



Advocate

Newsletter of the National Assistive Technology Advocacy Project
A Project of Neighborhood Legal Services, Inc.

295 Main Street, Ste. 495, Buffalo, New York 14203 • (716) 847-0650
FAX: (716) 847-0227 • TDD: (716) 847-1322 • Web Page: www.nls.org

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MEDICAID AND ASSISTIVE TECHNOLOGY

A Fresh Look at Medicaid as an AT Funding Source

INTRODUCTION

Medicaid serves more than 50 million low-income families, elderly individuals, and persons with disabilities. Persons with disabilities under age 65 account for approximately eight million of the total of Medicaid beneficiaries.

Many children and adults with severe disabilities look to Medicaid as a primary source, or the only source of health insurance. Medicaid often pays for key health-related goods and services, including specialty physicians, mental health counseling, home health care, and prescription drugs. Every state's Medicaid program will provide more than a dozen categories of "required services" and up to 29 different categories of "optional services."

Medicaid has historically been the most important funding source for assistive technology (AT) in most states, with the AT typically funded under Medicaid's durable medical equipment category of coverage. Among Protection and Advocacy for Assistive Technology (PAAT) advocates, Medicaid cases typically make up 70 percent or more of caseloads. Among Protection and Advocacy and Legal Services advocates who have handled just a few AT cases, it is most likely they have worked with Medicaid as the funding source.

Persons with disabilities have accessed a variety of AT devices through Medicaid, including the following:

- Custom and power wheelchairs

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- Augmentative and alternative communication devices
- Prosthetic limbs
- Environmental control units
- Therapy vests for treating the symptoms of respiratory conditions
- Lifting devices, such as hydraulic lifts and ceiling track lifts
- Assistive listening devices, including hearing aids and personal FM units
- Ramps, lifts and stair glides
- Specialized car seats and strollers

These devices and others have been obtained through regular Medicaid funding for adults or through Medicaid's Early Prevention, Screening, Diagnosis and Treatment (EPSDT) program for children. Additional devices may be available under one or more optional Medicaid waiver programs. The National AT Advocacy Project has collected more than 500 Medicaid fair hearing decisions in its Resource Library which have approved funding for each of the listed devices and many others.

This article presents an overview of Medicaid and the funding available for AT under Medicaid for both children and adults. This article fully replaces the lead article published in our April-May 1997 issue of *AT Advocate*. A more comprehensive publication on this topic, *Funding Assistive Technology Through State Medicaid Programs*, will be published later this year as part of our Funding of AT series.

TERMINOLOGY USED IN THIS ARTICLE

The Assistive Technology Act defines an AT device as an item or piece of equipment "used to increase, maintain, or improve functional capabilities of individuals with disabilities." 29 U.S.C. § 3002(4). Many of our readers work for PAAT programs that are mandated to assist individuals obtain funding for AT devices and services. See 29 U.S.C. § 3002(5), defining AT services. Most of the specialized equipment, discussed in this article, would meet the definition of an AT device.

The federal laws and regulations that govern state Medicaid programs do not use the terms AT device or AT service. Nor are these terms used in any federal Medicaid policies. One or two states may have incorporated some AT language into their Medicaid terminology.

Durable medical equipment (DME) is the most common term used by state Medicaid programs to define what we think of as AT. Ironically, the term DME is not found in either the federal Medicaid Act or its implementing

regulations. Even the term "medical equipment" (ME), used by the federal Health Care Financing Administration (HCFA) in a well-known 1998 policy letter, is not found in the federal Medicaid law. (HCFA has been renamed the Center for Medicare and Medicaid Services or CMS.)

The closest the federal regulations come to the DME or ME terminology is in the home health category and the separate categories for physical therapy, occupational therapy, and speech therapy. See, 42 C.F.R. §§ 440.70 (home health services include "medical supplies, equipment and appliances") and 440.110 (covering PT, OT and speech and providing that the service category covers "any necessary supplies and equipment").

The remainder of this article will use the terms DME and AT, somewhat interchangeably, to describe the equipment we are helping individuals to obtain through Medicaid. In fact, DME is the most common terminology used in all states to describe the AT devices we are seeking. DME tends to be used generically to describe all equipment funded by a Medicaid agency under any category. Keep in mind, as we point out below, that many of Medicaid's coverage categories can potentially serve as the basis for obtaining the AT or DME our clients seek.

MEDICAID: THE BASICS

Medical Assistance or Medicaid is a cooperative federal-state program authorized by Title XIX of the Social Security Act. 42 U.S.C. §§ 1396 *et seq.* A state's Medicaid program provides funding for medical care, rehabilitation and other services for eligible individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396. States are not required to have a Medicaid program, but if they choose to do so, they must submit a state Medicaid plan to the Secretary of Health and Human Services, which must be approved if it meets all requirements of Title XIX and its implementing regulations.

Medicaid is best described as a vendor payment program. A state's Medicaid program does not provide any goods or services directly; rather, it provides money to pay for them. For many routine items, including most prescription drugs and very inexpensive DME, a doctor's prescription and proof of Medicaid eligibility may be enough to obtain payment and receive the goods or services. With more expensive DME, such as a power wheelchair, every state appears to follow some type of prior approval process.

This article provides a framework for analysis of the issues typically encountered by the advocate who is appealing the denial of funding for DME under Medicaid. In back issues of *AT Advocate*, you will also find summaries of hearing decisions and court decisions in which the principles discussed herein are applied.

An individual who seeks Medicaid funding for AT/DME must generally meet a three-part test:

1. The individual must be eligible for Medicaid;
2. The device requested must meet the definition of one or more coverage categories;
3. The device requested must be medically necessary.

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 on other grounds, 117 F.3rd 1416 (5th Cir. 1997). In specific cases the individual may also need to establish that he or she meets the criteria of the

coverage category in question, *see, e.g., Fred C.*, above, 117 F.3rd 1416 (order unpublished) (remanding case to determine whether the plaintiff was eligible under the home health category).

ELIGIBILITY FOR MEDICAID

Under the three-part test for AT/DME coverage, we must first establish Medicaid eligibility. Individuals with disabilities generally will establish Medicaid eligibility in one of five ways:

- In 39 states, the District of Columbia, and the Northern Mariana Islands a Supplemental Security Income (SSI) recipient is automatically eligible for Medicaid. In the remaining 11 states (“section 209(b) states”), Medicaid eligibility is determined under state-specific criteria.
- Four classes of former SSI recipients can retain Medicaid (see box p.304).
- In 34 states, there is an optional “medically needy” eligibility category, allowing individuals to qualify if monthly income is

SOME FORMER SSI RECIPIENTS RETAIN ELIGIBILITY FOR AUTOMATIC MEDICAID

Supplemental Security Income (SSI) provides cash disability benefits to persons with limited income and resources. In 39 states, an SSI recipient qualifies for Medicaid automatically. In several situations a person who loses SSI due to increased income can continue automatic Medicaid eligibility.

Social Security Widow's/Widower's Recipients. A person who loses SSI when he or she becomes entitled to Social Security widow's or widower's benefits will retain automatic Medicaid if SSI eligibility would continue in the absence of the Social Security benefits. Eligibility continues only for so long as the person remains ineligible for Medicare — a period of 24 months following eligibility for Social Security. 42 U.S.C. § 1383c(d).

Social Security Disabled Adult Child's Recipients. Recipients of Social Security Child's Insurance Benefits, often referred to as Disabled Adult Child's (DAC) benefits or Childhood Disability Benefits, can continue automatic Medicaid eligibility if, after July 1, 1987, the person lost SSI due to entitlement to or an increase in DAC benefits. 42 U.S.C. § 1383c(c). DAC benefits are available through the Social Security record of a parent who is now disabled, retired or deceased. If the person would still be eligible for SSI if the DAC benefits or increase in DAC benefits were ignored, he or she is eligible for continued Medicaid.

Section 1619(b) Medicaid. This allows automatic Medicaid to continue if a person loses SSI due to increased wages. 42 U.S.C. § 1382h; Social Security Program Operations Manual System (POMS) SI 02303.010B. If the person is still disabled and would be eligible for SSI if the wages were not counted, Medicaid should continue. State eligibility thresholds range from \$22,000 to \$45,000 in wages per year. See POMS SI 02302.200. The income limit can be even higher if medical expenses are high enough.

The Pickle Amendment. Individuals who lost SSI because of cost-of-living or other increases in Social Security benefits may have their Medicaid eligibility re-established if the person would be presently eligible for SSI if Social Security cost-of-living increases, since the last month of dual eligibility for SSI and SSDI, are disregarded. For an excellent resource on this topic, see Bonnyman, G., *A Quick and Easy Method of Screening for Medicaid Eligibility Under the Pickle Amendment* (updated annually), available at: www.healthlaw.orgpubs200411.2005Picklechart.pdf.

lower than a designated amount, and allowing them to “spend down” if income is above that level.

- In more than half the states, there is an optional “Medicaid buy-in,” allowing working individuals to qualify for Medicaid, when not eligible under other categories. Depending on state options, eligibility can exist at wage levels between \$48,000 and \$70,000, with a monthly premium required in some cases.
- In most states, under one or more optional home and community based services waivers, some children or adults can establish eligibility despite significant income of a parent or spouse. The Medicaid program will waive the ordinary requirement that a part of the parent’s or spouse’s income be “deemed” available to the individual.

For a more comprehensive discussion of Medicaid eligibility, see Sheldon, J., *Medicaid and Persons with Disabilities: A Focus on Eligibility, Covered Services, and Program Structure*, available at www.ilr.cornell.edu/edi/publications/PPBriefs/PP_24.pdf or .txt. An extensive treatment of eligibility will also appear in our upcoming publication on Medicaid under our Funding of AT series.

WHAT AT DEVICES CAN BE FUNDED UNDER MEDICAID?

Having established eligibility, part two of the three-part test for obtaining AT/DME requires that the device fall within one or more coverage categories. In many cases, coverage is not in dispute and we can go right into the issue of medical necessity. However, often the threshold issue will be whether the device in question can ever be covered by the Medicaid program.

For example, during the early and mid-1990s, coverage was the major barrier to funding of augmentative and alternative communication (AAC) devices in several states. *See, e.g.*, references to the *Hunter* and *Fred C.* litigation above. During the late 1990s, coverage was the barrier, in several states, faced by individuals seeking Medicaid payment for therapy vests to treat respiratory conditions. As attorneys and advocates succeeded in most states in establishing coverage for AAC devices and later therapy vests, the battle lines sometimes shifted - - forcing advocates in some states to challenge policies, for example, that limited therapy vest coverage to certain diagnoses only.

When facing a denial of DME under Medic-

aid, the attorney or advocate must be careful to not immediately jump to the issue of medical necessity. Rather, first you must determine whether the agency is claiming that the item itself is not covered by the Medicaid program under any circumstances.

DME Available to Adults Under Medicaid

To qualify for DME as an adult, the device in question must be available under the state’s Medicaid plan or under an optional Medicaid waiver. By choosing to participate in Medicaid, a state must provide certain mandated services, 42 U.S.C. §§ 1396d(a)(1)-(5), (17) and (21), and may also choose to provide from a list of optional services. *Id.* §§ 1396d(a)(6)-(16), (18), (19), (20), (22)-(25).

Over the years, advocates have identified 10 separate coverage categories for potential funding of AT or DME, including both mandatory and optional categories.

Mandatory Service Categories for AT/DME Funding

- home health care services (medical supplies, equipment and appliances)
- EPSDT (for children under 21)

Optional Service Categories for AT/DME Funding

- home health care
- intermediate care facilities
- occupational therapy
- physical therapy
- preventive services
- prosthetic devices
- rehabilitation services
- speech, hearing and language therapy

Each service category is defined, to some degree, in the federal regulations.

See, e.g., 42 C.F.R. §§ 440.70(b)(3) (medical supplies, equipment and appliances, as mandatory items under home health services), 440.110 (physical therapy, occupational therapy, speech, hearing and language therapy), 440.120(c) (prosthetic devices), 440.130(c) (preventative services), 440.130(d) (rehabilitative services).

Many states define DME as equipment with the following characteristics:

- (1) can withstand repeated use;
- (2) is primarily and customarily used to serve a medical purpose;
- (3) is generally not useful to a person in the absence of illness or injury;
- (4) is appropriate for use in the home.

Many Medicaid agencies have denied a request for AT/DME, claiming that an item does not

meet one of these four criteria. For example, an air conditioner, which may be medically necessary for a person with multiple sclerosis to prevent exacerbations due to extreme heat, may be denied because it does not meet the criteria under (2)(i.e., is primarily used to serve a non-medical purpose) or (3)(is useful to many persons in the absence of illness or injury). To avoid this DME definition dilemma, the advocate may want to argue that this item meets the definition of a “preventative service,” i.e., it “prevent[s] disease, disability, and other health conditions or their progression” [42 C.F.R. § 440.130(c)], or meets the definition of a “rehabilitative service,” i.e., it is prescribed 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)].” Of course, these arguments are only available if your state covers one of these two optional categories. If your client is a child under age 21, these arguments will be available in all states since children will, under EPSDT, be covered by all optional categories.

Suggested Sequence for Analysis of AT/DME Case

To determine if your state’s Medicaid program should be expected to cover a specific device for an adult, the following analysis is recommended:

1. Determine which of the eight optional categories, listed directly above, are a part of your state’s Medicaid plan.
2. Review the federal regulations which define the mandatory home health services category and the relevant optional categories, and determine which category or categories the device potentially fits under.
3. Review your state Medicaid law, regulations and policy to determine: if your state has separately defined the service categories in question; has developed criteria for approval of DME, in general; or has developed criteria for the DME device in question.
4. Determine whether your state has ever funded the item in question or a device in the same family of items. What can be helpful is to identify previous fair hearing decisions that have approved the device or one like it.
5. Determine whether the Medicaid agency from another state has funded the item in question under a service category that is available in your state.

Items 4 and 5 present a special challenge as

a state’s Medicaid agency may not keep indexed files of what has been approved at the application stage and what has been approved at the fair hearing stage. (However, see 42 C.F.R. § 431.244(g), providing that the “public must have access to all agency hearing decisions.”) In some states the PAAT program has set up its own resource library of statewide fair hearing decisions. On a national level, the National AT Advocacy Project has established an AT Resource Library which includes more than 500 Medicaid fair hearing decisions collected from advocates nationwide. If a fair hearing resource library has not been established in your state, start one today. Then send us copies of your state’s decisions so that we can include them in our Resource Library.

AT/DME Available to Children Under EPSDT Program

EPSDT is a mandatory service under Medicaid. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(B), 1396d(r). EPSDT services are available to children from birth through age 21. A state must provide to Medicaid beneficiaries under age 21 any service among those listed in the Medicaid Act, including optional services, whether or not the service is included in the state’s Medicaid plan. *Id.* § 1396d(r)(5); CMS State Medicaid Manual, Part 5: EPSDT, § 5110.

MEDICAID RESOURCES AVAILABLE IN THE NATIONAL AT RESOURCE LIBRARY

Our National AT Advocacy Project has more than 500 Medicaid fair hearing decisions in our AT Resource Library. The great majority are favorable decisions awarding funding to purchase the equipment in question. Most of these are now available in a PDF format, allowing us to send you a decision by email attachment. In many cases we also have the written arguments that were submitted at the hearing. The great majority of these decisions have been abstracted, with the abstracts available in a word-searchable database on our website at www.nls.org/digest2.htm.

We also maintain an AT-related Court Documents Library, including briefs, complaints, other court-related documents, and some unreported decisions. Most of the more recent documents are in electronic format. The great majority of the court documents involve Medicaid.

The recommended five-part inquiry to be followed for adults also applies for children, with one exception — the advocate need not review the state Medicaid plan to determine which optional service categories are available. For children, you can simply measure your client’s need for a device against the regulatory language for any of the 10 categories listed above.

**THE CMS POLICY BARRING
“EXCLUSIVE LISTS” OF DME**

In 1998, the federal Health Care Financing Administration (HCFA, later renamed CMS) issued a policy letter to address the practice of state Medicaid agencies that operated “exclusive lists.” Items not appearing on the exclusive list are subject to an absolute exclusion of coverage as DME. This policy letter was the agency’s response to litigation involving Connecticut’s Medicaid program which, like many other state programs, maintained an exclusive list of covered DME. *See DeSario v. Thomas*, 139 F.3rd 80 (2nd Cir. 1998), cert granted, judgment vacated, *Slekis v. Thomas*, 525 U.S. 1098 (1999).

This 1998 policy letter is very important to AT advocates. While it allows state Medicaid

agencies to maintain lists of pre-approved DME for administrative convenience, it makes clear that state Medicaid programs must provide beneficiaries “a meaningful opportunity for seeking modifications of or exceptions to a state’s pre-approved list.” Specifically, the policy letter 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.
- States may not arbitrarily exclude items 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.
- A state’s list of pre-approved items of DME should be viewed as an evolving document that should be updated periodically to reflect available technology.
- The approved list and the process for seeking modifications and exceptions to the DME list must be made available to all enrollees.

Any review of a state’s list of covered DME (and list of excluded items) should be viewed with these principles in mind. The September 4, 1998 letter is available on CMS’s website at www.cms.hhs.gov/states/letters/smd90498.asp.

Application of the CMS Letter By the Courts
Since this policy letter was issued in 1998,

**“FUNDING OF AT WORK
GROUP” AND “NATIONAL
AT LIST SERVE”
- - AN OPPORTUNITY TO
NETWORK ON AT ISSUES**

Funding of AT Work Group. This meeting, by telephone conference, occurs about every two months, at no charge to participants. Meetings are chaired by Jim Sheldon of the National AT Advocacy Project and run between 60 and 90 minutes. This is an opportunity to keep up with legal developments, pose questions to other attorneys/advocates, and hear about what others are doing. Medicaid and Medicare tend to be the biggest areas of focus, but any AT-related subject is appropriate for the meeting. Meeting announcements are posted on our list serve.

National AT List Serve. This offers you the opportunity to post news or post questions and reach attorneys and advocates nationwide. To join our list serve, send an email to Jim Sheldon (jsheldon@nls.org).

several federal and state courts have addressed these issues. These cases illustrate that states' attempts to limit the scope of equipment covered by Medicaid often run afoul of the CMS letter. For example, a Florida federal district court, in *Esteban v. Cook*, struck down a cost cap of \$582 on wheelchairs for adult beneficiaries. Citing the September 1998 CMS letter, the court reasoned that the Medicaid agency failed to provide a reasonable and meaningful procedure for requesting items (in this instance, custom and power wheelchairs) that did not appear on the state's pre-approved list. The court held 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." 77 F.Supp. 2d 1256, 1260-61 (S.D. Fla. 1999).

Similarly, a state appellate court in Colorado, in *T.L. v. Colorado Department of Health Care Policy and Financing*, struck down the state Medicaid agency's use of a list of excluded DME, relying heavily on the 1998 policy letter. 42 P.3d 63 (Colo. App. 2001). At issue was the absolute exclusion of a hot tub that was needed for therapy. The court ruled that, "by expressly excluding home health [i.e., DME] coverage for hot tub or jacuzzi acquisitions under all circumstances and without regard to medical necessity," the state regulation "violates federal law and the objectives of Title XIX [of the Social Security Act] and is therefore invalid." 42 P.3d at 67. The court remanded the case to the administrative law judge to determine: i) whether the hot tub meets the DME definition; ii) whether the hot tub therapy is medically necessary; iii) whether, and at what cost, the petitioner could obtain that therapy outside the home (i.e., whether the home-based therapy is the least costly alternative); and iv) whether the primary purpose of the hot tub is to provide comfort rather than treatment to the petitioner.

These cases illustrate the limits on a state's discretion to categorically exclude a particular item of equipment from Medicaid coverage. Do not overlook the utility of this policy letter in challenging a denial of DME by a state Medicaid agency.

MEDICAL NECESSITY

Assuming that the device is one that can be funded for a person eligible for Medicaid (i.e., parts one and two of the three-part test are met), the question now turns to whether the device is

medically necessary. The provisions authorizing states to establish a medical necessity standard come out of Medicaid's statutory and regulatory language. The Medicaid Act provides funding for medical care, rehabilitation and other services for eligible individuals "to meet the costs of necessary medical services." 42 U.S.C. § 1396 (emphasis added). In operating its Medicaid program a state "may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." 42 C.F.R. § 440.230(d) (emphasis added).

Medical Necessity for Children Under EPSDT

The EPSDT benefit covers all medically necessary services for Medicaid-eligible children under age 21. The Medicaid Act's language supports a much more expansive definition of medical necessity for children than for adults. Under EPSDT, state Medicaid programs must cover "necessary health care, diagnostic services, treatment and other measures...to correct or ameliorate defects and physical and mental illnesses and conditions." 42 U.S.C. § 1396d(r)(5). Services must be covered if they correct, compensate for, or improve a condition, or prevent a condition from worsening, even if the condition cannot be prevented or cured.

A Good Letter of Justification Should Support Medical Necessity

A part of every prior approval packet, submitted to your Medicaid agency (or other decision maker designated by Medicaid), will be one or more letters of medical justification. These may be written by a physician or, in our experience, are often written by other health professionals such as physical therapists, occupational therapists, or speech-language pathologists. A good reference on this topic is our June/July 1998 issue of *AT Advocate*, with its lead article "Report Writing: Justifying the Need for Assistive Technology," available at www.nls.org/av/av-0798.htm.

If you are handling a fair hearing involving DME, a major part of your hearing preparation may be to ask the physician or other health professional to write or re-write a letter of justification. As you establish a rapport with the vendors and health professionals who are involved with the prior approval process, you may begin playing the more proactive role of counseling them regarding the content of justification letters before the prior approval packet is submitted.

INTERPRETIVE GUIDANCE IN LAW AND REGULATION

The Medicaid Act and its implementing regulations do not authorize funding of any particular item of DME. The federal law and regulations do not specify whether power wheelchairs or AAC devices, for example, are covered items within the scope of any mandatory or optional coverage category. Nor do they spell out a test of medical necessity or other criteria governing when a person is eligible for a specific device. However, the federal law provides a general framework and some federal regulations will spell out, in greater detail, what a particular category contemplates.

The federal law indicates, for example, that the primary goal of Medicaid is to provide medical assistance to persons in need and to furnish them with rehabilitation and other services to help them “attain or retain capability for independence or self-care.” 42 U.S.C. § 1396. The quoted statutory language was cited in the 1985 *Meyers v. Reagan* decision, in which the Eighth Circuit found the plaintiff entitled to Medicaid funding for an AAC device, reasoning that obtaining or retaining the capability for independence is the “primary goal of Medicaid.” 776 F.2d 241, 243 (8th Cir. 1985). The federal regulations provide that “each service must be sufficient in amount, duration and scope to reasonably achieve its purpose,” 42 C.F.R. § 440.230(b), a provision that has repeatedly surfaced in the AT-related litigation.

State laws may also provide language that can be referenced for interpretive guidance. For example, New York’s law provides that Medicaid will pay for services and supplies which are “necessary to ... correct or cure conditions in the person that ... interfere with [the recipient’s] capacity for normal activity” N.Y. Social Services Law § 365-a. In *Starkweather v. Wing*, a New York appellate court applied that language in a case involving funding for a wheelchair, holding that the wheelchair was needed for a 14 year old boy “to increase the independence and functional ability of petitioner’s infant, especially in emergency situations, and to prevent the development of ‘learned helplessness.’” 662 N.Y.S.2d 658, 659 (N.Y.A.D. 4 Dept. 1997). That same New York court, in *Lagowski v. Whalen*, held that the state statute in question “must be interpreted and enforced in a reasonable and humane manner in accordance with its manifest intent and purpose.” 706 N.Y.S.2d 283 (N.Y.A.D. 4 Dept. 2000), quoting

Sabot v. Lavine, 399 N.Y.S.2d 640 (N.Y. 1977).

DUE PROCESS PROTECTIONS IN DME CASES

The same due process rights afforded to Medicaid applicants and recipients, generally, also apply to individuals seeking AT/DME. These include the right to a timely decision, the right to a specific notice when a decision is made, and the right to a fair hearing when the decision is in any way adverse to the applicant or recipient.

Timely Decision Making. Once an individual is found eligible for Medicaid, the state agency must “furnish Medicaid promptly without any delay caused by the agency’s administrative procedures.” 42 U.S.C. § 1396a(a)(8); 42 CFR § 435.930. This reasonable promptness requirement is of particular importance when an individual must go through a prior approval process to obtain DME.

Notice of Adverse Decision. Timely and adequate notice must be sent whenever the agency takes “action” against a beneficiary. For due process purposes, the term “action” is defined to include “termination, suspension, or reduction of Medicaid eligibility or covered

CAN FAIR HEARING DECISIONS BE USED AS BINDING PRECEDENT?

If your state has provided a specific AT device under its state Medicaid plan, and not under a specific waiver, you should be able to use this as precedent for future cases. A state’s failure to provide the same device to your client would violate 42 U.S.C. § 1396a(a)(10)(B)(i), which requires that medical assistance made available to any individual, within the state, shall “not be less in amount, duration, or scope than medical assistance made available to any other such individual.” See also 42 C.F.R. § 440.240(b). A fair hearing decision which awards funding for a specific item of DME should take on added significance if these decisions are issued or approved by the state Medicaid agency rather than by an individual hearing officer.

Although your state’s Medicaid agency is not bound by decisions of other states, advocates have been successful in convincing a state that it should cover a particular device by showing that other states have covered the device in one of the mandatory or optional categories covered in your state.

services.” 42 C.F.R. § 431.201. The term “action” may also include an “approval” of service if the Medicaid agency approves the service with modifications. *See, Ladd v. Thomas*, 962 F. Supp. 284 (D. Conn. 1997)(notice and an opportunity for a fair hearing are required when a request for DME is approved, with modifications). This means that each time a beneficiary requests a Medicaid service, written notice must be provided if the request is reduced, modified, or denied.

The Medicaid Act and its implementing regulations require notices to contain specific information about the proposed action. These notices must include: a statement of the proposed action; the reasons for the proposed action; the specific regulations supporting the action; an explanation of the person’s right to request a hearing; and a description of the circumstances under which Medicaid eligibility in general or a specific Medicaid service is

continued pending the outcome of the hearing. 42 C.F.R. §§ 431.210, 435.912. The state Medicaid agency must also “make available ... a copy of the specific policy materials necessary ... to prepare for a fair hearing.” 42 C.F.R. § 431.18(e)(2).

The Right to a Fair Hearing. As noted above, the notice that Medicaid agencies must send in the case of any adverse action must advise the individual of the right to a fair hearing. Based on the experience of advocates, nationwide, it is reasonable to say that the fair hearing is, in the great majority of cases, an excellent opportunity to prevail on the issues and obtain funding for the device in question. In fact, most of the advocacy to obtain Medicaid-funded AT/DME occurs at administrative levels, either at fair hearings or in pre-hearing negotiations. Although fair hearing decisions are not published through any official reporting service, the National AT Advocacy Project has

AT COURT WATCH

New York Court Awards Medicaid Funding for EasyStand 5000

In *Layer v. Novello*, 795 N.Y.S.2d 810 (N.Y.A.D. 4 Dept. 2005), a New York appellate court reversed a fair hearing decision and awarded Medicaid funding for an electronic lifting device known as an “EasyStand 5000,” at a cost of more than \$4,500. The petitioner is a 30 year old man with spastic quadriplegia secondary to cerebral palsy who cannot stand without assistance. This device was prescribed to allow him to benefit from a therapeutic intervention known as passive standing.

In finding that the fair hearing decision’s rejection of the claim, as not medically necessary, was not supported by substantial evidence, the court noted the very specific medical benefits to be achieved by the requested device:

Petitioner presented evidence ... that the EasyStand would decrease contractures in his legs, provide prolonged stretching to elongate his leg muscles and increase bone density. He established that the EasyStand therefore would decrease the risk of broken bones from spasms, decrease muscular atrophy in his legs, decrease the risk of skin breakdown, increase functional mobility, improve circulation and elimination, and improve his comfort and ability to socialize with others. Petitioner also established that there were no less costly alternatives that would provide the same benefits. Consequently, petitioner met his burden of establishing that the EasyStand would “restore [him] to his ... best possible functional level” [citing state regulation, 18 N.Y.C.R.R. § 513.1(c)].

The court then held that the opinions of the treating physical therapist were entitled to special weight:

[The ALJ’s determination] was based on the conclusory and unsupported decision of [the state Medicaid agency] that standing is not a necessary treatment for petitioner. However, the testimony of petitioner’s physical therapist that petitioner is at risk for bone breakage and continued muscle atrophy without the use of the EasyStand “is entitled to significant weight and cannot be outweighed solely by the opinions of non-medical personnel or persons not within the same medical profession as the ordering or treating practitioner” (18 NYCRR § 513.6(e)). Petitioner’s physical therapist further testified that the EasyStand would increase petitioner’s ability to lead a more normal life (see 18 NYCRR 513.6 (a)(3)(iv)).

Congratulations to attorney, Linda Detine, and paralegal, Marge Gustas (who created the excellent record at the hearing), of Neighborhood Legal Service in Buffalo, New York.

established an AT Resource Library which contains AT-related fair hearing decisions from many states.

Hearing Preparation. Our National AT Advocacy Project has collected some excellent materials on this subject - - some prepared by our staff for presentations at conferences, some made available to us through others.

MEDICAID AND THE COURTS: PURSUING YOUR AT/DME CASE THROUGH LITIGATION

Attorneys will consider using the courts in two instances: when they receive an adverse decision following a fair hearing, or when they seek to challenge a systemwide policy with or without first pursuing the matter at the hearing level.

State Court, Judicial Review. Every state but Texas offers a state court appeal to challenge the final fair hearing decision. Generally, state courts will review the hearing decision and the hearing record to determine if the case was appropriately decided. Some of these judicial review decisions will turn on whether the agency's decision is supported by substantial evidence; some will turn on an analysis of the applicable federal and state law; and many will be decided on a combined legal/factual analysis.

A comprehensive summary of state and federal case law, related to AT/DME issues, appears in our Winter 2002-Spring 2003 issue of *AT Advocate*, available on our website at www.nls.org/av/spring03.htm. While attorneys do not typically view state courts as the forum to achieve broad systemic relief, many of the state court decisions have ruled favorably on Medicaid's obligation to fund unique equipment for our clients. *See, e.g., Blue v. Bonta*, 121 Cal. Rptr. 2d 483 (Cal. App. 1st Dist. 2002)(state cannot exclude stairway chair lifts); *Kindron v. DeBueno*, 697 N.Y.S.2d 794 (N.Y.A.D. 4 Dept. 1999)(approving funding for swimming pool lift to engage in hydrotherapy); *Forrest Johnson v. Minnesota Dept. Of Human Services*, 565 N.W. 2d (Minn. App. 1997)(approving funding for a standing wheelchair); *Brisson v. Dep't. of Social Welfare*, 702 A.2d 405 (Vt. 1997)(refusal to cover a closed circuit TV, i.e., CCTV, was impermissible limitation on optional eyeglasses category). If enforcement of Medicaid provisions through the federal courts is expected to be especially challenging in your part of the country, do not overlook the possibility of a broader systemic challenge initiated in the state courts.

The Federal Courts. Since the federal Medicaid Act does not create a private right of action, attorneys have traditionally turned to 42 U.S.C. § 1983 as the vehicle to enforce Medicaid provisions in federal court. When the attorney is successful and meets the criteria as a prevailing party, attorney's fees may be available through 42 U.S.C. § 1988.

During the last several years, the ability to routinely use section 1983 to enforce the Medicaid Act has been called into question. Now, before going into federal court on a Medicaid issue or issues, you must immediately consider: what provision or provisions of the Medicaid Act you are seeking to enforce; and what the federal courts, particularly those in your circuit, have said about whether those provisions can be enforced through section 1983. The National Health Law Project regularly updates a detailed reference, in column format, showing which courts have said that a particular Medicaid provision can be enforced under section 1983 and which courts have said that the provision cannot be enforced under 1983. You can obtain an updated copy of this document from Nhelp by emailing either Jane Perkins (perkins@healthlaw.org) or Sarah Somers (somers@healthlaw.org).

Faced with the increasing challenge of using section 1983, attorneys have also looked to the Americans with Disabilities Act (ADA)(*see, e.g., Fisher v. Oklahoma Health Care Authority*, 335 F.3d 1175 (10th Cir. 2003)) and the pre-emption doctrine under the U.S. Constitution's Supremacy Clause (*see, e.g., Planned Parenthood of Houston and Southeast Texas v. Sanchez*, 403 F.3d 324 (5th Cir. 2005)(includes comprehensive discussion of case law) as ways to address systemic Medicaid issues without a need to resort to section 1983. Keep in mind that a successful plaintiff can obtain attorney's fees on an ADA claim but not, apparently, on a Supremacy Clause claim.

CONCLUSION

This article has provided an overview of the Medicaid issues one needs to understand as an AT advocate. A more extensive discussion of these issues will appear later this year in a new publication on Medicaid as part of our Funding of AT series. Many of these issues are also more fully explored in the briefs submitted in various court cases. You can obtain copies of briefs and other materials collected in our AT Resource Library by calling us at the AT Advocacy Project (716-847-0650).

RESOURCES TO SUPPORT YOUR MEDICAID ADVOCACY: SELECTED PUBLICATIONS AND WEBSITES

These key resources are national in scope. You should make a separate listing of state-specific resources.

The Centers for Medicare and Medicaid Services (CMS). CMS was formerly known as the Health Care Financing Administration (HCFA). Many earlier references will use the HCFA name.

- Agency home page, www.cms.gov
- Medicaid home page, www.cms.gov/medicaid
- Medicaid law and regulations, www.cms.gov/regulations
- State Medicaid manual, www.cms.hhs.gov/manuals/pub45/pub_45.asp (policy manual that states must follow)
- Policy letters to state Medicaid officials, www.cms.hhs.gov/states/letters (includes links to policy letters dating back to 1994)
- Policy letter, coverage of medical equipment (ME), www.cms.hhs.gov/states/letters/smd90498.asp (9/4/98, policy that bars use of "exclusive lists")
- Policy letter, coverage of ME for individuals moving to the community from institutions, www.cms.hhs.gov/states/letters/smd71403.pdf

Using the Medicaid home page and the site for laws and regulations, the user can access a menu of many other resource materials.

State Medicaid Agencies. Many of these sites are very content-rich. Key information available on these sites may include: contact information, eligibility criteria, the state plan and amendments, waivers and demonstration programs, and Medicaid buy-in program information (if the state has one).

- State Medicaid agency sites, www.cms.hhs.gov/states/default.asp (use link at bottom of page)
- State Medicaid plans, www.cms.hhs.gov/medicaid/stateplans (follow links to view state Medicaid plan)
- State Health Facts, www.statehealthfacts.org (provided through the Kaiser Family Foundation; provides the latest state-level data on demographics, health, and health policy, including health coverage, access, financing, state legislation, and budgets)

Advocacy Agency Sites.

National Health Law Program - www.healthlaw.org (probably your best, up-to-date source of Medicaid information for the attorney or advocate; regular updates to legislation, regulations, and court decisions; written analysis of key Medicaid provisions and legislative proposals; most materials are free, some publications are for sale)

Families USA - www.familiesusa.org (wealth of information, from both an advocacy and watchdog perspective, on the range of health care options available to Americans)

Kaiser Family Foundation - www.kff.org (Follow links to the Kaiser Commission on Medicaid and the Uninsured, a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform, with a special focus on Medicaid and the uninsured)

Neighborhood Legal Services, Inc. of Buffalo - www.nls.org and its National AT Advocacy Project, www.nls.org/natmain.htm, includes newsletters, selected training materials, and links to other resources.

Books, Articles, Newsletters:

National Health Law Program

- *An Advocate's Guide to the Medicaid Program* (2001, 159 pages) (\$135 for nonprofit agencies)
- Perkins, J. & Somers, S., *Toward a Healthy Future: Medicaid Early and Periodic Screening, Diagnostic and Treatment Services For Poor Children and Youth* (2003, 97 pages)(\$55)
- Health Advocate (quarterly newsletter, \$85 per year)

Cornell University

- Sheldon, J., *Medicaid and Persons with Disabilities A Focus on Eligibility, Covered Services, and Program Structure* (2005)(24 pages) - available at www.ilr.cornell.edu/edi/publications/PPBriefs/PP_24.txt or pdf

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.



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

Update on The National Assistive Technology Resource Library

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.

Please send information to:

Attn.: Jim Sheldon
Neighborhood Legal Services, Inc.
Ellicott Square Building
295 Main Street, Rm 495
Buffalo, NY 14203

TEL: (716) 847-0650
FAX: (716) 847-0227
TDD: (716) 847-1322
e-mail: jsheldon@nls.org
Web Page: www.nls.org



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Ellicott Square Building
295 Main Street, Room 495
Buffalo NY 14203

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