DISABILITY RIGHTS IDAHO: WHO WE ARE, WHAT WE DO, & HOW YOUR CLIENTS CAN HELP

IDAHO STATE BAR HEALTH LAW SECTION – FEBRUARY 7, 2019 MEETING CLE

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DISABILITY RIGHTS IDAHO

Protection & Advocacy for Individuals with Disabilities

PRESENTATION OVERVIEW

- **Who We Are:**
  - Introduction to Protection & Advocacy System
- **What We Do:**
  - Overview of DRI Services & Current Priorities
- **How Your Clients Can Help:**
  - Medical Justification Letters
  - EPSDT
  - The New HCBS Rules
- **Questions/Comments**

WHO WE ARE – INTRODUCTION TO DRI & THE PROTECTION AND ADVOCACY SYSTEM

- **Protection & Advocacy System**
  - DRI is Idaho's designated Protection & Advocacy (P&A) System.
  - There is a P&A in every state within the U.S., every U.S. territory, and one serving the Native American population in the four corners region – all are members of the National Disability Rights Network (NDRN).
  - Initially created as a result of Geraldo Rivera's investigative broadcasts from early 1970's, exposing abuse, neglect, and lack of services and supports at Willowbrook, a state institution for people with intellectual and other disabilities in New York.
  - Inspired Congress to create the P&A system to safeguard the well-being of individuals living in institutions. Since expanded to offer a variety of services under programs serving those with developmental disabilities, mental illness, those seeking/receiving services from state rehabilitation agencies, those needing/using assistive technology, Social Security beneficiaries, those with traumatic brain injuries, and voter access.

WHO WE ARE – INTRODUCTION TO DRI & THE PROTECTION AND ADVOCACY SYSTEM

- **DisAbility Rights Idaho (DRI)**
  - A nonprofit, charitable 501(c)(3) corporation organized in Idaho.
  - Designated by the Governor as Idaho's Protection and Advocacy System since 1977.
  - Operates as a public interest law firm, representing only individuals with disabilities within the State of Idaho.
  - Offices in Boise and Pocatello.
  - Staffed by an Executive Director*, Legal Director*, Advocacy Director*, Staff Attorneys*, Non-Attorney Advocates, and Fiscal and Administrative Staff (*= Licensed Attorneys).
  - Funded by federal grants, donations (Access to Justice Fund).

WHAT WE DO: OVERVIEW OF DRI SERVICES & CURRENT PRIORITIES

- **DRI Services:**
  - Provide legal and advocacy services for individuals with disabilities within the State of Idaho.
  - Individual clients must meet our program eligibility guidelines and issue must be related to their disability and within our priorities (see next slide).
  - Case services generally only provided if the problem cannot be solved through self-advocacy or by other individuals, agencies, attorneys, or organizations.
  - Resolve issues through a variety of ways from providing information and referrals, to detailed technical assistance, to advocacy services from non-attorney advocates, to legal representation.

WHAT WE DO: OVERVIEW OF DRI SERVICES & CURRENT PRIORITIES

- **Current Priorities (fiscal year 2019):**
  - **Assistive Technology** (ensuring access to AT)
  - **Disability Discrimination** (addressing ADA Title II, III and Section 504 of the Rehabilitation Act violations)
  - **Special Education** (addressing suspensions, expulsions, restraint and seclusion, transition services)
  - **Employment** (assisting those accessing RSA services, social security beneficiaries who experience employment barriers)
  - **Guardianships** (assisting in terminating or modifying guardianships, promoting supported decision making)
  - **Medicaid** (representing children in denials, proposing rule changes, providing info on fair hearings)
  - **Outreach/Training** (in the community regarding DRI services)
  - **Public Policy** (workgroups, legislation, collaboration with other agencies)
  - **Rights in Facilities** (abuse and neglect investigations, monitoring facilities, administrative rules,)
  - **Voting** (ensuring equal voting access, reducing barriers to federal voting process)
- *See handout for more details or visit www.disabilityrightsidaho.org

HOW YOUR CLIENTS CAN HELP: MEDICAL JUSTIFICATION LETTERS

- **#1. Common Issue Faced by DRI Clients:**
  - Medicaid denies coverage of a treatment/therapy/service/equipment, stating it is:
    - needed only for *convenience*;
    - is *duplicative* (i.e. current equipment meets the individuals' needs);
    - is *not medically necessary*; or
    - is *not the least costly alternative*.

HOW YOUR CLIENTS CAN HELP: MEDICAL JUSTIFICATION LETTERS

- **How to Help:**
  - Craft a strong letter of medical justification which anticipates, addresses the common reasons for denial.
  - Explain the provider's credentials.
  - Explain provider's relationship to the patient.
  - Explain patient's disability.
  - Describe the treatment/therapy/service/equipment in as much detail as possible.
  - Explain how the item meets DME criteria (if applicable).
  - Explain how the item/service is medically necessary for the individual.
  - Explain how the item/service is the least costly alternative.
  - Provide or refer to peer-reviewed articles, studies for support.

HOW YOUR CLIENTS CAN HELP: MEDICAL JUSTIFICATION LETTERS

- **Medical Justification Letter Resources:**
  - See handouts for more details, sample letters.
  - Review rules governing medical necessity. (IDAPA 16.03.10.012.14).
  - Review rules governing durable medical equipment. (IDAPA 16.03.10.010.38)
  - Review Idaho Medicaid Provider Handbook (https://www.idmedicaid.com/Provider%20Guide/Provider%20Handbook.aspx)

HOW YOUR CLIENTS CAN HELP: EPSDT

- **#2. Common Issue Faced by DRI Clients:**
  - Providers, Medicaid are unaware of EPSDT, leading to inappropriate denials of services.
    - EPSDT: Early and Periodic, Screening, Diagnosis and Treatment
    - Federal program that applies to all Medicaid recipients under the age of 21.
    - Under EPSDT, Medicaid must provide all other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services. (42 C.F.R. §440.40(b)).
    - Specifically requires that the treating physician's opinion and recommendation be followed.
    - Requires that any services requested under EPSDT be medically necessary *to correct or ameliorate* a child's condition. A different standard than used for adults.

HOW YOUR CLIENTS CAN HELP: EPSDT

- **How to Help:**
  - Educate clients on EPSDT and its requirements.
  - Federal Regulations (42 U.S.C. §§1396a(a)(10)(A), 1396a(a)(43), 1396(a)(4)(B), 1396d(r); 42 C.F.R. §§441.50-441.62).
  - State Rules (IDAPA 16.03.09.880-883)
  - Again, stress importance of crafting a detailed medical justification letter.

HOW YOUR CLIENTS CAN HELP: EPSDT

- **EPSDT Resources:**
  - See handouts for more details, sample medical justification letters.
  - ESPDT Coverage Guide & Other Related Resources https://www.medicaid.gov/medicaid/benefits/epsdt/index.html.
  - For IDHW's EPSDT Policy and Request Form, see https://healthandwelfare.idaho.gov/Medical/Medicaid/EPSDT/tabid/3361/Default.aspx.

HOW YOUR CLIENTS CAN HELP: NEW HCBS RULES

- **#3: Common Issue Faced by DRI Clients**:
  - Providers not complying with recently updated HCBS requirements.
    - HCBS: Home and Community Based Services – long-term services and supports that assist eligible participants to remain in their home and community.
    - Applies to: adult day health providers, developmental disability agencies, certified family homes, residential assisted living facilities.
    - Does not apply to: nursing homes, ICF/IIDs, hospitals.
    - Providers must develop and implement policies and procedures to address the HCBS requirements.
    - Expected to fully comply with these requirements in order to be a Medicaid provider – enforced as of January 1, 2017.

HOW YOUR CLIENTS CAN HELP: NEW HCBS WAIVER RULES

- HCBS setting requirements:
  - Integration and access – setting is integrated and supports full access to the community, includes typical age-appropriate activities such as employment, control of personal resources, etc.
  - Selection of setting – setting selected by the participant or participant's decision-making authority.
  - Participant rights – ensures rights of privacy, dignity, respect, freedom from coercion, and unauthorized restraint are honored.
  - Autonomy and independence – optimizes an individual's initiative, autonomy, independence in making life choices including daily activities, physical environment, and with whom to interact.
  - Choice – promotes participant choice regarding services and supports provided.

HOW YOUR CLIENTS CAN HELP: NEW HCBS RULES

- Additionally, provider-owned or controlled settings must also meet 7 additional conditions regarding:
  - Written Agreement – lease, residency agreement, admission agreement, or other written agreement in place for each participant at time of occupancy. Must provide protections that address evictions and appeals comparable to those found under Idaho landlord tenant law.
  - Privacy – right to entrance doors which are lockable by the individual, with only appropriate staff having keys to those doors. Participants also have a choice of roommates in settings where units are shared.
  - Décor – participants have freedom to furnish and decorate their sleeping or living units.
  - Schedules and Activities – participants have the freedom and support to control their own schedules and activities.
  - Access to Food – participants have access to food at any time.
  - Visitors – participants are able to have visitors of their choosing at any time in accordance with the CFH rules (IDAPA 16.03.19) and RALF rules (16.03.22).
  - Accessibility – setting is physically accessible to the participant.

HOW YOUR CLIENTS CAN HELP: NEW HCBS RULES

- Person Centered Planning
  - All participants or their decision-making authority must direct the development of their service plan though a person-centered planning process.
  - Info and support must be given to the participant to maximize their ability to make informed choices and decisions.
  - Individuals invited to participate in the person-centered planning process should be identified by the participant or their decision-making authority.
  - All PCP Service Plans must have the 11 PCP Service Plan requirements. (See IDAPA 16.03.10.317.01-11).
- Note: While the new rules do not supersede a guardian's decision making authority, a legal guardian cannot direct a provider to restrict a participant's HCBS rights.

HOW YOUR CLIENTS CAN HELP: NEW HCBS RULES

- **How to Help**:
  - Educate Clients on their HCBS Requirements.
  - Have Clients meet their requirements.

- **HCBS Resources**:
  - See IDHW's HCBS webpage for lots of provider resources: https://healthandwelfare.idaho.gov/Medical/Medicaid/HomeandCommunityBasedSettingsFinalRule/tabid/2710/Default.aspx.
  - IDAPA 16.03.10.310 - 351.

QUESTIONS?

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AT Advocate

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Funded through a grant received from the Rehabilitation Service Administration, U.S. Department of Education, under contract number H224B020004. The opinions expressed herein do not necessarily reflect the position of the U.S. Department of Education, and no official endorsement by the U.S. Department of Education of the opinions expressed herein should be inferred.

Volume X Issue 1 Winter 2006

PREPARING LETTERS OF MEDICAL JUSTIFICATION

Key Components That Will Support the Need for Durable Medical Equipment Through Medicaid and Other Third Party Insurers

Our June/July 1998 issue of AT Advocate focused on report writing to justify the need for assistive technology (AT). We offered suggestions on writing reports for medical justification, educational needs, and vocational rehabilitation needs. Because we respond to so many questions regarding Medicaid funding of AT, the main topic of this updated and expanded newsletter will be the letter of medical justification or medical necessity, often abbreviated as the LMJ or the LMN. In most cases, what we think of as AT is referred to as durable medical equipment (DME) by Medicaid, Medicare, and private insurance plans.

This article should be a helpful reference to attorneys and advocates who must counsel health care professionals on what needs to go into a good letter of medical justification. This article is also intended for use by any health professional who is expected to write letters of medical justification that will support the need for DME or other specialized equipment. It should be a useful tool to the medical doctor, physical therapist, occupational therapist, speech pathologist, and a range of other professionals who are involved in assessing the need for DME.

Who Will Review the Letter or Report?

When we seek a letter of medical justification, we may assume that the reviewer has a medical background and will automatically understand and agree with the writer's medical opinion. This might be true if the health professional is referring a patient from physical therapy to occupational therapy or from a pediatrician to a rehabilitation specialist. However, this is not always the case when the writer is seeking payment for DME.

With both Medicaid and private insurance plans, the first reviewer should be a health professional but we cannot assume this reviewer will be a medical doctor or have a background in prescribing DME for patients. With Medicaid, the agency's reviewers may include nurses, physical therapists, or other health professionals. One regional Medicaid office in New York, for example,

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SPECIAL FEATURES

uses a licensed dentist for most of its DME reviews. Keep in mind that this reviewer is likely to view part of their job as keeping the outflow of funds under control.

With Medicaid, if the prior approval request is denied and goes to a fair hearing, it will be reviewed by an administrative law judge (ALJ), hearing officer, or hearing referee (we'll reference the ALJ throughout as the individual typically presiding over the hearing). If the hearing decision is unfavorable and the case is appealed in court, it will be decided by a judge or panel of judges. Most ALJs and all judges are trained as attorneys; it is unlikely they will have medical backgrounds.

In order to save precious time for the individual with a disability, the health care professional needs to write a letter of medical justification that can withstand different levels of review as it is passed from the first reviewer, to possibly a second reviewer, into an appeal process like a fair hearing and even, possibly, into court.

Establishing the Professional Appearance of the Report

Administering to the needs of individuals with disabilities can be a time-consuming job and many health professionals tend to overlook the small details in their letters of medical justification. However, taking extra time to pay attention to detail will help in getting the reviewer's attention.

The writer must impress upon the reader that his or her report is worthy of value and respect - - i.e., that it is written by a professional. Since the reviewer will learn about the patient primarily through this letter, the writer wants to impress upon the reviewer that this is a document written in a professional manner, representing the writer's authority to make valued medical decisions in relation to the patient's medical needs. This starts with the physical appearance of the document.

The following should be a starting point of every letter of medical justification:

- If the writer is a professional or works for an organization, the letter should be written on appropriate letterhead.
- The letter should be dated and signed.
- White paper should be used to maintain a professional appearance.
- The letter should be typed, proof read, and neat in overall appearance.
- The letter will be easy to read if the writer uses appropriate fonts, line spacing, topic headings, etc.

Getting Started: Five Key Principles for Writing Letters of Medical Justification

Although many funding sources will require a completed agency form, a supporting letter of medical justification is often required by a Medicaid agency and is always a good idea. There is no one special format for this letter, but there are some general rules to follow.

Prioritize information, getting the important facts at the beginning of the letter. Most readers pay more attention to the first page of a document, the first sentence in a paragraph, and so on. Present the most important pieces of information at the beginning of the letter and in the topic or lead sentences of each paragraph. Also, consider the use of headings as a way to organize information. Headings also offer a way of getting the most important information quickly reviewed. This newsletter, for example, has used different headings to draw your attention to specific information about writing the letter of medical justification.

Stay focused on one issue at a time to avoid confusing the reader. The writer often wants or needs to talk about several different medical conditions affecting their patient and their many medical needs in one letter of medical justification. Confusion arises when the writer jumps from one medical condition to another in the same paragraph, or worse yet, in the same sentence.

Educate the reader about the patient and their needs. Start the letter with the assumption that the reviewer knows nothing about the patient and very little about their disability and the requested equipment. Describe their needs in concrete functional terms and how the requested DME device will help overcome those limitations.

Strive for clarity. The goal is to effectively communicate the medical needs of the patient to a person who may not have the same professional background or education as the health professional writing the letter.

- Use simple sentences.
- Avoid technical medical terms unless they must be used.
- If they must be used, define what the terms mean or refer to, so that the reader understands their context in the letter.
- Avoid medical abbreviations and other medical shorthand.

Consider this excerpt from a letter written for a young man with cerebral palsy. Steve has used a manual wheelchair, but his physical therapist believes he now needs a power wheelchair and a new

seating system. What is wrong with this excerpt?

> *"Steve, age 9, has a diagnosis of CP, 2° to a TBI caused by an MVA when he was 2. He has limited use of his ↑ex. He has been using an adaptive stroller to meet his ambulatory needs. He can no longer use this stroller because he has outgrown it and he cannot self propel a manual chair. If Steve had a power chair, it would be easier for him to ambulate."*

This excerpt presents several problems for the reader. Does the reader know what CP, TBI, and MVA all stand for? How should the reviewer interpret *2°* and *↑ex*? When the therapist uses the term "chair," will the reader know she is referring to a wheelchair? What is the relationship between the inability to use the stroller and a manual wheelchair? What is the significance of the statement about a power wheelchair?

This revised excerpt gives a much clearer picture of Steve's needs:

> *"Steve, age nine, needs a power wheel chair and a new seating system. He has a diagnosis of cerebral palsy that resulted from a traumatic brain injury, sustained in a motor vehicle accident at age two. As a result of this injury, Steve also has limited use of his arms. Historically, Steve has used an adaptive stroller that was pushed by his parents or an aide to meet his mobility needs. However, Steve has outgrown his stroller, and due to the limited use of his arms, he cannot propel a manual wheelchair. Since Steve has the cognitive ability to use a power wheelchair, a power wheelchair is medically necessary to allow him to maximize his capacity for self-initiated functional mobility."*

Limit opinions to areas of professional expertise. For example, if a construction worker attempted to explain the medical need for a standing device, our first thought would be, "What does he know?" This is the same thought a reviewer might have if a physical therapist offers a psychological opinion on the medical need for a device. A writer who stays within his or her area of expertise will be more credible.

Consider the Funding Source and the Criteria it Will Follow

Whether the funding source is Medicaid, Medicare, or a private insurance plan, there will be rules defining what DME is and how to establish that the requested DME is medically necessary. We will discuss the definition of DME and medical necessity separately, focusing on Medicaid as the funding source.

Medicaid's Definition of DME

A funding source like Medicaid may deny a device or discourage an applicant from submitting a prior approval application by stating that the requested device does not meet the definition of DME. In some cases, the Medicaid agency may simply state that the item is "not covered" without any reference to DME or the DME definition. Since a state Medicaid agency is not permitted to maintain an "exclusive list" of covered DME, there must always be an opportunity to show that the item meets the DME definition. (See federal Centers for Medicare and Medicaid Services (CMS), Letter to State Medicaid Directors (Sept. 4, 1998), available on the CMS website at *www.cms.hhs.gov/states/letters/smd90498.asp*.

If you have clients that experience this type of reception when attempting to get a device funded, you might want to ask the health professional to address how the device meets the definition of DME in their letter of medical justification. For instance, what about adaptive tricycles? How many physical therapists have been told that these are not DME when they clearly meet the state Medicaid agency's definition as set forth below. Even if the letter shows how a device meets the definition of DME and the reviewer still denies the request, the writer's work is invaluable in addressing this issue in the letter of medical justification and can later lead to a winning fair hearing or court decision.

Federal regulations do not define DME and, therefore, you must look to state DME definitions. New York's Medicaid agency, for example, has its own DME definition that is similar to what you will find in many states. This definition can be found in Chapter 18 of the New York Code of Rules and Regulations in section 505.5 (a). 18 N.Y.C.R.R. § 505.5 states that

> "durable medical equipment means devices and equipment, other than prosthetic or orthotic appliances, which have been ordered by a practitioner in the treatment of a specific medical condition and which have all of the following:
>
> 1. can withstand repeated use for a protracted period of time;
> 2. are primarily and customarily used for medical purposes;
> 3. are generally not useful to a person in the absence of an illness or injury; and
> 4. are usually not fitted, designed or fashioned for a particular individual's use."

What If My Client Only Has Private Insurance? What Definitions of DME & Medical Necessity Do I Use Then?

If your client only has private insurance, DME will be defined by their insurance contract. Many insurance companies will have a definition similar to either Medicaid or Medicare but, if there are any differences, those differences will be important and must be dealt with. Similarly, the insurance contract can define what it means to be medically necessary and that language will ordinarily be controlling. You cannot necessarily look to Medicaid or Medicare policy for guidance.

One can readily see how a wheelchair meets this four-part definition. In fact, when funding for an expensive power wheelchair is denied in New York and most states, it is generally based on a finding that the wheelchair or a specialty component is not medically necessary or the least costly alternative to meet the patient's needs. (See discussion below on medical necessity.)

But what about the adaptive tricycle, the purpose of which is to assist with physical therapy and/or promote weight control, etc. Does the adaptive tricycle meet the DME definition? Let's put it through the four-part definition:

1. The adaptive tricycle can certainly withstand repeated use.
2. It is primarily and customarily used for a "medical purpose." Adaptive tricycles are used by therapists in working with individuals with disabilities as an adjunct to physical therapy, for mobility, or to promote weight control.
3. By design, adaptive tricycles are not useful in the absence of an illness or injury. The pedals may be placed in the steering bar position or the seat may have a high back with harness straps to hold the rider safely in the seat. You cannot buy an adaptive tricycle at your local toy store.
4. The tricycle will not be fitted or designed for the specific individual.

Even if you state Medicaid agency requires that DME be appropriate "for use in the home" – mimicking Medicare's DME language (see box, p.330) – the adaptive tricycle would probably meet that definition as well.

While individuals may often be told by their state agency that adaptive tricycles are not covered by Medicaid, their outright exclusion is illegal. Given that adaptive tricyles appear to meet the most common definitions of DME, the only basis for denial would be that the tricyle was not medically necessary or the least costly equally effective alternative. Knowing that a requested item, like the adaptive tricyle, is likely to be met with a "not covered" response, the letter of medical justification can be written in a manner that uses your state DME definition as a reference.

Medical Necessity

The is no specific reference to the term "medical necessity" in the federal Medicaid Act or its implementing regulations. It is widely recognized, however, that DME (and other medical interventions) must be medically necessary before payment for them can be justified.

You will need to look at the law, regulations, and policy of your state to see if the Medicaid program has a specific definition of medical necessity. In New York, medical necessity means that the device requested is both medically appropriate and cost effective. So, in New York, in order to justify that a device is a medical necessity for Medicaid the health professional needs to answer the following questions:

1. Will it meet the patient's medical needs by reducing the recipient's physical or mental disability?
2. Is the equipment medical or remedial in nature?
3. Is it the least costly medically appropriate alternative, and if not, why not?
4. Will it prevent, diagnose, correct, or cure a condition that causes acute suffering, endangers life, results in illness or infirmity, interferes with the capacity for normal activity or threatens to cause a significant handicap?

See N.Y. Social Services Law § 365-a; 18 N.Y.C.R.R. § 513. Most states medical necessity definitions will have this two-pronged focus: 1) the DME in some way must help overcome the affects of the disability or medical condition; 2) the DME requested must be the least costly equally effective alternative.

Let's say that we need a letter of medical justification for John who needs a power wheelchair. John is 22 years old with a primary diagnosis of Limb-Girdle Muscular Dystrophy and a secondary diagnosis of asthma. John cannot ambulate due to the effect of his muscular dystrophy on his hips. He also suffers from partial subluxation of his shoulders

making it impossible to use a manual wheelchair. A college senior, he is in a campus dormitory that is specially designed for the disabled. Consider the statements made by a physical therapist who wants Medicaid to pay for John's wheelchair. Has she addressed the issue of "medical necessity?"

> *"John is a 22 year old man with a diagnosis of Limb-Girdle MD. He is a senior in college. He needs a power wheelchair that will allow him to conveniently travel to classes on campus. When John is at school, he is often late for classes because he cannot travel quickly in his manual wheelchair. With a power wheelchair, it would be much easier for him to get from building to building for his classes in a timely fashion."*

This writer has made several mistakes. First, she uses an abbreviation, "MD," which many readers might associate with medical doctor and not with muscular dystrophy. Second, she suggests that John's need for the power wheelchair is based on convenience, quick travel, and easier movement around school. Third, she is addressing vocational or educational needs, not medical needs. Although the ability to get around school and participate in school activities is relevant (note: the word "independence" appears in the federal Medicaid law, 42 U.S.C. § 1396), we recommend that this be referenced as supporting and not primary information. Fourth, John's therapist offered no information about the effects of his muscular dystrophy on his mobility. While John may see getting to class on time as the biggest challenge he is currently facing, his physical therapist should be concerned with his overall medical need for functional mobility and not only with his inability to get from class to class.

Now, compare the paragraph above to the one below. The physical therapist has now provided good medical justification for the request.

> *"John is a 22 year old senior at State College. He has a primary diagnosis of Limb-Girdle Muscular Dystrophy and a secondary diagnosis of asthma. According to his doctor, his muscular dystrophy is progressive and will get worse. John is requesting Medicaid prior approval for a power wheelchair. He cannot ambulate due to the muscular atrophy affecting his hips. He also suffers from partial subluxation of his shoulders making it impossible to safely use any manual wheelchair including an ultra light weight wheelchair. Any pressure on John's shoulders caused by his attempts to push his body weight in a manual wheelchair will cause further damage to his shoulder area. For example, one day when John tried to get to his next class in an adjacent building on campus, he completely dislocated his shoulder. John also reports that the strenuous exertion of pushing his manual wheelchair has often brought on asthma attacks."*

Using Medicaid Coverage Categories Other Than DME to Fund Specialized Equipment

In our experience, coming from New York, 95 percent of requested devices meet the DME definition. This, of course, may vary from state to state. In every state, there may be equipment that the state Medicaid agency is unwilling to classify as DME, claiming it does not meet the four-part definition. For example, the agency may claim that medically-prescribed exercise equipment does not meet the DME definition because it is useful to individuals "in the absence of illness or injury." When this happens, we can look at several other Medicaid coverage categories as a way to fund a particular device. The service categories discussed below are optional and may not be available to adult Medicaid recipients in every state.

How Does Medicare's Definition of DME Differ Compared to Medicaid?

Since Medicaid is a partnership between the federal government and the states, some Medicaid criteria - - like the DME definition - - is left for regulation by each state. By contrast, Medicare is totally federal and has one DME definition that applies nationwide.

Medicare's four-part definition of DME is very similar to New York's Medicaid definition on parts one, two and three (see page 328). However, at part four it differs in that the equipment must be "appropriate for use in the home." 42 C.F.R. §414.202. This phrase has been interpreted by the federal Centers for Medicare and Medicaid Services as meaning that the requested device or equipment must be needed for use within the home and that any benefit outside the home is allowed but not relevant to whether the individual qualifies for the device. This interpretation can affect both what is considered to be DME and what is considered to be medically necessary. Do not confuse this definition with Medicaid's.

Prosthetic devices. Medicaid defines prosthetics as replacement, corrective, or supportive devices prescribed by a physician or a qualified practitioner to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. 42 C.F.R. § 440.120(c). Some state Medicaid agencies were historically unwilling to classify a dual-purpose augmentative communication device (i.e., one that generates speech and functions as a personal computer) as DME, claiming it is useful in the absence of illness of injury. Without conceding on that point, some advocates successfully argued that the dual purpose device met the prosthetic device definition as it replaced the functioning of the non-functioning speech organs.

Physical therapy (PT) and occupational therapy (OT). When either therapy is prescribed by a physician or other licensed practitioner within the scope of their practice and is provided under the direction of a qualified Physical Therapist or Occupational Therapist, this category includes any necessary supplies and equipment. 42 C.F.R. § 440.110(a), (b). If the exercise equipment, mentioned above, is medically prescribed as PT or OT, it can be funded by Medicaid even if it does not meet the DME definition.

Services for speech, hearing and language disorders. These are diagnostic, screening, preventative or corrective services provided by or under the direction of a speech pathologist or audiologist when referred by a physician or other licensed practitioner within the scope of their practice. This includes any necessary supplies or equipment. 42 C.F.R. § 440.110(c). If the Medicaid agency was claiming that a particular augmentative communication or hearing device did not meet the DME definition, it could likely be funded under this speech-language category.

Preventative services are services provided by a physician or licensed practitioner to prevent disability and its progression, prolong life, and promote physical and mental health. 42 C.F.R. § 440.130(c). A common preventative treatment for wheelchair users, to avoid decubitus ulcers, is daily whirlpool treatment. Some may argue that a home whirlpool unit is not DME because it is useful in the absence of illness or injury, but it certainly seems to fit as a preventive service. Similarly, a home whirlpool unit would seem to fit under the category of **rehabilitative services** - - which may include any medical or remedial services that reduce physical or mental disability, 42 C.F.R. § 440.130(d) - - if the individual already has decubitus and the whirlpool is prescribed to treat it and prevent it from getting worse.

Early and Periodic, Screening, Diagnosis and Treatment (EPSDT). EPSDT applies to all recipients under the age of 21. Under EPSDT, Medicaid must provide all other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services. 42 C.F.R §440.40(b). The EPSDT category envisions a much more proactive model of health care intervention for children that

AT Court Watch

Oral Arguments Expected Soon in Lankford v. Sherman

Our Summer-Fall 2005 issue of AT Advocate reported on this lawsuit, which challenges Missouri legislation, implemented through an emergency regulation that eliminates most durable medical equipment (DME) for adult Medicaid recipients who are neither blind nor pregrant. Under Missouri's cuts, adults in the limited benefit group no longer qualify for Medicaid funding of items such as hospital beds, decubitus care equipment, augmentative communication devices, wheelchair batteries, and wheelchair accessories. The seven named plaintaiffs are represented by the National Health Law Program (Jane Perkins, Sarah Somers), the Missouri P&A, and several other public interest law organizations.

The District Court's order, denying plaintiffs' motion for a preliminary injunction is now being appealed in the 8th Circuit Cout of Appeals. The case has been fully briefed and arguments should take place during the Spring. For copies of the complaint or any of the briefs, including the plaintiffs', defendant's, and amicus curiae's briefs filed in the 8th Circuit, contact Jim Sheldon or Diana Straube at the National AT Project (jsheldon@nls.org or dstraube@nls.org).

****Late Breaking News****

Oral arguments are now scheduled to take place on April 17, 2006. Any news about the appeal will appear on our National AT list serve.

should result in both a broad range of equipment available to them and an expanded view of what is considered medically necessary. [For instance, the federal Center for Medicare and Medicaid Services (CMS) in interpreting the scope of EPSDT coverage has stated that "Medically prescribed exercise equipment, including exercise bikes, swing sets, tricycles and other assistive devices are also coverable benefits of the Medicaid program when determined to be medically necessary and cost effective." *CMS Letter to Richard Allen, Medicaid Director (Colorado) March 7, 1996.*

Drafting the Report

The following suggestions should allow the health professional to draft one document that can be reviewed by the state Medicaid agency and then an administrative law judge and/or a reviewing court, if necessary. It will save the health professional and patient precious time by not having to continually submit additional information, which often extends the time Medicaid will use to process the request.

Introduce and establish the writer's credentials. In most cases, the writer is reporting as an expert. The writer can establish his/her expert credentials by describing: expertise, licenses, education, current job title, and how long the writer has been doing this work. Additional information can include relevant classes or clinics taught by the writer or taken as a student, and any articles written that relate to the content of the report.

When Ms. Jones, a speech pathologist for a group home, was asked to assist one of the residents who was asking for Medicaid to purchase an augmentative communication device, she reported her credentials as follows:

> *"I have been employed by the Oakvale Community Residence since 1996. I graduated from the State University with both a bachelors and a masters degree in Speech Pathology (in 1984 and 1986, respectively). Presently, I am working on my doctorate in this field. I specialize in the needs of people who suffer from traumatic brain injuries and have been doing so since 1986. I currently lecture at the University School of Medicine and the Occupational Therapy Department on the communication needs of individuals with Traumatic Brain Injuries (TBI)."*

This brief statement establishes the writer's credentials in both speech pathology and work with TBI patients.

Establish the relationship with the patient. Is the letter of medical justification based on a one-time consultation or weekly sessions with the patient over several years? A report will be more effective when it clarifies the nature of the relationship:

> *"I assumed responsibility for Mary's case when I started my employment with Oakvale in 1996. Currently, I see Mary twice each week for scheduled appointments and have done so for nearly 10 years. During our sessions I evaluate Mary's expressive and receptive language skills so that I can document both growth and regression. I also attempt to update or introduce new skills by which Mary can express herself through use of an augmentative communication device. Since Mary is currently using an eight year old, outdated communication device, when I am able I make adjustments to her current device to reflect her communication abilities and communication needs. It is also my responsibility to report her progress with speech, as well as any medical concerns."*

What if the writer is new to the job and has only worked with the patient for a few weeks or months? The writer should ask his or her supervisor how long they have worked with this individual and then state in the letter that while he or she has worked with Mr. Smith for only three months, the immediate supervisor has worked with him for many years and is familiar with his diagnosis and medical needs and that she has reviewed and concurs with your findings. In that situation, it would strengthen the letter if the supervisor co-signed it.

Educate the reader about the patient's disability. If the writer is a doctor or other health care professional, the letter of medical justification provides an opportunity to educate the reader, who may not be a medical professional, about the person's disability. The writer should discuss the patient's primary and secondary diagnosis, if any, his or her prognosis, what complications affect the patient, and how. Since the patient is seeking a device that will overcome the effects of a disability, those effects should be described in functional terms.

Consider these excerpts from the reports of Oakvale's staff doctor and speech pathologist.

> *Doctor : "Mary suffers from the effects of a severe frontal lobe trauma she sustained in a motor vehicle accident. She experiences short term memory loss and her speech is extremely slow and slurred. She has a secondary diagnosis of quadriplegia, which is a result of the same accident. Her quadriplegia is accompanied by spasticity of the upper extremities and the loss of fine motor control.*

She also suffers from depression. According to the staff mental health counselor, her emotional prognosis is poor due to Mary's inability to express herself."

Speech pathologist: "Mary's receptive language skills are adequate to meet her daily needs. For example, she can understand basic directions, conversations, the television, etc. However, because her very old communication device is often broken, she is losing her expressive language skills due to her inability to speak and partake in conversation."

Describe the type of equipment being requested. Since it is common for vendors to refer to their equipment by model names or numbers, the report should give a specific description of the requested DME. The report should also describe any accessories that will be included with the basic equipment.

State why the device is medically necessary. Just about every piece of DME, every adaptation to a piece of DME, even the electronics that allow someone to use DME were designed to take the place of a function that the patient's body cannot perform. This is probably the most important part of the letter of medical justification. The key word to remember here is *detail, detail, detail*! The health professional should always think to himself or herself when writing this part of the letter "because this condition exists, then this is what is needed to correct the disabling result." Again, with Medicaid the writer should state why the equipment would cure or correct the effects of the patient's condition, or prevent them from becoming worse or having new problems develop. Here is how Mary's speech pathologist addresses this issue:

"The Ready Voice 123 is medically necessary because it will correct Mary's inability to speak and aid Mary in preventing other health and safety issues from arising by allowing Mary to express herself. Through the use of the icons and the pre-programmed language, Mary should be able to recapture many of her expressive language skills and prevent any additional loss of her receptive language skills. For instance, if Mary has a dental appointment, she can program her device to explain to the dentist what tooth is bothering her, for how long and how intensely. This device is also flexible enough to provide Mary with spontaneous speech through the use of an alphabet key board so she can address her immediate needs. Because Mary is spastic, she has very little residual use in her arms. Therefore, as a primary consideration for selecting the device which will best meet Mary's needs, additional consideration must be given to the over-all accessibility of the key board. The Ready Voice 123 was selected because its key board uses larger common language icons for needs such as toileting and feeding and larger alphabet keys for spontaneous speech. These larger icons and keys will assist Mary in effectively communicating by allowing her to touch any part of the key or icon for selection while providing sufficient space between the keys or icons to minimize mistakes in selection."

One of the most common pieces of requested DME is the power wheelchair. If the health professional is writing a letter of medical justification in support of a power wheelchair he or she needs to justify the base of the wheelchair (why ther patient must have a K11 instead of a K10 base); the seating system (hard back, high back, sling back and seat, captain's chair, etc); positioning if necessary (tilt-in-space, recline, both, seat elevator, standing); all accessories; and don't forget electronics (programmable controls, MARK IV, drive systems). Electronics can be very expensive and often represent new technology. These items must get more than just a nod of acknowledgment. Writers must learn all they can about them and how they will help correct the patient's condition (or overcome the limitations resulting from that condition) and then address the new electronics with the same detail and care as the other parts of the requested wheelchair.

Describe any evaluations to determine need for DME. In many cases, the evaluations to determine the need for DME have been very comprehensive. Often, those evaluations have included trials on one or more pieces of equipment, including a proto-type of the one now recommended. The writer should describe any evaluations which have lead to the current recommendation. Again, Mary's speech pathologist:

"During my evaluation, I tested Mary on four different augmentative communication devices, including the Ready Talk 123 ... [describes other devices]. [Explain why other three devices were determined to be inappropriate.] Based on this extensive evaluation and trial use, I determined that Mary has both the cognitive ability and the physical ability to use the Ready Talk to meet her communication needs."

Explain that the recommended device is the least costly alternative. Remember, cost plays a big part in getting the DME one needs. The saying, "Never seek a Cadillac when a Chevy will do," is truly appropriate here. The writer must convince the funding source that they will not be spending money inappropriately or unwisely. The writer must always approach any justification regarding the cost of an item as a consumer who is well-educated and has shopped around. Provide the funding source with information about different prices for similar models or different features. What is the warranty on the parts? Are there service contracts that might appeal to the funding source? Here is what Mary's speech pathologist has to say about least costly alternative:

> *"I considered less costly alternatives, but determined that none of those items could adequately meet Mary's needs. The non-electronic picture boards were deemed inappropriate because their language level was not sufficiently sophisticated to meet the needs of a 32 year old woman. Further, the picture boards do not provide voice output and require the user to continually point to a picture to communicate. Mary's spasticity would limit her ability to point to the pictures on the board. There are some electronic devices for under $1,000, including the ... [name them], but these would be inappropriate because they only allow for a fixed number of phrases and would not allow Mary to speak spontaneously.*
>
> *As noted above, I did consider three other devices which were all determined to be inappropriate for Mary. The cost for these three devices was in the same range as the cost for the Ready Voice 123, which will cost $6,899 with accessories. The 'x device' would cost $6,150; the 'y device' would cost $7,400 and the 'z device' would cost $8,100. In my opinion, the Ready Voice 123 is the least costly alternative that can adequately meet Mary's communication needs. It also comes with a one year manufacturer's warranty on parts and labor."*

Use the concluding paragraph to restate the main points of the report. All well-written documents end with an effective conclusion. It summarizes the preceding information and allows the writer to briefly restate their case. It also offers a writer the opportunity to stress any important points that may be worthy of repetition:

> *"Therefore, based on my extensive evaluations, including a trial on four different augmentative communication devices, it is my opinion that the Ready Voice 123 is the least costly alternative that will allow Mary to effectively communicate."*

Conclusion

This article has provided what we hope to be a set of useful guidelines for any health professional who is expected to write letters of medical justification that will support the need for DME or other specialized equipment. The sample letter of medical justification that follows on pages 335-336 is an example of a letter that heeds the advice of this newsletter. By following the basic guidelines, the physical therapist has crafted a letter of medical justification that will support her seven year old patient's need for the requested power wheelchair, tilt-in-space system, and accessories.

Visit our Website:
www.nls.org/natmain.htm

Bridges to Better Advocacy Handouts Available

As this goes to press, we are nearly ready for our 10th annual, "Bridges to Better Advocacy" conference in Austin, Texas (April 5-7, 2006). 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. To view the conference agenda and get an idea of what handouts are available, go to:

www.nls.org/pre-conference.htm (pre-conferenceagenda)

or www.nls.org/conference06.htm (two-day conference agenda).

Nickel City Physical Therapy

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This SAMPLE letter of medical justification uses the advice given in this newsletter.

March 6, 2006

Medicaid Services Director
County Department of Health
Anytown, Anystate 10002

Dear Sir/Madam:

I am writing to support Jimmy Smith's request for Medicaid prior approval for a Sheldon 56 pediatric power wheelchair with a GREAT tilt-in-space positioning system and accessories.

I am a physical therapist employed by Nickel City Physical Therapy at their wheelchair seating and mobility clinic, full time, evaluating individuals with disabilities for wheelchairs or wheelchair modifications. I have an MS in physical therapy, have practiced for 20 years, am licensed in Anystate, and am current with continuing education units. I am also a clinical professor at Anystate University teaching graduate students wheelchair seating and positioning.

Jimmy Smith, his disabilities, functional limitations. Jimmy Smith, age seven, resides with his mother and sister. I have worked with Jimmy for the last four years in assessing his mobility needs. I see him every six months to make sure that his wheelchair is meeting his needs and is functioning safely.

Jimmy has a primary diagnosis of cerebral palsy, spastic quadriplegia type. He presents with a weak trunk and neck, scoliosis, limited hand and wrist movement and is right side dominant. He has a secondary diagnosis of asthma. Cognitive development is age appropriate and he attends the second grade. The only special education service he receives is one half hour of physical therapy for stretching and range of motion three times a week. Jimmy is small for his age, x feet x inches in height, xx pounds in weight.

Jimmy's current wheelchair. Jimmy's current manual wheelchair is three years old with a solid seat and back, chest and hip harnesses, swing away foot plates, a head support and stroller type handles. This wheelchair no longer meets his medical needs in the following ways:

1. It is too small for him.
2. It does not address his asthmatic condition.
3. It cannot be modified to meet his growth or asthma concerns.
4. It does not allow him to be actively responsible in his own health management.
5. It furthers the concept of "learned helplessness" by allowing Jimmy to be pushed instead of initiating mobility.
6. It fails to provide a safe means of mobility for Jimmy to remove himself from emergency situations.

The requested wheelchair. I am requesting a Sheldon 56 pediatric power wheelchair with special seating and a right side joy stick control, a GREAT tilt-in-space positioning system, side lateral supports, hip guides, standard leg rests with angle adjustable foot plates, hip and chest harnesses, and a head rest. This wheelchair meets Jimmy's medical and safety needs in the following manner:

1. It will be ordered to meet Jimmy's current measurements. If he gains weight or grows more through his hip region, this wheelchair can grow accordingly.
2. Jimmy is quadriplegic with poor trunk control and an asthmatic. He cannot propel a manual wheelchair because of his quadriplegia and poor trunk control. Additionally, his asthma can be exacerbated by his attempts to push a manual wheelchair. When in school, regulations mandate that his albuterol be kept

with the school nurse. As an asthmatic he must be able to access his albuterol immediately at the first signs of distress. If he cannot get the attention of his aide, teacher or another student to push him to the nurse's office or get his albuterol for him, he can stop breathing and die. With the requested power wheelchair, Jimmy will have independent functional mobility and, when necessary, can quickly access his asthma medication if the need arises.

The requested tilt-in-space positioning system will allow Jimmy to tilt his seating position back to allow the effects of gravity to pull his spine and trunk back against his wheelchair back. This will allow Jimmy's lungs to work more efficiently so he can breathe better. The combination of the tilt-in-space system along with the lateral supports and the hip guides will maximize proper positioning of his body in his wheelchair thereby controlling the progression of his scoliosis. Since Jimmy will be a life-long wheelchair user, the tilt-in-space option will also help to prevent skin breakdown.

3. Jimmy has developed cognitively at the same rate as his peers. At his age, it is imperative that he learn to take an active part in his own health care management. He cannot do this with his current manual wheelchair. The Sheldon 56 wheelchair is medically necessary so that he can actively participate in his health care management, i.e., such as getting to the bathroom to brush his teeth, taking the initiative to get to the school nurse at the first sign of an asthma attack, using his tilt-in-space when necessary, and bringing wheelchair malfunctions or needed repairs to the attention of his parents.
4. Jimmy has been pushed in a manual wheelchair for the first seven years of his life. This is an age when children who can walk are learning to meet simple needs on there own - - no longer needing their mother to get them a drink, to set out their clothes, or change the TV channel. Jimmy has not had this opportunity to meet these basic needs because he cannot push his manual wheelchair. Self-initiated activity is a long term goal of physical therapy. The requested power wheelchair will allow Jimmy to meet this goal by allowing him to initiate age appropriate activity and receive both the mental and physical health benefits associated with starting an activity and completing it.
5. Jimmy's current manual wheelchair will not allow him to remove himself from unsafe situations. For example, when the fire alarm sounds at school, he must wait for someone to push him to the wheelchair exit. If aides are not available, he could die from smoke inhalation before he would be rescued.

I have discussed the requested device with a representative of the Wheelchair Store. Together, we researched the possibilities of meeting Jimmy's needs in other ways before requesting this power wheelchair. Again, Jimmy cannot use a manual wheelchair because of his inability to propel this type of wheelchair. Although it may be less expensive in cost, it will be a waste of money since Jimmy will not fully use it.

Other power wheelchairs considered. One pediatric power wheelchair we reviewed had a manual tilt-in-space system. While less expensive, it will not meet Jimmy's needs. It is important that Jimmy learn how to use his tilt-in-space system effectively in order to be proactive in meeting his medical needs. Since he lacks the physical ability to manually tilt his chair, a manual tilt cannot be fully used. The second pediatric power wheelchair we reviewed had a base that was too wide to be used in Jimmy's home and in order for him to maximize the health benefits associated with this device, he should use it at home, at school and in his community. Again, it was less expensive than the requested wheelchair but it will not meet his medical needs. The last wheelchair we reviewed was made by a company that will only make their wheelchair with the tilt-in-space as a single unit. The power wheelchair package we are requesting is more economical than this last option because the wheelchair and the tilt-in-space do not have to be built as one. Instead, we were able to use the GREAT tilt system, which lowered the price of the entire wheelchair request by $1000.

Based on my clinical observations and my research with the Wheelchair Store, I have recommended the Sheldon 56 pediatric power wheelchair with tilt-in-space positioning and accessories to Jimmy's rehabilitative physiatrist. His physiatrist has agreed with my recommendations and is cosigning this letter as proof that he concurs with my findings and is prescribing the Sheldon 56 pediatric power wheelchair.

Very truly yours,

Riley Elizabeth Louis, PT Samuel Rayburn, MD

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 AT Advocate Newsletter 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:

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RETURN SERVICE REQUESTED

LETTERS OF MEDICAL JUSTIFICATION CHECKLIST

I. General:

- The letter should be written on appropriate letterhead.
- The letter should be dated and signed.
- Make the letter easy to read by using topic headings.

II. Writer's Credentials:

- Establish expert credentials by describing: expertise, licenses, education, current job title, and how long the writer has been doing this work.
- Include relevant classes or clinics taught by the writer or taken as a student, and any articles written that relate to the content of the report.
- Where appropriate attach a resume or curriculum vita.

III. Relationship with the Patient:

- Writer should describe whether he or she is a treating doctor/therapist or a consultant who only saw the patient once.
- Describe how often the writer sees or saw the patient (e.g., one time per month or two times per week).
- Describe how long the individual has been seeing his or her patient (e.g., six months or three years).
- Writer should state that he or she is familiar with the patient's diagnosis and medical needs.

IV. Patient's Disability:

- The letter is an opportunity to educate the reader, who may not be a medical professional, about the person's disability.
- Discuss primary and secondary diagnosis, if any, prognosis and any complications that affect the patient's functioning as related to the requested treatment/therapy/medical service, including medication side effects, if relevant.

V. Describe the Type of Treatment/Therapy/Medical Service/Durable Medical Equipment (DME) Being Requested:

- Include a statement that "After an EPSDT screen, I am prescribing (<u>name of treatment/therapy/medical service</u>).

- Provide a specific description of the requested treatment/therapy/medical service/DME with a specific prescription, i.e. duration and hours per week, month, etc.

VI. State Why the Treatment/Therapy/Medical Service/DME is Medically Necessary:

- Explain what treatment/therapy/medical service/DME is currently being used and why it is not meeting the individual's needs.
- Explain how the requested treatment/therapy/medical service will help to correct or ameliorate the patient's disabling condition, prevent the condition from worsening, or prevent regression.

VII. Explain that the Recommended Treatment/Therapy/Medical Service is the Least Costly Alternative:

- If asking for a more expensive treatment, explain why the similar but less expensive treatment/therapy/medical services/DME will not meet the needs that are to be address.
- Describe by name the other less expensive treatment/therapy/medical service/DME (and even the more expensive) considered and why they were ruled out.
- Describe whether or why the treatment/therapy/medical services/DME is within professional recognized standards and not experimental.

SAMPLE LETTER

[DATE]

Idaho Department of Health & Welfare
Division of Medicaid
P.O. Box 83720
Boise, ID 83720-0036

RE: (Name), DOB:
EPSDT Request for Name of Treatment/Therapy/Medical Service/DME

To Whom It May Concern:

I am a (type of professional). I have been practicing for ___ years. I am board certified in _____. I have been (patient's name)'s treating physician for ____ years. I treat (Patient's name) _____ times a (month/week).

(Patient's name)'s current diagnosis includes (include all). He exhibits the following symptoms: (description) These impairments in functioning have resulted in (increased isolation, loss of independent functioning, loss of ability to access community services, and/or the loss of education services). His prognosis is _____. He also experiences the following side effects from the medications he takes _____.

After an EPSDT screen, it is my profession opinion that (name of treatment/therapy/medical service/DME) is/are medically necessary to correct or ameliorate (Patient's name)'s conditions described above. I am specifically prescribing (name of treatment/therapy/medical service/DME) _____ times/hours per week/month.

(Patient's name) currently receives (#) hours or (#) days per month of (name of current treatment/therapy/medical service/DME). This is insufficient to meet (patient's name)'s needs and keep him/her in his/her current placement at home. In my profession opinion, additional hours/days of (name of treatment/therapy/medical service) are medically necessary to correct and ameliorate (Patient's name)'s (condition) and to treat the functionally, significant malfunctions in mood, behavior, thought and affect caused by (Patient's name)'s (condition). There are no other equally effective courses of treatment available or suitable for (Patient's name) that are more conservative or less costly available. Further the prescribed (treatment/therapy/medical service/DME) are medically necessary to prevent (Patient's name)'s condition from worsening and/or to prevent regression. A prescription of additional (treatment/therapy/medical service/DME) are within professionally recognized standards and is not experimental.

I believe that if (Patient's name) does not receive these additional (treatment/therapy/medical service/DME), he/she is at risk of a more restrict, more costly placement such as a group home, institution, hospital, or possible even incarceration due to increased aggression, paranoia, agoraphobia and worsening of other symptoms of his mental illness.

If additional information is needed, please contact me at _____.

Sincerely,

[PHYSICIAN NAME]

IDAHO MEDICAID POLICY FOR EARLY & PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES FOR INDIVIDUALS UP TO THE AGE OF 21 YEARS

I. POLICY METADATA

(1) Policy Type – Medical
(2) Policy Status – Approved
(3) Policy Author – Cindy Brock
(4) Initial Effective Date – 6/14/2017
(5) Revision Approval Date – NA
(6) Next Review Date – 6/1/2018 or as needed

II. POLICY INTENT/RATIONALE

Providing Medicaid reimbursement for services under EPSDT for children (through the month of their 21st birthday), is required by federal and state regulations. This policy defines the criteria and process for determining when Idaho Medicaid will approve services under EPSDT and provide reimbursement for those services.

III. BACKGROUND

Federal Medicaid law at 42 U.S.C. 1396(a) [1905(r) of the Social Security Act] requires state Medicaid programs to provide EPSDT Services for Medicaid participants (through the month of their 21st birthday).

The scope of EPSDT benefits under the federal Medicaid law and IDAPA 16.03.09.880, requires Idaho Medicaid to cover any medically necessary service which "corrects or ameliorates a defect, physical or mental illness, or a condition identified by the screening", whether or not the service is covered under the Idaho Medicaid State Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. 1396(a) [1905(a) of the Social Security Act]. See Section 2.8. of the General Provider and Participant handbook (located at www.idmedicaid.com) for the listing of EPSDT Services.

EPSDT Services include any medical or remedial care that is medically necessary to correct or ameliorate a physical or mental health condition. This means that EPSDT covers most of the treatments a participant (through the month of their 21st birthday) needs to stay as healthy as possible. Idaho Medicaid must provide or arrange for (directly or through referral to appropriate agencies, organizations or individuals) corrective treatment identified during the screening services.

IV. POLICY

a) Medical Necessity
   i. Services requested on the EPSDT Prior Authorization Request form require a signature of the licensed provider recommending the service and documentation of the need for the service. The documentation must support why the service is medically necessary (in accordance with IDAPA 16.03.09.880).
   ii. The licensed provider's recommendation must be within the scope of their practice.
   iii. All service requests will be reviewed in accordance with IDAPA 16.03.09.880 and all other applicable Medicaid requirements.

iv. Submitting documentation to support medical necessity as defined in IDAPA 16.03.09.880 is the responsibility of the licensed medical professional who is making the request for service(s). If necessary, the licensed medical professional may need to request records from other providers (e.g. developmental disability agency) to support the request for services.

v. The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in Idaho Medicaid clinical coverage policies, service definitions, or billing codes do NOT apply to recipients (through the month of their 21st birthday). This includes the hourly limits and location limits on Medicaid Personal Care Services (PCS).

vi. Other restrictions in the clinical coverage policies, such as the location of the service, prohibitions on multiple services on the same day or at the same time (e.g., day treatment and residential) may not apply if the services are medically necessary.

b) Provider Enrollment

i. EPSDT services can only be covered if they are provided by an Idaho Medicaid enrolled provider.

ii. If a provider chooses not to enroll with Idaho Medicaid, then an alternative provider may be recommended by the PCP/Specialty Physician.

c) Out-of-State Services

i. Upon request, Idaho Medicaid can assist with coordination activities such as identifying enrolled out-of-state providers or assisting with provider enrollment.

ii. If out-of-state EPSDT services are approved. Support services such as transportation and lodging are available. These support services must be requested and approved prior to the date of the service or procedure.

d) No waiting list for EPSDT services

i. Medicaid does not impose a waiting list for services and must provide coverage for corrective and ameliorative treatment for participants up to 21 years of age.

ii. Physicians and other licensed practitioners or hospitals/clinics chosen by the recipient and/or his/her legal representative may have waiting lists to schedule appointments or medical procedures, which may apply to participants regardless of whether they have EPSDT coverage.

e) No monetary caps on the total cost of EPSDT services

i. A child (through the month of their 21st birthday), who is eligible for Idaho Medicaid or the Idaho Children's Health Insurance Program (CHIP) is entitled to receive EPSDT services without any monetary cap.

ii. If the child is enrolled in a community based waiver, the participant may receive both waiver and EPSDT services. (see Section IV.h of this policy for additional waiver information)

f) Screening Services and Interperiodic Screens

i. Child wellness exams (physicals) are covered based on the requirements in Section 2.8 of the General Provider and Participant Information handbook (located at www.idmedicaid.com).

ii. More frequent screens are covered when there are indications it is medically necessary to determine whether a child has an illness or health condition that may require further assessment, diagnosis or treatment. More frequent screens may be provided to children if there are indications that a previously diagnosed illness or health condition has become more severe or changed significantly.

g) Limitations on EPSDT Services or Equipment

i. Only those services within the scope of those listed in the federal law at 42 U.S.C. 1396d(a) [1905(a) of the Social Security Act] can be covered under EPSDT. See Section 2.8. of the General Provider and Participant handbook (located at www.idmedicaid.com) for the listing of EPSDT services.

ii. Provider documentation must address why the service is medically necessary in accordance with IDAPA 16.03.09.880

h) Waiver Services

I. With the federal update on February 27, 2015 to Section 1302 of the Affordable Care Act, Idaho Medicaid was required to move services that fall into the rehabilitative and habilitative service benefit category out of the current 1915(c) waivers into Idaho Medicaid's state plan.

II. Waiver services are typically only available to participants in the waiver program due to the federal updates discussed above. However, rehabilitative and habilitative services are now considered State Plan services and are considered part of the EPSDT benefit. Support type services are not a part of the EPSDT benefit.

III. Any request for services for a waiver recipient (through the month of their 21st birthday) must be evaluated under BOTH the waiver and EPSDT.

IV. Any child enrolled in a waiver program can receive BOTH waiver services and EPSDT services. However, if enrolled in a waiver, the cost of the recipient's care under the waiver still must not exceed their allocated budget. EPSDT service expenses DO NOT decrease the participant's waiver budget. EPSDT services are not calculated in the recipient's cost of care under the waiver.

V. EPSDT services must be provided to recipients (through the month of their 21st birthday) enrolled in a waiver program. EPSDT providers must have the same qualifications and provide services meeting the same quality standards as services for children receiving State Plan Medicaid services.

VI. EPSDT services (i.e. daily in-school intervention services or personal care services) may be provided in the school setting, including to waiver participants.

VII. A community provider can deliver state plan eligible waiver services in a school setting, as long as the service is not already identified in the IEP. The service must be included in the participant's waiver budget.

i) Review Time

i. Requests for prior approval of services are to be decided with reasonable promptness. Requests for services covered by the Idaho Medicaid State Plan and provided by a provider enrolled with Idaho Medicaid will usually be decided within 15 business days. Requests for services not covered under the State Plan, may take longer to secure, enroll a provider, and to determine medical necessity for the service. No request for services for a recipient (through the month of their 21st birthday) will be denied, formally or informally, until it is evaluated under EPSDT. The timeframe for the review of the application will be longer if:

- Additional documentation is needed to make a determination of medical necessity
- The provider fails to submit requested documentation in a timely manner
- Medicaid must do further research on the request to determine if it meets the current standards of medical care

j) **Denial, Reduction or Termination of Services**
If services are denied, reduced, or terminated, proper written notice with appeal rights will be provided to the recipient and copied to the provider.

I. The notice must meet all federal noticing requirements including:
- Appeal rights
- The right to be represented at the hearing by anyone of their choosing including an attorney, family member, or friend.
- The right to continued Medicaid payment for services currently provided pending an informal and/or formal appeal. This includes the right to reinstatement of services pending appeal if there was less than a 10 day interruption after the date of the notice.

V. THIRD PARTY LIABILITY (TPL)

Idaho Medicaid providers are required to bill all known TPL sources prior to billing Medicaid, except for prenatal or preventive pediatric care including EPSDT screenings and diagnostic services. [see IDAPA 16.03.09.215.05]

Treatment services under EPSDT are not exempt from TPL. The State will only make payment if all requirements for billing the third party have been met and the liable third party has not made payment within 90 days after the date the provider submitted a valid claim to the third party. Please refer to Section 2.11 of the General Billing Instructions Handbook (located at idmedicaid.com) for more information.

VI. EXCLUDED SERVICES

All services under EPSDT must be considered safe, effective, and generally recognized as appropriate under acceptable standards of medical practice. Services listed as "Excluded Services" in IDAPA 16.03.09.390 (including experimental and cosmetic) are not covered.

VII. CRITERIA

Services can only be covered under EPSDT if each of the following criteria is met:

a) Service(s) must be determined to be medical in nature
b) Service(s) must be safe, effective, generally recognized as an accepted method of medical practice or treatment
c) Service(s) must not be experimental, investigational or cosmetic
d) Must be a Medicaid (EPSDT) coverable service within the scope of those listed in the federal law at 42 U.S.C. 1396d(a) [1905(a) of the Social Security Act]. (e.g. "rehabilitative services" are a covered EPSDT service, even if the particular rehabilitative service requested is not listed in clinical policies or service definitions.
e) Service(s) must be medically necessary to correct or ameliorate (needed to sustain or support) an illness or a health condition.
f) Illness or health condition must be diagnosed by the recipient's physician, therapist, or other licensed practitioner operating within the parameters of their licensure.
g) Utilization of other services to treat the illness or health condition must support the medical necessity for the requested service.

VIII. PRIOR AUTHORIZATION PROCEDURE

To request EPSDT services (other than community based behavioral health or dental services (see Section X below)) an EPSDT prior authorization is required.

a) Medical Services
To request services outside service limitations, you must submit the following:

- Appropriate prior authorization form from the Medical Care Unit website (i.e. Therapies, durable medical equipment, surgical services, etc.)
- Documentation to support medical necessity and how the service(s) will correct, maintain or improve the participant's health
- Physician's order and any other documentation specified on the prior authorization request form

b) Other Services
To request services not listed on the Idaho Medicaid fee schedule (i.e. Intervention Services, Residential Behavioral Health Services) you must submit the following:

- EPSDT prior authorization request form, (available at www.EPSDT.idaho.gov)
- Documentation to support medical necessity and how the service(s) will correct, maintain or improve the participant's health
- Physician's order and any other documentation specified on the prior authorization request form

X. BEHAVIORAL HEALTH OR DENTAL SERVICES

Community based mental health services are provided under the Idaho Behavioral Health Plan by Optum Idaho's provider network. EPSDT requests for community based mental health services must be completed on the Optum Idaho EPSDT form. Click here for the form or contact Optum Idaho by calling 1-855-202-0973 or visit the Optum Idaho website. Prior authorization requests for behavioral health services not provided in the community under the Idaho Behavioral Health Plan should be requested through the Division of Medicaid. (*See Section VIII Prior Authorization Procedure* of this policy.)

Preventive and restorative dental services are provided under the Idaho Smiles plan by Managed Care of North America's (MCNA) provider network. EPSDT requests for dental services must be designated on the MCNA prior authorization form. Click here for the form or contact Idaho Smiles by calling 1-855-233-6262 or visit Idaho Smiles website.

XI. OUTREACH

The State utilizes several informing mediums for outreach to Medicaid participants.

a) Routine notices
Mailed to parents/guardians at appropriate intervals based on the child's age. These notices provide: general education and information about EPSDT screenings and contact information for services available through our managed care organizations.

b) Participant handbook
The "Idaho Health Plan Coverage Handbook" has a section dedicated to EPSDT. It's located at www.Medicaid.Idaho.gov.

c) **EPSDT website**
www.EPSDT.dhw.idaho.gov provides basic information for the general public on EPSDT, prior authorization information and federal and state guidance

XII. REFERENCES

Federal Law & References

- 42 U.S.C. 440.345(a) {1902(a)(10)(A) of the Social Security Act}
- Medicaid.gov
- Medicaid Manual (sections 5000 & 5010-5360)
- EPSDT – A Guide for States "Coverage in the Medicaid Benefits for Children and Adolescents"

IDAPA

- IDAPA 16.03.09.215.05
- IDAPA 16.03.09.880-882
- IDAPA 16.03.09.390

Other

- Idaho Medicaid Provider Handbooks
- North Carolina Medicaid EPSDT Policy [1]

[1] Idaho's policy was patterned after the North Carolina EPSDT policy.

LETTERS OF MEDICAL JUSTIFICATION CHECKLIST

I. General:

- The letter should be written on appropriate letterhead.
- The letter should be dated and signed.
- The letter should be easy to read and use topic headings.

II. Writer's Credentials:

- Establish writer's expert credentials by describing: expertise, licenses, education, current job title, and how long the writer has been doing this work.
- Include relevant classes or clinics taught by the writer or taken as a student, and any articles written that relate to the content of the report.
- If appropriate, attach a resume or curriculum vitae.

III. Relationship with the Patient:

- Describe writer's relationship to patient, e.g., consultant, treating doctor or therapist.
- Describe how often the writer sees or saw the patient (e.g., one time per month or two times per week).
- Describe how long the writer has been seeing the patient (e.g., six months or three years).
- State how familiar the writer is with the patient's diagnosis and medical needs.

IV. Patient's Disability:

- Educate the reader, who may not be a medical professional, about the patient's disability.
- Discuss primary and secondary diagnosis, if any, prognosis and any complications that affect the patient's functioning as related to the requested treatment/therapy/medical service, including medication side effects, if relevant.

V. Describe the Type of Treatment/Therapy/Medical Service/Durable Medical Equipment (DME) Being Requested:

- Provide a specific description of the requested treatment/therapy/medical service/durable medical equipment with a specific prescription, i.e. duration and hours per week, month, etc.

VI. State Why the Treatment/Therapy/Medical Service/Durable Medical Equipment is Medically Necessary:

- Explain what treatment/therapy/medical service/durable medical equipment is currently being used and why it is not meeting the patient's needs.
- Explain how the requested treatment/therapy/medical service will help to treat the patient's disabling condition(s), prevent the condition(s) from worsening, or prevent regression, i.e., why the treatment is medically necessary.

VII. Explain that the Recommended Treatment/Therapy/Medical Service/Durable Medical Equipment is the Least Costly Alternative:

- If asking for a more expensive treatment or device; explain why similar but less expensive treatment/therapy/medical services/DME will not meet the patient's needs that are to be address.
- Describe by name the other less expensive treatment/therapy/medical service/DME (and even the more expensive) considered and why it was ruled out.
- Describe whether or why the treatment/therapy/medical service/DME is within professionally recognized standards and is not experimental.

SAMPLE LETTER

[DATE]

IDHW- Division of Medicaid
P.O. Box 83720
Boise, ID 83720-0036

RE: (Patient's name), DOB:
Medical Necessity Request for (Name of Treatment/Therapy/Medical Service/DME)

To Whom It May Concern:

I am a (type of professional). I have been practicing for ___ years. I am board certified in _____. I have been (Patient's name)'s treating physician for ____ years. I treat (Patient's name) _____ times a (month/week).

(Patient's name)'s current diagnosis includes (include all) _____. He/She exhibits the following symptoms: (description) _____ These impairments in functioning have resulted in (increased isolation, loss of independent functioning, loss of ability to access community services, and the loss of education services, etc.) _____. His/Her prognosis is _____. He/She also experiences the following side effects from the medications he/she takes _____.

It is my profession opinion that (name of treatment/therapy/medical service/DME) _____ is/are reasonably calculated to prevent, diagnose, or treat conditions in my patient that endanger life, cause pain, or cause functionally significant deformity or malfunction. Further, there is/are no other equally effective course of treatment available or suitable for my patient which is more conservative or substantially less costly. The requested medical service meets professionally recognized standards of health care. I am specifically prescribing

(name of treatment/therapy/medical service/DME) _____ times/hours per week/month.

_____(Patient's name)_____ currently receives (#_) hours or (#_) days per month of (name of current treatment/therapy/medical service) _____ or uses a __(name of DME)___. This is insufficient to meet __(Patient's name)_____'s medical needs and keep him/her in his/her current placement at home and allow full access to his/her community. **In my profession opinion, additional hours/days of __(name of treatment/therapy/medical service/DME)_____ are medically necessary to treat _____(the functionally, significant malfunctions in mood, behavior, thought and affect, digestion, circulation and access to community, etc.)_____ caused by (Patient's name)_____'s _____(Patient's condition).**

There are no other equally effective courses of treatment available or suitable for (Patient's name)_____ that are more conservative or less costly available. Further, the prescribed _____(name of treatment/therapy/medical service/DME) are medically necessary to prevent (Patient's name)'s condition from worsening and/or to prevent regression. A prescription of additional _____(name of treatment/therapy/medical service/DME)_____ is within professionally recognized standards and is not experimental.

I believe that if ____(Patient's name)_____ does not receive these additional (name of treatment/therapy/medical service/DME)_____, he/she is at risk of a more restrictive, more costly placements, more expensive medical treatments and worsening of other symptoms of his/her __(condition)___.

If additional information is needed, please contact me at _____.

Sincerely,

[PHYSICIAN NAME]