IMPACT 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. IMPACT 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 IMPACT 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 IMPACT email list, contact Lynn Urquhart at lurquhart@nls.org. Otherwise, look for the newsletter on our website at least three times per year.

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MEDICAID EQUIPMENT SERIES

Medicaid Funding of Sit-to-Stand Standing Frames

There are consequences to inactivity. According to the Healthy People 2010 report, produced by the Centers for Disease Control and Prevention (CDC) and the President's Council on Physical Fitness and Sports, “physically inactive people are twice as likely to develop coronary heart disease (CHD) as people who do regular physical exercises.” (See http://nyp.org/health/cardiac-exercise.html)

Inactivity also increases a person’s risk of developing osteoporosis with increased risk of fractures; certain cancers; adult onset diabetes; anxiety and depression; obesity; and premature death. A study by the American Cancer Society found that men and women who sat for more than six hours per day had 18% and 37% respectively higher likelihood of dying as those who sat for only three hours per day and the risks increased dramatically for those men and women who were also inactive outside of work (risks were 48% higher for men and 94% higher for women). Regular exercise, such as walking, running, hiking, dancing, tennis, and weight lifting, can vastly improve overall health and extend life.

Consider individuals who cannot walk, run, or even stand on their own, who may spend their entire day in bed or in wheelchairs. In addition to the health risks already mentioned, individuals who are sedentary due to mobility-related impairments are at risk for developing pressure sores (open wounds that develop when prolonged pressure is applied to skin covering bony prominences); muscle atrophy; recurrent urinary tract infections; constipation; spasticity (tight or stiff muscles or inability to control muscles); joint stiffness; and respiratory ailments such as atelectasis (collapse of part or all of a lung) or pneumonia. One of the interventions used in an effort to prevent or minimize these complications for individuals with mobility impairments is sustained weight bearing through supported standing. Passive standing in a standing frame is considered by the
medical community to be effective at preventing loss of bone density; decreasing muscular tone and spasticity; producing better spinal alignment and delaying development of skeletal deformities; extension of upper trunk, which in turn reduces pressure on internal organs; maintaining range of motion; increasing flexibility and preventing contractures of the hip, knee and ankle joints; preventing pressure sores; improving urinary drainage and renal function and reducing urinary tract infections; improving gastrointestinal, respiratory and bowel function; and improving cardiovascular health.

The Rehabilitation Engineering and Assistive Technology Society of North American (RESNA), in a position paper entitled, “RESNA Position on the Application of Wheelchair Standing Devices,” recommends that individuals stand as often and for as long as they can tolerate it. (See http://www.resna.org/resources/position_papers.dot) Some medical experts believe that in order to benefit from supported standing, an individual must have frequent and repeated standing opportunities throughout the day. After all, an individual without a disability who stood for only half an hour per day would be considered very inactive, subject to those health risks mentioned above. This issue of IMPACT will discuss Medicaid funding of standing frames with an emphasis on how to successfully request funding for the more expensive type of standing frames known as sit-to-stand standers.

There are Several Different Types of Standing Frames

Standing frames (or standers) fit within four broad categories: supine, prone, multi-position, and sit-to-stand. A prone stander is straight, or flat, like a board. A person is placed face down on the stander so that it supports the front of the person. The angle of the stander can be adjusted from horizontal to vertical, thereby allowing an individual to gradually adjust to weight bearing through standing.

A supine stander is similarly straight, or flat. However, the person is placed on it face-up. As with the prone stander, the angle may vary from horizontal to vertical so that the individual can be eased into an upright position. A multi-position stander is both supine and prone and can be used in either position.

Sit-to-stand standers differ significantly from the prone, supine, and multi-position standers. First, they are not straight or flat. An individual is placed in the stander in a seated position and raised to a standing position while in the stander. If the individual needs to come out of the standing position for some reason, the individual can be lowered and then raised again when conditions are appropriate for standing, without the need to repeatedly transfer the individual into and out of the stander.

There is even a stander that comes with a glider to allow for active standing: the user moves handles with their arms and causes a reciprocal movement to their legs. (Another option, a standing feature for a wheelchair, was discussed in the Summer 2012 issue of IMPACT and will not be discussed here.)
Medicaid Has Established Reimbursement Rates for Standers

Medicaid’s reimbursement rates are called “maximum reimbursement amounts” (MRAs). This is the amount that Medicaid pays an equipment vendor for the particular device. The MRA for a prone or supine stander using code E0638 is $1,273.22. The MRA for the multi-position stander using code E0641 is $1,663.88. Neither requires prior approval. The equipment vendor utilizes the Dispensing Validation System (DVS) by obtaining an authorization number. The vendor may then dispense the stander to the customer and bill Medicaid using the prior authorization number. The vendor does not submit the medical documentation to Medicaid, but instead, retains it for seven years to produce in case of an audit.

Sit-to-stand standers also have an MRA ($3,229.11 using code E0637) but require prior approval. That means the documentation medically justifying the stander must be submitted to Medicaid before the stander is dispensed to the individual, and Medicaid decides whether the stander is medically necessary.

Which stander is best depends on the unique medical condition of each individual. For example, in order to effectively use a prone, supine, or multi-position stander, an individual has to be able to tolerate being flat or stretched out long enough to reap the benefits of prolonged standing. Also, certain individuals may require the assistance of two people in order to be safely transferred into them. That may not be a viable option for some individuals. For a number of reasons, individuals may need to use a sit-to-stand stander. Unfortunately, sit-to-stand standers have higher MRAs than supine, prone, or multi-position standers. If the individual is seeking Medicaid reimbursement, cost alone does not make sit-to-stand standers inaccessible. It does mean, however, that the individual’s medical team and equipment vendor will have to be prepared to fight harder to win that all-important funding.

Seeking Medicaid Funding For Sit-to-Stand Standers

First, the medical team and equipment vendor must know the item is coverable under the New York Medicaid program. Medicaid funds durable medical equipment (DME), defined as devices and equipment that can withstand repeated use for a protracted period of time; are customarily and primarily used for medical purposes; are generally not useful to a person in the absence of an illness or injury; and are not fitted, designed or fashioned for a particular individual. Where equipment is intended for use by only one person, it may be either custom-made or customized. Sit-to-stand standers clearly meet this definition of DME.

Medicaid must fund coverable devices and equipment if medically necessary. Medical necessity is defined as devices which are necessary to prevent, diagnose, correct, or cure a condition of the recipient which causes acute suffering; endangers life; results in illness or infirmity; interferes with the capacity for normal activity; or threatens to cause a
significant handicap. The individual’s medical team must document that the individual is at risk from the secondary complications of immobility, can tolerate supported standing, and therefore can benefit from sustained weight bearing through standing. We have discussed in prior newsletters the importance of a well-drafted, detailed letter of medical justification. Letters should include the qualifications of the drafter; an explanation of how the drafter knows the recipient; a description of the recipient; what device the recipient is currently using (if applicable); what specific device the recipient needs; and why the recipient needs that specific device. (See our Winter 2005 issue of IMPACT for a more thorough discussion of letters of medical justification.)

Because sit-to-stand standers are more expensive than the prone, supine and multi-positional standers, the letter of justification must contain a thorough discussion of what other devices were considered and ruled out, and why. Perhaps the individual has only one caretaker, and it requires two people to assist with transfers into the flat standers. Perhaps seizures make it likely that an individual would fall or roll off the stander before the individual could be secured to it. These are just a few of the reasons why individuals have needed sit-to-stand standers rather than the less costly types.

**The Medicaid Prior Approval Request**

As noted above, sit-to-stand standers require prior approval. Prior approval requests are submitted by equipment vendors. The request is accompanied by a physician’s prescription and a letter of medical justification. Often, letters supporting requests for items of DME are written by treating physical or occupational therapists and are countersigned by the physician. While one well-drafted letter is normally sufficient, additional medical support may be submitted.

When writing a letter of medical justification for a sit-to-stand stander the writer will need to address whether or not the individual requesting the stander is currently in a standing program; whether the program is part of physical therapy and, if so, the goal of the physical therapy program; and how the sit–to–stand stander will further that medical goal. If the individual is not currently in a standing program, the writer should explain why there is a medical need for a standing program at this time and why the individual cannot be introduced to standing through a less costly stander. Also, if the individual has a problem with orthostatic hypotension (a decrease in blood pressure upon standing) the writer should address why a sit-to–stand stander will not exacerbate that condition. The writer should discuss a recommended standing program including how often the individual should come to a stand and for how long, the medical goals to be met, and the expected time line for meeting those goals. For example, “John will achieve a full stand within six months of receiving the device, will be able to maintain a full stand for 15 minute segments, and will repeat this goal at least four times daily.”

The Medicaid agency is required to issue a determination denying, approving, or modifying the request within 21 days of submission, unless the agency asks for additional information. Since the request for additional information will allow the agency extra time
to issue its determination (i.e., more than 21 days), it should be responded to as completely and promptly as possible.

The Medicaid agency’s determination must be in writing, and must be sent to the Medicaid recipient. If the recipient has a representative such as a legal guardian or parent, the representative must also get notice. If the determination denies or modifies the request, the notice must advise the recipient of the procedure for requesting an administrative fair hearing, including the time limits for requesting one. Hearings must be requested within 60 days of issuance of the written determination.

**Common Reasons Why the Medicaid Agency Denies Prior Approval for Sit-to-Stand Standers**

*Medicaid May Claim there are Less Costly Alternatives*

Medicaid often denies funding for sit-to-stand standers on the premise that less costly alternatives have not been adequately explored, ruled out or tried out. Medicaid can consider whether less costly alternatives would meet the individual’s medical needs. The individual’s medical team needs to consider the less costly prone, supine, and multi-position standers and explain why each will not work. The most thorough approach is to consider particular models and explain why each one was ruled out.

Using various types of standers as part of a trial period can help expedite the prior approval process. It is difficult for the Medicaid agency to convincingly argue that a particular stander has not been adequately explored when it has been ruled out as inappropriate after a trial of the stander. However, there may be good reasons why a trial would not be feasible. For example, equipment vendors may not have standers on hand and available for trial.

Also, if a particular stander would clearly not meet the person’s medical need, should it be tried out just on principle? This is basically what the agency argued at the fair hearing in the *Matter of Anonymous*, FH # 5615260J (NY 2011). The seven year old child in that case owned a multi-position stander she was outgrowing. The child’s mother was her primary caregiver and usually had to transfer her without assistance. The child had fluctuating tone, meaning sometimes she was rigid and sometimes floppy and she had seizures. Each time her mother transferred her onto the flat standers in either prone or supine position, she risked dropping her or having her fall off. The child used a prone stander at school, but she had at least two people available to transfer her. The school therapist stated that they would not be allowed to transfer her onto the prone stander in school if there were only one person to assist. Also, the therapist stated that the child did not tolerate the flat standers long enough to benefit from weight bearing. In contrast, after a one-week trial using a sit-to-stand stander, she had already far exceeded the tolerance she had developed in eight months using the prone stander. Although the therapist considered the prone, supine, and multi-position standers, she did not trial any other than those she was using because she considered them to be unsafe for the child.
Despite the overwhelming evidence demonstrating that supine, prone and multi-position standers were unsafe and inappropriate for the child to use, the Medicaid agency denied prior approval for the sit-to-stand, claiming that more prone, supine, and multi-position standers should have been trialed. The case was successfully appealed, and the Medicaid agency was directed to fund the sit-to-stand stander. The child should not have to trial equipment that could result in harm to her.

**Medicaid May Claim the Glider Feature is Exercise Equipment**

Certain standers have a glider feature. The user, with or without caregiver assistance, moves handlebars back and forth, causing a reciprocal movement in the legs. This feature can generate benefits not provided by passive standing alone. Benefits of the glider include upper body strengthening and improved range of motion of the legs. The Medicaid agency has routinely denied gliders, claiming they are exercise equipment and therefore, are not medical. This particular basis for denying standers with gliders, as well as adaptive tricycles, has been rejected by administrative law judges in fair hearing decisions. (See hearing decision in Matter of C, discussed in the fair hearing decisions section, below.)

**Medicaid Prior Approval Determinations Can be Appealed**

When a request for prior approval for a sit-to-stand stander is submitted to the Medicaid agency, it must send a written determination approving, denying, or modifying the request to the recipient and the recipient’s representative, if applicable. The agency may modify the request by approving the stander, but not approving some of the accessories. The agency may also change the code the equipment provider uses on the prior approval request. For example, a vendor may submit the request for a particular stander using the miscellaneous code, E1399, because the reimbursement rate under either E0638 or E0641 is insufficient to cover the provider’s cost of the stander. These are both instances of modification of a prior approval request.

The written determination must be made within 21 days of submission unless the agency asks for additional information. However, the agency should not be able to delay making a written determination by asking for additional information multiple times. A determination may be appealed by requesting a fair hearing within 60 days of the date of the determination. A hearing request may be made by fax or by telephone. The Medicaid recipient may also appeal if a determination has not been made in a timely fashion, or if the determination is other than approving, denying, or modifying. For example, the recipient may ask for a hearing if the agency voids, rejects, inactivates, returns, or otherwise fails to approve, deny, or modify the request. Voiding, rejecting, inactivating, etc., are not appropriate responses to a prior approval request, but the agency has been issuing these type of responses nonetheless. A person should also be alert to a denial masquerading as a missing information letter. One of the ways this
happens is when the agency purportedly asks for information but states that the item is non-coverable.

An individual need not go through this process alone. The New York State Assistive Technology Project at Neighborhood Legal Services can provide an advocate to assist an individual anywhere in the state, at no cost to the individual. The advocate can review letters of medical justification, attempt to resolve the matter without an administrative hearing, and advocate for the individual at the hearing if the matter cannot be resolved beforehand. Many prior approval determinations have been overturned by using the fair hearing process.

**Conclusion**

New York’s Medicaid agency is required to fund medically necessary standing devices. In fact, Medicaid can be required to fund the more expensive sit-to-stand standers, so long as written documentation shows that less expensive alternatives have been considered and ruled out as inappropriate (e.g., as unsafe or less effective than the requested device).

Our State AT Advocacy Project is here to assist individuals, their families, and the health providers who support them. We are very willing to provide technical assistance with prior approval requests, such as looking over letters of medical justification drafted to support the request. Importantly, we can represent both adults and children in fair hearing appeals if the Medicaid agency denies a request for funding. Feel free to contact Marge Gustas at 716-847-0650 ext. 256 or mgustas@nls.org if you seek our assistance.

**Fair Hearing Decisions Have Directed the Medicaid Agency to Fund Sit-to-stand Standers**

The following are examples of fair hearing decisions handled by the New York State Assistive Technology Project that have resulted in Medicaid funding of sit-to-stand standers.

In *Matter of N*, FH # 4025513P (2004), the medical documentation stated that the child needed a sit-to-stand stander because it allowed him to be raised to a standing position in a gradual and controlled fashion. This would prevent sudden changes in blood pressure or a quick stretch on muscles or tendons which could result in painful spasms. Further, the child’s mother testified that the child weighs 50 pounds and she cannot hold him up and, at the same time, try to keep his feet flat which is necessary for him to reap the benefits of standing. The requested sit-to-stand stander allowed her to raise him to standing with his feet flat. The hearing decision found the sit-to-stand stander to be medically necessary.

*Matter of M*, FH # 5108288Q (2008), involved a request for a sit-to-stand stander with glider for a 10 year old child. The Medicaid agency denied funding, claiming that he was
not experiencing weight bearing through his lower legs sufficiently to receive the benefits of standing. This assessment was based entirely on photographs submitted and not on a face-to-face evaluation. The treating physical therapist refuted this opinion, stating that she had measured him and not a photograph of him, and he was sufficiently weight bearing to benefit from the stander. She testified that he uses a similar stander for one hour per day while at school and she has noticed that following each session his breathing is better, his lungs are expanded to allow him to say a few names, and his diaper has to be changed showing an improvement in his bladder/bowel function. Also, she noted that his feet show more color after standing, showing improved circulatory function. Based on the evidence presented, the hearing decision directed the agency to approve funding for the stander.

In Matter of C, FH # 5126081L (2009), a request for a sit-to-stand stander with glider for a 19 year old with a diagnosis of cerebral palsy was denied as not medically necessary. The agency claimed that the recipient was able to meet her need for weight bearing through ambulation, and the glider had not been scientifically proven to provide a medical benefit given her current medical status. At the hearing, the recipient’s physician, who specializes in pediatric physical medicine and rehabilitation, testified that the recipient’s ability to walk had decreased over time and now she could not walk far enough to benefit from weight bearing. He also stated that walking would not provide her weight training/resistive exercises. As to the glide feature, he noted that it would provide movement across the hip joint in a weight bearing posture, necessary for hip flexion and hip extension, and upper extremity strength and stretch. He pointed out the stander with glider would provide walking with correct alignment along with movement of across the hips.

In reversing the agency’s determination and awarding funding, the hearing decision noted that the prior approval request had not been reviewed by a medical professional with credentials comparable to those of the treating/testifying physician.

If you would like copies of any of these decisions or are looking for fair hearing decisions to support funding of other equipment, contact Marge Gustas at 716-847-0650 ext. 256 or mgustas@nls.org.

The Technical Assistance Corner

Question Presented: Do I have any options if I lose a fair hearing?

Our Response: Fair hearing decisions can be reviewed by a court to determine whether the decision was supported by substantial evidence or whether the determination was made in violation of lawful procedure, was affected by an error of law, or was arbitrary and capricious or an abuse of discretion. Judicial reviews of administrative hearing decisions are brought pursuant to Article 78 of the Civil Practice Law and Rules (Article 78 proceeding). An Article 78 proceeding must be brought within four months after the
hearing decision becomes final and binding. We generally “play it safe” by counting the four months from the date the decision was issued.

Another option is to submit a new prior approval request. The fair hearing decision might be based on failure to properly document that the item is medically necessary or that less costly alternatives were not explored. The new application could provide medical documentation in more detail, or show that more alternatives were considered and ruled out.

Save the Dates

“For Free” Four-Part Teleconference Training

Starting on November 14th we will offer these training programs on four successive Wednesdays, all from 2:00 to 3:15 p.m., and all presented by the State AT Advocacy Project staff:

- November 14th, 2:00 to 3:15 p.m. – Overcoming Medicaid’s Most Common Reasons for Saying No to Requests for Durable Medicaid Equipment (DME): Turning a No to a Yes (Diana M. Straube and James R. Sheldon, presenters)
- November 21st, Letters of Medical Justification: Supporting the Need for DME Funding (Marge Gustas, presenter)
- November 28th, Medicaid, Medical Equipment and Kids: Their Unique Needs and The Special Mandates of EPSDT (Diana M. Straube, presenter)
- December 5th, Medicaid, Managed Care and DME Funding (Marge Gustas, presenter)

Although there will be no charge for attendance, pre-registration will be required. Announcements for all sessions will go out in mid-October.

The NY State Assistive Technology Advocacy Project

Our Staff, Our Services

Our Staff:
• **Marge Gustas, Staff Paralegal (mgustas@nls.org, 716-847-0650 ext 256)** – primary contact for new referrals/technical assistance questions; handles administrative hearings and other appeals

• **Diana M. Straube, Staff Attorney (dstraube@nls.org)** – handles administrative hearings, other appeals and litigation

• **James R. Sheldon, Jr., Supervising Attorney (jsheldon@nls.org)** – is also Project Supervisor of our National AT Advocacy Project

• **Lynn Urquhart, Project Secretary (lurquhart@nls.org)** – primary contact to get added to our newsletter electronic mailing list

**Our Services:**

• **Individual Representation** – before any agency which denies funding for assistive technology (e.g., Medicaid, Medicare, private insurance, special education programs, ACCES-VR, Commission for the Blind)

• **Publications, Including IMPACT Newsletter** – also have publications to support training; have access to materials produced by National AT Advocacy Project/other projects of Neighborhood Legal Services

• **Training** – **contact Marge Gustas if you** would like a speaker for your conference or agency training event

• **Resources to Support Attorneys, Other Advocates (includes technical assistance, resource materials, copies of winning hearing decisions)** – contact Marge Gustas

**Send Us Your Winning Hearing Decisions, Other Support Materials**

*We maintain a resource library of Medicaid hearing decisions, briefs from court cases, and medical/technology publications that will support advocacy before Medicaid and other funding sources. Please send us any of these documents so that we can use them and make them available to others.*

*Please note: If you no longer wish to receive e-mail announcements of upcoming IMPACT issues, please unsubscribe to our mailing list by contacting lurquhart@nls.org.*