DIRECTIONS

Technology in Special Education

Vol. 5 , No. 3 **October 1998**

Medicaid Guidance

Source: Federal Medicaid Administrators Issue Favorable National Guidance Regarding Medical Equipment Coverage

By: Lew Golinker, Esq

Thanks to the advocacy of UCPA staff members, countless other advocates and Clinton Administration officials, Sally Richardson, the Director of Medicaid and State Operations for the U.S. Health Care Financing Administration, the federal government's administering agency for Medicaid, issued guidance to all State Medicaid Directors. Friday, September 4, 1998, will significantly aid Medicaid recipients efforts to obtain access to needed assistive devices and other forms of treatment.

Strong advocacy and Administration support have paved the way for important improvements to access for assistive technology for Medicaid recipients. In an official letter on September 4, 1998 to all state Medicaid directors, the federal government has made clear that Medicaid cannot refuse to fund Medical Equipment based on lists of "approved" items. In other words, a determination about whether an item of Durable Medical Equipment is "medically necessary" must be made with reference to the facts of the particular case.

The State Medicaid Director letter expressly addresses and *prohibits the use of* two defenses currently being raised by state Medicaid programs to oppose providing equipment. It also addresses and prohibits, although indirectly, a third current defense used to deny access to treatment. State Medicaid programs are required to follow the guidance of the administering agency which is, in this case, the U.S. Department of Health and Human Services (HHS).

The letter confirms the interpretation of the Medicaid program that advocates have been asserting for many years: The Medicaid program should be covering and providing a wide range of medicaid equipment and assistive devices to people with disabilities. States cannot raise the defenses

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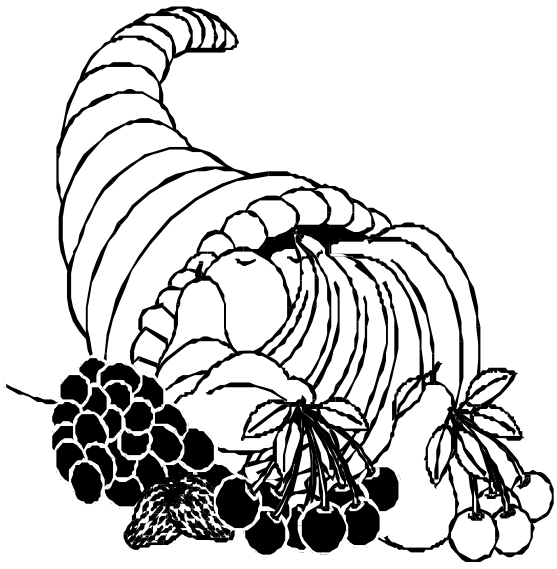

Inside

Accessible Learning

by Lorianne Hoenninger

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Older students with cognitive challenges are one of the most difficult groups to find age appropriate software for. There is a wide assortment of software for young children with special needs, and plenty of software for adults with physical and/or sensory disabilities. Locating software that emphasizes the basics of money, survival reading and vocational skills, in an age appropriate format, with options for customization, is a task that I have spent many hours exploring on the Internet.

Before I delineate my Internet finds, I must mention two outstanding commercial software developers that have taken on this challenge. The Attainment Company (1-800-327-4269) has a catalog of materials and software (Mac and Windows) designed for the older student with disabilities that emphasize basic concepts in math, spelling, language and money skills.

RJ Cooper (1-800 RJCooper or http://www.rjcooper.com) is a long time producer of software (Mac and Windows) for the special needs population. Two products especially worth mentioning here are "**Spell-a-Word" and "2+2"** . Both are large-print, early academic programs for beginning to advanced letter and number users that feature an errorless learning method. Spell-A-Word works on identification, spelling, & word recognition (for reading). 2+2 works on early arithmetic problems. Both have drill and test modes and are designed for you to easily enter lists of spelling words/phrases, or arithmetic problems (like 2+2=4), for the learner to practice and be tested on.

On the Internet, Bill Straub's website at http://www.northcoast.com/~hope/software.htm is treasure trove of shareware for DOS and Windows computers. Titles include **"Talking Community Signs", "Talking Letters and Numbers" and "Talking Money".**

"**Crosspix**" (http://www.softseek.com/Games/Just_for_Kids/Review_12345_index.html) is a fabulous Windows cross word puzzle program that uses picture clues. Vocabulary can be set to the user's reading level, from easy reader to advanced. It speaks each letter aloud as it is typed in, and has some customizable features. Unfortunately, the developer has changed her e-mail and snail mail address since this version was created, so I could not send her the shareware fee and purchase additional puzzles. If anyone knows the correct address, please tell me! I have an 18 year old student begging for more puzzles.

At http://www.latticeworksw.com are several simple Windows games, designed to teach basic skills in Go Fish and Bingo formats. **Roxie's Reading Fish**, for example, is a Go Fish game for preschool to late second grade high frequency vocabulary.

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Authors - We welcome editorial submissions. Please include name, address and phone. Submission will be returned with self addressed stamped envelope, if desired.

Vendors - We welcome product news. Please include pricing and contact name with press releases.

With purchase of the full version, the capacity to add and record customized vocabulary lists is available. Other titles include **Roxie's Math Fish, Roxie's ABC Fish, Penguin Math Bingo** and **Mattie's Math Games**.

For the Macintosh, "**Master Spell"** (http://www.kidsdomain.com/down/mac/masterspell.html) is a digitized speech customizable spelling test program.

Spellright at http://www.kidsdomain.com contains a spelling game, a crossword and a hangman game, with digitized speech and an on screen keyboard. Customization is possible with the registered version.

No list of Macintosh Internet software would be complete without mentioning David Bagno's software. David has created numerous titles, with a visually simple format appropriate for older students, with digitized speech and customization features. Titles include **Sentence Builder, Find the Missing Word, Dolch Sight Word Game, Math Bee, Talking Spelling Teacher and Alphabet Pro.** Unfortunately David does not have his own website, so his software is scattered all over the Internet. http://www.AMUG.com and http://www.gamesdomain.com are two sites that contain many of his titles. For a complete listing, contact David at dbagno@magnet.com

I hope that you find these programs as helpful as I have. Next month, let's explore the world of computer art!

If you have a specific question in the meanwhile, do not hesitate to e-mail me at lorianne@erols.com or write c/o: Accessible Learning Technology Associates, P.O. Box 597, Shirley NY, 11967. §

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that: 1) these devices do not fit within the scope or intent of the Medicaid program; 2) as a state policy, these devices are not deemed medically necessary; or 3) Coverage will not be extended to adults, even though the same equipment is covered and provided to children, under the same program vocabulary and menu of services.

The above excerpts have been taken from a special report received from the Assistive Technology Funding and Systems Change Project last month. If you are interested in a copy of the complete report, or a copy of the letter from Sally Richardson, from the Department of Health and Human Services, please contact us at 607-539-3027 or online at Info@dreamms.org, and we will send you out a copy! §

ATFSCP Notes

The Assistive Technology Funding and Systems Change Project

<http://www.ucpa.org/html/innovative/atfsc_index.html>

MEDICAID FUNDING FOR AUGMENTATIVE & ALTERNATIVE COMMUNICATION DEVICES - PART 2

By Lewis Golinker, Esq.

The Medicare regulations, 42 C.F.R. 414.202, describe the four characteristics a device must have to be classified as DME:

— can withstand repeated use;

— is primarily and customarily used to serve a medical purpose (Medicare guidance states that the equipment "can be expected to make a meaningful contribution to the treatment of the patient's illness or injury,");

— generally is not useful to an individual in the absence of an illness or injury; and,

— is appropriate for use in the home.

Medicare requires that durable medical equipment be prescribed by a physician and included in the physician's plan of treatment for the beneficiary, and that the physician will supervise the beneficiary's use of the equipment. Medicare will pay for DME, as well as for its repair, maintenance and delivery and for expandable and non-reusable items essential to the effective use of the equipment.

AAC devices, e.g., electronic communication devices such as a Dynavox or Liberator, satisfy all of these criteria. Without question, they are durable. Equally true, these devices are recognized as treatment for a range of severe expressive communication disabilities, such as dysarthria. AAC devices are not needed by or useful to a person without a severe expressive communication disability. Despite extraordinary technological advances in the past decade, the state of the art in AAC devices still limits speech production to an extremely slow rate as compared to the normal rate of oral conversation; and the tonal and pronunciation limitations of synthesized voices make them useful only to people whose capability for expressive communication is severely or completely compromised. Lastly, AAC devices are portable.

That AAC devices satisfy all of these criteria is further supported by the more than 20 Medicaid programs and many health insurance policies and benefits plans which classify AAC devices as durable medical equipment, including at least eight Medicaid programs which use a substantially identical DME definition. DME is the most common service used by Medicaid programs to classify AAC devices.

However, the Medicare DME definition can be read to exclude certain AAC devices: i.e., those which are based on a lap-top computer with AAC software. If these devices are reviewed as "computers" instead of as AAC devices, they will not pass the second or third of the DME criteria, stated above. Computers are not primarily and customarily used to serve medical purposes, and clearly are useful to people in the absence of illness or injury. On the other hand, this view of an AAC device arbitrarily focuses on the "package" in which its individual component parts are assembled, rather than on the device as a whole. This is both unnecessary and improper: there are few, if any, meaningful differences between the component parts of an AAC device assembled into a purpose-built "box," such as a Dynavox or Liberator, and those within a laptop computer with speech synthesizer and AAC software.

That electronic, voice-output or speech-synthesizer based AAC devices can be considered sophisticated or "high-tech" devices, or are relatively new technology, is not important in the assessment whether they fit the Medicare definition of DME. Medicare covers other electric or battery powered equipment, including power wheelchairs and scooters. It also covers sophisticated electronic equipment, including CCTV units for persons with severe vision impairments. That AAC technology has evolved primarily in the past two decades is also immaterial. They are widely accepted by every other major funding program and are known to be safe and effective.

Prosthetic Devices

The Medicare statute and regulations define prosthetic devices as devices that "replace all or part of an internal body organ." Other Medicare guidance expands the

definition of prosthetic devices to include devices that "replace all or part of the function of a permanently inoperative or malfunctioning external body member or internal body organ."

The broader "function-related" definition is required because Medicare covers equipment like cardiac pacemakers as prosthetic devices. Pacemakers do not replace all or part of the heart itself. Instead, they provide electronic pulses which regulate and support heart function. Thus, to cover devices of this kind, Medicare acknowledges that "functional" substitution or restoration, rather than actual substitution of the body part itself, is a characteristic of prosthetic devices.

Other, similar, covered devices include cochlear implants. These devices have been covered by Medicare since September 1986. They have two component parts: one is surgically implanted and stimulates auditory nerve fibers; it is connected to an external receiver which captures and amplifies sound. Cochlear implants do not replace the inner ear; rather, they substitute for and enhance its function.

The scope of Medicare prosthetic devices extends beyond those which are surgically implanted in the body. External devices which may be physically attached to the body (e.g., an artificial limb) or which otherwise serve functional substitution roles (e.g., a CCTV) also are covered.

AAC devices — two kinds at least — also are acknowledged and covered as Medicare prosthetic devices. Tracheostomy speaking valves (which are physically attached to the body) and artificial larynxes (an external device) both are covered.

Coverage for the artificial larynx is described in Medicare guidance related to "electronic speech aids," which states:

Electronic speech aids are covered under Part B as prosthetic devices when the patient has had a laryngectomy or his larynx is permanently inoperative. There are two types of speech aids. One operates by placing a vibrating head against the throat; the other amplifies sound waves through a tube which is inserted into the user's mouth. A patient who has had radical neck surgery and/or extensive radiation to the anterior (front) part of the neck would generally be able to use only the "oral tube" model or one of the more sensitive and more expensive "throat contact" devices.

Like a pacemaker and cochlear implant, these devices replace all or part of the function of the person's larynx, when that organ has been rendered inoperative due to disease or trauma. Unlike an artificial heart valve, or artificial ball-and-socket joint for the hip, neither the tracheostomy speaking valve or artificial larynx physically replaces an organ or body part. Rather, they substitute for larynx function and allow users to produce oral speech.

However, the tracheostomy speaking valve and artificial larynx represent only a small sub-category of AAC devices, and are appropriate only for persons with specific diagnoses. Other AAC devices, such as the Dynavox and Liberator, provide the same functional substitution role and same expressive communication opportunity. This class of AAC devices, which produce speech by means of an electronic speech-synthesizer — although not mentioned in the Medicare guidance applicable to "electronic speech aids"— nonetheless fully satisfy the Medicare definition of a prosthetic device:

People recommended for these devices typically have malfunctioning speech or language centers in their brain, neural pathways, and/or oral-motor mechanisms, which may arise from cerebral palsy, stroke, trauma or other cause. Although the larynx of these people may be intact, the larynx is not the only organ which impacts or controls the production of oral speech. The non- or mal-functioning of these other organs can produce speech and language impairments just as complex and severe — and just as effectively overcome by AAC devices — as those caused by a malfunctioning, permanently inoperative, or surgically removed larynx.

These AAC devices, as well as the artificial larynx, also are commonly classified as prosthetic devices under Medicaid, which applies a substantively identical definition.

The Medicare prosthetic device definition contains no criteria related to device components, assembly or manufacture. That electronic speech-synthesizer based AAC devices have parts that are commonly found in computers, or may include a computer and software as elements of an AAC system, are not relevant factors. In this regard, the Medicare prosthetic device definition is broader than the Medicare definition of durable medical equipment, discussed above.

At least one Medicare decision has reached the conclusion that speech-

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synthesizer based AAC devices are prosthetic devices. This decision was reached by a federal administrative law judge. It is known as In re: Emyln J. and is discussed further, below.

Speech Language Pathology Services

Medicare covers speech-language pathology services provided in a clinic, rehabilitation agency, public health agency or outpatient department setting, as well as speech-language pathology services provided as a home health benefit for beneficiaries who are "homebound." To be eligible, the beneficiary must be under the care of a physician and have a plan of care that identifies the need for skilled speech-language pathology services. The plan of care must show how the services "relate directly and specifically to an active treatment regimen" for an illness or injury, which most often will be developed jointly by the physician and SLP.

Special characteristics of the services which have implications for AAC intervention include:

— the services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition;

— the services must be of such a level of complexity and sophistication, or the condition of the patient must be such, that the services required can be safely and effectively performed only by a qualified speech-language pathologist or under an SLP's supervision;

— the services must be provided with the expectation that the patient's condition will improve significantly in a reasonable, and generally predictable, period of time, or the services must be necessary to the establishment of a safe and effective maintenance program;

— the amount, frequency, and duration of the services must be reasonable.

Medicare recognizes that therapy services can be covered even when full or partial recovery is not possible. Instead, the three key factors are whether the beneficiary needs skilled services; whether s/he will be capable of functional improvement and whether s/he requires design of a maintenance program to protect current functional levels or slow loss of functional abilities.

Medicare classifies SLP services into two categories: diagnostic and evaluation services and therapeutic services. Diagnostic and evaluation services identify the cause and severity of a speech and language disability. Therapeutic services are further sub-divided into restorative therapy and maintenance programs. Restorative therapy consists of services to significantly improve the patient's condition, while maintenance therapy consists of design of a program for the functional maintenance of the beneficiary's current level of functioning.

Medicare, in contrast to Medicaid, 42 C.F.R. 440.110(c), makes no mention of "equipment" also being covered under this service. Thus, it may be difficult to argue, as it has successfully been argued under Medicaid, Meyers v. Reagen, 776 F.2d 241 (8th Cir. 1985), that AAC devices must be covered under Medicare as an SLP service. Notwithstanding the Medicare guidelines' silence regarding equipment, AAC intervention satisfies all the specific requirements for Medicare SLP coverage. As to the first two criteria, evaluation of the need for and recommendation of an AAC device is a skilled service that must be performed by an SLP, perhaps in concert with other rehabilitation services providers, and AAC intervention has been recognized since 1981 as within the scope of practice of speech-language pathologists. As noted above, AAC intervention is well recognized as a form of treatment for severe expressive communication disabilities.

It is beyond question that the opportunity to use an AAC device will provide an immediate, extraordinary improvement in the user's expressive communication abilities, which will continue to improve as the person's familiarity and skill with the device increases. And utilization of an AAC device will be reasonable because this intervention will be recommended only when no other form of treatment will be able to provide comparable benefits.

Regardless whether Medicare will cover AAC devices under SLP services, it should nonetheless provide payment to an SLP for a diagnostic evaluation which identifies AAC intervention and recommends a specific AAC device as treatment. It also should pay for the SLP's development and periodic oversight of an AAC treatment plan. However, because it is well known that school teachers, parents and others are called upon — often out of necessity to provide ongoing AAC training services, these are not considered skilled SLP services, and will not be reimbursed. At this point, it is

possible to form some preliminary conclusions: Medicare will cover and provide reimbursement to an SLP for evaluation and assessment that identifies a beneficiary's need for AAC intervention, for recommendation of a specific AAC device, and for development and periodic oversight of an AAC intervention treatment plan. Medicare also provides at least two covered services: durable medical equipment and prosthetic devices that can reasonably be interpreted to include AAC devices. In regard to prosthetic devices, some AAC devices already are identified as covered; other AAC devices also should be covered because they provide the same functional benefits.

General Program Exclusions

In addition to finding AAC devices classified under one or more Medicare covered services, the inquiry must proceed to examine whether there are any applicable general program exclusions which may bar Medicare coverage of AAC devices. The answer is no.

Medicare guidance lists at least 20 general program exclusions for specific forms of treatment and equipment, but only two of them need be considered in regard to AAC devices. The first is the requirement that the equipment be "reasonable and necessary," and the second is that the equipment not be a "personal comfort item."

The "reasonable and necessary" standard is Medicare's phrase for "medical necessity." As with Medicaid, there is no serious question that AAC devices — in general — can satisfy this standard. AAC devices are treatment; they are not recommended except as a last resort, i.e., when there is no alternative form of treatment which is likely to be of benefit; and they are known to be safe and effective, as compared to being medically unproven, experimental or investigational. AAC intervention is not new, and it has long been generally accepted by the professional medical community as well as by other, similar health services funding programs.

In addition, AAC devices are not "personal comfort items." Those are items which "do not contribute meaningfully to the treatment of an illness or injury." While items such as radios and televisions (for patients in hospital settings), air conditioners, and beauty and barber services (for beneficiaries at home) are identified as being for personal comfort, no comparison exists to the need for, role, use, or benefit from AAC devices.

Are AAC Devices Covered or Excluded?

Based on this review of both the definitions of Medicare covered services, and its general program exclusions, it is reasonable to conclude that Medicare does and will cover AAC devices, and will provide reimbursement for their purchase in individual claims.

Medicare Claims Processing & Appeals

Medicare operates like many health insurance providers in its claims processing procedures. A beneficiary is required to order a device or purchase a device from a Medicare enrolled supplier, then submit a claim for reimbursement. Unlike Medicaid, "prior approval" before device purchase or delivery generally is not required. That concept applies in Medicare only to a very small number of devices. Medicare also operates like an insurance policy by having both a deductible amount ($100), as well as a beneficiary co- payment (20% of the reasonable charge).

A supplier can require the beneficiary to pay for the device in full, or the supplier is permitted but not required to "accept assignment." Accepting assignment means that the equipment vendor is willing to order and provide the equipment while awaiting payment from Medicare, rather than requiring advance payment from the beneficiary.

Claims for Medicare reimbursement, including SLP reports, physicians' prescriptions for the equipment and any other documents are sent to one of four Durable Medical Equipment Regional Carriers (or DMERC), which each have specific, geographic responsibilities for claims processing. (names and addresses of the DMERCs and their services areas are attached). The DMERC staff is required to determine whether the requested device is covered and if the documentation establishes the device to be reasonable and necessary for the beneficiary requesting reimbursement. If these criteria are satisfied, the DMERC also determines the "reasonable" cost of or "charge" for the equipment, and from that total, Medicare provides 80 percent reimbursement, less the $100 deductible.

The DMERC personnel are required to apply the Medicare law, rules, and other guidance in making these

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determinations, and it is here that people seeking AAC devices are likely to experience barriers. One of the Medicare guidelines the DMERC will review is known as the Medicare "DME Reference List." For many, many years this list has described AAC devices as "convenience items," which are "not medical in nature." A second reference to "speech teaching machines," describes them as "educational in nature," and not "medical in nature." Although the SLP report may explain in detail how characterization of an AAC device as a convenience item is inappropriate, how it is treatment and therefore medical in nature, how it is not "educational," and profess ignorance as to what is a "speech teaching machine," beneficiaries should expect the DMERC first level decision to be a denial.

Medicare Appeals

The initial determination of a Medicare claim is called an "explanation of Medicare benefits" (EOMB). If it is a denial, as expected for an AAC device reimbursement request, it will state the appeal process and the beneficiary should pursue that process immediately. There are five steps or levels of review, and it is essential that Medicare beneficiaries not be deterred by the number of steps, by the time required to pursue them, or by the likelihood that adverse decisions will be issued at the first levels of appeal. The key is to continue, to refuse to abandon the appeal or accept a "no" as the final answer.

— The first appeal step is simply an on-paper reconsideration of the claim by the DMERC. This is unlikely to result in a favorable outcome because the guidance being applied is the same as in the initial decision. While this step cannot be skipped, the adverse decision should be ignored, and a request for a second level review should be requested immediately.

— The second appeal step is a hearing before a hearing officer employed by the DMERC. It is possible to anticipate that the DMERC will continue to refuse to change its decision at this level as well.

— For any AAC devices that cost more than $500, the next level of review is a hearing before a Federal Administrative Law Judge (ALJ). Medicare beneficiaries should anticipate this as the first point in the entire process where a fair and legally-based decision can be anticipated. Unlike the DMERC, the ALJ does not follow Medicare manuals and informal guidance. The ALJ will follow the Medicare Act and rules, and it is at this level that an AAC device previously was approved for Medicare reimbursement. In re: Emyln J. discussed below.

— If, for some reason, the ALJ rejects the appeal, the fourth step is an on-paper review by a body known as the "Appeals Council."

— The fifth step, by a Federal court judge, is for AAC devices costing more than $1,000.

In August 1993, a Federal Administrative Law Judge issued a decision that upheld Medicare coverage and ordered reimbursement for a computer-based AAC device. Although anecdotes over the years have suggested that other Medicare beneficiaries also received funding approvals for electronic speech synthesizer-based AAC devices, this is the only Medicare decision ever produced related to AAC device funding.

The Medicare beneficiary, Emyln J., in his late 60's, suffered a stroke which caused severe physical disabilities, including the inability to speak. The decision correctly noted that the inability to speak was caused by the injury to the beneficiary's brain.

As part of a course of post-stroke rehabilitation services, Emyln J. was introduced to a computer-based AAC device, which restored his potential for oral expression. The computer apparently also was used for cognitive rehabilitation. The computer and AAC software were later prescribed for Emyln J.'s use by his treating physician.

Claims were then filed to Medicare seeking reimbursement for the cost of the AAC device. The claims initially were denied on the basis that computers are not a covered benefit. The initial levels of appeal also were unsuccessful: the reason provided was that computers did not meet the Medicare definition of durable medical equipment, and the device was not believed to be necessary to treat an illness or injury.

The Medicare administrative law judge who reviewed the appeal continued to consider the request as one for a computer, albeit for communication purposes, rather than as a communication device. By maintaining that the device was a computer, the ALJ agreed with the earlier decision that the device could not meet the Medicare definition of DME: a computer cannot satisfy the

criteria that the device "is primarily and customarily used to serve a medical purpose;" and "is generally not useful to a person in the absence of illness or injury."

But unlike the prior decisions, the ALJ continued his analysis. He then reviewed whether this device matched the Medicare prosthetic device definition, and concluded that it did.

The Act does not preclude a computer from being a prosthetic device. In fact, due to the peculiar facts of this case as well as the unusual medical and related facts involved, it clearly satisfies the statutory definition of a prosthetic device as it replaces part of the function of an impaired body organ, Mr. J.'s brain. In today's changing and evolving world with regard to computers and how they are applied with regard to disabled people means that the way in which prosthetic devices are viewed and defined is ever evolving. This case is a clear indication of how a computer can replace a damaged brain as a result of a stroke in a way that was not anticipated in the past. As a result, the undersigned determines that reimbursement for the claimant's computer/supplies is warranted.

To this ALJ, the facts were unusual, but there is nothing in Emlyn J.'s facts or decision that limits its applicability to any of the thousands of Americans who are predicted to be able to benefit from voice-output AAC device intervention. All will have similar or comparable expressive communication impairments; all will be recommended for an electronic speech-synthesizer based AAC device, which may be either computer-based or assembled within a purpose-built "box;" and all these AAC devices will provide functional substitution for the person's malfunctioning brain, neural pathways, and oral-motor structures, and will restore the person's ability to use oral speech to communicate.

For all of these reasons, the Emyln J. decision should be considered unique only because it is the first of its kind. Its rationale can and should be used repeatedly by other Medicare beneficiaries who are seeking AAC device reimbursement.

What Do I Do Now & Future Policy Reform

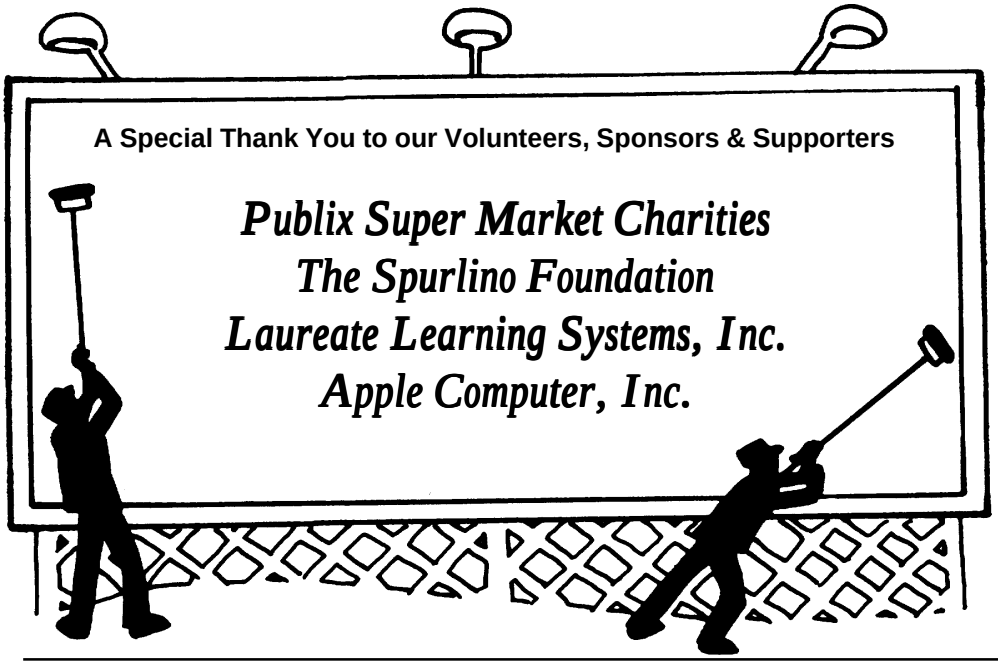
This report is intended to reinforce and support Medicare beneficiaries conclude that this program will cover and provide reimbursement for AAC devices. Learned helplessness may have allowed Medicare to escape having to consider many claims related to AAC funding, but there are no legal impediments within the Medicare program to a successful outcome.

The question, then, is what strategies should be followed to require Medicare to respond. Also, what is the likely Medicare response to each strategy? This report identifies three strategies: individual appeals; request for a formal policy review of the current Medicare guidance which bars DMERC approval of AAC device claims; litigation alleging the current Medicare guidance on AAC devices constitutes disability (diagnosis based) discrimination.

Each of these strategies has different strengths and weaknesses, and will yield different results. For this reason, it is recommended that all should be considered and pursued jointly.

A strategy of individual appeals is discussed in detail, below.

A direct request to Medicare to change the existing guidance is possible through a request for a policy review. But this process is not tied to any particular time frame, and there is no effective recourse if Medicare declines to respond. It also requires a prior commitment of significant professional resources: as a pre-requisite, AAC intervention professional literature and funding policies and practices all must be amassed and then submitted to HCFA for review. There also does not appear to be an effective means to challenge a Medicare decision not to change the existing guidance.



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A lawsuit directly challenging the existing guidance as disability based (diagnosis based) discrimination may be the most direct means of attacking the current guidance. This approach is more desirable than a request for policy review because the court process will follow a predictable course. However, the same professional resources required to prepare for a policy review also must be applied to litigation, and in addition to the substantive issues, Medicare may have strong procedural arguments to block the court's substantive review of the issue. These will require further research and discussion before they are pursued.

Individual Claims and Appeals

Individual Medicare claims and appeals will secure reimbursement for Medicare beneficiaries, one by one, and may have positive effects on Medicaid programs, which is described below. However, individual appeals are slow, and if a goal is to eliminate the existing DMERC guidance that precludes first level approvals of claims, it may take years before an individual appeal reaches a stage where that guidance becomes an issue under review.

For people who currently are Medicare beneficiaries, the best advice and recommendation is simply to "just do it." Overcome learned helplessness and file Medicare claims whenever it is possible to do so. And if those claims are denied, pursue every available appeal until the final outcome is "yes."

Not all current Medicare beneficiaries may be able to immediately act on this recommendation. Medicare requires either a prior purchase or that the vendor accept assignment as a pre-condition to filing a claim. Because there is no history of Medicare approval of these devices, it is unlikely any AAC vendor will agree to accept assignment. Thus, only those Medicare beneficiaries who can afford to purchase an AAC device will be able to file claims and seek reimbursement.

In addition to those individuals, every state Medicaid program also can pursue Medicare reimbursement for the cost of AAC devices purchased for people eligible for both Medicaid and Medicare. It is anticipated this will include a substantial percentage of the state's adult Medicaid beneficiaries. The Medicaid third party reimbursement regulations obligate Medicaid programs to pay claims when it is not established when the claim is filed that another funding source is responsible for payment, and then to pursue those third party sources for reimbursement for its expenses.

If Medicaid programs seriously pursue this procedure, there will be benefits to the state in terms of lower Medicaid expenditures, but there also will be benefits to people with disabilities who require AAC devices. First, because the net cost is reduced by Medicare's reimbursement, states are likely to be less objecting to coverage of AAC devices for adults, reducing the need for court challenges to adult exclusions. In addition, states also are more likely to adopt strong Medicaid AAC funding criteria for all beneficiaries, particularly in regard to the initial AAC evaluation and recommendation, such as the one incorporated in the AAC Model Policy (1995).

If states adopt an aggressive policy regarding Medicare reimbursement, they also may establish a revolving fund that may be used by people who are not eligible for Medicaid, but who do not otherwise have the resources to purchase a device and thereby start the Medicare claims and appeals process. Alternately, state assistive device loan programs may establish policies that assist people in those circumstances.

Conferences & Events

Date: December 6 - 9, 1998
14th Annual DEC International Early Childhood Conference on Children with Special Needs.
Chicago, IL
Contact: 1-888-232-7733

Date: January 28 - 30, 1999
17th Annual International Conference - Technology, Reading & Learning Difficulties
San Francisco, CA
Contact: 510-594-1249, 888-594-1249, FAX: 510-594-1838

Date: March 16 - 20, 1999
Technology and Persons with Disabilities, CSUN.
Los Angeles, CA
Contact: Not yet available

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Medicare beneficiaries pursuing individual appeals can be supported by state Protection and Advocacy programs and by the Assistive Technology Law Center, which will provide, at no cost, individualized consultation and other assistance to any person seeking Medicare reimbursement for AAC devices.

Conclusion

Medicare is a giant untapped resource for people needing AAC devices. The Emyln J. decision can be viewed as an "ice breaker" for successful individual appeals; at the same time, advocates as well as AAC professionals must invest in further research and strategy development regarding elimination of inappropriate Medicare guidance.

3/97 - Assistive Technology Funding & Systems Change Project - UCP

The opinions expressed herein do not necessarily reflect the position or the policy of the U.S. Department of Education, and no official endorsement by the U.S. Department of Education of the opinions expressed herein should be inferred. §

E-Mail Bulletin Board

Private School in Florida

Do you have information regarding private schools for children with physical handicaps? I have a daughter entering sixth grade who has cerebral palsy and is working at or a little below grade level. I am interested in a private school in Dade or Broward County, Florida.

MerlingJD@aol.com

Adaptive Tricycle

I am the service coordinator for a family support program inn Winston-Salem, NC called Triad First In Families. We try to locate items for families that have children with developmental disabilities, empowering the family to decide what is best for their lives an what their children need. A mother has come to us requesting a Tonicross Tricycle, foot supports, leg abductor system with two back/trunk supports. Do you have any suggestions or know of a clearing house for used adaptive equipment for children like this? New this will cost around $1,500.00. Thank you,

TriadFIF@netunlimited.net

Liberator for Sale

I have a Prentke Romich Liberator 1 with a Unity program and infra red sensor installed for sale. It was originally purchased in 1991 and is in good condition. Can be accessed with or without the infra red. Asking price $2800 (no carrying case, memory transfer cable included) Perhaps you know of a client in need of this device that cannot afford one otherwise. My 12 year old son was more successful using a Dynavox, therefore we are selling the Liberator. Please feel free to post my name and number in Rochester, NY

patzee@frontiernet.net

Baseball for the Visually Impaired

My sister in law is looking for a baseball that beeps so a visually impaired child will be better able to catch it. My nephew has ocular albinism and it is difficult for him to play catch with his fully sighted brother. Can you suggest a source?

EBHanley@aol.com

Piano Adaptation

I am looking for adaptive technology for a spinal cord patient so that he can use the pedals of a standard piano Any ideas??? Thank You for your time and consideration

rpbrock@earthlink.net §

Look for this new feature monthly in DIRECTIONS!

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