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HOW TO GET ASSISTIVE TECHNOLOGY FROM YOUR MEDICAL ASSISTANCE MANAGED CARE HEALTH PLAN

I. INTRODUCTION

Medical Assistance (Medicaid) is a public health insurance program for adults and children, including individuals with disabilities, who meet income and other eligibility rules. In Pennsylvania, Medical Assistance physical health benefits are delivered through ACCESS Plus (primary care case management), managed care health plans (HealthChoices and voluntary managed care[1]), and ACCESS (fee for service). This publication explains how to get assistive technology through a Medical Assistance managed care health plan[2] including the prior authorization process.

Assistive technology includes both devices and services that help a person with a disability to live more independently. Examples of devices are manual wheelchairs, motorized wheelchairs, augmentative communication devices, standers, hearing aids, canes, walkers, and other durable medical

[1] In some areas of Pennsylvania, managed care Medical Assistance is mandatory and is called HealthChoices. In other areas, a Medical Assistance recipient can voluntarily enroll in a managed care health plan.
[2] As of May 2011, Medical Assistance managed care health plans include Health Partners, United (ACPA), Keystone Mercy, Aetna, Coventry, Gateway, United (Unison), UPMC, and AmeriHealth.

equipment, prosthetics, orthotics, and medical supplies. Examples of services are an evaluation, maintenance, repairs, and training on the use of a device. Many – but not all – forms of assistive technology are covered by Medical Assistance, including a Medical Assistance managed care health plan.

II. CONTACT YOUR PRIMARY CARE PHYSICIAN TO FIND OUT WHAT IS NEEDED

If you are in a Medical Assistance managed care health plan, you were assigned or chose a Primary Care Physician. Your Primary Care Physician's job is to be your first contact when you have any health care issues. If you need assistive technology devices or services, including maintenance or repair to a device that you have, contact your Primary Care Physician.

It is important to discuss your needs with your Primary Care Physician and to know what documentation is required to seek assistive technology coverage through your Medical Assistance managed care health plan. Devices and services must be medically necessary, and certain documentation must be provided to the health plan. Your doctor should ask the health plan for any forms or documentation needed. Your doctor should also ask for any coverage rules regarding the specific assistive technology device or service that is being prescribed.

Also, for information and assistance, you can contact your Medical Assistance managed care health plan's Special Needs Unit, which is *not* the same as Member Services. The Special Needs Unit must ensure that

you have information about and access to physicians, specialists, and the services you need. The telephone number for the Special Needs Unit may be on your health plan card or website, or you can contact Member Services and ask for the Special Needs Unit.

If you also have private health insurance, it is important that your doctor and you contact your private health insurance plan for its rules regarding assistive technology coverage. Medical Assistance coverage is secondary to private health insurance coverage.

Your doctor should determine whether the device or service is on the Medical Assistance managed care health plan's fee schedule. The health plan's fee schedule is an extensive list of items that will be covered if medically necessary, but not all assistive technology is on this list. The health plan's fee schedule, however, must contain all of the benefits that are found on the Medical Assistance fee schedule of the Department of Human Services, which administers the Medical Assistance Program in Pennsylvania. A Medical Assistance managed care health plan's benefits cannot be more restrictive than those benefits covered by ACCESS and ACCESS Plus.

Furthermore, under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), children on Medical Assistance under age 21 are not limited to coverage of items on the Medical Assistance managed care health plan's fee schedule but are entitled to medically necessary services, including assistive technology, that are covered under the federal Medicaid statute. Also, if you are age 21 or older, your doctor can request a program

exception asking the health plan to pay for a medically necessary device or service that is not on the fee schedule or to exceed the limit of a particular item on the fee schedule.

Your doctor should also determine whether prior authorization or a program exception is required. Prior authorization or a program exception means that your doctor cannot simply prescribe the item to get Medical Assistance coverage but that the Medical Assistance managed care health plan must first approve the item, including items on the fee schedule. For children and adults, prior authorization is required for assistive technology that costs more than $600 or if the Department of Human Services otherwise requires prior authorization. The health plan can require prior authorization of additional items, but only if it receives approval from the Department of Human Services. If you are age 21 or older, your doctor must seek a program exception for a medically necessary device or service that is not on the fee schedule or to exceed the limit of a particular item on the health plan fee schedule.

If prior authorization or a program exception is *not* required, you usually will only need a prescription from your doctor. Such items may generally include standard durable medical equipment that is on the Medical Assistance managed care health plan fee schedule. Be sure to check with your health plan to ensure that all you need is a prescription. If so, you can take the doctor's prescription to a pharmacy or medical supplier that participates in your health plan. The provider can supply the item and bill

your health plan, after billing any other health insurance that you may have.[3] If prior authorization or a program exception *is* required, the following sections will help you through the process. You can also contact the Special Needs Unit of your Medical Assistance managed care health plan to ask for a case manager to help you through the prior authorization or program exception process.

III. WORK WITH YOUR DOCTOR TO SUBMIT INFORMATION FOR PRIOR AUTHORIZATION OR A PROGRAM EXCEPTION

If prior authorization or a program exception is required, your doctor will need to submit the following documentation to the Medical Assistance managed care health plan:

- Evaluation report
- Doctor's prescription
- Prior authorization or program exception forms
- Letter(s) of Medical Necessity

For complex or custom devices, it may also be helpful to work with a provider of the assistive technology from the beginning of the process. Providers often have staff that knows how to prepare a prior authorization or program exception request. Staff may also help you to get the needed paperwork from your doctor and others. Generally, you must get assistive technology from a provider that participates in your Medical

[3] Remember first to contact any other health insurance plan that you may have because Medical Assistance coverage is secondary to other health insurance coverage.

Assistance managed care health plan. Your doctor may be able to help you find a provider. You can also contact the Special Needs Unit of your health plan for help.

Evaluation Report: Your Primary Care Physician may first want to send you to a specialist for an evaluation to help decide on the assistive technology that will meet your needs. An evaluation is useful and necessary for many types of complex or custom assistive technology, such as an augmentative communication device or custom motorized wheelchair. You will need a prescription for an evaluation and a referral from your Primary Care Physician to visit a specialist. The specialist can be a physical therapist, occupational therapist, physiatrist, audiologist, speech-language pathologist, ophthalmologist, or other licensed medical professional. Generally, the specialist must participate in your Medical Assistance managed care health plan. Your Primary Care Physician or specialist doctor can write a prescription for assistive technology based on the specialist's evaluation report.

If you need a motorized wheelchair, you must have an evaluation at an accredited rehabilitation facility.[4] You will need a doctor's prescription for the evaluation. The rehabilitation facility's evaluator will need to complete the checklist called "Considerations for Motorized Wheelchair

[4] The following websites list accredited rehabilitation facilities: www.jointcommission.org and www.carf.org. Generally, the facility must participate in your Medical Assistance managed care health plan.

Prescriptions," which is found in Medical Assistance Bulletin 01-87-08. This checklist must be submitted to the Medical Assistance managed care health plan. Clarification of "unable to ambulate" can be found in Medical Assistance Bulletin 01-01-02. Medical Assistance bulletins may be found online at: http://services.DHS.state.pa.us/oldDHS/bulletinsearch.aspx.

Doctor's Prescription: To get durable medical equipment or other assistive technology, you will need a prescription from a doctor who participates in Medical Assistance. The doctor will also need to write a prescription for maintenance or repairs to a device that you already have. The prescription should be specific and describe any accessories or adaptations that are needed.

Prior Authorization or Program Exception Forms: Each Medical Assistance managed care health plan varies in the forms it requires for prior authorization or a program exception, so your doctor should contact the health plan for the necessary forms.

Letter of Medical Necessity: Your doctor and specialist evaluator should submit Letters of Medical Necessity. Medical Assistance will only pay for assistive technology devices and services that are medically necessary, and so a Letter of Medical Necessity explains why the assistive technology device or service being prescribed is medically necessary for you.

A device or service is medically necessary if it is covered under the Medical Assistance Program and if it 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 individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for Medical Assistance recipients of the same age.[5]

Therefore, the prescribing doctor and the specialist who evaluated you should submit Letters of Medical Necessity that explain why the assistive technology is medically necessary for you. A suggested template for the letter is attached to this publication. The Letter of Medical Necessity should explain in detail how the assistive technology is medically necessary for you by meeting at least one of the three standards listed in the previous paragraph. It is important to emphasize in the letter why any less expensive alternatives will not meet your needs. For example, if a motorized wheelchair is prescribed, the letter must explain why you cannot use a manual wheelchair to meet all of your mobility needs. If accessories or adaptations are prescribed, the letter should discuss the reasons specific to you why each of them is medically necessary. A copy of the evaluation report should be attached to the letter.

Information about the actual cost of the device, accessories, and

[5] From HealthChoices Agreement, effective July 1, 2010, www.DHS.state.pa.us/ucmprd/groups/webcontent/documents/communication/s_002105.pdf. This definition is also found in Pennsylvania regulation 55 Pa. Code § 1101.21a.

adaptations can be important to include with the Letter of Medical Necessity. This information could include invoices, quotes, catalogs, and other information about cost. Information on actual costs should be included when your doctor is seeking a program exception for the Medical Assistance managed care health plan to pay a higher fee for the assistive technology than is authorized by the health plan fee schedule.

Finally, the request should be mailed *certified mail-return receipt requested*. Ask your doctor or assistive technology provider for the date that the request was mailed and the date that it was received by the Medical Assistance managed care health plan. It is important for you to have a copy of all paperwork that is submitted.

IV. WAIT TWO BUSINESS DAYS FOR A RESPONSE REGARDING PRIOR AUTHORIZATION

The following timeframes do not apply to a program exception request. If prior authorization is requested, the Medical Assistance managed care health plan must within two business days of receiving the request make a decision and orally inform you of its decision. The health plan must then mail written notice of the decision within two business days after the decision is made.

In the alternative, within two business days of receiving the prior authorization request, the Medical Assistance managed care health plan can ask your doctor, specialist evaluator, or assistive technology provider for more information. It is very important that your doctor, specialist evaluator, or assistive technology provider provide any requested

information within 14 days. The health plan then has two business days from the date it receives the additional information to make a decision and orally inform you of its
decision. The health plan must then mail written notice of the decision within two business days after the decision is made.

In all cases, the Medical Assistance managed care health plan must approve or deny the request and you must receive notice of the decision within 21 days of the date the request was received, or the prior authorization request is automatically approved.[6] If the health plan does not make a decision or ask for more information, or if you do not know why the prior authorization request is being delayed, contact your doctor, assistive technology provider, or your health plan's Special Needs Unit.

V. IF APPROVED, WORK WITH YOUR HEALTH PLAN AND ASSISTIVE TECHNOLOGY PROVIDER TO GET THE ASSISTIVE TECHNOLOGY

When your Medical Assistance managed care health plan gives prior authorization or a program exception for the assistive technology, congratulations! You, your Primary Care Physician, and the prescribing doctor must get a written approval notice. The assistive technology provider should supply you with the device or service and bill your health plan, after billing any other health insurance that you may have. If a program exception is approved, the health plan may need to negotiate a fee with the provider.

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[6] From HealthChoices Agreement, effective July 1, 2010, www.DHS.state.pa.us/ucmprd/groups/webcontent/documents/communication/s_002105.pdf.

If the health plan does not have an appropriate provider in its network, the health plan must find an appropriate provider. In any case, you should be promptly provided with the device or service.

VI. IF DENIED, FILE A TIMELY APPEAL

The Medical Assistance managed care health plan may disagree with your doctor and deny prior authorization or a program exception for the prescribed assistive technology. Sometimes, the health plan will approve an alternative device, usually a less expensive one. If so, the health plan must timely send you, your Primary Care Physician, and the prescribing doctor a written notice explaining why the request was denied, including why an alternative device, if any, was approved.

The notice from the Medical Assistance managed care health plan will inform you of your right to challenge the denial, including any approval of a different device, by filing a complaint or grievance with the health plan stating that you disagree with the decision. The notice from the health plan will also explain your right to appeal the denial, including any approval of a different device, by requesting a fair hearing with the Department of Human Services. Your written appeal should state that you disagree with the denial, including any approval of a different device, and are asking for a fair hearing. You have the right to file a complaint or grievance with the health plan *and* to request a fair hearing with the Department of Human Services.

Your written complaint or grievance must be received by the Medical Assistance managed care health plan within the timeframe stated in its

denial notice. Your written fair hearing request to the Department of Human Services must be postmarked *within 30 days* of the date on the denial notice, but it is a good idea to make sure that your appeal is *received* within the 30 days. If prior authorization or a program exception is denied for continuation of benefits, you must submit a written complaint/grievance or fair hearing request within 10 days of the date of the denial notice for benefits to continue pending the complaint/grievance or appeal. Send your complaint/grievance and appeal *certified mail-return receipt requested*, and keep copies as well as the signed return receipt.

After you make a timely complaint or grievance, the Medical Assistance managed care health plan will review the denial, and you must be given the opportunity to attend this review. After you make a timely request for a fair hearing, you will have a hearing with a neutral hearing officer. You will be able to present evidence at the hearing. If you are not successful in the grievance/complaint or fair hearing, you can make further appeals.

It may also help for your doctor to contact the medical director of your Medical Assistance managed care health plan for a doctor-to-doctor consultation. You, your doctor, and your specialist evaluator can also submit more documentation to the health plan while you pursue your complaint/grievance or appeal.

More information on appeals can be found in our publication "How to Appeal a Medical Assistance Denial of Assistive Technology" at www.disabilityrightspa.org/publications.

VII. CONTACT INFORMATION

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.

The mission of the 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 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 Disability Rights Pennsylvania at 800-692-7443, Ext. 400, TDD: 877-375-7139 or intake@disabilityrightspa.org.

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Attachment (2 pages): Sample Template for Letter of Medical Necessity

- Identify yourself and your credentials, with particular emphasis on experience with the diagnosis(es)/condition(s) of your patient, the Medical Assistance recipient.
- Describe your relationship with your patient, including the length of time that you have treated him/her and any evaluations or testing performed, including dates.
- State the assistive technology device or service that you are prescribing.
- 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).
- Cite the Medical Assistance medical necessity definition and specifically explain why the assistive technology 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 will meet 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 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 has specific rules for coverage of the prescribed device, explain how these rules are met. Provide details to justify each feature or

adaptation of any prescribed device.

- Give information about and credentials of any other medical professional(s) (occupational therapist, physical therapist, speech-language pathologist, audiologist, etc.) you consulted in making the determination of what assistive technology is medically necessary. 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.
- 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 good compliance, lack of transportation, language issues, etc.
- Describe any less expensive alternatives that were tried or considered and why they are not appropriate and not adequate, and do not meet your patient's medical needs.
- Describe how the service being prescribed will avoid more expensive alternatives (least costly alternative).
- If there is a Medical Assistance prior authorization denial, including suggested alternatives, explain in detail why the reasons given in the denial notice are not correct. Explain in detail why at the current time the device or service being prescribed is more appropriate than the suggested alternatives.
- State your prescription again and explain the risks or consequences to your patient if the assistive technology device or service is not provided.