

## **Medicaid Funding Assistive Technology in Delaware**

Assistive technology (AT) is covered by the Delaware Medical Assistance Program (Medicaid) when it is medically necessary, covered under the State Plan, and prescribed by a physician. (The one exception to the State Plan requirement is the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for persons 0-21 years old. These individuals may access additional specialized equipment not available to other Medicaid members.) In the insurance world, AT may also be known as durable medical equipment (DME), home medical equipment, or prosthetic devices.

### **Medicaid Eligibility**

Two main categories of persons are eligible for Medicaid: poverty level-related groups and Supplemental Security Income (SSI)-related groups. Those qualifying for the poverty group must have incomes below a certain level, which is usually a percentage of the federal poverty level.

However, there are subgroups such as pregnant woman, children, and certain workers with disabilities who may qualify with higher incomes. The SSI group is made up of persons who are 65 or over, blind persons, and persons with permanent disabilities.

### **Medicaid Variations**

Each state devises a plan describing how it will follow the federal Medicaid guidelines and how it will administer the Medicaid program.

Delaware administers the Medicaid program in three ways. All three programs follow the State Plan and provide the same basic services. A brief description of the three program variations follows.

In the traditional fee-for-service program, the State directly reimburses Medicaid-authorized providers for covered services. Only a small percentage of Medicaid recipients (residents of long-term care facilities, dually eligible Medicaid/Medicare recipients, those needing a provider not available through a managed care plan, those eligible for the HCBS waivers) are enrolled in this program.

A Managed Care Organization (MCO) receives reimbursement based on a monthly rate for each beneficiary they cover. An MCO establishes its own network of authorized providers and makes approval or denial decisions on services based on its own internal procedures. Most Medicaid recipients in Delaware belong to one of the two MCOs, Diamond State Partners (managed by the state) or Delaware Physicians Care, Inc. An MCO has the option to provide services beyond those prescribed by the State Plan.

Home and Community Based Services (HCBS) waivers are intended for persons who require an institutional level of care but who, with medical and support services, are able to remain at home or in community settings. Medicaid recipients eligible for HCBS waivers are covered under fee-for-service Medicaid and receive additional services based on their disability. Delaware has four waivers—mental retardation/developmental disabilities, elderly/disabled, AIDS/HIV, and assisted living. A brain injury waiver is pending.

### **Obtaining AT and/or Related Services**

Medicaid will purchase, rent, or lease AT if a physician prescribes it and it is considered medically necessary. The first and most important step in developing an effective medical necessity justification for AT is the completion of a thorough assessment by an appropriate, certified healthcare professional. Generally, medically necessary AT is:

- directly related to a diagnosed medical condition
- sufficient to reasonably achieve its purpose
- the least costly alternative,  
and
- used to restore or approximate normal functioning of a missing, malfunctioning, or malformed body part, and
- expected to improve the user's ability to function.

Unless available through a Home and Community Based Waiver, Medicaid does not cover environmental modifications or adaptations made to an individual's home or vehicle. Visit <http://www.dati.org/funding/medicaid2.html#medical> for Delaware Medicaid's complete medical necessity definition.

### **Equipment Prescription and Claim Submission (Fee-For-Service/HCBS)**

After the assessment, the doctor writes a prescription and a Letter of Medical Necessity (LMN) justifying the need for the AT. Certain equipment, such as motorized wheelchairs, may require a prescription from a specialist. The patient then takes the prescription to an AT supplier. The supplier must be enrolled with Delaware Medicaid as a DME provider in order to bill and receive payment from Medicaid. The doctor sends the LMN to Medicaid. (Any supporting documentation should be sent to Medicaid along with the Letter of Medical Necessity.)

The supplier completes a Certificate of Medical Necessity (CMN), which includes information such as the supplier's name, the patient's name and Medicaid ID number, and the diagnosis. Next, the supplier sends the CMN to the doctor for his/her signature. After the doctor returns the completed CMN to the supplier, the supplier submits it to Medicaid for an authorization number. This number enables the supplier to bill for the AT and related services.

### **Equipment Prescription and Claim Submission (MCO)**

Both of Delaware Medicaid's MCOs require prior authorization for all AT purchases. This means that an MCO case manager must review the doctor's prescription and the LMN before authorizing an AT purchase. An MCO maintains its own list of doctors, health care providers, and AT suppliers that a member must use. (As of January 2002, MCOs are required to make referrals to a non-network provider when the network provider is unable to provide medically necessary services or cannot do so within a reasonable period of time. Other claim procedures, such as involvement of the supplier and preparation of the CMN, are generally similar to those described relative to Fee-For-Service coverage.

### **Equipment Ownership**

Any AT purchased through the Medicaid program belongs to the beneficiary. In some cases, Medicaid will cover the cost of equipment repair, new batteries, etc. Medicaid will also consider requests for replacement AT when a beneficiary's needs have changed substantially.

**Contact Information**

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