

# IMPACT

## Newsletter of the **ASSISTIVE TECHNOLOGY** Advocacy Project

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## **USING MEDICAID TO FUND ASSISTIVE TECHNOLOGY**

### **A Review of Medicaid Eligibility and the Process for Obtaining Specialized Equipment Through Medicaid's Durable Medical Equipment Provisions**

*This replaces a two-part series published in our Summer 2000 and Spring 2001 issues of IMPACT, which in turn replaced a three-part series, published in our November 1995, December 1995 and January 1996 issues of IMPACT.*

#### **INTRODUCTION**

Medicaid, also known as Medical Assistance, is an important program for persons with disabilities. It can pay for many services and supplies, such as doctor and hospital visits, mental health treatment, prescription drugs, physical, occupational and speech therapy, home health care, and transportation to and from the medical provider. Medicaid can also pay for assistive technology (AT), such as power and custom-made wheelchairs, augmentative communication devices, and many other items.

The Medicaid rules are a complicated maze of federal and state laws, regulations, court decisions, and policies. [See 42 U.S.C. §§ 1396 et seq.; 42 C.F.R. §§ 430 et seq.; N.Y. Social Services Law §§ 363 - 369; and 18 N.Y.C.R.R. Parts 360 (eligibility), 513 (prior approval process) and 358 (fair hearings).] This article provides a basic guide to Medicaid, including an in-depth discussion on how persons with disabilities can establish eligibility; how to obtain funding for AT, or what Medicaid calls durable medical equipment; and how to appeal adverse decisions through both

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fair hearings and court appeals.

## ADMINISTRATION OF MEDICAID

Medicaid is a program for persons with limited income and resources. An applicant who meets eligibility criteria is “entitled” to Medicaid benefits. The amount spent by Medicaid on a particular recipient is generally not governed by any overall spending limit or cap. Rather, eligibility for each service or item of equipment is governed by the person’s need for it.

The federal, state and local governments pay for Medicaid. It is administered at the federal level by the Centers for Medicare and Medicaid Services and at the state level by the State Department of Health (DOH). DOH also administers numerous policies governing Medicaid, including the Medical Assistance Reference Guide (MARG), Administrative Directives (ADM), Informational Letters (INFs), General Information System Messages (GIS), and Local Commissioner’s Memoranda (LCMs). Medicaid advocates should contact DOH to obtain the MARG. The ADMs, INFs, and GISs are available on DOH’s website, [www.health.state.ny.us/health\\_care/medicaid/publications](http://www.health.state.ny.us/health_care/medicaid/publications). At the local level, the county Departments of Social Services administer Medicaid, except in New York City where it is run by the Human Resources Administration. In this article both are referred to as the local DSS. Local policies must be consistent with federal and state law, regulations, and policies.

## SSI AND WELFARE RECIPIENTS QUALIFY FOR MEDICAID AUTOMATICALLY

In New York, Supplemental Security Income (SSI) recipients and recipients of cash welfare benefits [i.e., Temporary Assistance to Needy Families (TANF, formerly the Aid to Dependent Children program), and Safety Net benefits (formerly the Home Relief program)] qualify for Medicaid automatically.

### *Some Former SSI Recipients Continue to Qualify for Automatic Medicaid*

SSI provides cash benefits to persons with limited income and resources. In four situations, a person who loses SSI due to increased income can retain automatic Medicaid:

1. Individuals who lose SSI when they become eligible for Social Security widows/widowers benefits retain Medicaid during the 24-

month waiting period for Medicare. 42 U.S.C. § 1383c(d).

2. The Pickle Amendment applies to individuals who in the past were eligible for both SSI and SSDI and then lost SSI due to an increase in their SSDI benefit check. That individual will once again become eligible for Medicaid if they would be eligible for SSI today if cost of living increases in SSDI, since the month they lost SSI, are ignored. 42 U.S.C. § 1396a (note).
3. Individuals who lose SSI when they become eligible for Social Security Disabled Adult Child’s (DAC) benefits or an increase in those benefits retain automatic Medicaid if they would be eligible for SSI by ignoring the DAC benefits or most recent DAC increase. 42 U.S.C. § 1383c(c); 95 ADM 11; 92 LCM 41; 95 LCM-28.
4. Section 1619(b) allows automatic Medicaid to continue if a person loses SSI due to wages. If the person is still disabled and would be eligible for SSI if the wages were not counted, Medicaid should continue. New York’s 2005 income limit is \$37,575 in wages per year, an income limit that can be even higher if medical expenses are high enough. Social Security Program Operations Manual System (POMS) SI 02302.010 B. [For a more thorough discussion of 1619(b), see IMPACT, Jan.-Feb. 1999, *The SSDI and SSI Work Incentives: Funding Assistive Technology to Make Work a Reality.*]

The third and fourth categories are the most common.

**Example, Pickle Amendment.** Donna was receiving both SSI (\$80) and SSDI (\$520) in 1998 when the SSI living alone rate was \$580. In October 1998, her SSDI benefit amount increased to \$676 and she lost SSI. For 2005, her SSDI payment rate is more than \$800 and she would not be eligible for SSI today. However, under the Pickle Amendment, we would use \$676 as her SSDI payment rate to determine if she would be eligible for SSI today if we ignored cost-of-living increases since she lost SSI in 1998.

The 2005 SSI living alone rate is \$666. The SSI program would disregard the first \$20 of Donna’s SSDI check, making her countable income \$656 (\$676 - 20). This would make

her eligible for a \$10 SSI check (\$666 - 10). Since Donna would be eligible for SSI if we ignored SSDI cost-of-living increases since 1998, she is eligible for automatic Medicaid under the Pickle Amendment.

**Example, Social Security DAC Recipient.**

James, a man with mental retardation, receives \$602 in monthly SSI. His father dies and James becomes eligible for \$920 in Social Security DAC benefits. James will lose SSI benefits because his DAC income is too high. Since he loses SSI, ordinarily he would now have to apply separately for Medicaid and pay a \$233 per month spend down to retain eligibility. Under these facts, however, James is eligible for continued automatic Medicaid without a spend down.

**Example, section 1619(b) Medicaid.**

Denise, who lives alone was receiving \$666 in monthly SSI benefits. She goes to work and earns \$1,685 gross per month, or \$20,220 annually. As a working SSI recipient, the first \$65 she makes is not counted (or in her case, \$85 because she has no unearned income). Denise’s remaining income is then cut in half, leaving her countable income at \$800 per month ( $\$1,685 - 85 = \$1,600 \div 2 = \$800$ ). Since this is more than the \$666 SSI base rate for 2005, she will no longer qualify for an SSI check. However, as this is well under the 1619(b) eligibility threshold for New York (\$37,575 for 2005), Denise should be eligible for continued Medicaid so long as she meets the other 1619(b) criteria (a given in most cases).

**ALL OTHERS MUST SUBMIT A MEDICAID APPLICATION**

Persons who do not receive SSI or welfare benefits, including recipients of Social Security Disability Insurance (SSDI) benefits, must apply for Medicaid through the local DSS. Our focus will be on eligibility for persons with disabilities.

***Categorical Eligibility***

All applicants must establish categorical eligibility. Applicants are in the federal, “SSI-related” category if they meet the federal, SSI standard of disability. Similarly, applicants are in the federal, “Aid to Dependent Children (ADC) related” category if they meet the federal, ADC criteria (persons under age 21 and their caretaker(s),

and pregnant women). (Although ADC was replaced by TANF, the ADC-related Medicaid category still exists.) These applicants are in what is often referred to as the “medically needy” category. So, for example, SSDI recipients who do not receive SSI will still be “SSI-related” based on their disability. Single parents who do not receive welfare benefits will be “ADC-related” based on their caretaker relationship to a child under age 21. [The Medical Assistance Reference Guide has a complete discussion of all Medicaid eligibility categories.]

Medicaid’s budgeting rules for the SSI-related or ADC-related categories can be complicated. If a person appears to be in both categories (e.g., a single parent with a disability), the local DSS must consider eligibility under both the SSI and ADC-related rules. It must then allow the applicant to choose the budgeting method which is most advantageous.

The remainder of this section will focus on the SSI-related rules that apply to persons with disabilities or blindness. Compared to single adults who do not meet the disability standard, applicants in the SSI category of assistance qualify for the more generous federally-related income and resource guidelines, the more generous income deductions and, unlike single adults who are in a state category of assistance, may qualify for Medicaid with a spend down.

***Financial Eligibility***

This chart illustrates New York’s 2005 income and resource limits based on household size (these limits go up as household size increases):

Household Size	Monthly Income	Resources
1 person	\$667	\$4,000
2 people	\$975	\$5,850
3 people	\$984	\$5,900
4 people	\$992	\$5,950

All income must be verified, including earned, unearned, and in-kind income. Some sources of income will be excluded in part, while other sources will be excluded altogether. Therefore, we encourage people to apply for Medicaid, even if their income appears to be over the limit. Those persons with income above the monthly limit may qualify for a spend down.

**Example, Medicaid spend down.** Jack is

disabled, lives alone and receives \$820 per month in SSDI benefits. Medicaid will disregard the first \$20 of his income as an unearned income exclusion, leaving him with \$800 in countable income or \$133 more than the 2005 one-person monthly limit. Jack can qualify for Medicaid if he pays the first \$133 each month of his medical expenses or after he incurs \$133 in medical expenses. Medicaid will now pay for his remaining expenses. If Jack has medical bills each month that are well above \$133, his local DSS should allow him to pay his \$133 spend down directly to the Medicaid office.

All resources must be verified, including liquid and non-liquid resources. Certain resources, like a person's home or vehicle, will be exempt. The amount of available resources held by the household cannot exceed those allowed by Medicaid. When in doubt it is always best to apply for Medicaid, even if resources appear to be over the limit. A Medicaid recipient must immediately report changes in income, resources, and household composition.

#### ***Persons with Disabilities Are Allowed Special Deductions from Income and Resources***

A single individual with a disability will be eligible, under 2005 rules, if countable income is no more than \$667 per month and resources no more than \$4,000. If income is more than \$667 they will qualify only with a spend down. If countable resources are above \$4,000 they will not qualify for Medicaid. (Note: If seeking eligibility under the Medicaid buy-in program, discussed below, a higher \$10,000 resource limit is allowed.)

**Income Disregards for Persons Who are Working.** The Medicaid rules for disregarding income are nearly identical to SSI's rules. The first \$20 of unearned income is disregarded. The following amounts are disregarded from earned income or wages: the first \$65 (or \$85 if there is no unearned income); impairment related work expenses; one half of remaining earned income; blind work expenses, for persons who are legally blind; up to \$1,460 per month, but not more than \$5,910 per year for a full-time student under age 22; and any income set aside in a Plan for Achieving Self Support. [For a listing of all income disregards, see 18 N.Y.C.R.R. § 360-4.6(a).]

**Example.** June, who is deaf, receives \$710

in SSDI benefits. After disregarding \$20, \$690 of this income will be counted by the SSI program, which is too high to receive an SSI check. It is also \$23 more than the \$667 income limit for Medicaid, meaning that June will have a \$23 per month Medicaid spend down. June goes to work and earns \$465 gross per month. The Medicaid program will disregard the first \$65 and an additional 50 percent, leaving her with \$200 in countable wages ( $\$465 - 65 = 400 \div 2 = \$200$ ). Her total countable income is now \$890 per month (\$690 unearned + \$200 earned), making her spend down \$223 per month. Thus, as her income went up by \$465, her spend down increased by \$200. June's countable income could be reduced further if she were to put all or part of this \$230 into an approved Plan for Achieving Self Support (see immediately below). We will also learn below that June will probably be eligible, without a spend down, under New York's Medicaid buy-in program.

**Medicaid's Plan for Achieving Self Support (PASS).** The PASS is best known as an SSI work incentive. It allows a person to take income or resources that would be counted by SSI and exclude the money by using it to help the person achieve a vocational goal. For example, SSI's PASS has been used to take SSDI benefits or wages and use the money for items like tuition, computer equipment, or a vehicle. When the PASS is approved, the person qualifies for SSI without counting the excluded income. Typically, this allows the person to qualify for a higher SSI check. [See the Spring-Summer 2002 issue of *IMPACT*, *SSI's PASS: Using the PASS to Purchase Assistive Technology to Reach a Work Goal*, [www.nls.org/at/atspr-sum02.htm](http://www.nls.org/at/atspr-sum02.htm).]

A PASS can also be used to exclude income or resources that would be counted by Medicaid. 18 N.Y.C.R.R. § 360-4.6(a)(2)(xxiv). We can assume that all the policies that apply to the PASS in the SSI program will also apply to Medicaid's PASS.

**Example.** Mary has a spinal cord injury and receives \$970 in monthly SSDI benefits. After the first \$20 of her SSDI is excluded, Mary's monthly income is \$283 above the one-person Medicaid limit of \$667, meaning she will face a \$283 spend down to obtain Medicaid coverage.

Mary proposes to set aside \$250 per month

(\$3,000 per year) in a PASS to save toward the purchase of a modified van and a laptop computer to pursue a career in accounting. If approved, Mary's countable income is reduced from \$950 to \$700 and her spend down is reduced from \$283 to \$33 per month. If Mary sets aside \$283 in an approved PASS her spend down will be eliminated altogether. Mary can also reduce her countable resources below the \$4,000 limit by designating part of her savings toward PASS expenses.

A PASS can fund a wide range of items, including child care, equipment or supplies to start a business (including a business operated from the home), and modifications to vehicles or buildings to allow use by the person with a disability. So long as the cost is connected to the vocational goal, it should be allowed under Medicaid's PASS.

**Medical expenses incurred or paid by a program of the state, county or city** must be counted as medical expenses under the spend down provisions. 42 U.S.C. § 1396a(a) (17)(D); 18 N.Y.C.R.R. § 360-4.8(c)(1); 91 ADM-11. Examples of such programs are: the Physically Handicapped Children's Program, programs administered by the Offices of Mental Health (OMH) or Mental Retardation and Developmental Disabilities (OMRDD), the Aids Drug Assistance Program (ADAP), and the Child Health Insurance Program (CHIP). Medical expenses paid by public school districts, counties, or municipalities on behalf of children with handicapping conditions are specifically mentioned in 91 ADM-11 as qualifying under this provision.

**Example.** Kevin, age 13, has cerebral palsy and receives speech, physical and occupational therapy at his public school as special education services. Kevin lives with his mother and, based on his mother's income, is not eligible for SSI and is eligible for Medicaid with a \$900 per month spend down. We learn that the special education program incurs \$650 per month for the therapies mentioned above and also incurs \$200 per month in expenses as payments the school makes for an augmentative communication device which it purchased for Kevin. These \$850 in school-based medical expenses will reduce the spend down to \$50 per month. This means that for \$50 per month, Kevin's mother can obtain Medicaid coverage for him. This will

now provide a payment source for a power wheelchair, prescription drugs, doctor visits, home health care, and a range of other services. (Note: If Kevin's mother was required to contribute for premiums in an employer-provided health insurance plan, those payments would further reduce the spend down.)

## **THE MEDICAID BUY-IN FOR WORKING PEOPLE WITH DISABILITIES**

The Medicaid buy-in is an optional program that started in New York in July 2003. It allows working individuals with disabilities ages 16 to 64, who would not otherwise be eligible for Medicaid without a spend down, to establish Medicaid eligibility.

The buy-in follows the same rules as the Medicaid spend down program for what income and resources are counted or excluded. There are three key differences, however: eligibility is allowed at much higher levels of income; the resource limit for non-excluded resources is \$10,000 rather than \$4,000; and the Medicaid agency is authorized to charge a monthly premium at higher levels of income.

The buy-in allows for eligibility if countable income is no more than 250 percent of the federal poverty level. In 2005, this would allow for countable income of \$1,994 per month. If countable income is above 150 percent of the poverty level (\$1,197 in 2005), the Medicaid program can charge a premium based on a sliding-scale formula. Since countable income means after SSI-related exclusions, including the \$65 plus 50 percent exclusion for earned income, gross wages can be as high as \$4,000 per month (\$48,000 per year) and the individual will still be eligible for Medicaid under the buy-in.

**Example.** Let us return to June from the Medicaid spend down section, above. June was receiving \$710 in SSDI and paying a \$23 spend down when she started working. When she started making \$465 in gross wages per month, her countable income increased by \$200 to \$890 per month, increasing her spend down to \$223. Under these facts, since June is disabled and is working she should be eligible for the Medicaid buy-in program. Eligibility for the buy-in would eliminate her obligation to pay a spend down. Also, since her countable income is less than 150 percent of the federal poverty level (\$1,197 in 2005),

she will not be required to pay a premium when New York starts charging premiums at the higher levels of eligibility.

For more information on the Medicaid buy-in, see the *Benefits Planner's* two-part series, Summer 2003 and Fall 2003 issues, [www.nls.org/planner/summer03.htm](http://www.nls.org/planner/summer03.htm) and [www.nls.org/planner/fall03.htm](http://www.nls.org/planner/fall03.htm) or call the State Work Incentive Support Center's toll-free work incentives hotline at 1-888-224-3272.

### **MEDICAID FUNDING OF DURABLE MEDICAL EQUIPMENT**

Medicaid will pay for a wide range of DME, including power and custom wheelchairs, power scooters, augmentative communication devices, specialized beds and cribs, and many other items. However, in most cases Medicaid recipients cannot go out and purchase DME on their own. They need to obtain formal prior approval of the State Department of Health (DOH).

Since DME can be expensive, the regional DOH office responsible for reviewing requests may deny many of them. We recommend persistence. In our experience, DOH denials are often reversed at a fair hearing.

#### ***Medicaid Coverage of DME: a Three-Part Test***

An individual who seeks funding for DME, such as a power wheelchair, must satisfy a three-part test:

1. The individual must be eligible for Medicaid.
2. The item in question must be covered by New York's Medicaid program, i.e., it must meet the definition of DME or some other coverage category (such as prosthetic devices).
3. The item must be medically necessary and the least costly alternative.

Medicaid also requires that the individual first seek funding from all available resources, including private insurance and Medicare, before it will pay for DME.

The previous section discussed part one of this test, eligibility. In this part we discuss part two (coverage under the DME provisions) and part three (medical necessity).

#### ***Meeting the DME Definition***

New York's DOH, by regulation, has established a definition for DME:

“Durable medical equipment means devices and equipment, other than prosthetic or orthotic appliances, which have been ordered by a practitioner in the treatment of a specific medical condition and which have all of the following characteristics:

- (i) can withstand repeated use for a protracted period of time;
- (ii) are primarily and customarily used for medical purposes;
- (iii) are generally not useful to a person in the absence of illness or injury; and
- (iv) are usually not fitted, designed or fashioned for a particular individual's use. Where equipment is intended for use by only one person, it may be either custom-made or customized.” 18 N.Y.C.R.R. § 505.5(a).

Most equipment sought by Medicaid recipients will meet the DME definition. For example, the DOH readily acknowledges that items like power and custom wheelchairs meet this definition. When an expensive wheelchair is sought, any controversy surrounding approval will involve medical necessity or whether there is a less costly alternative, as described below.

The DOH will sometimes deny prior approval requests on the grounds that an item does not meet the definition of DME. For example, throughout the 1980s and 1990s DOH had a longstanding policy that Medicaid funding of power scooters could not be approved. It took the position that scooters did not meet the DME definition as they were not “primarily and customarily used for medical purposes.” In three fair hearing decisions decided the same day (10/18/2000), that position was ruled illegal, opening the door for a change of policy and now allowing funding of a power scooter in any case where it can be shown that the requested item is medically necessary.

In reality, the outright exclusion of all scooters was probably illegal under federal Medicaid law. The federal agency overseeing Medicaid, the Centers for Medicare and Medicaid Services (CMS), informed State Medicaid directors by a letter dated September 4, 1998, that states violate federal law when they try to categorically exclude items that otherwise fit the definition of DME. The CMS policy letter states that any list of approved DME must be for administrative convenience only. A state must have a procedure available for approving equipment not on the list. In particular, states must have a process for ap-

proving newly developed equipment as states must remain open to developing technologies. A copy of the CMS letter can be obtained from the CMS website at [www.cms.hhs.gov/states/letters/smd90498.asp](http://www.cms.hhs.gov/states/letters/smd90498.asp).

### ***The Medical Necessity Test***

The prior approval regulations provide guidance on what constitutes “medical necessity.” DME is considered medically necessary when it will “prevent, diagnose, correct or cure a condition that: (1) causes acute suffering, or (2) endangers life, or (3) results in an illness or infirmity, or (4) interferes with the capacity for normal activity, or (5) threatens the Medicaid recipient with a significant handicap.” 18 N.Y.C.R.R. § 513.1(a).

DME will be approved when it is necessary to “restore the recipient to his or her best possible functional level ...” Medical necessity “must be determined in light of the recipient’s specific circumstances and the recipient’s capacity to make use of the requested [DME] and appropriate alternatives.” *Id.* § 513.1(c).

In most cases, the DME is sought to address some limitation created by a medical condition. Consider the person who seeks a power wheelchair to address an inability to walk. This limitation might be caused by cerebral palsy, muscular dystrophy, multiple sclerosis, or a spinal cord injury. The purpose of the wheelchair would be to

allow the person to move about (in the home and in the community) despite the limitations caused by the disability.

In striving to meet the medical necessity test through reports (and testimony if the case goes to a hearing), the case is strongest if traditional medical needs are stressed first. This would include using the DME to get out of bed, to use the bathroom, to take care of personal hygiene, and to get to medical appointments. The reports or testimony can then stress those activities that deal more with independence and “normal activity,” including doing one’s own shopping, cooking, getting to work or church, and attending recreational activities.

### ***Establishing “Least Costly Alternative”***

Often, the focus of a dispute with DOH is not on whether the individual has a particular disability or whether equipment is needed to overcome the effects of that disability. Instead, the focus is on what intervention can get the job done at the least cost. *See id.* § 513.4(d), which requires the ordering practitioner (i.e., doctor) and potential vendor to assure DOH that “adequate and less expensive alternatives have been explored.”

Let’s go back to the person who seeks the power wheelchair. Medicaid will fund a number of items that are geared to help an individual achieve a functional level of mobility. Consider the following groupings of mobility-enabling devices:

- crutches, walkers, and wheeled walkers;
- standard and manual wheelchairs;
- custom, light weight, and ultra light manual wheelchairs;
- power scooters;
- basic power wheelchairs;
- power wheelchairs with extra features (e.g., tilt in space, power tilt in space, standing mechanism).

Each item can be and has been funded by Medicaid. However, as we move through this list, the cost will go from under \$100 for the crutches to more than \$20,000 for some power wheelchairs with special features. In fact, the cheaper items (crutches, walkers, standard manual wheelchairs) are not subject to prior approval and can be obtained with a doctor’s prescription.

With the more expensive items, there will be a need to establish, through supporting documen-

## ***IMPACT is Back!***

Our State AT Advocacy Project last published the *IMPACT* newsletter in 2002. After regularly publishing the newsletter since 1995, a reduction in funding and loss of resources made it impossible to continue this very popular publication.

During the past year our funding has stabilized and, with increased resources, we will resume publishing *IMPACT* as a quarterly newsletter. As before, we plan to publish lead articles covering all of the primary assistive technology funding sources, including Medicaid, Medicare, special education programs, VESID, the Commission for the Blind, and private insurance programs.

tation, that the item sought is the least costly alternative that can meet the individual's medical needs. In other words, it must be documented that less costly alternatives will not provide the recipient with an adequate or functional means of mobility. It will also be necessary, in some cases, for the documentation to address the individual's ability to both safely operate the equipment and receive benefit from its use. A successful trial in the requested wheelchair can be very persuasive evidence to prove its appropriateness for the individual.

### **THE PRIOR APPROVAL PROCESS**

Most DME is purchased from a participating Medicaid vendor rather than from a pharmacy or retail store. Medicaid vendors should be familiar with the prior approval process and will help recipients with the application. Remember, however, that only the Medicaid recipient or those working on his or her behalf can give a case the individual attention to help assure success.

To establish that DME is "medically necessary," Medicaid recipients must have the support of health professionals. For example, a recipient who needs a power wheelchair will generally need the support of a physical or occupational therapist and a medical doctor. A recipient who seeks an augmentative communication device will need the support of a speech pathologist and a doctor. In our experience, health professionals like occupational, physical and speech therapists often first identify and document the need for DME.

Assuming such support, a Medicaid recipient (or a person acting on his or her behalf) must then contact a Medicaid-approved vendor. The vendor will often work closely with the individual's treatment team, including occupational and/or physical therapists. For example, if the individual needs a power wheelchair, the vendor will send an employee to the home or day program to determine the type and size wheelchair that is needed and, if possible, to let the recipient try the equipment to make sure it will accomplish its purpose.

Before submitting the prior approval request, the vendor will gather proof of medical necessity. The proof will include, at a minimum, a prior approval form (with or without a prescription) signed by a medical doctor, and a letter of medical justification signed by the doctor and therapist. The medical justification letter summarizes information about the individual's condition, the requested equipment, the exploration of other alternatives, and the effect of the requested equipment on the individual's home life, employment, education, and medical needs.

The vendor and health professionals must assure the DOH that they are recommending the least costly alternative. Therefore, the medical justification should explain the other less costly alternatives that were considered and why they were rejected. The reports should state what equipment is currently being used, if any, and why the equipment is no longer meeting the recipient's medical needs. The reports might also explain additional features and warranties that make the DME in question a better buy, as contrasted with features that are lacking with less expensive alternatives.

We recommend supplementing the medical justification form with additional support if possible. This could come from another doctor, occupational therapist, physical therapist, nurse, home health aide, psychiatrist, psychologist, or counselor. Professional letters of support should be written on letterhead; summarize the writer's professional qualifications; recite the length of time the writer has worked with the recipient; provide details on the recipient's diagnosis and prognosis in non-medical terms; and explain clearly and simply, in compelling terms, why the DME, in his or her professional opinion, is medically necessary. [For a guide to preparing reports, see our March-April 1998 issue of *IMPACT, Report Writing: Justifying the Need for Assistive Technology*, available at [www.nls.org/at/at0398.htm](http://www.nls.org/at/at0398.htm).]

The Medicaid recipient should consider submitting letters from other sources, including schools, employers, case managers, family members, personal care aides, and neighbors. These letters can address more practical issues and explain why the individual needs the DME for matters of safety, independence, maximizing capacity for normal activity, and performing activities of daily living. Remember, a piece of DME is "medically necessary" if it prevents or corrects a

**For a complete and updated listing of Medicaid income and resource limits for various types of households, see the Neighborhood Legal Services website at: [www.nls.org/medichrt2005.htm](http://www.nls.org/medichrt2005.htm).**

condition that “interferes with the capacity for normal activity.” The letters should be on letterhead (where appropriate), neatly and legibly written, dated, and signed with a phone number and address.

Once the prior approval form, the medical justification form, and the other supporting documents are gathered, the vendor will submit them to DOH, which has 21 days to grant approval, deny approval, or modify the request (unless DOH asks for additional information). If DOH requests additional information, it should be provided as soon as possible. If DOH denies, modifies or voids the request, or otherwise fails to act upon it within a reasonable time, the recipient can ask for a fair hearing to challenge the denial, modification, etc., before the New York State Office of Temporary and Disability Assistance (OTDA), formerly the State Department of Social Services.

## **WHAT IF A MEDICAID APPLICATION OR A REQUEST FOR DME IS DENIED?**

### ***Medicaid Must Provide Written Notice of its Determinations***

**Denial of application.** The local DSS must inform the applicant of its decision to approve or deny a Medicaid application within 30 days of the application date. If eligibility is dependent upon disability status, the agency has 90 days within which to notify the applicant of its determination.

If approved, the notice must inform the applicant of its approval, the application date, the period of Medicaid coverage, and any limitations on coverage. If denied, the notice must inform the applicant of its denial, the application date, the reason(s) for the denial, the regulations allowing the agency to deny the application, and the right to a fair hearing. The notice must explain that the applicant has 60 days within which to request a fair hearing.

**Termination or reduction of benefits.** A Medicaid recipient is entitled to a similar written notice if the local DSS seeks to terminate benefits or change the terms of eligibility (e.g., impose a spend down). A termination or reduction notice must advise the applicant that aid will continue at its current level if a hearing is requested within 10 days. Also, if a recipient’s right to a particular service is subject to prior approval, the person is entitled to a similar notice when that service or

item is approved or denied.

**Denial of DME request.** When a prior approval request for DME is denied, the DOH must send a written denial notice which should contain the reasons and the legal basis for the denial. (However, the DOH may fail to provide a notice in the case of a voided application or involving items DOH refuses to recognize as DME.) The notice must also contain both a toll-free number to call and an address where the recipient may write to request a hearing. Since the toll-free number is usually busy, you may want to write to request a hearing. If you do so, we recommend that you mail the request from the Post Office and ask for a certificate of mailing as proof that you mailed it. You can also request a hearing by fax (518-473-6735), the method our office uses for requesting most hearings because it is quick and efficient and provides a fax receipt to verify the request. Remember to include all of the reasons why you are asking for the hearing. Keep in mind that the hearing must be requested within 60 days of the date of the denial notice! Although DOH made the decision, the hearing request goes to OTDA.

### ***The Fair Hearing***

Following receipt of the hearing request, OTDA will usually send the recipient two notices. The first confirms receipt of the hearing request; the second contains the date, time and location of the hearing. The hearing will be before an administrative law judge (ALJ), who is an employee of OTDA with no prior knowledge of the case. The Medicaid recipient can appear with or without a representative. Anyone can represent the individual at the hearing — it does not have to be an attorney. We recommend representation by a trained advocate.

Prior to the hearing, the individual’s representative is entitled to review all documents that DOH will submit at the hearing. The individual or the representative can obtain a copy of the documents by sending a letter to DOH requesting a copy of all documents to be submitted at the hearing. A representative should enclose an authorization from the individual, allowing the representative to review the records. Upon receipt of these documents, particular attention should be paid to the “Fair Hearing Summary” since it will contain more detailed reasons for the decision.

The ALJ will conduct the hearing, hear the

testimony of witnesses, and ask the witnesses questions. The entire hearing will be recorded. Most counties are now equipped to record telephonically. The ALJ will not issue a decision at the end of the hearing. Rather, he or she will make a recommendation to the Commissioner of OTDA. The Commissioner or his/her designee will then issue a decision.

Medicaid DME hearings are unlike most other OTDA fair hearings. Often, no one from the DOH will personally appear. Instead, the DOH will submit to the ALJ the same documents it previously sent to you and ask for a waiver of appearance. This waiver request should be included in the DOH file sent to you. If it is not, and a waiver request is not produced at the hearing, point this out to the ALJ. Despite the waiver request, many ALJs are calling the DOH reviewer who denied the request and allowing him or her to appear by telephone.

The hearing is the representative's chance to show why the denial or modification is incorrect and why the DME is needed. The representative should make a complete presentation. Remember, the final decision maker will not be present at the hearing. Also, if you lose the hearing, you can ap-

peal the decision in court. You must make a complete record at the fair hearing to increase your chances of success on appeal.

The good news is if the vendor submitted a complete package at the application phase, much of your work is already done. If that package was incomplete, you can now gather further support to present to the ALJ. You may want to forward additional support in advance of the hearing and ask the DOH to reconsider its denial. Sometimes DOH will reverse its denial based on the new or supplemental information.

At the hearing, the representative should produce witnesses who are able to testify to the individual's need for DME. Typically, this might include the individual, a friend or family member, health professional, and vendor as witnesses. If the DOH reviewer appears by phone, he or she will be allowed to state the agency's position first. The representative is then permitted to question the reviewer and respond through witnesses and testimony. The ALJ may ask questions of each witness after you are done. We recommend that you prepare an outline of the questions you will ask so that you do not forget any. Recipients who are able to testify can tell their story through your questions. What is the nature of the disability? How long has he or she been disabled? How does the disability affect daily life? The ability to leave home? The ability to care for himself or herself? The ability to conduct daily living activities? The individual's testimony can be very compelling, especially if you bring out one or more anecdotes that illustrate the problems the individual faces without the necessary DME.

You should also try to have one or more of the professionals who submitted supporting documentation testify. Through your questions, they should speak to their professional qualifications (if any), their knowledge of the recipient, and their knowledge of the individual's disability. Through your questions, they should speak to why the DME is "medically necessary." In our experience, occupational and physical therapists and speech pathologists are much more available to testify than medical doctors. Sometimes, even these professionals are not available. When this is the case, have them write a supplemental letter on why the decision to deny the request for prior approval is wrong. They can add further details (if any) on why the DME is medically necessary. If

**FAIR HEARING DECISIONS OPEN DOOR FOR MEDICAID FUNDING OF THERAPEUTIC TRICYCLES, POWER ASSIST WHEELS, AND STOCKTON BEDS**

It is not unusual for the DOH to deny prior approval for new technology or for new applications of technology. Recent fair hearing decisions involving therapeutic tricycles, E-motion power assist wheels, and Stockton beds highlight the importance of requesting medically necessary equipment when it seems to fit within the definition of DME and challenging the denials at fair hearings. In decisions involving therapeutic tricycles, power assist wheels, and Stockton beds, the ALJ rejected the DOH's argument that the items were not DME, thereby making it easier for future requests. For a copy of any one of these hearing decisions, call the AT Advocacy Project at 716-847-0650.

possible, send the additional documents to DOH prior to the fair hearing and then submit them as evidence at the hearing.

Finally, we recommend that you prepare a short closing statement. This is your opportunity to sum up your case and convince the ALJ why the denial of prior approval should be reversed. If the agency reviewer remains on the phone during the fair hearing, resist the impulse to argue with him or her. The person you must convince at this point is the ALJ.

### ***Court Appeals: What to Do If You Lose a Hearing***

If you lose the fair hearing, you may appeal it in court. Generally, these appeals are filed as Article 78 proceedings in State Supreme Court. Alternatively, you may want to consider filing a civil action in federal district court. Persons considering a court appeal should consult a lawyer and do so promptly, as the law provides strict time limits within which they may appeal (e.g., four months for an Article 78 appeal in state court). A successful petitioner or plaintiff is often entitled to recover attorney's fees from the defendant under either the State Equal Access to Justice Act or 42 U.S.C. 1988 (on a federal claim filed pursuant to 42 U.S.C. § 1983). [Attorneys can obtain sample pleadings and briefs by calling the AT Advocacy Project at 716-847-0650.]

## **CONCLUSION**

This newsletter has summarized basic Medicaid eligibility rules, including some special Medicaid rules which apply to persons with disabilities. Many of these special provisions are either not well-known or are under-utilized. In many cases, persons who appear to be ineligible for Medicaid can use these special rules to establish eligibility or to drastically reduce a Medicaid spenddown. Advocates, persons with disabilities and others who work with them need to become familiar with these provisions. They also need to become familiar with the special Medicaid waiver programs.

This article has also discussed the prior approval process for obtaining Medicaid funding of durable medical equipment. Vendors and community agencies who frequently deal with prior approval requests may want to keep this newsletter handy for reference, along with a copy of the March-April 1998 newsletter on Report Writing.

Where an individual faces an appeal – either a fair hearing or a court appeal— a call to the AT Advocacy Project at 716-847-0650 will allow us to help you to identify the next steps in the process. If necessary, we may also be able to help you find an attorney or other representative to assist you with the appeal. Representatives who are doing their first Medicaid appeal should also feel free to call us.

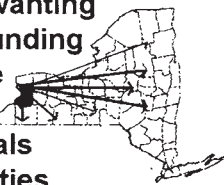
### **AT COURT WATCH**

In *Layer v Novello*, 795 N.Y.S.2d 810 (4<sup>th</sup> Dept 2005), the agency had denied a request for an Easy Stand 5000 standing frame, made on the petitioner's behalf by his nurse practitioner and physical therapist. The ALJ affirmed the denial after a fair hearing, finding there was lack of medical justification for the standing frame. In an article 78 appeal the court held that the agency's determination that standing was not a necessary treatment for the petitioner was conclusory and unsupported by the evidence. Citing 18 N.Y.C.R.R. § 513.6(e), the court declared that the physical therapist's testimony that petitioner is at risk for bone breakage and continued muscle atrophy without use of the standing frame, was "entitled to significant weight and cannot be outweighed solely by the opinions of non-medical personnel or persons not within the same medical profession as the ordering or treating practitioner."

This was a ground-breaking ruling because it recognized the professional expertise of physical therapists and occupational therapists in cases dealing with durable medical equipment. It has been our experience that physical and occupational therapists are often more readily available to write supplemental letters of medical justification and appear at fair hearings, and this recognition by the court should make it easier to prove medical necessity at a fair hearing.

[For copies of the decision or the Appellate Division brief filed in *Layer*, contact the AT Advocacy Project at 716-847-0650.]

The AT Advocacy Project will provide statewide services: including limited advocacy services and technical assistance to advocates wanting to access funding for assistive technology for individuals with disabilities.



For a complete and updated listing of Medicaid income and resource limits for various types of households, see the Neighborhood Legal Services website at:  
[www.nls.org/medichrt2005.htm](http://www.nls.org/medichrt2005.htm).

If you would like the *IMPACT* Newsletter sent to you in a large-print format or other alternative, please let us know.

## Welcome to Neighborhood Legal Services' data bank!

Do you have decisions of interest relating to assistive technology in the following areas? Medicaid, Medicare, Vocational Rehab, VA, Special Education, Physically Handicapped Children's Program, Private Insurance, etc.

Other advocates can benefit from your experience. If you have fair hearing decisions or are involved in or have completed litigation in these areas, we want to know about it.

**Please send information to:**

Neighborhood Legal Services  
Ellicott Square Building  
Attn.: Marge Gustas  
295 Main Street Room 495  
Buffalo, NY 14203

**Or contact Marge at:**

(716) 847-0655 ext. 256  
(716) 847-1322 TDD  
**FAX:** (716) 847-0226  
**E-mail:** [mgustas@nls.org](mailto:mgustas@nls.org)  
**Web Site:** [www.nls.org](http://www.nls.org)

**The Assistive  
Technology  
Advocacy Project:  
(716) 847-0650**

The logo for IMPACT, with the word "IMPACT" in a stylized, bold, italicized font.

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