PHILIP D. MURPHY
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State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

SARAH ADELMAN
Commissioner

GREGORY WOODS
Assistant Commissioner

MEDICAID COMMUNICATION NO. 25-02 **DATE: February 26, 2025**

TO: NJ FamilyCare Eligibility Determining Agencies

SUBJECT: Update to **State Medical Review Team Process**

The Division of Medical Assistance and Health Services' Medical Review Team (MRT) administers the State disability determination process for the NJ FamilyCare Aged, Blind, Disabled programs. This process is in place to assist applicants and members who do not have a disability determination completed through the Social Security Administration. In response to stakeholder feedback, the MRT disability forms that are distributed to applicants and members by the County Social Service Agencies (CSSAs) have been updated for ease of use by applicants and their physicians.

Effective immediately, CSSAs should provide the attached revised PA-5 form (Examining Physician's Report) to applicants seeking a state disability determination. Applicants should be directed to give the form to their treating physician for completion and return the form to the CSSA along with any medical records that the applicant and/or their physician consider relevant to consideration for a disability determination by the MRT. The CSSAs will be responsible for forwarding the completed PA-5 form along with the submitted medical records to the MRT.

The PA-6 form (Medical-Social Information Report) is no longer required and should not be given to applicants.

If you have any questions regarding this Medicaid Communication, please refer them to the Division's Office of Eligibility field service staff member for your agency at 609-588-2556.

GW:bp

c:

Sarah Adelman, Commissioner
Department of Human Services

Valerie Mielke, Deputy Commissioner
Department of Human Services

Kaylee McGuire, Deputy Commissioner
Department of Human Services

Michael J. Wilson, Deputy Commissioner
Department of Human Services

Natasha Johnson, Assistant Commissioner
Division of Family Development

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Division of Mental Health and Addiction Services

Jonathan Seifried, Assistant Commissioner
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Peri Nearon, Director
Division of Disability Services

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Division of Aging Services

Christine Norbut Beyer, Commissioner
Department of Children and Families

Kaitlan Baston, M.D., Commissioner
Department of Health

Joshua Lichtblau, Director, Medicaid Fraud Division
Office of the State Comptroller

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
DISABILITY REVIEW UNIT

Form PA-5
(Rev.02/25)

EXAMINING PHYSICIAN'S REPORT

Name of physician completing this evaluation: _____

County Social Services Agency: _____

Name of Patient _____ Client Reg. No. _____

Social Security Number: _____ Related Reg. No. _____

Home Address _____ Birth Date _____ Sex _____

To be found disabled for purposes of Social Security disability benefits, individuals must have a severe disability (or combination of disabilities) that limits one or more major life activities and has lasted, or is expected to last, at least 12 months or result in death, and which prevents working at a "substantial gainful activity" level. Please note that Social Security's disability criteria is the same criteria used for this process. However, the outcome does not provide a Social Security disability determination. This determination is for NJ Medicaid purposes only.

MEDICAL SUMMARY:

1. Major Diagnoses _____
2. Approximate date of onset _____
3. Minor Diagnoses (if any) _____
4. CHARACTERISTICS OF MAJOR DISABILITY: Static (stable) ☐ Progressive ☐ Improving ☐
5. DEGREE OF INCAPACITY:
   - ☐ Bedridden
   - ☐ Ambulatory

   If ambulatory indicate:
   - ☐ only with wheelchair
   - ☐ brace(s)
   - ☐ crutches
   - ☐ cane
   - ☐ prosthesis
   - ☐ Other (specify)_____

Is patient *now* receiving any medication or treatment? (If so, give details, as name of drugs, dosage, duration and name of any other treating physician or clinic).

_____

_____

_____

LIMITATIONS: If there is limitation, check and describe below

STANDING	☐	BENDING	☐
WALKING	☐	LIFTING	☐
CLIMBING	☐	USE OF HANDS	☐
COGNITION	☐	PSYCHOLOGICAL	☐

OTHER (State which) _____

_____

_____

EMPLOYMENT EVALUATION:

1. In your opinion, could this individual *now* work *full-time* in the type of occupation or job (including homemaker) he/she formerly held? ____
   If "No" could individual now work part-time in former occupation? _____

2. **If the individual is considered to be incapacitated to the extent that he/she cannot work, cannot participate in training, or cannot perform the activities involved in homemaking and child care, is it your opinion that *duration of incapacity* will be:**

   - ☐ **Less than 30 days**
   - ☐ **More than 30 days but less than 90 days**
   - ☐ **More than 90 days but less than 6 months**
   - ☐ **More than 6 months**
   - ☐ **More than 12 months (Please specify). _____**

3. Additional comments or remarks (including any opinion you may have as to this individual's physical or mental ability to engage *full-time* in any useful employment or training, or to carry on normal responsibilities of homemaking or child care on a regular and predictable basis, etc.

   _____

   _____

   _____

CERTIFICATION:

I hereby certify that these statements are based on current or past examinations of the patient, and that they are true to the best of my knowledge, information and belief.

Date _____ Signature of Physician _____

_____

(Please Print Name)

_____

(Telephone Number)

Specialty (if any) _____Certified by American Specialty Board? Yes ____ No ____

TO BE COMPLETED BY CLIENT

I HEREBY GIVE PERMISSION TO THE State Agency/County Board of Social Services for Medicaid, GA program purposes and The New Jersey Division of Vocational Rehabilitation to secure my past and present medical records.

Client's Signature: _____

SUPPORTING PHYSICAL ASSESSMENT:

Physicians should address each body system that supports determining an individual disabled. The description should be detailed. Supporting laboratory, radiologic or rehabilitation therapy evaluations should be attached.

INTEGUMENTARY SYSTEM: Is there evidence of pallor, cyanosis, pigmentation, ulcers, decubitus, skin lesions, etc. If present, state location, cause and diagnosis if known.

_____

_____

GENITOURINARY SYSTEM: Is there Kidney disease/failure? _____ Dialysis?_____
Urinary Incontinence? _____ Please note any diagnoses, if known:

_____

_____

_____

DIGESTIVE SYSTEM:
Is there incontinence of Bowel? ___ Any Colitis, IBS or Liver disease? ____Any known cancer? _____
Note evidence of malnutrition and make any appropriate remarks. Please note any diagnoses if known:

_____

_____

_____

MUSCULOSKELETAL EVALUATION:
Is there an absence of any extremity? If so, which? _____
Is there a defect, deformity, or impairment relating to neck, back, or any extremity? _____
Is there difficulty with ambulation? _____

Describe in detail the extent, muscle weakness and limitation of joint range of motion of involved parts, and classify the patient functionally, if there is a musculoskeletal disability, according to criteria adopted by the American Rheumatism Association. (See Table II for information.)

_____

_____

_____

_____

PROSTHESES AND APPLIANCES:

List those prostheses and appliances the patient now possesses (include artificial limbs, braces, crutches, canes, hearing aid, special shoes, wheelchair, etc.).

_____

_____

_____

List those you feel might assist patient in his/her daily activities at home or on the job.

_____

_____

_____

Do you think function could be improved or the patient's condition corrected or controlled by medical, surgical, or rehabilitative procedures? Specify if possible.

_____

_____

_____

_____

CARDIOVASCULAR RESPIRATORY SYSTEMS:

Is there dyspnea on effort? _____
Any history of A-Fib, CHF, Congenital Heart Disease or Ischemic Heart Disease? _____
If yes, identify the condition and approximate date _____
NYHA classification if applicable _____
Blood Pressure_____ Pulse Rate _____ Regular or Irregular _____

Record nature of any defect, disease, impairment of pathology relating to above systems including physical, laboratory, x-ray and other diagnostic findings, if available, upon which your diagnosis is based. If a diagnosis of cardiac disease is made, include an estimate of functional or work capacity according to Table I (attached)

Additional Information and description of cardiac conditions resulting in disability:

_____

_____

_____

NEUROLOGICAL EVALUATION

Is there a history of seizures/convulsions? _____ Are Seizures controlled by medication? _____
Any history of Parkinson's, Cerebral Palsy, or other neurological debilitating diagnoses? _____

Please describe:

_____
_____
_____
_____

Does patient have muscle weakness or paralysis? _____
If so, state part of body involved, type (flaccid, spastic, etc.), and note any pathological reflexes, evidence of clonus, involved nerves (if known), cause and diagnosis if known.

_____
_____
_____

Does patient have a sensory deficit of any part of the body? _____
State sensory level (if any), deficiency in perceiving or appreciating sensations (i.e. touch, pin-prick, pain, temperature, position sense, and vibratory sense.) Record part of body having above deficit, cause and diagnosis, if known.

_____
_____
_____

Is there any atrophy or hypertrophy of skeletal muscle? If so, state location, cause and diagnosis.

_____
_____
_____

PSYCHIATRIC EVALUATION:

Is patient disoriented? _____Is the Patient Delusional? _____ Does patient suffer from an obvious mental or emotional disturbance, psychosis? _____In your opinion, does the patient have sufficient mental ability, judgment or competence to make decisions concerning his/her well-being?_____
If 'no", explain in detail and cite psychiatric opinion and/or psychological test results, if any, supporting such opinion.

_____
_____
_____
_____
_____

INTELLECTUAL or DEVELOPMENTAL DISABILITY:

Does patient have an intellectual or developmental disability? _____ Does the individual have sufficient mental ability, judgment or competence to make decisions concerning his or her well-being? _____ If "no" Explain in detail. _____

_____

_____

_____

_____

_____

Does patient have a developmental disability? _____ Does the individual have ability, judgment or competence to make decisions concerning his or her well-being? _____

If "no" Explain in detail. _____

_____

_____

_____

_____

SPECIAL SENSES:

Record any objective signs of a deficiency, disease, impairment, or pathology relating to Eyes (record visual acuity of each eye, with and without glasses), Ears, Nose, Throat, and Speech. If present, describe, give cause and diagnosis if known.

_____

_____

_____

PERTINENT DIAGNOSTIC AIDS:

Give date, and *cite the results* of any significant and pertinent laboratory or diagnostic studies which *you possess* or to which you have had access in making this evaluation. Attach documentation to this form.

_____

_____

_____

_____

TABLE I

OFFICAL CRITERIA

FOR CLASSIFICATION OF

CARDIAC DISEASE

ESTIMATE OF FUNCTIONAL OR WORK CAPACITY FOR PATIENT WITH ORGANIC HEART DISEASE

Class 1	Class 2	Class 3	Class 4
Organic heart disease exists but without resulting symptoms Walking, climbing stairs freely, and the performance of the usual activities of daily living do not produce symptoms Prolonged exertion, emotional stress, hurrying, hill-climbing, recreation, (asterisk) or similar activities do not produce symptoms Signs of congestive heart failure, are not present	Organic heart disease exists but without resulting symptoms at rest Walking freely in the level, climbing at least one flight of stairs and the performance of the usual activities of daily living do not produce symptoms Prolonged exertion, emotional stress, hurrying, hill-climbing, recreation, or similar activities produce symptoms Signs of congestive heart failure are not present	Organic heart disease exists but without resulting symptoms at rest Walking more than one or two blocks on the level, climbing one flight of ordinary stairs, or the performance of the usual activities of daily living produce symptoms Emotional stress, hurrying, hill climbing, recreation, or similar activities produce symptoms Signs of congestive heart failure may be present, and if so are usually relieved by therapy	Organic heart disease exists with symptoms even at rest The performance of any of the activities of daily living beyond the personal toilet or its equivalent produces increased discomfort Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest Signs of congestive heart failure, if present, are usually resistant therapy

Prophylactic-restriction of activity such as strenuous competitive sports does not exclude a patient from class 1.

TABLE II

OFFICIAL CRITERIA

FOR CLASSIFICATION OF

MUSCULOSKELETAL DISABILITY

FUNCTIONAL CLASSIFICATION OF MUSCULOSKELETAL INADEQUACY OR FAILURE
(Criteria adopted by American Rheumatism Association)

Class I	Complete functional capacity with ability to carry on all usual duties without handicaps.
Class II	Functional capacity adequate to conduct normal activities despite handicap of discomfort or limited mobility of one or more joints.
Class III	Functional capacity adequate to perform only little or none of the duties of usual occupation or of self-care.
Class IV	Largely or wholly incapacitated with patient bedridden or confined to wheelchair permitting little or no self-care

EXAMINING PHYSICIAN'S BILL

Dr. _____ Date _____

County Social Services Agency_____

Name of Patient _____ Client Reg. No. _____

Social Security No. _____ Related Reg. No. _____

Address _____ Birth Date _____ Sex ____

Date		(Check)	
_____	☐	Examination at office	$20.00
_____	☐	Examination at hospital	$20.00
_____	☐	Examination at patient's home	$30.00
_____	☐	Examination in public institution	No Fee
_____	☐	Other (explain) _____	

Approved for Payment

Date_____ Signature _____

NAME OF PHYSICIAN _____
(Print or type as name should appear on check)

SIGNATURE _____

ADDRESS _____

NOTICE TO EXAMINING PHYSICIAN

(Please read carefully - Complete all sections including negative answers where applicable.)

The patient named above has applied to the State Agency/County Board of Social Services for assistance and has designated you as the physician of his/her choice to make a medical examination and report which is required in connection with his/her application.

The information requested in the attached report is necessary in order for this agency to reach a decision as to whether the patient is "INCAPACITATED" for purposes of granting public financial assistance, or has a permanent medical condition that is totally disabling and will persist for at least one year for purposes of granting Medicaid benefits. Definitions of these two categories appear below:

1. An INCAPACITATED person means a person who has a physical or mental defect, illness or impairment of such a nature as to reduce substantially or eliminate the ability to support or care for himself/herself or his/her children. Such "incapacity" must be likely to continue or persist for at least thirty (30) days from the date this form is completed.
2. An individual is medically eligible for Medicaid Programs if he/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months (or, in the case of a child under the age of 18, if he/she suffers from any medically determinable physical or mental impairment of comparable severity).

A presumption is made that any person presenting this "Examining Physician's Report" to you has some DEFECT, DISEASE OR IMPAIRMENT. The preparation of this report shall be based on a complete medical and physical EVALUATION OF THE PATIENT. If the patient has been under your care recently, the report may be prepared on the basis of your cumulative knowledge and clinical records WITHOUT A NEW EXAMINATION. However, if you have not personally examined the patient within three months, a new examination is required. You must (in order to receive payment for your service) complete ALL SECTIONS OR PARAGRAPHS including negative answers where applicable. The medical evidence submitted must be ADEQUATE TO SUBSTANTIATE OBJECTIVELY your diagnosis, the existence of an "incapacity" which will persist for at least 30 days; or verify the degree of permanence and totality which can be expected to result in death or can be expected to last for a continuous period of not less than 12 months. The information must be such that a reviewing physician would reasonably accept your diagnosis or your identification of the defect, disease or impairment without examining the patient. It should be understood that although a diagnosis is desired, it may not be known because of insufficient data. In such cases, PRESENT A FULL PICTURE OF THE DEFECT, DISEASE OF IMPAIRMENT. OPINIONS without objective evidence WILL NOT BE ACCEPTED.

We urge you to furnish the information as PROMPTLY AS POSSIBLE to avoid delay in reaching a decision about the medical eligibility of the patient. This information will be held CONFIDENTIAL within the agency, and the patient will be referred to you any information he/she wants concerning the contents of this report, except in the event of a Fair Hearing (appeal procedure) when the evidence will have to be made available to the appellant.

Please mail this report to the agency in the attached, self-addressed post-paid envelope. DO NOT HAND IT TO THE PATIENT FOR DELIVERY. Your fee for service, when billed on the upper portion of this sheet, will be paid promptly WHEN YOUR REPORT IS COMPLETE.