

Medical Justification for Assistive Technology Funding
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Let me begin the presentation by saying this is my first webinar, so I apologize for the technical difficulty, we just got the camera up and rolling about two minutes ago, so it's fitting that we're talking about technology. Let me begin by saying, if you have questions, go ahead and post those questions and I'll take them throughout the presentation. We want to make this as interactive as possible. Second, everyone should have a copy of an evaluation, so please fill that out and send that back to Heather. Third, I just want to acknowledge that this presentation is in partnership with the Utah Assistive Technology Program, affectionately known as UATP. It looks like they're saying the sound is in and out as well, so I apologize, I'm not quite sure what to do with that.

Today's presentation is called Medical Justification for Assistive Technology. Some of you have heard this presentation before. I noticed Terry Holden is logged on, so it's great to have you participate Terry. I guess I should say the more things change, the more they stay the same and this is a template of a presentation that was developed a number of years ago and still we found to be very effective in terms of getting a wide array of technology funded through what we'll call the healthcare system. Specifically today, we're going to talk about Medicaid. So with that, I'm going to go ahead and get started. I want to talk about the process. One of the things we do here at the Disability Law Center is set up cases to see sort of their readiness for appeal and this process was developed a number of years ago in order for us to get past "no." We're basically in business to help people that have been denied assistive technology, but this process we've found to be quite effective on the front end if you go through the steps that we're going to talk about this afternoon. The hope and the intention is that you can prevent a denial. So, you need to answer what we've found are three very important questions. They're going to appear maybe trivial, maybe very intuitive, but you'd be surprised how often we can get into an issue and have difficulty if we haven't identified answers to these questions. The first question is, "Is the person covered by the insurance policy?" Again, there are a lot of issues that come up with this, whether the brother or son or family member is on the policy or not. We need to have a yes or no answer to this question in order to proceed. It should be a yes or a no. If it's yes, we can move onto question two and that is, "Is the item being sought covered by the policy?" We're going to go into what that means in a minute in terms of covered, but just to be thinking about in terms of a yes or no answer there. The third question is, "Is the item medically necessary?" Medical necessity is really a term of art and it is a legal term in this context that we need to understand and address and we'll go through the elements of the Medicaid definition. In another insurance context, medical necessity can kind of take on a little bit different flavor, but the basic principles range true. I'm hoping the sound comes through loud enough for folks. Just let me know if you're having an issue and I'll continue. So, that's the framework. If we can get answer to yes on all of those three questions, the likelihood of us getting our requested assistive technology funded is great. So, let's talk about what a covered service is. A covered service can be more than the two items that I've selected for today's presentation, but we found that these are the biggest covered service

categories in health insurance policies that we face. There are some nuances that we'll talk about and some other issues that come up. The first one is durable medical equipment, affectionately known as DME. We're just going to go through the Utah definition of DME and see how we can satisfy the requirements of fitting a lot of equipment within this area of coverage. So, the first one is, "Can the DME item withstand repeated use?" I think it goes without saying that in the assistive technology context, the equipment that we're looking at clearly is designed for repeated use just by its nature. Second, is it primarily and customarily used to serve a medical purpose? Again, this is going to require us to be creative and to not use this as an opportunity to exclude items, but to think outside of the box in terms of what medical purpose can mean and we'll go into that with some examples in a minute. Three, generally is not useful to a person in the absence of illness or injury. Four is appropriate for use in the home. For three, most of the people that we work with, there is no cure for their disability, so the idea that somehow the person is going to be cured is not necessarily an issue of concern for us here with item number three and the appropriateness in the home can be a tricky one and can be one that we see a lot of rationales for denial over in a number of different contexts. But again, for most of the things that we work with people for, to get in terms of AT is absolutely appropriate for the use in the home. Under this area of coverage, we need to make sure that we're satisfying all of the elements. That these are four elements grouped together that we need to go through and if we can answer "yes" to these four questions, we can move on to the next phase. But before we move on, I want to just talk about another area of coverage and it's a very popular area that a lot of equipment can get funded under and that's prosthetic devices. And again, I mean this requires us to think a little more critically about prosthetic devices than what we may historically have thought of as replacements for an extremity. When you look at the definition, a prosthetic device takes on a whole different meaning and it's important and that's why we're going to go over the definition. A replacement, corrective, or supportive device as prescribed by a physician or other licensed practitioner or other licensed practitioner of the healing arts within the scope of his or her practice is defined by state law. So far so good for prosthetic devices. One of the elements that we need to talk about in terms of where assistive technology fits. Traditionally, the first one is what most folks think about – artificially replaces a missing portion of the body. Number two, prevent or correct physical deformity or malfunction, including promotion of adaptive functioning, or the third one is support a weak or deformed portion of the body. These are not stand alone items and it really gives us an opportunity to fund a wide array of equipment within the prosthetic device category. Communication devices fall within this very well. When I first started many years ago, we got bath chairs for children funded within this category. I've seen car seats – just a whole host of assistive technology can be categorized as providing support for a weak or deformed portion of the body. Now that we know kind of two areas where we can satisfy the requirement of a covered service, DME, and prosthetics and a host of others, rehabilitation technology, supports for equipment provided by OTs and PTs. The list is actually pretty extensive, but for today's presentation, those are probably the two big ones: DME and prosthetics. Once we satisfy that, we're not done, we're not out of the woods in terms of actually getting the equipment funded and delivered to the person that we're working with. We need to satisfy the medical necessity definition and this is where we can run into some difficulties,

so we always go back to the language and use the language to address the equipment that's being recommended. A question just came in. I would argue if someone can't speak, is a communication device considered prosthetic? Absolutely. I think that the courts have recognized that there are a number of federal court cases where communication devices have satisfied prosthetic device coverage. Interestingly, in Utah, our Medicaid program has decided to try to cover communication devices in hearing and audiology and it raises a whole host of issues, but we feel very confident that communication devices can satisfy prosthetic devices. I hope that answers your question – that's a great question. Getting back to medical necessity, for folks that work in the AT world, it's very important for us to know the language and know what we're up against, so we need to satisfy this two part definition and I think it's worth just kind of going through. The service is considered medically necessary if reasonably calculated to prevent, diagnose, or cure a condition in a patient that endangers life, causes suffering or pain, physical deformity or malfunction or threatens to cause a handicap – there's a whole lot there and there's no equally effective course of treatment available for the recipient who is more conservative or less costly. Two very distinct parts of this definition and I think we need to look at them separately for a moment and sort of get our hands around this issue. Most of the equipment that we look at and work with and help folks with assists somebody with a functional limitation, so we feel, and we have been very successful in arguing its reasonably calculated within the prevention diagnosis or curing the condition, although nothing that we do actually cures a condition, but it does address the other malfunctioning issues that folks with disabilities face. That part of the definition is not a big problem for us. The big problem for us is the less costly course of treatment and I'm sure for folks that have been out there and doing this, if you've looked at denial letters or dealt with this before, you've seen your requested item come back and say well is the Jazzy – is there a different version, can we downgrade, is the Dynavox the requested speech communication device – is there a less expensive device? Medicaid really, really looks hard at this. And, I can say so do insurance companies. Most insurance policies have a clause around the least costly, most appropriate alternative, so it's something that we have to pay attention to and lead out on. It isn't necessarily a barrier to us if we know it and we address it. So with that said, we've now kind of gone through our test. If the person eligible, yes or no, they're either eligible for the policy, their eligible for Medicaid or they're not. If they are, is the item that we're looking at a covered item? Does it fit DME or prosthetic or a whole host of other issues and then is it medically necessary? We've done all that and we should be able to say, yes, yes, yes, and we're good to go. We're going to talk in a minute that we've laid the groundwork and we've put everything together, but for some reason, we still get a "no." That's just sort of the nature of the work that we do and the system that we're up against. So actually, Terry Holden was the one that worked with me a number of years ago to come up with some critical components when we're looking at dealing with medical necessity and how as advocates and medical providers and therapists we can do a better job building our case, identifying the elements early on so that we've established without a doubt that the requested item is in fact covered, so we found that these bulleted items which we'll go through are critical. Without them, we're going to run into problems, so the first one is diagnosis. So often we find ourselves kind of jumping the gun, leading out on the particular type of equipment without building the case around this as a person that needs equipment and what is it

about this person that's unique. What is it about this person that we can say to build the case? So diagnosis, absolutely important. Spastic cerebral palsy – use the clinical terms within the diagnosis – absolutely critical to do that. Medical history – put some language in the letter of medical necessity that paints the picture of what the person is up against, what they've been through, what their condition does. Next is prognosis. What's the long term outcome? There is yet to be a cure for cerebral palsy. Maybe the day will come, but right now what we're faced with, with most individuals is the prognosis is that their condition is going to worsen over time and without access to adequate AT, their life is going to be compromised. We need to address the issues around prognosis. We also need to look at evaluation results and developmental levels and this is more in the clinical realm, so if you're a clinician, this probably makes perfect sense to you. If you're not, it's something that if you're working with a speech therapist, an OT or PT, you'll want to make sure that you get copies of evaluations and that side of the therapy.

Documentation – this goes without saying. This may sound very, very basic, but you've got to build the record in the way to build the record is to get documentation and have access to that, so that includes a letter of medical necessity from your doctor and evaluation results. What I tell parents and therapists all the time – you've got to gather that information and hold on to it. It's going to serve you well in the future. Photos – photos and now videos are very, very important. A lot of times review committees don't know the type of technology that's being recommended. So, as the saying goes, a picture is worth a thousand words and video is even more powerful. I had a case a number of years ago of a child whose parents were requesting a power wheelchair and the kid was under two years of age and the review committee could not believe in their minds that someone that age could operate a power chair. They lived in rural Utah. We got a video of the child driving the power chair and it floored the review committee. All of a sudden the questions of, it's not appropriate, safety issues, those kinds of things we were able to address those quickly, because we had a video. And again, that goes for photos, especially with new technology. Creating a summary – again this may sound pretty intuitive, but it's absolutely important that you summarize what the requested item is. You can put it in medical context and paint an accurate picture. Signatures – again this may seem very intuitive, but more often than not we'll get a letter from a doctor without a signature or a therapist without a signature and we have to have it. You have to have signatures. With that said, those are the critical components when we're looking at our letters of medical necessity to satisfy that last definition. So now we've done all this work, we've created this great picture for our reviewers, so where does this lead us? And again having done this work now for a number of years, these questions just keep coming up time and time again and I think when you're looking at items using these as tools to test yourself to say, "How strong is my case?" The first question is, will it meet the patient or individual's medical needs, physical or mental disability, you need to be thinking about the equipment and you can substitute some words for individual or family member, but thinking about the physical and mental functional limitations are obviously important. Is the equipment medical or remedial in nature? I've always been surprised by the amount of equipment that we've been able to get funded that may have gotten dismissed on the first go around – car seats, bath chairs, standing frames, and walkers. People don't think of that in medical terms, but in fact, it does address a functional limitation and we have been successful in getting items like that funded. The next

question is the cost issues and that gets back to the two part definition of medical necessity. We always need to be thinking about money. I hate to be cynical and say that a lot of denials are based on money, but a lot of the cases that we see tend to be pricier items. We don't see a lot of cases that are lower end assistive technology, and maybe that's just a function that we're the Disability Law Center and we're advocates, but the cost issue is a big issue and when you look at some of the power chairs that are out there, upwards of \$20,000, you can be certain that reviewers are looking to make sure that upgrades are appropriate. Again as I said earlier, if you lead out on the issue of the cost, you can address it and use it to your advantage so you're not caught off guard. The next one is again that medical necessity definition and just to kind of be thinking about it in that context. What we're requesting, can it reasonably prevent, diagnose, or cure a condition? It takes us back sometimes to think of our work and assistive technology in these terms and that's fine, that's okay, but if we want to get funding through Medicaid or private health insurance policies, we have to be thinking this way. We have to get out of our mindset and into the medical model mindset. It's not a judgment, it's just a reality. I offer those questions up to be thinking about and to use and use to your advantage. So now that we've done all this work and we've laid the groundwork and I'm sure there's a number of you out there that over the years have followed this advice or similar advice, done everything, got your signatures, took photos, got a video, did all of that and you still got a denial. Well, again it's not a judgment on you or the individual per se, it's just a reality. It's just what happens, so I like to think that it's just the next step in the process and not to get too hung up on the fact that something's been denied. It's okay that it's been denied because there is an appeals process and you get a second bite out of the apple. A question just came up around a communication device that maybe more expensive. How could you justify that over another type of system? And again, going back as a speech/language pathologist would be going back to the individual and saying, what's their capacity? Is their vocabulary capacity high? Is their use rate high? Does the system really allow for them to communicate their needs to the fullest? If you can demonstrate through what the individual's functional limitations are, if you have an opportunity to do a trial period with some more expensive equipment that can be of a big benefit. It's probably not a black and white issue. I've seen it go both ways and what it really comes down to is the more expensive system really going to meet the individual's communication needs to the highest level to the most effective? If you can build the case and document it, I think you've got a shot. Here's a great question. Does Medicaid have a list of things they will never cover? Probably. Whether or not we would ever get access to that is another question. I think a number of us who have done this for a number of years have seen many iterations around lists. This issue has been litigated. For Medicaid there's a very interesting case called Thesario out there, I think was in Massachusetts where they tried to put a prescriptive list in place and said, "We're only going to do this and nothing else." That case has been overturned. There's been some Medicaid directive letters that says you can provide some guidance, but you can't have a list per se. I think our experience is somewhere in between and it's one of those issues where to administer the program, to be fair to Medicaid for a second, they are looking at something they need as some guidance, but with the worry of me just rambling on and on about lists, I guess a short answer is they could have a list, but they can't use that as the ultimate justification of why they wouldn't cover something, but we can talk about that a

little more. Another great question. So we've done all this, you've been denied, you missed the timeframe, how long do you have to wait to try again? Very good question. I've seen it play out a number of different ways. I would recommend if you can catch it early to just resubmit and send it through the system and see what kicks out. They may deny it again, but they denied it already and what you really want to do is build the record for appeal. I don't have a hard and fast rule for how long to wait, so I guess I would lean towards going quickly. Terry has a great question. So, the acronym is EPSDT, which is early periodic screening detection and treatment. This is a program within the federal Medicaid program for children. You'll hear it referred to in Utah as CHECK, but it's basically the EPSDT program. Her second part of the question is, Medicaid has to pay for something that is determined to be medically necessary. Under EPSDT, absolutely. I didn't get into the whole statutory framework of Medicaid because it can be kind of tricky business. We can say with a level of certainty that prosthetics and DME are covered. Now we get into a whole host of other issues. Where to begin? Those issues being services that may be outside the state plan. In order to participate with Medicaid, the state says yes, we're going to participate and they get a federal match and they have to provide what are called core covered service items. They can do more, they can't do less. For children, if the item being requested is medically necessary, they have to provide it even if it's not in the state plan. It's fabulous and Terry and I have seen a ton of stuff get funded for children, but not for adults. If you're working with the population under 21, you really have an opportunity to get a whole host of equipment more easily than you do when you age out of that category. You're still eligible for Medicaid, but the benefit looks different. That's an excellent question. I'm hoping I was able to get at what you were asking there. We've done everything which we thought was right and here we are with a denial. What do we do? The most important thing to do, this gets back to the question about missing a timeframe is getting a copy of the denial letter. If you don't have a copy of the denial letter, you don't know when the clock has started. We've heard time and time again from insurance companies that we're just going to give you a verbal denial. Well, you have a right to have your denied claim put in writing and I tell just about everybody that I come in contact with in this area that you need to get it in writing, request it in writing. If they won't put it in writing, usually you can find someone you can leverage to get that in writing. In Medicaid, it's actually within the statute. There's a whole language out there about denial letters, what they require in terms of an appropriate notice, what your due process rights are and they need to be spelled out in the denial letter. It's the cornerstone of the appeal to get the denial letter. When you get the denial letter, you're going to need to look to see what your timeframe is for appealing. Thirty days in Medicaid. You've got to watch in some cases whether or not they allow date of mailing. I believe in Medicaid it's 30 days, so as advocates, we pay very close attention to that and don't try to do any fudging with the mailing date. Private insurance can get a little strange. I believe Blue Cross Blue Shield right now is around 180 days, so you go from 30 to 180 and everything in between. The next thing you're going to want to do is contact the individual who did the evaluation. If you are the evaluator yourself, you've obviously got that covered but for parents or family members, you're going to want to talk to the therapist. If it's a communication device, it's going to be your speech/language pathologist. If it's a wheelchair, it's going to be your OT or PT. You're going to want to contact them early and see if they can help you. You can also contact the

Disability Law Center anytime during this process. We can walk you through some of the steps we're going to need to get a paper trail started and that usually starts with the denial letter for us to take a case. Again, these are common sense advocacy approaches, but it is absolutely critical that you keep all correspondence, evaluations, and prescriptions. I didn't touch on the idea around medical necessity, that letter of medical necessity and prescription needs to come from the doctor. The therapist can do the writing. Building the paper trail is absolutely important. The prescription can actually just be something on letterhead from the doctor's office and then a full letter of medical necessity can be done and I've seen advocates provide doctors and therapists outlines, I've seen it done a number of different ways. The bottom line is you want a good letter of medical necessity and you want copies of correspondence and evaluations to build the case. The last piece that we touch base with is being aware of the appeal time frame. The question earlier was spot on. I saw a couple of cases regarding communication devices recently miss the deadline for whatever reason and they're going to have to start all over again. That's unfortunate, but that's what we're up against. I believe that's the thrust. We've got some stuff around the appeals process. I'll go into some more detail on some things, but let's talk about the appeals process and this is the last slide before I put up my contact information. This is where the rubber meets the road in terms of the practicality of the evaluation process and the trial period and the selection and doing all of that stuff and then really trying to get it passed. I guess that's the message that I really want to send to people today is, you've done all this fabulous work, you've put a lot of time, energy and effort in, don't take no for an answer – as the final answer. Appealing is absolutely critical. If it wasn't for advocacy efforts over a number of years, we wouldn't see things like communication devices being covered. With that said, it looks like we've got another question. The PowerPoint I can make available for download and I apologize for the sound, I'm not sure if it's me. I can make this Power Point – between myself and Heather, we can absolutely make sure that folks get a copy of this. We've got additional information around flushing out medical necessity issues and further steps around the appeals process. This is an overview of that and we can provide additional information if people would like. So, what is it about the appeals process? Let's take a look at it and break it down with some helpful advocacy tips that I've found over the years to work quite well. For Medicaid it's very straightforward. It's a one page form that is required to start that process. It hasn't gone electronic yet. To my knowledge, we're still getting that hard copy. We fill it out with basic client information. The reason we feel the issue should be overturned and list folks that we want to be included. This is where working with your therapist and doctors to get their name on that list. I always think it's nice to build that case and let Medicaid know that you've got a cadre of medical professionals standing behind it and they're going to be available for the appeal. I'm just reading a second question regarding communication devices. The Medicaid rate issue. Yes, it's an issue. Dynavox has gotten better. I can't say that the problem is solved, but we hear that all the time from vendors, around wheelchairs, you name it, a whole host of issues. This is not a simple problem. Terry's got a question around a high end wheelchair. Medicaid is going to say, or there's a private insurance and it looks like they've got dual coverage and the vendor wants to bill the family for the balance. Is this legal? I would want to talk about the specifics of that. Those are tricky. I don't have a definitive answer for that. We've seen that time and time again. I think it's worth pushing Medicaid on, especially if they're

only doing the 20 percent. I think it's problematic that the vendor is trying to leverage the \$3400 from the family. I don't like those cases. I'm not completely answering the question Terry, but that would be one I would want to talk in greater detail about. That is a problem. We see that a lot with Medicare that the rate is way too low, that vendors won't even opt in. We've seen it come up with communication devices. We've seen it in a number of different settings. So the question is if a person has been denied Medicaid, so that's just being eligible for the program. No, I don't know the answer to that off the top of my head. Unfortunately our advocacy efforts are geared for folks that have already established that. I don't know the in's and out's of that eligibility process but there are folks out there to call and to follow up. I don't have that available in front of me so I apologize. That's a great, great question. These are going to seem pretty straight forward common sense, but you've got to do them. The big one I learned early on is using return receipt. Medicaid uses the 30 day time frame, so I want to know if I submit an appeal that the clock is also running from our end, that we then have a date record. We know when they got it and we can monitor and follow-up and that goes true with private insurance also and I'm sure that folks have experiences out there that things just get lost and when it comes to appeals, having proof can really be a great way to cover yourself. It just goes without saying, do a return receipt for all correspondence with your insurance provider. In the Medicaid context, we have really found that the pre-hearing conference is just critical. A full blown hearing can take some time. You get the appeal, you've got 30 days, you try to get all your stuff together, you submit and then scheduling and back and forth, back and forth. We use the fact that the administrative law judge at Medicaid is good. She is thoughtful, she's smart and she's over turned a ton of denials in our favor and we use the conference call with her to try to get the issue resolved as quickly as we can. So we try to get the party members there. If it's a therapist around a particular piece of equipment, we'll typically ask them to be on the conference call with us. The individual doesn't have to participate or the parents or family members. We make that available if they want to. Typically they don't, just because it's a lot of jargon back and forth. That's their decision. We offer that to them. A lot of times it's an exercise in, oh we didn't get that, or could you fax us that, or we'll take a second look at that. We can get those issues resolved at the pre-hearing, but you can't get a pre-hearing unless you submit a formal appeal and I've seen a ton of stuff get settled before going to a full hearing by utilizing the pre-hearing call. Then if you can't resolve something within the pre-hearing, a formal hearing is set up. Utah is very lucky that we've got a very thoughtful, intelligent administrative law judge who understands assistive technology, understands the Medicaid statute and regulations and applies them very fairly, so we've got a very solid track record with getting decisions over-turned. We just did a case outside of the AT realm, but within this process for a type of surgical intervention that was denied, went to a full hearing and got that approved, so I just put that out there. A couple other questions that I want to look at and address. The question is, if you've got double coverage, Medicaid is supposed to pick that up. Yes. The problem is more times than not they won't, or the vendor will for whatever reason not seek that reimbursement from Medicaid, or try to stick it to the parents. When there is that dual eligibility piece, yes, it's supposed to happen. The second question, unfortunately the video is skipping for this person and I apologize, I'm not sure what is happening on that front. Those are some really great questions. I offer up, if folks want

to take some time, we were scheduled for an hour plus questions and I think we're at about 50 minutes. If folks have some other questions, here's our contact info. Also, check out our website. We try to keep it updated. Our big issue that we're working with right now is a rule change in Medicaid to limit durable medical equipment and some other things around communication devices. We provided some testimony and some written testimony. We have not heard back from Medicaid on that. That was over the summer. We thought it would come out in mid-August, we're now into October and it hasn't happened so that's an issue that we're watching. Terry is just typing this information about the Medicaid rate issue and they cannot be billed, so that you for that Terry. You've got to be careful with vendors with that. We've seen that happen where the vendor will try to recommend an expensive piece of equipment which may be appropriate and Medicaid will come back and say, well we'll downgrade it and then the vendor will say, ya but you covered the other part of that. There's a lot of gray area in between. You've just got to be careful about that. A couple other questions, has Medicaid ever paid for a computer for a child that can't write, shown progress in school? That's tricky, because Medicaid's very good about saying if it's a child with a disability that's in school, where does the distinction become between an item for educational benefit versus an item for medical benefit. I can't think of a case that I've come across where Medicaid has paid for a kid that can't write. That's not to say that something hasn't come out. You may have more luck with something like that in terms of written communication, getting it on the child's Individual Education Plan and getting it funded through Special Ed. That's an interesting one – I haven't seen that. The next question is an individual's power chair hit by a car. I'd like to hear about that case that Medicaid says that they used the chair outside the home; therefore they won't pay for it. I'm just going to bite my tongue and not editorialize too much on that. I mean it's just absurd. Medicaid likes to hide behind this whole in home use thing and it just doesn't hold water. Medicare unfortunately has a ton of stuff out there about the use in the home. It's a completely different program believe it or not, statutorily, Medicaid likes to adopt Medicare. Terry raises the question of ya, why not get the person who was hit, get their insurance to cover it and you wouldn't have to deal with Medicaid – so that's another angle. To say that they're not going to cover it because a person used it outside the home – that's just crazy. Here's a question about Medicaid and wheelchairs and getting a power chair for a child and again around the use in the home. The use in the home thing – don't buy it. They're going to say it over and over again. It's not an appropriate justification for a denial. If you follow those steps that we went through in the PowerPoint in terms of if the kid's eligible, you can get the therapist to do an evaluation and get the appropriate documentation, find a vendor and I would really advise taking time to shop around to find a vendor. We could go into vendor issues – we're dealing with a whole host of vendor issues around repairing chairs and timeliness of repairs. I think it makes sense for parents and consumers to really push that issue and to look at that. A vendor will gather that needed packet and submit it to Medicaid. If the vendor is telling you, we're not going to do that because Medicaid won't pay for things that are used outside the home; the Disability Law Center absolutely wants to hear about it. I hope that answers your question. It looks like the question around the wheelchair and the car – hit and run, so I guess trying to track down that private insurance. The car insurance carrier is not an option with a hit and run, but getting a police report would be good and I would use that in a Medicaid justification to say you

need to repair this. That's a great question. Other things that are coming up. I guess for us the big ones are obviously the communication devices and wheelchairs are probably our two biggest ones right now and communication devices, we thought we had this settled about 10 years ago and it turns out that Medicaid has figured out a creative way to deny them all over again, so we're running through those hoops. That's what we're up to and again, our website has a ton of information. We've got an 800 number. The other thing that I didn't say is our services are free. That's probably one of the greatest things I can say about my job is that we do this with no cost to the individual in terms of representing and helping. A couple of other questions that have come in, let's see, one question is on a wheelchair that was stolen. There you go. A stolen wheelchair covered by Medicaid. I love it. The creative way they're denying communication devices is they are saying they recognize that communication devices are a prosthetic. They meet the definition of prosthetic devices, but they've decided to categorize them as a benefit under audiology or speech and hearing, which is fine, they can do that. It's an optional service within Medicaid. They then make the leap that says, okay we'll cover these, but we're not going to cover them for adults, because it's an optional service and we only have to do medically necessary services for children. That goes back to Terry's question about why it's so important to look at kids and their medical needs and get things covered, so the creative way is they're saying, we've decided on our own that communication devices fit outside a different covered service area – not prosthetics and we can limit that. The center for Medicaid services CMS allows us to do that and we've just seen a host of those come through and we're challenging those, so that's one creative way that really, really startled me that they looked at the coverage issue creatively sort of like I do to see what we could fit in there and they looked at ways to exclude it. I hope that answers your question. Is a shower chair considered durable medical equipment? I would argue absolutely yes. I actually started as an AT advocate many years ago. My first cases involved shower chairs and we were successful in getting those covered. We went to bat and said that hygiene is an essential part of someone's medical condition and if you don't pay attention to hygiene issues, it can result in skin breakdown, all the way up through decubitous ulcers and you're going to end up having to treat those if you don't provide a way for someone that cannot sit independently to be bathed. To be honest, shower chairs aren't that expensive. Over the years I've seen them fund them, deny them, fund them, deny them, we just go round and round. I would argue that they absolutely fit. A question regarding a recent public hearing that was held regarding the DME rule in home. A majority of consumers and advocates wanting the in home language taken out. So what's Medicaid's responsibility to respond to the public hearing? Perfect question and thank you for bringing that up. That's what I alluded to earlier. We're waiting. They are supposed to publish the rule, as far as we know, they have not published the rule. If you were there at the hearing, you heard our side of the story and how upset we were about it and we've been monitoring it on a daily basis. I believe they publish those rules twice a month, but we've got it flagged and we look to see when they are going to address that in home rule. We feel it's completely inappropriate, it's not part of the Medicaid statutory framework and we're going to challenge it. We hope to see them do the right thing. Another question regarding kids and the lifetime communication needs. It's not to say that you can't get the devices over the age of 21 and I would argue that Utah Medicaid, as long as they remain Medicaid eligible, it's a covered benefit. It should not be an issue.

If they are under 21, it's just more straightforward. Once they've got it, until Medicaid changes, you should be able to go back to Medicaid for a repair or other communication device issues that arise after the age of 21. Twenty-one is not an area of distinction for Medicaid regarding communication devices. They like to think so, they continue to say it, they continue to interpret it and we continue to challenge them. I hope that answers your question – excellent question. Good question regarding standing frames. A vendor recently told me that only certain standing frames would be covered, but they didn't say which ones on the list. I have not heard that particular one. It doesn't surprise me. We've gotten standing frames covered. I don't know a lot about standing frames. They can be tricky and I think all the basic advocacy rules apply in terms of the documentation. There are some fabulous studies out there to talk about passive standing and the medical benefit. I don't think it's an issue in terms of whether or not they're recognized and covered, but then it just gets to be what type of models and I think those are good cases to challenge and to fight for to make sure that they're not excluding equipment that could be of some benefit. I hope that answers your question. Excellent questions. We've got time for more, so I'm willing to sit and take questions if folks would like to do that. I've appreciated the questions so far – these are excellent. Keep them coming if you want. That's the overview of where we are and I guess I can say in the number of years that I've been doing this, we see patterns over time. Things get covered and we get creative about how to get things covered, we go along for awhile thinking we're done and all of a sudden, the other side gets creative about ways to deny it and then we're back to where we started. We thought we had this communication device issue settled back in 1998 and we did a federal lawsuit, but here we are in 2007, nine years later and we're fighting it all over again, but that's what we do and why it's so important to stay vigilant and to be communicating with each other around these things, because a lot of stuff as you'll know, the perception out there can be very, very difficult. Medicaid is a very difficult program to understand. Medicare is even more difficult. Private insurance has its own complexities. Information that people get can be very, very confusing and those perceptions then play out. Vendors won't evaluate or submit, people won't ask, and we see that kind of trickle through the system and that's why we're here to really keep that check in the system alive and make sure that folks get the items that they need. This kind of dialogue is really, really important, because we need the support of each other in order to challenge denials and get things funded. I think the thing we will be looking to do is when we hear about the DME rule and I really appreciated the comment about the in home use that we'll be letting folks know one way or the other. We're kind of bracing ourselves for the bad news and we'll celebrate if it's good news. But, we're not out of the woods yet on that, so all the folks out there that are doing wheelchair issues and work with Medicaid, this is something to really watch. We're nervous. Heather has mentioned that we will have this presentation available on the UATP website and we've got to thank and love UATP. They do a fabulous job and they were able to walk me through this, so I recommend that if anybody was to try to do a webinar, if we can pull this off in a short amount of time, it can be done, so I'm very, very pleased by that. Are there other things that people are dealing with? Private insurance issues is a huge one. That could be a whole other training in terms of contract implications. They're able to write excluded items in. I've seen contracts or insurance policies that exclude communication devices. We've tried to challenge those and have been unsuccessful. Hearing aids is a huge

issue in terms of coverage or lack of coverage, so that's out there. Another question coming in regarding someone's doctor. This is a good question in terms of the old, "there's no reimbursement code for the item that I'm requesting." Well, Medicaid has a catch all reimbursement code in the hit pick codes there is one out there. Whether or not that would specifically meet our case criteria, that's a hard one, because it's sort of the denial before the denial, but at a minimum, please call our office. Our phone numbers are up here and we could have an advocate or someone walk through that process. Another minimum is to say fine, if you can't find an authorization for it then you can write me a denial letter and tell me that in writing. I've seen that before. It's very, very frustrating. I hear you – no pun intended on that one, but it's difficult – it's something that Medicaid likes to hide behind. Glad to hear that for other people it worked well for them. Some folks typing in their responses. I did a prior authorization regarding not being able to find a code for their bone conduction hearing aid, therefore we can't process it. I guess they're being creative like we are, but don't take this as a final no. They've got a catch all code. Other questions? A question regarding a vendor for a wheelchair for a student. That's a great one. I love these stories. The scenario is that they had a vendor working with a kid trying to get a wheelchair and the vendor said that Medicaid wouldn't pay for it so the individual asked to talk to Medicaid personally. The vendor said, "No you can't do that." Ten months later, which you would argue can be an eternity for someone that's needing a chair, but the good news is the person got the chair, so to me; the lesson there is that you've got to push for those. Great to hear that. It's too bad they had to wait 10 months, but it's always fun to push a vendor in order to get something funded. Other stories or interesting issues people are facing just to use this time while we've got it? We still have quite a few folks signed on, it looks like a few folks have signed off and again I'm available for the next little bit for additional questions so I can hang out for a couple of minutes and see what we've got. Looks like folks are starting to sign off in larger numbers. Why don't we just wrap it up? You've got the contact information here. If you have issues or concerns, let us know. We'd love to help you out where we can. Thank you so much, I really appreciated the opportunity. A big thank you to Utah Assistive Technology Program – they do a fabulous job and it's always a delight to partner with them. They really are the experts in setting this up and getting the technology together to do this and I greatly appreciate the opportunity. Thanks everybody. I will begin to sign off.