



## **HOW TO APPEAL A MEDICAL ASSISTANCE DENIAL OF ASSISTIVE TECHNOLOGY**

### **I. INTRODUCTION**

Assistive technology devices and services are very important to a person with a disability. Assistive technology devices and services help a person with a disability to perform everyday tasks. Examples of assistive technology devices are manual and motorized wheelchairs; scooters; augmentative communication devices; hearing aids; eyeglasses; and other durable medical equipment, medical supplies, orthotics, and prosthetics. Assistive technology services include an evaluation, adaptation of a device, training in the use of a device, and maintenance and repair of a device.

Medical Assistance (Medicaid) requires a prescription from your doctor. Many items of assistive technology require prior authorization in addition to the prescription. There are some items that are not usually covered by Medical Assistance for which your doctor will have to request a program exception instead of prior authorization. Your doctor will know which items require something besides your prescription. You will find more information about the prior authorization/program exception process in Section II below.

You have rights when Medical Assistance (Medicaid) denies prior authorization of, or denies a program exception for, the assistive technology device or service that your doctor prescribed. These rights also apply if Medical Assistance authorizes something less or different than what your doctor prescribed (approved other than as requested). You have these rights whether you get your Medical Assistance through ACCESS, ACCESS Plus, or a Medical Assistance managed care health plan, including HealthChoices.

Your rights include:

- The right to a timely written notice from Medical Assistance or your Medical Assistance managed health care plan explaining why the assistive technology is being denied, including why something less or different is being approved.
- The right to a fair hearing through the Department of Human Services, which runs Medical Assistance, including the Medical Assistance managed health care plans. The fair hearing will be before a neutral hearing officer who was not involved in the decision to deny the assistive technology.
- The right to present witnesses, documents, and other evidence in support of your need for the assistive technology.
- The right to make the other side (Medical Assistance or the Medical Assistance managed care health plan) present its evidence before the hearing officer.
- The right to a timely appeals process.

This manual will explain these rights when Medical Assistance, including your Medical Assistance managed health care plan, denies prior authorization or denies a program exception. This includes an approval of something less or different than what your doctor prescribed (approval other than as requested).

This manual does not cover the complaint/grievance procedures of Medical Assistance managed care health plans, including HealthChoices. When you are in a Medical Assistance managed care health plan, in addition to the fair hearing rights described in this manual, you also have the right to file a complaint/grievance. Contact the Special Needs Unit of your Medical Assistance managed care health plan or contact our office for more information on how to make a complaint/grievance. Be sure to follow the complaint/grievance deadlines as stated in the letter from your Medical Assistance managed care health plan.

This manual also does not cover the appeal procedures for Medicare or private health insurance.

## **II. PRIOR AUTHORIZATION**

In order to have your assistive technology device or service approved for payment by Medical Assistance (Medicaid), including your Medical Assistance managed health care plan, you will need a prescription from your doctor. It is a good idea to get an evaluation by a qualified medical professional—such as a doctor, physical therapist, occupational therapist, speech-language pathologist, audiologist, or ophthalmologist—which will help your doctor decide what assistive technology device or service to

prescribe. This assistive technology evaluation must also be prescribed by your doctor. The evaluator should make a written report that includes why you need the assistive technology device or service and how the device or service will help you.

Generally, your doctor must then submit a prior authorization request (or program exception request for items or rates not on the Medical Assistance fee schedule) to Medical Assistance or your Medical Assistance managed care health plan to get approval before Medical Assistance or your Medical Assistance managed care health plan will pay for the assistive technology. The prior authorization or program exception request includes a prescription, letters of medical necessity from your doctor and evaluating medical professional detailing how the prescribed assistive technology device or service meets the Medical Assistance definition of medical necessity, the evaluation report, and any required forms. It is important that you ask for and keep a copy of the prior authorization request or program exception request and other documentation that is submitted. After receiving a request for prior authorization (but not after receiving a program exception request), Medical Assistance, including the Medical Assistance managed care health plan, has 21 days to take action on your doctor's prior authorization request by approving the request, in part or in full, or by denying the request. This 21-day rule does not apply to a program exception request, but Medical Assistance or your Medical Assistance managed care health plan must still act upon the program exception request by approving the request, in part or in full, or by denying the request.

If you need more information on how to request prior authorization or a program exception for assistive technology, please review our brochures on this topic, which can be found on our website at [www.disabilityrightspa.org](http://www.disabilityrightspa.org) or requested at the address in Section X below. These brochures also contain a suggested outline for a letter of medical necessity that you may wish to provide to your doctor and evaluating medical professional.

### **III. DECISION NOTICE**

When either a prior authorization request or a program exception request is made, Medical Assistance (Medicaid), including your Medical Assistance managed health care plan, is required to send you a written notice when a decision is made to approve or deny the assistive technology device or service that your doctor has prescribed. This includes a decision to deny what your doctor prescribed and approve something less or different (approved other than as requested). If denied, the notice should give you the reasons for the denial, including the reasons for the approval of an alternative item, as well as information on how and where to appeal. Be sure to keep the written decision notice.

**You can appeal a denial and request a fair hearing, including when something less or different is approved. You should follow the instructions in the notice and mail an appeal, requesting a fair hearing, as soon as possible but not later than 30 days from the date on the notice (or 10 days if you want a continuation of services already being received). The appeal must be postmarked or hand**

**delivered by the 30-day or 10-day deadline.** More information on how to make your appeal is in Sections IV and V below.

You may get a denial (including an approval of a different item than was requested) because not enough information was submitted in support of your doctor's prescription. If so, you should appeal and request a fair hearing as soon as possible while taking other steps at the same time. These other steps include working with your doctor, the evaluating medical professional (e.g., physical therapist, occupational therapist, speech-language pathologist, audiologist, ophthalmologist, etc.), and the assistive technology provider to ensure that more written documentation is obtained and submitted to Medical Assistance or your Medical Assistance managed health care plan. This additional documentation should provide more information on the need for the assistive technology and show why the reasons stated in the decision notice are incorrect. This additional documentation may be in the form of supplemental letters of medical necessity and other clinical documentation. Be sure to send all items *certified mail-return receipt requested*. Send copies of the additional documentation and keep the original documents and the signed return receipt for the fair hearing. It may also help for your doctor to contact the Medical Assistance or the Medical Assistance managed care health plan medical director as soon as possible for a peer-to-peer discussion regarding the decision notice and medical necessity.

You can appeal and request a fair hearing and provide more information to Medical Assistance or the Medical Assistance managed health care plan at

the same time. If your request for the assistive technology is approved by providing more information, you can always withdraw your appeal.

#### **IV. APPEAL DEADLINES**

##### **A. Times to Appeal**

You must appeal within the following deadlines to ensure that you protect your right to have a fair hearing:

- 1. Within 30 days of the date of the notice that gives the decision that you are challenging.**
- 2. Within 10 days of the date on the notice for a change, reduction, or end to services that you are already receiving if you want your services to continue during the appeal.**
- 3. Within 60 days of any decision for which no written notice was sent and was not required to be sent.** A written notice is required when your doctor's prior authorization request or program exception request is denied, however.
- 4. Within 6 months of any decision for which no written notice was sent but was required to be sent.** This may be the case when you have gotten a verbal denial of your doctor's prior authorization request or program exception request. Also, if you have had no response from Medical Assistance or the Medical Assistance managed health care plan within 21 days of your doctor's request for prior authorization, you can appeal and ask for a fair hearing.

If you did not get a decision notice but got a verbal denial, you can send your appeal to:

If ACCESS or ACCESS Plus:  
Department of Human Services  
Division of Operations  
P.O. Box 8171  
Harrisburg, PA 17105

If Medical Assistance managed care health plan:  
Department of Human Services  
Office of Medical Assistance Programs  
HealthChoices Program  
Complaint, Grievance, and Fair Hearing  
P.O. Box 2675  
Harrisburg, PA 17105-2675

You should send your appeal letter requesting a fair hearing and copies of documentation to support your appeal *certified mail-return receipt requested* to the Department of Human Services, at the address listed in the decision notice. If you are in a Medical Assistance managed care health plan, send a copy of your appeal letter to the health plan but be sure to send the original appeal letter to the Department of Human Services. Send copies of your supporting documentation and keep the original documents for the fair hearing. Also be sure to keep a copy of your appeal letter as well as the signed return receipt.

## **B. Good Cause for Late Appeals**

You may be allowed to file an appeal late, but only if good cause is shown. Good cause is narrowly defined as only a few types of circumstances. It is best not to rely on this but to file your appeal on time. However, if you do file the appeal past the deadline, the reasons that you filed late must be included with your appeal. The hearing officer may still reject your appeal, though, if good cause is not met.

## **V. WHAT TO INCLUDE IN YOUR APPEAL REQUEST**

Read carefully the instructions for requesting a fair hearing that are contained in the decision notice from Medical Assistance or the Medical Assistance managed care health plan. A sample appeal letter is in

Appendix 1 of this manual, but following are important items to include in your appeal letter.

**A. Copy of Decision Notice**

Include a copy of the decision notice. Be sure to keep the original notice for yourself in a safe place.

**B. Prior Authorization or Program Exception Reference Number**

If you are in ACCESS or ACCESS Plus, include the prior authorization or program exception reference number printed on the first page of the decision notice.

**C. Your Daytime Telephone Number(s) and Other Information**

Include telephone numbers where you can be reached during the day. Include your Medical Assistance number and date of birth as well.

**D. Request for Fair Hearing**

It is very important to state that you want a fair hearing. Remember, your appeal right includes the right to a fair hearing through the Department of Human Services that is before a neutral hearing officer who was not involved in the decision regarding the assistive technology.

**E. Reasons for Appeal**

Include a statement of the reasons for your requesting a fair hearing. This can be as simple as, "The doctor prescribed this equipment, and I need it. I do not agree with the denial."

## **F. Location of Fair Hearing**

State whether you want a telephone or in-person fair hearing. In-person fair hearings usually give you the best opportunity to explain to the hearing officer why you need the assistive technology. The disadvantage of an in-person fair hearing is that fair hearings are only held at six different locations: Harrisburg, Reading, Plymouth, Philadelphia, Pittsburgh, and Erie.

If it is a hardship for you to get to one of these fair hearing locations, you may prefer a telephone fair hearing. The hearing officer can call you at your home phone, a phone at the County Assistance Office, or some other location such as a provider or doctor's office. Because you will likely need more witnesses than yourself to testify, it might be more convenient to gather at the speaker phone at the County Assistance Office or your doctor's office. You do not have to specify a location for your telephone hearing in your appeal letter, but you should include your daytime telephone number so that the hearing officer can contact you to arrange for the telephone hearing.

## **G. Length of Fair Hearing**

You should request that your fair hearing be scheduled for a sufficient length of time. You should request a minimum of two hours for your fair hearing. If there is a lot of complicated medical information or more than one witness who will testify, you can request more than two hours. If you run out of time, the fair hearing may be continued to a later date.

## **H. Accommodations or Interpreters**

If you need any accommodations due to your disability, or if you need an interpreter (sign language or a language other than English), be sure to include this information. You should state what accommodation or interpreter you request and why you need it.

## **VI. PREPARING FOR THE FAIR HEARING**

The fair hearing system is designed to be less formal than court and available for individuals to use without having to hire a lawyer to represent them. You are entitled to bring a lawyer or advocate with you, however.

To prepare for the fair hearing, you need to gather evidence to disprove the reasons given in the decision notice from Medical Assistance or the Medical Assistance managed care health plan to deny the assistive technology, including an approval other than as requested. Some items are denied (or a cheaper substitute is approved) because it is claimed that the items are not medically necessary. Devices and services are medically necessary if they meet the following three standards: 1) Compensable under the Medical Assistance Program; and 2) Necessary to the proper treatment or management of an illness, injury, or disability; and 3) Prescribed, provided, or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice.<sup>1</sup>

A device or service is “necessary to the proper treatment or management of an illness, injury, or disability” if it meets one of the following standards:

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<sup>1</sup> This is found in Pennsylvania regulation 55 Pa. Code § 1101.21.

(1) Will, or is reasonably expected to, prevent the onset of an illness, condition, or disability; (2) Will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (3) Will assist the Medical Assistance recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and those functional capacities that are appropriate for recipients of the same age.<sup>2</sup>

Whatever the reasons that Medical Assistance or your Medical Assistance managed care health plan gives in writing to deny the assistive technology, including an approval of something less or different, you will need to gather evidence to convince the hearing officer at the fair hearing that the reasons were incorrect. This evidence is usually in the form of documents and the testimony of witnesses. You can also be a witness yourself and communicate on your own behalf about why you need the assistive technology and what you will be able to do using the assistive technology that you would not be able to do without it.

### **A. What You Need to Prove at the Fair Hearing**

What you need to prove at the fair hearing will depend on the reasons stated in the decision notice from Medical Assistance or the Medical Assistance managed care health plan and the unique facts of your situation. The reasons given in the notice should be the only ones that you need to address in the fair hearing. At the fair hearing, Medical Assistance

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<sup>2</sup> This is found in Pennsylvania regulation 55 Pa. Code § 1101.21a.

or the Medical Assistance managed health care plan is not allowed to bring up any other reasons besides those listed in the notice.

It will be helpful to gather evidence that answers the following questions:

1. What is the disability, illness, condition, or injury that you have?
2. How does your disability, illness, condition, or injury affect or limit your functioning?
3. What is the assistive technology device or service that your doctor has prescribed?
4. How is the assistive technology specifically medically necessary for you? For example, how will the assistive technology prevent the onset of a disability, illness, condition, or injury? And/or, how will the assistive technology reduce or make better the physical, mental, or developmental effects of your disability, illness, condition, or injury? And/or how will the assistive technology maximize your functional capacity and make your functional ability more like that of a Medical Assistance recipient your age who does not have a disability?
5. What less expensive alternatives were tried or considered? Why are they not appropriate, not adequate, and do not meet medical necessity?
6. What more expensive alternatives were tried or considered? Why, at the current time, is it more appropriate to start with the less expensive alternative being prescribed?
7. Why, at the current time, is the assistive technology being prescribed more appropriate than the alternatives suggested by Medical Assistance or the Medical Assistance managed care health plan?
8. What are the risks or consequences to you if the assistive technology is not provided?

9. Have you shown that the reasons given for denying the assistive technology, including approving an item other than as requested, were incorrect?

## **B. Documents for the Fair Hearing**

Documents that can help answer these questions can include the following:

1. Your medical records: You can request your medical records from your doctor, evaluating medical professional (e.g., physical therapist, occupational therapist, speech-language pathologist, audiologist, ophthalmologist, etc.), and/or assistive technology provider.
2. A copy of the doctor's prescription, letter(s) of medical necessity, evaluation report, other reports, and the prior authorization request or program exception request that was submitted to Medical Assistance or your Medical Assistance managed health care plan. You can get these from your doctor, evaluating medical professional (e.g., physical therapist, occupational therapist, speech-language pathologist, audiologist, ophthalmologist, etc.), assistive technology provider, Medical Assistance, and/or the Medical Assistance managed health care plan.
3. A copy of the file kept by Medical Assistance or the Medical Assistance managed health care plan, including your prior authorization request or program exception request, and anything developed in deciding to deny the assistive technology or to approve something less or different. Appendix 2 contains a sample request letter that you can submit, which will get you a copy of the file and other useful information (such as a witness list, discussed below). Be sure to send the request *certified mail-return receipt requested*. Save a copy of the request and the

signed return receipt to show that the other side (Medical Assistance or the Medical Assistance managed health care plan) got the request.

4. School records, records kept by the County MH/MR office, or other agency or provider records that show how the assistive technology will help you.
5. Your doctor's and evaluating medical professional's statements in support of your appeal. Although the live testimony of your doctor and evaluating medical professional (e.g., physical therapist, occupational therapist, speech-language pathologist, audiologist, ophthalmologist, etc.) at the fair hearing is most effective, sometimes they cannot be available. Appendix 3 contains an outline that they can use to write statements to give to the hearing officer.
6. Detailed description of the assistive technology, including brochures and pictures. Especially if the assistive technology is unusual, a detailed description will give the hearing officer a sense of how the assistive technology works and what needs it is designed to meet.

You can get much of this documentation by requesting it, but there are occasions when you will need a subpoena to get the documentation. A subpoena is a formal order issued by the hearing officer requiring that records be turned over. You can call and request a subpoena from the hearing officer. The name and telephone number of the hearing officer should be in the letter that you receive from the Department of Human Services notifying you of the fair hearing date. A subpoena can only be used to request existing records. A subpoena cannot compel your doctor or evaluating medical professional to write a statement for the fair hearing, as described in # 5 above.

### **C. Witnesses for the Fair Hearing**

Witnesses can include the following individuals:

1. Your doctor and evaluating medical professional (e.g., physical therapist, occupational therapist, speech-language pathologist, audiologist, ophthalmologist, etc.) who can testify about any or all of the following:
  - Your disability, illness, condition, or injury;
  - The reason that the assistive technology was recommended and prescribed;
  - How the assistive technology is medically necessary and will address your needs and functional capacity; and
  - Why the reasons given in the decision notice from Medical Assistance or the Medical Assistance managed care health plan are wrong.
2. The provider of the assistive technology, which can address what the assistive technology is designed to do and how it will address your needs and functional capacity.
3. You, your family members, care providers, personal assistants, support persons, etc. who can testify regarding your disability, illness, condition, or injury; your needs and functional capacity; and how the assistive technology will address your needs and functional capacity.

It is most effective for your witnesses to testify in person. If needed, however, you can contact the hearing officer to arrange for a witness to testify by speaker phone if he or she cannot be available to testify in

person. This option may be especially helpful to enable medical professionals to testify.

It is usually best if your witnesses agree to attend the fair hearing voluntarily. However, if needed, the hearing officer can issue a subpoena that will order a witness to attend. An individual may be willing to attend the fair hearing voluntarily but still need a subpoena to miss work to attend the fair hearing. If you need a subpoena, contact the hearing officer and ask for one to be issued.

Generally, if you do not have a lawyer or advocate to represent you, you will be expected to ask the witnesses questions so that they can explain the facts they know to the hearing officer. You should prepare the questions in advance. To do so, it may be helpful to think about what information each witness has that is important for your case and write down what that particular person's testimony is supposed to prove; then, you can write a list of questions that will help him or her give that information in an organized way. It is a good idea to go over the questions with your witness before the fair hearing so that the person understands the questions and you know what the person will answer.

Medical Assistance or the Medical Assistance managed care health plan will also have representatives attending the fair hearing. You should be sure that your witnesses know that the representatives may also ask questions. You may also want to prepare your witnesses by asking potential cross-examination questions (questions by the other side).

#### **D. Special Arrangements for the Fair Hearing**

You should contact the hearing officer well in advance of the fair hearing to make any special arrangements that you require. These can include requesting subpoenas, discussing accommodations, assuring that the fair hearing is of sufficient length, or arranging for the testimony of witnesses by telephone. The name and telephone number of the hearing officer should be in the letter that you receive from the Department of Human Services notifying you of the fair hearing date.

### **VII. THE FAIR HEARING**

The hearing officer is in charge of conducting the fair hearing. Both sides will have the chance to present evidence, in the form of documents and witnesses, to help the hearing officer understand and decide the case. The hearing officer's job is to determine what the facts are, including resolving any disputed facts. The hearing officer also must apply the Department of Human Services' regulations and policies in deciding whether Medical Assistance or the Medical Assistance managed care health plan should pay for the assistive technology. The hearing officer will issue a written decision a few weeks after the fair hearing is held.

#### **A. The Other Side's Case**

The other side (Medical Assistance or the Medical Assistance managed care health plan) will have the opportunity to present its case first, including witnesses, documents, and other evidence.

## **1. Witnesses: Cross-Examination and Objections**

You will have the chance to cross-examine, or ask questions of, the witnesses that the other side (Medical Assistance or the Medical Assistance managed health care plan) brings to help make its case. It is helpful to know who the witnesses will be so that you can prepare any questions that you may have for them in advance and bring the questions to the fair hearing. You can then add other questions that you think of during the person's testimony so you do not forget to ask them during your cross examination.

If you use the records request letter discussed in Section VI.B. above and included in Appendix 2, you should receive a list of witnesses from the other side before the fair hearing. If you requested but did not receive a witness list, you can object at the fair hearing to the testimony of *any* of the other side's witnesses because you were entitled to have notice and you never got notice. You can also object if the other side tries to present testimony from witnesses not on the witness list. Your objection should be made before any of these witnesses testify. Bring a copy of your request letter and signed return receipt to prove that the other side received your request for a witness list but did not comply with the request.

The general rule for cross-examination is "do no harm." It is okay not to ask questions of the other side's witnesses or only to ask questions when you are certain that the answers will help your case. You may wish to question the other side's witnesses to prove facts that are not in controversy, such as that you are a Medical Assistance recipient and that

the other side received your prior authorization request or program exception request.

## **2. Objecting to Documents**

If you use the records request letter discussed in Section VI.B. above and included in Appendix 2, you should receive copies of all documents from the other side (Medical Assistance or the Medical Assistance managed health care plan) before the fair hearing. You can object at the fair hearing to *any* documents that the other side tries to submit that it did not send you in advance. (You had the right to receive these documents ahead of the fair hearing to prepare, and it is unfair for the other side to try to use them now.) Bring a copy of your request letter and signed return receipt to prove that the other side received your request for documents but did not comply with the request. Your objection should be made as soon as the other side tries to submit any document that it did not provide to you in advance.

NOTE: The duty to provide a witness list or documents in advance is only on the other side (Medical Assistance or the Medical Assistance managed health care plan), not you.

## **3. Other Objections**

The reason given by Medical Assistance or the Medical Assistance managed care health plan in the decision notice that was sent to you is the only reason that can be at issue during the fair hearing. This is because you would not know about or be able to prepare for a reason that you were not told about in advance. Therefore, you should object to any documents or testimony that is offered to support any reason other than the reasons given in the notice.

It is important to note that even though you make any of these objections, the hearing officer may allow the information into the hearing record anyway. For example, if the other side offers a document that you were not given in advance and you object, the hearing officer may give you time to review the document before proceeding but still allow the document to be part of the record. Your objection is also part of the record, though, and can be considered if you later request that the hearing officer's decision be reconsidered. Therefore, it is important for you to make objections during the fair hearing even if the hearing officer does not always follow them.

## **B. Presenting Your Case**

After the other side (Medical Assistance or the Medical Assistance managed care health plan) is done presenting its side of the case, you will be able to present your case, in the form of witnesses, documents, and other evidence.

### **1. Witnesses**

You will have the chance to ask questions of your witnesses to get them to tell the information that is helpful to your case. When you are the witness, you do not need to ask yourself questions, but you should be prepared to make a statement about the important facts. You may find it helpful to make a list of the facts so that you will not forget anything important. The hearing officer may also ask questions of you and the witnesses to help understand the facts. The other side (Medical Assistance or the Medical Assistance managed health care plan) can also cross-examine you and your witnesses. This means that the other side will be able to ask

questions of you and your witnesses to try to get out the facts that it thinks are helpful.

## **2. Documents**

In addition to the testimony of witnesses, you have the right to submit documents or other written evidence to the hearing officer. You should bring an original for the hearing officer, a copy for the other side (Medical Assistance or the Medical Assistance managed health care plan), and keep a copy for your records. You will need to request to have the documents accepted as evidence; this must be done at the fair hearing.

If an issue comes up at the fair hearing and you have a helpful document at home or elsewhere, you can ask the hearing officer to leave the record open (usually for about two weeks) for you to send in the information. In addition to the hearing officer, you will need to send a copy of the document to the other side (Medical Assistance or the Medical Assistance managed health care plan).

## **VIII. CLOSING ARGUMENT OR POST-HEARING LETTER**

You will have the opportunity to make a closing argument at the fair hearing. This is a chance to sum up the facts and explain why the assistive technology device or service prescribed by your doctor should be approved, such as the reasons it is medically necessary. You can prepare a written document in advance or give an oral summary.

For some individuals, it is easier to submit a closing argument in writing after the fair hearing. If that is your preference, you can ask the hearing officer to let you send him or her a post-hearing letter. You must also send

a copy to the other side (Medical Assistance or the Medical Assistance managed care health plan). The letter you write should explain why the assistive technology device or service should be approved based on the evidence presented at the fair hearing, including, if medical necessity was an issue, the reasons that the assistive technology is medically necessary.

## **IX. THE HEARING OFFICER'S DECISION**

The entire appeal process from the date that you request a fair hearing to the hearing officer's decision should take 90 days. You must receive a written decision that states the reasons for the decision and the facts upon which the decision was based. The written decision must also give you information about your appeal rights.

If the appeal takes longer than 90 days, you may request interim assistance. This requires Medical Assistance or the Medical Assistance managed health care plan to provide the assistive technology device or service until the fair hearing decision is issued. A sample request for interim assistance is included in Appendix 4 of this manual.

If you win your appeal, you should contact your doctor, evaluating medical professional (e.g., physical therapist, occupational therapist, speech-language pathologist, audiologist, ophthalmologist, etc.), and the assistive technology provider immediately to make sure that you get the assistive technology as soon as possible. If you are in fee-for-service Medical Assistance (ACCESS or ACCESS Plus), you should call the Medical Assistance Recipient Hotline at 800-433-1324 to ensure that all appropriate paperwork is sent to the assistive technology provider. If you are in a

Medical Assistance managed health care plan, you should contact the Special Needs Unit of the health plan to ensure that all appropriate paperwork is sent to the assistive technology provider.

If you are unsuccessful in your fair hearing, you have the right to request Reconsideration from the Secretary of the Department of Human Services within 15 days from the date of the order. You also have the right to file an appeal in Commonwealth Court within 30 days of the date of the order. Because the deadlines are complicated and overlapping for these further appeals, you should get legal advice as soon as possible after you receive the hearing officer's decision.

As a final note, if you are unsuccessful, your doctor can prescribe the assistive technology and apply for prior authorization or a program exception again, including more documentation of the need for the assistive technology device or service. You can also get another evaluation by a medical professional (e.g., doctor, physical therapist, occupational therapist, speech-language pathologist, audiologist, ophthalmologist, etc.) and get a new prescription from your doctor. Your doctor can then apply for prior authorization or a program exception.

## **X. GETTING HELP**

If you need more information or need help, please contact Disability Rights Pennsylvania (DRP) at 800-692-7443 (voice) or 877-375-7139 (TDD). Our email address is: [intake@disabilityrightspa.org](mailto:intake@disabilityrightspa.org).

The mission of Disability Rights Pennsylvania (DRP) is to advance, protect, and advocate for the human, civil, and legal rights of Pennsylvanians with disabilities. Due to our limited resources, DRP cannot provide individual services to every person with advocacy and legal issues. DRP prioritizes cases that have the potential to result in widespread, systemic changes to benefit persons with disabilities. While we cannot provide assistance to everyone, we do seek to provide every individual with information and referral options.

**IMPORTANT: This publication is for general informational purposes only. This publication is not intended, nor should be construed, to create an attorney-client relationship between Disability Rights Pennsylvania (DRP) and any person. Nothing in this publication should be considered to be legal advice.**

**PLEASE NOTE: For information in alternative formats or a language other than English, contact DRP at 800-692-7443, Ext. 400, TDD: 877-375-7139 or [intake@disabilityrightspa.org](mailto:intake@disabilityrightspa.org).**

## HOW TO APPEAL A MEDICAL ASSISTANCE DENIAL OF ASSISTIVE TECHNOLOGY

### Appendix 1: Sample Appeal Letter to Request Fair Hearing

Note: This letter must be postmarked within 30 days of the date on the decision notice from Medical Assistance or the Medical Assistance managed care health plan. Or, to receive a continuation of services, the letter must be postmarked within **ten** days of the date on the decision notice. This letter should be mailed to the Department of Human Services. If you are in managed care, it is essential to send a copy of this letter to your Medical Assistance managed care health plan if you want a continuation of services. Send the letter *certified mail-return receipt requested*. Also be sure to keep a copy of this letter as well as the signed return receipt.

**[Date]**

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

**[If ACCESS or ACCESS Plus:]**

Department of Human Services  
Division of Operations  
P.O. Box 8171  
Harrisburg, PA 17105

**[If Medical Assistance managed care health plan:]**

Department of Human Services  
Office of Medical Assistance Programs  
HealthChoices Program  
Complaint, Grievance, and Fair Hearing  
P.O. Box 2675  
Harrisburg, PA 17105-2675

Re: Appeal From **[Denial/Reduction/Termination]** of Medical Assistance Services Request for Fair Hearing  
Medical Assistance number: **[insert Medical Assistance number]**

Dear Sir or Madam:

I am writing to appeal the **[denial/reduction/termination]** of **[type of assistive technology device or service]** by **[ACCESS, ACCESS Plus, or name of Medical Assistance managed care health plan]**. The decision notice is dated **[date of notice from ACCESS, ACCESS Plus, or Medical Assistance managed care health plan]**. A copy of this decision notice is enclosed. **[If ACCESS or ACCESS Plus:]** The prior authorization or program exception reference number is **[reference number]**.

I can be reached at **[address and daytime telephone numbers]**. **[You can contact name of representative, who will represent me in this matter, at address and daytime telephone numbers]**. My Medical Assistance number is **[insert Medical Assistance number]**, and my date of birth is **[insert date of birth]**.

I do not agree with the decision of **[Medical Assistance or name of Medical Assistance managed care health plan]** to **[deny/discontinue/reduce]** the **[type of assistive technology device or service]**. I request a fair hearing. I disagree with the decision because **[short description of reason you disagree]**.

I request an **[in-person or telephone]** fair hearing. The hearing will take approximately **[number of hours or days]**, so I request that the hearing be scheduled for this length of time. I need **[describe accommodation(s) or interpreter needed]** because **[give reasons accommodation(s) or interpreter needed]**.

**[If this is an appeal from a reduction/termination of services or a refusal to re-authorize services state the following:]** I request continued receipt of full services pending the resolution of this appeal. This appeal is filed within ten days after **[date on the decision notice, or I did not receive written notice of the ten-day deadline to appeal and maintain benefits, or I did not receive the written notice in time to appeal within ten days]**.

Sincerely,

**[Signature]**

**[Name]**

Enclosure

cc: **[if applicable, Medical Assistance managed care health plan name]**

## HOW TO APPEAL A MEDICAL ASSISTANCE DENIAL OF ASSISTIVE TECHNOLOGY

### Appendix 2: Sample Letter to Request Records and Other Information

Note: This letter should be sent to the Office of Medical Assistance Programs or the Medical Assistance managed health care plan (whichever entity made the denial). Send the letter *certified mail-return receipt requested*. Be sure to keep a copy of this letter and the signed return receipt, and bring both to the fair hearing.

**[Date]**

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

**[Name and address of entity making denial, from decision notice]**

Re: Request for Records and Other Information

Medical Assistance number: **[Insert Medical Assistance number]**

Dear Sir or Madam:

Pursuant to 55 Pa. Code Section 275.3(a), please immediately provide copies of the following items to **[name, address, and telephone number of individual or representative]** regarding the appeal of **[name of individual and Medical Assistance number]** involving the **[denial/reduction/termination]** of **[type of assistive technology device or service]**:

1. Any and all state or federal regulations, manuals, statements of policy, Medical Assistance Bulletins, contracts with the Department of Human Services, rate letters from the Department of Human Services, and other documents containing the rules, regulations, and policies upon which the decision to **[deny/reduce/terminate]** **[type of assistive technology device or service]** was based.
2. Any and all documents, correspondence, notes, or other items that are part of any case file, case record, and other data maintained or possessed by **[the Department of Human Services or name of Medical Assistance managed health care plan]** regarding **[name of individual]**, including, but not limited to, any and all requests for a **[type of assistive technology**

**device or service at issue]** by **[name of individual]**, **[his/her]** family, **[his/her]** physician, specialists, or anyone acting on his/her behalf. This includes any information concerning the evaluation(s) of the **[type of assistive technology device or service]** at issue.

3. Any and all correspondence; emails; electronic or facsimile transmissions; notes of meetings, telephone calls, or other conversations or communications; and all other such documentation regarding the decision to **[deny/reduce/terminate]** a **[type of assistive technology device or service]** to **[name of individual]**.

4. Any and all internal protocols, guidelines, or standards that **[the Department of Human Services or name of Medical Assistance managed health care plan]** relied on to evaluate the **[type of assistive technology device or service requested]** at issue.

5. Information concerning the names, experience, and credentials of any medical or other employees or outside consultants that participated in or were consulted for the decision to **[deny/reduce/terminate]** a **[type of assistive technology device or service]** to **[name of individual]**.

6. Information concerning the names, experience, and credentials of any and all witnesses who will appear on behalf of **[the Department of Human Services or name of Medical Assistance managed health care plan]** at the fair hearing in this matter.

7. Any and all documents or other evidence that **[the Department of Human Services or name of Medical Assistance managed health care plan]** will introduce as evidence at the fair hearing in this matter.

Sincerely,

**[Signature]**

**[Name of Individual or Representative]**

## HOW TO APPEAL A MEDICAL ASSISTANCE DENIAL OF ASSISTIVE TECHNOLOGY

### Appendix 3: Sample Outline of Doctor's and Evaluating Medical Professional's Statements

I, **[Name]**, declare as follows:

1. Identify yourself and your credentials, with particular emphasis on experience with the diagnosis(es)/condition(s) of your patient, the Medical Assistance (Medicaid) recipient.
2. State the assistive technology device or service that you prescribed.
3. Describe your relationship with your patient, including the length of time that you have treated him/her and any evaluations or testing performed.
4. Describe your patient's diagnosis(es) and the effects of the diagnosis(es), including his/her functional capacity limitations/needs caused by the diagnosis(es).
5. Cite the Medical Assistance medical necessity definition and specifically explain why the assistive technology device or service prescribed is medically necessary for your patient to address the functional capacity limitations/needs described above. Citing all relevant medical evidence, explain in detail how the assistive technology device or service is necessary for the proper treatment or management of your patient's illness, injury, or disability by meeting one or more of the medical necessity criteria (prevent illness, condition, or disability; reduce/ameliorate effects; and/or achieve or maintain maximum functional capacity). Carefully describe the assistive technology device or service prescribed. Attach any information you may have on it and cite relevant medical research and journal articles, especially if unusual. If Medical Assistance (including the Medical Assistance managed care health plan) has specific rules for coverage of the prescribed assistive technology device or service, explain how these rules are met.
6. Give information about and credentials of any other medical professional(s) you consulted in making the determination of what assistive technology device or service is medically necessary (occupational therapist, physical therapist, speech language pathologist, audiologist, etc.). State that you have reviewed and concur with any evaluation report(s) by the other medical professional(s). Attach a copy of the report(s) to your letter.

7. Describe any relevant family, support, or environmental information, including limitations or disabilities of family members or support persons. Describe any other relevant information, such as history of compliance, lack of transportation, language issues, etc.
8. Describe any less expensive alternatives that were tried or considered and why they are not appropriate, not adequate, and do not meet medical necessity.
9. Describe any more expensive alternatives with a statement that at the current time, it is more appropriate to start with the less expensive alternative being prescribed.
10. Directly address the reasons given in the decision notice and explain why they are not correct. Explain in detail why at the current time the assistive technology device or service being prescribed is more appropriate than the suggested alternatives.
11. State your prescription again and explain the risks or consequences to your patient if the assistive technology device or service is not provided.

Conclude with the following statement, following with your signature and the date:

I declare under penalty of perjury of the laws of Pennsylvania that this statement is true and correct to the best of my knowledge and belief.

**[Signature]**

**[Name]**

**[Date]**

# HOW TO APPEAL A MEDICAL ASSISTANCE DENIAL OF ASSISTIVE TECHNOLOGY

## Appendix 4: Sample Request for Interim Assistance

[Date]

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

**[If ACCESS or ACCESS Plus:]**

**[Name of Deputy Secretary]**

Deputy Secretary  
Office of Medical Assistance Programs  
Department of Human Services  
P.O. Box 2675  
Harrisburg, PA 17105-2675

**[If Medical Assistance managed care health plan:]**

**[Name of Executive Director]**

Executive Director

**[Name and address of Medical Assistance managed care health plan]**

Re: Request For Interim Assistance

Dear [Deputy Secretary or name of Executive Director]:

On **[date]**, I requested a fair hearing with the Department of Human Services to appeal the **[denial/reduction/termination]** of **[type of assistive technology device or service]** by **[ACCESS, ACCESS Plus, or name of Medical Assistance managed care health plan]**. A copy of the letter requesting the fair hearing and a copy of the signed certified mail return receipt showing the date of delivery is enclosed. The Department has not yet issued a decision. I request that you authorize interim assistance to begin without delay on the 91st day after the appeal as required by 55 Pa. Code Section 275.4. You may reach me **[or my representative]** at **[address and daytime telephone numbers]**. Thank you for your prompt attention to this matter.

Sincerely,  
**[Signature]**

**[Name]**

Enclosure

**cc: [Name of Deputy Secretary, if Medical Assistance managed care health plan]**