



Advocate

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CONFRONTING THE MOST COMMON REASONS WHY MEDICAID AGENCIES SAY NO TO DURABLE MEDICAL EQUIPMENT REQUESTS

Advocacy Strategies for Turning a No Into a Yes

Most of the Protection and Advocacy for Assistive Technology (PAAT) programs have been around for 13 years or more. Our National Assistive Technology (AT) Advocacy Project and this newsletter, *AT Advocate*, have been around almost that long, both starting in 1996. Throughout this period, state Medicaid programs have continued to be one of the most important funding sources for AT and the most frequent subject matter for PAAT casework.

One seasoned AT advocate recently remarked that all the old reasons that Medicaid agencies have used to say “no” to prior approval requests continue to resurface. Even the 1998 Centers for Medicare and Medicaid Services (CMS) policy letter that clearly precludes the use of exclusive lists of durable medical equipment continues to be ignored as advocates respond to denial notices that deny Medicaid funding, reasoning that the item sought is not on the state’s list of covered equipment.

This article will identify some of the most common reasons why Medicaid agencies, or their contractors, deny prior approval requests for a range of items that we would identify as AT and are typically referred to as durable medical equipment (DME) by Medicaid agencies. For each of these reasons we will provide one or more common examples of when a Medicaid

agency might use this rationale for a denial. We will then address strategies available for overcoming this rationale. Wherever appropriate, we will provide the reader with citations to key provisions to law, regulation, and policy, or case law that may help support your case for approval (i.e., for turning a “no” into a “yes”).

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The reader should keep in mind that the focus of this article is the traditional Medicaid program. Although the analysis addressed below may, in some cases, apply equally to Medicaid waivers, Medicare, private insurance coverage, or other sources of third party insurance, each of those other programs will have some features which distinguish its funding criteria from that of the traditional Medicaid program.

Background on Medicaid Funding of DME: Some Key Concepts

This article will not attempt to provide a general overview of Medicaid funding of AT/DME (see our Spring 2005 issue on that topic, available on the National AT Advocacy Project's website at www.nls.org/av/spring05.htm). However, in order to give the remaining discussion some context, we will provide a brief discussion of some of the key Medicaid concepts that should be familiar to the AT advocate.

States need not participate in the Medicaid program, but all states have chosen to do so. Congress has created categories of required Medicaid services that states must cover, 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(1) - (5), 1396a(a)(17), (21), and categories of services that are optional, 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(6) - (16), (18) - (20), (22) - (25). While there may be 10 or more required and optional categories under which AT may be covered, the most common coverage category for AT is durable medical equipment (DME), a category that has no definition in the federal Medicaid Act. (See 42 U.S.C. § 1396d(a)(7); 42 C.F.R. § 440.70(b)(3), providing that "medical supplies, equipment and appliances" are mandatory home health services.) Other categories for potential coverage of AT include physical therapy, occupational therapy, and speech, hearing and language therapy, see 42 C.F.R. § 440.110 (with each category covering necessary supplies and equipment); prosthetic devices, id. § 440.120(c); preventive services, id. § 440.130(c); and rehabilitation services, id. § 440.130(d).

At least two reported decisions have recognized a three-part test for determining the right to Medicaid-funded DME:

- i) the individual must be eligible for Medicaid;
- ii) the requested item must fit within at least one required services category or an optional category that is covered in the state;
- iii) the requested item must be medically neces-

sary for the individual requesting it.

See *Hunter v. Chiles*, 944 F.Supp. 914, 916 n.1 (S.D. Fla. 1996); *Fred C. v. Texas Health and Human Services Commission*, 924 F.Supp. 788, 791 n.2 (W.D. Tex. 1996), vacated, 117 F.3d 1416 (5th Cir. 1997).

This article will not discuss part one of the test, including the many ways that individuals with disabilities can establish eligibility for Medicaid or the litigation that has focused on eligibility issues. Rather, the focus of this article is on Medicaid agency decisions that deny prior approval requests based on parts two or three of this test.

Establishing the Context For Your Advocacy

Attorneys and advocates will be confronted with the actual or expected rationale for denying a DME prior approval request at one of four key points in the approval and appeals process: at the time the approval request is submitted; following the denial and fair hearing request, but before the administrative fair hearing is held; at the fair hearing; or during the court-related review following an adverse fair hearing decision. Readers should note that federal or state court litigation could be filed, in some circumstances, to challenge the underlying Medicaid agency policy, without first pursuing an administrative fair hearing. (See box, p. 408, regarding resources available from the National Health Law Program to deal with the growing challenge of using 42 U.S.C. § 1983 to enforce Medicaid Act provisions and the alternative use of the U.S. Constitution's Supremacy Clause to enforce those provisions.)

Some rationales for a denial can be adequately addressed at any one of these four points. For example, the determination that a specialized wheelchair is not the least costly alternative to meet the individual's needs - - in essence a determination that it is not medically necessary - - can usually be overcome with good evidence or testimony. If the PAAT program or AT advocate regularly deals with equipment vendors or the prescribing health care providers (e.g., doctors and therapists), the most effective advocacy may be to provide technical assistance to the vendor or health care provider to ensure that any letters of medical justification adequately address these issues. See our Winter 2006 issue of *AT Advocate* and its lead article "Preparing Letters of Medical Justification"

The National Health Law Program's Section 1983 Docket - A Great Resource for Attorneys Pursuing Medicaid Litigation

For several years now, the National Health Law Program (NHelp) has regularly updated this section 1983 docket under the title: "42 U.S.C. § 1983 and Enforcement of the Medicaid Act." After a brief discussion of the continuing challenge of using section 1983 to enforce the Medicaid Act, including a brief discussion of case law, the 41-page document provides a section-by-section breakdown of which courts have held that section of the Medicaid Act to be enforceable or unenforceable through section 1983. (This document is not available on the NHelp website, but is available by contacting them or by contacting the National AT Advocacy Project.)

In response to the challenges of enforcing the Medicaid Act through section 1983, many advocates have turned to the U.S. Constitution's Supremacy Clause as a separate way to challenge state laws and regulations when they are inconsistent with the Medicaid Act. Sarah Somers of NHelp has written two short Question and Answer (Q&A) documents that address this issue: "Preemption and the Medicaid Act" and "Preemption and the Medicaid Act: State Court." (Both documents are available on NHelp's website, www.healthlaw.org and are also available by contacting the National AT Advocacy Project.)

(available at www.nls.org/av/winter06.htm) for a good reference tool for supporting vendors and health care providers at this prior approval level.

A Survey of Why Medicaid Agencies Deny DME Requests

The following are some of the more common reasons that Medicaid agencies use when denying requests for DME. To provide structure for this discussion, we divide these into three categories: denials that relate to "coverage" of the device; denials that relate to "medical necessity"; and "other denials" that do not neatly fit into either the coverage or medical necessity categories. Keep in mind that the distinction be-

tween coverage and medical necessity can be less than clear in some cases.

Denials Relating to Coverage of the Equipment

- *The item sought is not DME.*
- *The item sought is not DME because it is often used for non-medical reasons.*
- *The item sought is covered at the rate of \$x (where rate is well below what a vendor would ever accept).*
- *The item sought is not covered because it is considered a convenience item.*
- *The item sought is not on our list of approved DME or the item appears on a list of items that can never be approved.*

Denials Relating to Medical Necessity

- *The item sought is not medically necessary.*
- *The item sought is not the least costly equally effective alternative.*
- *The item sought is covered but would be a convenience for this recipient.*
- *The individual does not need the item because he or she has care givers present that can perform the needed function with a less expensive device (such as pushing a child's manual wheelchair or aiding in transfers with a manual rather than electric patient lift).*

Other Denials

Some of the reasons discussed below might arguably be included in the coverage or medical necessity discussion.

- *The item sought is experimental and cannot be approved.*
- *This item can only be approved once every five years and only three years have elapsed since you received it.*

Handouts Available From "Bridges to Better Advocacy" Conference

This year marked our 12th annual conference for AT advocates, held once again in Austin, Texas. Handouts are available in electronic or hard copy formats. If you would like handouts from one or more sessions, or a conference CD containing all the handouts, contact either Jim Sheldon (jsheldon@nls.org; 716-847-0650 ext. 262) or Diana Straube (dstraube@nls.org; ext. 220). Selected handouts will also soon appear on our website, www.nls.org/natmain.htm.

- *The item is not covered because it is excluded by the Medicare program.*
- *A Medicaid Managed Care Organization states that the item does not meet its own definition of DME.*

The Reasons for the Denial Must Appear on the Notice of Denial

The overwhelming majority of these reasons for denial will be encountered by attorneys and advocates in response to prior approval requests. Unfortunately, many initial decisions contain little more than a cryptic phrase such as: “not medically necessary,” or “not covered by Medicaid.”

Since the federal Medicaid regulations mandate that a notice of denial must contain the specific reasons for the denial (see 42 C.F.R. §§ 431.210, 435.912; *see also, Goldberg v. Kelly*, 397 U.S. 254 (1970)), you should insist that the notices be much more specific as to the reason for the denial. From a due process standpoint, the notice should provide sufficient information to allow the Medicaid recipient (or the recipient’s representative) to adequately prepare to challenge the denial at a Medicaid fair hearing. On a practical level, the earlier you know the details of the agency’s rationale for denial the easier it will be to prepare to contest it.

Denials Related to Coverage

Many denials will in one way or another assert that an item does not meet the state’s DME definition. While there is no universal DME criteria for Medicaid coverage, it often consists of something like this four-part test:

- can withstand repeated use;
- is primarily and customarily used for medical purposes;
- is generally not useful to a person in the absence of illness or injury; and
- is suitable for use in the home.

Since the DME criteria can vary somewhat from state to state, it is critical that you become familiar with the DME criteria in your state.

The Item Sought Does Not Meet the Criteria for DME. We often see something like this as the reason when a Medicaid agency is confronting an item that represents newer technology. This was true of augmentative and alternative communication (AAC) devices during the late 1980s and throughout much of the 1990s. It was true of therapy vests (for treatment of cystic

fibrosis and other respiratory conditions) during much of the 1990s and into the present decade. It continues to be true for items like environmental control devices which allow individuals to control much of their environment (e.g., opening doors, using the phone, using appliances) from a device nearby or one mounted on a wheelchair. In many cases, Medicaid agencies refuse to recognize that an unfamiliar technological intervention can be a form of treatment or an appropriate means to overcome the limitations created by a disability.

If at all possible, you should ask the Medicaid agency to produce a more specific notice or other document to explain which of the four-part DME criteria is not met. This could serve as a concession, for example, that three parts of the test are met. Absent such an expanded notice or statement, a good starting point is to walk through the four-part DME definition and, through written documentation or testimony, have your health-care providers explain how the device sought meets each part of the test. For each of the examples used - - the AAC device, the therapy vest, the environmental control device - - there should be no question that the device meets the four-part test. Once we satisfy the decision maker that the item meets the DME definition and is “covered,” the approval of the device will then turn on whether it is medically necessary.

The device sought does not meet the DME definition because it is “not primarily used to serve a medical purpose.” This was, in the past, a common reason for refusing to approve AAC devices. The rationale often seemed to be that any communication that went beyond that needed for expressing medical symptoms or to call out for help was considered a “convenience” and not needed for a medical reason. (This is where coverage and medical necessity can sometimes blur together.) The response to this is that the goal of the intervention, whether it is speech therapy or an AAC device, is to achieve functional communication in all settings and with all communication partners. Since most Medicaid agencies have, in effect, accepted “functional communication” as the desired outcome for AAC devices, this can be useful by analogy when confronting non-coverage decisions with other equipment (e.g., functional mobility should be the desired outcome for any wheelchair or other mobility-enhancing device that is approved).

The family of mobility-enhancing devices which includes ramps and stairlifts are routinely denied by nearly all state Medicaid programs. In New York, where advocates have had to take cases to hearings or to court to get these devices approved, it is common to have the Medicaid agency argue that these devices are not covered because they are not primarily medical in nature. To counter this as a non-coverage decision, it is not enough to show that it will be used by the particular recipient for a medical purpose (i.e., to overcome the limitations of a disability). Rather, to meet the “primarily and customarily used for medical purposes test,” the focus should be on the equipment or intervention in general, not just on one person’s use of it. In the case of a ramp or stair lift, it is fair to say that it is never installed at a residence in the absence of illness or injury of an occupant. Here again, a good strategy is to work with the health professionals who are writing reports or testifying and prepare them to address the four-part DME test or that part of the test that will be in dispute. A letter from the equipment vendor, stating that this equipment is always installed to assist a person with a disability, can also be helpful.

The item sought is not DME because “it is useful in the absence of illness or injury.” The quoted language comes from part 3 of the sample four-part DME criteria and is a close cousin to part 2 just discussed (“not primarily used to serve a medical purpose”). When dealing with items that are only used for individuals with disabilities (e.g., AAC devices, wheelchair ramps, ceiling track lifts), we should be able to quickly establish that this criteria is met.

What about the medically prescribed air conditioner, home whirlpool unit, or exercise equipment that is typically used by many individuals, without disabilities or medical conditions? It becomes quickly apparent that all three of these items fail to meet parts 2 and 3 of the DME criteria. But, you say, the air conditioner is medically necessary for the individual with multiple sclerosis (MS) to avoid the expected exacerbation of his or her condition due to very hot temperatures. And whirlpool treatment is a recognized medical intervention to treat or prevent debilitating skin breakdown (i.e., decubitus). And the exercise bike or treadmill is a recognized approach of physical therapy to retain or regain mobility following the onset of disability or following knee or hip surgery. This is where the AT advocate needs to be reminded

that you do not get to the issue of medical necessity if you cannot first establish that the item in question meets the criteria for one or more coverage categories.

Here, the advocate may be able to address the denial by identifying a coverage category, other than DME, for the item. *Preventative services*, an optional service category for adults, are services provided by a physician or licensed practitioner to prevent disability and its progression, prolong life, and promote physical and mental health. 42 C.F.R. § 440.130(c). Since avoiding extremes of heat is often a way to promote physical health and prevent the progression of disability for the MS patient, arguably the air conditioner would fit under this coverage category. The home whirlpool unit would seem to fit under this category as well. A common preventative treatment for wheelchair users, to avoid decubitus ulcers, is daily whirlpool treatment. The home whirlpool unit would also seem to fit under the optional category of *rehabilitative services* - - which may include any medical or remedial services “for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level,” 42 C.F.R. § 440.130(d) - - if the individual already has decubitus and the whirlpool is prescribed to treat it and prevent it from getting worse.

Physical therapy (PT) and occupational therapy (OT) may also be used in some cases in which the DME criteria is not met. When either therapy is prescribed by a physician or other licensed practitioner within the scope of their practice and is provided under the direction of a qualified physical therapist or occupational therapist, this category includes any necessary supplies and equipment. 42 C.F.R. § 440.110(a), (b). If the exercise equipment, mentioned above, is medically prescribed as PT or OT, it can be funded by Medicaid even if it does not meet the DME definition. In this case, the advocate should be prepared to provide evidence that the purchase of the exercise equipment is the least costly, equally effective alternative compared to the use of this equipment at a PT or OT therapy center. Keep in mind that PT and OT are also optional services for adults and will not exist in every state.

The item sought is not covered because it is a convenience item. Advocates often see this language in notices when the more expensive version of a covered item is sought. For ex-

ample, the Medicaid agency may cover manually-operated hydraulic lifts but will not cover the more expensive electrically-powered lifting devices. If the notice is unclear, the advocate must first determine whether the agency is taking the position that the device is covered by the program but not medically necessary (i.e., a convenience) for this individual, or always considered a convenience and not available for anyone. We'll assume the latter, but often the advocate must be prepared to address these issues as related to both coverage and medical necessity.

First, the advocate facing such a denial should build a case for establishing that the coverage criteria is met. In the case of a powered lift, this will probably be a walk through of the four-part DME criteria. It will also be helpful to have a doctor, preferably a specialist, explain that powered lifting devices or in some cases ceiling track lifts are required by the class of patients whose individual circumstances limit their ability to benefit from the use of a non-powered lift. For example, some of the powered lifts are designed to allow the individual to use it without the help of a second person. For those class of patients who have no second person in their environments, a non-powered lift would be worthless. It would also be useful to reference the federal requirement that Medicaid must provide its services in such a manner as to reasonably achieve their purpose. *See* 42 C.F.R. § 440.230(b) ("Each service must be sufficient in amount, duration and scope to reasonably achieve its purpose.").

The item sought is not on our list of approved DME; or the item appears on a list of items that can never be approved. Most Medicaid agencies will have lists of items that they routinely fund. For example, many wheelchairs, walkers, and hospital beds will be routinely available to Medicaid recipients. What if the agency denies a three-wheeled scooter because it does not appear on the Medicaid list of approved mobility devices? This outright exclusion from coverage would probably be illegal under the terms of a 1998 policy letter issued by CMS.

The September 1998 Dear State Medicaid Director Letter, available on the CMS website at www.cms.hhs.gov/smdl/downloads/SMD090498.pdf, sets out the following requirements for DME coverage:

- States may use DME formularies (i.e., approved lists) as an administrative convenience,

but the state must provide a reasonable and meaningful procedure for requesting items that do not appear on a State's approved list.

- The process for approving items that do not appear on the list must be timely and employ reasonable and specific criteria by which an individual item of DME can be judged for coverage.
- These criteria must be sufficiently specific to permit a determination of whether an item of DME that does not appear on the state's approved list has been arbitrarily excluded from coverage based solely on a diagnosis, type of illness or condition.
- In evaluating a request for an item of DME, a state may not use a "Medicaid population as a whole" test which requires a beneficiary to demonstrate that, absent coverage of the item requested, the need of "most" Medicaid recipients will not be met. This test, in the DME context, establishes a standard that virtually no individual item of DME can meet.
- The approved list and the process for seeking modifications and exceptions to the DME list must be made available to all Medicaid beneficiaries.

Any review of a state's list of Medicaid-covered DME (and list of excluded items) should be viewed with the above principles in mind. Readers who encounter exclusive list issues are encouraged to read the key court decisions that have addressed the issue. *See Lankford v. Sherman*, 451 F.3d 496 (8th Cir. 2006); *Esteban v. Cook*, 77 F.Supp. 2d 1256 (S.D. Fla. 1999); *T.L. v. Colorado Department of Health Care Policy and Financing*, 42 P.3d 63 (Colo. App. 2001); *Bell v. Agency for Health Care Administration*, 768 So.2d 1203 (Fla. App. 1 Dist. 2000).

The strategy that should be used by the advocate is to provide the Medicaid agency with a copy of the policy letter. The advocate should then be prepared to argue that the device in question (a scooter in our example) meets the four-part criteria for DME (or the criteria of another coverage category) and is medically necessary for the individual.

The item is covered at the rate of \$x (where the rate is well below what a vendor would ever accept). The classic example of this phenomena is from the *Esteban v. Cook* case cited above.

Private Insurance Company Approves Funding for Standing Power Wheelchair on Appeal

Amy Peterson, an attorney with the Illinois P&A program (Equip for Equality), successfully appealed a decision by the CIGNA insurance company which had denied coverage for a Permobil C500 standing power wheelchair. Her 61 year old client incurred a complete C5-6 spinal cord injury in 2000 and was still recovering from a pressure sore when Ms. Peterson accepted the case. Despite the best medical treatment and excellent care provided by his wife, the pressure sore had lingered and not healed completely. All of his treating medical professionals recommended a power standing wheelchair as the one mechanism by which he could independently obtain 100 percent relief from the pressure sore throughout the day.

CIGNA's initial denial stated that the company did not cover this type of equipment because it is not medically necessary. After the client's doctor challenged this finding, CIGNA issued a second denial adding that there was insufficient published peer reviewed medical literature supporting clinical effectiveness and claiming that the devices were investigational/experimental, as additional reasons for their decision.

Ms. Peterson consulted with a number of sources, including attorneys from the AT advocacy network and our National AT Advocacy Project, to put together a strong legal and medical case to support the appeal. Using a number of hearing and court decisions gathered from these sources, she was able to establish that Medicaid and other health insurance companies had paid for the standing mechanism on similar wheelchairs as a means to either prevent or treat a range of medical complications, including decubitus or pressure sores. Through her contacts with Permobil, the equipment vendor, she was able to assemble a packet of medical literature to support the efficacy of passive standing as an effective medical intervention. This packet nicely complimented the extensive packet of letters of medical justification from her client's doctors and other health care providers. All of this evidence was complimented by Ms. Peterson's 10-page appeal letter.

CIGNA then reversed its original denial with a short, two-paragraph letter, awarding funding for the standing power wheelchair. Congratulations to Amy Peterson on a job well done. Her appeal letter to CIGNA is available through the National AT Advocacy Project.

There the plaintiffs brought a class action to challenge a state Medicaid policy that covered both motorized and custom mobility devices for individuals under 21, but limited coverage of mobility devices for adults to wheelchairs costing \$582 or less. Citing the September 1998 CMS letter, the court reasoned that the state failed to provide a reasonable and meaningful procedure for requesting items (in that case, custom and power wheelchairs) that do not appear on the state's pre-approved list. 77 F.Supp. 2d at 1260. The court went on to hold that the state's absolute limitation on coverage for wheelchairs "runs counter to its articulated purpose for including wheelchairs under its DME coverage: to minimize the effects of mobility impairments." Id. at 1261.

The Esteban decision provides additional helpful language that can be useful as these is-

sues come up in other cases:

Once the state elects to provide a service under its Medicaid plan, the service offered "must be sufficient in amount, duration and scope to reasonably achieve its purpose." 42 C.F.R. § 440.230(b).

* * * *

The State provides wheelchairs to an eligible Medicaid recipient "when the recipient is non-ambulatory, has severely limited mobility or it is necessary to accommodate the recipient's physical characteristics." DME coverage handbook, 2-39 (May 1996). Yet, the manual wheelchair that the State provides is insufficient to "minimize the effects of" the Plaintiffs' mobility impairment. Thus, the State's absolute limitation on coverage for wheelchairs runs counter to

its articulated purpose for including wheelchairs under its DME coverage: to minimize the effects of a mobility impairment. The limitation on coverage also runs counter to the Federal Medicaid purpose of helping individuals “attain or retain capacity for independence or self-care.” 42 U.S.C. § 1396. Accordingly, this Court finds that the \$582 cap on wheelchairs for adults diagnosed as having a severe mobility impairment is insufficient to reasonably achieve the State’s own purpose for providing wheelchairs to such individuals. 77 F.Supp. 2d at 1260-1261.

Medical Necessity Denials

The Medicaid program has no federal definition of medical necessity. However, the use of a medical necessity standard is recognized by federal regulation. See 42 C.F.R. § 440.230(d) (“The agency may place appropriate limits on a service based on such criteria as medical necessity or utilization review.”). Every state Medicaid agency will follow a general rule that a covered service or item of equipment will only be approved if it is medically necessary.

For those who are new to AT advocacy, it is important to understand that medical necessity in the equipment context, while a bit different from medical necessity in traditional medicine, often should be viewed based on the similar outcomes that traditional medical interventions and technological interventions are seeking to achieve. For example, if the patient is seeking restored mobility through ankle surgery, we are dealing with traditional medicine and the intervention of a surgeon. However, when the surgical intervention is not possible because of paralysis, we are typically looking to achieve the restored mobility through a technological intervention such as a wheelchair. In both cases, the ultimate goal of the intervention is similar – restoring functional mobility. Therefore, as we analyze the medical necessity denials it can be very helpful to analyze these cases from the standpoint of what the ultimate medical goal of the intervention is (e.g., functional communication, functional mobility).

The item sought is not medically necessary. Like the summary conclusion of non-coverage (i.e., “is not DME”) discussed above, the advocate should always start by attempting to get an

expanded notice or statement from the agency that answers the question: Why is this item not medically necessary? Absent that, your best approach is to start with your state’s definition of medical necessity, if it has one, and make sure that your documentary evidence and testimony for the hearing (if one is scheduled) meet this medical necessity standard. Of course, if you can get the agency to zero in on a specific reason, it is always easier for the advocate to prepare his or her case.

The item is covered but denied because it would be a convenience item for this individual. Many advocates have encountered the “convenience item” rationale for denials. For example, we often see this reason given when a power wheelchair is denied, claiming that a manual wheelchair will meet the individual’s needs. Often, we find Medicaid agencies making this argument when the individual’s functional mobility with the non-power wheelchair is limited to travel within the home and very short distances outside the home. The advocate should be prepared to argue that the individual is entitled to a power wheelchair if needed to achieve functional mobility based on that individual’s circumstances. For example, if the individual will use the wheelchair to go to the bus stop, grocery store, or attend college, and could not do so with a manual wheelchair, the power wheelchair would be appropriate. Here the “amount, duration, and scope” language from the federal regulations can be very helpful. See 42 C.F.R. § 440.230(b). In fact, for an individual whose disability prevents him or her from self-propelling a wheelchair for distances of more than 50 feet, limiting that person to a manual wheelchair means that the wheelchair benefit for that individual is not meeting its purpose of overcoming the mobility limitation. See *Esteban v. Cook*, 177 F.Supp. 2d at 1260-1261.

The item sought is not the least costly equally effective alternative. Many states incorporate the “least costly alternative” language right into their prior approval or medical necessity criteria. However, even if this language appears no place in state regulation or policy, advocates should always assume that this is part of the test for medical necessity (i.e., that the recipient is entitled to the least costly equally effective alternative to meet his or her needs).

Many advocates have encountered this ratio-

nale for denial when an individual has been using a hydraulic (non-electric) lifting device for transfers and is now seeking a more expensive electric stationary lift or a ceiling track lift. Responding to this kind of decision, either with letters of medical justification or with testimony, invariably turns on the individual facts related to the recipient.

The individual does not need the item because he or she has care givers present who can perform the needed function without the equipment sought. Many advocates report this rationale being used to deny power wheelchairs to young children who always have adults present in their home or school environments. While this rationale would run counter to the purpose of Medicaid for both children and adults (see 42 U.S.C. § 1396, providing that the general purpose of the federal Medicaid Act is to help individuals “attain or retain capacity for independence or self-care.” 42 U.S.C. § 1396), it is particularly inappropriate for children. Medicaid recipients under age 21 are covered, in all states, by Medicaid’s Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

The CMS State Medicaid Manual, Part 5, § 5123.2(a)(1)(a), addresses the extensive assessments that must be done of children, under EPSDT, to assess such things as: gross motor development; self help and self care skills; and social-emotional development, focusing on the ability to engage in social interaction with other children, adolescents, parents, and other adults. Once a defect or condition has been identified by these assessments, any service necessary to “correct or ameliorate” the condition must be provided whether or not the service is otherwise included in the State Medicaid Plan. 42 U.S.C. § 1396d(r)(5); 42 C.F.R. § 441.50; CMS State Medicaid Manual, Basic Overview §§ 5110, 5122. See our Winter 2008 issue of AT Advocate and its lead article, “Medicaid, AT and Kids” for a more expanded discussion of the EPSDT mandates (available at www.nls.org/av/winter08.pdf).

Viewing the EPSDT mandates in the context of a power wheelchair denial for a young child, the advocate could argue that the “defect or condition” (Medicaid’s language) to be addressed is one that limits both walking and the ability to self-propel a manual wheelchair. The service needed to “correct or ameliorate” that condition

Ethics Training Available Through Webcast

Those who attended our annual conference will recall that Diana Straube and Jim Sheldon presented a 90-minute ethics session: “Practical Ethics: When Can You Interview the Employees of Your Adversary?” For that training, we used an extensive handout and a case scenario involving a special education issue.

A two-hour webcast version of this will take place on June 18th from 2:30 to 4:30 p.m. Eastern Daylight Time. Since we will be working with two New York co-sponsors who primarily serve the Legal Services network, we have written a new case scenario to deal with Medicaid-funded private duty nursing services for a child, an issue that crosses over to both the P&A and Legal Services networks. This course is approved in New York for 2.0 hours of ethics credit through the Empire Justice Center. The cost for P&A attorneys attending this session will be \$25; all others must pay \$50.

Contact either Jim Sheldon (jsheldon@nls.org; 716-847-0650 ext. 262) or Diana Straube (dstraube@nls.org; ext. 220) for more information on how to register or check our website at www.nls.org/training.htm.

is the power wheelchair. Regarding the agency contention that this need could be met by care givers who would push the manual wheelchair, a 2005 New York hearing decision is helpful. In Matter of John W., FH # 4337314K (Feb. 9, 2006), a power wheelchair was sought for a five year old with cerebral palsy and spastic quadriplegia. In that case, the Medicaid agency reasoned that the power wheelchair was not needed because the child had sufficient care givers, at home and in school, to push him in his manual wheelchair. At the hearing, the child’s current and former physical therapists testified that continued reliance on care givers would be “developmentally inappropriate.” Noting that the testimony of the therapists was both persuasive and unrefuted, the administrative law judge ruled that the power wheelchair must be approved: “In light of the Appellant’s prognosis

that he will never ambulate independently, achieve functional assisted ambulation, or functionally propel a manual wheelchair, it would be pointless to delay the Appellant's transition to powered mobility by requiring continued reliance on caregivers to manually push the Appellant in his wheelchair." (Hearing decision available through the National AT Advocacy Project.)

Other Denials

The item sought is experimental and cannot be approved. This is a rationale often used to deny newer technology. For example, several years ago many advocates throughout the country handled the appeals of individuals with cystic fibrosis and other respiratory conditions who were seeking a fairly new intervention commonly known as a therapy vest. The purpose of the therapy vest is to accomplish, through mechanical means, the moving of retained secretions from smaller to larger airways where they can be removed through coughing. According to its proponents, the therapy vest thus avoided various medical complications such as respiratory infections.

When confronted by an agency's contention that a device is experimental, a helpful approach is to seek evidence that will establish that the item or device is generally accepted by the medical community as an effective and proven treatment or intervention to address a specific condition. *See Weaver v. Reagan*, 886 F.2d 194, (8th Cir. 1989) (court held that the drug AZT could not be excluded for AIDS patients, whose diagnoses and conditions did not match the conditions specified on the Food and Drug Administration (FDA) label for the drug, where evidence established that AZT was generally accepted by the professional medical community as a treatment for AIDS). Typically, your evidence will begin with the report of the treating physician. Hopefully, the physician can note in the report any medical literature which supports the use of the device as an appropriate intervention for the condition which your client has. In some cases, the approval of the device by the FDA can further serve as evidence that it is considered an appropriate intervention for your client's condition.

Where a device is fairly new to the marketplace, the device manufacturer can sometimes help you build the record to support its ap-

proval. Many advocates report that vendors and manufacturers have been helpful in producing the journal articles and other medical evidence needed to overcome this kind of denial. For example, some readers will recall the excellent presentation given by Peter Wankelman of Altimate Medical, Inc., at our April 2007 conference, on the many sources of medical evidence to support the medical benefits of passive standing. (Mr. Wankelman's company manufactures a number of devices that are used in passive standing therapy.)

The item can only be approved every five years and only three years have elapsed since the individual received it. Many state Medicaid programs have policies which provide for approval of a new wheelchair only after a certain number of years elapse. What if the period is five years and your client has a three year old wheelchair that is no longer meeting his or her needs? This could be the case for a myriad of reasons (e.g., this could be a teenager who has gone through a growth spurt; it could be a person with a progressive condition, like muscular dystrophy, who is no longer able to use a manual wheelchair; it could be a person who has moved from an institutional setting into the community, creating a greater need for independent mobility; or it could be a very active wheelchair user who has worn out the wheelchair more quickly than his or her less active peers).

A good starting point for analysis is Medicaid's reasonable standards and amount, duration and scope mandates. As related to DME and wheelchairs, the state Medicaid agency must have approval policies in place that constitute reasonable standards for approving coverage. 42 U.S.C. § 1396a(a)(17)(A). Where the policies governing how long a person must wait in between wheelchair approvals do not allow for case-by-case exceptions based on individual circumstances, the policies should be found to violate the reasonable standards provisions. They would also be contrary to the federal Medicaid provisions requiring that services be "sufficient in amount duration and scope to reasonably achieve [their] purpose," 42 C.F.R. § 440.230(b), and requiring that services be provided "in a manner consistent with simplicity of administration and the best interests of the recipients." 42 U.S.C. § 1396a(a)(19).

The item cannot be funded because it is ex-

cluded by Medicare criteria. Based on the anecdotal information we get from attorneys and advocates within our AT advocacy network, our sense is that this rationale for a denial is becoming more commonplace. Where the reliance on Medicare rules to exclude coverage of a specific item occurs, without any independent analysis of its potential coverage under Medicaid, this should be considered illegal as both a violation of the reasonable standards provision of 42 U.S.C. § 1396a(a)(17)(A) and the CMS policy letter of September 1998 which precludes the use of exclusive lists to deny DME.

In the case of *Pragano v. Wilson-Coker*, the Connecticut Medicaid agency had a policy which, after determining that a requested item did not appear on a pre-approved list, denied coverage if the item would be excluded by Medicare. The plaintiffs were represented by New Haven Legal Assistance and Connecticut Legal Services and their brief, supporting a motion for preliminary injunction, does a great job of explaining the many differences between the Medicaid and Medicare programs. For example, some items might be excluded by Medicare because they are excluded by statute, do not meet the restrictive Medicare definition of durable medical equipment, or do not meet the criteria of a Medicare National or Local Coverage Decision. To rely on Medicare criteria to exclude coverage under Medicaid, without any separate analysis under Medicaid law and policy, would be a violation of the reasonable standards provision.

Using a Medicare non-coverage policy to create an outright exclusion from coverage under Medicaid would also violate CMS's 1998 policy letter which is discussed earlier in this article. In essence, the Medicaid agency is not permitted to exclude the item from coverage without offering the Medicaid recipient a meaningful procedure for requesting coverage of the excluded item. (The plaintiffs' brief in *Pragano* is available through the National AT Advocacy Project.)

A Managed Care Organization says: "This item does not meet our definition of DME." Since so many Medicaid agencies have adopted a managed care model for all or part of their Medicaid programs, advocates can expect to deal with managed care organizations (MCOs) on some DME-related requests. Recently, a New York advocate represented a 10 year old,

with multiple disabilities, who was seeking Medicaid payment for a customized wooden adapted feeding chair. The MCO in that case denied Medicaid funding, finding that the special chair was a personal comfort item or a personal furniture item that was not available under the MCO's plan.

At the MCO appeal level, the advocate pointed to the following federal regulation which applies to MCOs:

42 CFR § 438.210 Coverage and authorization of services.

(a) Coverage. Each contract with an MCO . . . must do the following:

(1) Identify, define and specify the amount duration and scope of each service that the MCO . . . is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in § 440.230.

The advocate also provided the MCO with two different Medicaid fair hearing decisions which, in approving funding for similar adapted chairs, determined that the items met Medicaid's definition as DME. By employing these strategies, the advocate was able to resolve the case favorably without the necessity of going to a traditional Medicaid hearing following exhaustion of the MCO appeal.

Conclusion

This article has presented some of the most common reasons Medicaid gives when it says "no" to prior approval requests for what we refer to as AT devices. We then provide a number of legal arguments and evidentiary approaches that have worked to change the no to a "yes."

We know there may be numerous other reasons why Medicaid agencies deny equipment requests. There may also be other arguments and strategies that have worked for you when faced with one of these cases. Please share those successes with us so that we can, in turn, share them within our AT advocacy network. As always, as your successes come in the form of hearing decisions or court decisions, please share them with us and we will put them into our resource library.

The **AT Advocacy Project** will provide nationwide services to PAAT projects including technical assistance to advocates wanting to access funding for assistive technology for individuals with disabilities.



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We have designed a word-searchable digest, using computer technology, to store and retrieve hearing decisions and other administrative documents. We also have indexed nearly 700 documents from more than 125 pending and decided court cases. All documents are available through our AT Resource Library. Please send us your hearing decisions, briefs and other documents involving AT.

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