Advocate

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MEDICAID, ASSISTIVE TECHNOLOGY, AND THE COURTS

An Updated Summary of AT-Related Federal and State Court Decisions

INTRODUCTION

The Medicaid program was established by Congress in 1965 as Title 19 of the Social Security Act. More than 40 years later, this federal-state partnership provides an entitlement to medically necessary health care to approximately 42.5 million low income individuals, families, and persons with disabilities across the country. The federal Centers for Medicare and Medicaid Services (CMS) has described Medicaid as the nation's largest health care provider, covering the needs of more Americans than Medicare or any other health insurer.

Those of us who specialize in assistive technology (AT) advocacy also recognize Medicaid as the largest single funding source for AT devices in most, if not all, states. State Medicaid programs, including the optional Home and Community Based Waiver programs, have paid for many AT devices for both children and adults with disabilities, including: custom and power wheelchairs/scooters; augmentative communication devices; specialized strollers and car seats for children; therapy vests; electronic lifting devices; therapeutic tricycles; and specialized beds and cribs, to name just a few.

AT advocates have also come to know that even wheelchairs are not routinely funded in every case and in every state. As the customization of or adaptations to the wheelchair or other pieces of equipment become more expensive, there is a greater chance that it will take a hearing or even litigation to get the item approved. In some cases, litigation has been necessary to

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establish that the equipment in question is medically necessary. In other cases, litigation has been necessary because the state Medicaid agency has, through payment limits or outright exclusions, denied funding for a whole class of AT (most typically termed durable medical equipment or DME by Medicaid).

This article will summarize many of the most important AT-related court decisions going back to the mid 1980s, with most of these decisions published during the 1994 - 2007 period (i.e., since the Protection and Advocacy for Assistive Technology or PAAT programs have been funded). The great majority of these cases involved attorneys from P&A programs or attorneys who we could identify as part of our extended AT advocacy network. Given the limitations of space, this article will not highlight unreported court decisions (i.e., not reported in either official reporters or Westlaw) or court settlements, except insofar as later reported cases relied on the unreported or settled case in some way. Space limitations will also mean that some important decisions may either get left out of this summary or be summarized more briefly than others. This article updates and replaces a similar article that appeared in our Winter 2002-Spring 2003 issue of *AT Advocate*.

FUNDING OF AT: SOME KEY CONCEPTS

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

States need not participate in the Medicaid program, but all states have chosen to do so. Congress has created categories of required Medicaid services that states must cover, 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(1) - (5), 1396a(a)(17), 1396a(a)(21), and categories of services that are optional, 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(12). While there may be 10 or more required and optional categories under which AT may be covered, the most common coverage category for AT is durable medical equipment (DME), a category that has no federal definition. (*See* 42 U.S.C. § 1396d(a)(7); 42 C.F.R. § 440.70(b)(3), providing that "medical supplies, equipment and appliances" are mandatory home health services.) Other categories for potential coverage of AT include physical therapy, occupational therapy, and speech, hearing and language therapy, *see* 42 C.F.R. § 440.110 (with each category covering necessary supplies and equipment); prosthetic devices, *id*. § 440.120(c); and rehabilitation services, *id*. § 440.130(d).

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

i) the individual must be eligible for Medicaid;

ii) the requested item must fit within at least one required services category or an optional category that is covered in the state;

iii) the requested item must be medically necessary for the individual requesting it.

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

This article will not discuss part one of the test, including the many ways that individuals with disabilities can establish eligibility for Medicaid or the litigation that has focused on eligibility issues. Rather, the focus of this article is on AT-related court decisions that will deal with parts two or three of this test.

Medicaid Resources on National AT Advocacy Project's Website

We encourage the reader to visit our project's website *www.nls.org/natmain.htm* from time to time to check on the Medicaid-related resources available. These include newsletters, articles, and training handouts prepared by our staff, and similar documents prepared by others for distribution at our national conferences.

INTERPRETIVE GUIDANCE USED BY THE COURTS

The Medicaid law and its implementing regulations do not provide for the funding of any particular AT devices. For example, the law and regulations do not specify whether motorized wheelchairs or augmentative communication devices are covered items within the scope of any particular mandatory or optional category of coverage. Nor do they spell out a specific test of medical necessity or other criteria governing when a person is eligible for a specific device. Rather, the federal law generally provides a framework with federal regulations spelling out, in greater detail, what a particular category contemplates.

The purpose of the federal Medicaid law 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; *see Meyers v. Reagan*, 776 F.2d 241, 243 (8th Cir. 1985) (In finding the plaintiff entitled to Medicaid funding for an augmentative communication device, the court reasoned that obtaining or retaining the capability for independence is the "primary goal of Medicaid."). 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.

The law of your state 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. *See Lagowski v. Whalen*, 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)("[t]he statute 'must be interpreted and enforced in a reasonable and humane manner in accordance with its manifest intent and purpose.'"); *Starkweather v. Wing*, 662 N.Y.S.2d 658, 659 (N.Y.A.D. 4 Dept. 1997)(wheelchair was needed for 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'").

KEY AT-RELATED CASE LAW

The great majority of AT-related court decisions have been published since the PAATs were first funded during the mid-1990s. As a network, we have built off each other's successes. With help from the National AT Advocacy Project and many of you, we have shared briefs, alerted others to progress on our cases, and shared theories for pursuing both hearings and litigation. While the following discussion highlights the successes within our PAAT and AT advocacy networks, it also suggests that we must be ever-evolving if we are going to continue to be successful.

As an organizational tool, we have broken the cases down under several headings: exclusive list cases; denials based on age; Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); and the category of device. Many of the cases cross over two or more headings.

The Exclusive List Cases

This line of cases had its genesis with a very bad U.S. Court of Appeals decision in *DeSario v. Thomas*, 139 F.3rd 80 (2nd Cir. 1998), *cert granted*, *judgment vacated*, *Slekis v. Thomas*, 525 U.S. 1098 (1999). In *DeSario*, the Second Circuit held that Connecticut's Medicaid program can limit the availability of DME to items which appear on an exclusive list. Following this decision, the federal Health Care Financing Administration (HCFA, now renamed CMS), issued a very important State Medicaid Director letter dated September 4, 1998 (located at *http://cms.hhs.gov/smdl/downloads/SMD090498.pdf*) in which it clarified agency policies concerning the coverage of "medical equipment." According to the letter, federal policy allows state Medicaid agencies to maintain lists of pre-approved DME for administrative convenience, but states are required to provide individuals "a meaningful opportunity for seeking modifications of or exceptions to a State's pre-approved list." The U.S. Supreme Court, in *DeSario*, granted plaintiffs' petition for certiorari, vacated the Second Circuit's decision, and remanded it to the Second Circuit with a direction to consider the guidance set forth in the September 4, 1998 HCFA letter.

Key Websites to Support Your Medicaid Advocacy

Federal: The Centers for Medicare and Medicaid Services (CMS)

- Agency home page - *www.cms.hhs.gov*
- Medicaid home page - *www.cms.hhs.gov/home/medicaid.asp*
- Medicaid waivers and demonstration projects - *www.cms.hhs.gov MedicaidStWaivProgDemoPGI*

NOTE: Using the Medicaid home page, the user can access a menu of many other resource materials.

State Medicaid Agencies

Most state Medicaid agencies now have web sites. You can probably locate the state web site by doing a search by the agency's name with one of the popular internet search engines like Google, *www.google.com*, or Alta Vista, *www.altavista.com*.

Advocacy Group 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 and regulations; written analysis of key Medicaid provisions; most materials available for free, some publications are for sale)(highly recommended)
- Families USA - *www.familiesusa.org/site/PageServer* (a great 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 a wide range of materials on Medicaid and related topics, with many of the materials analyzing health care coverage and access for the low-income population and assessing options for reform, striving to bring increased public awareness and expanded analysis to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured).
- State Health Facts - *www.statehealthfacts.org* (within the Kaiser Family Foundation site, this provides links to state Medicaid agency sites and a wealth of state-related health insurance information)
- Neighborhood Legal Services, Inc. of Buffalo, NY - *www.nls.org* and our National AT Advocacy Project *www.nls.org/natmain.htm* - includes many 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/s-PPBriefs.cfm* (then select brief # 24 in text or pdf format).

In short, the natural extension of this HCFA policy letter is that states should not be permitted to maintain lists of items that are never covered as DME. Since its issuance, several court decisions have cited it in striking down a state Medicaid program's policy of not approving a whole class of DME.

In *Esteban v. Cook*, 77 F.Supp. 2d 1256 (S.D. Fla. 1999), the plaintiffs brought a class action to challenge a state Medicaid policy that covered both motorized and custom mobility devices for individuals under 21, but limited coverage of mobility devices for adults to wheelchairs costing $582 or less. Citing the Septem-

ber 1998 HCFA letter, the court reasoned that the state failed to provide a reasonable and meaningful procedure for requesting items (in that case, custom and power wheelchairs) that do not appear on the state's pre-approved list. 77 F.Supp. 2d at 1260. The court went on to hold that the state's absolute limitation on coverage for wheelchairs "runs counter to its articulated purpose for including wheelchairs under its DME coverage: to minimize the effects of mobility impairments." Id. at 1261.

In *T.L. v. Colorado Department of Health Care Policy and Financing*, 42 P.3d 63 (Colo. App. 2001), the Colorado Court of Appeals, relying heavily on the September 1998 HCFA letter, declared as illegal the state Medicaid agency's use of a list of items that would not be approved as DME. At issue was a hot tub which was prescribed for therapeutic purposes to treat an arthritic condition which caused constant hip pain. 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." *Id*. at 67. The court then 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 for T.L.; iii) whether, and at what cost, T.L. could obtain that therapy outside the home (i.e., whether the home-based therapy is the least costly alternative); and iv) whether T.L.'s comfort is the primary purpose of the hot tub.

In *Bell v. Agency for Health Care Administration*, 768 So.2d 1203 (Fla. App. 1 Dist. 2000), the appellant was an adult Medicaid recipient whose doctor prescribed an insulin pump and supplies. He was able to obtain the insulin pump through his Medicaid health maintenance organization (HMO), apparently having opted for service through managed care. Although the appellant's HMO continued to pay for supplies for the insulin pump, he wanted to change back to the regular Medicaid program but did not want to do so until he was assured of coverage of his insulin pump supplies. If he was a child under age 21, the regular Medicaid program could have approved the supplies under a miscellaneous code; however, as an adult, the Florida Medicaid rules included an exclusive list of DME and supplies for adults and the insulin pump supplies did not appear on that list.

The court observed that the Florida Medicaid rules did not provide a procedure for adult beneficiaries to seek insulin pump supplies or any other item of DME or DME supplies not on the exclusive list. Citing both *Esteban v. Cook*, above, and the September 1998 HCFA letter, the court held the Florida rule in question invalid, reasoning that "[t]his disparity in coverage discriminates against Florida Medicaid recipients age 21 and older and violates federal law by arbitrarily and unreasonably excluding coverage of benefits that may be medically necessary." 768 So.2d at 1205.

Plaintiffs in *Lankford v. Sherman* filed a complaint seeking a preliminary and permanent injunction after Missouri enacted an emergency regulation that eliminated most items of DME for all Medicaid recipients but those under the age of 21, pregnant, or blind. Plaintiffs alleged that the new regulation violated the comparability and reasonable standards requirements of the federal Medicaid Act. 42 USC §§ 1396a(a)(10)(B), (17). The District Court denied Plaintiffs' request for preliminary injunction and the plaintiffs appealed to the Eighth Circuit Court of Appeals. Citing its own directives and those from CMS (the September 1998 HCFA letter), the Eighth Circuit noted that the new regulation restricts the provision of DME and offers Medicaid recipients no other procedure to obtain it. 451 F.3d 496 (8th Cir. 2006). Finding that plaintiffs had "established a likelihood of success on the merits of their preemption claim as it relates to Medicaid's reasonable-standards requirement," *id*. at 513, the Eighth Circuit reversed the District Court and remanded the case back to the District Court for findings regarding the other three factors in determining preliminary injunction requests: the threat of irreparable harm to the movant; the balance between the harm and the injury that granting the injunction will inflict on other interested parties; and the public interest. *Id*. at 503. Advocates should note that the Eighth Circuit held that the reasonable standards provision is not subject to private enforcement under 42 U.S.C. § 1983.

On remand, the District Court granted a permanent injunction, directed the state to amend its DME program to bring it into compliance

with the reasonable standards provision of the federal Medicaid Act, and gave the state 30 days to notify the court of the actions it is taking to bring the program into compliance. *Lankford v. Sherman*, 2007 WL 689749 (W.D. Mo. 3/2/07). In so ruling, the District Court relied heavily on the findings of the Eight Circuit that while a state may choose to use a pre-approved list of DME items, it must also provide the recipient a meaningful opportunity for requesting non-covered items; that the Missouri DME program failed to provide a meaningful opportunity for requesting non-covered items; and that it's failure to do so rendered the program per se unreasonable and inconsistent with the federal Act. This case demonstrates the potential for future Medicaid litigation based on federal preemption of inconsistent state law, regulation, or policy, with the federal claim grounded under the U.S. Constitution's Supremacy Clause.

Denial of Funding on the Basis of Age

Since 1989, Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program has required states to cover all medically necessary mandatory and optional services for Medicaid eligible children under the age of 21. 42 U.S.C. § 1396d(r). This means, for example, that a state must cover the optional categories of dental services and physical therapy for children, but may choose not to cover those service categories for adults. The cases in which the courts have held that state Medicaid agencies cannot treat children more favorably than adults involved a request for AT under a mandatory coverage category or under an optional category which the state had chosen to cover in its adult program.

One of the first AT-related decisions to deal with the disparity in coverage for adults compared to children was *Hunter v. Chiles*, 944 F.Supp. 914 (S.D. Fla. 1996). The court in *Hunter* held that augmentative communication devices, which were potentially covered as DME for Medicaid recipients under age 21 through Florida's EPSDT program, could not be denied to an adult plaintiff with severe speech difficulties, solely on the basis of age. *Id*. at 920. The court cited, with approval, the Arizona Supreme Court's decision in *Salgado v. Kirschner*, 878 P.2d 659, 660 (holding it was unreasonable to allocate treatment, i.e., liver transplants, within a service category solely on the basis of age). Both the *Hunter* and *Salgado* holdings were cited by the court in *Esteban*, above, in holding that Florida's absolute limitation of $582 on the coverage of wheelchairs, resting entirely on the basis of age, "fails the reasonableness test and is contrary to the purposes of the Medicaid statute." *Esteban*, 77 F.Supp. 2d at 1261-62. *See also*, *Fred C. v. Texas Health and Human Services Comm'n*, 924 F.Supp. 788, 791-92 (W.D. Texas 1996), *vacated on other grounds*, 117 F.3rd 1416 (5th Cir. 1997); *Bell v. Agency for Health Care Admin.*, 768 So.2d at 1204-05.

EPSDT and Children Under Age 21

In *S.D. v. Hood*, 2002 WL 31741240 (E.D.La. 2002), *aff'd* 391 F.3d 581 (5th Cir. 2004), a 16 year old plaintiff with spina bifida brought an action to assert his right to "medically necessary" incontinence underwear pursuant to EPSDT requirements. The district court found that the state's policy of refusing to provide incontinence underwear for Medicaid beneficiaries for whom such "medical assistance" has been found medically necessary by EPSDT screenings violates the federal Medicaid Act. The court compared this medical assistance to the plaintiff's wheelchair, which allows him to move about his home, to travel, and to engage in age appropriate activities.

The Fifth Circuit Court of Appeals affirmed the decision, holding that: incontinence supplies are covered under the category of home health supplies and must be provided to eligible children under EPSDT if necessary to correct or ameliorate a condition discovered by a screening; the Medicaid agency violated the Medicaid Act by denying payment for disposable incontinence underwear for the EPSDT recipient; and the EPSDT provision was enforceable under 42 U.S.C. § 1983.

Unfortunately, there have been setbacks to section 1983 private enforcement of certain provisions of the federal Medicaid Act. One such example is *Lankford v. Sherman*, discussed above, in which the success of the case turned on the federal preemption claim, with the Eighth Circuit holding that the reasonable standards provisions could not be enforced through section 1983. For extensive information on how the federal courts have ruled concerning the enforceability of various Medicaid Act provisions

under 42 U.S.C. § 1983, including an updated list of relevant court decisions, contact either Jane Perkins (*perkins@healthlaw.org*) or Sarah Somers (*somers@healthlaw.org*) at the National Health Law Program.

Specific Categories of AT or DME

Augmentative Communication Devices (ACDs). These are also known as augmentative and alternative communication (AAC) devices or speech generating devices (SGDs). The first reported decision to address ACDs was *Meyers v. Reagan*, 776 F.2d 241 (8th Cir. 1985). Now over 20 years old, this decision continues to be important in two major ways. First, as noted in the section above on interpretative guidance, the Eighth Circuit, in finding the plaintiff entitled to Medicaid funding for what it referred to as an electronic speech device, confirmed that the primary goal of Medicaid is to provide services to help the recipient "attain or retain capability for independence or self-care." *Id*. at 243 (citing 42 U.S.C. § 1396). Second, the court analyzed the plaintiff's eligibility for the device under the optional category of services for individuals with speech, hearing, and language disorders, which includes funding for any necessary supplies and equipment. 42 C.F.R. § 440.110(c)(1). The court reasoned that once Iowa's Medicaid program chose to offer these services under the broader optional category of "physical therapy and related services," it was bound to cover any service within that optional category. 776 F.2d at 243 (quoting *Eder v. Beal*, 609 F.2d 695, 702 (3rd Cir. 1979)("[O]nce a state elects to participate in an 'optional' program, it becomes bound by the federal regulations which govern it.").

The *Hunter* and *Fred C.* cases are important ACD cases decided by the courts in more recent years. In *Hunter v. Chiles*, *supra*, the Florida Medicaid agency did not cover augmentative communication devices for adults and claimed it only covered them for those under 21 after all other funding sources had been exhausted. Regarding the claim of the adult plaintiff, the court observed that ACDs met the general characteristics of DME and were considered to be DME for those under 21. The court then rejected the state's argument that it could limit services it covers within the DME category, citing *Meyers*, *supra*, and held that ACDs are covered as DME under Florida's home health care provision. 944 F.Supp. at 919-920.

Regarding the seven-year-old plaintiff's claims, keep in mind that pursuant to the EPSDT program, children under 21 are entitled to services under all mandatory and optional Medicaid categories, including those optional categories not covered for adults in that state. 42 U.S.C. § 1396d(r)(5). The plaintiffs argued that, pursuant to EPSDT, the ACD was covered under the optional categories of speech therapy, prosthetics, and rehabilitation services, in addition to DME. Without specifying whether the device was covered in all these categories, the court held that ACDs are covered for children under age 21 through the EPSDT program. 944 F.Supp. at 920-921.

The *Hunter* court also rejected the defendant's assertions that Medicaid need not pay for these devices because funding is available for ACDs through various other programs. The court deemed these assertions to be "self-serving and conclusory" and not supported in the record. *Id*. at 920. The court specifically rejected the availability of funding from local special education programs as a basis for denying funding, noting that "[t]he Medicaid statute clearly states that the availability of special education funds cannot be used to deny medically necessary services under Medicaid." Id. at 921 (citing 42 U.S.C. § 1396b(c)).

Fred C. v. Texas Health and Human Services Com'n has a more involved history than *Hunter*. 924 F.Supp. 788 (W.D. Tex. 1996)(*Fred C. I*), *vacated*, 117 F.3d 1416 (unreported slip opinion remanded case to determine whether plaintiff is

Bridges to Better Advocacy Handouts Available

As this goes to press, we are nearly ready for our 11th annual, "Bridges to Better Advocacy" conference in Austin, Texas (March 28-30, 2007). As usual, all of the conference handouts will be available (hard copy or electronic formats) for those who could not attend the conference. To arrange for copies, contact either Jim Sheldon (*jsheldon@nls.org*) or Diana Straube (*dstraube@nls.org*) at our National AT Advocacy Project. Most of these will also begin appearing on our website, *www.nls.org/natmain.htm*, shortly after the conference takes place.

qualified to receive home health services under state's Medicaid program); *on remand* (Fred C. II), 988 F.Supp. 1032 (W.D. Tex. 1997), *aff'd*, 167 F.3d 537 (5th Cir. 1998). In *Fred C. I*, the court held that the ACD was covered under the Texas Medicaid program as both DME and a prosthetic device. It is of import that the court, in addressing the DME issue, analyzed the pivotal role communication plays in the lives of Medicaid recipients (enabling "adult Medicaid recipients to live on their own, maintain employment, pay taxes, and become productive members of the community rather than wards of the state"). 924 F.Supp. at 792. In analyzing the prosthetic devices issue, the court emphasized that the ability to speak through the ACD was necessary in order for the plaintiff "to be restored to 'his best functional level.'" *Id*. at 792-93.

On appeal, the lower court's decision was vacated and remanded "for the purpose of establishing whether Fred C. is qualified to receive home health services under the Texas Medicaid program." 988 F.Supp. at 1033. On remand, the state defendants did not question the plaintiff's eligibility to receive home health services (and thus, DME). Instead, they requested the lower court to reject its previous findings that the ACD is a covered benefit. In a decision strikingly similar to the *Fred C. I* decision, the court in *Fred C. II* held that the ACD was covered as both DME and a prosthetic device.

Standing Frames and Standing Wheelchairs. An intervention known as passive standing may help maintain bone mineral density; improve circulatory, respiratory, bowel and kidney function; increase range of motion; reduce pressure sore occurrence (decubitus ulcers); improve muscle tone and spasticity; and reduce occurrence of skeletal deformities. Passive standing may be provided either by separate standing frames or a recent technological innovation that allows the wheelchair (and its user) to rise to a standing position. The potential social, vocational, and practical benefits of this innovation should be obvious (e.g., the individual can interact with others from a standing position, can reach objects in cupboards at home, or in bookshelves at a job). The three reported cases, discussed below, have justified these standing mechanisms based on the documented medical benefit to be derived from passive standing.

In *Forrest Johnson v. Minnesota Dept. of Human Services*, 565 N.W.2d 453 (Minn. App. 1997), the court went through an extensive recitation of the individual's medical condition associated with the diagnosis of multiple sclerosis. The record included extensive testimony of his treating physician on the benefits of passive standing that can be achieved through the standing device on the wheelchair, potentially alleviating many of the problems caused by prolonged immobility, including bone calcium loss, urinary tract and bladder infections, muscle spasticity, muscle contractures, loss of range of motion, muscle atrophy, and decubitus ulcers. It also included similar testimony from the individual's physical therapist and occupational therapist. *Id*. at 454-457. Based on this testimony, the court held that the administrative hearing decision could not be sustained on the findings that the standing wheelchair was neither medically necessary nor the least expensive appropriate alternative. Accordingly, the court affirmed the decision of the lower court, ordering the Medicaid agency to pay for the item.

Similarly, in *Sorrentino v. Novello*, 744 N.Y.S.2d 592 (N.Y.A.D. 4th Dept. 2002), the court awarded Medicaid funding for a standing power wheelchair. This decision recited evidence and testimony that supported this individual's need for the standing device to promote circulation, bone density, bladder and bowel function, prevent pressure sores, and prevent loss of muscle mass and muscle atrophy.

The petitioner in *Layer v. Novello*, 795 N.Y.S. 2d 810 (N.Y.A.D. 4th Dept. 2005), challenged denial of a standing frame after an administrative fair hearing. The court reversed, holding that the testimony of the physical therapist as to the medical benefits of passive standing was entitled to significant weight and cannot be outweighed solely by the opinions of non-medical personnel or persons not in the same medical profession. In this case, the Medicaid agency had failed to offer any medical testimony that refuted the testimony of the physical therapist as to the benefits of passive standing.

Stairway Chairlifts. In *Blue v. Bonta*, 121 Cal.Rptr.2d 483, 99 Cal. App. 4th 980 (Cal. App. 1st Dist. 2002), the California appellate court ruled that the state's Medicaid agency cannot, by regulation, specifically exclude stairway

chair lifts (sometimes referred to as stair glides) from the scope of coverage under Medi-Cal's DME category. The plaintiff was a woman with severe physical disabilities who had difficulty going up and down stairs to use the home's only bathroom. The court pointed out that Ms. Blue had once fallen while attempting to climb the stairs which forced her to remain on the upper floor for days, unable to leave the home in the event of a daytime emergency when her daughter was working.

The decision turned on whether the device in question met California's definition of DME, with the state arguing that the chair lift does not serve a "medical" purpose. In finding that this device meets California's DME definition (very similar to the Medicare definition), the decision contains some good language that attorneys may find useful in pending or future cases (e.g., "a stairway chair lift alleviates a medical condition such as osteoarthritis by restoring the ability to move about the different levels of a home, where this is medically necessary for a patient."; "As in the case of a wheelchair, a stairway chair lift restores mobility lost as a result of a medical condition or disability, enabling the patient to reside at home rather than in an institution."; "the evil to be remedied by the relevant Medicaid and Medical statutes is the denial of necessary medical equipment for use in home health care, leading to unnecessary disability or institutionalization."). 99 Cal. App. 4th at 989-990.

Surprisingly, the court did not address the issue of this regulation acting as an exclusive list. Pursuant to the analysis of the court in the *T.L.* case, *supra*, an item or list of items of DME specifically classified as not available should be held to run counter to the 1998 HCFA policy letter prohibiting the use of exclusive lists.

Specialty Features on a Wheelchair. *Johnson v. DeBouno*, 654 N.Y.S.2d 902 (N.Y.A.D. 4 Dept. 1997), involved a man with quadriplegia who required a power wheelchair with a built-in power tilt-in-space feature so that when he was alone, he could reposition himself to promote better circulation and prevent further incidents of decubitus ulcers. The court determined that the power tilt-in-space was both DME as well as medically necessary for the petitioner. This same court's decision in *Ray v. Wing*, 661 N.Y.S.2d 163 (N.Y.A.D. 4 Dept. 1997), approved a Enduro Hemi-Height Wheelchair with custom seating, as petitioner established it would "prevent skin breakdown, decubitus ulcers and edema, . . . would provide better support and prevent back, shoulder and neck pain ..." *Id*. at 164.

A Back-Up Manual Wheelchair. In two cases, a New York appellate court approved Medicaid funding when the petitioners established the need for a customized manual wheelchair to back up a power wheelchair for those occasions when the existing wheelchair could not reach environments the individual must access, or because of the periodic need for a back up when the primary wheelchair is in for repairs. *See*, *Gartz v. Wing*, 654 N.Y.S.2d 702 (N.Y.A.D. 4 Dept. 1997); *Dobson v. Perales*, 572 N.Y.S.2d 562 (N.Y.A.D. 4 Dept. 1991).

A CCTV. In *Brisson v. Dep't of Social Welfare*, 702 A.2d 405 (Vt. 1997), the Supreme Court of Vermont held that the state Medicaid agency's refusal to cover a closed circuit television (CCTV), under the optional eyeglasses category, was an impermissible limitation on the amount, duration, and scope of that service category because the state failed to provide for those in greatest need of that service. *Id*. at 408; 42 C.F.R. § 440.230(b). The plaintiff, who had a diagnosis of macular degeneration, was legally blind and could read only if print was magnified to eight times its normal size. The court held that the CCTV met the federal definition of eyeglasses, 42 C.F.R. § 440.120(d), an optional category of coverage. In addressing the state's arguments that it could deny coverage for the CCTV because of its expense, the court cited evidence that the plaintiff, if not given the CCTV, would be either confined to a nursing home or require full-time, Medicaid-funded nursing care. It then reasoned that the state "cannot credibly maintain that coverage is too expensive where providing a CCTV would be fiscally expedient and would maintain the recipient's ability to live independently." 702 A.2d at 408, citing 42 U.S.C. § 1396. More recently, the Vermont Supreme Court reaffirmed much of this reasoning in ruling that the state Medicaid agency's exclusion of all coverage for partial dentures was an impermissible limitation of services under the optional dental services provision. *Cushion v. Department of PATH*, 807

A.2d 425 (Vt. 2002), citing 42 U.S.C. § 1396d(a)(10); 42 C.F.R. § 440.100.

A Body Brace. In *Ohlson v. Weil*, 953 P.2d 939 (Colo. App. 1997), as modified on denial of rehearing, 7/17/97, *cert denied*, 4/27/98, the plaintiff, who had muscular dystrophy and used a wheelchair, sought Medicaid funding for a molded plaster body brace in order to sit up and breathe properly in her wheelchair. The device was not to be surgically implanted, but rather clamped to the outside of her body and would need replacement once per year. The state Medicaid agency conceded that the brace was medically necessary, but argued that it did not meet the state's DME definition because it was not an item that would be needed for a finite period of time, but would be needed for the rest of the plaintiff's life. Basing its DME analysis wholly on an interpretation of the state regulation, the court found nothing in the regulation's plain language that would support this position. Moreover, the court noted that the state's interpretation of the regulation "is belied by its coverage, as [DME], of such items as wheelchairs, wheelchair seating devices, and other wheelchair attachments." *Id*. at 942. It held that the brace met the state criteria and must be covered as DME. Noting that state regulations were amended while the case was pending, the court ordered reimbursement for past costs related to the brace and remanded the case to determine whether the brace would be covered under the new regulations under the prosthetic device category. In remanding the case to the lower court, the court held that the state Medicaid agency "failed to show that Colorado's refusal to cover all non-surgically implanted prosthetic devices is an appropriate limit based on medical necessity under 42 C.F.R. § 440.230(d)." 953 P.2d at 945.

Hot Tubs, Jacuzzis. See discussion of *Blue v. Bonta* with the exclusive list cases, above.

Swimming Pool Lift. In *Kindron v. DeBuono*, 697 N.Y.S.2d 794 (N.Y.A.D. 4 Dept. 1999), a 15 year old girl with spinal

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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. Nearly all of the more recent documents are now available in electronic format. Although we have many of the complaints and briefs that supported cases like the*Lankford*, *Fred C.*, *Estaban*, and *T.L.* cases discussed in the feature article, we also have collected documents from many cases that never resulted in a reported decision. Copies of relevant documents can be mailed or emailed (if available electronically) to support your work. Currently, we have several hundred documents from more than 140 cases, nationwide.

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muscle atrophy requested Medicaid funding for purchase of a swimming pool lift which would allow her to engage in therapeutic activities in her home swimming pool. In reversing the fair hearing decision, the court noted that the hearing record "established that the medical benefits of hydrotherapy for Jennifer include increases in her ranges of motion, muscle strength and bone density, a reduction in cardiovascular deterioration and the prevention of venostasis and osteoporosis," noting that the treating physical therapist testified that those benefits would not be realized through other forms of physical therapy. Observing that the state Medicaid agency offered no proof to challenge this evidence of medical necessity or the contention that it was DME within that state's definition, the court held that the hearing decision was not supported by substantial evidence and must be annulled.

Binaural Hearing Aids. *Jasset v. Rhode Island DHS*, 2006 WL 2169891 (R.I. Super. 2006), involved a request for binaural hearing aids. Rhode Island's Medicaid policy provided that a hearing aid would be covered when "a recipient's hearing loss is such that it impairs daily living activities and the purchase of which would improve the recipient's quality of life." *Id.* at 1. However, payment for binaural hearing aids was considered only for individuals under the age of 21, individuals over the age of 21 who already use two hearings aids and they now require replacement, individuals who are gainfully employed or are likely to become employed if the hearing loss is corrected, or individuals who are visually impaired. The court found that because this policy regarding binaural hearing aids involved criteria unconnected to medical necessity, the policy was arbitrary and capricious. The court noted that "[t]he concept of 'medical necessity' is the set- the touchstone- for evaluating the reasonableness of a participating state's Medicaid standards." *Id.* at 5.

CONCLUSION

This article has summarized most of the important AT-related Medicaid case law decided during the last 20 years. It should not be lost on the reader that 90 percent of these cases have been decided since 1996, i.e., after the PAAT projects were established and fully operating in every state. Nearly every one of these post-1995 decisions was a case handled by a Protection and Advocacy Program or a Legal Services/Legal Aid office that we could identify as part of our broader AT advocacy network.

Hopefully, this article will serve as a resource to attorneys and advocates who are involved in or contemplating AT-related litigation in state or federal courts. Readers should keep in mind, however, that the reported cases discussed in this article represent only a fraction of the litigation that has been handled by the P&As and other organizations (see box, p. 379, regarding the material available through our Court Documents Library). For specific questions about the cases discussed, readers should contact either Jim Sheldon (716-847-0650 ext. 262 or *jsheldon@nls.org*) or Diana Straube (ext. 220 or *dstraube@nls.org*) at the National AT Advocacy Project.

"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).

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

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