



Advocate

Newsletter of the National Assistive Technology Advocacy Project

A Project of Neighborhood Legal Services, Inc.

237 Main Street, Suite 400, Buffalo, New York 14203 – (716) 847-0650

Fax: (716) 847-0227 – TDD: (716) 847-1322 – Website: www.nls.org

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***AT Advocate is now an electronic only newsletter.** We will make our Internet-only newsletter available to regular readers through email alerts with links to the latest newsletter on our website. AT Advocate continues to have the same front-page look it has had since 1995 but we will no longer be constrained by the eight-page format we used for most issues. Some issues will now be shorter, some longer. We will continue to view AT Advocate as an ongoing curriculum on funding of assistive technology (AT) and include resource links to our publications and other online resources. Finally, we will also use our new email readers list to provide you with other news related to our common goal of getting AT and specialized equipment into the hands of children and adults with disabilities.*

If you would like to be added to the AT Advocate email list, contact Lynn Urquhart at lurquhart@nls.org. Otherwise, look for new issues of the newsletter on our website.

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POWER WHEELCHAIRS AND ACCESSORIES FOR YOUNG CHILDREN

Justifying Medicaid Funding for Kids as Young as 18 Months

This article is geared to meet the needs of health care professionals – including physicians, physical therapists, and occupational therapists – who will prepare letters of medical justification to support requests to have a Medicaid program fund a pediatric power wheelchair. Simultaneously, this article should prove to be a useful tool for attorneys and advocates who will work with those health care providers as they represent young children who have been denied Medicaid funding for a power wheelchair.

Readers can follow up with Marge Gustas (mgustas@nls.org 716-847-0655 ext. 256), lead author of this article, if you have questions about how this may apply to an individual with whom you are working.

Introduction

There is a strong probability that children with certain types of cerebral palsy, other congenital conditions, spinal injuries, and disabilities associated with neurologic events will need wheelchairs for functional mobility at some point in their lives. Also, as these children go through their developmental phases, functional mobility will play a big part in their physical, mental and emotional development. Whether or not a young child can use a manual or power wheelchair will depend on both their cognitive and their residual functional capacity. A child's cognitive capacity can be more advanced or diminished than his or her chronological age. Studies have shown that infants, some as young as 18 months, have sufficient cognitive capacity to effectively use a power wheelchair for their functional mobility needs. Some young children will have the residual functional capacity to effectively and efficiently use a manual wheelchair; others may have limited residual functional capacity and will need a more expensive power wheelchair.

Young children, especially toddlers, seeking Medicaid prior approval for a power wheelchair are more likely to be denied than older children. Medicaid programs often argue that young children in power wheelchairs are a health and safety risk to both themselves and others. The actual health and safety risk lies in not allowing these children to acquire a power wheelchair, to develop at near the same pace as their peers, which in time can lead to learned helplessness and other developmental problems. Also, not having the right device to ameliorate or correct a condition can lead to secondary physical problems.

In this issue we will discuss how to approach a letter of medical justification, to Medicaid, for a power wheelchair and accessories including a seat elevating feature for a young child. We will focus on two distinct parts of medical need. First, we will focus on the need to achieve functional mobility through the power wheelchair and accessories. Any individual with one of the above-stated conditions could document this need to achieve independent functional mobility regardless of whether they are 3 or 33, provided they have sufficient cognitive capacity to safely and effectively use a power wheelchair. Second, we will focus on Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate and the medical need for appropriate physical and cognitive development in a young child as on-going until their late teens or early twenties – development that is enhanced by independent functional mobility.

The Need for Independence and Development is Recognized in the Federal Medicaid Act.

In order to contain cost, many state Medicaid programs try to limit the concept of independence as a medical need, especially when it comes to children. The state may come right out in its denial and state that independence is not a medical need. The state may deny the relevance of independence, without using the term, by finding no medical need for a power wheelchair because parents can push the child, the child is too young, the child's disability is too limiting, or the child is never alone and always has an aide. If unchallenged, these denials mean less expenses for the agency, but they will also deprive the child a means of independent mobility. Federal law has appropriated Medicaid funds for the states to use for the "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." 42 USC 1396-1. For a child, any child, disabled to not, attaining independence is extremely important. However, this development is not immediate, but rather, a process that takes time, trial and effort.

The proactive language of EPSDT furthers this concept of attaining independence through its screening mandate – screening for conditions that can be corrected or ameliorated through the timely introduction of Medicaid services into the care plan for the child. 42 USC 1396a(a)(10)(A), 1396d(a)(4)(B), 1396d(r)(5). The state screening services must include a developmental assessment that assesses at least the following elements:

- gross motor development focusing on strength, balance and locomotion;
- fine motor development, focusing on eye-hand coordination;
- communication skills or language development, focusing on expression, comprehension, and speech articulation;
- self-help and self care skills;
- social-emotional development, focusing on the ability to engage in social interaction with other children, adolescents, parents, and other adults; and
- cognitive skills, focusing on problem solving or reasoning.

Centers for Medicare and Medicaid Services (CMS) State Medicaid Manual, 5123.2(A)(1)(a). It is obvious from this and the language above that both Congress and CMS acknowledge that the development of a child into an independent individual is a primary medical need and one that Medicaid must support.

Functional Mobility, a Need at Any Age

Any child born with a severely disabling condition may need a power wheelchair incorporated into his or her care plan if he or she cannot effectively push a manual wheelchair. Pushing a manual wheelchair requires the child to have the necessary strength in his or her arms, neck and trunk to be able to move both the weight of the wheelchair and his or her own body. Using a manual wheelchair requires the user to pull the drive wheel for a certain distance and then to push off the drive wheel for a certain distance for movement. When using a manual wheelchair the child must be able to continually accomplish this pull/push for mobility across all of the customary environments where a child lives, plays, or goes to school. He or she must also be able to accomplish this pull/push motion quickly if the child needs to ascend inclines or cross busy streets. Likewise, the child must be able to use his or her arms like brakes in order to control speed when descending inclines.

Very often, children with advanced or severe conditions will not have the muscular stamina to utilize a manual wheelchair for functional mobility. Additionally, the accompanying fatigue, possible over-use syndrome, and inappropriate and/or over-development of certain muscles at the expense of others will inhibit or diminish functional mobility. Since functional mobility is the base for so many of our enriching experiences, it must be protected at all costs. A power wheelchair will address all of the above, and like any request for Medicaid prior approval, you are going to need to medically justify the device and all accessories.

Will the Child Be Able to Use a Power Wheelchair Safely?

The threshold issue for any young child requesting a power wheelchair is going to be his or her cognitive capacity to independently and safely use a power wheelchair, and this should be addressed early on in the request for prior approval. The ability to independently use a power wheelchair must be based on what is "age appropriate." A child is not born independent; it takes an acquired amount of experience and learning to become so. A child of three will not have the same independent skills as one who is 13. However, a child with the cognitive capacity of a three year old, whether that child is three or nine, *can learn* to independently and appropriately respond to the same situations as any three year old child without a disability.

When documenting a child's cognitive capacity start by informing the reviewer of the child's chronological age, his or her cognitive age, and what you believe the appropriate mobility achievements should be for this child, cognitively. Discuss the child's ability to follow directions. Does the child respond to one step, two step, or multi-step directions? Is he or she capable of self-direction? Does the child show curiosity and a desire to independently explore his or her environment? Discuss the child's perceptive abilities, attention span, memory capacity, visual and spatial processing, and executive functions. Document anecdotal situations that demonstrate that the young child or toddler has an understanding of social interaction and appropriate responses to daily situations, *for his or her cognitive age*. Provide the Medicaid reviewer with sufficient

information to appreciate that this child can use a power wheelchair and can continue to develop mobility skills.

Documenting the Need for Functional Mobility and the Appropriate Power Wheelchair

Documenting the Need for a Power Wheelchair Base for a Child Is No Different than Justifying a Similar Device for an Adult.

Once you have documented the child's cognitive capacity to use a power wheelchair, you will need to document the medical need for the power wheelchair to achieve functional mobility as part of the child's care plan. Your documentation should address the child's medical diagnosis and prognosis and why a power wheelchair is a physical, medical need. Be sure to give any history of mobility decline – e.g., the child may have walked independently or used a walker, weakened to the point of needing a manual wheelchair, then needed power assist rims for functional mobility, and now needs a power wheelchair. In very young children who have never walked, combat crawling may be the only form of functional mobility that the child has achieved. Discuss why combat crawling is not appropriate.

In any situation where the child must start using a power wheelchair, discuss the medical reasons why manual wheelchairs, walkers, gait trainers, etc., are not appropriate for functional mobility. Also include in your letter where this child lives, e.g., city or country. Does the child live in a ranch house or two-story house that is mobility accessible, including a means of ingress and egress to and from the house itself? The letter should also address the child's daily activities at home, at school, and in the community, to make sure that the power wheelchair you select is a proper fit for his or her life style and can be used in all of the child's customary environments.

Seat Elevation Will Allow the Child to Participate in Age Appropriate Activities of Daily Living.

Children with disabilities need to learn how to interact with their personal environment and the environments of others. Most of us who are in the company of young children and toddlers who are not disabled have more than one "step-stool" in our homes, usually located in the bathroom and kitchen areas. "Step-stools" allow children the ability to access sinks, tables, counter-tops, get into bed, etc. This access is necessary so that the child can learn from observation and mimicry how to complete everyday tasks. Who would ever think of teaching a four year old how to bake cookies by handing them a cookbook? Every mother knows that her cookie helper will need a stool or chair to stand on, not only to access the table, but also to see what mom is doing.

Children who use a wheelchair for functional mobility cannot use a step-stool to reach or be at eye level with higher objects or environments. Seat elevation on the wheelchair will allow a young child access to his or her normal activities of daily living. Seat elevation allows for the child to be transferred or to learn how to independently transfer

from bed to wheelchair and vice versa, to eat at different table heights, to wash his or her hands and face in the sink, to brush his or her teeth, to learn how to brush or comb his or her hair, join in family activities, and be at eye level with his or her peers. Also, when out in the community, not all environments will be Americans with Disabilities Act compliant, but they may be developmentally enriching, all the same. Consider providing information about how the power wheelchair and seat elevator will be used at the mall, at church, in a park, and in the homes of family and friends for events like dinners, birthdays, and holidays.

Also, many young children with severe muscle impairments will benefit from a seat elevator when reaching for different objects. The effect of gravity can be very taxing on an individual who needs to reach “up” to get a glass, a toy, or other object. Even if the child has the fine motor control to grab the object, the weight of the object will now add to the strain of fighting gravity. A seat elevator may be used by a child to raise his or her seat so that instead of reaching overhead the child is reaching outwards while resting his or her arms on the cupboard or table. If the child can use the seat elevator to “reach” for him or her and pull the object towards himself or herself, the child may be able to include far more activities of daily living in his or her everyday life.

Additional Accessories like Positioning, Seating, and Input Devices Also Must Be Medically Justified.

If you are adding accessories to the power wheelchair, you need to make sure that you are working with a base that will accept those features. Tilt-in-space and recline positioning should be evaluated and documented for prevention of skin breakdown, suctioning, trunk and head control, fatigue, diaper changes, nutritional intake, etc. Although we don't see it often, “acutely ill infants and children are at risk for pressure ulcers.” (Quigley & Curley, 1996; Zollo et al, 1996 as quoted in *Predicting Pressure Ulcer Risk in Pediatric Patient*; Curley et al, Nursing Research Jan/Feb 2003, Vol 52, No.1.) As Dr. Curley states, “The negative effect of immobility and physiological instability on a patient's skin does not discriminate on age or developmental level.” (Nursing Research, p. 22). Infants and toddlers spending a significant amount of time in an ICU may develop pressure ulcers in addition to their other medical conditions.

Specialty seating and input devices need to be evaluated and justified as well. Youngsters with spinal curvatures or pelvic obliquities will need specialized seating for stability that addresses their needs. Input devices such as head arrays and joy sticks need to be carefully evaluated and documented for this population. “Throw” in a joystick is the amount of movement required to work the joystick. Children with low trunk and arm control might do better with an input device where the “throw” is more sensitive to the touch. This would mean children who already suffer with muscle fatigue would not exacerbate it by using additional muscle pressure on the joy stick.

Attendant Controls Can Allow a Family Member to Take Control of the Power Wheelchair if the Child Becomes Fatigued, Ill, or in a Situation Where a Parent Would Need to Physically Intervene in the Functional Mobility of the Child.

Growing takes a lot of energy, and young children need to replenish that energy often by taking naps. Young children tire easily. Just look at the number of parents walking through a mall, shopping and carrying a sleeping toddler on their shoulder. Not an uncommon sight. Now imagine trying to carry a napping child with a disability through the mall and trying to push a power wheelchair at the same time. No problem, leave the child in the power wheelchair and push the weight of the wheelchair plus the weight of the child. Power wheelchairs are heavy, so what do we do?

How do we handle a sick child who doesn't have the strength to operate his or her power wheelchair throughout the entire day? If you feel miserable with a chest cold, how do you think a child that has no trunk control feels with a cold? Remember, the simplest of childhood diseases can be life threatening for a child with a disability.

What do we do when a child must maneuver the wheelchair up a steep ramp? Down a narrow sidewalk? Across a six lane street? If our child did not have a disability we would carry the child, take the child's hand, or use our own body as a guide to keep the child safe. For a child with a disability using a power wheelchair, we can use the attendant control.

The attendant control is the remote control device used with certain power wheelchairs. It can be a useful training tool for reinforcing safe use of the wheelchair. It can also be used to provide independent steering by the parent or guardian when the child becomes tired or is having a bad day. Again, this needs to be justified as a medically necessary limited auxiliary device for the wheelchair and never as a continual means of driving the wheelchair.

Age Appropriate Development Is its Own Medical Need

Age appropriate development is its own medical need and its progress is evaluated using developmental milestones. All developmental milestones measure the progress of the body and the mind's ability to gather and use information, consciously or unconsciously, for mental, physical and emotional growth. Young children start meeting developmental milestones very soon after birth; they are sequential and appear in tandem. For example, a baby learns to crawl before learning to walk (gross motor), but while crawling also learns to focus on desired destination (visual - spatial processing) so that he or she can play with a toy (fine motor). Gross motor milestones are significantly important as a foundation for many of the other milestones and should appear before a child's first birthday. In the example above, if the child could not get to the destination, he or she would not learn spatial relationships, acquire problem solving information such as navigating large pieces of furniture, or develop fine motor skills for grasping and independent play.

Children with disabilities are often introduced to a power wheelchair long after significant milestones should have been met. If children master walking somewhere between their first and second birthday and can independently explore their world, under supervision, what has been lost to the four year old who just received his or her first power wheelchair and is just now learning how to independently maneuver through

his or her environment? These losses should be identified and medical justification should address how these losses will be overcome and whether immediately or in time.

Development is Not Static. Therefore, it is Important to Justify Not Only What the Child Can Do Currently, but Also What He or She Is Capable of Learning.

Whether or not the child is using a power wheelchair, the younger the child the more cautionary directives and interactions will be appropriate. Reminding a child who uses a wheelchair to stop at the corner, not to go too fast, or to be careful, is no different than those directives we offer to children without disabilities. Age appropriate cuing is not the same thing as a parent or the therapist continually putting his or her hand over the child's hand to drive the wheelchair or continually using an attendant control to provide mobility for the child. The Medicaid reviewer should be directed to see these situations for what they are – learning opportunities and not medical issues associated with the disability.

Children Using Power Wheelchairs for the First Time Will Experience the Cause and Effect of Independent Mobility.

Learning by making mistakes, correcting mistakes, and not repeating the same mistake are all aspects of healthy development. Using a power wheelchair to overcome gross motor deficits creates opportunities for the child to understand where both the child and the wheelchair are in space, which is necessary for situations such as going through doors or maneuvering through crowded walkways. The child can develop visual range and executive functioning skill sets. By developing his or her visual acuity the child can acquire a sense of distance, determine whether an object or place is near or far, and how much speed is needed to cover that distance efficiently, but not overshoot the mark. Gross motor development will also help establish discipline and judgment in executive reasoning and functions. For example, "I always need to stop at the street corner, look both ways, and use the curb cut before crossing the street."

Language Development Can Be Significantly Affected by Gross Motor Development.

If a child is always in the presence of a person who anticipates his or her needs, the child has no need to work on developing expressive language skills. Children who are denied access to the independent functional mobility that is necessary for gross motor development may also show a deficit in both expressive and receptive language skills. In addition to limited vocabulary and a lack of control for those muscles necessary for speech, lack of linguistic skills may appear as a difficulty in initiating or participating in the use of language for social interaction. The child who has independent mobility will not be as isolated from peers and authority figures and will develop the proper muscles for speech, a broader vocabulary, and learn effective communication skills.

We Are Social Beings. We Are Hard Wired to Interact with Others.

Social interaction is how we relate to others at a particular time, under certain situations, and in a particular manner. We need to learn social skills to adapt in our society. A deficit in gross motor development and its effect on other developmental milestones can leave a child without appropriate skill sets for interacting with others. Independently mobile children have the opportunity to introduce themselves into social situations whether it be group play, scholastic activities, or activities in the home. Likewise, they can remove themselves from an interaction that is overwhelming. Having this ability to independently decide who we are going to associate with, when we want to associate with them, and how we will respond to them allows a child to appropriately bond with others while respecting his or her own space and the space of others.

Conclusion

The information we discussed above is not intended to be a scientific discussion on either functional mobility or child development. That can be addressed by the occupational therapist, physical therapist, speech pathologist, and/or the child's doctors. This article was intended to give some insight into certain aspects of medical need that can be addressed in a letter of medical justification or through testimony at an administrative hearing. We are providing a link to a New York State fair hearing decision, below, so you can see how the testimony addresses some of these medical issues. The most important thing to remember about this article is that a child needs to be mobile in order to grow, and the earlier the child has that need met, the healthier the child will be.

When to Contact the National AT Advocacy Project for Technical Assistance

The National AT Advocacy Project of Neighborhood Legal Services (NLS) is a technical assistance (TA) and training project which provides services to a primary customer base of attorneys and advocates who work under a Protection and Advocacy for Assistive Technology (PAAT) grant or who do AT-related advocacy through another Protection and Advocacy (P&A) grant. All of our services are geared to providing the legal and policy analysis and related supports to help advocates secure appropriate AT devices and AT services through a range of funding sources. Services are available nationwide and in the U.S. territories that receive a PAAT or P&A grant. Although Medicaid is by far the most common area for TA requests, we regularly provide TA related to special education, state vocational rehabilitation agencies, Medicare, private insurance, and any number of other funding sources. If in doubt, contact one of our TA people listed below.

In addition to serving the PAATs and other P&A staff, we also provide more limited TA to a much broader base of individuals who play a role in helping individuals with disabilities secure appropriate AT. This includes other entities funded under the AT Act (including State AT Projects and Alternative Financing Projects), attorneys and advocates who work for a range of not-for-profit entities, health care providers (including physical therapists, occupational therapists, and speech pathologists), equipment suppliers and manufacturers, vocational rehabilitation counselors, and anyone else who plays a role in the process. We will typically make sure the caller (or person who emails us) is made aware of the PAAT services in their state.

Our TA staff at NLS includes: attorney Jim Sheldon (jsheldon@nls.org 716-847-0650 ext. 262); paralegal Marge Gustas (mgustas@nls.org ext. 256); and attorney Diana Straube (dstraube@nls.org ext. 220). Our TA person at our subcontractor, the National Disability Rights Network (NDRN), is attorney Ron Hager (ron.hager@ndrn.org 202-253-5252).

Additional Resources to Support Your Work

The following are key resources you may want to look at if involved in a case involving Medicaid funding of a power wheelchair for a young child:

- AT Advocate newsletter: *Medicaid, AT and Kids: How Medicaid's EPSDT Program Expands the Availability of Assistive Technology for Children Under 21 in All States*, available at

www.nls.org/files/AT%20Advocate%20Newsletters/Advocatewinter08.pdf .

- AT Advocate newsletter: *Preparing Letters of Medical Justification: Key Components That Will Support the Need for Durable Medical Equipment Through Medicaid and Other Third Party Insurers*, available at

www.nls.org/files/AT%20Advocate%20Newsletters/Advocatewinter06.pdf

- From Did You Know series:

Remembering EPSDT in the Wake of Medicaid Cuts, available at

<http://www.nls.org/Disability/NationalAssistiveTechnologyProject/DidYouKnow/Medicaid/RememberingEPSDT>

Power Wheelchairs for Young Children: Supporting Medicaid Funding for Children as Young as Two Years Old, available at

<http://www.nls.org/files/Disability%20Law%20Hotlines/Did%20You%20Know/DY%20Know%20-%20Power%20Wheelchairs%20for%20Young%20Children.pdf>

- The Funding of AT “Toolkit Series”: This is a collaborative effort between our National AT Advocacy Project and New York’s State AT Project, known as TR Aid. The toolkits will be on the New York Justice Center website at

<http://www.justicecenter.ny.gov/services-supports/assistive-technology-traid/at-toolkits>

The first toolkit in this series is devoted to funding of standing wheelchairs through Medicaid with three documents currently on the site, a funding checklist, a sample letter of medical justification, and a sample supporting letter of medical justification. Our second toolkit to appear soon will focus on funding of the pediatric power wheelchair.

Medicaid Hearing Awards Two Year Old a Power Wheelchair with Power Tilt, Power Seat Elevation, and Other Accessories

The child in question, aged two years and seven months on the day of the hearing, with a diagnosis of Spinal Muscular Atrophy Type 2, sought a Permobil K300 power wheelchair with power tilt, power seat elevation, a MicroPilot micro touch mini joystick, attendant control, and other accessories. In denying funding, the New York Medicaid agency stated that the documentation did not establish that this child would be safe and independent with a power wheelchair.

In the 15-page fair hearing decision, the administrative law judge (ALJ) details the extensive summary of the agency doctor which contends, among other things: that agency policy is to approve a power wheelchair for a young child only if the child is fully independent in operating the chair; that the power seat elevation is not appropriate because she will continue to need help with transfers; and that the ability to sit at different table heights or go up or down may be desired but are not medical necessities.

The ALJ also summarized the extensive testimony of the child's treating occupational therapist (OT) and her treating physical therapist (PT) who each see her twice per week. The OT testified that the seat elevator will allow the child to complete her own activities of daily living such as eating and brushing her teeth, allowing her to bring herself up to table height so she can rest her arms on it and do those activities and added that the seat elevator will aid in the child's social and emotional development by allowing her to lower herself to peer level for social interaction. The PT testified that the child can independently use the power chair to navigate obstacles, go forward and backwards, and stop upon command. The PT acknowledged there will be a learning process with the proposed wheelchair and that the child "absolutely" has the capacity to independently learn what is needed. The PT also testified that the child's independent mobility, achieved through the requested wheelchair, is a key to higher level problem solving and achievement of developmental milestones.

The ALJ, in ruling for the child, referenced the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandates for Medicaid beneficiaries who are under age 21. He then reasoned that the requested power wheelchair and accessories are necessary to "correct and ameliorate this child's physical illness or condition," citing the EPSDT statute and regulations, 42 USC 1386d(r)(5) and 42 CFR Part 441. The ALJ also emphasizes that the detailed and persuasive testimony of the treating OT and PT was "detailed and persuasive" and "uncontradicted by the Agency."

Congratulations to Marge Gustas on a job well done. This decision is available at <http://www.nls.org/files/Disability%20Law%20Hotlines/National%20AT%20Advocacy/Matter%20of%20Appeal%20of%20AF.pdf> or you can contact Marge for a copy of it - mgustas@nls.org. The child's story, with a video of her using her new wheelchair was broadcast by a Syracuse, New York TV station and continues to be posted at <http://www.localsyr.com/story/d/story/your-stories-connection-liverpool-family-gets-new/19943/YOZtprNmAk2K4bYfVmt03Q>

Our National AT Resource Libraries

Our National AT Advocacy Project maintains two resource libraries to support the work of AT advocates, nationwide.

Our Court Documents Library is best described as a brief and pleadings bank, containing complaints, briefs, discovery papers, unreported decisions, and other court papers to support AT and related litigation in the state and federal courts. All of the more recent documents are available in electronic format. Although we have many of the complaints and briefs that supported cases like the *Lankford*, *Fred C.*, *Esteban*, and *T.L.*, cases regularly cited in our Medicaid materials, we also have collected documents from many cases that never resulted in a reported decision. Copies of relevant documents can be emailed (or in some cases mailed) to support your work. If we do not have documents from a particular case we may be able to help you track them down.

Our Hearing Decisions Library contains primarily Medicaid hearing decisions, any supporting briefs, memoranda of law, and other written arguments supplied to us by attorneys and advocates. We also have a few miscellaneous policy documents (such as policy letters from the Centers for Medicare and Medicaid Services or CMS). Many of these are documents that are not published anywhere (or are not easily found).

If you want to see if we have documents to support your work, you can contact Diana Straube (dstraube@nls.org; 716-847-0655 ext. 220), Marge Gustas (mgustas@nls.org; 716-847-0650 ext. 256) or Jim Sheldon (jsheldon@nls.org; ext. 262).

NOTE: Our resource libraries are only as good as the materials we get to put into them. Please get us your materials so that everyone can benefit from them.