consider neurodegenerative disorders of the central nervous system under 111.17 that we do not evaluate elsewhere in section 111.00, such as juvenile-onset Huntington's disease (HD) and Friedreich's ataxia. When these disorders result in solely cognitive and other mental functional limitations, we will evaluate the disorder under the mental disorder listings, 112.00.

M. What is traumatic brain injury, and how do we evaluate it under 111.18?

1. Traumatic brain injury (TBI) is damage to the brain resulting from skull fracture, collision with an external force leading to a closed head injury, or penetration by an object that enters the skull and makes contact with brain tissue. We evaluate a TBI that results in coma or persistent vegetative state (PVS) under 111.20.
2. We generally need evidence from at least 3 months after the TBI to evaluate whether you have disorganization of motor function under 111.18. In some cases, evidence of your TBI is sufficient to determine disability. If we are unable to allow your claim within 3 months post-TBI, we will defer adjudication of the claim until we obtain evidence of your neurological disorder at least 3 months post-TBI. If a finding of disability still is not possible at that time, we will again defer adjudication of the claim until we obtain evidence at least 6 months after your TBI.

N. What are coma and persistent vegetative state, and how do we evaluate them under 111.20? Coma is a state of unconsciousness in which a child does not exhibit a sleep/wake cycle, and is unable to perceive or respond to external stimuli. Children who do not fully emerge from coma may progress into persistent vegetative state (PVS). PVS is a condition of partial arousal in which a child may have a low level of consciousness but is still unable to react to external stimuli. In contrast to coma, a child in a PVS retains sleep/wake cycles and may exhibit some key lower brain functions, such as spontaneous movement, opening and moving eyes, and grimacing. Coma or PVS may result from a TBI, a nontraumatic insult to the brain (such as a vascular insult, infection, or brain tumor), or a neurodegenerative or metabolic disorder. Medically induced comas should be considered under the section

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pertaining to the underlying reason the coma was medically induced and not under this section.

O. *What is multiple sclerosis, and how do we evaluate it under 111.21?*

1. Multiple sclerosis (MS) is a chronic, inflammatory, degenerative disorder that damages the myelin sheath surrounding the nerve fibers in the brain and spinal cord. The damage disrupts the normal transmission of nerve impulses within the brain and between the brain and other parts of the body causing impairment in muscle coordination, strength, balance, sensation, and vision. There are several forms of MS, ranging from slightly to highly aggressive. Milder forms generally involve acute attacks (exacerbations) with partial or complete recovery from signs and symptoms (remissions). Aggressive forms generally exhibit a steady progression of signs and symptoms with few or no remissions. The effects of all forms vary from child to child.
2. We evaluate your signs and symptoms, such as flaccidity, spasticity, spasms, incoordination, imbalance, tremor, physical fatigue, muscle weakness, dizziness, tingling, and numbness when we determine your ability to stand up, balance, walk, or perform fine and gross motor movements, such as using your arms, hands, and fingers. If you have a vision impairment resulting from your MS, we may evaluate that impairment under the special senses body system, 102.00.

P. *What are motor neuron disorders, and how do we evaluate them under 111.22?* Motor neuron disorders are progressive neurological disorders that destroy the cells that control voluntary muscle activity, such as walking, breathing, swallowing, and speaking. The most common motor neuron disorders in children are progressive bulbar palsy and spinal muscular dystrophy syndromes. We evaluate the effects of these disorders on motor functioning or bulbar and neuromuscular functioning.

Q. *How do we consider symptoms of fatigue in these listings?* Fatigue is one of the most common and limiting symptoms of some neurological disorders, such as multiple sclerosis and myasthenia gravis. These disorders may result in physical fatigue (lack of muscle strength) or mental fatigue (decreased awareness or attention). When we evaluate your fatigue, we will consider the intensity, persistence, and effects of fatigue on your functioning. This may include information such as the clinical and laboratory data and other objective evidence concerning your neurological deficit, a description of fatigue considered characteristic of your disorder, and information about your functioning. We consider the effects of physical fatigue on your ability to stand up, balance, walk, or perform fine and gross motor movements using the criteria described in 111.00D.

R. *How do we evaluate your neurological disorder when it does not meet one of these listings?*

1. If your neurological disorder does not meet the criteria of any of these listings, we must also consider whether your impairment(s) meets the criteria of a listing in another body system. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. See § 416.926 of this chapter.

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2. If your impairment(s) does not meet or medically equal a listing, we will consider whether your impairment(s) functionally equals the listings. See § 416.926a of this chapter.
3. We use the rules in § 416.994a of this chapter when we decide whether you continue to be disabled.

111.01 Category of Impairments, Neurological Disorders

111.02 Epilepsy, documented by a detailed description of a typical seizure and characterized by A or B:

A. Generalized tonic-clonic seizures (see 111.00F1a), occurring at least once a month for at least 3 consecutive months (see 111.00F4) despite adherence to prescribed treatment (see 111.00C).

OR

B. Dyscognitive seizures (see 111.00F1b) or absence seizures (see 111.00F1c), occurring at least once a week for at least 3 consecutive months (see 111.00F4) despite adherence to prescribed treatment (see 111.00C).

111.03 [Reserved]

111.04 Vascular insult to the brain, characterized by disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities, persisting for at least 3 consecutive months after the insult.

111.05 Benign brain tumors, characterized by disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

111.06 [Reserved]

111.07 Cerebral palsy, characterized by disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

111.08 Spinal cord disorders, characterized by A or B:

A. Complete loss of function, as described in 111.00J2, persisting for 3 consecutive months after the disorder (see 111.00J4).

OR

B. Disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities persisting for 3 consecutive months after the disorder (see 111.00J4).

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111.09 Communication impairment, associated with documented neurological disorder and one of the following:

A. Documented speech deficit that significantly affects (see 111.00K1) the clarity and content of the speech.

OR

B. Documented comprehension deficit resulting in ineffective verbal communication (see 111.00K2) for age.

OR

C. Impairment of hearing as described under the criteria in 102.10 or 102.11.

111.10 [Reserved]

111.11 [Reserved]

111.12 Myasthenia gravis, characterized by A or B despite adherence to prescribed treatment for at least 3 months (see 111.00C):

A. Disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

OR

B. Bulbar and neuromuscular dysfunction (see 111.00E), resulting in:

1. One myasthenic crisis requiring mechanical ventilation; or
2. Need for supplemental enteral nutrition via a gastrostomy or parenteral nutrition via a central venous catheter.

111.13 Muscular dystrophy, characterized by disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

111.14 Peripheral neuropathy, characterized by disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

111.15 [Reserved]

111.16 [Reserved]

111.17 Neurodegenerative disorders of the central nervous system, such as Juvenile-onset Huntington's disease and Friedreich's ataxia, characterized by disorganization of

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motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

111.18 Traumatic brain injury, characterized by disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities, persisting for at least 3 consecutive months after the injury.

111.19 [Reserved]

111.20 Coma or persistent vegetative state, persisting for at least 1 month.

111.21 Multiple sclerosis, characterized by disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

111.22 Motor neuron disorders, characterized by A or B:

A. Disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

OR

B. Bulbar and neuromuscular dysfunction (see 111.00E), resulting in:

1. Acute respiratory failure requiring invasive mechanical ventilation; or
2. Need for supplemental enteral nutrition via a gastrostomy or parenteral nutrition via a central venous catheter.

112.00 Mental Disorders

A. Introduction: The structure of the mental disorders listings for children under age 18 parallels the structure for the mental disorders listings for adults but is modified to reflect the presentation of mental disorders in children. The listings for mental disorders in children are arranged in 11 diagnostic categories: Organic mental disorders (112.02); schizophrenic, delusional (paranoid), schizoaffective, and other psychotic disorders (112.03); mood disorders (112.04); intellectual disability (112.05); anxiety disorders (112.06); somatoform, eating, and tic disorders (112.07); personality disorders (112.08); psychoactive substance dependence disorders (112.09); autistic disorder and other pervasive developmental disorders (112.10); attention deficit hyperactivity disorder (112.11); and developmental and emotional disorders of newborn and younger infants (112.12).

There are significant differences between the listings for adults and the listings for children. There are disorders found in children that have no real analogy in adults; hence, the differences